

Ambiguities and Complexities of Obtaining Value for Money in the National Health Service: Storytelling Approach

Zrinka Ana Mendas

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I dedicate this thesis to my father who is fighting his long-term illness with a remarkable courage. His unbreakable spirit has inspired me to complete this journey.

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Russian psychologist Vygotsky (1983, p.77) once wrote about disability: ‘...in the social world deafness is a more severe handicap because it prevents mastering of speech, blocks verbal communication, and bars entry to the world of culture...’ The doctorate has become my quest for overcoming this. To achieve this I needed not only an explorer of new ideas but also a true believer in me. I am heavily indebted to my principal supervisor, Professor Robin Matthews, for leading me through this journey of discovery. He has been the best mentor one could possibly wish for, providing me with the environment in which to flourish and grow. I am especially grateful for his numerous discussions on deconstruction, Différance, and the nature of ‘*Other*’. I am also indebted to Sue Balmer for her kindness and generosity in sharing her thoughts on the problems facing the National Health Service, and for organising the interviews. Without both, this thesis would never have taken the shape I wanted it to have.

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ABSTRACT

This thesis examines a quest for Value for Money in the United Kingdom National Health Service, and how this quest has evolved over time. In the 1980s and 1990s the main issue was efficiency. After 1997 the focus shifted to effectiveness in achieving centrally determined targets. This thesis argues that in spite of considerable achievements, the Value for Money approach has “crowded out” CARE. Essentially, CARE involves sympathy, empathy and compassion. It has so many different manifestations in practice that a) it can only be shown through narratives, and b) this requires a more decentralised–bottom up–approach than has been adopted by the Value for Money strategy.

We represent Value for Money as a Grand Narrative in the sense of Lyotard (1979, 1984), and treat it as a representation of the archetypal Net Present Value model. The Grand Narrative is adapted to form the proposition of an Adapted Grand Narrative; that is, if implementers of the Value for Money strategy have different views of the categories than the designers of the strategy, then it will not be carried out as originally conceived.

To capture the idea of CARE, a story approach, which we summarise as multi narratives, is adopted. The multi narratives derived from interviews are deconstructed using panel data, further stories and Socratic Dialogue, including ongoing academic dialogues. Using an open-ended interview approach, we find that disparity exists between the Value for Money strategy as perceived by the strategy designers in one part of the National Health Service hierarchy (or network) and those implementing the same strategy in another.

The methodology adopted in the thesis becomes part of its recommendations. Asking people who implement strategies to tell individual stories that illustrate CARE will enhance the Value for Money strategy, and CARE can then become a route for enhancing the existing Value for Money strategy by placing value on the stories about the delivery of CARE. CARE, we will demonstrate, has multidimensional qualities, with some unique characteristics determined by situations and experiences. The framework of the approach emerges from a wide range of current and historic literatures related to Value for Money, ranging from the models of Irving Fisher to postmodern and post-structural perspectives of deconstruction, narratives, Socratic Dialogue, Différance, and the presence of the ‘*Other*’. This multidisciplinary approach constitutes a significant contribution to the body of academic knowledge. In addition to this academic contribution, practical aspects result from the commissioning of parts of the study by the National Health Service.

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1. INTRODUCTION

Introductory Aims and Rationale

This introductory chapter is designed to introduce the reader to numerous aspects of the thesis that draw on a multidisciplinary approach: such as Fisher's (1930) Net Present Value model; deconstructionism; postmodernist and post-structural approaches; Derrida's (1982) Différance; Matthews' (2002) archetypes; Boje's (2001) storytelling; and also economics, demographic issues and health care service policies.

This thesis examines the ambiguities and complexities of obtaining Value for Money in the National Health Service in the United Kingdom. This is a vital issue, given population trends, public aspirations and scrutiny of taxation, and recently the pressures of global debt. It is also concerned with the issue of improving Value for Money – that is, getting better Value for Money in the National Health Service.

The focus of this dissertation is that Value for Money evolves through time. When the strategy first came to the fore in the 1980s and 1990s, the main issue concerning Value for Money was that of efficiency. Later, we argue that the drive for Value for Money has also become one of effectiveness in achieving goals. In turn, the question of effectiveness becomes an issue of trying to foster a spirit of empathy and compassion, qualities so necessary to CARE.

Context

Achieving CARE with efficiency involves very subtle demands upon the health service. It also demands new approaches to research, both (i) with respect to this dissertation, and (ii) with respect to further research which will be necessary to achieve continuous improvement in health services. Generally, the study argues that

considerable gains have been made in efficiency and Value for Money in the National Health Service, and that the evolution of the service in order to improve further requires attention to the issue of CARE as well as adaptation of the Value for Money strategy. One of the concerns of the research is to consider how this adaptation can be achieved. It will require a different approach to research; instead of focusing only on targets and outcomes, attention needs to be shifted towards the stories of stakeholders in the health service.

Complexity

Consider the following two stories, each representing a summary of the experience of a participant in the study. Together they reflect the balance between Value for Money and CARE. It is argued in the thesis that important aspects of CARE can be shown by stories more effectively than they can be defined in dictionary terms. One story illustrates the complexity of achieving tangible Value for Money outcomes. The other story illustrates an aspect of what is meant by CARE, or the lack of it. Both stories were longer and less direct in their original form, and are reported, for brevity, in indirect speech. It is recognised that the narrator, in this and many other sections of the thesis dealing with responses, stories and narratives, is an objective observer to the extent that the process is made transparent, but the involvement of the researcher is recognised and is indeed part of the research process. A participant in the study told the following contrasting stories, which illustrate just how complex it is to pursue both Value for Money and CARE.

Story 1

A crisis: A relative visiting her house began to miscarry ... National Health Direct (a hotline) was called. The call was answered immediately, simple advice was given and the participant was assured that the emergency services (response team) would come within the hour. It was peak traffic time ... The response team arrived within half an hour, already briefed on the situation ... After temporary remedial action and the patient and the family reassured, she was taken to the hospital. Tragically, she lost her baby but her situation was stabilised ... Over the next twelve hours, the staff continued to care for the patient physically, taking account of the trauma of the situation and treating the issue as a family problem ... The next day she returned to her family.

Story 2

A crisis: An old woman in her late nineties, was taken ill and hospitalised. She was unconscious when the rest of the family arrived. A young consultant explained that things were not clear. Drugs might be tried, or exploratory surgery. Doing nothing or using drugs or an operation to explore the condition would all be risky. He decided to operate.

The participant narrates the story as follows. “When we saw my mother afterwards, we could see she was dying. She died during the night. We thought: Drugs might have worked, but drugs were risky too. No one is perfect. But exploration surgery! What did he expect to find in someone nearly one hundred years old? We needed to understand. Just talk about it.”

A senior consultant arrived; the family (niece, brother and herself, her niece very distressed) were ushered (“more like herded”, she said) into a corner of the ward. Curtains drawn, but no real privacy. They wanted to talk it through, not complain or blame; perhaps we blamed ourselves. The consultant snaps: “Let’s deal with this once and for all; I will deal with this now. What’s your problem?” He went through things smartly; first this; then that; then that’s all. And off he went. ‘I think one of us said; ‘She would have liked a letter from the Queen on her hundredth (birthday).’ My grandmother said she was looking forward to it’.

These two stories encapsulate the differences we are highlighting in this study. From the participants’ points of view, one situation was dealt with efficiently and with care, while the other was dealt with, probably as effectively as could be expected, but with a lack of care. In both situations we rely on perceptions. The contrast between the stories, we think, gets us closer to the meaning of CARE than does a dictionary definition. The essence of CARE involves ‘feeling as if one was the other’, but it is difficult to capture the meaning of CARE, in the sense we are using it in this thesis, with a dictionary definition alone. CARE, in the sense used in this thesis, has an emotional content. Empathy, for example, appears as an injunction in many religious texts, possibly the most famous being the instruction to “Love one another”, attributed to Jesus.

One of the contentions of the thesis is that what we mean by CARE can be shown, but perhaps not precisely defined. The meaning of CARE is shown by stories about CARE. The second story above illustrates CARE. The second story especially has

further aspects that are returned to in the thesis. To an extent it is chaotic and disordered: “We” thought, not “I” thought; “perhaps blamed ourselves”; “she would have liked”. The speech is reported in such a way that the (anonymous) narrator and the researcher are part of the story. To a certain extent, the same aspects are present in the first story. Fisher (1930) and other economists have spoken about important psychic elements of Value for Money, which are difficult to define and perhaps can only be *shown* by stories.

One of the reasons for adopting a story telling approach as the research evolved was to use stories to *show* aspects of Value for Money in the National Health Service that would otherwise be impossible to define (for example, empathy, sympathy, CARE).

Commissioning Research

The London Development Centre for Mental Health, the project sponsor, was set up by the Department of Health in 2004, and is responsible for implementing government guidance and identifying the healthcare needs of London’s population.

The London National Health Service itself is an interesting case, because it is considered to be the most complex in the United Kingdom because of the combination of demographic, social and economic factors. It cares for the health needs of 7.5 million people. London has the most diverse population of any city in England, with over ninety ethnic minority groups making up over thirty-three per cent of the population. Over three hundred languages are spoken in London, and twenty-five per cent of England’s poorest districts are in the city. This makes funding London’s healthcare extremely complicated. It is estimated that on an average day last year, £31.5 million was spent meeting London’s healthcare needs. It is also estimated that by 2016–17 the London Primary Care Trust’s healthcare budget will have risen to £13.1 billion per year. This is an increase from the current figure of £11.4 billion per year (London National Health Service, 2007). Given the complexity of London’s demographics, this study pays particular interest to obtaining Value for

Money via investment in workforce education. We point to a few reasons for doing so. The modernisation of a demoralised and poorly performing workforce has been one of the key issues tackled in health service modernisation since 1997. Education and training can be considered as the root of this research, from which we have moved on to explore other aspects, such as the networks within the National Health Service as an organisation, and the importance of issues of compassion as well as quality.

The need for this study was also affected by previous academic research in this field. In 1998, in order to examine the current state of workforce performance the Department of Health commissioned some research (Borrill *et al.*, 1996; 2001; 2002). The study found that when clinicians have a clear understanding about their roles and objectives, there is a higher level of commitment to clinical quality and to delivering improved services. However, the study failed to show how effective decisions relating to education and training really are, and this is particularly relevant seeing that managers consider that team effectiveness is determined largely by the quality of the education and training that their staff receives. Thus, this research was driven by a practical problem, concerning the issues surrounding healthcare education in the National Health Service.

According to the project sponsor, from the decision makers' perspective, little is known about what constitutes value in decisions relating to education and training; specifically, what criteria they use for assessing training needs, and how they address those needs and priorities. This is important to know since the London Development Centre for Mental Health is currently supporting the delivery of a number of high profile training programmes to London National Health Service trusts. The project sponsor encountered difficulties in convincing Trusts to buy in these programmes, a fact that became evident to the researcher when she attended an initial meeting in 2004, during which the project sponsor made a representation about the purpose of an education programme and the benefits it aimed to deliver to Trusts. Numerous senior service managers attended the meeting.

The meeting was organised in such a way that all the participants could express their views about the programme, and the project sponsor could identify potential problems with regard to launching the programme. The most frequent issue that arose was Value for Money, because the Trust managers saw the investment into education and training as a discouraging factor. Often, participants would ask the question: how could this programme deliver value to my organisation? In order to attract stakeholders to its programmes, the project sponsor is keen to understand how Trusts make decisions concerning healthcare education, training and the Value for Money these bring to their services. This would enable them to tailor their programmes in order to respond better to stakeholders' needs, which would inevitably have a desirable impact in terms of the delivery of government strategy at a local level.

It is interesting to note how the empirical work evolved in these respects. The initial question was concerned with the effectiveness of the training programme as seen by the trainees. However, the ambiguity associated with desired outcomes revealed that the problem of understanding Value for Money was not restricted to the upper hierarchical levels, but also affected lower levels of the National Health Service, not only in London but also in the health service as a whole. Nor can justice be done to the problem unless the network of relationships and issues interacting with training are taken into account, in a manner that is consistent with maintaining feasible project boundaries. Thus, a larger problem emerges from these specifically training-oriented questions, concerning how decisions are made in a general sense. The project sponsor has now become interested in finding out what various stakeholders in the project at other levels of the National Health Service hierarchy had in mind when they spoke about Value for Money from this kind of investment. After consultations between Kingston University and the project sponsor, it was agreed that a researcher from Kingston University would carry out some research into these issues. In this way, the study was developed in order to answer the following question: how is Value for Money understood in healthcare provision generally, and in relation to education and training specifically? (see Appendix 1)

Initially, it will be useful to explain to the reader the organisational structure of the National Health Service (next page), and in particular, the local context in which the research described in the thesis took place.

National Health Service Organisational Chart

We introduce the reader to an organisational chart for decision making, in Figure 1.1 (below).

Figure 1.1 National Health Service Organisational Chart

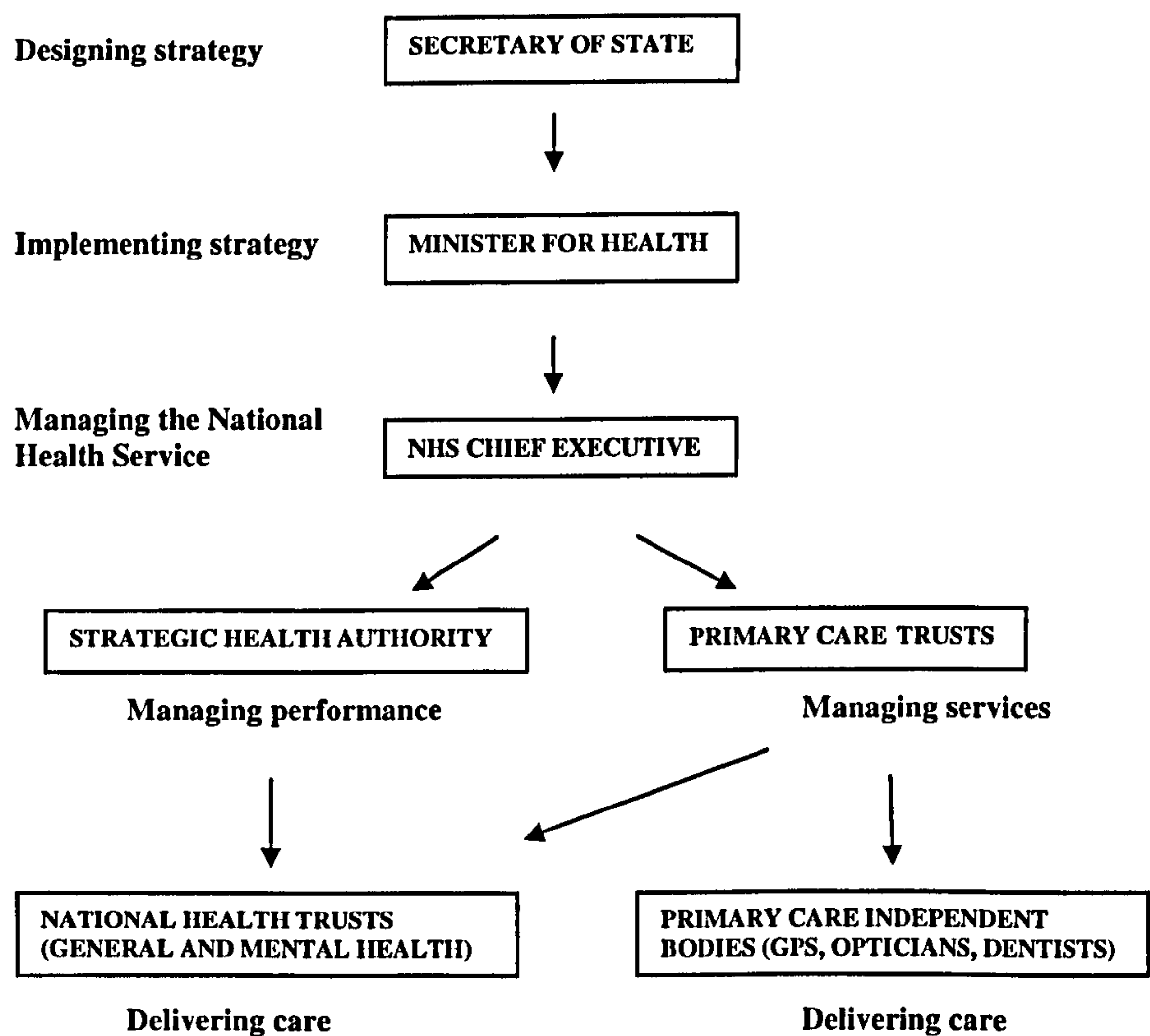


Figure 1.1.shows a simplification of the rather complex hierarchical structure of

decision making in the National Health Service. At the top level, the Secretary of State has powers under National Health Service primary legislation to give direction to various organisations managing the National Health Service. He or she issues directions to the Minister for Health, who is responsible for the stewardship of almost £70 billion of public funds for allocation within different areas of the Department of Health. One of those areas is the National Health Service, with the chief executive officer in charge of managing Strategic Health Authorities and Primary Care Trusts in England. These organisations then manage their local National Health Service Trusts, which deliver healthcare. This involves managing independent contractors such as general medical practitioners, dentists, pharmacists and opticians; Strategic Health Authorities and Primary Care Trusts distribute funds from their investment portfolio to their local health service organisations, which they have responsibility for managing. For example, an increase in demand for a specialist cardio service in a local community will inevitably increase the demand for education and training of cardio nurses.

The next step is to circulate the strategy to the lower level, *face workers* at the National Health Service Trusts, who will look at how they can address specific priorities in their own area. They are responsible for delivering strategy to the services. At this level, this study includes a geographical constraint; we shall concentrate on the National Health Service in London, because the study examines a specific project initiated by the project sponsor (London Development Centre for Mental Health).

In terms of its structure, London Strategic Health Authority implements government strategy within London. Provision of healthcare in London is characterised by complex social and economic factors, making London the most complex geographical area in the United Kingdom. The Health Authority covers thirty-two London boroughs and provides services to 7.2 million people. London Strategic Health Authority has responsibility for the performance of thirty-one Primary Care Trusts, twenty-four acute trusts, three mental health trusts and the London

Ambulance Service, with a further fourteen trusts in London that are foundation trusts and are regulated by Monitor (an independent regulator of National Health Service foundation trusts).

In conclusion, it should be pointed out that we should not oversimplify the process. If continuous strategies are constantly adapted or revised, further strategy is formed as a result of the hierarchy of networks of decision makers and agents. This is especially relevant in this thesis on Value for Money in the National Health Service. The structure described above resembles a top-down approach to management, neglecting to leave room for learning and creativity. We shall discuss this further in Chapter 7. For now, the structure opens the door for a discussion of various issues facing decision makers at different levels of the National Health Service hierarchy; these issues are not only restricted only to the lower levels, they also raise some important points concerning the top-down management style.

The Wider Situation of Healthcare

We also emphasise the wider situation of healthcare. The landscape of healthcare is rapidly changing. Somehow, government must find ways of providing more for less: more services using fewer resources, more services from existing resources, and greater productivity. So far, the government has accomplished this through the injection of large amounts of public funds, changes in contracts, reorganisation of services and so on. These changes in the National Health Service must be also set against the background of an ageing population, immigration, globalisation and increased expectations from the public. There appears to be a certain reluctance by the population to face the increased burden of taxation, as well as a demand for increased accountability in public expenditure. Healthcare provision is also a major source of anxiety among the electorate, which political parties must address if they are to gain or retain power.

To complicate matters still further, the demand for health might be considered to be

infinite, because there is no way of completely satisfying it. It can also be seen as asymmetric, with younger people and taxpayers having many priorities of which health is only one, while older people, the sick and those in need of care would prioritise healthcare as a priority demand. Many people have ailments, disorders, serious illnesses, disabilities and disadvantages that prevent them from living happily, or at least from feeling satisfied, in a society that for the most part is experiencing increasing wealth and opportunity. The health service is an enormously complex organisation, employing 1.2 million people and offering a huge range of services to a wide variety of people.

The situation is further complicated by the residual memory of the National Health Service itself. It was set up following the Second World War, and it was in many ways an idealistic creation. Back in 1945, the founders of the National Health Service genuinely believed that universal healthcare would improve the health of the United Kingdom health so much that it would reduce the need and demand for healthcare. Bevan (1952) once famously said:

[T]he collective principle asserts that no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means. (Bevan, 1952, p.100)

In spite of the privations of the war and the shortages that followed it, a kind of national euphoria gripped the country in the immediate post-war years. There was a belief that in setting up the National Health Service, Great Britain was showing that it was a world leader. Expectations were perhaps unrealistically high; whatever the reforms instituted by subsequent governments, there was bound to be a feeling that the health service had not lived up to the idealistic expectations that had existed at the time that the National Health Service was first set up. Consequently there was a feeling, however unjustified, that there has been a decline in the service.

The debate regarding Value for Money remains as important as ever in the current economic climate, constituting a sensitive political issue for governments and taxpayers. Speaking at the Labour Party annual conference in 2008, the Prime

Minister pledged:

[A]s a result of the events of recent weeks there are going to be tougher choices ... [this] government must and will ensure that we get Value for Money out of every single pound of your money that is spent ... [and] ... we will invest it wisely. (Guardian, 2008)

We shall return to this in the final chapter especially with regard to the emphasis on quality. For now, clearly, obtaining Value for Money is crucial to the government for political, economical and social reasons. Value for Money is an important component for the welfare and happiness of the community, and for future economic growth. Both the government and the health service face a dilemma: however much is done, it may still not be enough. Expectations are simply too high. However, managing expectations may be a cynical approach. The thesis focuses on one aspect of how this dilemma may be approached, through the search for Value for Money.

In this sense, the thesis deals with a highly relevant current problem for our society, not just in the United Kingdom but also in all the developed and emerging economies of the world, as well as in poor countries where the issues include survival and living below the poverty line.

Extended Rationale

In this section we try to give the reader an overview of the thesis. We extend the rationale to include issues of practicality and pragmatism, so essential to a Doctor of Business Administration thesis, and the academic contribution that is also a crucial component of doctoral work. Also, we review the research aims using a methodological approach, and sketch some ethical issues relevant to the work.

We begin by introducing a novel approach to the study. The Net Present Value is defined as an archetype, and Value for Money is introduced as a representation of this archetype and a Grand Narrative of strategy. We use Boje's (2001) critique of Grand Narrative as a basis for developing the research and examining the perceptions

of relevant decision makers. Then we discuss, in greater depth, the global problem of obtaining Value for Money. Healthcare issues in developed and emerging countries all share one common problem – the provision of life itself, freedom from incurable diseases, and the avoidance of pandemics. Although this thesis focuses on a set of problems facing the provision of healthcare in the United Kingdom, the issues discussed will no doubt also affect emerging nations as they develop. Hopefully these nations will make sufficient progress that the issues raised here might become their priorities. Then we move onto the problem of obtaining Value for Money in the United Kingdom, and touch upon an operational aspect of the research. A government agency originally commissioned a study of some of the aspects of the research discussed here, and in return facilitated interviews and contacts that enabled this study to be carried out. This particular aspect fits in with the requirement for fulfilling doctoral studies in business research (p.234).

Net Present Value as an Archetype

The argument is as follows. Essentially, efficiency is conceptualised in an economic sense, as can be seen from various government publications that talk about ‘getting more for less’ or ‘getting more from a given set of resources’, or ‘getting maximum value from any additional expenditures’. These are common sense versions of Pareto’s (1935) optimality, and in particular they are the essence of Fisher’s (1930) Net Present Value rule. In this sense, the Net Present Value is an archetypal rule. It has many representations. Value for Money is one of these representations, and Value for Money in the National Health Service is a more specific representation. In this thesis, we examine this representation.

Usually, the Net Present Value model’s approach implies rational or optimal decision making. It is extensively used in the business sector, and is also advocated in the public sector through the Green Book (2003). It is also broad enough to embrace other motivations, such as emotional and bounded rationality, variety of pay-offs reflecting stakeholder interests, trade-offs and the capital rationing situation in the

National Health Service.

In other words, the model provides us with a framework consisting of a ready-made set of categories – benefit, cost, cost of capital, and risk (p.46, figure 2.1) – to examine issues surrounding Value for Money in a wide variety of circumstances, including the National Health Service. There are special nuances in the framework of an institution like the National Health Service, which will be discussed later.

We also examine the issue of effectiveness, which includes the more subtle issue of CARE as well as efficiency as we noted above. Fisher (1930) emphasised that psychic aspects as well as monetary aspects were present in Net Present Value calculations. He did not, however, go beyond a brief general description of what these psychic benefits were. We provide a much deeper description of psychic aspects of cost and benefit, drawing on the field of health service provision.

A Grand Narrative of Strategy

We represent the National Health Service strategy concerning obtaining Value for Money as a Grand Narrative. As explained below, Value for Money is a special case of Net Present Value. Net Present Value is an archetype; Value for Money is a representation of this archetype. The Grand Narrative of the Value for Money strategy is illustrated by the quotation from the current Prime Minister (p.11).

Simply put, the original hypothesis is that if the people who are responsible for implementing the Value for Money strategy have a different view of what constitutes Value for Money than those who design that strategy, then the expectations of the designers of the strategy will not be met. This is the special narrative of Value for Money discussed in this thesis. The necessary step in developing this discussion is to find out, using the categories provided by the Net Present Value model, how the people implementing the Value for Money strategy perceive these categories.

The government has chosen to implement and adhere to a strategy that is executed in a top-down management style, but which lacks the flexibility necessary to engage both principals and agents in the health service. It is useful to set out a definition of the strategy before examining the particular case of achieving value in the National Health Service. As a starting point, we use Matthews' (2007) approach to strategy that forms part of what he terms the Enneagram. According to Matthews (2007), strategy is a continuous process involving the following steps:

- (a) Mission or objectives
- (b) Search among alternatives
- (c) Choice
- (d) Implementation
- (e) Adaptation

It is necessary to make a few remarks on this view of the strategic process in terms of the Grand Narrative, in the sense used by Lyotard (1979, 1984) and Boje (2001); this is a term that we will return to throughout the thesis. The narrative goes as follows: top management decides on the best course of action, and conceives strategy accordingly. Once the strategy has been decided upon, desired actions are implemented in the form of choices by middle level management, and also by the lower level of management and staff who are responsible for the actual delivery of the strategy, interpreting, implementing, and adapting it to local circumstances. Very generally, strategy in the National Health Service over the last two decades has had three main strands:

- (a) Setting up internal markets
- (b) Emphasising patient choice
- (c) The requirement for Value for Money

The thesis focuses on the third strand, but it is also appropriate to discuss the other two. The concepts of choice and internal markets have dominated the National Health Service since Labour came to power in 1997 and introduced the internal

market (Culyer, 1990), and later when government shifted towards the provision of a patient choice model (Department of Health, 2004). Both these strategies are aimed at introducing an element of competition into the National Health Service, with a view to increasing efficiency. Therefore they are complementary to the third strand, especially given the unprecedented investment in the National Health Service since 2001. Taxpayers want to see tangible returns, and this desire will become even more important in the future as successive governments face an increased burden of debt, which they will probably pass on to households as increased taxation. These policies are related, but the third, the emphasis on Value for Money, is fundamental, since no markets or choice are politically feasible unless the National Health Service is perceived as offering this. This thesis focuses on the problems involved in achieving this goal.

In terms of government strategy which gives a central importance to Value for Money, such strategies typically (and the Net Present Value approach specifically) fails to take account of the strategic process, especially regarding implementation steps. Using the example of the National Health Service, strategy passes through a hierarchy of decision makers. At the top levels of the hierarchy, senior decision makers set out the desired outcomes, many of which are specified in very general terms and are therefore subject to a degree of ambiguity of interpretation. The next step involves a percolation to lower levels of the hierarchy and more junior decision makers, whose individual perceptions of the desired outcomes will determine how the strategy is implemented.

This study examines these issues in the sense that it puts forward the following argument. If perceptions about the categories of the Grand Narrative differ, then this gives rise to all sorts of principal-agent problems that may impede the success of the chosen strategy. We will be concerned with issues such as defining expectations about Value for Money, granting agents (or implementers) the power to make decisions based on their experience and knowledge, and verifying their performance. These are part of the much broader context of corporate governance. We shall return

to this issue in the empirical section of the thesis (Chapter 7).

Thus, to be clear, we can think of the Net Present Value approach as providing a set of archetypal equations and as a Grand Narrative of strategy. The pursuit of Value for Money in the National Health Service is one of its representations. Once we establish the Net Present Value as the archetype and the Grand Narrative of Value for Money, the research may begin to deconstruct that Grand Narrative in order to illuminate other issues and considerations.

At this point, we introduce a table 1.1 (next page) that we will return to at various points in the thesis.

Table 1.1 Grand Narratives, Archetype and Deconstruction

GRAND NARRATIVES AND ARCHETYPES	
FRANCOIS LYOTARD (1979, 1984) GRAND NARRATIVE (OGN)	Grand Narratives are defined as: - implying a philosophy of history of progress through scientific method... used to legitimate knowledge (1979, p.24) - an “Enlightenment narrative” defined as “a possible unanimity between rational minds” (1979, p.23) - “the hero of knowledge [who] works toward a good ethical-political end – universal peace” (1979, p.24); a progress towards Socialism (the Marxist Grand Narrative) - globalisation; progress and growth through competitive markets; the pursuit of efficiency, with human beings treated as resources (1984, p.37); the Grand Narrative of capitalism
GRAND NARRATIVE OF VALUE FOR MONEY (GNVFM)	Investment decisions and efficiency measured in terms of Net Present Value and the categories of Net Present Value rational choice; expected benefits and costs; the cost of capital, risk and attitudes to risk. Value for Money is a representation of Net Present Value in the National Health Service
ADAPTATION OF GRAND NARRATIVE OF VALUE FOR MONEY IN THIS THESIS (AGN)	If perceptions of the Net Present Value/Value for Money categories vary between implementers and designers of strategy, then outcomes may differ from the original intent
DECONSTRUCTION	
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (1)	Examination of the categories of the Adapted Grand Narrative in the context of investment in a training project. Extension of the study into National Health Service networks in addition to hierarchies
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (2) MULTI NARRATIVES	Examination of patterns excluded by the Adapted Grand Narrative: 1. Networks 2. Pure qualities 3. Dimensions of CARE omitted in Original Grand Narrative (and Grand Narrative of Value for Money; for example, compassion, empathy, sympathy) Incorporating new dimensions into the study in addition to the Adapted Grand Narrative; little narratives, local narratives, vignettes. The terminology used for such narratives in the thesis is multi narratives; they are less coherent, more diverse and more chaotic than Grand Narratives. Illustrative stories effect the transition from Adapted Grand Narrative to Multi narratives
DECONSTRUCTION AND SOCRATIC DIALOGUES	
PANEL DATA 1	Re-examining and reflecting upon preliminary observations; building upon multi narratives.
PANEL DATA 2	Amplifying, reflecting and showing dimensions of CARE
DECONSTRUCTION OF THE PROCESS PANEL DATA 3 and 4	The role of the researcher in the research process: completing dialogue. At each stage described in the rows above, we gradually include what has been excluded in previous stages.

Table 1.1 describes the direction of the thesis. The contents are explained as the thesis proceeds.

The research developed through an evolutionary learning process, and it will be useful for the reader to hear the story about how this evolution occurred.

Evolution of the Study

The study began by focusing on a training project. This was the original area, the research base of the commissioned research, in return for which the researcher was given access to respondents. However, it became clear very early on in the research that the National Health Service was not merely a hierarchy, but also a network of relationships and stakeholders. Hence, the research focus for the purpose of the doctoral thesis had to be expanded.

The argument at the early stages of the research was as follows. If perceptions about the categories of the Grand Narrative differ, then this gives rise to principal-agent problems at many levels, and this may impede the success of the chosen strategy.

It became clear in the initial interviews that the people implementing strategy held perceptions of the categories of the Value for Money (Net Present Value) model that were substantially different from the perceptions of those designing the strategy. It was also clear that the respondents were reluctant to restrict their conversation with the researcher to these categories. Therefore, a choice had to be made: either (a) treat the respondents' reluctance to keep to the categories as an inconvenient aberration, giving rise to a series of outliers that could be conveniently ignored; or (b) to take the apparent outliers into account in the study.

It also became apparent that the unexpected responses formed a pattern. Respondents felt uneasy about the Value for Money strategy because they felt that it crowded out

issues of CARE. The question then arose as to what these issues of CARE were. They were highly specific to the work of the individual concerned, constituting a set of multi narratives in addition to the Grand Narrative. We use the term multi narrative because although the discourses followed a pattern around issues of CARE, they had individual qualities that were closely related to the respondents' jobs and positions within the hierarchy.

The next part of the study was concerned with analysing these multi narratives and forming some preliminary conclusions about them. The multi narratives often illustrated a certain reluctance to focus entirely on Value for Money. In this respect the respondents' perceptions were fragmented, and took the form of small stories, accounts of events, and the expression of feelings about the tasks they were doing and the strategies they were implementing. Therefore, the decision was made to obtain provisional conclusions and impressions about the Value for Money strategy, using discussion panels composed of experts or specialists in the National Health Service. This gave rise to another layer of perceptions. The feeling of the researcher was that we were gradually introducing more and more aspects that had been ignored in the earlier Grand Narrative formulation of the National Health Service. Progressively it became clear that proceeding in this way represented a deconstruction of the original Grand Narrative, both conceptually (p.17, Table 1.1) and empirically through a series of panel discussions that took place (p.135, Table 4.3).

An additional conclusion emerged from the research process thus far; this was that the researcher herself was an inescapable part of the process. The process was not one merely of reporting and analysing data, since all results about the perceptions of the interviewees were being filtered through the perceptions of the researcher herself. These perceptions were based on hearing what respondents said in a particular way. There were two influences at work. Firstly, the researcher was herself a user of the service she was reporting on and analysing. Secondly, all the perceptions of the researcher regarding the perceptions of '*Other*' were the result of HEARING what

the respondents had to say, either singly or in the panels that were organised. This hearing took a particularly intense form because the researcher herself has a hearing disability, meaning that the hearing process took the form not only of hearing spoken words, but also of relying on audio recordings and perceptions of non-verbal signals. This aspect of the research involved an inclusion of some aspects of interaction that had previously been excluded.

Pursuing this logic further, it became clear that a number of dialogues were forming a part of the research process: interactions between the researcher and the interviewees; between the researcher and the panels; and between the researcher and the supervisor. All these dialogues were moderated by the particular way in which the researcher both HEARD and listened. The third dialogue, between the researcher and the supervisor, had so far been excluded from analysis. The natural vehicle for its inclusion was the Socratic Dialogue; in fact, such a dialogue had been present all along, unrecognised in the dialogues described so far. Therefore, in the case of the dialogue with the supervisor, it was decided that this element should be included explicitly as a Socratic Dialogue.

Another important issue also emerged in connection with the research. The research was being carried out by a researcher with a hearing disability: this is an interesting phenomenon in two senses. Firstly, as described above, research which fundamentally involved hearing perceptions was being carried out by a researcher with a hearing disability – or, more precisely, by a researcher who heard in a particular way (the supervisor was careful to point out that he considered that everyone is disabled in one way or another, but usually not as explicitly as in this case). Secondly, and perhaps more importantly, what precisely is the position of a researcher who is disabled? If the deconstruction process should include what would otherwise be excluded, how do we include this issue?

Proceeding in this way also gave rise to a very practical and relevant conclusion. If it is true that perceptions of Value for Money strategies differ at different levels of the

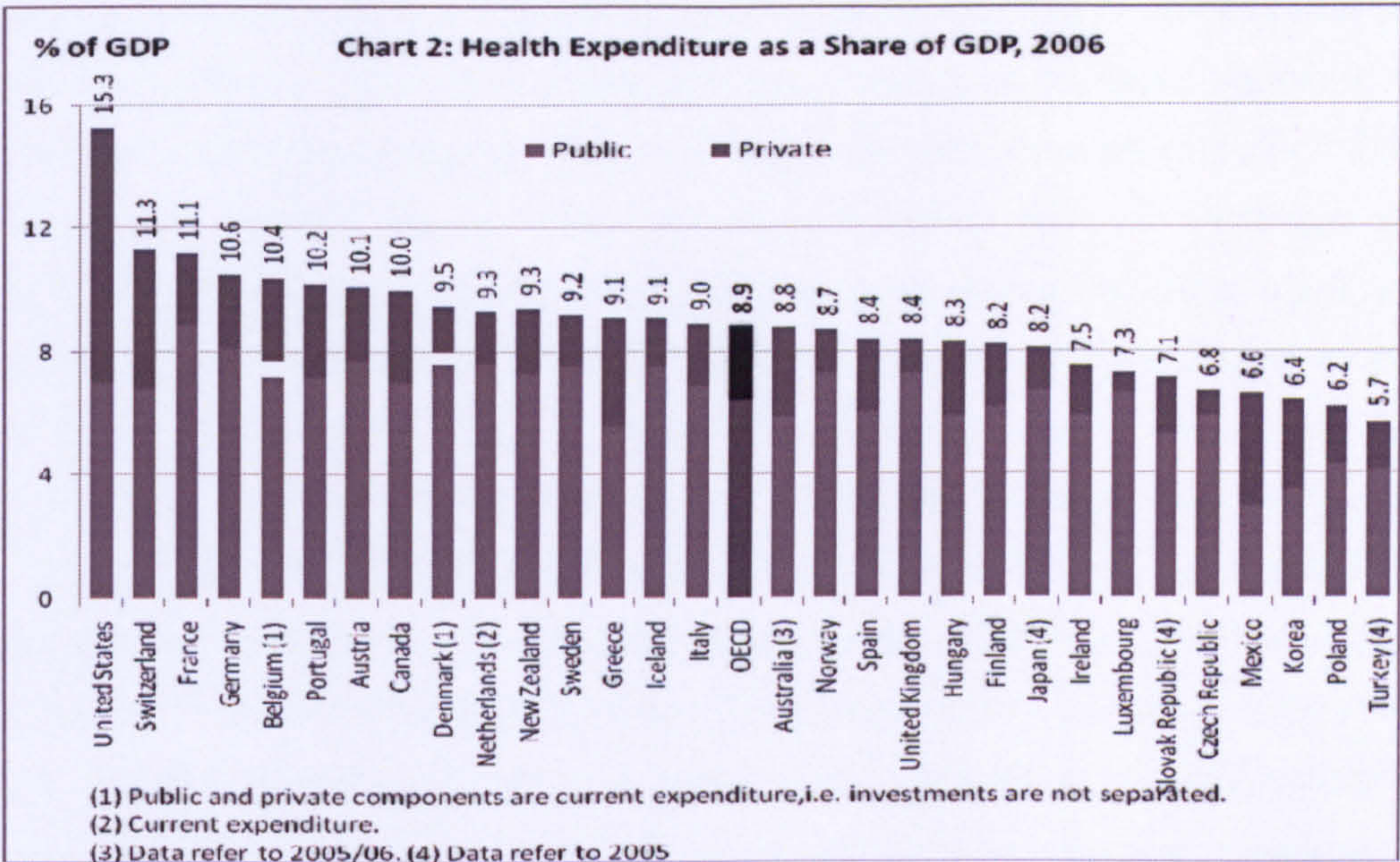
hierarchy and in different parts of the network, and if this means that the strategic intent underlying Value for Money is either not being realised or is not being realised effectively, then the kind of bottom-up approach implicit in asking for and taking account of multi narratives and panel data represents a methodology for resolving the problem. Furthermore, if one of the issues for the future of Value for Money in healthcare is that of achieving CARE and achieving a balance between CARE and the kind of tangible outcomes narrated in our first story above, then stories at the micro level, recounted by people caring for patients, managers of the service and carers, might be a step forward in successfully achieving such a difficult and delicate balance.

At this point, we return to the extended rationale in order to discuss the novel approach further below.

Global Search for Value for Money

The thesis places emphasis on the universality of obtaining Value for Money as a global issue. Countries' demographics differ. In emerging nations the problems assume a different form, with faster economic growth but without the availability of healthcare in societies that were previously or still are denied such facilities. In the developed world, as consumer expectations and longevity increase, naturally there are pressures for better healthcare services, delivered more economically and with an emphasis on receiving Value for Money. It is useful to start this section by looking at the healthcare reforms in European countries. European healthcare systems have faced the greatest issues to date: an ageing population, and providing services to 732 million people (United Nations, 2008). This is illustrated in Figure 1.2 (next page).

Figure 1.2 Health Expenditure in the OECD



Source: Organisation for Economic Co-operation and Development (2008)

A report from the Organisation for Economic Co-operation and Development (2004) revealed that, during the period 2000–2008, in many countries health expenditure grew rapidly between 2000 and 2003, with an annual average growth rate of 6.2%. However, this growth rate has slowed to an average of 3.6% per year since then. This attitude suggests that since the end of the last century, European countries have embarked on reforms in order to improve the funding of their healthcare systems in a way that delivers Value for Money.

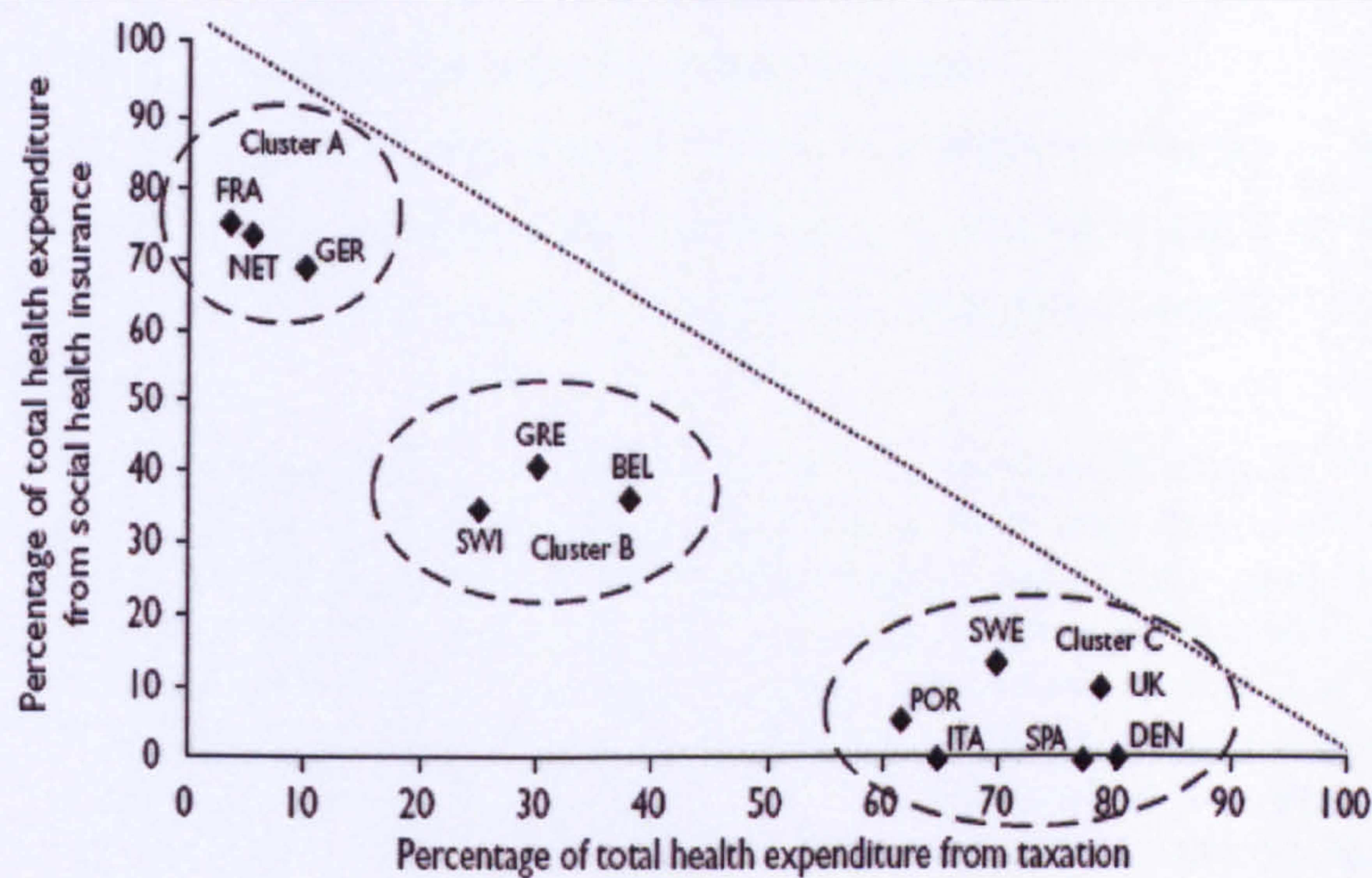
Across Europe, but particularly in Central Europe, the focus of governments is shifting toward monitoring and ensuring Value for Money in the health sector (European Observatory on Health Care Systems, 1999). Among the countries of the former communist states of Eastern Europe, Croatia provides an interesting case of transition from the old communist healthcare system. Recent reforms are seen as

challenges for the newly established democratic government, and there is a need to anticipate cost escalation in order to ensure the sustainability of the Croatian healthcare system. Durán *et al.* (2006) reported on the situation in southern Europe and suggest that in Spain, for example, the main objective of the health system is to focus on health improvement, equity and responsiveness. Glenngård *et al.* (2005) reported on Northern Europe, where the Swedish system faces the challenges of being able to continue delivering Value for Money and putting financing on a more stable and sustainable base. Hilless *et al.* (2001) investigated the situation in the former Commonwealth, where countries face healthcare issues relating to the transition from the old commonwealth status. In Australia, one of the main objectives of the government has been the attempt to build a high performing and sustainable healthcare system that is fair, affordable and represents good Value for Money. The Canadian Institute for Health Information (2008) reported that the transformation of the Canadian healthcare system is an urgent need. Corbacho *et al.* (2002) studied South and Central America, where improving efficiency in spending is seen as a powerful tool for poverty reduction.

There is also a general feeling that health systems must reconcile rising demands for healthcare with public financing constraints. Dixon *et al.* (2001) reported that funding health services through public taxation has become a sensible strategy in many states. Their report suggests that there has been a shift in the means of financing healthcare among governments, either towards social insurance or towards funding through public taxation. Figure 1.3 (next page) indicates this shift.

Figure 1.3 Health Expenditure: Health Insurance versus Public Taxation

Figure 1



Source: Dixon *et al.* (2001, p.69)

The main reasons behind these changes were a reduction of high labour costs and the need to introduce competition into healthcare, or perhaps in order to provide universal healthcare. This type of healthcare financing is subject to a paradox. On the one hand, taxpayers have become increasingly concerned with how their contributions are spent. On the other, governments are reluctant to increase tax contributions in the short term, which in itself is seen as a sensitive issue for their voters. Balancing both sides of this equation remains a formidable challenge for governments. The illustrations above perhaps also suggest that, having spent significantly between 1990 and the present, the next step for governments should involve finding out how effectively taxpayer money is spent.

In this sense, this thesis deals with a highly relevant current problem for our society. All these things are important components of welfare and happiness, not only for the community, but for economic growth too. Government and the health service both

face a dilemma. This thesis focuses on one aspect of the way that they approach this dilemma, through the search for Value for Money.

Obtaining Value for Money in the United Kingdom

The experience of the United Kingdom is not very different from that in other OECD countries. Clearly, obtaining Value for Money is crucial to the United Kingdom government for political, economic and social reasons. The statement below provides a starting point:

Substantial challenges remain for health and social care services. Public expectations rightly continue to rise. People want care that is closer to home and tailored to their specific needs. Individuals need to be supported to take control of their own care, while services need to be provided where and when they are most convenient. In the long term, increasing life expectancy and lifestyle changes pose additional challenges. Future technological developments need to be grasped to further improve the quality of life people are able to enjoy. After a decade focused on expansion and reform, the levers are now in place to lock in sustained productivity improvements to ensure further advances are delivered with Value for Money to the taxpayer. (Her Majesty's Treasury, 2007, p.205)

The demographics of the healthcare landscape have changed considerably in recent years, mainly due to the improvement in living standards and the taxpayer's demand for a better quality of healthcare. Figure 1.4 (next page) shows the demographic factors affecting health and healthcare generally.

Figure 1.4 Demographic factors affecting health and healthcare



Source: Dahlgren and Whitehead (1991)

Dahlgren and Whitehead (1991) classified the determinants of health into five categories: biological, health related behaviour, social and community networks, living and working conditions. Biological determinants include genetic dispositions, sex and age. Health related behaviour and life style include salutogenic behaviour; both healthy (e.g. nutrition, sports) and unhealthy (e.g. risky behaviour, smoking, drugs, alcohol). Social and community networks (or social integration) influence health status, reducing the risk of mortality and leading to better mental health. Living and working conditions (work environment, education, hygiene and housing) are seen as important determinants of health status. Finally, general socioeconomic, cultural and environmental conditions represent the macro-level influencing health.

Arguably, the increasing complexities of these demographics make it difficult for any government to design their strategies effectively. There are also taxpayers to be taken into account, who are concerned as to how their contributions are being spent.

The Departmental Report for 2007 (Her Majesty’s Treasury, 2007) predicted that National Health Service expenditure would increase to £106 billion by 2010–11. This is shown in Table 1.2 (below).

Table 1.2 National Health Service expenditure for the period 2000 – 2011

Period	£ billion	% Increase	Real terms % increase
1999–2000	40.2	–	–
2000–2001	43.9	9.3	11.6
2001–2002	49.0	11.6	8.9
2002–2003	53.9	9.9	6.5
2003–2004	63.0	13.1	10.2
2004–2005	69.7	10.6	8.4
2005–2006	76.4	9.6	6.9
2006–2007	84.3	10.4	7.5
2007–2008	92.6	9.9	7.0
2008–2009	94.4	10.3	7.2
2009–2010	99.9	–	–
2010–2011	106.4	–	–

Source: Pre-Budget Report and Comprehensive Spending Review (Her Majesty’s Treasury, 2007)

In addition, the expenditure for workforce education and training (which this study is particularly concerned with) has so far reached £450 million per year, as the Departmental Report for 2008 states (Department of Health, 2008). Spending at this level reflects the government’s commitment to improving the National Health Service, and it will certainly be questioned as to whether it has a desirable impact on healthcare provision and the workforce, and delivers Value for Money to services and its users. An Interim Report (Her Majesty’s Treasury, 2002) emphasises the need for Value for Money from all these investments. A Review by Wanless *et al.* (2007) concluded that the National Health Service has failed to generate even relatively modest improvements in unit cost productivity, while a report from the National Statistics Office (Office for National Statistics, 2008) argues that productivity fell by

an average of one per cent per year.

Another dilemma is that since human resources are the largest expense and probably the most important aspect of the National Health Service, much of the review (Wanless *et al.*, 2007) promoted the view that the budget has not been spent on services – a problem compounded by centralised decisions which failed to wait for productivity contracts to be sealed before allocating money. For example, according to a parliamentary report concerning workforce planning (House of Commons, 2007), as a result of the recent spending, large pay increases were granted to consultants for doing less, without adequate steps being taken to ensure increases in productivity in return.

Thus, the debate about Value for Money, measured by an increase in productivity, is becoming more important than ever and has become a crucial weapon in political and public debate (King's Fund, 2005). It has also become the rationale for this study, reflected in the fact that a government department commissioned this study to learn more about how Value for Money is understood in the health service.

Setting the rationale in this way has helped to refine the study's aims, described below.

Research Aims

Discussion in the preceding sections has encapsulated the rationale for this research, placing it in the context of the need for a better understanding of how Value for Money is applied by decision makers in the National Health Service and especially with reference to healthcare education and training. In this way, the preceding discussion provides a base for formulating the research aim.

At this point the principal aims are summarised as follows. A full discussion is

contained in the methodological chapter (p.117–121).

The main aim of the research is to examine the issue of obtaining Value for Money in the health service, both:

- 1. as an issue in itself; and**
- 2. as a means of getting better Value for Money**

We place particular emphasis on examining the perceptions of various stakeholders, who are the actual ‘on the spot’ decision makers involved in the process of implementing and adapting the Grand Narrative of Value for Money, a strategy designed at the top level by governments and their advisors. This adaptation and implementation is termed the Adapted Grand Narrative of Value for Money.

The idea of Grand Narrative is elucidated in the thesis. An Adapted Grand Narrative is then constructed¹. In the later stages of the research it became clear that there is a richer perception of the situation than can be encapsulated by the Adapted Grand Narrative.

Perceptions of ‘Other’ are filtered through the perceptions of the researcher. The research process must be transparent. This issue is confronted in two ways in the thesis:

- (a) in the panel discussions; and**
- (b) in the Socratic Dialogue**

The last step in the process was to include the researcher herself, as well as the research supervisor, explicitly in the process.²

¹ See Table 1.1 (p.17) for clarification of what we mean by an Adapted Grand Narrative.

² For further clarification, see Chapter 4 (p.129) and table 1.1 (p.17), which are developed through the thesis.

Delineating the research aim in this way will ensure that the reader is aware of how the considerations that have been discussed in the previous sections were cemented in the eventual formulation of the study’s aims.

Initially, the study examined a specific project concerning Value for Money in investment in healthcare education and training. However, it soon became clear that the research needed to be extended to encompass the National Health Service in general. There are around three hundred different types of organisations that provide healthcare in the UK, and the National Health Service employs over 1.2 million staff (London National Health Service, 2007). We also needed to consider the complexity of healthcare provision, the existence of a complex web of relationship networks among different groups of stakeholders, and the fact that decisions in healthcare are inevitably not made by a few but by many people. Because of these considerations, we decided to widen the scope of the research enquiry and consider the broader implications of the study, because they inevitably shaped the choice of methodology for the research.

Methodological Approach

The aims of the thesis suggest a practical methodological approach to Value for Money in the United Kingdom National Health Service, a vital issue given current population trends, public aspirations and the scrutiny of taxation, and recently the pressures of global debt.

The research approach takes the form of Deconstruction (of the Grand Narrative) as used by Boje (2001). It follows an evolutionary path:

- Stage I Deconstruction of the Grand Narrative of Value for Money
- Stage II Multi narratives
- Stage III Panel Data
- Stage IV Socratic Method

This evolution suggests the need to outline briefly some of the methodological issues in relation to these stages. It is useful at this point to refer to Table 1.1 (p.17), summarising some of the key concepts adopted in the thesis. We shall return to the table and elaborate on its contents at various points in the thesis, but at this stage it provides the reader with a map of the contents of future chapters, although the full contents will not be expanded until later.

Stage I: Deconstruction of the Grand Narrative of Value for Money

The study started by examining what we might call a Grand Narrative of Value for Money in the National Health Service. We then went on to deconstruct that Grand Narrative in order to shed light on other issues and considerations.

We examined the preliminary responses of three groups (p.135) within the National Health Service with regard to the Grand Narrative of Value for Money:

- (i) top level decision makers, concerned generally with designing strategy
- (ii) decision makers at the Strategic Health Authority level, concerned generally with funding training projects
- (iii) *face workers*, concerned generally with implementing strategy

This was a natural evolution because very soon it became clear that the National Health Service could sensibly be viewed as a hierarchy for the purposes of the thesis. It consists of networks of relationships. Therefore, the preliminary interviews involved extending our reach into these networks.

The choice of interviewees at the preliminary stage of the interviews for the project was determined by the project itself: the commissioner's people who provided us with this opportunity, the sponsoring manager, and the trainees on the programme. The scope also widened out to include a wider group of key stakeholders.

The interviews were centred on a deconstruction of the Grand Narrative of Value for Money, firstly based on a model constructed from the literature (concerning the business and public sectors). This led the researcher to ask questions about a set of the model's categories. Secondly, during the interview process the Grand Narrative was deconstructed by the interviewees themselves.

The next step was to provide some conclusions. Two issues emerged from Stage I of the analysis. Firstly, the participants were reluctant to confirm the observation regarding the Grand Narrative of Value for Money/Net Present Value categories. Secondly, it became clear that the participants from the National Health Service were part of an interconnected network of stakeholders (staff, clients, and community). This was acknowledged with the subsequent broadening of the study.

With regard to the first issue, there was considerable evidence for our initial proposition, that the implementers of strategy have different conceptions of the categories described when compare to the top-level decision makers, with the consequence that strategy will not be achieved in the way that the top-level decision makers originally conceived it. Therefore, it is necessary to examine how these categories are perceived by the implementers.

The problem arose as to how we should treat outlying responses that did not fit our initial proposition. In trying to fit responses into the mould of the Grand Narrative of Value for Money/Net Present Value, much was being lost. We decided not to treat these responses as outliers, but instead to incorporate them into the research with an analysis of the complex issues that our initial respondents and the respondents from the first group of stakeholders were recounting.

This analysis took the form of the multi narratives. It then became possible to find out whether these multi narratives formed a pattern that could be interpreted in such a way as to give guidance to decision makers in the National Health Service who are trying to achieve Value for Money. Hence, the next stage of the study – multi

narratives.

Stage II: Multi narratives

The second stage ran concurrently to the first, with the same respondents. It became clear that although value was a concern of the interviews:

- (i) It was not the only concern, or even the primary concern. Where it was a concern, it was associated with a sense of loss; loss as an excluded set of '*Other*' in the Grand Narrative of the Value for Money journey. The responses from these '*Other*' were much richer than the Grand Narrative of Value for Money allowed for.
- (ii) For the most part the interviewees did not perceive their work in terms of the imposed categories of the Grand Narrative of Value for Money. Work in the National Health Service has and should have an emotional content, concerned with empathy, compassion and so on. This emotional content can be best understood (or be indirectly inferred) through personal stories.

Thus, the richness of the interviewees' responses was embodied by considering multi narratives, reporting on people's narratives and letting the stories speak for themselves as far as possible.

In conclusion, and perhaps unsurprisingly, the multi narratives demonstrated that:

- (a) The respondents felt that views of CARE, compassion and empathy were being crowded out by the imposition of measurable tangible outcomes (i.e. targets).
- (b) The governmental approach to the National Health Service management was too top-down.

One of the effects of the quest for Value for Money was actually to suppress empathy. Consider the tone of our initial stories: the senior consultant's statement that "I will deal with this now" acted to summon the family to the waiting area, and he then asserted in a defensive way that the operation and the events leading up to it followed procedure, and that no one was to blame for the patient's death (something that had never been suggested by the patient's family). This and other stories started to emerge from the interviews, although mostly in a crude and incomplete form. We needed to analyse them further, hence the next stage of the study – panel interviews.

Stage III: Panel Data Interviews

In the further stage of the interviews in this study, we utilised panel data according to an adaptation of the Delphi method. The Delphi method is primarily concerned with making the most of imperfect information, exploring reliable and creative ideas and dealing systematically with complex problems using a panel of experts. The usefulness of this method has been explored extensively by Wissema (1982), and it has been widely used in the investigation of public health issues: policies for drug use reduction, prevention of sexually transmitted diseases, and areas for education (Adler and Ziglio, 1996; Cornish, 1977).

The basic process is as follows: the experts share knowledge through questionnaires (Adler and Ziglio, 1996). Fowles (1978) provided an overview of the steps for an adapted Delphi method. The person conducting the panel interviews (the researcher) asks participants – (the experts) a series of questions so that they can develop and refine responses to a specific problem. The researcher controls the process and the interactions among the panel of experts. In this way, he or she is able to filter out information that is less important (Martino, 1983) and facilitate the formation of a group judgement (Helmer 1977), which is then used for further analysis and general statements later.

Some issues need to be considered in the use of the Delphi technique. According to Delbecq *et al.*, (1975), the most important issue is the quality of the responses from

the participants, so it is necessary to make them aware of the importance of following the method. Some argue that the respondents to the questionnaires should be well informed in the appropriate area (Hanson and Ramani, 1988), or that a high degree of expertise is not necessary (Armstrong, 1978). The number of participants may vary, depending on the study design, but experiments suggest that groups as small as four can perform well using this method (Brockhoff, 1975). We took these criticisms into consideration, and designed two sets of panel data interviews for this study.

Panel Discussion 1

In the first round of panel data interviews, the members of the panel were an academic supervisor, a researcher and a senior National Health Service manager. The aim was to confirm the preliminary findings from the interview data and to investigate these findings in the context of the broader considerations surrounding a top-down approach to the Value for Money strategy.

The fundamental problems were touched upon and identified: the disconnectedness between top and *face worker* level; the measurement issues; and the difficulties of decision making in networks of relationships. These issues also touch upon the research problem from the perspective of the principal-agent problem within the National Health Service. As such, they needed further investigation. In this sense, the first panel discussion stage provided the basis for investigating this issue further in the second panel data interviews, described below.

Panel Discussion 2

The second round of panel data interviews checked the preliminary interview results from the Grand Narrative and the multi narratives against the opinion of the experts:

- (a) Firstly, we checked our impressions of the initial responses about the Grand Narrative and the multi narratives;

- (b) Secondly, we introduced novelist Hilary Mantel's (2008) story (p.213) and sought further responses about empathy.

It is interesting to note that the conversations took the form of stories, but they also took the form of reflective dialogues, as much between the panel members themselves as between the panel members (including a senior director and a commissioner in the National Health Service), the researcher and the academic expert. The experts were encouraged not only to give their own responses to the preliminary findings, but also to add their own perceptions and their own stories about Value for Money. They were introduced to a novelist's narrative (Mantel, 2008), recounting her feelings and reflections in relation to a particularly harrowing personal experience with the National Health Service. The discussion was then extended to include more a complex set of problems (from the multi narratives): the complexity of obtaining Value of Money; questioning the effectiveness of a top-down approach to strategy at the point of CARE (*face workers*); and providing a set of recommendations for future improvements.

At the end of the panel interview stage we reached further conclusions. We had discovered that not all the initial findings could be squeezed into the Grand Narrative of Value for Money. This is partially because there is no such a thing as a perfect account, and partially because it is not always possible to force data into a prescribed framework (especially given the fact that this is a qualitative enquiry). This conclusion prompted us to extend the analysis (described in Chapter 6) to include multi narratives: loose bits of information, such as interdependence issues associated with multiple projects, the presence of many stakeholders and decision makers, and the pay-offs and the trade-offs involved. These aspects of the data are inevitable, and not necessary a bad thing, since they serve as a bridge between the Grand Narrative and storytelling. One subset of the multi narratives was derived from the preliminary set of interviews, while others were found in an advanced set of interviews, as part of the panel data, and they fitted in very well there.

In conclusion, with regard to panel interviews, these sessions enabled us to further develop a broader set of considerations that we could not capture during the preliminary interview stage. Moving on from the Grand Narrative of Value for Money to multi narratives and storytelling enabled us to engage in a further examination of broader strategic issues – the principal-agent problem in the National Health Service, and the success of the current strategy. These stories will be presented in detail in Chapter 7.

Even after applying a broader deconstruction framework, we still felt that something was missing. A further phase of deconstruction was needed, regarding how the researcher fits into the stakeholders' group. What is her role, her perceptions? We introduced the Socratic Method to deal with this issue.

Stage IV: Socratic Method

Earlier we discussed the usefulness of the Socratic Method in some depth. In this fourth and final stage of reflection, two interviews took place, taking the form of a self-reflective dialogue between the academic supervisor and the researcher, bearing in mind confidentiality and the true spirit of the Socratic Dialogue:

- (i) The first dialogue is reported in Chapter 3 (p.130–134), reflecting on the methods used in this thesis.
- (ii) The second dialogue is reported in Chapter 8 (p.248–252); the researcher's story is told and reflected upon in relation to the stories, interpretations and methods adopted in the thesis. This gives the interviewer–researcher story a degree of importance in addition to the importance of the Grand Narrative or multi narratives.

The results are summarised, and a phenomenological approach is taken to the phenomenological method which was adopted in the research. In this sense, the use of the Socratic Method completes our deconstruction process.

Research Ethics Considerations

This thesis considers an important issue – the ambiguities and complexities of obtaining Value for Money in the National Health Service. Particular emphasis has to be placed on the fact that the study was commissioned by a government agency that is keen to improve its own processes (and keeping in mind that one outcome of the thesis is a presentation to be made to the National Health Service management). The government agency also requested confidentiality for the participants involved. Both these issues, naturally, make it more difficult to obtain relevant information.

Research concerning human subjects usually requires the researcher to comply with a code of clinical research ethics, and as with all such research, this matter was raised in this study. We especially paid attention to complying with:

- (i) Codes of Ethics Concerning Research Involving Human Subjects (Kingston University, 2007)
- (ii) Guide to Good Research Practice (Kingston University, 2004)

The project sponsor (London Development Centre for Mental Health) asked for the anonymity of participants involved, and so did the participants. Confidential interviews and a selected number of participants were chosen. To ensure a good turnaround of the participants, the researcher issued an introductory letter to all participants in which she undertook to preserve the anonymity of the participants during the interviews. Transcriptions are available, but are subject to ethical and confidentiality considerations arising from conducting this type of research.

In this way, carefully planned interviews provided us with access to invaluable confidential information while maintaining an appropriate ethical stance.

**2 LITERATURE REVIEW (1): THE BUSINESS SECTOR
BACKGROUND TO THE ADAPTED GRAND NARRATIVE**

Introduction

This chapter begins with an evaluation of business sector literature; the overall subject matter of the literature review may be described as ‘Decision Theory’. The literature review is in two parts. Chapter 2 is concerned with deconstructing the Grand Narrative of Value for Money in the business sector.

Since Net Present Value is the archetype and Value for Money is one representation of this archetype, this section of the literature review examines the categories of Value for Money in relation to empirical research concerning their application in the business sector. Chapter 3 extends the review to the public sector and the National Health Service.

In both chapters, the categories of the fundamental Value for Money equation (as embedded in Net Present Value) are discussed in relation to the literature, and are used to construct a conceptual framework for the Adapted Grand Narrative of the thesis. These categories may be classified under the headings usually found in Decision Theory as the rational choice model, and as the version of the Grand Narrative of Value for Money.

The literature review involves a large number of issues. The reader may find that Table 2.1 (next page) provides a helpful conceptual framework for the literature review that follows. This table should be viewed in relation to Table 1.1 (p.17) in Chapter 1, but the subject matter is modified for the purpose of this chapter.

Table 2.1 Conceptual framework for the Adapted Grand Narrative: Analysis of business sector literature

Conceptual framework for the Adapted Grand Narrative: Analysis of business sector literature	
CATEGORY	COMMENT
<p>The left-hand side of the Adapted Grand Narrative (Net Present Value):</p> <p>RATIONAL BEHAVIOUR (V)</p>	<p>The assumptions of rationality are usually replaced by the concept of bounded rationality: decisions are made with limited powers of cognition and calculation. Sometimes all that can be expected is procedural rationality: decisions are made with the categories of the fundamental equation in mind.</p>
<p>DECISION CRITERIA</p>	<p>The foundations are usually subjective utility and, for future outcomes, expected utility. Time preference is expressed by the discount rate. Non-monetary components (psychic income) were considered vital components of decision criteria in classical literature. The concern of the modern literature is threefold:</p> <div><div>1. Descriptive; how governments decide</div><div>2. Normative; how governments should decide</div><div>3. Prescriptive; how governments can make better decisions</div></div> <p>This thesis is concerned with all three aspects.</p> <p>Modern literature tends to ignore the psychic aspects of choice that are expressed in behavioural economics.</p>
<p>CAPITAL RATIONING</p>	<p>Capital rationing is used to control decision making at the level of implementation.</p>
<p>The right-hand side of the Adapted Grand Narrative (Net Present Value):</p> <p>BENEFITS</p> <p>COSTS AND COST OF CAPITAL</p> <p>RISK AND ATTITUDES TO RISK</p>	<p>In the hierarchical decision process, actual outcomes provide a measure of the success of strategy in achieving strategic intent.</p> <p>The expected difference between revenues (benefits or outcomes) and costs together with the cost of capital is the basis of rational decision making and procedural rationality.</p> <p>Usually, strategic decision making and implementation are done by different groups of people with different attitudes and measures of risk. Risk (and uncertainty) is expressed by the high discount rate (implicit or explicit) that implies short-term thinking, assessment of high risks, or both.</p> <p>Extensive literature exists on the operation of Net Present Value and Value for Money in practice in the business sector.</p>
<p>The categories and comments in the table are used to construct the Adapted Grand Narrative. The Adapted Grand Narrative is adopted from the literature review in Chapters 2 and 3.</p>	

The categories of the left-hand and right-hand side of the Grand Narrative of Value for Money (as embedded in the Net Present Value equation) are deconstructed in this table.

At this stage, it is useful to remind the reader of the concepts that are presented in Table 1.1 (p.17) and recur throughout the thesis, providing a preliminary clarification of the approach: Archetype; Grand Narrative of Value for Money; and Deconstruction. The latter concept will also be discussed in more detail in the methodology chapter.

Archetype

As Jung (1968) explained, archetypes are general principles or categories that have many different representations. Jung (1968) applied the notion in analytical psychology, and Matthews (2002) has used it in a number of business and economics contexts.

In this thesis, Net Present Value is considered to be an archetypal structure underlying any attempt to maximise some objective (profits, satisfaction, or optimisation of efficiency in Pareto's (1935) sense of utility). The objective is also subject to scarcity, which acts as a constraint on the extent to which the objective can be achieved.

The first coherent expression of Net Present Value was by Fisher (1930); his work, together with that of Hirschleifer (1958, 1970), expressed the conceptualisation of Net Present Value that forms the fundamental equation of the Grand Narrative of Value for Money that we present in this thesis.

We argue that decision makers do use the archetype (i.e. the Net Present Value equation) in the way we suggest. However, the representation of the archetype may differ, and this is particularly likely in the case of the National Health Service that

this study explores. The specific representation of the archetype discussed is that of attempting to gain value in the National Health Service, so the value is referred to as Value for Money throughout this thesis.

The Grand Narrative of the Value for Money Strategy

The thesis examines the Grand Narrative of Value for Money as a strategic decision making process, and represents this as follows. Strategy is designed at one level in an organisation, but in large organisations, such as the National Health Service, it is implemented at lower levels of the decision making hierarchy –for example, by *face workers*, a term we use for people who deal directly with clients, implementing the strategies that are designed elsewhere in the organisation.

The argument is as follows: if the people implementing the strategy have different perceptions of that strategy than those who designed it, then the original intention will not be carried out. If, for example, value is the goal, then the perceptions of the factors affecting value will determine how the strategy of obtaining it is carried out, whether it is carried out, and whether it is carried out efficiently or effectively.

Within the Grand Narrative of Value for Money, the Net Present Value equation provides the categories generally affecting Value for Money (costs, benefits, discount rates, time preference, risk and so on). Efficiency, in this case, means getting more for less, or making the best use of resources. Effectiveness, on the other hand, means meeting more general requirements of strategy in the National Health Service, which include emotional aspects especially concerned with CARE, as well as the rational categories that appear in the value equation.

As we will show, Fisher (1930) and other economists were well aware of these emotional aspects – or, as they called them, psychic factors (p.52).

Deconstruction

The purpose of this literature review is to show how the research carried out in this study evolved out of an existing body of associated theoretical work. Then the reader will be able assess the extent to which the theoretical foundations have been applied and extended.

The evolution of the literature was achieved through deconstruction. Approaching the Grand Narrative of Value for Money through the fundamental Value for Money equation (according to the Net Present Value archetype) represents a deconstruction of the narrative, achieved by looking at the categories provided by the equation through the responses of our interviewees. This is only a partial deconstruction, in that Value for Money is approached through these categories.

As explained above (and in Table 1.1, p.17), the research process involves deconstructing the Grand Narrative of Value for Money. It is necessary to describe two initial stages. Firstly, the Grand Narrative should be explained and summarised succinctly. This is achieved by setting out a fundamental equation, the Net Present Value model (p.46), which will become the starting point for subsequent deconstruction. Secondly, the basis of the Grand Narrative of Value for Money in the health service should also be explained and summarised. This is achieved by setting out a diagram capturing the essence of the Grand Narrative and the consequences of the split between top level decision making and by *face workers* (p.7).

The criticisms and extensions of Net Present Value in business sector applications are also considered in this chapter, since these provide a basis for showing the extent to which representations of the issues of the Grand Narrative of Value for Money in the National Health Service are distinct from applications in the business sector. There is a deeper discussion about these issues later in this chapter.

In this way, a deconstruction of the Grand Narrative of Value for Money (embedded in the Net Present Value equation), especially as it is applied to business sector

issues, provides a useful framework for the literature review in this chapter (and in Chapter 6).

Foundations of the Study: Fisher's (1930) Net Present Value

In the remainder of this chapter, we examine the literature that has provided:

1. The fundamental equation of the Grand Narrative of Value for Money
2. The basis of the Grand Narrative of Value for Money in the National Health Service, which was used to construct the conceptual framework for the Adapted Grand Narrative of Value for Money

The initial focus is on the literature relating to the application of the Net Present Value model to the business sector. Later we discuss corresponding applications in the public sector (see Chapter 3).

1. The Fundamental Equation of the Grand Narrative of Value for Money

Economist Irvin Fisher, in his book *Theory of Interest* (Fisher, 1930), made two important contributions to the theory of investment: Time Preference, and the Separation Theorem. Both had implications in developing his Net Present Value equation. We shall discuss their influence in more depth in relation to the historical development of Decision Theory (p.55–58).

Fisher (1930) suggested the following investment rule: Net Present Value requires projects to be discounted for each year at the appropriate interest rate, and this relies on estimating the size and timing of all of the incremental cash flows resulting from the investment project. All projects along the Investment Frontier that yield positive Net Present Value should be chosen. Fisher (1930) also developed two further ideas: (i) the investment decision of the firm is affected by the owner's desired

consumption-savings decision; and (ii) the nature of the relationship between the firm's investment decision, its financing decision and wider financial markets.

Hirshleifer (1958, 1970) re-examined Fisher's (1930) theory and suggested modifications to the Investment Frontier, naming it the 'Fisher Separation Theorem'. Hirshleifer (1958, 1970) noted that it is inevitable that the preferences of the firm owner or entrepreneur affect investment decisions, and for this reason, the firm must integrate Fisher's consumption-savings decision into the investment decisions of the firm that the entrepreneur owns. He separated Fisher's theory of investment into a two-stage budgeting process. In the first stage, he used Fisher's consumption-savings decision and called it the first approximation. In the second stage, he used the investment decision and called it the second approximation. This separation clearly illustrates the issue of rational decision making and time preference, and the theorem can easily be generalised to cover as many periods as are required. As long as the pay-offs can be mapped to the National Health Service in a quantitative form, and can be unambiguously mapped into a numerical system, then we have a defined boundary line.

In an important way, Fisher's theorems may be interpreted in terms of the subject matter of this thesis in order to obtain Value for Money, since we represent Value for Money in terms of the project objective and the utility functions of the people involved in decision making. For the purposes of this study, we can adapt the principles of the Investment Frontier so as to address the issues of Value for Money as the Grand Narrative of the Value for Money strategy and the problems of obtaining it; this is clearly a special case of the principal-agent problem.

Arguably, using Fisher's original framework, Hirshleifer demonstrates one important issue – that Fisher's Separation Theorem (or the Investment Frontier) implies a broader governance approach that recognises the importance of multiple stakeholders, in which case value represents a trade-off function between different stakeholders and also represents a social welfare function. This is inevitable in a

complex system like the National Health Service. We shall revisit this argument in Chapters 5 and 8.

For now, however, the focus is on explaining Fisher’s equation and thereby setting out the logic for this chapter.

2. The basis of the Grand Narrative of Value for Money in the National Health Service, used to construct the conceptual framework for the Adapted Grand Narrative of Value for Money

The fundamental equation is illustrated in figure 2.1 (below).

Figure 2.1 Equation 1: Fisher’s (1930) standard Net Present Value equation

Left hand side Right hand side

$$V = \sum_{t=0}^T \left\{ \frac{E [B (t) - C (t)]}{(1 + r)^t} \right\}$$

We remind the reader that this is the beginning of the deconstruction process (as illustrated in Table 1.1, p.17). We deconstructed the fundamental equation into two parts: left and right-hand side.

The left-hand side of the equation consists of V as the objective function, representing the project objective and the utility function of the people involved in decision making. In a general sense, V represents value to stakeholders as well as their attitude to risk and uncertainty, and reflects economic rationality as their intrinsic motivation.

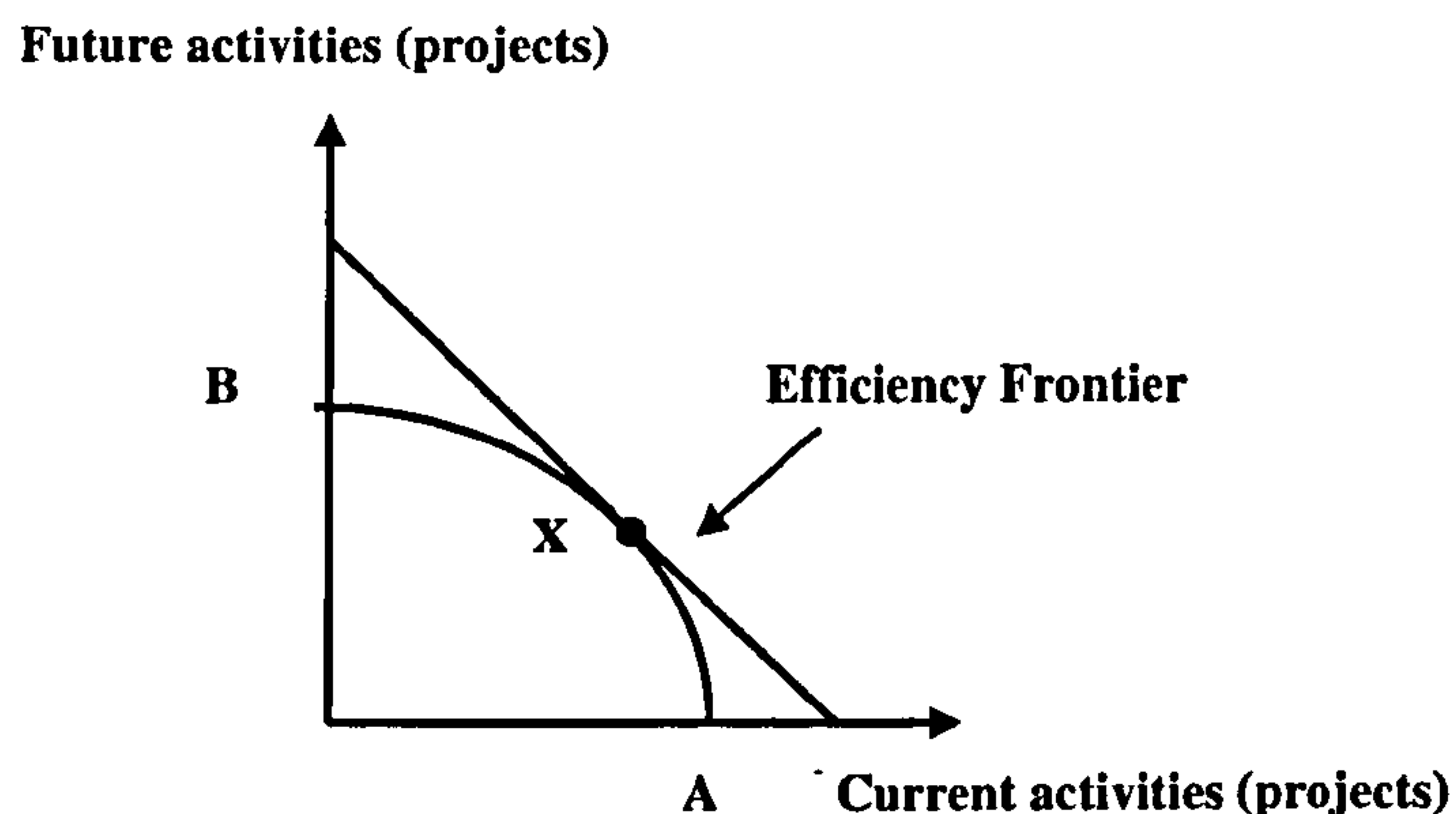
The right-hand side of the equation consist of operational variables – the categories

that are the determinants of Net Present Value:

- $E [B (t) - C (t)]$ represents expected net cash flow for each year
- $(1 + r)$ represents discount rate (with risk embedded into it)
- $t = 0, 1, \dots, T$. T is the time horizon of the project. Short-term projects will have a short-term horizon (low T), longer term projects will have a longer time horizon (high T).

Fisher's (1930) standard Net Present Value equation Standard (i) is simplistic, but nevertheless it provides a set of categories for our adapted Grand Narrative. This fundamental equation can also be illustrated diagrammatically by the Fisher / Hirshleifer diagram, shown in Figure 2.2 below.

Figure 2.2 Fisher's (1930) Efficiency Frontier



The line AB represents an efficiency frontier; that is, it represents the various combinations of future and current projects (activities). On the horizontal axis, we represent a particular activity or project. On the vertical axis, for simplicity, we represent other possible alternative activities or projects.

The curve AB represents efficient combinations of the two sets of activities; that is,

Value, in the sense that it is not possible to increase one activity without reducing another given the available resources. This is the Pareto's (1935) optimality principle. So, curve AB is an efficiency curve.

The first step for the firm is to decide which productive opportunities along the Investment Frontier line generate positive Net Present Values. Given the preferences of decision makers, the optimal choice is at X on the diagram, and any project below or above the Investment Frontier (i.e. projects generating negative Net Present Values) should be ruled out. These principles provide the basis for adapting the Grand Narrative of Value for Money to the public sector, and especially to the National Health Service, discussed in Chapter 3 (p.80).

In this way, we establish the status of Net Present Value as an archetype and the Grand Narrative of Value for Money. We use it as the basis for building the conceptual framework of the Adapted Grand Narrative in the business sector, since it provides a set of categories under which Value for Money in the National Health Service can be examined. It also forms a basis for empirical work in later chapters (Chapters 5 and 6 respectively).

Further development of the chapter

The rest of this chapter is organised as follows. We first examine the left-hand side for the conceptual framework of the Adapted Grand Narrative (as illustrated by Table 1.1, p.17), which can approximately be described as profit or utility maximisation³. The discussion focuses on rationality for two reasons. Earlier writers in the history of economic thought provided insight into the pitfalls of using aspects of Fisher's equation; these pitfalls have been forgotten, but they reappear as fundamental practical problems in the application of Value for Money thinking to the National Health Service. In this respect, Fisher's (1930) emphasis on the psychic element is especially significant, because Value for Money in the public sector, and particularly the National Health Service, is not well understood. We shall build on

³ We discuss this aspect later, during the discussion of the Decision Criteria.

these considerations of the equation later on in the empirical chapters of this thesis (Chapters 5 and 6). We then engage in a discussion of subjective value, risk and uncertainty, subjects which generally fall under the heading of Decision Theory. The reason for embarking on a historical review and an examination of the antecedents of value theory is that early classical economists were aware of the subjective basis of decision theory, and of the fact that value (V) was not a simple matter of monetary returns but also included important psychic aspects. Unfortunately, classical economists did not spell out what was meant by psychic factors, and later economists have attempted to associate purely rational behaviour with non-monetary factors. We then continue with the examination of the right-hand side of the equation, including the categories of the conceptual framework for the Adapted Grand Narrative: benefit, cost, cost of capital and discount rate, risk and capital rationing. At the same time we outline some of the critiques associated with these categories that appear in the literature related to the business sector. These categories provide a benchmark for assessing the contribution of this research to the practical problem of applying Net Present Value / Value for Money in the public sector and in the twenty-first century business environment, which is becoming increasingly aware of government's role in the economic process.

These discussions form the structure of the rest of this chapter.

The Left-hand Side of the Conceptual Framework for the Adapted Grand Narrative

As Table 2.1 (p.40) suggests, the left-hand side of the conceptual framework for the Adapted Grand narrative equation involves three issues:

- i. Rationality and Emotion
- ii. Decision Criteria
- iii. Capital Rationing

i. Rationality and Emotion

Investment decisions are made by a few decision makers, whose preferences are driven by their appetite for monetary gains and risk. However, emotion also exists. Not all the decision makers are driven by the same selfish motives; some may be motivated by other reasons, for example empathy, compassion or sympathy. This factor is important for this study, since the later empirical chapters will examine the linkage between one form of the rational behaviour (the Value for Money strategy) and CARE. For that reason, we discuss economic rationality first, and then go on to introduce emotion into the domain of economic rationality.

a. Economic Rationality

Assumptions of pure rationality are usually replaced by the concept of bounded rationality: decisions are made with limited powers of cognition and calculation. Sometimes all that can be expected is procedural rationality; decisions are made with the categories of the fundamental equation in mind. Clearly, the pure form of rationality is an oversimplification, as Simon (1986) pointed out. It implies that decision makers are seeking to optimise the use of resources by an exhaustive examination of alternatives. This raises two issues, both essential to Simon's (1986) concept of bounded rationality. The first is cognition, and the second is calculation.

Regarding cognition, economists like Veblen (1899), Keynes (1936), Simon (1992), and others of the Austrian School, place limits on cognition by arguing that the future cannot be predicted, and therefore no expectations can be truly rational, simply because we cannot know the future. Simon (1997) argues that the neoclassical economic theory is inadequate for describing what goes on inside the business firm:

Neoclassical economics is right in finding the core of its subject in the act of rational decision; its deficiencies arise from failure to ascertain how decisions are actually taken. And to ascertain that, we need to know about the processes that occur within heads. (Simon, 1997, p.71)

Simon also argues that under the substantive rationality concept, the assumption is that due to inconsistencies of individual preference and belief, the conflicts of value

among people and groups of people, and the inadequacy of the computations we can carry out, the process is subject to limitations:

If you are only interested whether something is rational, in fact, meets the conditions of environment or not; then it should be sufficient not to think of processes. The link between rationality and process lies in one's concern with the processes, where you have to be concerned with the limits on rationality because the process does not allow you to do optimisation. (Simon, 1992, p.273)

Simon also raises a second problem, regarding problems of calculation. Decision makers cannot consider all the available alternatives. Therefore, Simon (1992) suggests that at best the decision maker is a satisfier rather than an optimiser, because of the scarcity of information and a lack of the ability to determine all the possible outcomes.

Empirical studies by Tversky and Kahneman (1979, 1986, 1991), specifically those studies concerning Prospect Theory, questioned the assumption that investors are rational by demonstrating the tendency of investors to make risk-averse choices in gains, and risk-seeking choices in losses. In this sense, Prospect Theory violated economic rationality as it is usually understood. Prospect Theory emerged as a psychologically realistic alternative to expected utility theory. It gave rise to the pseudocertainty effect, based on the observation that people may be risk-averse or risk-acceptant depending on the amounts of money involved and on whether the gamble relates to becoming better off or worse off (e.g. buying an insurance policy compared to buying a lottery ticket). An important implication of Prospect Theory is that the way economic agents subjectively frame an outcome or transaction in their mind affects the utility they expect or receive.

By exploring behavioural assumptions, Prospect Theory marked a new era for behavioural economics, placing importance on the influence of psychology on decision making behaviour. Fisher's (1930) emphasis on the psychic element (the emotional enjoyment of the income) is especially significant and relevant to this thesis.

Perhaps the most important criticism of economic rationality is that it fails to consider the existence of a set of preferences, such as moral and political duty and selfless attitude, toward other human beings (including altruistic behaviour). These preferences are, to a great extent, difficult to capture in numerical form. Therefore, we need to say something about the link between rationality and emotion.

b. Emotion and Rationality

As this study will discuss in the empirical chapters to follow, decision making in the public sector differs from similar processes in the business sector because selfish motivation has been replaced by the government's moral obligation and duty to act in the best interests of the taxpayer. This difference is especially evident in the National Health Service.

The importance of emotion in rationality has been explored in terms of altruism. Coleman (1995) observed that emotions always exist, even in the most rational decisions. Emotions persist because of the way individuals feel about the choices they make. This was explored in the context of game theory by von Neumann and Morgenstern (1947), but it was Axelrod (1984) who applied it in the context of decision making and the evolution of cooperation, and Hirshleifer (1970) who applied it in the context of investment decisions and afterwards extended it to cooperation and conflict in political economics (Hirshleifer, 1978) and to economic logic (Hirshleifer, 1993).

Perhaps Fisher's (1930) principal contribution is his definition of income as 'psychic' (emotional) enjoyment rather than monetary gain:

Income is a series of events ... It is these events – the psychic experiences of the individual mind – which constitute ultimate income for that individual. Neither these intermediate processes of creation and alteration, nor the money transactions following them, are of significance except as they are the necessary or helpful preliminaries to psychic income – human enjoyment ... Enjoyment income is a psychological entity and cannot be measured directly. We can approximate it indirectly, however, by going one step back of it to what is called real income. (Fisher, 1930, p.7)

Traditionally, academics and practitioners alike have favoured observing the notion of income as monetary utility. However, Georgescu-Roegen (1971) criticised this viewpoint, which places economics firmly as a mathematical science. He argued that Fisher's voice was heard, but was not followed:

The true product of the economic process is an immaterial flux, the enjoyment of life by every member of the population ... It is this psychic flux which, as Frank Fetter and Irving Fisher insisted, constitutes the pertinent notion of income in economic analysis. (Georgescu-Roegen, 1971, p.290)

Shackle (1949) also observed emotions in investment decisions, and associated these emotions with the experience of the loss and gain. To him, loss or gain is a psychic experience, which is charged with the emotions of happiness when winning or distress when losing money.

To conclude this section, Fisher (1930) reminds us that income should be seen as psychic and emotional experience. Georgescu-Roegen (1971) developed Fisher's (1930) argument further, in the sense that economic processes are in a continuous state of flux and are not merely static. It is interesting that the qualifications and warnings of Fisher (1930) and Georgescu-Roegen (1971), cast in theoretical terms, reappear in very practical terms in our interviews with National Health Service managers in Chapter 6.

ii. Decision Criteria

The individual categories of the Grand Narrative of Value for Money (benefit, cost, cost of capital and risk) are classified under the headings usually found in Decision Theory, and for that reason, in this section we discuss some historical developments ranging from the seventeenth to the twenty-first century with respect to earlier neoclassical economics as well as today's Decision Theory:

- a. the foundations are usually subjective utility and, for future outcomes, expected utility and time preference, expressed by the discount rate

- b. risk and uncertainty
- c. we also discuss some criticisms of approximations of Net Present Value in practice

Non-monetary components (or psychic income) were also seen as vital components of decision criteria in classical literature. Modern literature tends to ignore the psychic aspects of choice that are expressed by behavioural economics. Even early antecedents in the literature raise questions for the modern context. Early classical economists were aware of the subjective basis of decision theory, and of the fact that value (V) was not a matter of monetary returns but also includes important psychic aspects. However, they did not spell out what was meant by psychic factors, and later economists have tended to associate rational behaviour purely with non-monetary factors.

Many contributions have been made since Smith (1759) associated the term utility with behavioural economics, an area whose role and path has been intertwined with mainstream (neoclassical) economic thinking in many ways. For that reason, we discuss the historical developments of these two paths simultaneously. Due to limitations of space, the aspects we are interested in relate to value over time and future income flows (psychic or monetary) and discussions that taken place over more than a century.

We first explore the early classical period, including the rise of subjective utility which marks the beginning of behavioural economics. We shall focus especially on psychological principles of individual behaviour, expected utility theorem and evolution, economics under risk (an important part of today's Decision Theory), and the influence of psychology on behavioural economics. Then we move on to discuss various domains of practical application: the economics of welfare, political economy and altruism, and the human capital approach in more recent times.

a. The Foundations of Subjective Utility and Decision Theory

The detailed discussion of the historical development of Decision Theory is organised as follows: (i) the early classical period; (ii) the classical period; and (iii) the mid twentieth century onwards.

(i) Early classical period

In the early classical period, Smith's (1759) *The Theory of Moral Sentiments* is an important text describing the psychological principles of individual behaviour. He used the term 'sympathy' to describe the experience of moral sentiments. The notion of sympathy is close to what we refer to later in this thesis as CARE. In his book *The Principles of Morals and Legislation*, Bentham (1843, 1907) wrote of utility as a great happiness, based on the moral principles governed by distinguishing right from wrong. He wrote extensively about the psychological underpinnings of utility, and he was concerned with valuing pleasures and pains in terms of intensity, duration and certainty of occurrence. These arguments set a precedent for the future employment of the maximisation principle in the economics of the consumer, the firm, and the search for an optimum in welfare economics. This period also marks the expansion of mathematical economics (today's Decision Theory).

The term expected value was invoked in the seventeenth century by Pascal (1670) in his book *Pensées*. The concept was extended to the measurement of risk by Bernoulli (1738), who suggested conceptualising expected utility as an absolute term rather than as an expected financial value. The St. Petersburg paradox became the basis of the economic theory of risk aversion, and generally of the literature surrounding attitudes to risk. In his 1881 essay *Mathematical Physics: An essay on the application of mathematics to the moral sciences*, Edgeworth (1881) attempted to apply mathematical principles to various social phenomena, including the capacity for happiness and the capacity for work. This work introduced his famous 'Edgeworth Conjecture', the 'Edgeworth Box', and the 'Edgeworth Theorem'. Menger (1871) and Jevons (1871) both adopted very different views on the role of

mathematics in economics; in *The Theory of Political Economy*, Jevons (1871) defined utility as an abstract concept rather than as an intrinsic quality, while Menger (1871) refers to it only as a degree of satisfaction in relation to a particular considered need.

In relation to the development in time preference (a concept which was influential in the development of Fisher's equation), Wieser (1889), in his seminal work *Natural Value*, refers to value as to a marginal value. In his treatise *Principles of Economics*, Menger (1871) developed the time-preference theory of interest, and in his *Principles of Economics*, Fetter (1904) asserted that time valuation is a prerequisite for the determination of the market rate of interest (Rothbard, 1977). Boehm-Bawerk (1890), in his work *Kapital und Kapitalzins*, built upon the concept of time-preference as described by Menger, but disagreed with Menger on the grounds that there is always a difference in value between present goods and future goods of equal quality, quantity and form. His own time-preference theory was perfected by other economists such as Wicksell (1907), who, in his paper *Lectures on Political Economy* (first published in 1901), developed the idea of two distinct rates of interest: a natural rate and a loan rate.

(ii) Classical period

During the classical period, in the early twentieth century, value as subjective utility of desire was fully embraced by Marshall (1920) in *Principles of Economics*:

Utility is taken to be correlative to *Desire* or *Want*. It has been already argued that desires cannot be measured directly, but only indirectly by the outward phenomena to which they give rise; and that in those cases with which economics is chiefly concerned the measure is found in the price which a person is willing to pay for the fulfilment or satisfaction of his desire. (Marshall, 1920, p.14)

Pigou (1932) continued Marshall's work on subjective value, defining utility as the intensity of desire:

The term utility, which naturally carries an association with satisfaction, represents intensity of desire. Thus, when a person desires one thing more keenly than another, it is said to possess a greater utility to that person. (Pigou, 1932, p.1)

(iii) Mid twentieth century and onwards

In the mid twentieth century and onwards, expected utility theory also provided the basis for the development of perhaps one of the most influential operational models of rational choice game theory, published in the book *Theory of Games and Economic Behavior* by von Neumann and Morgenstern (1944). Game theory was developed and explored in the 1950s by many scholars. Nash, Selten and Harsanyi each made distinctive contributions to equilibrium analysis in non-cooperative game theory: Nash (1951) provided the foundations for game theoretical analysis; Selten (1975) developed the theory with respect to dynamics; and Harsanyi (1967–1968) developed the ideas with respect to incomplete information. Game theory was also extensively applied in biology, largely as a result of the work of Maynard Smith (1982) and his evolutionarily stable strategy. Game theorists Schelling (1960) and Aumann (1974) also applied game theoretical analysis to conflict and cooperation.

Other theoretical contributions regarding subjective value have also applied the principles to various practical contexts, for example time-preference (which is relevant to this study), paving the way for today's discount rate. Mises (1966) extended and applied the subjective value theory to money and indirect exchange in his work *Contribution to Interest Theory*, suggesting that an individual would be willing to postpone all his satisfaction to the indefinite future. Wicksell's thoughts influenced Buchanan (1969), who pioneered public choice theory. Fisher (1930), in his *Theory of Interest*, sees the investment decision of the firm as an inter-temporal problem, and develops a further discount rate. Miller and Napier (1993, p.640) argue that while Net Present Value has been a fundamental notion in finance since Fisher (1930), nevertheless the technology of discounting is not an invention of the twentieth century. Discounted cash-flow analysis has been used since the eighteenth century (Brackenborough, McLean and Oldroyd, 2001; Parker, 1968; Edwards and Warman, 1981). Today, discount rates are often found by making use of the classical Capital Asset Pricing Model (Sharpe, 1964; Lintner, 1965; Mossin, 1966).

An important paper in the development of the fields of behavioural finance and

economics was written by Kahneman and Tversky (1979, 1986, 1991); the theories presented in their work *Prospect Theory: An Analysis of Decision Under Risk* violated generalised expected utility theory, arguing for the descriptive inaccuracy of expected utility theory (p.48). Hirshleifer (1978, 1985) started to explore connections between economics and socio-biology and conflict, turning his attention to behavioural economics when applying economic logic to a variety of non-economic problems. Pigou's (1932) work also influenced Becker (1993) in his work on family and human capital. Becker was one of the first economists to branch into sociology, including racial discrimination (Becker, 1971), crime (Becker, 1968), and family organisation (Becker, 1981). Simon (1986) focused on the ways in which the actual decision-making process influences decisions, and termed decision makers' behaviour as bounded and rational. In this sense, bounded rationality became a central theme in behavioural economics, relaxing one or more of the assumptions of expected utility theory.

The search for a better understanding of decision making continues into the twenty-first century. In *Anomalies*, Thaler (1994) documented individual instances of economic behaviour that seemed to violate traditional microeconomic theory. Rabin (1998; 2006) and Camerer (1997, 2003; Camerer *et al.*, 2004) defend the use of experiments in behavioural economic research, and discuss recent progress in behavioural game theory. Levine (1998) focuses on experiments for exploring altruism using game theory, while Fisher *et al.* (1999) focus on the role of behavioural factors such as frames and cognitive errors, self-control, and regret in time diversification in portfolio analysis.

b. Risk and Uncertainty

Another area of Decision Theory that is relevant to this thesis is the notion of risk and uncertainty. Modern Decision Theory focuses heavily on treating risk and uncertainty as probabilities. For example, risk is referred to variously as: the size of dispersion of the probability distribution of the input element, in conditions where it

is possible to assign probabilities to the outcomes of a random event (Luxhoj *et al.*, 2003); a synonym for uncertainty (Hirshleifer, 1970); a factor for evaluating the attractiveness of projects in portfolio analysis (Sharpe, 1964; 1970); a variation in return rather than a danger or likelihood of failure (Markowitz, 1952); or even as a condition in which there exists a quantifiable dispersion in the possible outcomes from any activity (CIMA, 1996, p.101). Under uncertainty, these probabilities are unknown (Van Horne, 1966; 1969), and firms do not seek to maximise any objective function but to achieve satisfactory levels based on their history (Giraud, 1995; Kalu, 1999).

It seems that economists' disagreement about the nature of risk stems mainly from difficulties in defining precisely what is meant by risk and uncertainty. These differences have played a major role in the debate among followers of subjective and expected utility, and have shaped what is known today as Decision Theory. Again, because of space limitations it is not possible to discuss all the arguments in depth; instead we must limit the discussion to mentioning a few of them.

Keynes (1921) argued that uncertainty has two dimensions, probability and weight, neither of which needs to be measurable. While he was anxious to describe all uncertainties as probabilities, he saw the risk as subjective and ignored it. Knight (1921), in his distinction between measurable risk and immeasurable uncertainty, shared Keynes' view that probabilities are not necessarily measurable. Fisher (1930) regarded uncertainty as expressible in terms of probability, and concluded that risk varies with knowledge.

Arrow (1951) argued that the list of devices used to reduce uncertainties in Knight's thesis is much the same as that given by Fisher (1930). However, Ford (1990) criticised Knight's work, arguing that he did not offer any alternative mechanisms by which uncertainty could be evaluated. Egerton (1960) argued that Knight raised some of the conditions under which it would be appropriate to rely on objective probability as a measure of implication where uncertainty was risky. Nevertheless,

there was general agreement between Knight (1921) and Shackle (1949), who both argued that if the individual does not have the ability to repeat the experiment indefinitely, probabilities are irrelevant.

Perhaps the first significant point of reference belongs to Shackle (1949), who did not share Knight's view of uncertainty, arguing that Knight remained encapsulated in a probability concept (which was borrowed by Keynes). This is represented by the view that uncertainty could be captured and measured by subjective probability. Shackle (1949) rejects the degree of belief theory of probability, since a distribution can never be verified, even ex-post, and frequency theory is inapplicable where indefinite repetition is impossible. He suggested that the decision-maker could best approach uncertainty through estimating the degree of potential surprise.

Arrow (1951) and Ford (1990) also argued that Knight remained wedded to the prevalent view that uncertainty had to be encapsulated in probability concepts. Egerton (1960) argued that Shackle paid very little attention to risk, thereby denying it as a useful and meaningful concept in relation to an isolated unique investment project. Ford (1990, 1994) managed to demonstrate that multi-asset portfolios were feasible if the Shackle apparatus was employed in its entirety. Ford's (1983, 1987) proof arose from three assets that could be chosen optimally in the Shackle model. Simon (1992) also acknowledged that Shackle's approach to dealing with uncertainty through bounded imagination was a process theory for what is going on in the mind of an investor, underpinned by the necessity of a human mind to simplify the problem in order to be able to deal with it.

Economics, traditionally deriving both its descriptive and prescriptive approaches from Subjective Expected Utility (SEU), also started to pay more attention to the context of pragmatic (business) decision making. The work of Allais (1953) and Ellsberg (1961), and later the Prospect Theory of Kahneman and Tversky (1979), challenged the argument that expected utility theory also provided a theory of actual human decision-making behaviour under risk. The latter emphasised that in actual

human decision making, losses loom larger than gains; people are more focused on changes in their utility states than the states themselves, and the estimation of subjective probabilities is severely biased by anchoring (p.48).

In concluding this section, a discussion of the differences between uncertainty and risk suggests that individual decision makers at different levels of the organisation may have different attitudes to risk, and this influences their choices. A certain appetite for risk might not be shared by the organisation's owners, and this suggests that in business decision making, the principal agent's behaviour guides the decision maker. In decision making in the business sector, we discussed risk in terms of the discount rate. The public sector does not hold that risk should be included in the discount rate; instead, a social discount rate is used, which excludes the element of risk. We shall discuss this assumption in more detail in Chapter 3.

c. Approximations of the Net Present Value in Practice

We should also discuss some critiques associated with approximations of the Net Present Value equation. This is necessary for two reasons: one useful thing about the Net Present Value model is that it provides a set of categories under which Value for Money in the National Health Service can be examined; another is that the concept of Net Present Value is so standard that it has been extensively critiqued and refined. Examining these critiques and refinements in business sector applications provides a set of benchmarks, allowing an examination of the concept's application in the National Health Service (which we undertake in Chapter 3), and identifying ways in which the concept corresponds and differs between the two sectors.

The literature suggests that in spite of numerous deficiencies, Net Present Value remains a preferential choice for governments across different continents. As with any ideal model, it is open to scrutiny and criticism when it comes to practical application. This section constitutes a reminder to the reader that the archetypal model has a number of criticisms of its application in the business sector. This is an

important set of considerations, since one of the points of the thesis is to show the extent to which these critiques overlap with public sector considerations, which criticisms do not overlap and why not, and what separate issues arise in the National Health Service. This section discusses how well Net Present Value has been adopted, as well as examining critiques from various authors about how they suggest that decision makers deal with certain issues concerning the application of the model in the business sector. To examine and discuss these critiques, we look at some practical situations involving Net Present Value:

- (i) Standalone, use or in combination with other techniques
- (ii) Sub-optimality and relaxation of the Net Present Value rules

(i) Standalone use or in combination with other techniques

In relation to using Net Present Value as a standalone model or using it in combination with other techniques, the empirical research into capital budgeting techniques within the United Kingdom business sector indicates a growing tendency to use a mix of quantitative techniques. Among the traditional accounting measures for project appraisal are payback, discounted payback, average rate of return (ARR), internal rate of return (IRR) and Net Present Value.

Arnold *et al.* (2000) suggest that there has been a significant increase in the use of Net Present Value on its own (4%), in combination with two other methods – either ARR (5%) or IRR (8%) – and in combination with three methods, payback and ARR. There has also been an increase in the use of Net Present Value in combination with IRR and ARR (6%), or payback and ARR (5%). The study also showed a slight decline in the use of the model in combination with all four methods: Net Present Value, ARR, payback and IRR (29 %). This should be compared with Pike's (1996) findings of 30% for the same combination.

A survey done by Akalu (2003) suggests that there is a growing trend showing that

an increasing number of companies combine two, three, and four models. A combination of two models is employed by 30%, a combination of three models by 27%, and four models by 35% of the companies.

A survey by Alkaraan *et al.* (2006), complementary to the survey by Arnold *et al.* (2000), suggests that managers prefer techniques such as Net Present Value and IRR rather than payback for the financial analysis of much more complex strategic projects.

A survey by Abdel-Kader and Dugdale (1998) did not attempt to survey the same companies surveyed by Pike and Arnold, and selected only the largest manufacturing companies in the United Kingdom on the assumption that these firms make substantial capital investment expenditures. In this way these authors sought to complement and update the Arnold *et al.* (2000) survey.

It is clear from empirical studies that the popularity of Net Present Value is shifting towards its greater use in practice, but its popularity as a single method is overshadowed by its increasing use in combination with other methods. This suggests that decision makers are aware of the model's limitations.

(ii) Sub-optimality and relaxation of the Net Present Value rules

In relation to sub-optimality and relaxation of the Net Present Value rules, Arya *et al.* (1998) argue that the standard Net Present Value rules have been overlooked or relaxed to the extent that firms may be forced to make sub-optimal decisions, or that assumptions underlying the model's rule are not always met in practice. This has led to some suggestions that the model's assumptions might have been violated, and the mechanism of coping with uncertainty when conducting appraisal is to use multiple criteria as a means of evaluating the project from different perspectives.

A survey by Akalu (2003) among business sector companies in the UK has also

suggested that the continuous application of traditional capital budgeting techniques reveals significant limitations in their capacity to address some of the basic problems of investment appraisal.

Concluding this section, many modifications have been sought since the appearance of Net Present Value in 1931, and it is not the purpose of this thesis to discuss them. Instead, the thesis adopts the model as the archetype because it recognises four key elements necessary to conducting investment appraisal. In principle, Net Present Value is widely accepted across the spectrum of business and government sectors around the world. It recognises the time value of money, it recognises not only the costs but also the expected benefits, it recognises the importance of considering risks by using the associated project hurdle rate or discount rate, and it offers flexibility in terms of adjusting for inflation.

We also need to mention something about capital rationing, because it influences business as well as public sector decision making.

iii. Capital Rationing

The research literature concerning capital rationing is substantial (Naslund, 1966; Hillier, 1971; Hayes, 1989). A central issue is the allocation of limited financial resources among alternative projects, with the aim of achieving the maximum profit over time. Classical methods of investment appraisal, such as the Net Present Value model, are useful for measuring the attractiveness of an individual project. So, in the case of pure capital rationing, in which no borrowing, lending or carrying forward of unused funds from one period to another is permitted, the objective is to maximise a linear function of the Net Present Value of the net cash flows associated with individual projects by selecting a subset of available projects, subject to two sets of constraints: (i) total cash outflow cannot exceed the available budget in any period; and (ii) a project cannot be partially adopted.

Capital rationing remains an issue for many firms. The choice between project alternatives becomes subject to inter-temporal budget constraints. Among the empirical work in the United Kingdom business sector, the survey by Arnold *et al.* (2000) reported that firms impose budget ceilings as a constraint, leading to the rejection of viable projects. The main reason for imposing this constraint is attaining central control for the whole group. For small firms it reached up to 87%, for medium sized firms up to 79%, and for large firms to 67%, with a total average of 77%. This suggests that, in the business sector, an internal form of capital rationing is used for the purpose of central management control. From a purely theoretical point of view this is counter to Net Present Value reasoning, but, given the kind of issues raised in this research, it may not be inappropriate; this is an issue to pick up later, taking a holistic view of the research.

Again, consider the case of capital rationing in the National Health Service. As we descend the hierarchy of decision making in the National Health Service, we could argue that the extent of capital rationing becomes greater and greater. The extent to which investment funds are allocated becomes more and more specific. Choice becomes an issue not of what to spend money on, but of how to allocate it most effectively. The implications for the National Health Service are that not all healthcare needs can be met, because it is simply not feasible to do so. Instead, resources are allocated according to the current priorities. In that sense, capital rationing serves as the yardstick against which the expenditure is established at different levels of the National Health Service hierarchical structure. We shall come back to this issue in Chapters 3 and 6. For the present moment, the discussion has focused our attention on examining the left-hand side of the conceptual framework for the Adapted Grand Narrative equation (see p.46, Figure 2.1).

We now proceed to examine the right-hand side of the conceptual framework.

The Right-hand Side of the Conceptual Framework for the Adapted Grand Narrative

We continue the examination of the business sector in respect to the right-hand side of the conceptual framework for the Adapted Grand Narrative equation, in terms of:

- i. Benefits
- ii. Costs
- iii. Cost of Capital and Discount Rate
- iv. Risk and Attitudes to Risk

With respect to the right-hand side of the equation, we first make some remarks. The projects are considered as independent. We consider the stream of opportunity cost (Buchanan, 1969; Shackle, 1949). We consider revenue or benefits (which must be related to objective function so that we can link them to training and consider many stakeholders, various trade-offs and government issues). We suggest using pay-offs rather than net cash flows, and we remark on time preference and the cost of capital.

We also discuss some critiques associated with these categories, for two reasons. Firstly, one useful thing about the Net Present Value model is that it provides a set of categories under which Value for Money in the National Health Service can be examined. Secondly, the concept of Net Present Value is so standard that it has been extensively critiqued and refined. Examining these critiques and refinements in the context of business sector applications provides a set of benchmarks to examine the model's application in the National Health Service (which we do in Chapter 3), and to identify ways in which it corresponds and differs between the two sectors.

Table 2.1 (p.40) provides a conceptual framework for the further literature review that follows, concerning the right-hand side of the Grand Narrative of Value for Money (as embedded in the Net Present Value equation). Table 2.2 (next page) illustrates a set of preliminary findings in respect to these categories.

Table 2.2 Extended Results for the Adapted Grand Narrative: Analysis from business sector literature

Extended Results for the Adapted Grand Narrative: Analysis from business sector literature	
CATEGORY	COMMENT
The right-hand side of the Adapted Grand Narrative (Net Present Value)	The term <i>Net Present Value</i> describes the difference between the present value of a stream of costs and a stream of benefits.
BENEFITS	Revenues are variously treated as cash flows or benefits (which may or may not include non-monetary items) or pay-offs (which are the game theory version of benefits).
COSTS	Cost is seen as displaced opportunity and related to the behaviour of a person (Buchanan, 1968), and as the sacrifice of a second (Shackle, 1949).
COST OF CAPITAL AND DISCOUNT RATE	Capital Assent Pricing Model is used to estimate a discount rate. Identifying the cost of capital is a crucial issue for firms and is subject to wide variations across firms with regard to the overall figure, the precise computation of its components, and fluctuations in share prices (McLaney <i>et. al.</i> , 2004; Arnold <i>et. al.</i> , 2000; Pike, 1988; Pindyck, 1994).
RISK AND ATTITUDES TO RISK	Risk represents the likelihood that a particular event will occur. Projects are taken over a certain period; their duration may be known with certainty, but the cash flow may be probabilistic, and the interest rate may range between assumed high and low limits (Luxhoj <i>et al.</i> , 2003). Sensitivity analysis is the most popular method of risk assessment in practice (Pike and Ho, 1992; Arnold <i>et al.</i> , 2000).

i. Benefits

Revenues on the right-hand side of the conceptual framework for the Adapted Grand Narrative equation in the business sector are variously treated as cash flows, benefits (which may or may not include non-monetary items), or pay-offs (which are the game theory version of benefits). The notion of pay-offs is conceptualised in broader

terms than receipts or benefits in from game theory. This idea may be more illustrative of the nature of decision making in the National Health Service, where, as we will show, pay-offs relate to a number of different stakeholders.

The term's relevance and its importance to this thesis is broad enough to include the huge variety of outcomes associated with the National Health Service. The notion of multiple pay-offs strengthens arguments about the subjective nature of both costs and benefits in the National Health Service. We are not dealing with the subjective assessments of single individuals, but with groups of individual decision makers who need to agree on what the specific outcomes or pay-offs of investments should be, what their value is, and what the priorities are.

The numerous political debates about these issues demonstrate just how difficult they are to resolve (Her Majesty's Treasury, 2002; Wanless *et al.*, 2007). In other words, the goal of obtaining Value for Money in a general sense is easy to justify, but when we come to an examination of the empirical details, the issue becomes increasingly complex. It is complex because, arguably, the need for pay-offs affects the implementation of policy, and any kind of investment project in the National Health Service opens itself up to criticism simply because people have different subjective valuations and different priorities; whatever decisions are made are the result of trade-offs between different stakeholder interests.

To put it another way, the principal-agent problem, which features centrally in the theory of the business firm, takes on additional significance and complexity in public sector applications. Objective function of the Net Present Value equation assumes that the individual decision maker is only interested in pursuing personal gain, purely mechanically and selfishly (Marshall, 1920) in terms of a simplistic shareholder value point of view. We also know that money may not always be the only motivator. In the context of the National Health Service, even if we treat the categories as utilities (according to Marshall), it is clear that some categories cannot be expressed in numbers because very often the benefits (or outcomes) from

healthcare intervention are seen as intangible; for example, decision making in healthcare involves emotional aspects such as CARE and compassion. Again, we must remember Shackle's (1949) notion of emotional outcome –surprise at realising either a loss or a gain, and emotional distress due to loss – and Fisher's psychic experience of income (Fisher, 1930), which we shall come back to in the empirical chapters.

At this stage, we introduce the reader to the idea of benefits (outcomes or pay-offs) and costs (discussed in the next section) as emotional concepts.

ii. Costs

In line with economic tradition, the decision maker chooses the opportunity that seems to be the most economical, in the sense that it yields more profit than others per unit of cost expenditure. This poses the question: 'What alternative profit opportunities am I forgoing because I undertake this particular project?' It suggests that the chosen project obtains Value for Money only when the sum invested is expected to produce a profit or return at least as great as would be produced in the best alternative project. This is exactly what the Net Present Value rule does: it discounts the expected stream of costs and benefits at the most appropriate discount rate – that is, the opportunity cost of funds. In this sense, the opportunity cost is fundamental to all investment decisions.

The application of the Net Present Value rule also seems to be deceptively simple. The question immediately arises: Whose opportunities are we considering, and how do we value them? Opportunity cost appears to be very precise, but in fact it may be very subjective. This comment is particularly relevant in situations where those individuals carrying out the implementation of an investment decision are different from the people who originally made the decision. In such situations, the decision makers must specify the outcomes they are looking for. We shall follow up this aspect in the context of the National Health Service in later chapters.

The problem of defining cost from a subjective position has a long history. Many economists, for example Shackle (1949) and Buchanan (1969), see costs as a subjective phenomenon and have criticised the traditional view of economic cost, arguing that choice is based on desire or utility rather than cost alone, and is influenced by the behaviour of the decision maker. This strengthens the point made in the previous paragraph about the consequences of a split between the original decision maker and those responsible for implementing a decision.

It is useful to examine the problem further by looking at historic antecedents to what has become the Net Present Value rule – a framework which is firmly embraced by finance textbooks, even though both academics (Arnold, 2006) and professional accounting bodies, like the Chartered Institute of Management Accountants (Ogilvie, 2006), choose to ignore the subtleties of the arguments involved.

Differences in views of the opportunity cost are also important to us. The thesis examines the representativeness of cost in the National Health Service, particularly the perceptions of many decision makers, from top decision makers (who decide on the strategy) to *face workers* (who actually implement the strategy). They might have very different views (including Fisher's (1930) emotional or psychic aspects) of the investment decision, but these differences may be ignored in business decision making. For that purpose, it will be useful to discuss and compare Buchanan's and Shackle's differences.

Buchanan (1969) argues that neoclassical economics did not satisfactorily remove the root of the ambiguity surrounding the true meaning of the economic cost. The usual definition is in terms of alternative cost, best formulated as displaced product cost, and suggesting that cost is inevitably related to the behaviour of a person. He suggests that when a person faces the possibility of taking at least two courses of action, they consider their relative significance and find that one course is of higher significance than the other. In taking the preferred course they displace the alternative opportunity. In that sense, the cost is a displaced cost.

Buchanan (1969) adheres to the subjective-cost doctrine, and therefore his pure subjective-cost approach denies that the actual costs of any action can ever be known even by the decision-makers. This is because the act of choice is itself a cost being subjectively perceived, and the costs are inherently not observable and are therefore not measurable. Debate about National Health Service policy is a testament to the real-world significance of this problem. The issue of obtaining Value for Money is not as simple, even in principle, as it may seem, precisely because there is some subjectivity in the way that both costs and benefits are measured.

Like Buchanan (1969), Shackle (1949) argued that the notion of opportunity cost encompasses the general aspect of choice, and the sacrifice of a second-best option represents part of the essence of any act of choice. Shackle goes further and attaches an emotional aspect. To him, cost is a sacrifice and results in a psychic experience of loss and gain in the process of what is going on in the investor's mind. The outcome would be perceived as an emotional outcome; for example, loss would lead to distress, and gain would lead to a good feeling or even happiness.

In conclusion, the main argument that we suggest here is that we enrich the notion of opportunity cost. Although their views differ, both Buchanan and Shackle belong to a school of thought advocating the subjective theory of value discussed earlier. We introduced the reader to the idea of the cost as emotional; we shall come back to this issue in the empirical section (Chapter 5).

iii. Cost of Capital and Discount Rate

The discount rate expresses the cost of capital associated with a project, and embodies the notion of time preference (on the part of the decision makers) and risk. In brief, high discount rates are associated with short-termism and are very relevant for Ministers. who have a short time between elections to make a mark. However, this consideration is not limited to politicians. It is generally accepted that high positive discount rates favour programmes where the cost occurs later or benefits

occur earlier. Therefore, identifying the cost of capital is a crucial issue for firms, because it provides the discount rate in the evaluation of capital investment projects. The hurdle rate should also reflect the riskiness of the investment, which is measured by the volatility of cash flows and must take into account the financing mix. In such situations, decision makers apply theoretically sound models, such as the Capital Asset pricing model built on Markowitz's (1952) modern portfolio theory and further developed independently by Sharpe (1964), Mossin (1966), Lintner (1965) and Treynor (1962).

Decision makers use the Capital Asset pricing model in order to estimate a discount rate appropriate for a particular project. They also use the Weighted Average Cost of Capital (Modigliani and Miller, 1958; 1963) for reflecting the financing mix, representing the level of risk of the company. The Weighted Average Cost of Capital value is calculated by looking at the returns of securities (for example, stocks and bonds) with a risk profile similar to that of the company being evaluated.

In business sector practice literature, the cost of capital calculation has long been a subject of debate. It is generally accepted that the cost of capital is subject to wide variation across firms with regard to the overall figure and the precise computation of its components, as well as being affected by fluctuations in share prices. Because the weighted average cost of capital based on market values can change daily, the estimation of the risk premium is important, particularly in regulated industries where the return on equity, as a surrogate for the cost of equity, effectively determines the prices of goods and services – as suggested in a survey by McLaney *et al.* (2004). This survey also suggests that the cost of capital decision is of strategic importance for the longer-term maintenance and expansion of firm value, and it is almost always made within the domain of the board of directors, especially in the case of assessing the benefits from corporate restructuring. The Capital Asset pricing model remains the most widely used, as reported by studies within the United Kingdom carried out by Gregory *et al.* (1999), Al-Ali and Arkwright (2000), Arnold *et al.* (2000) and McLaney *et al.* (2004). Similar studies were carried out in the USA:

by Graham *et al.* (2001) and Bruner *et al.* (1998).

To conclude this section, apart from opportunity costs, in practice, high discount rates can imply a high subjective preference for short-term rather than long-term returns on investment. It could be argued that in contrast with the business sector, the pressures on public sector managers, especially in the National Health Service, indicate that high discount rates appropriate to short-term successes are to some extent imposed on them through the public demand for immediate results.

Discount rates also reflect the assessments of organisations and individual decision makers' attitudes to risk, considerations which lead us to the next section.

iv. Risk and Attitudes to Risk

Risk in business sector finance has become a central preoccupation of corporate governance, and is examined in the context of project risk assessment. The subjectivity of many of the pay-offs and costs associated with National Health Service projects is apparent with respect to risk. Risk is important because:

- (i) Each project has a number of possible outcomes, and these outcomes are probabilistic rather than certain
- (ii) Projects are taken over a certain period; their duration may be known with certainty, but the cash flow may be probabilistic, and the interest rate may range between assumed high and low limits (Cigdem *et al.*, 2003)

Using sensitivity analysis to measure risk in probabilistic terms is perhaps the most popular method of risk assessment in practice, and this is discussed below.

In the literature concerning the business sector in the United Kingdom, Pike and Ho (1992) reported that the most common among the primary risk appraisal techniques adopted in evaluating project returns and risk were risk-adjusted, discounted rate and

sensitivity analysis methods, also called probability techniques, and that a significantly higher percentage of firms used these techniques.

Later studies (Pike and Ho, 1996; Arnold *et al.*, 2000) revealed that the most popular technique for assessing the risk of both strategic and non-strategic investment projects is sensitivity analysis, which is a trend also evident in previous studies. The least used techniques across the board were computer simulation and beta analysis, also confirming previous observations that these theoretically superior methods are perceived to be less useful, even for high risk strategic projects, despite their apparent 'scientific' rigour (Abdel-Kader and Dugdale, 1998).

Another set of findings (Alkaraan *et al.*, 2006) appears to contradict those of Arnold's study (Arnold *et al.*, 2000) when it comes to trends in the use of risk analysis techniques. Alkaraan *et al.* argue that the use of risk analysis techniques in large United Kingdom-based companies is increasing over time, and state that the use of techniques other than sensitivity analysis is lagging behind.

This longitudinal survey (Alkaraan *et al.*, 2006) only examined the techniques that had been surveyed in previous studies (Pike and Ho, 1996; Arnold *et al.*, 2000). Other empirical studies suggest that organisational participants socially construct risk (Collier *et al.*, 2002; Harris, 1999).

In conclusion, these empirical results show that organisations do recognise the importance of assessing risk as a major factor. Therefore, the risk behaviour of the organisation may influence the extent of capital rationing. Decisions are made at many levels of the hierarchy, and, as will be argued later, they occur as part of a network of relationships, each with differing assessments of risk. This in turn affects priorities, and strengthens our point that the intentions of decision makers at upper levels of the hierarchy are likely to differ from those of the individuals actually carrying out the decisions – this is the issue which we shall examine in an empirical context.

Conclusions

We extend our literature survey to the public sector in the next chapter. At this point, however, it may assist the reader if we summarise and reflect upon the issues that have so far emerged.

We have established the equivalence between Value for Money and Net Present Value, their status as archetypal, and the Grand Narrative of Value for Money. We clarified the difference between these two concepts. As an archetype, Net Present Value is seen as a universal form that can have many representations. Value for Money is seen as a particular interpretation of this archetype: 'getting more for less'. To put this another way, the Net Present Value equation enables us to identify categories relevant to achieving Value for Money. This is our fundamental Grand Narrative of Value for Money equation, and the categories are used to construct the conceptual framework for the Adapted Grand Narrative of the thesis.

We applied the deconstruction technique suggested by Boje (2001) to deconstruct the archetype Net Present Value equation. Although there are problems in applying the framework to the business sector, it remains the archetypal framework. Nonetheless, work on business sector applications has also anticipated some of the problems that will be encountered in an institution like the National Health Service. Deconstruction of the Grand Narrative of Value for Money (as a first step in constructing the conceptual framework for the Adapted Grand Narrative) enables us to show how obtain Value for Money is a fundamental concern, as well expose its limitations.

The concept of Net Present Value is so standard that it has been extensively critiqued and refined. Examining the critiques (using the categories of the Net Present Value equation) and refinements in business sector applications provides a set of benchmarks to examine its application in the public sector, especially the National Health Service. We do this in Chapter 3, when we examine the left- and right-hand sides of the equation in more depth. In the empirical Chapter 5 we will look at the concept's applicability in the National Health Service. Therefore, it will be useful to

make a preliminary examination of the literature on the Grand Narrative of Value for Money equation at this point.

The literature surveyed has begun to shape our thinking about the status of these issues in the National Health Service because, bearing in mind the various critiques of the Value for Money equation, we argue that very few of those should be applied to the public sector. This argument provides the basis for the next chapter.

3. LITERATURE REVIEW (2): THE PUBLIC SECTOR BACKGROUND TO THE ADAPTED GRAND NARRATIVE

Introduction

This chapter provides the second stage of the literature review. Whereas in the previous chapter issues surrounding business decision makers were central, in this chapter issues of social benefits and outcomes, social discount rates and social cost, and capital rationing become more important. This section of the literature review extends to examining the public sector and the National Health Service very generally. Net Present Value represents the archetype and the original Grand Narrative (Lyotard, 1979; 1984) of investment decision making, as illustrated in Table 1.1 (p.17). The categories are discussed in relation to the literature, and are used to construct the conceptual framework for the Adapted Grand Narrative of the thesis. As in the previous chapter, these categories may be classified (under headings usually found in Decision Theory) as the rational choice model and the version of the Grand Narrative of Value for Money.

Later in the investigation, we discover complex issues in relation to the Value for Money strategy more generally. Political considerations are a key aspect of decision-making. The National Health Service is a network organisation with an extensive group of stakeholders – trade-offs must be decided between their interests. Value for Money has to compete with ever-higher expectations of CARE.

Since the literature review of the public sector in relation to the Adapted Grand Narrative of Value for Money involves a large number of complex issues, the reader may find that Table 3.1 (next page) provides a useful pathway through what follows. As in the previous chapter, it is adapted from Table 1.1 (p.17) in order to deconstruct the left-hand and right-hand side of the Grand Narrative of Value for Money equation.

Table 3.1 Conceptual framework for the Adapted Grand Narrative: Analysis from public sector literature

Conceptual framework for the Adapted Grand Narrative: Analysis from public sector literature	
CATEGORY	COMMENT
<p>The left-hand side of the Adapted Grand Narrative (Net Present Value)</p> <p>RATIONAL BEHAVIOUR (V)</p>	<p>The assumptions of rationality are usually replaced by the concept of bounded rationality: decisions made with limited powers of cognition and calculation. Procedural rationality and transparency are critical to government decisions. The Green Book (2003) emphasises the categories of the fundamental equation, as adapted for the public sector. Political considerations are a key aspect of decision-making. There is an extensive group of stakeholders; trade-offs have to be decided between stakeholder interests. Value for Money has to compete with ever-higher expectations of CARE.</p>
<p>DECISION CRITERIA</p>	<p>The foundations are usually targets that express social utility and social welfare. Time preference is expressed by the social rate. Qualitative outcomes are mapped into achievement rankings. As in the business sector, concern is threefold:</p> <ol style="list-style-type: none"> 1. Descriptive; how governments decide 2. Normative; how governments should decide 3. Prescriptive; how governments can make better decisions <p>For government, Value for Money is an element of a three-part strategy in healthcare: extending choice, internal markets and Value for Money. These three approaches are complementary. The thesis focuses on VFM.</p>
<p>CAPITAL RATIONING</p>	<p>Capital rationing, exercised at different levels of the National Health Service hierarchy, is an important tool of control. Rationing can be defined as the withholding of potentially beneficial healthcare through financial or organisational features of the healthcare system in question.</p>
<p>TRADE-OFFS</p>	<p>Trade-offs are a necessary and essential means of control following capital rationing. They are made between:</p> <ol style="list-style-type: none"> 1. equity and efficiency 2. options and priorities
<p>COMPLEXITIES</p>	<p>Complexities such as the principal-agent problem, decision making in a complex web of networks, and measuring qualities, all emerge in National Health Service hierarchies.</p>
<p>The right-hand side of the Adapted Grand Narrative</p> <p>BENEFITS</p> <p>COSTS</p> <p>COST OF CAPITAL AND DISCOUNT RATE</p> <p>RISK AND ATTITUDES TO RISK</p>	<p>The expected difference between revenues (benefits or outcomes) and costs, together with the cost of capital, is the basis of rational decision making and procedural rationality. Mapping benefits into outcome measures is critical. A large number of outcome measures exist in the public sector. Often they conflict.</p> <p>As in the business sector literature, opportunity cost is a key criterion for obtaining VFM in projects. Network effects and social cost are important.</p> <p>Social rather than private rates of discount are used in the public sector. They should reflect both external affects in the network (different parts of the service are interdependent) and concern with the future (future demographic trends and expectations).</p> <p>Usually strategic decision making and implementation are done by different sets of people, with different attitudes and measures of risk</p>
<p>The categories and comments in the table, together with Table 1.1 (p.17) are used to construct the Adapted Grand Narrative that is adapted from the literature review in Chapter 2 and Chapter 3.</p>	

At the outset of this chapter (and as discussed in the previous chapter), it would be useful to remind the reader of the basis of the Grand Narrative of Value for Money in the National Health Service, the foundation that is used to construct the conceptual framework for the Adapted Grand Narrative of the thesis.

Extending Foundations of the Study to the Public Sector

This chapter extends the literature review to the public sector (with special reference to the health sector) by deconstructing the categories of the Grand Narrative of Value for Money (embedded in the Net Present Value equation) in the National Health Service. In the remainder of this chapter, we examine the literature that has provided:

1. The fundamental equation of the Grand Narrative of Value for Money as adapted to the public sector
2. The basis of the Grand Narrative of Value for Money in the National Health Service, used to construct the conceptual framework for the Adapted Grand Narrative of Value for Money

The initial focus is on the literature relating to the application of the Net Present Value model to the public sector. Later we discuss the model's application in the health sector.

1. The Fundamental Equation of the Grand Narrative of Value for Money as adapted to the public sector

In this section, we introduce the adapted version of the model in the sense that we present the model as the Value for Money strategy, and introduce additional problems such as project interdependencies, many decision makers, and trade-offs and pay-offs into the model. We also place emphasis on the fact that a complex system like the National Health Service as an organisation is made of many parts, who themselves have the task of implementing projects. Many projects are

interdependent and are implemented not merely in different periods, but are also subject to a continuous capital-rationing situation. In this view, it is possible to see an organisation, using the modified equation discussed earlier, as a collection of projects. We represent this in Figure 3.1 (below).

Figure 3.1 Equation 2: Fisher's (1930) Net Present Value model as a collection of projects

Left hand side

Right hand side

$$V = \sum_{j=0}^J \sum_{t=0}^T \left\{ \frac{E [B_j(t) - C_j(t)]}{(1 + r_j)^t} \right\}$$

The left-hand side of Fisher's (1930) fundamental equation consists of objective functions: the project objective and the utility function of the people involved in decision-making in a general sense. Value represents the Value for Money to taxpayers. It also represents Government attitude to risk and uncertainty and reflects a different kind of rationality as intrinsic motivation.

The right-hand side of the fundamental equation consists of operational variables: the categories that are the determinants of Net Present Value. Because we focus on the literature concerning the public sector, we speak of those variables as social costs, social benefits, social discount rates and general factors that determine the cost of capital.

- $E [B(t) - C(t)]$ represents expected net cash flow for each year
- $(1 + r)$ represents discount rate (with the risk embedded into it)
- $t = 0, 1, \dots, T$. T is the time horizon of the project. Short-term projects will have a short-term horizon (low T), longer term projects will have a longer time horizon (high T). Here, as in Equation 1 (p.46), t denotes time horizon of a project.
- $j = 0, 1, \dots, J$. Additional complexity arises from the fact that there are many projects that are indexed.

Equation (2) assumes that the projects are independent. Our discussion of networks shows that this assumption of independence is too simplistic, but at this stage it is useful.

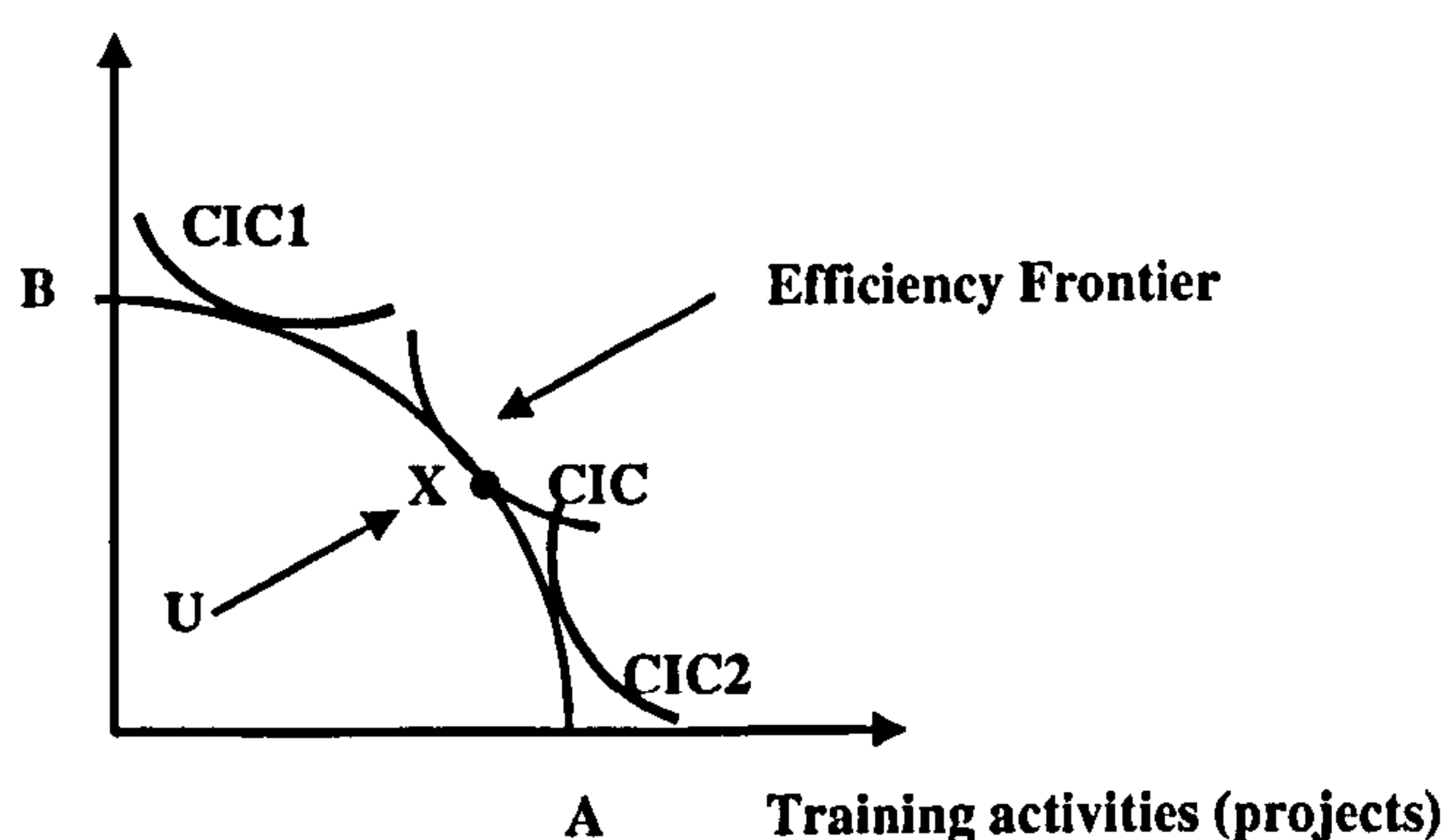
Next we revisit the graphical version of the fundamental equation as set out in Chapter 2 (p.47, Figure 2.2), the basis of the Grand Narrative of Value for Money as adapted to the National Health Service, and use it for constructing a conceptual framework for the Adapted Grand Narrative below.

2. The basis of the Grand Narrative of Value for Money as adapted to the National Health Service, and its use for constructing a conceptual framework for the Adapted Grand Narrative

We apply Fisher's (1930) previously illustrated principles to the subject matter of the thesis, in the sense that we adapt, on a basis of the conceptual framework for the Adapted Grand Narrative of Value for Money, using the simple Figure 3.2 below (also presented on p.47 as Figure 2.2).

Figure 3.2 Grand Narrative as adapted from Fisher (1930)

Other activities (projects)



We first attempt to illustrate the model's general application to the business sector concerning investment in education and training (see commissioning part on p.4).

In Figure 3.2, the line AB represents the Value for Money frontier; that is, the various combinations of training and other activities that give maximum Value for Money. U represents the point at which, given the available resources, Value for Money is not achieved. On the horizontal axis, we represent a particular activity: in the context of this thesis, this activity is a training programme concerning Team Leadership (Appendices 1 and 2). On the vertical axis, for simplicity, we represent other possible alternative activities. So, the curve AB represents efficient combinations of the two sets of activities; that is, the curve represents Value for Money in the sense that given the available resources it is not possible to increase one activity without reducing another. Thus, we have a picture of Pareto's (1935) optimality. At point U we are not getting Value for Money, in that both activities can be increased using the same resources. So, AB is an efficiency curve.

What follows is the subject matter for the first stage of our investigation: if perceptions about the categories of the Grand Narrative differ, then this gives rise to principal-agent problems at many levels, which may impede the success of the chosen strategy and may not deliver Value for Money. In the National Health Service, the aim of the Value for Money strategy is to try to move the standard of services toward the efficiency frontier. Policy in the National Health Service is such that the Strategic Health Authorities allocate funds to particular National Health Service Trusts, who will then have to decide how to spend their funds, subject to national targets.

We can represent this process (in Figure 3.2) with a community indifference curve (CIC), which reflects choices made at the National Health Service Trust level. This CIC is drawn in the diagram, and point X is both an efficiency point and a choice point. Other possible choice points are represented by alternative CICs: CIC1 and CIC2. Pure Value for Money is achieved at point X on the diagram.

The curves CIC1 and CIC2 also describe implementers' preferences or trade-offs between the goal of Value for Money (on the vertical axis) and other sets of goals (on the horizontal axis). On the vertical axis, we express Value for Money as it is

understood by top-level decision makers. On the horizontal axis, we express other sets of goals associated with implementation. These include emotional issues associated with CARE, and other issues important to those implementing top-level strategy: working conditions, intensity of work, issues of status, perks and so on. At this stage we only need to outline them in principle, because more detailed specification is one of the tasks of the multi narratives set out in Chapters 6 and 8 respectively.

The first task of *face workers* (those who are implementing the strategy) is to get onto the curve. The next task is to choose between the activities. As stated previously, the implementation stages are represented by the group indifference or trade-off curves CIC1 and CIC2, which represent implementers' (or *face workers*') preferences or trade-offs between the two sets of activities. Given their preferences, the optimal choice is at X on the diagram. This is efficient, but it may not be effective from the original strategists' point of view. It may not represent their intentions. So, we need to ask the question in the Grand Narrative of the research: how do *face workers* interpret the categories of the fundamental equation?

First, we must establish a benchmark. How are these categories interpreted in the literature? This will give us our theoretical base. Then, apart from pragmatic questions associated with Value for Money and with the Grand Narrative of Value for Money, we may be able, as a result of our research, to throw light on how the fundamental equation is interpreted in the National Health Service and thus contribute to the theoretical core regarding the search for Value for Money.

Also, we emphasise that Fisher (1930) attached great importance to psychic factors, i.e. non-monetary factors such as enjoyment, satisfaction or utility. According to this argument, in the context discussed in the thesis, the Investment Frontier should include issues of CARE, compassion, empathy and a general emotional context.

We also note that in the traditional version of the Fisher / Hirshleifer Separation Theorem (or Efficiency Frontier), consumption and investment decisions are

separated. In Figure 3.2, our version of the Separation Theorem is adapted to the subject matter – the National Health Service – and is illustrated in a rather different way. The separation is between:

1. Top-level decision makers, with the goal of achieving Value for Money at X in the diagram, allocate funds and try to motivate implementers (*face workers*) to achieve Value for Money.
2. Implementers, or *face workers*, exercise choice between activities, as illustrated by their trade-off curves CIC1 and CIC2, but who may trade-off Value for Money for other goals.

Thus, in Figure 3.2, CIC1 represents top-level preferences and CIC2 represents the implementers' or *face workers*' preferences.

The diagram illustrates our initial remarks. Even if value for money is achieved, actual project choice (by the implementers or *face workers*) along CIC2 may differ from the original intention of CIC1. The stakeholder analysis also means that the vector of other activities is very complex, and the CIC is indeterminate.

The basis of the Grand Narrative of Value for Money, as illustrated in this section, will form a base for the empirical work to be discussed in later chapters (Chapters 5 and 6); this is presented in Table 1.1 (p.17). In this sense, this chapter should be seen as a further part of the process of designing our empirical model: the Adapted Grand Narrative of the thesis.

In the previous chapter (Chapter 2) we looked at how these issues have been dealt with in the business sector. In this chapter we look at their application in the public sector. The structure of this chapter follows the same pattern as that presented in Table 2.1 (p.40) in the previous chapter. We first discuss issues related to the left-hand side of the Grand Narrative of Value for Money equation in the National Health Service, emphasising the notion of rationality and emotion. We also introduce approximations that make the application of the Grand Narrative difficult (and not

just in the context of the specific project in this study), such as interdependence issues concerning human capital, and projects running simultaneously through the stakeholders' networks and at different layers of decision making in the National Health Service.

Further, and this is something we wish to comment upon now, attributes such as altruism, empathy, compassion and CARE for others are essential ingredients of a healthcare service. We merely introduce this concept here; it will be reintroduced again during the empirical analysis. Then we discuss the right-hand side of the equation, in terms of social benefits, social cost, social preference rate, and risk.

In this way, further comparison of the business and public sectors enables us to discuss the limitations of the purely rational model (used to describe Decision Theory) that takes these issues for granted. We shall discuss them in full in the empirical Chapter 6.

The Left-hand Side of the Conceptual Framework for the Adapted Grand Narrative

We discuss the issues concerning the left-hand side of the Grand Narrative of Value for Money equation (p.78, Table 3.1) under the following headings:

- i. Rationality and Emotion
- ii. Decision Criteria
- iii. Capital Rationing
- iv. Trade-offs
- v. Complexities

i. Rationality and Emotion

Decisions in the public sector, and especially in the National Health Service, involve empathy, compassion and sympathy. In other words, they involve CARE, a term to which we shall return in the empirical chapters. Therefore, this section is highly relevant to the later study. This section attempts first to establish the link between rational behaviour and emotion, and then the link between emotion and capital rationing.

a. Economic Rationality

The assumptions of rationality are usually replaced by the concept of bounded rationality: decisions are made with limited powers of cognition and calculation. Procedural rationality and transparency are critical to government decisions. Political considerations are a key aspect of decision making. There is also an extensive group of stakeholders; trade-offs must be decided between stakeholder interests. Value for Money has to compete with ever-higher expectations of CARE. The emphasis is on achieving quality, rather than measuring unit productivity. How to measure quality remains critical. These issues make the adoption of the normative rational choice model more difficult.

As Shackle (1949) argued, preferences are driven by emotional aspects – the feelings of happiness at gaining or pain at losing – as well as by rational choice. Hence, we need to say something about the emotional aspect of decision making.

b. Emotion and Rationality

Another major point when emphasising Value for Money in healthcare is the notion of emotion and CARE. They are essential components of quality of patient CARE. Working with patients always requires the healthcare professional to exhibit some form of altruism and, particularly, empathy. Every day they see people suffering from illness, or even dying. What else can they do but feel empathy? A general definition of *altruism* suggests that it can be defined as an unselfish concern for the

welfare of others, focusing on a motivation to help others or a desire to do good without expecting material reward, although it may well entail the internal benefit of a good feeling, a sense of satisfaction, higher self-esteem, fulfilment of duty, or the like. So altruism and empathy are important parts in any decision-making process that involves improving the quality of human life. They are critical to the survival of the National Health Service because the taxpayer is also the main stakeholder in and source of funding for the National Health Service.

The attachment of empathy to social welfare has been studied in several medical contexts, from the donation of organs and genetic material to patients' participation in trials, and it is embodied in many cultural stereotypes of the good doctor. For example:

- philosophical and ethical thought (Comte, 1852; Rand, 1996; De Bernières, 1994)
- politics (David, 1996)
- psychology and sociology (Seelig *et al.*, 2001; Wagner *et al.*, 1996)
- evolutionary biologists and ethologists (Axelrod *et al.*, 1981; Dawkins, 1990; Price, 1972; Agrawal, 2001; Sigmund *et al.*, 2001)
- general medicine (Preston *et al.*, 2002; Stein, 1989; Kohut, 1984; Batson, 1994, Eisenberg, 2002; Hoffman, 1987; Schafer, 1959; Berger, 1987; Greenson, 1960; Rogers, 1959; Jones, 2002)

It appears that the understanding of the term *altruistic* must encompass a much wider definition. In some contexts, like health, altruism is an important part of decision making. Individuals make decisions concerned with helping another person, so the decisions involve emotion. For example, knowing that the correct decision has saved someone's life yields an emotional satisfaction.

Pure economic rationality, on the other hand, assumes that the decision maker will make the best choice given the information he or she has available, based on selfish preferences for risk and uncertainty, and this provides therefore him or her with value in monetary terms. However, this view fails to consider that the decision maker

might also be driven by a different set of preferences: a moral and political duty, and a selfless attitude toward other human beings. These are, to a great extent, difficult to capture in a numerical form.

It is not surprising that people see the objective function of the health service in terms other than the purely rational; i.e., CARE, sympathy or empathy. These emotional responses are essential to healthcare, and determine the quality of CARE. Although Fisher (1930) calls such issues psychical enjoyment (rather than happiness expressed in monetary terms) and is at pains to emphasise their importance, economics models such as Net Present Value exclude these important aspects of decision making. For that reason, we reintroduce this aspect in this section.

There is also a body of evidence suggesting that altruism in the health service is in decline (Reynolds *et al.*, 2000). Although we have not discussed the emotional aspects of decision making directly when examining the categories of the Net Present Value model (bearing in mind that the model does not capture such aspects), it is useful to present some representative statements of what decision makers at the highest levels of the hierarchy say about it. For example, the former Minister for Health, Alan Johnson, recognised the importance of being empathetic:

What nurses tell us is that you can have the best surgeon in the world, who carries out the most terrific operation on you, but your stay in hospital won't be satisfactory if you don't get a high level of compassion and care. If your experience involves nurses looking grumpy, or someone being rude, or not getting people there when you need them, then it ruins the whole experience ... Compassion and sensitivity, aspects of care which are so important but rarely measured ... It will be very difficult to measure and benchmark compassion, particularly at the level of the ward. (Carvel, 2008)

Putting these comments into the context of this study, these opinions further enforce the need to examine empathy, and we shall examine these issues in the empirical discussion in Chapter 7. For now, we are going to move on to examine some general issues associated with decision criteria on the next page.

ii. Decision Criteria

The foundations of decisions are usually targets that express social utility and social welfare. Time preference is expressed by the social rate of return in projects in equation 2 (Figure 3.2, p.81). As in the business sector, the concerns are threefold:

1. Descriptive – how governments decide.
2. Normative – how governments should decide
3. Prescriptive – how governments can make better decisions

The advancing application of subjective value theory to the economics of welfare is very relevant to this study.

Hirshleifer (1964) extends Fisher's (1930) work to the social discount rate in public investment, and develops the time-state-preference approach (which we now call the state-contingent model). This approach was applied to a number of traditional problems in economics: gambling and insurance; the Modigliani-Miller Theorem; and the evaluation of public projects (Hirshleifer 1965, 1966). The state-preference approach was introduced by Arrow (1963) and further detailed by Debreu (1959), Radner (1968, 1972) and others in finance and general equilibrium.

Net Present Value Criterion

In the United Kingdom Health Service and government, Value for Money is one element of a three-part strategy for healthcare: extending choice, internal markets, and Value for Money (p.14). The thesis focuses on Value for Money. The Green Book (2003) emphasises the categories of the fundamental equation as adapted for the purpose of examining the literature regarding the public sector. It recommends Net Present Value as a primary criterion for investment appraisal:

The Net Present Value is the primary criterion for deciding whether government action can be justified. (The Green Book, 2003, p.26)

The Green Book (2003) clearly implies that that there is an increased concern about two things: how the taxpayer's money is invested, and the effective testing of

government resources that have been used. It also sends out a clear message to the public, with government emphasis on improving the transparency of capital investment. It has indicated that there is scope for future improvement, particularly related to research into projects where it is difficult to measure the benefits in quantitative terms. As such, it recognises the difficulties of putting monetary values on benefits, or whether the necessary income or socio-economic information are available at an acceptable cost, given the importance of the proposal and the likely scale of the impact of the proposal.

The issue of obtaining Value for Money is also sensitive to party politics. For example, the former Minister for Health, Alan Milburn, emphasised the importance of the delivery of Value for Money:

It is vital in the National Health Service, as in every public sector organisation, that every penny is spent in the most cost effective manner and to the maximum benefit of patients. (Department of Health, 2000)

This study begins by examining the particular project at the centre of the research, so it would be useful to note how Value for Money is perceived by the government in the context of education and training in the National Health Service. Take, for example, the definition provided by the National Audit Office, describing the concept as follows:

Value for Money is about cost and quality of the training and the extent to which the student is fit for purpose on qualification. (National Audit Office, 2001, p.32)

This study takes these issues into consideration, but it goes a step further. It argues that the real issue is not whether people in the public sector use the crude Net Present Value model (the Grand Narrative of Value for Money), but whether its categories are part of their consideration in the decision making process. If so, exactly how do they interpret various categories, which are relatively important or unimportant? Which categories simply do not feature, and why, given capital rationing as a constraint and a lack of measurement of the outcomes? We discuss capital rationing on the next page.

iii. Capital Rationing

In the National Health Service, capital rationing exists because not everyone needs all the services that are available, nor is it possible to satisfy everyone's needs (Culyer, 1990; Williams, 1978). Capital rationing in this sense provides an insight into how stakeholders manage their funding. Presumably, the top level of management (including Ministers, the Department of Health and Strategic Health Authorities) decide on an implicit social discount rate that determines how they allocate funds between, for example, different government departments and ministers, between different geographical areas, according to different priorities with respect to healthcare; and between different projects. Therefore, for the most part, at the National Health Service Trust level we have capital rationing.

There are situations in which the principles of ethics and empathy come head to head with the principles of equity, and thereby emerge into the public spotlight. Not every need can be met because health service resources are finite. Conversely, empathy may have little concern for the distribution of welfare, focusing instead on a single individual – the rule of rescue, which urges us to expend vast quantities of money on a single case. Bearing in mind this rationing of resources, a top-down approach requires, for example, the National Institute for Clinical Excellence to establish whether any recommended drug provides Value for Money. However, one criticism is that in doing so the National Institute for Clinical Excellence relies heavily on the use of evidence-based medicine and econometric methods. Thus, a clear advantage is given to the drugs that have a lower cost per treatment per improvement in health. In such cases, the need to make decisions at a national level can conflict with what is (or is believed to be) in the best interests of an individual patient. In this way NICE argues that it ensures Value for Money and a fair rationing of resources at the same time.

There is also a question of the role of the state and its intervention to promote morally desirable ends. The National Health Service's golden rule – 'to everyone according to their needs, not their ability to pay' – colludes with that of National Health Service decision makers, who believe that they must intervene to alleviate pain and suffering, and both are bound by their own sets of values, clearly different from values in the

business sector. The National Institute for Clinical Excellence has been criticised for incompetence and delays in delivering guidance (Royal National Institute of Blind People, 2008). The rules have been used as an excuse for denying treatments – an example is provided below.

In the case of the drug Herceptin (Lister, 2006), a cancer treatment which was extensively reported in the media, many primary health trusts denied patients the drug on the basis that its safety remained unproven and that the funding implications of the treatment had not been met. Costing about £20,000 a year to treat a single patient, some breast cancer patients across England and Wales were denied Herceptin because of a postcode lottery. In spite of GPs demanding that the drug be provided, and recent research (Piccart-Gebhart *et al.*, 2005) demonstrating that Herceptin reduces the risk of the disease returning in women with early-stage HER2-positive cancer by 46 percent, the National Institute for Clinical Excellence remained unconvinced. Many clinicians were reluctant to fight the National Institute for Clinical Excellence's decision, but the case went to the High Court which ruled that Somerset Primary Care Trust must supply Herceptin to Barbara Clark, aged 50, in October 2005. The National Institute for Clinical Excellence had to concede, and Herceptin was approved in May 2006. In spite of recent criticisms, the Care Quality Commission has pledged to crack down on organisations that fail to adopt the guidelines provided by the National Institute for Clinical Excellence (Santry, 2008).

To conclude this section on a general note, we return to capital rationing, at least for the purposes of cross-referencing. Empathy is difficult to express in numerical values, but it is essential to decision making in the health service. Given the caution about the role of capital rationing, the extent to which it can be used as a control over expenditure (taxpayer's money) and potential conflict with the moral principles of the National Health Service, there is a danger here that an emphasis on targets and a top-down approach could be counterproductive. There is too much emphasis on cost reduction at the expense of lives. People are scared of exercising the kind of emotional issues needed in the health service, and this situation needs to be rectified.

Again, we return to the need for a bottom-up approach. There will always be a kind of conflict between the top-down approach pursued by the government – the rationing policy – and those who implement it at the bottom level, including taxpayers whose expectations ('to everyone according to their need, not their ability to pay') are grounded in strong moral and ethical principles, the so-called 'communism of health' (Culyer, 1990; Bewan, 1952). In this sense, empathy remains critical for the National Health Service. We shall return to this issue later in the discussion of empirical findings in Chapters 6 and 7.

The decision-making process is complex, and therefore reaching a consensus is difficult and time consuming. Certain trade-offs have to be made, so at this point we introduce them to the reader.

iv. Trade-offs

It is a generally accepted view that in most situations trade-offs of some kind will occur. This is especially the case in a network organisation such as the National Health Service. Extensive capital rationing control results in the emergence of a complex set of trade-offs, both necessary and essential. They are necessary because the resources for health services are limited, so some kind of prioritisation must take place. They are essential because not all needs are seen as priorities. A concept closely related to the notion of the trade-off is fairness in resource allocation – for example, between equity and efficiency. It is important to ensure that funds are balanced and distributed among stakeholders.

The trade-offs between equity and efficiency have been debated extensively among politicians, economists and sociologists alike. The underlying ambiguities associated with the term *fair* are well known (LeGrand *et al.*, 1993). Economists try to avoid it in their analyses, so that the emphasis is switched from fairness to identifying the impact of public sector programmes (Stiglitz, 2000).

Le Grand *et al.* (1993) provides an interesting insight into trade-offs in the National Health Service. The most scrutinised trade-off is between equity and efficiency across the National Health Service (Williams *et al.*, 2000). For example, the general conception of this type of trade-off is its application to rural and remote areas with a thinly distributed population. In these cases, it is presumed that the cost per unit of effectiveness will be relatively high, and from an efficiency point of view this implies that community health could be improved by redistributing resources away from such localities toward those where population density is greater and the cost per case lower. In practice, distribution nearly always involves both equity and efficiency issues, and in such cases, principles of efficiency stand in opposition to equity principles, as Culyer (1990) indicates:

It is natural to allocate general resources (say, in the form of regional or district budgets) on a capitation basis, with the pursuit of efficiency in the meeting of local needs being conducted within the constraints that the equity rules impose, and accepting that the ultimate cost of equity may be higher overall mortality and morbidity than it actually lay within our power to attain. (Culyer, 1990, p.9)

There is a similar debate in relation to the fairness of resource allocation. The current weighted capitation system, that distributes healthcare resources according to a series of complex formulae, has been criticised on both philosophical and technical grounds. This is because by targeting deprived areas that suffer the worst health using standardised measures, the government is drawing upon a relative definition of need. This perhaps suggests that the concept of health equity (a reduction in health inequalities between the most and the least advantaged groups) is displacing healthcare equity as the core principle of resource allocation in the National Health Service (Asthana *et al.*, 2004).

Another common type of trade-off occurs between investment options and the priority of those options. Options are usually compared by reducing all costs and benefits to a financial equivalent. In an ideal situation, costs and benefits are easily comparable, but in practice, this becomes more difficult to determine because it is very often difficult to put a monetary value on the expected social costs and benefits of healthcare intervention programmes (Epstein and Sherwood, 1996). This is due to

the variety of costs and benefits that very often cannot be compared directly with each other. There may also be differences in the valuation of costs and benefits as they are perceived by those directly affected, and by the government or other observers. This difference is very relevant to the research in this study, since it examines these perceptions. We shall return to the notion of trade-offs and how they are perceived and dealt with in the National Health Service in the empirical part of the thesis (Chapter 5).

We must also acknowledge that, given the sheer complexity of the decision making process in the National Health Service, there must be additional complexities. Therefore, at this point we introduce these complexities to the reader, and we shall return to them in the empirical Chapter 6.

Complexities

The purpose of this section is to introduce the additional complexities surrounding decision making in the National Health Service, which we shall examine in the empirical chapters of the thesis (Chapters 5, 6 and 7 respectively). These complexities are as follows:

- i. Principal-agent problem
- ii. Networks
- iii. Qualities

As we shall see in the empirical part of the thesis, the study has identified these issues as key challenges for the delivery of the Value for Money strategy. Very generally, these issues form a special case of the principal-agent problem in the National Health Service, so we introduce this problem first.

i. Principal-Agent Problem

The principal-agent problem has been framed in the context of agency theory, using the metaphor of a contract. The underlying problem is the issue of motivating one party to act on behalf of another (Jensen and Meckling, 1976; Fama, 1980; Fama and Jensen, 1983). This problem has been explored extensively in an organisational context. Eisenhardt (1989) suggests that agency theory offers insight into information systems, uncertainty, incentives, and risk. Hill and Jones (1992) explore the link between agency theory and stakeholder theory.

Given the role of the public sector in terms of spending taxpayer's money in the most efficient way (i.e. so that no-one is left worse off), the taxpayer needs to know the quality of the good or service so to be able to judge the value of the benefit it can provide. For example, when government buys services from suppliers on behalf of the public and sets standards for those services, it is acting as an agent for the service users. Provision of the wrong type and level of service can sometimes be attributed to a lack of incentives within government to reward efficiency, quality and innovation among its service providers. The issue then becomes how the government can motivate agents at different hierarchical levels to provide proper and effective services to the public. Incentive pay structures in the business sector are sometimes used to address this issue. Establishing a similar regime of incentives can become a complex problem within government (The Green Book, 2003).

This study examines a specific case of the principal-agent problem in the National Health Service: the issues concerning the implementation of the Value for Money strategy, as discussed in Chapter 1. Our concern is this: if there are differences in perception between principals (top-level decision makers) and agents (*face workers*), the successful implementation of government strategy will be impeded. Inevitably differences do exist, but the key thing is to try to understand why the perceptions of the principals and the agents differ. One also has to consider that taxpayers want to see Value for Money. This thesis examines these issues.

It was clear from research that the National Health Service is a network of relationships. Therefore, it is appropriate at this point to remark upon networks and the related concept of social capital.

ii. Networks

Various authors have explored the notion of networks. Barnes (1954) argued that social networks can be seen as social structures between actors, mostly individuals, or organisations. He suggested that they are rich in social capital that flows through in the form of a social network, and that they also indicate the ways in which actors are connected through various social familiarities, ranging from casual acquaintance to close familial bonds. Putnam (1993) refers to social capital as a collective value of all social networks and the inclinations that arise from these networks to do things for each other, and that this represents a key component in building and maintaining democracy. Burt (2000) provides well-documented literature regarding social capital, exploring the notion of social capital in business organisations.

This thesis begins with a specific project, an investment in social capital. Lyotard (1978, 1984) spoke of social capital playing an influential role in globalisation, he described it in terms of progress and growth through competitive markets, the pursuit of efficiency (Lyotard, 1984) and as the Grand Narrative of capitalism. We examine it in a specific context, that of the National Health Service. Marshall (1920) stressed the importance of investment in human beings. Pigou (1928) continued Marshall's work, alongside the founders of the concept of human capital (Schultz, 1961, 1963; Mincer, 1958; Becker, 1993), who applied the concept to various practical domains.

In this study, the argument is that since the National Health Service is a service organisation that provides healthcare to citizens, the principal form of capital is social capital (training and education, as in the case of the commissioned research), and reference to social capital will be discussed in more detail in the empirical Chapter 5. Here, we provide some preliminary comments.

The key resource in the National Health Service is human capital. The National Health Service employs more than 1.5 million staff. Of those, just short of half are clinically qualified, including some 90,000 hospital doctors, 35,000 general practitioners (GPs), 400,000 nurses and 16,000 ambulance staff (Department of Health, 2008). At the national level, each year the National Health Service in England and Wales spends in excess of £1.2 billion on education and training for healthcare staff (other than doctors and dentists). Around eighty per cent of this budget is spent on the pre-qualification education and training of students, and is entirely drawn from national levies. According to a report from the National Audit Office (National Audit Office, 2001, p.5), the remainder (around £350 million) is spent on the existing healthcare workforce; approximately fifty per cent of this amount comes from national levies and the remaining fifty per cent from local trust sources. Another governmental report (London National Health Service, 2007) states that in London alone the National Health Service spends £1 billion annually in training and developing its staff. We shall come back to the issue of networks of relationships in the methodological Chapter 4 and the empirical Chapter 6 in this thesis.

National Health Service networks are also made of complex relationships between many stakeholders, so we ought to say something about them. Many politicians, managers, consultants and academics object to a narrow view of decision making, arguing that we must take other stakeholders into account. This is especially important in the National Health Service, where there are many groups of stakeholders, each involved in their own local health service, and bearing in mind that the effective planning for and management of, for example, nursing and junior doctors affects the overall efficiency of frontline healthcare local services to a great extent.

The literature on stakeholding is extensive. Clarkson (1995) introduced a stakeholder framework for analysing and evaluating corporate social responsibility, while Brenner and Cochran (1991) discussed its implications for business and society. Burton *et al.* (1996) provided a useful compilation of who is included as a

stakeholder. Donaldson and Preston (1995) examined and integrated the literature related to the theory, including the modern theory of property rights. Freeman (1984) applied a stakeholder approach to strategic management. Friedman *et al.* (2002, p.46) stated that stakeholders can be described as ‘any group or individual who can affect or is affected by the achievement of the organisation’s objectives’. Hence, by consensus, stockholders, employees of all types, suppliers, customers, governments, competitors, and activist groups could all be considered stakeholders. We shall return to the notion of stakeholder in the empirical part of the thesis (Chapter 6).

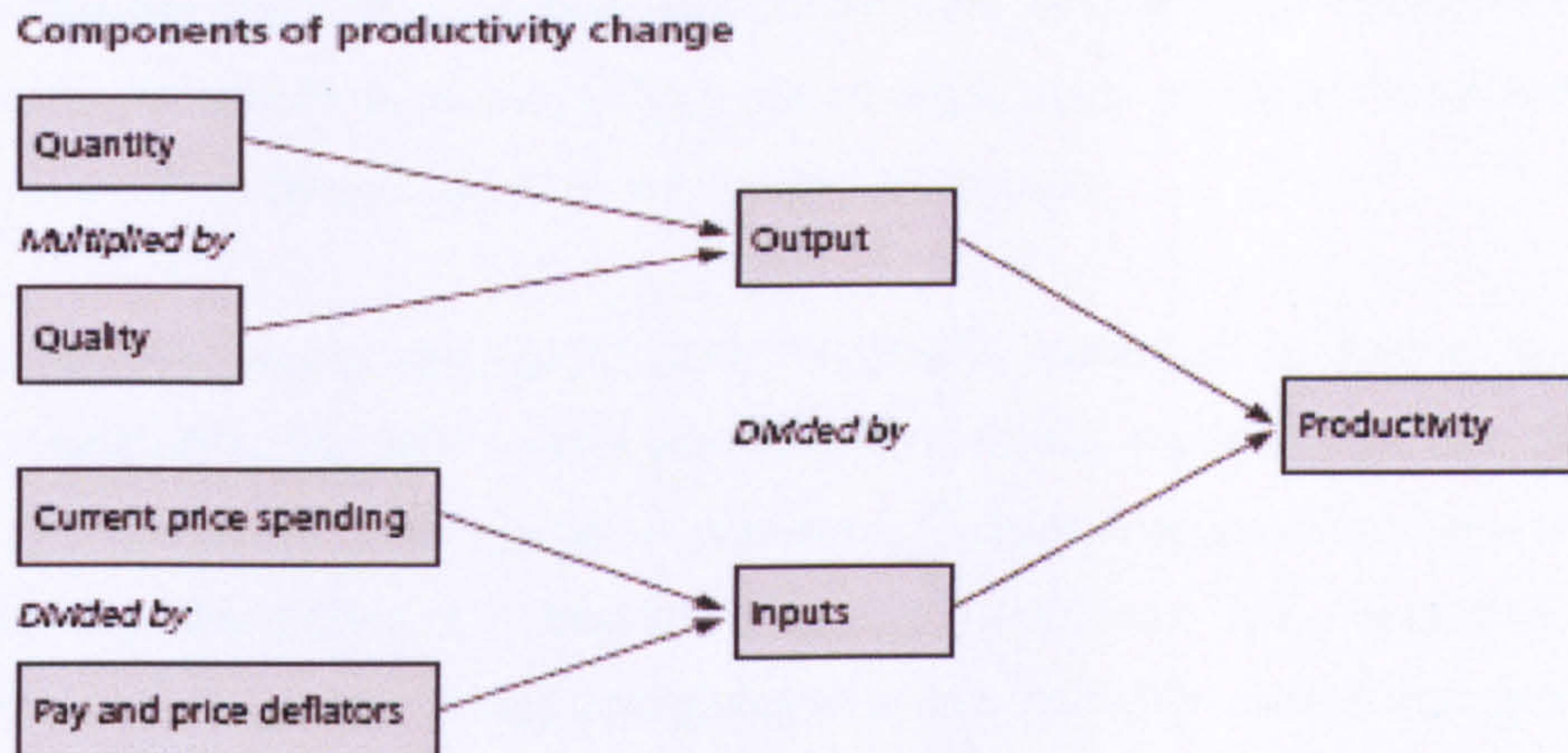
The actual spending of these proportions of resources is not without its challenges. Resources must be spent in the most efficient way. Transparency is key. The issue becomes one of measurement of the overall quality of the benefits, which in the traditional sense has been defined as unit productivity; therefore we will describe this aspect in the next section.

iii. Qualities

One of the current problems facing decision makers in the National Health Service is how to measure productivity, as an essential part of measuring the success of the Value for Money strategy. Traditionally, the productivity of social capital has been measured in monetary terms. More specifically, a report from the Office for National Statistics (Office for National Statistics, 2008) states that one of the most prevalent approaches to measuring productivity is that people think about it as a cost reduction. For example, if one can increase productivity per unit of factor cost (i.e. wages and so on), one can reduce costs overall. The same report suggests that labour costs are the largest component of healthcare expenditure. In 2006, labour expenditure was £47.3 billion, around fifty-three per cent of total healthcare expenditure.

We will make a few comments about measuring productivity in this sense. An illustration of the components of productivity measurement is provided in Figure 3.3 (next page).

Figure 3.3 Components of Productivity Change



Source: Office for National Statistics (2008, p.4)

One particular problem that arises from using this approach is that productivity is measured qualitatively, at least in part, and the quantitative approach to measuring productivity does not account for this. We discuss a number of issues:

- (i) the problems with the current productivity measures; and
- (ii) complexity of relationships between policy, targets, and outcomes

As we shall see later, it is important to discuss these issues (see Chapter 6) because National Health Service strategy heavily relies on achieving targets, and this depends on a complex web of networks of relationships between the designed policy, the construction of targets to achieve this policy, and the desired outcomes of the policy (the impact).

(i) The problems with the current productivity measures

Initially we will discuss problems with the current productivity measures. A report by Atkinson (Office for National Statistics, 2005) indicated that one problem with the Office for National Statistics productivity formula is that comparing inputs (staff

and resources) with outputs (activities such as prescriptions, appointments or operations) excludes cost savings from better procurement (and any extra costs of above-inflation pay). It also fails to measure the outcomes of health service treatments, is unable to account fully for changes such as more cost-effective alternative care pathways, and does not account for change.

Following this report, the Department of Health published a further report (Department of Health, 2007) which puts forward potential enhancements to address some of these issues. Although these new quality adjustments have not been fully accepted by the Office for National Statistics, this body recognises that its measurement of quality is not comprehensive and probably understates quality improvement. Both departments agree that more work needs to be done on improving the measurement of National Health Service output and productivity.

There is also an argument that a number of improvements produce results that are not registered by the current way of measuring productivity, or produce results that make improvements in quality look like a loss of productivity (National Health Service Confederation, 2005). Here, the dilemma is that since human resource is the largest expense and probably the major resource, a significant part of any review will necessarily point out that money has not been spent on services – a problem compounded by centralised decisions which fail to wait for productivity contracts to be sealed before allocating money. For example, as a result of the recent spending on the National Health Service large pay increases were granted to consultants, who were effectively being paid more for doing less, without adequate steps being taken to ensure increases in productivity in return, as pointed out by the government (House of Commons, 2007).

(ii) The complexity of relationships between policy, targets, and outcomes

In an organisation like the National Health Service, with its complex political and organisational hierarchical structure, obtaining Value for Money is further complicated by this complexity. In ensuring that public investments deliver Value for

Money, the strategic process must confront relationships between policy, targets, objectives and outcomes, as the Green Book (2003) recommends. For the reader to understand the complexity of these relationships, an example of the relationship between objectives, outcomes and targets is provided in Appendix 3.

In justifying government intervention, the role of the public sector is to pursue policy objectives, in order to promote the public's (i.e. the taxpayer's) interests. In this sense, the public sector pursues Value for Money, defined as an optimisation of net social costs and benefits. As the Green Book (2003) indicates, in the delivery of policy, decision makers must appraise and set out the linkages between objectives, outcomes, outputs, and targets. In some cases, the expected benefits (outcomes) for society cannot be directly measured, and in such cases it is appropriate to specify outputs: the results of activities that can be clearly stated or measured. Setting targets also requires measuring productivity within the established period, achieved by setting up activities with a complex set of measurements regarding treatment over the given period (see Appendix 4).

We could conclude on the discussion of productivity that in cases where it is difficult to establish clearly productivity in monetary terms, decision makers must nevertheless provide clear and robust linkage between objectives, outcomes and targets as required by the Green Book (2003). In other words, if the Net Present Value categories are to be fully satisfied, any marginal productivity considerations must be satisfied. In this thesis, the Net Present Value/Value for Money model is used as a framework rather than an optimising model.

To sum up the discussion in this section, the never-ending question of how effectively money is spent has become a crucial weapon in public debate (King's Fund, 2005). We argue that Net Present Value, in the form of our Grand Narrative of the Value for Money equation, is part of a top-down approach to strategy, which places emphasis on the quantification of outcomes. Decision makers in the public sector are required to (and do attempt) to use the Grand Narrative of Value for Money as emphasised in the Green Book (2003).

However, the argument is that obtaining Value for Money is much more complex than it is summarised by the Grand Narrative. There are many ambiguities and complexities surrounding Value for Money and this study approaches them. We shall examine in more depth these complexities in empirical parts of the thesis: chapters 6 and 7 respectively.

The next step is to provide the reader with an overview of the deconstructed categories of the Grand Narrative of Value for Money (p.78, Table 3.1) on the next page. The Green Book (2003) is used as a point of reference.

The Right-hand Side of the Conceptual Framework for the Adapted Grand Narrative

Reminding the reader that Value for Money inevitably involves a consideration of various issues, as follows:

- i. Benefits
- ii. Costs
- iii. Cost of Capital and Discount Rate
- iv. Risk and Attitudes to Risk

It will be useful to set out the major findings in relation to the conceptual framework for the Adapted Grand Narrative; see Table 3.2 (next page), which mirrors Table 3.1 (p.78) shown earlier in this chapter. Later, when we discuss individual categories, we will present quotes derived from the Green Book (2003) and referenced accordingly.

Table 3.2 Extended results for the conceptual framework for the Adapted Grand Narrative: Analysis from public sector literature

Extended results for the Adapted Grand Narrative: Analysis from public sector literature	
CATEGORY	COMMENT
The right-hand side of the Adapted Grand Narrative (Net Present Value)	
BENEFITS	The total increase in the welfare of society from an economic action – the sum of the benefit to the agent performing the action plus the benefit accruing to society as a result of the action
COSTS	The total cost to society of an economic activity – the sum of the opportunity costs of the resources used by the agent carrying out the activity, plus any additional costs imposed on society from the activity
COST OF CAPITAL AND DISCOUNT RATE	The cost of capital at 3.5% raising funds and expressed as an annual percentage rate. The Social Time Preference Rate of 3.5% is a rate used for discounting future benefits and costs, and is based on comparisons of utility across different points in time or different generations
RISK AND ATTITUDES TO RISK	Risk represents the likelihood, measured by the probability that a particular event will occur

We now turn to each of the categories on the right-hand side of the equation. As we focus our attention on non-quantifiable (or psychic, as Fisher puts it) elements associated with cost and benefit streams, we can proceed to discuss the issues relating to benefits. Later this will form a basis for discussing findings in the empirical part of the thesis.

i. Benefits

The Green Book (2003) encompasses the notion of benefit in the public sector as a social benefit:

The total increase in the welfare of society from an economic action – the sum of the benefit to the agent performing the action, plus the benefit accruing to society as a result of the action. (The Green Book, 2003, p.105)

In relation to this category, the Green Book (2003) emphasises the identification, quantification and monetary valuation of benefits (see Appendix 5), with the purpose of yielding more information on whether investment proposals provide Value for Money. The following quote specifically emphasises the distributional impacts of the values of costs and benefits:

The purpose of valuing benefits is to consider whether an option's benefits are worth its costs, and to allow alternative options to be systematically compared in terms of their net benefits or net costs ... Even if it is not feasible or practicable to value all the benefits of a proposal, it is important to consider valuing the differences between options. (The Green Book, 2003, p.21)

We need to take into account the distributional effect of investments, meaning an evaluation of the different impacts of costs and benefits on various groups in society. One possible recommendation is to focus on differing impacts according to income group, but differing impacts according to age, gender, ethnic group, health or location also need to be stated and quantified wherever feasible. Again, there is a requirement for any distributional effects to be explicitly stated and quantified as much as possible:

The net benefit of an intervention equals the gross benefits less the benefits that would have occurred in the absence of intervention (the 'deadweight') less the negative impacts elsewhere (including 'displacement' of activity), plus multiplier effects. (The Green Book, 2003, p.54)

As the Green Book (2003) indicates, it seems that the impact of a policy, programme or project on an individual's well-being will vary according to his or her income, the rationale being that an extra pound will give more benefit to a person who is deprived than to someone who is well off. In economics, this concept is known as the diminishing marginal utility of additional consumption. Yet some of these benefits, such as the relief of pain or suffering, are referred to as intangible. These are difficult to quantify, but attempts have been made to place value on them using, for example, cost-utility based approaches such as Quality Adjusted Years of Life or Willingness-to-Pay (Drummond *et al.*, 2005). However, in a situation where the valuation of a benefit such as providing better CARE to the patient is required, the decision making process becomes much more complex. It is often difficult, if not impossible, to

calculate the monetary value of many of these benefits – for example, to measure in financial terms the educational achievements of a nurse. This needs to be demonstrated through the provision of better patient CARE to users of the service and their overall experience, which represents a kind of final outcome. For this reason, we prefer the term ‘social benefit’ when speaking of the outcome of healthcare interventions or services in the National Health Service.

In conclusion, we argue that the valuation of benefits in the National Health Service is complicated. In the National Health Service there are many stakeholders involved at different hierarchical levels, with different sets of objectives and different means to achieve those objectives. It is also very likely that they will have conflicting objectives, different goals, and different attitudes towards risk. They might also have different perceptions of costs, benefits and time, and different sets of pay-offs or expected outcomes (which are constituted partially of monetary and partially of non-monetary elements). For example, the direct outcome of nursing education is to become fit for practice – an intangible outcome that needs to be achieved out of investment in health services, and which is supported by top-down, politically supported government targets. We shall discuss these in the empirical Chapter 5.

At this point, we follow on with discussion of the expected costs.

ii. Costs

As a starting point in our discussion regarding some general observations about costs, this section introduces some issues surrounding the notion of costs in the public sector. The Green Book (2003) suggests that full economic costs should be calculated and adjustments made for risk and optimism bias, alongside considerations of affordability and viability. It uses the same kind of general cost classification as is applied in the business sector. Generally speaking, one could argue in the context of this study that one of the major difficulties in obtaining a true estimate of cost in healthcare is that the economists’ notion of cost extends beyond the cost falling on the health service alone, and includes costs falling on other

services and on patients themselves. Drummond *et al.* (2005) provide an excellent and extensive overview of what is meant by costs in healthcare interventions, demonstrating the sheer complexity of cost classification in health services and healthcare intervention. In other words, the National Health Service conception of cost includes social cost. Table 3.3 (below) illustrates this.

Table 3.3 Complexities in cost classification in healthcare intervention

COST TYPE	DEFINITION
avoided	Caused by a health problem or illness, avoided by healthcare intervention.
direct	Borne by healthcare system, community and patients' families in addressing illness. Direct cost arises as result of direct intervention or its side effects.
indirect	Mainly productivity losses to society caused by health problem or disease. Indirect costs relate to indirect monetary value of lost wages and productivity due to morbidity or death of the person affected.
intangible	Refers to consequences that are difficult to measure and value, such as the value of improved health or the pain and suffering from illness.
social	From a societal perspective, as one alternative perspective of looking at total cost of interventions to all payers needs to be included in the analysis.
as benefit obtained	A benefit that could have been obtained providing that resource allocated has been applied in the most beneficial alternative way provides alternative meaning of cost as the benefit occurring.

Source: Drummond *et .al.* (2005, p.57–92)

Looking at Table 3.3, we can see a detailed description of what is meant by health service costs emerging from the literature and from the Department of Health’s directives and publications, even in the area of general education in the National Health Service. Further, and this is something we wish to comment on, when assessing the cost of a healthcare intervention (besides the use of cost-benefit and

cost-effectiveness analysis) decision makers have to consider preventive cost, and in many ways this is intrinsically linked to providing better patient CARE.

Prevention measures are designed to save people's lives. Therefore, the cost of prevention is justifiable from the societal point of view. The problem arises when there is too much emphasis on quantifiable measures, and this area is not without controversy. Take the example of the National Institute of Clinical Excellence, which focuses heavily on measuring cost efficiency, and the story about the patient who took her fight for cancer drug treatment to court (see p.91). In other words, the cost is referred to as a social cost. Therefore it will be useful at this stage to discuss social cost in the health service in more depth.

Decisions in the National Health Service are also inevitably influenced and driven by some kind of emotional aspect attached to the notion of cost. We have discussed the notion of cost as displaced cost influenced by the decision maker's behaviour (Buchanan, 1969; Shackle, 1949).

Placing this concept of cost into the context of the health service, while one can easily put a monetary value in terms of monetary loss, it is not so easy to put a monetary value on the distress arising from taxpayer's or patients' outrage at money being wasted. Seeing cost as loss inevitably has an important role when it comes to politicisation in the National Health Service, and its accountability for the best use of taxpayer's money.

In that sense, cost becomes not the cost to the individual, but rather the cost to society as a whole – the social cost. Evidence of this can be seen in the form of a quote that brings these issues to life, presented below.

In 2006, the Alzheimer's Society commissioned the London School of Economics and the Institute of Psychiatry at King's College London to produce a report on dementia in the United Kingdom. In a nutshell, the report argues that dementia costs the country £17 billion per year, and links these costs to the social and economic

impacts that dementia has on the country's economic growth. We illustrate this with the following narrative:

With every second ticking by, dementia costs the United Kingdom £539. The report warns that, as the proportion of older people in the population increases and family members are less able or willing to provide care, there will be an explosion of demand, placing an intolerable strain on service. With lifestyles as they currently are, couples delaying starting a family and both having to work to maintain higher mortgages and the rise of single households, there will more than likely be a reduction in the numbers of carers available in the future. (King's College, 2007)

The narrative account stresses the importance of social cost, and illustrates two sides of the same coin. On the demand side, ignoring the social cost might lead to another market failure within the National Health Service to handle this type of imperfection (a shortage of carers). On the supply side, fiscal policy relating to National Health Service recruitment will need to be adjusted to take into consideration these issues alongside workforce recruitment, as this will affect the budgets of service providers.

We could conclude that although it is difficult to provide a definition that accurately captures their meaning, it is the case that the above concepts can be illustrated or shown by narrative accounts, and examples will be presented in different parts of this thesis. In anticipation of our results, although the concept of cost, especially social cost, plays a major part in government analysis of the Value for Money problem, respondents in the National Health Service place much more emphasis on benefits. Perhaps this represents a certain irrationality regarding these issues, which we will also consider. Our anticipation is that National Health Service respondents were keen to emphasise aspects of cost such as sympathy and empathy, and they considered these aspects to be more highly represented on the right side of the equation than on the left. We shall return to this argument in the empirical Chapter 5.

Closely related to social cost is the notion of cost of capital and social discount rate, and we proceed with a discussion of these categories on the next page.

iii. Cost of Capital and Discount Rate

Setting an appropriate discount rate in public sector investment has always been the subject of much disagreement and discussion (Stiglitz, 2000). Arguably, the social rate of discount should be lower, given the positive spill-overs (the external effects of many healthcare investments). Becker (1993) pointed out that education is an investment, and studied the relationship between earnings, costs and return on investment. He argues that the importance of an investor's own time in the production of his own human capital (or, according to Schultz (1961, 1963), his *forgone earnings*) is closely dependent on the embodiment of human capital. This is particularly so because the measures of general education and training are often in terms of years spent, so training is measured entirely by the input of one's own time. As the person continues to invest, the amounts of time and capital accumulated become increasingly valuable. However, as Becker argues, measurement remains difficult, because the effect on earnings of a change in the rate of return has been difficult to distinguish empirically from a change in the amount invested over a long and variable period.

In the United Kingdom, the government (through the Green Book) has adopted a definition of discount rate as applied to the public sector as follows:

The Social Time Preference Rate (STPR) is a rate used for discounting future benefits and costs, and is based on comparisons of utility across different points in time or different generations. (The Green Book, 2003, p.97)

The aim here is to take into account the fact that National Health Service expenditures are replete with positive external effects, so that a low discount rate for health expenditure in monetary terms may be an appropriate and defensible strategy. In the business sector, on the contrary, the cost of capital is generally higher than in the public sector (it is regarded as virtually risk-free, and higher than the social time preference rate as set out in the Green Book). Recent changes to the discount rate have taken place, and this is reflected in the latest Green Book (2003). It suggests that society has a preference for receiving benefits now rather than later, and, conversely, society shows a preference for bearing costs later rather than now.

In conclusion, setting the right social discount rate remains a complex affair since it needs to take many other factors into account. It could be argued that the problems of estimating an appropriate discount rate in the public sector, in contrast to the business sector, is further complicated by the following considerations:

- (i) The government is responsible for setting charges for goods and services sold commercially at market prices, and for recovering full costs for monopoly services (including cost of capital)
- (ii) The sheer size of the public sector (a complex hierarchical structure)
- (iii) Complexity of contracts under the Private Finance Initiative
- (iv) The discount rate must take into account the long-term view of return in delivering the Value for Money strategy, due to the time delay caused by the above mentioned complexities i), ii), and iii); hence, Social Time Preference is preferred over the business sector discount rate (Green Book, 2003).

Closely related to the social discount rate is the notion of risk, traditionally embedded into discount rates in business sector applications, which we now proceed to discuss.

iv. Risk and Attitudes to Risk

In business sector decision making, risk is incorporated into the discount rate and is valued by means of valuing the diversification of risk profiles within an asset portfolio (Markowitz, 1952). The public sector, on the other hand, does not generally diversify assets in this way. Instead, it focuses on the treatment of risk associated with projects. The Green Book (2003) has adopted various business sector types of operational risk in the broadest sense (see Appendix 6). As the table in Appendix 6 indicates, most of these types of operational risk are related to specific projects rather than being embedded into the discount rate, especially in the case of the business sector where risk analysis appears in the form of sensitivity analysis.

Risk enters the Net Present Value equation in two ways, as Figures 2.1 (p.46) and 3.1 (p.80) illustrate. For example, consider the numerator of (1) and (2); costs and revenues are expected rather than actual before the event (before the project is undertaken), and expectations can be presented by a probability distribution. Also consider the determinant of (1) and (2); risk is represented by the discount rate in the denominator.

Because of the size and complexity of public sector projects, risk and uncertainty in capital investments were given special attention in the Green Book (2003), by means of introducing an optimism bias. Government is concerned with public sector appraisers, who have a demonstrated tendency to be overly optimistic when assessing projects. The Orange Book (2004) specifically advises on the risk in investment projects, stating that:

Discounting makes no allowance for endogenous project risk and optimism bias. A large element of risk, which would be included in a private sector market discount rate, is therefore necessarily removed from the STP discount rate ... The Green Book requires that endogenous project risk and optimism bias should be transparently identified and managed as part of a proposal's explicit cost. Plans are made for the risk to be transferred to where it is best managed and the project-specific costs of managing and mitigating risk are built into the overall project costs. The optimism bias allowance is reduced to take this into account. (The Orange Book, 2004, p.5)

The Orange Book was designed to address the problems of project risk, explaining that this is mainly because the equity risk premium (as an essential component of most business sector financing) has no real equivalent within public discounting.

In concluding this section, an in-depth review of risk was undertaken in the previous chapter. There is a real attempt to use the categories of the Net present Value Model (Green Book, 2003). This may suggest that the government, because of an inherent systematic tendency for projects to overrun, places emphasis on identifying, transferring and mitigating risk, and that adjusting for optimism bias should result in better project management practices. There is a growing pressure to exhibit transparency, since the government hopes that such transparency will reduce the risk

associated with not having appropriate risk management mechanisms in place. We shall discuss the perceptions of risk in more detail in the empirical Chapter 5.

Conclusions

In concluding this chapter, we have so far deconstructed all the elements of the Grand Narrative of Value for Money in the public sector, and very generally in the health sector. The picture is clearly a complex one because the National Health Service has a unique set of demographics. We examined the issues related to the categories of the Grand Narrative of Value for Money in the context of the specific project in this thesis, and looked at the general issues about funding resources within the National Health Service. Our focus is Net Present Value as the Grand Narrative of Value for Money, and this inevitably involves consideration of various issues.

As discussed earlier, the Net Present Value model, especially as it is applied to business sector issues, provides a useful framework for this chapter (and Chapter 6 to follow) because this approach provides a framework for investigation as a useful launch pad for the deeper study of specific problems, and forms a basis for tackling more complex issues. For this reason, we treat Net Present Value as an archetype, following Matthews' (2002) treatment of competition as an archetype and as a universal ordering principle underlying human behaviour.

This chapter discussed complex issues concerning pay-offs and the perceptions of Net Present Value by stakeholders (see Chapter 5) at various levels of the National Health Service hierarchy. Frequently, financial decisions are taken at one level of the hierarchy, and are implemented at another. Inevitably, many different perceptions and evaluations of outcomes or pay-offs affect how decisions are arrived at and are later implemented. Trade-offs between stakeholders' interests and between outcomes or pay-offs must be determined. This is also a special case of the principal-agent problem, because of the fact that outcomes in the National Health Service are not independent, and social costs and benefits are involved. Similarly, decisions are

filtered through networks of relationships within and between the National Health Service, suppliers, clients, agencies and institutions. Furthermore, decision making in the National Health Service is not a purely rational process or a case of maximisation behaviour or even bounded rationality; instead it involves emotional rationality, the CARE which is provided to patients.

These complex issues are introduced in this chapter, with the aim of discussing them further in the empirical chapters to follow (Chapters 6 and 7). The examination of these factors also requires a carefully designed methodology, and this is the focus of the next chapter.

4. METHODOLOGY

Let us wage a war on totality; let us be witness to the unrepresentable; let us activate the differences and save the honor of the name. (Lyotard, 1984, p.83)

Introduction

The methodology of this thesis has followed an evolutionary path. It began by deconstructing and examining what we might call a Grand Narrative of Value for Money, as set out in the Green Book (2003). A particular training project was chosen as an illustrative example of the perceptions of Value for Money for those involved in carrying out the project, as compared to the perceptions of those in the upper echelons of the National Health Service. The argument of the thesis is expressed in the augmented Adapted Grand Narrative, and goes as follows: If the perceptions about what constitutes Value for Money of those carrying out a strategy differ from those conceiving that strategy, then problems closely resembling those in the principal-agent situation will arise. It is, therefore, important to look at perceptions from the perspective of the *face worker* (a term we use for people who deal directly with clients and implement the strategies that are designed elsewhere in the organisation) and ask the question: What are their perceptions of Value for Money?

Although the research began by focusing on a training project, it became clear that because the National Health Service is a complex network, the study had to be extended to other groups and other layers within the National Health Service. Do perceptions at these levels differ from those of the top-level decision makers who design strategy? If so, what are the consequences? These questions are relevant to us because they indicate important problems that are associated with the more generalised principal-agent problem, which, we emphasise, takes on a particularly complex form in the National Health Service.

The process of deconstruction then moved on to include multi narratives and a

storytelling approach. In Table 4.1 (below) we provide an adapted version of Table 1.1, presented in Chapter 1 (p.17), encapsulating the methodological progression.

Table 4.1 Grand Narratives, Archetypes and Deconstruction

DECONSTRUCTION	
Deconstruction is illustrated, and we show how it works in practice and in the thesis. The adapted <i>antenarrative</i> process is described. The process of deconstruction adopted in the thesis means incorporating the richness of the interviews by including patterns in addition to the original Adapted Grand Narrative.	
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (1)	Examination of the categories of the Adapted Grand Narrative in the context of an investment in training project. Extension of the study into National Health Service networks, in addition to hierarchies.
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (2)	Examination of patterns excluded by the Adapted Grand Narrative <ol style="list-style-type: none">1. Networks2. Pure qualities3. Dimensions of CARE omitted in the original Grand Narrative, for example: compassion, empathy, sympathy
MULTI NARRATIVES	The third dimension is incorporated through little narratives, local narratives and vignettes; stories 1 and 2 in the introduction and stories 3 and 4 in Chapter 6. Story 5 from Hilary Mantel also illustrates the dimensions of CARE and introduces transparency into the phenomenological approach adopted in the thesis.
DECONSTRUCTION AND SOCRATIC DIALOGUES	
PANEL DATA 1	Re-examining and reflecting upon preliminary observations; building upon multi narratives.
PANEL DATA 2	Amplifying, reflecting and showing dimensions of CARE
DECONSTRUCTION OF THE PROCESS PANEL DATA 3 and 4	The role of the researcher in the research process: completing dialogue. At each stage, described in the rows above, we gradually include what has been excluded in previous stages.

Two influential and key themes play a role in developing the method: (a) the Socratic Method, that is used as a tool for (b) deconstruction. Much of this chapter is concerned with explaining how these two aspects have been used.

Foundations of the Methodological Approach

We have already noted that the research has been an evolutionary process. Therefore, in setting out the aims, it is necessary to place them in an evolutionary context. The aims were briefly discussed in Chapter 1 (p.29)

Research Aims

The outline of the principal research aim is as follows:

The main aim of the research is to examine the issue of obtaining Value for Money in the health service, both:

- 1. as an issue in itself; and**
- 2. as a means of getting better Value for Money**

The first stage of the research has the general aim of exploring how the notion of Value for Money is represented and applied at a practical level in the National Health Service as a Value for Money strategy, which implies the adoption of a formal technique, Net Present Value. The initial area of application is the specific context of healthcare education and training programmes.

We place particular emphasis on examining the perceptions of various stakeholders who are the actual ‘on the spot’ decision makers involved in the process of implementing and adapting the Grand Narrative of

Value for Money, a strategy designed at the top level by governments and their advisors. This is termed the Adapted Grand Narrative of Value for Money. This stage of the thesis is concerned with decision makers' perceptions of the strategic processes, their evaluation of outcomes, and their perceptions of a number of relevant categories: costs and benefits, risk, their priorities, and the significance of those issues at a practical level. These are set out in Table 1.1 (p.17). We maintain that it is the perceptions of decision makers that drive the Value for Money strategy.

As the survey of the literature revealed, the process of achieving Value for Money (and high Net Present Values) involves psychic and other aspects that are difficult to measure, but that throw light on strategic decision making processes that are especially relevant to the National Health Service.

The Adapted Grand Narrative is as follows. If implementers of strategy have different conceptions of the categories described above than do the top level decision makers, then the strategy will not be achieved in the way that the top level decision makers originally conceived it. Therefore, it is necessary to examine how these categories are perceived by the strategy implementers. Initially, a training project was examined in order to carry out this part of the thesis.

In a subsequent stage of the research it became clear that there exists a richer perception of the situation than can be encapsulated by the Adapted Grand Narrative, especially in relation to people lower down the hierarchy, *face workers* who have direct contact with patients. Aspects arise that do not fit into either the Grand Narrative of Value for Money or the Adapted Grand Narrative. The question arises as to what this richer perception consists of? Do patterns emerge?

We detected three distinct patterns, centred upon:

- (a) networks**
- (b) mapping qualitative outcomes into quantitative measures**
- (c) CARE, which involves a deconstruction of the Grand Narrative**

We adopted a multi narrative approach to detect patterns in the richer picture.

The National Health Service is a network, with the consequence that projects, for example training projects, extend into a network of relationships within the service. It is not easy and sometimes not convincing to map qualities associated with CARE in the National Health Service into pure numbers.

Efficiency is only one of the considerations involved in healthcare: issues of CARE, which we summarise as compassion, empathy and sympathy, are essential, and may be more important than quantitatively measured outcomes. In any case, a balance has to be struck between the quantitative and the qualitative, and prioritisation must take place. The following issues then arise:

- (a) how is the balance taken into account?**
- (b) how are priorities considered?**
- (c) since CARE is a desired outcome and part of the balance, how can it be encouraged? Surely, it is an essential component of Value for Money.**

The thesis follows a phenomenological approach. A significant contribution to phenomenology from Husserl (1927) was phenomenological reduction. He wrote of *intentionality*, describing the

quality that the mind needs to possess in order to be directed at something.

Consider a simplistic example of experiencing objects and the relation of an observer (or researcher) to objects – the existence or not of a table, and the relationship of the knower to that object, the table. According to Husserl (1927), it does not matter whether there is a table out there or not. What we can be certain of is that we perceive a table to be there (or not). Therefore, perceptions become of prime importance. Intention is focused on perceptions. This is the stance taken in the thesis, not in relation to material objects, like tables or chairs, but in relation to entities such as thoughts, emotions, memories and so on, which we label under the heading of perceptions.

However, returning to the issue of detecting perceptions and what this means, *an issue is always present* not only with respect to our own perceptions but to the perceptions of ‘Other’. Perceptions of ‘Other’ are filtered through the perceptions of the researcher. The research process must be transparent. Also, the perceptions of the researcher must be subjected to *a reality check*. *A reality check in this connection mean asking the question, : are the perceptions of the researcher shared?*

This issue is confronted in two ways in the thesis:

- (a) in the panel discussions; and
- (b) in the Socratic Dialogue

In panel sessions, we asked ‘Other’ to reflect on the researcher’s perceptions and to add their own perceptions. The Socratic Dialogues are reflections by the researcher (and the supervisor) on her (and his) own perceptions; they represent self-reflection. This complex issue emerged during the research process, and it was decided that panels

of experts and participants in the National Health Service should be set up in order to provide a (phenomenological) reality check. In turn, these panels raised new issues, often concerned with their detailed work and experience.

The last step in the process was to include the researcher herself and the supervisor explicitly in the process.

One of the interesting aspects of this research is that it looks at how Value for Money is actually perceived in the National Health Service through the Net Present Value model. Even if the decision makers in the National Health Service often do not use the model explicitly, they do apply its principles. Thus, the Grand Narrative of Value for Money (encapsulated in this model) provides a set of convenient categories for carrying out our aims.

It soon became clear in our interviews that the responses, whilst fitting the categories, also contained some variability that needed to be examined because it illustrated variations in interpreting and implementing the strategy at the middle to lower levels of decision making, and at patient/client level.

Many practical issues were clarified, and emotional as well as rational aspects began to surface. We recognised variability in terms of what we called multi narratives, which illustrate as stories the subtleties of the issues involved although they do not necessarily fit into the Net Present Value model. We needed to ask ourselves the question: do we treat variability (multi narratives) as noise?

From this point a novel core approach emerged.

The Core Approach through Deconstruction and Socratic Dialogue

It is appropriate to express the essentials of the methodological approach in two ways:

- i. conceptually, attempting also to relate theoretical constructs to practice; and
- ii. as a dialogue between the researcher and an academic

i. Conceptual Approach

The method for examining the conceptual framework is reported in this chapter with respect to each of the Net Present Value/Value for Money categories. In carrying out the interviews, a certain disquiet arose. The reason for the disquiet was as follows. Value for Money and Net Present Value were being treated as part of a Grand Narrative of Value for Money in the sense of Lyotard (1979, 1984) and Boje (2001). During this process, interview material was being squeezed into the framework prescribed by the Grand Narrative of Value for Money.

One convention states that material that does not fit the Grand Narrative of Value for Money should be treated as outlying data. However, it seemed clear that the picture was one of variability and richness. Some material just did not fit the framework of the Value for Money strategy as applied to the National Health Service. We treated these materials as multi narratives. From this point forwards, the approach started to evolve.

We describe our approach using Boje's (2001) term *antenarrative*. As the name suggests, according to Boje (2001), an *antenarrative* corresponds to a crude story that is spoken or written prior to the formal narrative. He attaches two meanings to the term. First, he sees it as an account that happened earlier:

First story is 'ante' to narrative, it is *antenarrative* ... Story is an account of incidents or events, but narrative comes after and adds 'plot' and 'coherence' to the story. Story is therefore 'ante' to story and narrative is post-story. Story is an 'ante' state of affairs existing previously to narrative; it is in advance of narrative. Used as adverb, 'ante' combined with 'narrative' means earlier than narrative. (Boje, 2001, p.1)

Then Boje (2001) also attaches a second meaning of *antenarrative*, this time as a bet:

Secondly, ante is a bet, something to do with gambling and speculation. ... a poker stake usually put before the deal to build the pot – the dealer called for dollar ante (Merriam Webster Dictionary). In horse racing, ‘ante-post’ is a wager made on a horse before that day of the race. As a verb is anteing. (Boje, 2001, p.2)

The interpretation of this second aspect of ante as a bet is that narrative imposes order, ruling out some options or interpretations *in favour* of other options or interpretations. They exclude other interpretations or other possible *bets*. Treating the story as a bet allows the possibility of other interpretations *running* (to preserve the horse race metaphor).

Our approach tries to preserve both aspects of Boje’s *antenarrative*. The approach here differs from that used by Boje in that what he terms an *antenarrative* emerges as a result of the research process, because the *antenarrative* emerges at the end of the research process. Perhaps a close approximation of Boje’s *antenarrative* is to say that it represents a stage in a process that precedes exclusion of the ‘*Other*’. Put this way, it is clear why it is so difficult to define the term. As is the case with deconstruction, our entire tradition is premised on the exclusion of the ‘*Other*’; often we exclude considering the ‘*Other*’ in order to focus on and understand a particular issue. However, we might argue that the excluded ‘*Other*’ is always present and may be significant. Here we see parallels with the notion of deconstruction.

Deconstruction

Deconstruction is central to this thesis. The term deconstruction was introduced by Derrida (1983), who described it as follows:

“Deconstruction is neither analysis nor a critique ... it is not a method ... the difficulty [with] all the defining concepts ... are also deconstructed.”
Derrida (1983, p.40)

The concept was further advanced and applied to other branches of social science by other theorists between the late 1960s and the early 1980s: in literary criticism (Miller, 1976; de Man, 1986; Hartman, 1981); ethics (Critchley, 1992); understanding political

terms (Beardsworth, 1996); understanding community and society (Nancy, 1982); and storytelling (Boje, 2001). Matthews (2001) describes deconstruction as discovering layers of meaning; gradually including in the analysis that which has been excluded by grammar (rules) adopted earlier in the analysis. He writes of the parallels between deconstruction and certain contemplative practices (Matthews, 2004; 2006; 2008). As Derrida notes, deconstruction is not a technique, but it can be demonstrated or “shown”. It consists of including what was previously excluded. He defined this as follows:

[Deconstruction is an] unclosed, unenclosable, not wholly formalisable ensemble of rules for reading, interpretation and writing. (Derrida, 1983, p.40)

Other writers follow the same path. Boje (2001), whose framework we use in this thesis, takes this issue further, saying:

Deconstruction is *antenarrative* in action. Every story excludes. Every story legitimates a centered point of view, a worldview, or an ideology amongst alternatives. No story is ideologically neutral; story floats in the chaotic soup of bits and pieces of story fragments. Story is never alone; it lives and breaths it’s meaning in a web of other stories. And, every story since it is embedded in changing meaning contexts of multiple stories and collective story making, “self-deconstructs” with each telling. Deconstruction is both phenomenon and analysis. It is phenomenon because “story deconstruction” is all the constructing and reconstructing processes happening all around us. It is analysis, as I have come to read it. I will speak of two levels: the level of action and the analytic level. (Boje, 2001, p.1)

In trying to clarify the application of deconstruction, Boje (2001) makes a further comment, advocating the use of term ‘resituate’:

The point of doing the deconstruction analysis, is to find a new perspective, one that resituates the story beyond its dualisms, excluded voices, or singular viewpoint. The idea is to reauthor the story so that the hierarchy is resituated and a new balance of views is attained. Restory to remove the dualities and margins. In a resituated story there are no more centers. Restory to script new actions ... [I]f we deconstruct, without resituation, then we are rightfully open to challenge by the critics of deconstruction, who say it is just destruction (tearing apart). At, the same, time I think even without resituation, it must be pointed out, that deconstruction is going on in the text, and in our lives, both text and our lives are unraveling. Deconstruction, as an analysis, traces the lines and fissures, and transformations. Still, to resituate, is to include some new line of flight, which eventually, gets deconstructed. (Boje, 2001, p.1)

The research method in the thesis adopts the same approach as that illustrated in the quotations above. It does not attempt to define deconstruction, but rather to demonstrate its operation in the practical context of the National Health Service. Adapting Boje's notion of *antenarrative*, this research, by including more and more aspects of the data, ends with an *antenarrative*. The richer picture occurs at the end rather than at the beginning.

This process enables practical proposals related to Value for Money in the National Health Service to be set out, and it can be linked to the literature that was reviewed earlier in the thesis.

Différance (in Derrida's terms)

We should also relate our discussion to what we might call difference in a special sense, related to Derrida's notion of Différance (Derrida, 1982). The point here is that the interviews aimed to elicit the interviewees' perceptions, first regarding the categories implicit in the Value for Money equation, and then regarding the interpretations necessarily put on these perceptions. These perceptions were initially given orally, but were then put down in writing as interpreted by the interviewer. Hence, we have, as it were, perceptions of perceptions and speech and writing. Then, the interviewer's perceptions were discussed during the interview panels, with the purpose of validating, extending and enriching them and thereby adding yet another layer of perceptions.

There is also a need to express theoretical concepts in a concrete manner. The notion of Différance can be expressed in practical terms. Faced with huge problems in healthcare, policy makers may argue as follows:

- a. First, let us not separate CARE from concrete measurable outcomes and targets, and let us assume that there is no difference between the two;
- b. Second, in doing so, we are deferring (postponing), for the moment, the issue of CARE as such, and treating things purely in terms of targets (deferring to targets).

Thus, we have illustrated the two aspects of Différance; difference and deferring. There is a difference between CARE and outcomes and targets as they are formulated in the Value for Money strategy, but we defer consideration of that Différance, for the moment, by focusing solely on Value for Money. In this way we defer to that approach.

It is obvious that recording the perceptions of '*Other*' is not a simple matter. They are not replicated, they are filtered. Perhaps this complexity is what Boje has in mind when he implies that *antenarrative* is a state that may be unattainable. Further issues arise in connection with this complexity. We have an interviewer with a severe hearing problem working in a second language, and also issues of the perceptions of the interviewer/researcher. Should we ignore these issues, or should we recognise the value of Différance? We constantly come up against the problem of the interviewer's perceptions being influenced by such considerations. Pure representation is impossible. Pure *antenarrative*, in Boje's sense, is impossible. However, the problem can be dealt with. The path taken in this research is to remind the reader that the researcher is conscious of these philosophical difficulties, which may be significant in theoretical terms and in the search for practical implications. The reader is also reminded that although the issues involved (regarding exactly what perceptions are) may ultimately be impossible to decide, the process of eliciting these issues is made as transparent as possible in the presentation the research, so that at least in principle the study could be replicated – with, of course, the qualification we made earlier, that an event can never be repeated exactly at two different times. In addition to this, the research also develops practical proposals that can be tested out in practice.

Even when applying a broader deconstruction framework, the researcher felt that something was missing. We needed to find the best possible way to develop our storytelling approach. The approach uses a multilayered set of interviews, so naturally the concern became the quality of those interviews. We argue that the interview method inevitably leads to a problem of the distortion of participants' views. We used the Socratic Method to introduce clarity and transparency into the process.

ii. Socratic Method: Socratic Dialogue 1

The Socratic Method represents a dialectic method of inquiry, also known as the method of “elenchus”. The Greek philosopher Socrates developed and applied this method to examine key moral concepts: philosophical belief, knowledge, virtue, religion, justice and politics. His purpose was to solve a problem by breaking it down into a series of questions, and then providing answers that would gradually develop further into a coherent story.

Arguably, the Socratic Method is the earliest known negative method of hypothesis elimination still present in the modern scientific method. Plato was the first philosopher to start using this method in the sense of a Socratic Dialogue in his early works, and indeed his later works, such as *Phaedo* (Plato and Gallop, 1999) and the *Republic* (Plato and Waterfield, 2008) are considered to be Plato’s own elaborations to the Socratic Method.

It would be useful to illustrate the comparability between Socratic Method and the scientific method in general terms, as indicated by Dye (1996). For this comparability, see Table 4.2 (next page).

Table 4.2 Socratic Method versus Scientific Method

Socratic Method	Scientific Method
1. <i>Wonder</i> . Pose a question (in the “What is X?” form).	1. <i>Wonder</i> . Pose a question.
2. <i>Hypothesis</i> . Suggest a plausible answer (a definition or <i>definiens</i>) from which some conceptually testable hypothetical propositions can be deduced.	2. <i>Hypothesis</i> . Suggest a plausible answer (a theory) from which some empirically testable hypothetical propositions can be deduced.
3. <i>Elenchus</i> . “Testing,” “refutation,” or “cross-examination.” Perform a thought experiment by imagining a case which conforms to the <i>definiens</i> but clearly fails to exemplify the <i>definiendum</i> , or vice versa. Such cases, if successful, are called <i>counterexamples</i> . If a counterexample is generated, return to step 2, otherwise go to step 4.	3. <i>Testing</i> . Construct and perform an experiment which makes it possible to observe whether the consequences specified in one or more of those hypothetical propositions actually follow when the conditions specified in the same proposition(s) pertain. If the experiment fails, return to step 2, otherwise go to step 4
4. Accept the hypothesis as provisionally true. Return to step 3 if you can conceive any other case which may show the answer to be defective.	4. Accept the hypothesis as provisionally true. Return to step 3 if there other predictable consequences of the theory which have not been experimentally confirmed.
5. Act accordingly.	5. Act accordingly.

Source: James Dye (1996)

We need to ask ourselves the question: what does this procedure offer to decision makers in the National Health Service in concrete practical terms? In a sense, the procedure is not very different from the conventional approach, in which the researcher is asked to reflect on the research process, adding his or her own interpretation and giving reasons for this approach, allowing for the exercise of

controlled subjectivity, and providing an overview of the hard facts. In addition, the viewpoint taken here is that the interviewer's/researcher's story is interesting in itself, partly because he/she is not only an interviewer and researcher but also a client and patient of the service.

We need to test this viewpoint, and there are many ways that this can be done. The method adopted in the thesis is to look at the usefulness or practicality of the storytelling approach, from the point of view that it would be users who were involved in setting up the project initially. So, it would be useful to the reader to assess how we adapted the Socratic Method to the study's particular requirements.

Actual dialogue: Discussing Methodology

The dialogue reproduced below summarises the way that the research methodology evolved. It illustrates the use of the Socratic Method at various stages in the research process. The reader can also refer to Table 1.1 (p.17), referred to at the start of this chapter.

The discussion is presented in an edited and stylised form that nevertheless preserves the essence of the original conversations⁴ in the spirit of Socrates, as a discussion between academic supervisor (A) and research student (R).

A: Summarising in advance the purpose of this meeting, we reflect on some fundamental methodological issues and to get your response. You say that your methodology evolved during the process of writing and researching your thesis. What do you mean by this?

R: I began the research by adapting the Grand Narrative of Value for Money strategy as follows: the initiative for the strategy is basically top down, beginning with the government, the Department of Health and filtering down to the Strategic Health Authority, the National Health Trusts to the service providers and the individuals actually providing services to patients, or as we now prefer to call them, clients. The initial proposition was that if people lower down in the hierarchy have different perceptions of the various categories that make up Value for Money in relation to the people who initiate the strategy, then there

⁴ We emphasise the need for following the codes of research ethics. Participants' names have been removed in order to protect their identities. We discussed this issue in Chapter 1 (p.38).

is no guarantee that the intended strategy will actually be carried out. The Value for Money strategy is essentially top down, so we have the possible emergence of the principal-agent problem in the National Health Service. So, it is important to identify perceptions at the grass roots level of providing services. My initial research, at the instigation of the commissioner of the project, related to a training project, but I soon realised that we need to expand it to the National Health Service because of this top down strategy. This is the first stage of evolution.

A: Isn't this a variation on the theme of the principal-agent problem?

R: Yes.

A: You say you were interested in perceptions of the categories associated with Value for Money. Why perceptions?

R: I adopted a phenomenological approach. What is interesting is not the categories as such, but the way people perceive the categories. Perceptions will govern what they actually do.

A: You were analysing unstructured data. Why did you decide not to use qualitative software packages such as Qualrus to structure your data?

R: There were a number of reasons. Moods are important in determining perceptions. I wanted to capture these, and I do not think that those packages would have enabled me to do this. Qualrus is useful for building new constructs for a model. I was not doing that. I was deconstructing a well-known theoretical model. Also, in the way I hear, I am very sensitive to non-verbal signals, facial expressions, atmosphere and gestures, and I wanted to include them. I have tried to do so, especially in the stories, and by using reported speech.

A: Part of your research was sponsored. What problems emerged there?

R: In conjunction with my sponsor, I carried out interviews with people connected to the training project. The interviews were structured according to the various categories associated with Value for Money; perceptions of costs, benefits, time preference, discount rates and so on. I got some interesting answers but I realised before long that although respondents understood the categories and I received interesting responses generally in support of the hypothesis, they seemed to think that this structured way of thinking was artificial. The responses I received, to use Boje's expressions, were less coherent, more fragmented, more chaotic, than I expected. They were discursive, consisting of little stories related to their experiences at work. Also, I became conscious that there were many different voices speaking. In Boje's terms, the responses were polyphonic, relating to the same subject matter, but I could only get a consistent picture by screening out

differences and treating digressions (deviations) and often refusal to see things strictly in terms of the categories, as noise.

A: So you felt that you could only keep strictly to the Grand Narrative of Value for Money or the Adapted Grand Narrative you had constructed that attempted to identify gaps and divergences in perceptions about what Value for Money entailed at the cost of losing some of the richness emerging from the interviews. Did this not mean that your original hypothesis was invalidated? A false start? A misconception?

R: No. Clearly, variations of the principal-agent problem exist in the National Health Service, but they are quite complex since there are so many levels of decision making and so many different networks. Clearly, perceptions of strategy at various levels of the hierarchy differed, and this was interesting and significant. But, rather than treat deviations from the initial theme as noise, I decided to look more closely at the rich variety of responses, especially their emotional content.

A: Noise? Please explain this further.

R: Noise is irrelevance to the main message. I was thinking of richness. We lose richness because we try to squeeze the data back into the model. It is the traditional way of doing research, where you would have to feed data back into the model, and we as researchers are too ready to eliminate outliers rather than asking whether the outliers are significant and whether they represent, as in this case, not just deviations from strategy, but ways of enriching strategy. Here we have stories, and these stories are always evolving because people add their own little stories. Their descriptions are chaotic but understandable. They try to explain what happens in the decision making process. Squeezing this rich experience into short quotes cannot capture this richness, so I decided to take a multi narrative approach.

A: You could say that all these aspects, especially those relating to the principal-agent problem, exist in the business sector. What is new then?

R: The National Health Service is specifically about caring for others and society's social responsibility. There are many stakeholders. So problems take a different form in the National Health Service. And I think that the motivations of people who go into public service, especially the health service, are different. The panel data seems to support this.

A: What is to be gained, do you think, by this approach? Richness or confusion?

R: There is richness about how people make decisions. Assuming

rationality assumes an order that is not there – the emotional context: moods, fears, pressure, concerns, anxiety about targets and about their jobs. A phenomenological approach considers these. The upper level expressed their concern that they do not know how people at lower levels make decisions, whether they make the right ones or whether they do follow their instructions. The Green Book makes no reference to this. Although it is clearly concerned with obtaining Value for Money, it is not concerned with the emotional aspects of decision making. It treats everyone as if they were super rational. It is not concerned with how people implementing decisions think or feel, or how these things may affect decision making.

A: A bit like treating people as resources: human capital as in Lyotard's Grand Narrative...

R: Yes, I think so.

A: So you think that top-level managers need to know more about what is happening at the lower level. Does the multi narrative approach facilitate this?

R: Probably, decision making and target setting in the National Health Service are too top-down. I began to see this as something I should examine.

A: But, isn't this inevitable in an organisation as large as the National Health Service, which is such an important part of the government's agenda?

R: To some extent yes; a top-down approach is inevitable but, as I said earlier, perceptions of those implementing decisions about Value for Money are critical to outcomes. A further point is that a top-down view is too simplistic. It became clear, for example, that the original project was part of a network of projects and a network of decision makers. So, I needed to extend the interview base and the investigation beyond the original training project to the whole National Health Service.

A: But, does this not mean that by extending the interview base to a network of interconnections, you get an even more fragmented and chaotic picture than you described above?

R: To some extent, yes, and this is the reality. Nevertheless, certain patterns emerged from the multi narratives that were absent if I tried to squeeze everything into the Grand Narrative.

A: What kind of patterns?

R: Patterns associated with working in networks; problems of

measurement; patterns associated with the emotional content; compassion, empathy and sympathy; dimensions that are essential to an efficient health service and risk being lost if the focus is entirely on measurable targets.

A: But such things are difficult to capture. They are difficult to map into the research project. How did you deal with such problems? Just what are they? You said ... (earlier) that it was difficult to define aspects of CARE, for example...

R: To a certain extent, I dealt with them by allowing the stories to speak for themselves. I drew on interviews with individuals, but I also tested out my interpretations of the stories with the panels of experts. I tried to make the process of interpretation as transparent as possible, but even in discussion panels, I found the same process emerging: personal stories, individual concerns.

A: But the stories you report and the way you report them are still filtered by you. Exactly what are you trying to do? Where is the objectivity? How does this add to academic knowledge and aid decision makers?

R: In the first place, I make the processes that I carried out and how I carried them out transparent. So the procedure could be repeated, at least in principle, because you can never repeat anything exactly. Second, please remember that I am examining perceptions. I take a phenomenological approach. Perceptions are the reality according to this philosophical standpoint. Third, I include my own narrative. I tell my own story, so that the reader can have a view of my own position and viewpoint in the research process. I see myself as both as a researcher with a certain objectivity, making the research process as transparent as I can, and presenting my own story as both researcher and client of the service ... I am interested in the practical implications of the study for the National Health Service (part of it was commissioned and this gave me introductions to people, decision makers and a network of contacts). From an academic perspective, the process of trying to obtain Value for Money in the National Health Service entails novel aspects and dimensions of the principal-agent problem ...

In a period when corporate governance and corporate ethics and responsibilities are becoming a general concern, these aspects and dimensions may be of critical importance to both business and public sectors...

Methodological Approach

The original approach took the form of deconstruction, as defined by Derrida (1982) and developed by the other theorists introduced earlier (Boje, 2001). This study takes the approach further and adapts it to the specific context under investigation. In this sense, the method follows an evolutionary path:

Stage I: The deconstruction of the Grand Narrative

Stage II: Multi narratives

Stage III: Panel data interviews

Stage IV: Socratic Method

This process was illustrated at the start of the chapter by reference to Table 1.1 (p.17). Before moving on to explain these stages in detail, it would be useful to explain to the reader the process of designing the interviews for all four stages.

Design of Interviews

This study used face-to-face, in-depth, open-ended interviews. These enable the researcher to adapt the questions if necessary, clarify doubts, and ensure that the respondents understand the questions properly. The researcher could also pick up nonverbal cues from the respondents, and this provided the scope for introducing storytelling. The interviews were organised into two stages:

- i) preliminary stage of the interviews (stages I and II)
- ii) further stage of the interviews (stages III and IV)

The preliminary interviews correspond to stages I and II of the deconstruction (Grand Narrative and multi narratives), and the further interviews to stages III and IV (panel data and Socratic Method). We illustrate this in Table 4.3 (next page).

Table 4.3 Design of Interviews

	INTERVIEWS		
	Stage I and II	Stage III	Stage IV
	Preliminary Interviews	Panel Data Interviews	Socratic Dialogue
AIM	Training Project	National Health Service	Research Process
TYPE	In-depth	In-depth	In-depth
PERIOD	2005 – 2006	2007– 2008	2008 – 2009
NUMBER	17	2 panel discussions: panel 1: 4 members panel 2: 4 members	2
DURATION	1 hour	1 hour	1 hour
PARTICIPANT	<p>Three groups:</p> <ol style="list-style-type: none"> 1. People associated with designing the training project at the sponsor (top level) 2. An extended group concerned generally with funding the training projects (Strategic Health Authority level) 3. Extending to include <i>face workers</i> concerned generally with implementing strategy (National Health Service Trust level) 	<p>Panels:</p> <ol style="list-style-type: none"> 1. Experts: <ol style="list-style-type: none"> (i) a commissioner (C) delivering Value for Money to the clients (ii) a senior director (D) involved in designing strategy (iii) a former nurse now a management consultant (MC) (iv) former NHS Trust CEO (FCE) 2. The academic supervisor, an expert on the strategy 3. A researcher with experience in the delivery of health services and a user. 	<p>Panel:</p> <ol style="list-style-type: none"> 1. The academic supervisor 2. The researcher

In stages I and II, the preliminary responses concerning the Grand Narrative of Value for Money in the National Health Service, we organised one-to-one in-depth interviews into three sets or groups within the National Health Service. The groups were as follows:

- (a) People associated with designing a training project at the top level
- (b) An extended group of interviews at the Strategic Health Authority level with people concerned with funding training projects
- (c) Further extensions of the interviews with decision makers at trust level, with people concerned with implementing strategy

A complete list of the participants is provided in Appendix 9.

Then, we developed the panel data approach using further in-depth, open-ended interviews. The purpose was to test the complex issues described above, that we were unable to examine by multi narratives.

At stage III, we examined the stories further, and developed panel data through in-depth interviews, including a carefully chosen panel of members and experts, with the interviews taking the form of a discussion. Two sets of panel data were collected:

Panel 1 was introductory and designed to test the approach. This panel discussion was made up of four members:

- (i) a commissioner (C)
- (ii) a National Health Service Trust director (D)
- (iii) a researcher (R)
- (iv) an academic supervisor (A)

The findings related to the Adapted Grand Narrative were re-confirmed. A preliminary discussion about the complexities and ambiguities of obtaining Value for Money was touched upon, and some issues started to emerge. We afterwards felt that this was an

exploratory panel interview that needed further development.

Then we introduced panel 2, again consisting of four members:

- (i) a former nurse, now a management consultant (MC)
- (ii) a former National Health Trust Chief Executive Officer (FCE)
- (iii) a researcher (R)
- (iv) an academic supervisor (A)

We extended the Adapted Grand Narrative in order to discuss the complexities and ambiguities of obtaining Value for Money and explore the critique of the current top-down target-driven approach to strategy in the National Health Service from the experts' viewpoints. We introduced the dimensions of CARE: empathy, compassion and sympathy, using Hilary Mantel's story to get panel reactions and to elicit emotions, and then to link the importance of CARE to strategy – that is, balancing the hard and soft sides of the elements of the strategy.

Finally, we constructed the last panel interview, also known as Socratic Method, between the academic supervisor and the researcher. We wanted to address two important issues:

1. Recognition of the fact that the researcher herself has a critical role in determining and shaping the research process. This needs to be made transparent.
2. Also, the researcher comes at the problem from a particular perspective – that of sense-making. First, the researcher views herself as both a client and a researcher, and this introduced a focus on empathy, CARE and compassion. Second, the researcher has a hearing difficulty, which means that she has a distinctive listening style. (These considerations are discussed in the final Socratic Dialogue, in Chapter 8.)

In conclusion, although they are fundamental to the thesis and to the Adapted Grand

Narrative that emerges from the literature review, stages I and II were stimulated by the practical considerations of providing feedback to managers of the training project. As the reader will see, the results of the Value for Money investigation in stages I and II were reported to the interviewees for preliminary feedback and to get the respondents' views on CARE and compassion. These views were then followed up in stages III and IV.

What follows is a discussion of each stage of the research process in greater depth.

Stage I: Deconstruction of the Grand Narrative of Value for Money

The study began by examining what we might call a Grand Narrative of Value for Money in the National Health Service, and then deconstructing that Grand Narrative in order to shed light on other issues and considerations. We examined the preliminary responses of three sets or groups within the National Health Service with regard to the Grand Narrative of Value for Money.

We carried out preliminary interviews with the three groups as explained earlier: i) top-level decision makers concerned generally with designing strategy; ii) decision makers at the Strategic Health Authority level, concerned generally with funding training projects; and iii) *face workers* concerned generally with implementing strategy. This was a natural evolution because it very soon became clear that the National Health Service could be viewed as a hierarchy for the purposes of the thesis. It consists of networks of relationships. Therefore, the preliminary interviews suggested extending our reach into these networks.

The choice of interviewees at the preliminary stage of the interviews of the project were determined by the project itself: the commissioner's people, who provided us with this opportunity, the sponsoring manager, the trainees on the programme. However, then the scope widened out to encompass a wider group of key stakeholders. The interviews were centred on a deconstruction of the Grand Narrative of Value for Money: first, based on a model constructed out of the literature (surrounding the

business and public sectors), which led the researcher to ask questions about a set of the model's categories; and second, as a result of deconstruction by the interviewees themselves.

The next step was to provide some conclusions. Two issues emerged from the first stage of the analysis. First, the participants were reluctant to confirm certain observations regarding the Grand Narrative of Value for Money / Net Present Value categories. Second, it became clear that participants in the National Health Service are part of an interconnected network of stakeholders (staff, clients, and community). This was acknowledged by broadening the study.

With regard to the first issue, there was considerable evidence for our initial hypothesis. The problem arose as to how we should treat outlying responses that did not fit our initial hypothesis. In trying to fit responses into the mould of the Grand Narrative of Value for Money/Net Present Value, much was being lost. We decided not to treat these responses as outliers, but instead to incorporate them with an analysis of the complex issues that our initial respondents and the respondents from the first group of stakeholders were recounting, in the form of multi narratives. The question then arose as to whether these multi narratives formed a pattern that could be interpreted in such a way as to give guidance to decision makers in the National Health Service, who were trying to achieve Value for Money. Hence, the next stage – multi narratives.

Stage II: Multi narratives

The second stage ran concurrently to the first, with the same respondents. It became clear that although value was a concern of the interviews:

- (i) it was not the only concern, or even the primary concern. And where it was a concern, it was associated with a sense of loss of excluded '*Other*' in the Grand Narrative of Value for Money journey. The interviewees' responses were much richer than the Grand Narrative of Value for Money

allowed for.

- (ii) for the most part the interviewees did not perceive their work in terms of categories within the Grand Narrative of Value for Money. Work in the National Health Service has and should have an emotional content concerned with empathy, compassion and so on. This emotional content can be best understood (or inferred indirectly) through personal stories.

Thus, the richness was first embodied by considering multi narratives, reporting on people's narratives and letting the stories speak for themselves as far as possible.

In conclusion, the multi narratives unsurprisingly demonstrated that:

- (a) the respondents felt that views of CARE, compassion and empathy were being crowded out by measurable tangible outcomes (i.e. targets)
- (b) the governmental approach to National Health Service management was too top-down

One of the effects of the quest for Value for Money was actually to suppress empathy. Consider the tone of our initial stories: "I will deal with this now" summoned the family to the waiting area, and defensively asserted that the operation and the events leading up to it followed procedure and that no one was to blame for the patient's death (something that had never been suggested). This and other stories started to emerge, although mostly in a crude and incomplete form. We needed to analyse them further, hence the next stage – panel interviews.

Stage III: Panel Data Interviews

In the further stage of the interviews in this study, we collected panel data using the adapted Delphi method. Broadly speaking, the Delphi method is primarily concerned with making the most of imperfect information, exploring reliable and creative ideas and dealing systematically with complex problems using a panel of experts. The usefulness of this method has been explored extensively by Wissema (1982), and has

been widely used in the arena of public health issues: policies for drug use reduction; prevention of sexually transmitted diseases; and education areas (Adler and Ziglio, 1996; Cornish, 1977).

The basic process is as follows. The experts share knowledge through questionnaires (Adler and Ziglio, 1996). Fowles (1978) provides an overview of the steps for the Delphi method; broadly speaking, the person conducting the panel interviews (the researcher) asks the participants (the experts) a series of questions so that they can develop and refine their responses to a specific problem. The researcher has to control the process and the interactions among the panel of experts. In this way, he or she can filter out information that is less important (Martino, 1978), and facilitate the formation of a group judgement (Helmer 1977) which is then used for further analysis and to make general statements later.

Some issues need to be considered when using this method. According to Delbecq *et al.* (1975), the most important issue is the quality of the responses from the participants, so it is necessary to make them aware of the aims of the method. Some argue that the respondents to the questionnaire should be well informed in the appropriate area (Hanson and Ramani, 1988), while some state that a high degree of expertise is not necessary (Armstrong, 1978). The number of participants may vary, depending on the study design, but experiments suggest that groups as small as four can perform well (Brockhoff, 1975). We took these criticisms into consideration and designed two sets of panel data interviews for this study.

Panel Discussion 1

In the first round of panel data interviews, the members of the panel were an academic expert, a researcher, a commissioner and a senior National Health Service manager. The aim was to reconfirm the preliminary findings and to investigate these findings in the context of broader considerations facing a top-down approach to the Value for Money strategy. The fundamental problems were touched upon and identified: for example, the disconnectedness between top and *face worker* level, the measurement

issues, and the difficulties of decision making in networks of relationships. These issues also touch upon the research problem from the perspective of the principal-agent problem in the National Health Service, and all needed further investigation. In this sense, this stage provided the basis for investigating these issues further in the second panel data interviews.

Panel Discussion 2

The second round of the panel data interviews checked the preliminary results from the Grand Narrative and multi narratives against the opinion of the experts:

- (a) First, we checked our impressions of the initial responses about the Grand Narrative and the multi narratives
- (b) Second, we introduced a novelist's narrative (Mantel, 2008) and sought further responses about empathy

It is interesting to note that the conversations took the form of stories, but they also took the form of reflective dialogues, as much between the panel members themselves as between the panel members (including the senior director and the commissioner in the National Health Service), the researcher and the academic expert. The experts were encouraged not only to give their own responses to the preliminary findings, but also to add their own perceptions and their own stories about Value for Money. They were introduced to a novelist's narrative (Mantel, 2008) concerning her feelings and reflections in relation to a particular (harrowing) personal experience with the National Health Service. The discussion was then extended to bring aboard a more complex set of problems (from the multi narratives): the complexity of obtaining Value of Money, questioning the effectiveness of a top-down approach to strategy at the point of CARE (*face workers*) and providing a set of recommendations for future improvements.

Then we reached further conclusions. We discovered that not all the findings could be squeezed into the Grand Narrative of Value for Money. This is partially because there is no such a thing as a perfect account, and partially because a complete accounting of

the data is not always possible to do (given the fact that this is a qualitative enquiry). This prompted us to extend the analysis to another chapter (Chapter 6) to include multi narratives; loose bits, such as interdependence issues associated with multiple projects, the presence of many stakeholders and decision makers, and the pay-offs and trade-offs involved. These are inevitable and not necessarily a bad thing. They serve as a bridge between the Grand Narrative and storytelling. One section of these multi narratives were derived from the preliminary set of interviews, while others were tackled in a further set of interviews, as part of the panel data, and which fitted in very well there.

In conclusion with regard to panel interviews, they enabled us to further develop a broader set of considerations that we could not capture during the interview preliminary stage. Moving on from the Grand Narrative of Value for Money, through multi narratives to storytelling enabled a deeper examination of broader strategic issues – the principal-agent problem in the National Health Service and the success of the current Value for Money strategy. These stories will be presented in detail in Chapter 7.

However, even after applying a broader deconstruction framework, we felt that something was missing. A further phase of deconstruction was needed: How does the researcher fit into the group of stakeholders? What is her role? What are her perceptions? We introduce the Socratic Method to deal with this issue.

Stage IV Socratic Method

We discussed the usefulness of the Socratic Method in depth earlier. In this fourth and final stage of reflection, two interviews took place in the form of self-reflective dialogues between the academic supervisor and the researcher, bearing in mind confidentiality and in the true spirit of Socratic Dialogue:

- i) The first dialogue is reported in this chapter, reflecting on the method used in this thesis

- ii) The second is reported in Chapter 8 (p.248–252); the researcher's story is told and reflected upon in relation to the stories, interpretations and methods adopted in the thesis. This gives the interviewer/researcher story importance in addition to the importance of the Grand Narrative or multi narratives.

The results are summarised, and a phenomenological approach is taken to the phenomenological method itself adopted in the research. In this sense, the Socratic Method completes our deconstruction process.

Lev Vygotsky's work

On a final note, perhaps the greatest influence regarding the introduction of the Socratic Method was the pioneering work of Russian psychologist Lev Vygotsky. Vygotsky established the foundations of modern day defectology, the branch of experimental psychology that focuses on studying the cognitive functions of disabled children and adults. He was particularly interested in the study of cognitive functions of deaf, profoundly deaf and blind children and adults. Vygotsky (1983, p.77) noted: '...in the social world, however, deafness is a more severe handicap because it prevents mastering of speech, blocks verbal communication, and bars entry to the world of culture, therefore it disrupts a person's social connections in a more substantial way than blindness...'

Vygotsky (1978, p.89) also observed that '...learning is a necessary and universal aspect of the process of developing culturally organised, specifically human, psychological functions, thus learning leads to the development of higher order thinking...' He developed the concept of the Zone of Proximal Development (ZPD), which suggests that human potential is theoretically limitless, but the practical limits of human potential depend upon quality of social interactions and residential environment. He argued for the identification of a disability in a person from the perspective of strengths, not weaknesses (Gindis, 1995). He also demonstrated that other forms of cognitive growth compensate for disruption through the development of

skills representing higher mental functions, such as abstract reasoning, logical memory, voluntary attention or goal-directed behaviour.

Disabled students do not only need more time to learn; they also require dedicated specialist teachers, a differentiated curriculum and special technological auxiliary aids. From a realistic viewpoint, the question then becomes how these demands can be met in a regular classroom environment (Gindis, 1995). Socratic dialogue, as applied to this thesis, is used to examine the issue of the interconnectivity of learning and development, and is seen as useful tool for evaluating the process advocated by Vygotsky. In this sense, it has practical pedagogic implications in the area of supervision for disabled research students.

Conclusions

The methodological approach adopted in this study has allowed us to develop a rich understanding of how decision makers in the National Health Service perceive Value for Money. This has opened up a novel perspective on using the Net Present Value model as a Grand Narrative of Value for Money. This particular project (healthcare education and training) provides an opportunity to employ this novel approach to examine the problem of Value for Money. Most importantly, the practicality of this method is seen as being conceived in this study. We discuss this in Chapter 8.

The study began with deconstruction, in order to examine perceptions about the Grand Narrative of Value for Money. Then the process evolved. The researcher became a part of the process, and had to deal with a whole set of issues:

- a. Problems with the interview process, showing what actually happened.
- b. The fact that one cannot segment the empirical work into a training programme alone, because the network and interconnections between tasks and decision makers at various levels is part of the story.
- c. The relationship with the sponsor is also part of the story; the sponsor's

anxiety, difficulties, reflections on decision processes and on the relationship between top decision makers and *face workers* in a concrete way.

- d. The researcher's development is also important. (This is discussed in Chapter 8).

We would like to mention how we dealt with these problems. The preliminary interview process showed that the interviewees were reluctant to see things in terms of the Value for Money categories. In trying to fit responses into the Value for Money/Net Present Value mould, much was being lost. In fact, it became clear that the representation of the archetype in the National Health Service was in the form of multi narratives. This is reported in Chapter 5.

Further analysis showed that obtaining Value for Money was a complex process involving decision makers at different hierarchical levels of the National Health Service. A pattern emerged with respect to the process. Within that general pattern, there was great variation as a result of different stakeholder interests, trade-offs between these interests, and network aspects of decision making. This stage of the work is reported in Chapter 6.

Further analysis suggests that these emerging patterns reveal emotional aspects of the decision making process, and perhaps most interestingly they reveal the emergent properties of decision making. Emergent properties depend very much upon people – in this case, the *face workers* – actually implementing Value for Money decisions. They take the form of creativity and innovation in client – patient CARE. It is important that top decision makers in particular should understand the emergent properties of the system they are managing, especially the role of *face workers* in implementing a bottom-up approach to strategy – including controls, and monitoring with patient interests at the forefront. In this sense, this chapter attempts to provide that information, but, more importantly, it provides a methodology that can be used as a part of a bottom-up approach to the Value for Money strategy. We discuss the findings related to this matter in Chapters 7 and 8.

The methodology developed in this study ensured that every effort was made to capture perceptions in the best possible way, so that the captured data does reflect reality – which is seen as understanding the situation from the perspective of the people involved in the study. We had to contemplate the presence of ‘Différance’, which, according to Derrida (1982), is impossible to see. The researcher becomes a part of the experiment in addressing these ‘Différences’, and clarifying them as in the sense of including what has been excluded (‘*Other*’). The Socratic Method is used as a tool for the deconstruction of more complex issues that have arisen from the multi narratives, and which were examined in panel data interviews, and also as a tool for self-reflection on the research process.

Putting the methodological issues aside, the next stage in the research is a preliminary empirical investigation of the Grand Narrative of Value for Money (as we emphasised in Chapters 2 and 3 respectively) and its categories: costs, benefits, risks, and time preference. This is the theme for the next chapter.

5. INVESTIGATING THE ADAPTED GRAND NARRATIVE (1)

Introduction

This chapter represents the first level of our empirical analysis. It illustrates the Adapted Grand Narrative of the study, with reference to the categories of the Value for Money equation that are set out in Chapter 3. To remind the reader of the fundamental proposition in the Value for Money strategy situation described by this thesis: if perceptions of what constitutes the Value for Money strategy differ at various levels of the hierarchy, then the eventual outcomes are likely to be different from the outcomes as they were originally conceived by the designers of the strategy. These outcomes are important to government and the taxpayer, so it is important to recognise that these differences can affect the consequences.

We emphasise that the Value for Money strategy is something that is approached rather than reached. Simon (1982) points out that in real life, decision makers recognise their own limited powers of cognition and incomplete information, and make cognitive short cuts. In this sense, Simon (1982) maintains that all that can be expected is a procedural rationality. The categories provided by Fisher's (1930) Grand Narrative (Net Present Value) provide just such a rational choice procedure. This chapter presents the Adapted Grand Narrative as a process in which the objective value is set out by government Ministers and the Department of Health, and defined in the Green Book (2003). The study chose a particular training project as an illustrative example of perceptions on the issue of value for those involved in carrying out the project. This chapter examines the findings concerning this project, as originally commissioned.

We also remind the reader that the whole thesis is a deconstruction process, and we begin the empirical work by deconstructing our version of the Grand Narrative of Value for Money. Concerning this first stage in the process of deconstruction, the Net Present Value model suggests that we examine the problem of Value for Money

through its framework – in terms of benefits, costs, cost of capital, discount rate and risk – so that we consider it as a particular representation of the archetype in the National Health Service. Thus, in the empirical work, we tackle first the representation of these categories in the National Health Service with reference to education and training, before embarking on an investigation of more complex issues in the second and third stages of the empirical work. The next level of deconstruction takes place when those responses that do not always fit neatly into the categories are themselves examined, revealing a set of multi narratives or polyphonic voices (Boje, 2001) underlying the Grand Narrative of Value for Money. The deconstruction then goes to another level when these polyphonic voices, as well as the Grand Narrative, are themselves deconstructed by panels of experts who are exposed to the preliminary interpretations of the earlier interviews and asked to respond, often with their own narratives. Finally, we attempt to open up the role of the researcher in the research process. Thus, the entire thesis can be considered as a process of deconstruction. At this point, it will be useful to remind the reader of the Adapted Grand Narrative of Value for Money in the National Health Service.

The Adapted Grand Narrative of Value for Money in the National Health Service

Underlying the Adapted Grand Narrative of Value for Money is a version of the principal-agent problem that is particularly applicable to the National Health Service. We could also argue that earlier explanations have to be adapted because successive levels of management impose their preferences (CIC) through capital rationing (p.82). We return to this point at the end of the thesis (in Chapter 8). We discussed earlier (in Chapter 3) the complexities of the National Health Service that make this difficult to achieve: there are many stakeholders with different objectives, different risk appetites, and with complex sets of trade-offs required. In illustrating the findings in this chapter, which are concerned with the fundamental categories of the Adapted Grand Narrative of Value for Money in the National Health Service, we are

now in a position to illustrate the choice between activities that appear in the conceptual Figure 2.2 (p.47) in Chapter 2. Similarly, we can comment on the goals of the implementers (apart from Value for Money)

This chapter focuses on a discussion of the Adapted Grand Narrative categories that were captured from interviews with decision makers at both the top and bottom levels of the National Health Service hierarchy, concerned with education and training programmes. As a result of the interviews we can discuss perceptions at various levels of the decision making hierarchy, in a way that makes sense to the reader. We start with a discussion of the right-hand side categories alone, because this is exactly how Net Present Value represents them. Then we move to the left-hand side, or the objective function, when we look at the complex set of perceptions about rational decision making in the National Health Service: value, risk, and capital rationing.

Extended Results for the Adapted Grand Narrative: Analysis from the National Health Service

We begin by discussing the right-hand side of the Net Present Value equation (the deconstructed categories) individually and in depth. Then in Chapter 6 we discuss more complex issues. Therefore, we now turn to each of the categories of the right-hand side of the equation:

- i. Benefits
- ii. Costs
- iii. Cost of Capital and Discount Rate
- iv. Risk and Attitudes to Risk

We summarise the findings of this stage of the research in Table 5.1 (next page), which mirrors Tables 2.2 (p.67) and 3.2 (p.104) in the last two chapters of the literature review.

Table 5.1 Extended Results for the Adapted Grand Narrative: Analysis of the National Health Service

Extended results for the Adapted Grand Narrative: Analysis from the National Health Service	
CATEGORY	COMMENT
The right-hand side of the Adapted Grand Narrative	<p>At the top level of decision making, the emphasis is on staff career, motivation and retention. At implementation or <i>face worker</i> level there is a rich picture of what constitutes Value for Money. There is anxiety with respect to understanding what is actually required at the <i>face worker</i> level.</p> <p>Value for Money reflects the top-down approach to strategy in the National Health Service. In spite of all the targets, implementers seem to be very vague and uncertain about what training is supposed to achieve. If there were more flexibility this would reduce anxiety and perhaps increase the efficiency and effectiveness of the Value for Money strategy.</p>
BENEFITS	<p>Emphasis and importance of positive benefits on CARE and responsibility:</p> <ul style="list-style-type: none">– to the general health of population,– establishing reputation is very important at senior level. <p>The Value for Money strategy is driven by the need to deliver social benefits to the taxpayer: a type of outcome that we can specify as better value. Operational or lower levels of management focus on benefits, outcomes and pay-offs rather than cost. It resembles the top-down approach to strategy.</p>
COSTS	<p>Cost efficiency is high on the agenda of senior- and middle-level management. There is also a shift to cost effectiveness by increasing awareness among senior management of non-monetary considerations in training: fitness for practice.</p>
COST OF CAPITAL AND DISCOUNT RATE	<p><i>Face workers</i> are required to deliver the Value for Money strategy at the point of providing CARE. This suggests high and immediate return from investment in education.</p>
RISK AND ATTITUDES TO RISK	<p><i>Face workers</i> are conscious that they are using taxpayers' money and feel their responsibilities strongly with respect to this aspect. Risk is also identified with the safety of the patient rather than categories in the Value for Money equation.</p> <p>It reinforces the case for a <i>face worker</i> approach: to get people to specify risks and negotiate the risk policy with them, consultation rather than mere target setting should perhaps be recommended as part of the appraisal process.</p>

At this point, we remind the reader that a discussion of top-level interpretations of the categories of the fundamental equation was undertaken in Chapter 3. Our comments in this respect are in addition to those earlier comments. The discussion here takes the form of providing a brief introduction to each category using relevant government quotes from the Green Book (2003), to which we add a quote reflecting the views of the respondents.

We proceed to examine each category in the order of its appearance in Table 5.1 (p.151).

i. Benefits

In Chapter 3, we discussed the notion of benefits in the public sector, encompassing the notion of a social benefit, as suggested by the Green Book:

The total increase in the welfare of society from an economic action – the sum of the benefit to the agent performing the action plus the benefit accruing to society as a result of the action. (The Green Book, 2003, p.105)

We also pointed at some deficiencies; the Green Book (2003) struggles with the measurement of non-monetary benefits from various healthcare interventions. In the context of this study, we are particularly interested in the benefits from education and training programmes:

It is often difficult, if not impossible, to calculate the monetary value of many of the benefits of good design, such as civic pride, educational achievement or user experience. For smaller projects, where contingent valuation may prove too complicated, research studies can help with comparisons and benchmarking to ensure good design is accounted for. (The Green Book, 2003, p.63)

This suggests two things. There are sets of issues around what these benefits are, and how they are measured. This perhaps suggests that there is a gap that this study could fill; for example, it could provide insight into the particular sets of benefits that are perceived and measured. Taking these issues into account, this study provides short

quotes dealing with these issues with respect to how the benefit is perceived by top-level decision makers and *face workers* respectively. In discussing the findings relating to this category and concerning the training project, we discuss four varieties of benefit:

- a. making a difference
- b. retention
- c. quality
- d. reputation

We proceed to first discuss making a difference.

a. Making a Difference

This type of benefit is significant for the participants at the top level in this study, referred to as commissioners, who are responsible for managing the performance of National Health Service Trusts. For example, one of participants at the top level in this study stressed:

I want to know what difference education and training makes to practice; is somebody doing things differently and in a more effective or efficient way, or if they have developed their career. (Workforce Manager, Strategic Health Authority)

It seems that top level decision makers are concerned with a broader impact on the actual performance of the health services, bearing in mind that Strategic Health Authorities have responsibility for managing the performance of the National Health Service Trusts and ensuring that investment in a particular set of programmes actually delivers benefits in the form of positive impact, not just on practice but also on staff development. In this way, the investment in training aims to target the problem of high staff turnover.

b. Retention

At the level of implementation and the point of delivery of CARE, the interpretation of benefit is seen as being more specific, and is adapted to the local context. Another participant, a *face worker* in the study, explains:

In delivery of good patient care, which is what our core business is, training provides the added value it gives us, as it helps us retain really good, well-trained staff, who we know, because we did the training.
(Service Manager, National Health Service Trust)

The point here seems to be that *face workers* see things in benefit terms rather than cost terms. They also have very specific objectives that may or may not coincide with those of the senior decision makers. The notion of retention of staff as a benefit of training is very important in the context of the broader human resources strategy for the organisation. If we look back at the complexity of the National Health Service structure (p.7), the retention of staff has significant implications for National Health Service strategy in general. So this type of benefit represents a more subtle interpretation of the benefit at the top level. We also emphasise that respondents deliberately shifted the discussion to express their concerns regarding benefits rather than costs. This has implications for how we think about the Value for Money strategy. This emphasis on the outcome rather than the cost suggests that it does not matter how cost-efficient the allocation of resources is, there will always be doubt as to whether it actually delivers social benefits.

This emphasis on benefits rather than cost prompts us to examine this argument in more detail. What follows is a discussion of quality, another type of benefit in relation to the training project.

c. Quality

In considering benefit as a kind of outcome or expected benefit to society that specific projects are intended to achieve, the preliminary analysis suggests a degree of variation about the dimension in which this category appears. It seems that decision makers tend to set out desired outcomes, of which many are specified in

general terms, and are all subject to a degree of ambiguity or interpretation. For example, according to one participant at the top level:

The benefits clearly are that, they will go on a training course and achieve a higher quality of providing patient care. Ultimately, education and training should benefit the health of the community, and that has to be the ideal and top priority. (Finance Director, Strategic Health Authority)

It seems that these outcomes, set out in terms of achieving better quality, are directly linked to the delivery of patient CARE. How do they achieve this? Presumably, transferring the quality of education's intangible outcome – benefit to the patient – becomes the main objective. In other words, the ability to translate the quality of education and training becomes a benefit, as one participant, a *face worker*, adds:

You want them to be kind and caring and you want them to be safe practitioners. You do not want them going out there being rough with patients. That is the key. (Manager of Nursing Programmes, Education Provider)

We could argue that when looking more closely at quality as one of the main factors in the delivery of better CARE, we can see that there is another dimension that defines the quality in terms of a non-monetary benefit: this is an altruistic behaviour, or CARE.

This perhaps suggests that the major goal of education providers is not to simply educate their students, but also to increase their productivity in terms of the quality of CARE they provide for patients, which involves compassion, CARE, and empathy. This is in line with the principles underlying a career in the National Health Service. We also recognise this emotional element of investment for the first time in this chapter, and we shall return to it in the following empirical chapters; we shall examine this issue in more depth in Chapters 6 and 7.

Closely linked to this variety of benefit is another kind –organisational reputation – to which we now turn our attention.

d. Reputation

In the wake of recent heavy criticism from independent bodies (King's Funds, 2005; National Health Service Confederation, 2005) which focused criticism on the government's failure to increase productivity in the National Health Service in spite of a huge investment in healthcare, it seems that reputation is like a two-edged sword. On one side, there is a political element to the reputation, the desire of the government to deliver on its promise; and on the other, there are anxious taxpayers who want to be reassured about the quality of the services the government has promised to deliver. In this sense, reputation is perceived as a political kind of benefit, according to another participant at the top level:

Our reputation is as good as who we are and what we deliver. We have to be careful of our reputation and I think we have to be seen as practical and efficient, because we need to have that to engage people in our work.
(Programme Director, London Development Centre for Mental Health)

Reputation in this sense is important for government organisations, because this is seen as the way forward for establishing and building a reputation as a good employer, as another participant at the *face worker* level described:

Because we did the training, it also gives us a reputation on the street that people want to work here because they are valued and treated as individuals for the future. (Service Manager, National Health Service Trust)

It could be argued that having a reputation as a good employer represents an important benefit, because the aim is to make a difference to service in terms of providing better quality of patient CARE. On the other hand, there is a suggestion that this same reputation must be promoted by caring professional staff who need to show commitment to their work and demonstrate a quality of service to patients. Furthermore, reputation cannot be achieved alone, but only in partnership with the independent sector, who work to deliver quality education and training to the health service. For example, another *face worker* states:

For us the reputation of the education providers is probably the critical thing, and is built up over a period of time. (Manager of Nursing Programme, Education Provider)

What seems clear is that there is pressure to achieve reputation, and that this is seen as a significant benefit. It remains more important than ever from the organisational point of view, because a good employer values its staff, and the staff in turn feel more motivated to stay in the organisation and provide a better quality of CARE. We again emphasise the element of CARE, to which we shall return later. However, at this stage, and in line with the literature review, we also need to mention some approximations related to measuring benefits and outcomes. We shall return to these in Chapter 6 when we speak of complexities (such as networks), since these are a part of the broader problem of measurement of non-monetary and emotional aspects of benefits – for example, the quality of CARE. For now, we introduce the reader to these approximations below.

Some approximations related to measuring benefits

The participants place great emphasis on benefits. They also indicate various problems concerning the measurement of non-monetary benefits in the training project. This section introduces this issue.

In the findings concerning the training project, on a number of occasions the participants pointed at the importance of the measurement problem, which they defined as the lack of standard measures for the evaluation of student-learned skills once they return to practice – in other words: whether training delivers value. This is a useful finding because it suggests the difficulties of a top-down approach to implementing Value for Money. We begin with a narrative from a participant at the top level:

I think it is manager feedback that we have not been as good at ... we are aware of that ... but we do not know how they make decisions, how they measure the benefits from training. (Workforce Manager, Strategic Health Authority)

It seems that the top-level decision maker acknowledges that the problem exists and that it needs to be dealt with. We take a further step and examine this viewpoint from

the perspective of another *face worker* participant in the study, who agrees with the above narrative, and adds:

How do you know that that has improved her practice is something that a lot of managers are concerned about, because managers don't always know that students have failed modules, and they feel that they have put a lot of investment into them, sent them on the course, given them study time, and the students are often evasive. (Manager of Nursing Programme, Education Provider)

In conclusion, the lack of standard measures for the evaluation of student-learned skills once they return to practice indicates the difficulties in demonstrating the value of this kind of investment. Different levels cite their own reasons. The main point to make is that these benefits are very often qualitative, and this presents a problem; for example, how to measure compassion. We shall return to this issue in Chapter 6.

In conclusion, the general observations from this section are as follows:

- a) There is a greater focus on benefits than on cost. There is an emphasis on the importance of positive benefits on CARE and responsibility for the general health of the population, and establishing reputation is very important at senior level. Top level decision makers place a strong emphasis on achieving Value for Money through establishing a good reputation among the workforce and the taxpayers. Reputation in that sense is important for the survival of the National Health Service strategy in the long term; and the retention of a quality workforce by investing in human capital may facilitate the success of the long-term strategy. Reputation enters the picture as follows:
 - (i) Health is part of the political platform of the government. A good reputation in health provision adds enormously to the political capital of the government. A poor reputation reduces political capital. Hence, reputation is a risk factor. It may be affected by random unpredictable events as well as by public mood. We illustrated the story about politics and cancer drugs earlier (p.91).

- (ii) Authorities (Strategic Health Authorities and Primary Care Trusts) are especially vulnerable to random events, which can destroy both reputations and careers (consider the case of Baby P).
 - (iii) Managers at all levels are concerned with achieving reputation that has tangible benefits (and costs) with respect to the availability of staff. Loss of reputation due to random events can make it difficult to attract good staff.
- b) The issue of CARE and compassion is emerging, although indirectly, through the discussion of the different types of benefit.

The discussion of benefits also requires us to specify the costs of training in the National Health Service. This leads us to the next section.

ii. Costs

Cost remains as important as ever to the National Health Service. The top-down approach uses capital rationing as a part of strategy, and this inevitably means using costs as a core element. We have discussed the notion of cost in the literature review, where we referred to the cost as the opportunity cost or economic cost. This definition implies that cost is the value of the most valuable of the alternative uses; the Green Book (2003) outlines the dimension in which cost appears in healthcare, and where refers to the cost as a social cost:

The total cost to society of an economic activity – the sum of the opportunity costs of the resources used by the agent carrying out the activity, plus any additional costs imposed on society from the activity.
(The Green Book, 2003, p.105)

There is also the notion of economic efficiency, which suggests that no one must be left worse off, and requires planners to ensure that resources are allocated and used in the most productive manner possible. Very generally, this definition of efficiency sometimes used by economists is named after Pareto (1935), who formulated it in

terms of an allocation of resources being efficient if it is impossible to change that allocation to make one person better off without making someone else worse off. Cost efficiency also appears to be a standard feature of the public sector, and particularly the health service. It is a huge budget centre, with the Department of Health allocating funds, Strategic Health Authorities and Primary Care Trusts distributing them, and trusts spending them. Decision makers acknowledge that the emphasis on cost remains more important than ever, as one participant, a *face worker*, mentioned:

There is always a cost efficiency measure because we are an organisation with expenditure over £22m, so you cannot do anything then without thinking about it. (Service Manager, National Health Service Trust)

For particular reasons, healthcare managers have to rely heavily on the use not only of monetary measures, such as cost efficiency, but also of cost effectiveness. For example, one participant at the top level mentioned:

But ... it is not just about achieving cost efficiency, because you have to be effective, as well as efficient. (Workforce Manager, Strategic Health Authority)

As the above narrative suggests, it seems that the way forward is to shift from measuring perceived monetary productivity to measuring intangible aspects of investment into training and education. This also links to the measurement issues discussed earlier (p.100) The issue of social cost reappears in a situation where top-level decision makers and *face workers* strongly disagree about the true cost of training. For example, mobility issues have a significant impact on obtaining Value for Money in general. Disagreement between top-level decision makers and *face workers* is particularly clear here. We begin with the narrative of one participant at the top-level:

I think first of all managers need to have an understanding of the value of training and how it can enable them to retain their staff, but also understand that some staff will need to move on. If you train someone, it's not a failure if they move on because you have to look at the greater good of the health service. Whether it is the National Health Service or the independent sector, you have to acknowledge that there is a degree of movement and that that actually refreshes and revitalises the service, you would not want it to remain static. (Workforce Manager, Strategic Health Authority)

It seems clear that Strategic Health Authorities remain confident of the positive cost impact of workforce mobility; arguably this is because it is necessary for them to look at the wider picture, rather than the local. However, the study found that Strategic Health Authority views are not shared amongst *face workers* from the trusts. It is important to consider their views, since the mobility of the workforce affects them directly when they are delivering actual CARE. We present this view with another respondent's, a *face worker's*, interview comment:

A lot of the time, with turnover, we send people on expensive training; one day a week, plus 50% of their tuition fees paid, and then at the end of the training they are gone to another place, another country. So, we lose that staff and the trust in some ways is not giving us return on our investment. (Service Manager, National Health Service Trust)

The above quote suggests two dimensions of social cost:

- (a) negative implications of the social cost (in the context of the training project), which suggest a risk aversion toward investment into training in general.
- b) positive implications of the social cost, encouraging moderate risk-taking with the long-term view on the costs associated with the training

It could be argued that these differences in perception might lead to a widening gap in how the Value for Money strategy is perceived at different hierarchical levels.

In concluding this section, the general observations are as follows:

- a) In the upper echelons of the service (p.7, Figure 1.1) decision makers are conscious of the cost and the opportunity cost, but as we go further down the hierarchy, the *face worker* is also conscious, but is also resistant about speaking within the categories of the fundamental equation. *Face workers* prefer to talk about actual benefits. On the training project side, the managers are afraid of spending their resources on training staff and then losing them to other parts of the service. This represents a failure to implement the social cost consideration, that a loss to one part of the

service through staff transfer is not a loss to the National Health Service as a whole.

- b) Cost effectiveness is high on the agenda of senior decision makers. There is a shift towards cost effectiveness by increasing the awareness of senior management regarding non-monetary considerations in training (i.e. fitness for practice).
- c) Lower level *face workers* focus on the delivery of non-monetary benefits.

Another point may be that the focus on targets and top-down decision making means that *face workers* do not consider the opportunity cost, but instead they focus on the outcome for the cost allocation they are given. To some extent this is a good thing. However, it does not allow sufficient initiative, since there is very limited choice to consider investing somewhere else. Given the fact that there is strong capital rationing at the implementation level, and the fact that capital rationing is, in fact, a kind of cost control mechanism, it is not surprising that there is little emphasis on cost at *face worker* level. Planning in the National Health Service is by targets and quantitative outcomes, rather than in terms of prices and costs, so it is not surprising that decision makers lower down the hierarchy think in terms of outcomes. This raises the question of whether it is better to have a more bottom-up management approach in view of this.

As the decisions will inevitably involve considering a return on investment, this suggests that we need to look at this category more closely.

iii. Cost of Capital and Discount Rate

We have discussed time preference in a number of different contexts: in terms of the discount rate, at least in principle; in terms of its importance in the literature review (p.96); from a subjective perspective; and in terms of individual preference rate measured by the real interest rate on money lent or borrowed. In practical terms, time preference and discount rate reflect preference for short-term rather than long-term

results. A high discount rate (or a high time preference) is reflected in the preference for short-term rather than long-term results.

In this study, we focus on the Social Time Preference Rate, defined as the value society attaches to present as opposed to future consumption; this has been widely accepted by the government. The Green Book (2003) recommends the Social Time Preference Rate for discounting future benefits and costs, based on comparisons of utility across different points in time or different generations; therefore it is to be used as the standard real discount rate. In this study, we discuss the notion of time in terms of the long and short term on investment. To put it another way, in this section we differentiate between different levels and the type of return.

a. Long-term Return on Investment

In terms of long-term return on investment, the observations from this study suggest a great degree of complexity. For example, one participant at the top level stressed:

From workforce planning to having qualified professionals from pre-registration, for nursing and allied health professions can be anything up to about six years. (Workforce Manager, Strategic Health Authority)

This suggests that those at the top level perceive time in terms of the long return on investment, for various reasons. For example, it takes four years to train staff. Their expectation is that once staff are trained they should be able to deliver Value for Money to the service immediately after their training is completed. We referred to this earlier as fitness for practice. This suggests that decision makers display a desire for a short or immediate return on their investment from education and training, presented below.

b. Immediate and Short-term Return on Investment

Emphasis on seeking immediate short-term gains from investment in education and training is particularly important to the top level, as another participant, a *face*

worker, indicated:

The payback can be fairly quick in training terms, given that people really appreciate being given the time and the space to do it. We have seen people feel that there is a difference and that is an immediate short-term gain. (Service Manager, National Health Service Trust)

This suggests that the National Health Trusts expect the investment into education and staff training to be compensated with a high short-term return on the investment. Putting this in another way, they expect high discount rates, which can take the form of making an immediate positive difference to practice. This implies that it is then expected that the *face workers* will deliver the Value for Money strategy at the point of CARE.

In conclusion, we can summarise our results in this section as follows:

- a) the long-term nature of investment in human capital
- b) short term gains can be appropriate (one of the goals of training is to learn to show CARE, and this is an immediate value of the training)
- c) services favour short-term gains due to the pressure of reaching targets

This emphasis on how quickly benefits of education over a certain period should be translated into Value for Money suggests that, due to capital rationing, top-level decision makers and *face workers* are under pressure to deliver a short-term return on investment.

We may also argue that, very generally, a short-term rate implies a higher return, but may also influence risky behaviour. This leads us to the next section.

iv. Risk and Attitudes to Risk

We have discussed risk from a theoretical (p.58) and a practical perspective (p.73) in business sector applications. Public sector investments, on the other hand, are subject to many types of risk. A complete breakdown of the types of risks is provided in

Appendix 6. Here we continue discussing risk in terms of investment in education and training projects. This study observed risk in terms of the collective risk behaviour at the upper and lower levels of the National Health Service hierarchy. For example, we found that risk behaviour was risk averse. This particular type of risk behaviour is especially relevant, as one participant at the top level stressed:

I think as far as this sort of line of business is concerned, you can't afford to take high risks, because there are people's jobs at risk because of it.
(Workforce Manager, Strategic Health Authority)

It seems that upper level implementers are conscious of the need for taking risks, but at the same time they recognise risk aversion so that they do not jeopardise jobs.

The notion of risk aversion is far stronger at the bottom level for one very special reason – patient safety, which decision makers see as the clear justification for being risk averse. Another respondent, a *face worker*, explains thus:

We are very risk averse in how we manage clinical care, because you have to be, because you're dealing with people's lives and it's the right thing to do, you need to be safe before you're anything else. (Service Manager, National Health Service Trust)

It seems that risk aversion is not only a consequence of considerations of patient safety, but also because of the political impact of the decisions made. Workers remain strongly risk averse because we are talking about patient's lives.

To conclude in this section, the general observations are as follows. It is important that decision makers take account of risk because:

- a) *Face workers* are conscious that they are using taxpayer's money and feel their responsibilities with respect to this aspect strongly.
- b) Risk is also identified with regard to the safety of the patient, rather than the categories in the Value for Money equation.
- c) Implicitly, workers' attitudes towards risk will determine whether they take a long- or short-term point of view (the higher the risk perceived, the higher the discount rate, hence the more short-term the policy implementation will be).

This again reinforces the case for a bottom-up approach: get people to specify risks and negotiate the risk policy with them, and engage in consultation rather than simple target setting, a strategy which should perhaps be recommended as part of the appraisal process. Decision makers, in the wake of uncertainties arising from constraints such as capital rationing and the fact that they tend to adopt risk-averse tactics, emphasise the importance of risk aversion in the health service. Risk-averse decisions seem to some extent to be influenced by the capital rationing situation that exists in the National Health Service.

Conclusions

It may assist the reader if we summarise and reflect upon the issues that have so far emerged in this chapter.

- a) The principal-agent problem involves richer and more complex relationships in the National Health Service than in the business sector context. Many stakeholders are involved, with a variety of goals, and they form a network of relationships.
- b) In this section we began to notice how difficult it is to translate the many aspects of the National Health Service (including CARE) into measurable outcomes.
- c) The nearer we get to the *face worker* task – dealing with clients or patients – the greater the concern with aspects of CARE.
- d) In the search for Value for Money, top-level managers speak of CARE in general terms that can only be understood in detail by *face workers* dealing with the huge variety of different individual circumstances.
- e) We find evidence within the Adapted Grand Narrative that differences in perceptions of Value for Money exist at different parts of the National Health Service network or hierarchy, and that these differences bring about divergences between top-level strategy and implementation.

- f) In particular, the emphasis of implementation is upon meeting short-term local targets. Capital rationing is too top-down to solve this problem.
- g) There is an awareness of the above issues, but it is difficult to see how they can be addressed within the tight framework of top-down target setting.

The Value for Money equation puts things in monetary terms, and it is not surprising that people see the objective function in other terms; i.e., CARE, sympathy, or empathy. So we introduced emotion in this chapter. We assume the following. Decisions involve an emotional aspect that is invisible in strategy, but is implicitly a part of it, and is an essential part of a bottom-up approach. Bearing in mind that those decisions are negotiated through networks of relationships, decision makers must make certain trade-offs and have their own pay-off functions. In this way, emotion becomes an explicit part of the decision. We shall discuss this in more depth in Chapters 6 and 7.

We also emphasise that the quotes are getting richer. The complexities and ambiguities of decision making are emerging. We pick up these issues in the next empirical chapter (6) by pointing out network effects and then moving on to discuss multi narratives.

6. EXTENDING THE ADAPTED GRAND NARRATIVE (2): THE TRANSITION TO MULTI NARRATIVES

Introduction

The previous chapter related primarily to the framework of the approach set out in the first section of the literature review in Chapter 2. This chapter develops the framework of the approach further, drawing on the literature reviewed in Chapter 3. We begin by refining the Adapted Grand Narrative more explicitly in a public sector context. We then examine patterns that emerged from the primary interviews relating to broader aspects of the Adapted Grand Narrative, which are difficult to measure and yet are essential to the quality of the service itself and also, from the point of view of many of the interviewees, an integral but undervalued part of their job. We conclude by trying to illustrate the contention that aspects of CARE can be shown by narratives that illustrate actual circumstances.

This chapter is seen as a transitional chapter, making a bridge between considerations associated with the Adapted Grand Narrative and the new issues that emerge as a result of the multi narratives. Multi narratives illustrate more complex issues than the original Grand Narrative – dimensions such as networks, pure qualities and emotional aspects, or CARE.

We recognise that the Grand Narrative approach is too narrow and excludes too much, especially the psychic element of Fisher's fundamental equation and the pure qualities that Fisher (1930) and Georgescu-Roegan (1971) spoke about. This chapter provides a first step in broadening the understanding of these pure qualities in a number of ways. It recognises multi narratives, a type of account that goes beyond the boundaries of the Grand Narrative. It suggests treating this type of narrative as information, rather than noise. It recognises all sorts of problems concerning the top-down strategy, and it also recognises the network characteristics of the National Health Service and suggests how trade-offs may be resolved.

This discovery of variations in narrative suggests a shift in focus, from a specific project to the National Health Service generally. This is because human resources are a key resource, and if we are to understand how the National Health Service operates, we must consider the variety of perceptions of all the people in the organisation.

To remind the reader of the deconstruction process, this level of deconstruction takes place when the responses that do not fit neatly into the categories are themselves examined, revealing a set of multi narratives or polyphonic voices (Boje, 2001) underlying the Grand Narrative of Value for Money. Two things became clearer in the interviews:

1. The complex nature of the original Grand Narrative of Value for Money in practice indicates that complexity enters the thesis through three themes (networks, pure qualities and CARE).
2. The problem of outliers in the original Grand Narrative. We collected our outliers under the heading of multi narratives. This should lead to summing up and some preliminary conclusions.

Table 6.1 (next page) is adapted, with reference to the content of this chapter, from Table 1.1 in Chapter 1 (p.17) and Chapter 2 (p.40) , and it also develops the content of Table 5.1 (p.151). Later in the chapter, we introduce Table 6.3 (p.185) which relates to the left-hand side of the Grand Narrative equation (including complexities such as networks, trade-offs, qualities and the issue of CARE). We introduced these complexities in Chapter 3.

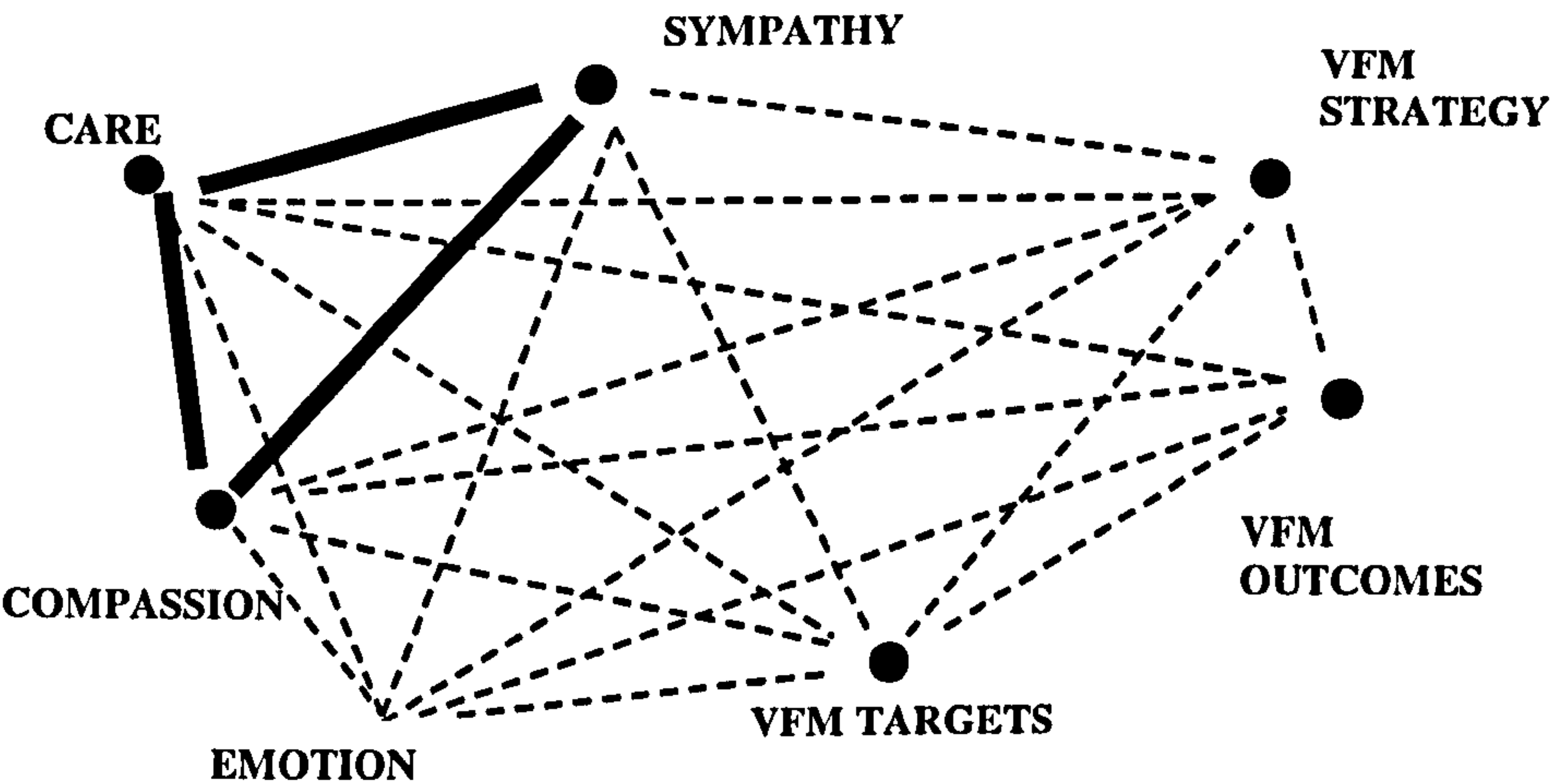
EXTENDING THE ADAPTED GRAND NARRATIVE (2)

Table 6.1 Extending the Adapted Grand Narrative (2): The transition to multi narratives

Extending the Adapted Grand Narrative (2): The transition to multi narratives	
DECONSTRUCTION	
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (1)	Examination of the categories of the Adapted Grand Narrative in the context of the commissioned training project. Extension of the study into National Health Service networks in addition to hierarchies. This was carried out in Chapter 5.
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (2) MULTI NARRATIVES	Chapter 6 is in two parts: A. Extension of the Adapted Grand Narrative B. Examination of patterns excluded by the Adapted Grand Narrative: 1. Networks of decision makers superimposed on hierarchies; there are multiple stakeholders; trade-offs and priorities have to be arranged. 2. Pure qualities; issues of psychic income (Fisher, 1930) and problems of translating qualities into pure numbers (Georgescu-Roegan, 1971). 3. Differences between issues of CARE and targeting or outcome measurement are shown by stories 3, 4 and 5. Complementing the Adapted Grand Narrative, multi narratives illustrate the three patterns above.
CATEGORY	COMMENT
THE LEFT-HAND SIDE OF THE ADAPTED GRAND NARRATIVE: RATIONAL BEHAVIOUR (V) DECISION CRITERIA CAPITAL RATIONING TRADE-OFFS AND PRIORITISING	<p>There are many decision makers operating within networks and hierarchies so that decision making involves trade-offs, politics and negotiating priorities between interested stakeholders. Procedural rationality becomes the issue rather than maximisation or minimisation. Practical issues associated with social welfare and social costs emerge.</p> <p>On description, norms and prescription; decisions are taken at many levels, often with different priorities, and making better decisions is a matter of trade-offs between different decision makers. Decisions are difficult to make at any level. The implementers or <i>face workers</i> are no exception when it comes to decisions about the allocation of funds to the ones that need it most. Too little knowledge at the top about what happens at the implementing stage. The needs of a bottom-up approach: consulting more and allowing more flexibility for people lower down to set their own targets in consultation.</p> <p>Capital rationing represents a constraint imposed by the Department of Health on the objective function of decision makers. Capital rationing is an expression of risk aversion on the part of decision makers, and is thus imposed at successive levels within the National Health Service hierarchy. It reflects a top-down approach and a supply oriented strategy. The demand aspects of resource allocation in the National Health Service are seen as an issue of offering and extending consumer choice. Because of the way the hierarchy operates, the objective function is to ration funds so there is limited scope for using the experiences of local managers to get Value for Money.</p> <p>Trade-offs are seen in the sense that they represent the additional constraint of bounded rational decision.</p> <ol style="list-style-type: none"> 1. At the top level – between resource allocation and organisations 2. At the <i>face worker</i> level – between availability of funds and organisation priorities

The relationship between this and the previous chapter can also be expressed in Figure 6.1 (below).

Figure 6.1 Emerging patterns



The above figure suggests that compassion, sympathy and empathy are aspects of CARE that have been emphasised, and which can be shown better than they can be defined. The subtlety of the concept (CARE) is illustrated by a number of stories, including the first accounts reported in this thesis – stories 1 and 2 (p.1–2) – and the excerpt from novelist Hilary Mantel (2008) (p.212). These stories are illustrated by the bold lines in the figure above.

However, they cannot be considered without being linked to other parts of the network: Value for Money, outcomes, and targets. Hence, the thinner broken lines represent the need for connecting the strategy with CARE. These are examined in Chapters 6 and 7 respectively.

In the sense the figure illustrates the emergence of patterns. In the figure, patterns

emerging from the multi narratives are viewed as being excluded by the Grand Narrative of Value for Money. Three patterns emerge:

- i. Networks
- ii. Pure qualities
- iii. Issues of CARE

Before considering the new patterns, we discuss findings from the initial interviews in terms of the categories (on the left-hand side of the Grand Narrative of Value for Money) referred to earlier in Table 6.1 (p.170).

Further Development of the Chapter

Setting out the content of the chapter in terms of the figure above, the first part (A) is concerned with refining the Adapted Grand Narrative. We initially add three dimensions to the original Grand Narrative:

- a) As the National Health Service is networked and one cannot view projects (especially human capital projects) in isolation, capital rationing is a means of achieving top down control
- b) There is no single decision maker or group of decision makers. In fact, there are groups of stakeholders, who have to some extent conflicting objectives or intentions. As a result of this we need to think in terms of priorities and trade-offs between stakeholders.

The second part (b) is concerned with discussing the patterns that emerge from discussion of the multi narratives. This suggests that the preference (CIC) for investing is a much more complex case than was initially postulated in the diagram in the earlier literature review of the thesis (p.82).

Having reviewed the issues, it is clear that what we are presenting in the thesis is the principal-agent problem in quite a complex form. Then we finish the chapter with a summing up.

Refining the Adapted Grand Narrative

So far the study has found that perceptions of Value for Money differ at different levels of the National Health Service hierarchy. This has a number of implications. Strategy as implemented may differ widely from the original aim. If we describe the process as asking how far achieving strategy (and implementation) fits into the Grand Narrative of Value for Money, then it becomes clear that the researcher needs to check the different narratives in interview responses related to the Adapted Grand Narrative.

Even within the Adapted Grand Narrative, we need to recognise the interdependency within networks of relationships. It is clear that the National Health Service is a hierarchical organisation with a network structure. It is hierarchical in the sense that overall strategy is designed at the top level and delivered at *face worker* level. However, closer examination reveals that are many decision makers conducting activities and interacting with other networks in various ways. They compete for health service resources; for example, they decide about training and education at various levels of the organisation. Capital rationing is a means of top-down control. Therefore, decisions have to be made on the basis of what the priorities are. Decisions involve significant trade-offs between priorities and needs. Certain issues also arise; for example, labour mobility and de-motivated staff inhibit health service resources, meaning that staff retention is an issue for departments. This application to the health service is also just a particular example of the more generalised principal-agent problem, which we will return to in a later chapter (Chapter 7).

We remind the reader that above mentioned issues provide the medium for transition to multi narratives. The issues are as follows:

- i. Rationality
- ii. Decision criteria
- iii. Capital Rationing
- iv. Trade-offs and Prioritising

We begin the discussion by first considering the left-hand side of the Adapted Grand Narrative equation, including rationality, decision criteria, capital rationing and trade-offs. This chapter is in fact an extension of the left-hand side of the equation (as illustrated in Table 6.1 (p.170) and also in Table 3.1 (p.78), especially in relation to the complexities that we introduced in Chapter 3). These complexities make the decision making process itself much more challenging, so we discuss them under the rationality and decision criteria column.

At this point we make few brief arguments regarding rationality and decision criteria more generally.

i. Rationality and Emotion

There are many decision makers operating within networks and hierarchies, so that decision making involves trade-offs, politics and negotiating priorities between interested stakeholders. Procedural rationality becomes the issue rather than maximisation or minimisation. The picture becomes more complex when the psychic element (in Fisher's sense) is introduced. It becomes clear that decision making is not just a question of bounded rationality, but rather of emotional rationality, including feelings for others, compassion, empathy, or sympathy for someone in need of treatment. This is something that we shall discuss in more depth in Chapter 7.

ii. Decision Criteria

Also in relation to decisions, as the above paragraph suggests, they are difficult to make and are taken at many levels, often with different priorities. Making better decisions becomes a matter of trading-off between different decision makers. The implementers, or *face workers*, are no exception when it comes to decisions about the allocation of funds to those that need them most. There may be too little knowledge at the top about what happens at the implementation stage, so there is the need for a

bottom-up approach – consulting more, and allowing more flexibility for people lower down to set their own targets in consultation. We shall return to this discussion in more depth in Chapter 8.

At this stage we focus on capital rationing and trade-offs in more detail.

iii. Capital Rationing

Broadly speaking, the way the National Health Service hierarchy operates the objective function is to ration funds, so that there is limited scope for choice at the implementation level. We have already discussed the notion of capital rationing in the literature (p.91).

In the context of the training project, it seems that capital rationing is imposed at successive levels within the health service itself. For example, capital rationing is an expression of risk aversion on the part of decision makers, as a participant at the top level mentioned:

Strategic Health Authority is only empowered to make investment decisions up to a capital value of £25 million. Any investment which has a capital value of more than £25 million has to be referred to the Department of Health to be approved, and the Department of Health is only able to make investment decisions up to a capital value of £100 million. Then the Department of Health will need to get the business case approved by the Ministers as well. If the investment is over £100 million, the Department of Health does not have the authority to sign it off. They have to take it to the Treasury because it is over £100 million. (Head of Capital Investment, Strategic Health Authority)

It seems that strict budgetary control exists. If we look further down, in the context of capital rationing for medical education, another participant at the top level added:

We have £33 million for medical students. Because we have a lot of continuing commitment, our future new investment is in the margins, we may only have £4 million or £5 million out of more than £30 million that we have true discretion on. (Finance Director, Strategic Health Authority)

The above quote illustrates the extent to which capital rationing affects future

investment planning, and this also reflects the extent of the budgetary control passed further down the hierarchy. Going further down, we can see how this control is imposed on *face workers*. The quote from another participant at the top level illustrates this:

We have an envelope of funding which we then notionally allocate to each of our partner trusts, on the basis of their staffing numbers. They have to say how they're going to spend it, they can't just spend it, so they have to let us know, and it will be over a wider range of professionals and it can be done more creatively and that sort of thing, so that's up to them as to make those decisions, because obviously they have a greater understanding of their more local need. So we try not to centralise too much and determine where there are pooled resources, to make the most of those resources. (Workforce Manager, Strategic Health Authority)

How well the implementers of strategy respond to working with capital while under to strict control is demonstrated by another participant, a *face worker* in this study:

If you ask whether there is money, there is no money. If you ask for more money for your mental health service, there will be less money for acute, they might increase the revenue needed for acute, so they might charge us more for our pharmacy services. It has to be spent within this bubble. (Service Manager, National Health Service Trust)

The above quote describes well how capital rationing penetrates deeply into the hierarchical levels, affecting decisions and the development of services. A further quote reveals some interesting insight into funding and the relationship between decision makers at the top and bottom. Another respondent, a *face worker*, says:

I think organisationally and across the whole sector, we are bankrupt. We are all looking for the same pot of gold. We are competing for the same resource. We are trying to persuade people why they need to invest more, and their aim is to de-invest, because they have not got the money to spend. I guess that's a massive problem, because if we resolved our financial situation X by getting more income, by getting agreement to do more work, that doesn't sort the Primary Care Trusts' problems out because they have massive financial problems. I know that our Primary Care Trusts are definitely planning to de-invest with us because they do not have the money. They are going to withdraw funding. The whole sector and the Strategic Health Authority as a whole are under-funded. It is not a matter of too much money in one place and not enough someplace else, or just a matter of redistributing it. We are under a lot of pressure to do less activity and to shrink as an organisation. (Service Manager, National Health Service Trust)

The earlier quote provides an even richer account. The complexities and ambiguities of decision making are starting to emerge. Competing for the same pot of gold is linked to sector underinvestment. Lack of funds inevitably signals changes in the organisation's strategy. This inevitably results in the closure of hospital wards and redundancy for staff. The cycle seems to be never-ending.

In conclusion, general observations about capital rationing are that:

- a) It represents a constraint imposed by, in the first place, the Department of Health on the objective function of decision makers in the National Health Service.
- b) Capital rationing is also imposed at successive levels within the National Health Service itself. For example, capital rationing is an expression of risk aversion on the part of decision makers.
- c) Because of the way the hierarchy operates, the objective function is to ration funds so that there is limited scope for choice at the implementation level. The net effect is that there is no loss of control over expenditure, but there is little scope for using the experience of local managers in local circumstances to get the best Value for Money.

The argument in this section is that due to the finite amounts of resources, capital rationing is used as a tool for control over expenditure. So far, in spite of all the targets and so on, *face workers* seem to be very uncertain about the future of the services and what training they could afford. They try to interpret what the Strategic Health Authorities want, but there is a great deal of uncertainty about what they actually do want and this causes anxiety. Uncertainty in these respects also means that *face workers* are likely to focus on local issues, such as staff retention, with respect to what the service actually needs. They feel uncertain, and from what we have seen here, they also tend to adopt risk-averse tactics. With respect to immediate patient safety this is good, but with respect to the bigger picture of fusing experience and initiatives to get better value, the system could be improved by having a bottom-up approach. All this may reinforce the need to have a more bottom-up and perhaps

more individualised approach to target setting (perhaps according to local circumstances).

iv. Trade-offs and Prioritising

In the National Health Service, dealing with trade-offs inevitably involves making choices between different set of priorities, so we need to say something about how priorities are managed.

Prioritising

As expectations change frequently, the demand for a particular priority changes too. In deciding which need shall become a priority, it is necessary to form a judgement about the likely size of the related benefit in terms of enhanced health or potential health improvement. Very generally, not all needs become priorities simply because not all needs can be afforded by the National Health Service, or all needs are regarded as priorities due to the low usage of the particular services. In such cases, some kind of prioritising must take place among the stakeholders. Prioritising is necessary because it helps the decision maker to identify the most urgent need, but there are a variety of different types of priority. We begin by discussing first type of priority.

a. Political Priority

The Department of Health engages with stakeholders to identify their needs for the provision of specific services that they perceive to be in steady demand, and whose importance is not stressed enough or is ignored. For example, one participant at the top level said the following:

The needs are set by the Secretary of State, who decides what is important. Then we decide upon what we think we can actually achieve within a certain period, what we think is politically sensitive and will get us good press. (Programme Director, London Development Centre for Mental Health)

It seems that a priority may be imposed and recommended by the top level of management and government Ministers, who normally commission research beforehand. In this sense, the priority is target driven and politically motivated.

b. National / Sector Priority

Political objectives are then translated into national priorities, which come under the responsibility of Strategic Health Authorities. They distribute funds from their investment portfolios to the local health service organisations for which they have management responsibility. For example, an increase in demand for a special cardio service in a local community will inevitably increase the demand for the education and training of cardio nurses. However, it is not sufficient that demand is identified locally; it must also be seen as a demand at the national level. This suggests that in order to be seen as a priority, the need has to be defined at the national level. One participant at the top level explained:

The project must link with the development plan, with local and national management strategic objectives. Especially now as money gets tight, we're less likely to just fund a project and say 'Let's see how this goes', so we need to justify why we should be funding ... so ... the courses that are not being applied to will be taken off the portfolio and the trust cannot offer it. So whenever we have a decision about the need to make trade-offs, and to resolve conflicts, we normally resolve those conflicts within the framework of these criteria. If somebody is going onto a course, they need the opportunity to use the skills and knowledge that they are going to have developed at the end in order to put that into practice. (Finance Director, Strategic Health Authority)

The above suggests the full extent of the top-down approach to strategy, and is perhaps one example of exercising control over the process of stakeholder engagement. Once the need becomes identified as a national or sector priority, various stakeholders will move on to discuss it with their local National Health Service trusts, which will then look at how they can address this priority in their own areas.

Furthermore, Strategic Health Authorities require that in order to be eligible for

funding, the trusts must clearly state their principal driver for investment. We discuss this issue below.

c. Organisational Priority

As the trusts must clearly state their principal driver for investment, we need to examine priorities from an organisational perspective. For a priority to be classified as an organisational need, it has to be seen as a real and legitimate priority. For example, another participant, a *face worker*, in this study argued:

We look at the business plan and the demographic information affecting the service, political and government policies, what we must achieve in five years' time, and whether that particular training is more important or urgent. We also look at how many people have not been trained in that and of those who have not trained in that, what pressure and what level are they at the moment, what level of resources we have and what their motivation is, and whether the training is needed or not. (Service Manager, National Health Service Trust)

In concluding this section, the above discussion suggests that organisational assessment of priorities depends on urgency, maturity of workforce group, degree of staff movement, and the personal development plan of each person. Therefore, it must be of concern to service managers, who have to make decisions about who is to be given training. Then again, the organisational priorities have to coincide with sector priorities. Establishing linkages between what is required for the service as well as the workforce is quite important for top-level decision makers, especially when we talk about meeting certain general targets.

Prioritising inevitably involves making trade-offs between many priorities, so we discuss them next.

Trade-offs

Trade-offs are negotiated through the networks of relationships between the wide range of stakeholders involved in healthcare education and training. We have already

discussed trade-offs in the literature review (p.93)

Here, however, we take a step further by discussing the specific trade-offs captured by this study in more depth. These findings are useful because they will be noted in the report to the project sponsor who commissioned this study, who will in turn inform the stakeholders in this research about how decisions are made regarding investment in training. We examine those trade-offs because they are inevitable in situations like this, where there are many different but equally important stakeholders. The first trade-off we shall examine is that between resource allocation and the different organisations needing it.

a. Trade-off between Resource Allocation and Various Organisations

The study identified a particular trade-off between resource allocation and the demands of various organisations, as one participant at the top level noted:

There is always going to be disputes between Trusts and the Department of Health, so between X and Y Trusts and between primary care and acute services. There will always be people wanting money for something and there will never be enough money. Therefore, it will always be making decisions, choosing between different sectors and specific organisations. (Workforce Finance Director, Strategic Health Authority)

This trade-off is very common for top-level decision makers, who are under constant pressure to exercise the principles of fairness (and equity) in resource allocation across the National Health Service.

Moving away from the top level and going lower into the hierarchy, the study also identified another type of trade-off, between the availability of funds and priorities.

b. Trade-off between Availability of Funds and Organisation Priorities

In parallel, very often organisations face another type of trade-off, this time between funds and priorities. Resolving this type of trade-off seems to be a difficult task,

mainly because not all organisations can expect to receive as much as they need, mostly due to capital rationing and because not all their needs are considered to be priorities. One participant at the top level noted:

It was very difficult to get organisations to agree and accept that another organisation's proposals were a higher priority than the proposal from their organisation. We were able to resolve the problem when we asked them not to look at this from a narrow organisational perspective, but at the bigger picture, taking the wider sector requirements into account. We were able to demonstrate to them that some of the organisations within the sector did not have any significant investment for many years; so there might be a need there for some catching up, some equity. People must not just look at it from the perspective of 'our' organisation, but take a wider view. (Head of Capital Investment, Strategic Health Authority)

Not surprisingly, decisions are difficult to make at any level and the implementers are no exception when it comes to decisions about the allocation of funds to those that need them most. However, this trade-off is also very common at the lower level; for example, one *face worker* mentioned:

We have a limited pot of funding for the leadership programme, so you had to make a decision as to which were the priority groups. The other big trade-off is in terms of what other mandatory training we expect these people to do. For example, because quality is obviously very important, we have mandatory training for many of the staff on the leadership programme. (Service Manager, National Health Service Trust)

Often due to a shortage of funds, trusts have to make trade-offs between funding and priority groups, and between the quality of programme and the time spent on it. So in this sense, the trade-off becomes more specific given the organisation's priorities.

The wide range of trade-offs at different levels are illustrated in Table 6.2 (next page).

Table 6.2 Summary of a Wide Range of Trade-offs at Different Levels

LEVEL	ISSUE	COMMENT
National	Is it a national priority? Is it an organisational priority? Is it part of the Learning and Personal Development Plan?	Reject the courses that do not meet Strategic Health Authority criteria; or, if the National Health Service Trust already meets their targets this may not be a driver for investment.
Organisational	Consider the business plan and demographics of workforce What can be actually achieved within a certain period of time, and is it politically sensitive? Consider political and government policies Look at the priorities in terms of importance and urgency	Consider whether it is sensible and practical to implement all investments that trusts need to invest Not having a clear role in that area Not having the expertise Not having the responsibility Not having the resources
Personal	Look at the Personal Development Plan of each person.	Reject if staff do not see the training as an opportunity to transfer skills, or if staff refuse to have assessment as part of the course

In conclusion, trade-offs are both unavoidable and necessary. They are unavoidable in the sense that not all options can be taken. Obviously, these trade-offs arise when stakeholders' priorities clash, but they are essential in a sense because the presence of these trade-offs suggests that there must be some kind of priority classification, which will help to avoid conflict. We shall come back to this issue in Chapter 8, when we introduce and discuss more complex trade-offs associated with Value for Money and CARE.

New Patterns Emerging from the Multi narratives

We noted above that three patterns emerged from the multi narratives:

- i. Networks
- ii. Pure qualities
- iii. Issues of CARE

It is useful to set out the extended results in relation to the Adapted Grand Narrative in Table 6.3 (next page) which mirrors Table 3.2 (p.104) in Chapter 3.

Table 6.3 Extended Results for Adapted Grand Narrative: Analysis from the National Health Service

Extended Results for Adapted Grand Narrative: Analysis from the National Health Service	
CATEGORY	COMMENT
NETWORKS	<p>At the top level of decision making, expert networks are set up in order to design the Value for Money strategy. Government uses networks to ensure control, to work more effectively with other stakeholders, and to address specific issues in their networks.</p> <p>At the bottom level, the <i>face worker</i> level, the networks take the form of the provision of clinical services to patients in order to deliver the Value for Money strategy.</p> <p>The extent to which decision makers can exercise choice spurs creativity in networks. This could be seen as a part of a bottom-up approach.</p> <p>Engaging in networks represents a specific form of principal-agent relationship:</p> <ul style="list-style-type: none"> – decisions are made by networks of relationships that overlap between the upper and bottom levels – a complex set of trade-offs is made – there is a capital rationing situation, as a part of a top-down strategy – networks are critical for handling unanticipated problems that are difficult to capture with formal structures <p>Networks bring additional complexities in delivering the Value for Money strategy: funding, trade-offs, and quality measurement (CARE)</p>
PURE QUALITIES	<p><i>Face workers</i> employ various measures:</p> <ul style="list-style-type: none"> – staff productivity – staff satisfaction – staff performance after completion of training – patient experience <p>The top level demands transparency and probity of the process, as a means of control, or more specifically, a standard procedure in achieving good corporate governance. <i>Face workers</i> adapt these measures to their local requirements.</p>
ISSUES OF CARE	This is the section that leads into the need for multi narratives

Table 6.3 provides an overview of the main complex issue that this thesis approaches, in the given context of education and training. It serves as a reminder for the rest of the chapter.

i. Networks

As in many networks in the National Health Service, power lies at the nodes of the networks (represented by purchasers and providers), and the productivity and the functioning of the networks depend on the quality of their connections; social and informal networks as well as formal networks are important. It is difficult to squeeze many of our findings about networks into the Adapted Grand Narrative framework because in the National Health Service there are literally thousands of networks running and overlapping with each other. It is also difficult to work out the contribution of individual projects because of these linkages and synergies. Hence, rational decision making in its pure form becomes clouded by the interactions within and between networks. The principal-agent problem becomes a complex issue of interactions and interdependencies within multiple networks, rather than taking its simple binary form: co-incidence and conflicts of interest between principals and agents or managers and workers or decision makers and implementers.

Three considerations arise here. The National Health Service has a network as well as a hierarchical structure, so that projects cannot be considered in isolation from one another. There is no single decision maker. Instead there are stakeholder groups who have, to some extent, both conflicting and co-operative interests. As a result, we have to think in terms of trade-offs and priorities between stakeholder interests. Thus, for example, the Community Indifference Curves that we saw in previous diagrams (p.82) are much more ambiguous and difficult to construct than those in earlier diagrams. When we go on to discuss issues of translating pure qualities into numerical scores, ambiguities associated with the possibility frontier become apparent.

This section offers an insight into what it is about the way the particular network operates that is interesting to us. Note that the particular network that has been examined started to emerge in 2005 (when the research for the training project was carried out), and the formal networks of relationships had just been established to deal with the problems surrounding investment appraisal.

One immediate observation is that networks are important in the context of implementation and delivery of government strategy to the National Health Service. Thus, we need to discuss the National Health Service as a network because that is how decisions are transmitted and communicated among stakeholders, as well as those concerned with education and training. The purpose of the networks also varies between different levels in the National Health Service. The complexity of the structure suggests that it is not possible to look at the National Health Service as a whole, but only to examine small parts of its structure. Even so, the study should prove to be a valuable insight into how different levels of the same organisation build bridges, in the form of relationships and networks of relationships, and use them to identify the best investment options. Another observation here is that such a structure allows us to penetrate into the particular network and capture how value is identified – for example, in the case of this study, we are interested in the value of investment in education and training of the future workforce, which is also an essential part of the wider National Health Service's human resource strategy. Like any other structure, the purpose of these networks varies, and this study shows why and how.

According to top decision makers, these networks are formed through the involvement of senior management and leading experts or researchers. As such, they are seen as expert networks, as one participant at the top level mentioned:

We had a new guidance from Department of Health. My job was to implement this within London. For example, I try to embed and develop personality disorder services. I have set up a personality disorder guidance group, which has the lead people from the mental health trusts, getting together to talk about what they are doing, to share best practice, to encourage and make sure that front line staff and service users and carers understand the issues around personality disorder and start providing a better service. I had to try different academic experts together at different levels of service, who had not worked together previously. (Programme Director, London Development Centre for Mental Health)

One purpose of networks is based on the need to share sensitive information. In this particular case, the network participants are considered to be an expert network that was particularly set up for people to turn to for advice and to develop and build on new sets of skills. They might also be used for transferring skills, knowledge and experiences among stakeholders who use networks for personal gain. This suggests that what drives participants in these networks is based on personal motivations of stakeholders.

It could be also argued that one particular aspect of the top-down approach involves promoting guidance through these kinds of networks. In this sense, they represent a vital tool for a top-down approach to strategy. In this way, government engages people in its work, gives directions and ensures their implementation.

Speaking of networks of relationships as a basic structure, we provide below the general example of the network at a practical level, according to a response from one *face worker*, who explained:

My starting point is it's not just the stakeholder, it's the issue, and who is going to want to have a say in developing this issue and making the world a better place, and contributing to that in a kind of value-added type way, from a health perspective, for patients, for the academic good, for the financial, etc. For example, it starts with the patient and what he needs, and then where the patient goes to get care. It might be that if we have a super specialist area of care that we deliver here, rather than making all the patients come to X trust they might come to one of Y trusts from our sector. It may be if there are enough patients at X trust that our doctors will go and do a session over there. It is reciprocal. It is about quality for patients, providing care local to your home. There is also about cost effectiveness, so you need a critical mass of key people, doctors, nurses, and other professions, to deliver something. For example, we have set up a neurology centre at Y trust, and the neurology service is a one-stop shop for neurology patients, so that on the day they go they have diagnostic tests, they get their diagnosis, and get their procedure done in one day. They get to see the consultant, the specialist nurse, or a physiotherapist or other therapist, or a social worker. They have a whole team of people from different areas, from community, from X trust, from Y trust. They come together to deliver a service to patients. Financially it works if there are enough patients in that area requiring the service. (Service Manager, National Health Service Trust)

The narrative reveals a rich account of the complexity surrounding how strategy is defined in a simple sense (the government uses these networks to implement strategy) and how it is adopted in practice. It suggests that the priority of issues will ensure that the right type of stakeholders get involved, and this will improve network efficiency. These stakeholders might be highly motivated to work together to deliver Value for Money on the ground. However, they might also have different motivations for joining the network, so we need to say something about this.

Stakeholder motivations inevitably differ, partially due to their own interests and needs, and particularly because they are numerous. For example, one participant at the top level suggested:

People want to develop their own careers, personal and professional development, they want to get the experiences, want to do different jobs. I think, an interest and a commitment to their service, if people really want to see better services for their service users and the staff that they work with. (Programme Director, London Development Centre for Mental Health)

This perhaps suggests that stakeholders join the networks with various types of expectations – learning, compassion, reputation, a history of working together on similar projects, or help to overcome certain deficiencies. It also suggests that the value added from working together – the productivity of the network – depends on stakeholder motivation.

We could even argue that the degree of stakeholder motivation, commitment or trust – common kinds of pay-offs – have an impact on the distribution of those common sets of pay-offs (reputation and learning).

It also seems both convenient and desirable for top-level decision makers to set up these networks and take the advantage of such a structure to work more effectively with stakeholders.

It would be true to say that this is also the case for *face workers*. The majority of the

face workers see the networks as very useful:

It started recently. We have a key liaison and a trust named person forum, and there are representatives from all local trusts and representatives from us in different areas. I represent X hospital as a key liaison. We meet here in the faculty once a month in a formal meeting to look at issues with student placements, learning in practice, and mentorship. Then, I meet with my trust named person on a regular basis outside of that formal meeting. Then I would go to the hospital, look at the forecasts of sending students, and talk about issues. For example, maybe there had been a bad evaluation in one of the ward areas, so we would look at why that had happened.—what's good, what is bad, what they have learnt. (Manager of Nursing Programmes, Education Provider)

This suggests another interesting reason behind setting up the network: how *face workers* use the National Health Service structure to handle unanticipated problems. The networks seem to be highly adaptive, and are sometimes a mix of formal and informal. Very often the formal structure is set up to handle easily anticipated problems. When the problems are not easily identified, then the informal network steps in to deal with those often hidden problems that lie beneath the surface. Setting up a network between the education provider and the trust is an example of the joint desire to solve problems.

In concluding this section, the first notable observation is that the networks are at the heart of National Health Service decision making. They give us an insight into how strategy is implemented. For example, it has been found that the purpose of networks varies between different levels in the National Health Service hierarchy. At higher levels (consisting of strategy designers) they are expert networks based on trust and learning. These networks share sensitive information, and they are driven by the need to learn from each other and to be mutually reciprocated. However, to be created, these networks also require trust, commitment and imagination, and these qualities are unlikely to be achieved unless all of the participants feel they have a common outcome – i.e. an understanding of how to deliver Value for Money.

Government uses the rich social capital embedded in networks, and they provide a medium for high-level strategy to be transmitted and implemented in the National

Health Service. In this sense, they are seen as partnerships – coalitions of stakeholders. Moving down to the local or *face worker* level, these networks take a much more subtle form in the context of the provision of clinical services to patients. Because these parts sometimes lack the efficiency by themselves for the network to run successfully at the bottom level, their success or failure depends solely on the stakeholders' desire and motivation to solve unanticipated problems collectively in order to increase the efficiency and quality of the network.

In this way, networks are able to move across the National Health Service hierarchy, skipping entire functions to get things done. They are especially critical for handling unanticipated problems that are difficult to capture with formal structures. Sometimes they solidify over time into surprisingly stable networks, and sometimes they simply dissolve due to a lack of interest. This section demonstrates the extent to which a top-down approach to strategy penetrates the structure. It does not indicate how effectively it has been implemented. This framework could be applied to the wider context of public sector decision making and delivery of Value for Money.

Closely related to networks and trade-offs is the issue of quality and its measurement. This leads us to the section below.

ii. Qualities

It has long been a tradition that productivity is measured in terms of economic cost efficiency. In this sense, productivity is defined as the ratio of volume measure of output to volume measure of input (Office for National Statistics, 2008). One of the most prevalent approaches to measuring the increase of productivity is that people think about it as a cost reduction. For example, if one can increase productivity per unit of factor cost (wages and so on), one can reduce costs overall.

One problem that arises from this approach is that it misses out the fact that, at the *face worker* level of the National Health Service hierarchy, productivity seems to be

measured qualitatively (partly at least), in terms of the outcomes from education and training. These benefits, such as staff satisfaction, cannot be directly measured, so there is the need to somehow measure Value for Money from investment in education and training. We provide a few narratives below.

a. Measuring Staff Productivity

In the previous chapter we discussed productivity as a social benefit, and the quality of the outcome (p.152–154) Here we examine variations in productivity as a product of the kind of benefit. We draw attention to what one participant at the top level explained:

The benefits clearly are that they will go on a training course and achieve a higher quality. The benefits of training, for example nurse prescribing, you can send nurses on nurse prescribing courses, and they become better at prescribing medicine, so that saves the doctor time. So that's a real type of benefit as it can save the trust money in terms of, say, doctor's load, therefore you need less doctors, so obviously that saves costs. In terms of recruitment costs, when you want to fill a vacancy and advertising. This goes back to the intangible benefits connection, because clearly from a nurse's point of view it is empowering for them to be able to do prescribing. It will also mean that they are more likely to stay, and there is a link between the amount of training and the number of staff staying and feeling motivated. If that nurse goes on a course and comes back motivated she can take a more senior position, I suppose it is tangible again. This is good Value for Money as there are benefits to staff and to patients. (Finance Director, Strategic Health Authority)

This narrative suggests the way in which benefits are perceived from the top level. It suggests a link between monetary and non-monetary ways of measuring benefit. It also indicates the kinds of difficulties associated with measuring these benefits. Given these difficulties, what is particularly interesting in this study is that implementers at the bottom level have developed their own measures. Measuring staff satisfaction and performance is one such example, and we present it on the next page.

b. Measuring Staff Satisfaction

The presence of difficulties like the ones exposed above perhaps suggests that there are inconsistencies in how benefits are perceived by decision makers at the top and bottom levels. It would be prudent to say that there will be cases in which alternative measures need to be developed. For example, measurement of this kind of benefit has sometimes been translated in a kind of non-financial quantitative measure, as one participant, a *face worker*, indicated:

We measure the quality of education and training through staff attitude survey results. We ask staff questions about levels of job satisfaction, levels of engagement, involvement, levels of respect with their line manager, the level of engagement they have with the trust strategy and objectives, the levels of turnover in the organisation, and also the levels of sickness in the workplace. And that's very good measurable criteria. (Service Manager, National Health Service Trust)

This suggests that although decision makers at lower levels try to follow the vision from the top about how benefits ought to be delivered and measured, they have also either developed their own measurements or tailored them to suit their own needs. They have not stopped there; it could be argued that they continue to learn to adapt in response to government requirements. A further example of this adaptation is seen in another kind of benefit – how do *face workers* measure the impact of staff members' newly learned expertise? We provide one such example below.

c. Measuring Staff Performance after Completion of Training

For example, another participant, a *face worker*, suggested the following:

It really depends on what the training is because sometimes it's about attitude. Some courses are very practical and need to be observed. I think a mixture would be through supervision and through observation. If there's a change coming up, then through supervision may be looking at, "Well, how are you doing that? What did you get from the course that you can apply to this, how are you going to manage this? (Section Manager, National Health Service Trust)

It becomes clear from the above set of narratives, describing various kinds of measures of the value from investment in education and training, that decision

makers at the bottom level have developed a wide range of their own methods in an attempt to measure the benefit from acquired skills. This also suggests that, with the quality of CARE being a top priority, top level decision makers stress the importance of measuring benefits in order to demonstrate the potential improvement in patient CARE in general. However, it remains the job of the *face workers* to produce a better quality of CARE, and to measure the impact of staff education and training and judge whether it has been worthwhile.

So far, we have discussed how decision makers deal with the complexities around measuring the quality of patient CARE, in terms of staff satisfaction and evaluation of staff performance. To these considerations we add a third important measurement of the quality of patient CARE – the patient experience. We discuss it on the next page.

d. Measuring Patient Experience

Measuring patient experience is often referred as to a non-financial qualitative or quantitative measure. It has been subject to continuous debate (Buchan *et al.*, 2007). To give the reader a flavour of the measure we intend to discuss, one participant, a *face worker*, describes it as:

The qualitative side tends to be around issues like patient experience and the patient journey, things like waits and delays, if they have to wait four hours for a procedure, or if they can't park somewhere, or if their appointment keeps being cancelled or changed. (Service Manager, National Health Service Trust)

This suggests that *face workers* are aware of all sorts of qualitative benefits that patients would like to see, to ensure the provision of CARE in the most effective way.

To conclude this section, the discussion provides another example of how a top-down approach to strategy, with a strong emphasis on meeting national targets, influences decision making processes across the National Health Service hierarchy.

The example exposes the problem; it seems that differences exist in how the decisions ought to be made and imposed by the top level, and how the decisions are actually made at the bottom level. The top level demands transparency and probity of the process (demonstrated by a set of criteria) as a means of control, or perhaps more specifically, as a standard procedure in achieving good corporate governance. Unquestionably, this matters not just to the National Health Service but also to other organisations. We could almost describe this situation like this: all the procedures are in place, and as usual the top-level decision makers pay a lot of attention to targets and ticking all the boxes. However, the real picture captured by multi narratives shows something quite different.

It would be true to say that the variety of measures developed by the *face workers* does indicate the attempt to somehow define the essential outcome of the training – that is, compassion and empathy toward the patients. We argue that the measures are part of what is meant by a broader definition of CARE. We introduced this aspect in this section, but we also need to expand on it further. This leads us into another section, dealing with issues of CARE.

iii. CARE

It was stated at the beginning that the meaning of some of the concepts referred to could be shown, but not precisely defined. This was said to be so of concepts like deconstruction and CARE, and the attributes associated with it such as empathy, compassion and sympathy. It was also said in the methodology chapter (p.123–127) that processes such as deconstruction, setting out ante-narratives and eliciting differences were connected. These observations are illustrated by stories 3 to 5. One represents a target-driven approach (story 3); one reduces targeting to parody (story 4); and story 5 illustrates the issue of CARE. Story 3 excludes anything other than Value for Money. Story 5 illustrates and mingles the two issues, but the ‘*Other*’ in story 4, in the form of CARE, refuses (literally) to be excluded and competes with the target-driven Value for Money strategy.

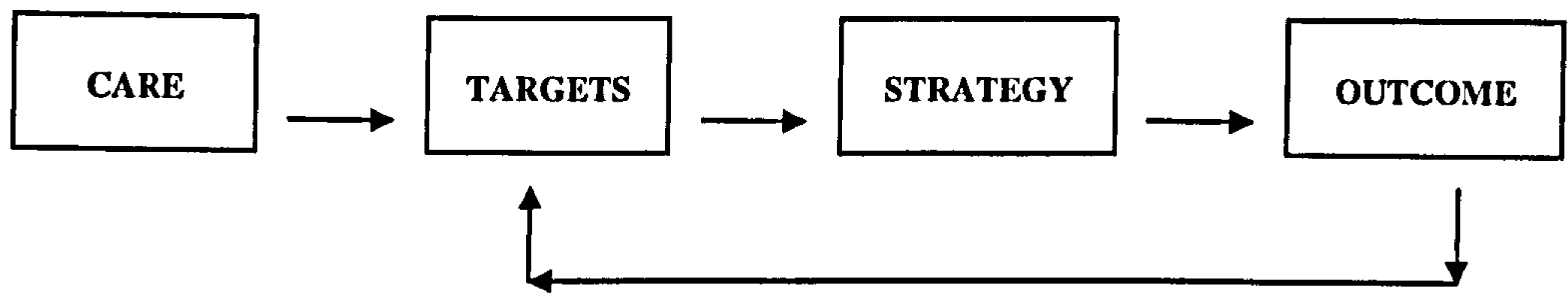
In the following story, the respondent – the head of capital investment at a Strategic Health Authority – described the Value for Money strategy.

Story 3

He is very focused. He won't be diverted from Value for Money and targeting that relates to the details of his own job. The researcher noted some non-verbal cues. His manner is urgent, intense, and perhaps breathless. "We have a need to make sure the services are provided and make strategic sense ... [They must be] ... consistent with national priorities and with national direction. The National Health Service ... [must be] ... travelling ... in the right direction... [as directed] ...by Ministers ... [Also] there is a need to make sure that the National Health Service ... [is] ... able to deliver the various targets set for these organisations. Let me give you an example of a target; there is a target ... that 98% of people who visit a hospital, the A&E department in a hospital ... should be seen by the appropriate clinician within four hours. It is important for that target to be met; you need to make sure you have the right type of physical infrastructure to make that possible, so you can get people through the system so to speak, in a very speedy, efficient and effective way. So from the point when they register to the point at which they make contact with a clinician to diagnose their condition, to the point where they get treated, and subsequently discharged from hospital, you will need to have the right type of rooms, treatment rooms, reception rooms, without people having to spend too much time travelling all over the hospital to access the services they need to access. So that is an example of a national target. [T]hat is what we call an access target, the waiting target to see a professional..."

This story illustrates a target-driven approach. It excludes everything but Value for Money. We can show this in diagrammatic terms (next page). We have a linear progression; CARE is embedded in measurable outcomes.

Figure 6.2 Linear relationship in measuring CARE progression



The figure above demonstrates the government's perspective regarding how CARE ought to be delivered. To achieve CARE, top level decision makers design measurable targets that are translated into the Value for Money strategy. These quantitative outcomes need to be measured to see whether the original targets are achieved. Thus, CARE in this case is viewed as being measurable by targets without emotional aspects included. Hence CARE is not included into the feedback loop that exists between targets and outcome (for a detailed discussion of the relationship between targets and outcomes, see appendix p.4).

Next we recount another story (next page) that illustrates the reduction of targeting to parody. The case of the ambulance chasing the target instead of caring for patients reflects the parody of obsession with a target-driven top-down approach to Value for Money strategy in the National Health Service.

Story 4

Patients kept waiting for hours in ambulances as NHS chases targets

LAURA DONNELLY
Health Correspondent

SERIOUSLY-ILL patients are being routinely held for hours in ambulances outside accident and emergency departments amid a crisis at NHS hospitals across the country.

Thousands of 999 patients are being left waiting for treatment for up to five hours in car parks, ambulance holding

bays and in hospital corridors, an investigation by *The Sunday Telegraph* has found.

Experts gave warning last night that hospitals were delaying accepting patients, and diverting others miles across the country, in order to hit Government targets to treat patients within four hours of them being admitted.

Correspondence between senior health service officials reveals:

□ A warning by the head of one ambulance service that "constant and prolonged delays" outside A&E units are putting patients at risk daily.

□ An investigation into the

death of a patient who waited three hours to be seen by A&E staff after being taken to a West Midlands hospital by ambulance.

□ Hundreds of occasions on which casualty departments have closed their doors to all ambulance arrivals for hours at a time, forcing paramedics to take critically-ill patients on lengthy diversions to other hospitals.

□ Furious rows about the case of a terminally-ill woman treated in a hospital bathroom in Liverpool because ambulances were too busy.

□ Thousands of patients waiting hours in ambulances at

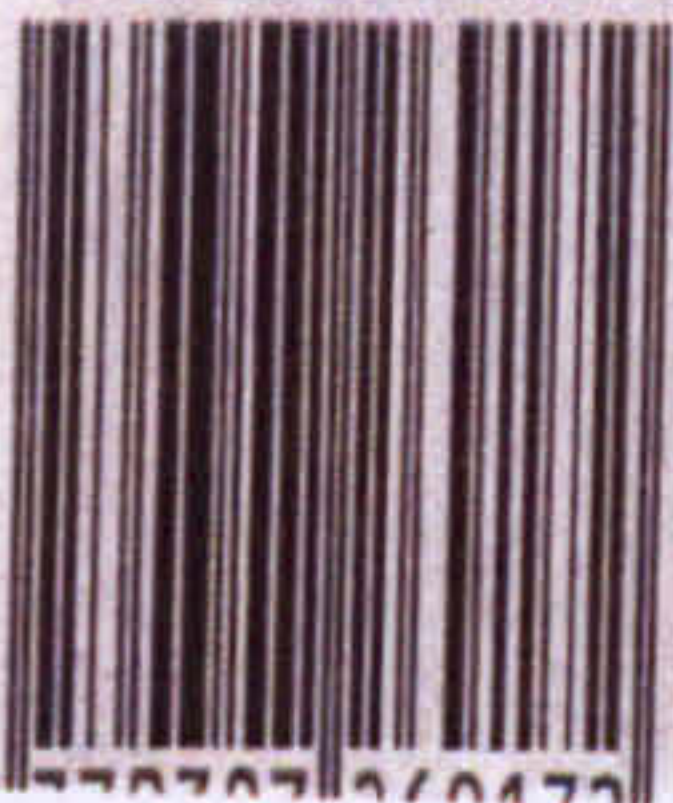
every stage of the year, including large numbers delayed up to five hours last winter, when officials admit two-hour waits were "relatively common".

The letters, obtained under the Freedom of Information Act, reveal that senior figures in the emergency services repeatedly expressed fears that unacceptable risks were being posed to patients.

More than 100,000 ambulance journeys were delayed at casualty units by more than 30 minutes in the month of March alone - an increase of 18 per cent in 12 months.

FULL STORY: PAGE 8

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Source: Donnelly (2009)

We continue by relating story 5 below. Story 5 illustrates the issue of CARE. It mingles two issues; the '*Other*' in story 4 in the form of CARE refuses (literally) to be excluded, and competes with the target-driven Value for Money strategy.

Story 5

The interviewee is a ward manager of a secure unit in a mental health trust in London. She personally invited the researcher to interview her despite a heavy workload. When entering the unit, the first thing that the researcher noticed was an overcrowded room; narrow like a hallway. Not very long into the conversation things were suddenly disrupted by a deafening alarm going off. One of the patients started to scream. "Excuse me, I have to deal with something and will be straight back ..." the manager said, running off ... When she came back she said: "It was a false alarm. Someone switched it accidentally ... and one of my patients started to panic. So I had to calm him down. You know, they can get upset quite easily.'

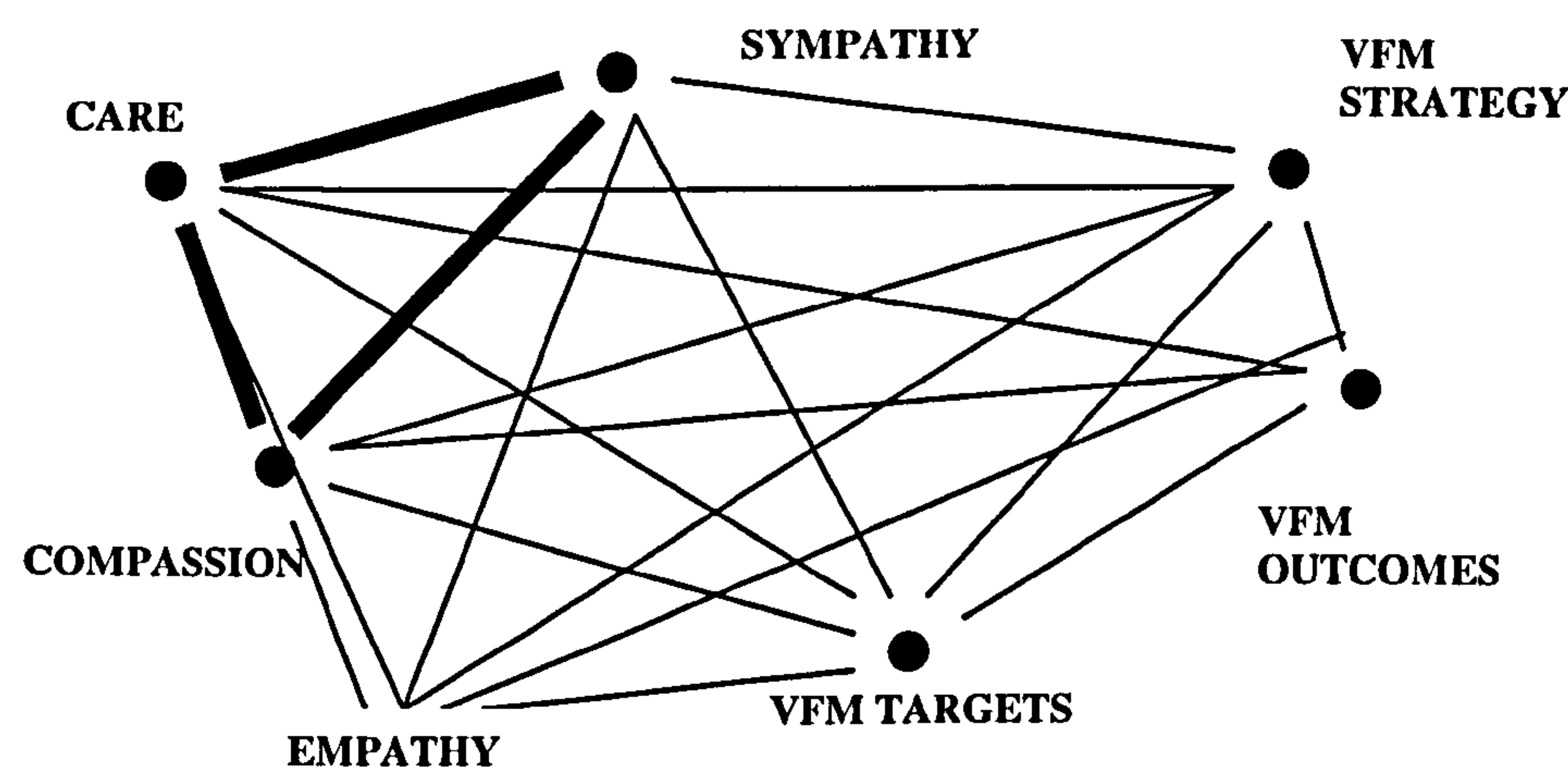
There was a look of compassion in her eyes; and a feeling of the frustration in the air. Then she said: "You see, this is our problem. Look at these crowded rooms. We don't need the money for more management, but [we need] ... to provide ... better conditions for these patients. Let me show you around".

We went into another room where the majority of patients were watching full volume TV ... some of them walking around and talking to themselves ... muttering. It was very noisy, voices, the television ... The room seemed to be too small for 20 patients. One patient approached ... agitated, excited ... wanted to speak to the researcher. The manager asked him very gently to return to his chair. The patient calmed down and went away.

The manager excited, watching the group for another disturbance, speaking loudly above the noise, said: "You see, these small crowded rooms are against the standards of basic care for mental patients. Not only do we have the problem of providing basic care, but we have now created the additional problem. They don't want to leave. Every one of them ... has complex ... needs. How can we help them to return to the outside world if we do not have enough resources, trained nurses who will help them gain the confidence to leave?" Then she apologises for raising her voice. The researcher felt frustration and a bit of anger about the situation ... and about the manager's job, which seemed pretty impossible ... yet it was being done ... as well perhaps even better than one could imagine it could be done. And on her part too. She thanked the manager for her time. The manager said: "Would you write this as it is ... please?"

If we return to the diagram (presented at the start of this chapter), we can present this account as a modified diagram; the researcher saw the situation like this:

Figure 6.3 Linking emerging patterns



Looking at Figure 6.3, CARE emerges as a complex issue – it is a complex term. Dotted lines are now replaced with solid ones, as stories begin to illustrate the problems of the current Value for Money strategy. Traditionally, when Ministers or policy makers speak of CARE they refer to it simply as compassion. This chapter goes beyond this simplistic term, and encompasses the issues beyond the original Grand Narrative. We attempt to illustrate the richer picture of what is meant by CARE, which can be shown precisely by stories. We shall return to this figure in Chapter 8.

Conclusions

We have extended our empirical analysis to the discussion of our findings concerning some complex issues underlying the Adapted Grand Narrative. We discuss them as multi narratives. It may assist the reader if we summarise and reflect upon the issues that have emerged so far in this chapter.

We emphasise the particular form of the principal-agent problem as follows:

- a. Importance of non-monetary issues, what we have called emotional issues, which need to be fleshed out (this we do in next chapter)
- b. The fact that we do not have a single goal, but many goals, both monetary and non-monetary. There are many stakeholders, so that the principal-agent problem has a greater complexity in the health service than in purely business sector organisations. What we find in the public sector may be of great relevance to the business sector if, as a result of the current crisis, ethical considerations become an important part of the business sector corporate agenda
- c. The principal-agent problem in the health service takes place in a network, a complex framework of relationships.

In this section we have developed the framework of approach further, drawing on the literature reviewed in Chapter 3. We began by refining the Adapted Grand Narrative explicitly in a public sector context. We then examined some patterns that emerged from the primary interviews relating to broader aspects of the Adapted Grand Narrative that are difficult to measure, and yet essential to the quality of the service itself. They are also, from the point of view of many of the interviewees, an essential but undervalued part of their job. We then illustrated the contention that aspects of CARE can be shown by narratives that illustrate actual circumstances. The study has been extended into the network of relationships in the National Health Service to a limited extent, but there is a need to extend it further. As illustrated in some of the multi narratives, we begin to see the importance of the emotional issues associated with CARE.

We have taken a step towards deconstructing the Adapted Grand Narrative. The next step is to further examine some of the preliminary conclusions noted at the end of Chapter 5 above, adopting the technique of panel data analysis.

7. EXTENDING THE ADAPTED GRAND NARRATIVE (3): VALUE FOR MONEY AND CARE

Introduction

In this chapter, the results and interpretations in previous chapters are discussed in panel sessions. In particular, the discussion of issues raised in the previous chapter relating to the complexities associated with networks, measuring qualities and CARE is extended, again using a panel discussion technique. The issue of CARE is discussed especially in relation to a story (story 6) by novelist Hilary Mantel (2008).

Chapters 5 and 6 gave us some preliminary results with respect to the Adapted Grand Narrative of Value for Money, with the former chapter focusing solely on its categories and the latter focusing on multi narratives. This chapter checks these preliminary results against the opinion of experts, and, possibly, extends and amplifies the preliminary results. We decided to do this using panel data by putting together a number of panels (experts), the results of which we report in this chapter.

At the start of this chapter, we remind the reader of the preliminary findings from Chapters 5 and 6, which we summarise below. We have a set of findings about the National Health Service relating to our Adapted Grand Narrative:

- (i) A version of the principal-agent problem exists in the National Health Service in a complex form, since the hierarchy has many levels and a large number of complex networks are superimposed within and between the levels of the hierarchy.
- (ii) Generally, agents or *face workers* implementing strategy have different perceptions of the categories of Value for Money than those designing the strategy.

- (iii) There seems to be a consensus that the Value for Money strategy is bringing about improvements, although there is confusion about what this actually means at a practical level.
- (iv) It is also recognised that in the current political climate the Value for Money strategy is 'here to stay'. Recent evidence reveals that it is becoming even more refined.
- (v) The issue of CARE is not separate from that of Value for Money, and achieving and valuing CARE requires a different approach from that currently taken. Stories 1–5 illustrate this aspect, as do the multi narratives.

Further, we have seen qualifications expressed about the top-down approach to strategy adopted in the National Health Service. This latter point strengthens our initial Adapted Grand Narrative hypothesis, since perceptions about what needs to be done to achieve Value for Money at the *face worker* level do not coincide with the Value for Money categories laid down by economic theory and expressed in the Green Book (2003). Therefore, the models outlined in Chapters 2 and 3 (the literature review chapters) do not coincide in detail with the practical findings outlined in Chapters 5 and 6.

It is necessary to check these general findings, and to examine these complex issues in more detail. To achieve this, a series of panels were set up, composed of experienced senior managers in the National Health Service.⁵

The above issues (i–v) form the basis for discussion of the last two remaining issues: the principal-agent problem concerning the top-down approach to perceiving Value for Money; and the presence of complex issues surrounding rationality in the National Health Service – empathy, CARE, and compassion. So far, we have merely introduced these issues. We now consider them in depth and in terms of how they shape National Health Service strategy. We further expand on these preliminary findings by setting up a panel to revisit them. Our procedure is to report the

⁵ See Appendix 9 for details of panel composition.

conversations that took place during the panel discussions. Interestingly, the conversations took the form of stories, but they also took the form of reflective dialogues as much between the panel members as between the panel members and the researcher. This point illustrates the deep involvement of National Health Service employees in the services they offer, and the potential for consultation between top-level decision makers and deliverers of the service. It also illustrates a general point that the researcher is an essential participant in the research process, which leads us to strive in the final chapter to include the researcher's story.

An important aspect of this method of research is that it provides an opportunity for reflection and learning, which we will discuss further in our recommendations. The National Health Service may be too top-down in terms of management style, and may promote an excessive level of control over the processes and managers at the bottom of the hierarchy. Too much control also threatens to take away initiative at lower levels of the organisation, and may be interpreted as a lack of trust. As a consequence, the effects can be good and bad. Putting this another way, this represents a special case of a principal-agent problem in the health service. In this chapter, we confirm what we argue are the consequences of implementing government strategy in the broadest sense.

It is useful to summarise some of the issues relating to the complex form which the principal-agent problem takes in the National Health Service; see Table 7.1 (next page).

Table 7.1 Extended Results for the Adapted Grand Narrative (3): Analysis from the National Health Service: Value for Money and CARE

Results for the Adapted Grand Narrative (3): Analysis from the National Health Service: Value for Money and CARE	
CATEGORY	COMMENT
PRINCIPAL - AGENT PROBLEM FORM	<p>The evidence for thinking about the Adapted Grand Narrative in the context of the principal-agent problem is introduced .The broader implications of the principal-agent problem are examined:</p> <ul style="list-style-type: none">a. Focus is on extending the analysis to consider the whole National Health Service, and provide an in-depth insight into the principal-agent problemb. Emotional issues are important <p>The emotional context is starting to emerge, in the sense of disillusion and frustration on the part of participants. This allows for making a more distinct boundary line between quantitative and emotional aspects.</p> <p>The current management style (reflected by a top-down approach) is perceived to be too focused on creating business leadership style, with an attitude of promoting secrecy and competitive behaviour rather than being CARE oriented (with an attitude of sensitivity, compassion and empathy)</p> <p>This reinforces the need for a more bottom–up approach to managing services. Evidence emerges about the current strategy being far too top-down, and about a lack of quality leadership. It suggests that the government should focus on finding the way to stimulate empathic leadership.</p> <p>This again reinforces the argument for a bottom–up approach, where more consultation and more flexibility for people lower down to set their own targets could be built into appraisals to a greater extent.</p> <p>In this sense, this story reinforces the idea that the bottom–up approach is essential to the survival of the National Health Service.</p>
CARE	<p>Relationship between Value for Money and CARE is complex.</p> <p>People carrying out the strategy in the National Health Service either do not understand or are confused by the current system (of targets) that is in place. The current system has resulted in a failure to create or a loss of qualities (empathy, CARE sympathy).</p> <p>Recommendations for reintroducing these qualities (balancing hard and soft elements of services in the National Health Service):</p> <ul style="list-style-type: none">1. go back to grass roots of providing CARE, not focusing on targets2. educating for leadership should focus on providing CARE rather than business thinking3. CARE must be an integral part of decision making

Table 7.1 provides some concluding remarks for the chapter regarding the particular principal-agent problem that this study examines, as a part of a bottom-up approach.

We now enter into a discussion of the panel data. This third stage of the interview process checked the preliminary results from the Grand Narrative and multi narratives against the opinions of experts.

- a) First, we check our impressions of the initial responses about the Grand Narrative and multi narratives
- b) Second, we introduce the Hillary Mantel story and seek further responses about empathy.

Panel Discussion 1

This panel discussion was made up of four people: a researcher (R), an academic supervisor as a chairman (A), a Commissioner of Services (C), and the National Health Service Trust Director (D). The discussion extends to the measurement of qualities at a detailed level. A substantial part of the discussion is about training programmes in the area of mental health.

After a brief introduction in which the participants introduced themselves, the discussion proceeded as follows.

- R: Thank you for coming. We have spoken about the main lines of my research. Let me summarise some findings and get your reaction. The first set of findings is about Value for Money itself. Generally, the people I spoke to concurred with the strategy. They had reservations which we will discuss.
[At this point the Researcher briefly summarises some of the findings that had been obtained up to this point]
Generally, I found that there was a great deal of variety of perceptions about what Value for Money actually means. Director, what does it mean to you?

- D: There are different meanings of Value for Money. There is me in a role in the National Health Service, and then there is me as a person. I think I will talk about my current role because then it's easier to focus down...
- I am working for City and Hackney Primary Care Trust, setting up something called IAPT, Improving Access to Psychological Therapies, which is a government initiative and the money has come from the Department of Health. We're training hundreds of therapists over the next few years. The local target, for London this year, is that we get 125 new therapists trained up in one year. They need to start work in October; they start training in October and after a year they'll be fully trained therapists and will work in Primary Care. So the Value for Money is very much being driven by hard activity. Each high intensity therapist and low intensity therapist will see 20 people a week. The high intensity people will have 40 on their caseload at any one time; low intensity will have 80 on their caseload. Huge numbers.
- A: So you measure it by the number of people the therapists see?
- D: Yes, and the activity. Within that activity there are quality scores because this is something you can measure quite well. There's GAD scores and PHQ scores to measure depression and anxiety. So if you were my patient, I would see you, you would fill in a very basic questionnaire at the beginning of every single time I saw you, so there would be 20 sessions for instance and every time you'd fill in this form. Over time, we'd plot it and your depression would hopefully be getting better. So, it is very quantitative.
- A: Commissioner, turning to you; what do you understand by Value for Money?
- C: For services to be commissioned there must be Value for Money. For example, we commission support for carers. What we're looking at and asking for is what the outcome will be. So we have somebody that is [about to] go into residential care because the support system is breaking down, and [if that happens and the patient is taken into care] ... there is a ... breakdown of the family. So for us it is very much outcome-led. We want to avoid that happening.
- There's a quality framework in place so we would expect people to adhere to that quality framework and that's inspected on a regular basis. So there is lots of procedures in place. Perhaps there's too many and what you actually make people do is then, instead of the service fitting the client, the client then has to fit the service.
- Staff will be given a framework and within that framework, there are certain points you have to have, such as a policy in place for adult protection. It's a very sensible and practical point of the quality framework.

Then you start to get to the point where you have to get service users' involvement, and they actually probably don't want to be involved, they don't want to take part in that part ... but we're making the providers do these things without actually going to the service user and saying "What do you want from our service?" We're putting together a package and saying, "This is it," and the providers have to provide that package. ... It's not actually in consultation with the service user.

So [on the one hand] there is where we think they're getting Value for Money because it's part of our outcome, our framework, but [on the other hand] the service user probably doesn't [think in the same way] because what the Researcher was saying at the beginning – that there's so many targets and everyone's so busy reaching and fulfilling all these requirements – the reasons for what they're doing and why they're doing it has kind of got lost in time.

... the client, the service user is not really consulted ... instead of being up there as a priority seems to be going further and further down the ladder. In the end you can produce all this documentation, that people get inspected once a year and to take part in this inspection, or to fulfil this inspection.

It's almost as if a client rings up and we say, "Oh sorry, we're about to have an inspection, we can't deal with you." There are some elements of it that you need. You need to make sure that people are protected and aren't at risk, but there are other aspects that you don't need. I think that it is just too much about targets.

D: It's like that Fawlty Towers bit when Fawlty says to the guest: "Will you go away, I'm trying to run a hotel here."

A: Yes. Let us resume the discussion on the responses we made to the theoretical framework (Adapted Grand Narrative) ... they were very varied. I got the impression sometimes that the situation is not so good. As Director, will you respond to this?

D: As ... Director of a ... Service in ..., I felt I had to work very closely with the voluntary sector, with the Primary Care Trust (PCT), with the Local Authority, with my partners, because you can't deliver mental health services unless you're working with the local community and delivering, particularly with service users and carers. My bosses, who were at HQ, were telling me that I could not have those close relationships with the PCT, the Local Authority, because they wished to be in charge of the strategy. So they were taking it away from the three local boroughs and pushing it into a central point, and wanting to take hold of the decision-making, which made my job totally impossible, tied my hands behind my back.

What they wanted me to be was a puppeteer of their ideas and what they are doing is managing. I left because I couldn't manage the stress between what they expected from me and how I felt the job should be

done. I had to become a puppet of what they wanted. They are also now managing to alienate the local PCT and the partners. Over time they will have a very dysfunctional organisation.

Their belief is that having become a Foundation Trust, they are a business rather than a public service. If you are a business, they thought, you don't share your secrets with other people. They're more the enemy rather than the partners. That's how the ethos was sort of growing and changing, which is totally wrong. It won't get them anywhere. But, in the short term, they are an extremely successful Trust because they have huge amounts of money which they've got in their coffers, building up and buying things. They're doing very well in the business sense. Meanwhile they have staff who are frightened to do or say things. The workforce is becoming more and more alienated. They won't be able to deliver a decent service.

C: I used to be a nurse in the National Health Service. I saw some fantastic things and it was very much about the patient. But there were problems there and it wasn't being monitored, and it needed to be monitored and become more business-like, but it just seems that it's gone so much.

I may be completely wrong and this may be a daft thing to say, but when Margaret Thatcher came and wanted to start putting the business into the public sector that happened. She was right about the idea, but the practices that have come in place and what seems to have happened was that instead of the resources going into nurses, doctors etc, it's gone into management. There is so many tiers of management.

D: The managers have got the wrong ethos in their heads, and it's partly to do with MBAs. They think, good management is tough management. They've lost the understanding of people and the care's come out of the whole system. So it's sort of hierarchical, bullying, macho sort of stuff which doesn't work. It certainly doesn't work in the hierarchy, in the wards or in the home.

C: They've taken their eye off what they're actually supposed to be doing and I think that's why now the National Health Service has got the problems that it's got, why often the standards have gone down, because the actual hands-on on-the-ward work has been left almost. All attention is been to put into place targets or business plans.

D: Yes. So a nurse on the ward now will be rewarded for having filled in her paperwork but not because she's been kind to Mrs Jones, you know, because that's not quantifiable, but it is quantifiable if you have a really good ward sister who understands what her business is about and knows her staff and notices that somebody's been kind to Mrs Jones and rewards it by saying "thank you" or whatever, you know, and builds that ethos up. But that's very difficult to quantify.

We can make a few observations about this story. Both respondents concur with the Value for Money strategy in general terms. They liked the approach of the Adapted Grand Narrative, and thought it was fruitful. They said they “would not have put things in exactly those terms, but generally we try to think about things in that way and explain what it means in practical terms [to the people they manage]”. The director provides a very specific illustration of an exact situation where a top-down, target-driven approach is useful. The government has been convinced that:

- a) A large number of working days are lost through mental illness, depression and so on.
- b) These conditions can be divided into those requiring high intensity treatment and those needing low intensity treatment.
- c) A methodology, known as Cognitive Behavioural Therapy (CBT), exists for treating these conditions, and the overall (measurable) benefits in terms of output, gained through fewer working days lost and reduced welfare payments, exceed the cost.
- d) Success that is directly attributable to the treatment can be measured by combining a set of outcome measures (GAD and PHQ) with targets in terms of numbers of people, in order to achieve target scores.

Clearly, if people get better and feel happier, this is an example of the psychic aspects that Fisher (1930) spoke about. In the commissioner’s account the intangible psychic elements are more apparent when he talks about family breakdown. Network effects are apparent in accounts involving the patient, his or her family and the local community, as well as the community in general, since admitting people into hospitals or care homes is perceived as being more expensive than CARE within the patient’s own home and family. There are trade-offs between the needs of the carer (or carers within the family), the patient and the community (who pay the bills in the form of taxes, and who may or may not be at risk according to the decision about the patient). Clearly the carer is not consulted in designing the measurement process. Furthermore, it is apparent that in the commissioner’s view there are too many

measures. The National Health Service also seems to break the (business sector) rules governing Critical Success Factors (CSFs) and Key Performance Indicators (KPIs); there are just too many of them. These points are strengthened if we ‘drill down’ more deeply into the director’s situation.

The question arises as to whether we are simply recounting a set of common criticisms about the operation of (so-called) business sector techniques in the public sector; ‘there are too many forms to fill in, they take up too much time, the opportunity costs outweigh the benefits’ and so on. There are two substantive points to be made here, however. First, these common criticisms, despite being aired very often, are still valid. More important, however, is the point that target setting must be a bottom-up as well as a top-down process; implementers ‘on the spot’ at the point of delivery of the service have information about its detailed operation that needs to be incorporated more effectively into the outcome measures.

Further, although the remarks by the panel were quite guarded, there is clearly a certain amount of frustration about measurement. Perfect control systems, designed from above, do not exist. At some point, especially in the National Health Service, we have to trust the deliverers of the service. How can this be incorporated into Value for Money? The panel discussion continues.

Panel Discussion 2

So far, in the first set of panel data, we checked our impressions of the initial responses about the Adapted Grand Narrative and the multi narratives. Panel members were encouraged not only to give their own responses to preliminary findings, but also to add their own perceptions and their own stories. Emotions started to emerge. The researcher sensed the need to unlock these emotions, because they make the recounted stories more explicit and more relevant. We felt that we needed to go further, so we introduced a second set of panel data. The story from novelist Hilary Mantel (2008) was given to a panel consisting of the researcher (R),

the academic supervisor as chairman (A), a former nurse, now a management consultant in the National Health Service (MC), and a former trust chief executive (FCE). They were given fifteen minutes or so to read the story, which they were told would set the background for the panel discussion.

At this stage, it would be useful to explain why we chose novelist Hilary Mantel (2008), so we introduce her background, below.

About Hilary Mantel

Hilary Mantel is a British novelist, short story writer and critic. Her work, ranging in genre from personal memoir to historical fiction, has been short-listed for major literary awards, among which are the Commonwealth Writers' Prize, the Sunday Express Book of the Year, and the Orange Prize for Fiction. She has written extensively in the domain of social care and health in the United Kingdom; for example, she published a story on problems in mental health. In 2003 Mantel published her memoir, *Giving Up The Ghost*, which won the MIND (formerly the National Association for Mental Health) 'Book of the Year' award, and in the same year she brought out a collection of short stories. Her background, as a social worker and later a nurse, as well as her status as one of the most accomplished British novelists today, was the major reason for introducing her short story below.

Story 6

At 6 p.m. on a damp late June evening, I look up from my book and see my husband across the room, faint and grey with pain. What to do? It's Sunday, and whereas until recent years you couldn't on a British Sunday buy a pound of carrots or see a play, these days you can't be taken ill, unless you're prepared for a long and uncertain wait for your GP's deputising service. Go to A&E? Perhaps it can be avoided. A few weeks ago, he had a similar pain, and an abdominal X-ray showed no cause for alarm. He lies down. The pain ebbs. We spend a restless night, turning and muttering, waiting for Monday when crisis is more convenient.

In the late afternoon he sees his GP. She sends him to hospital with a note. He can hardly stand upright now. Twenty-four hours after that first attack, he is lying white as paper on a trolley in A&E. It is an ordinary evening, quiet enough – no inner-city brawls here in Surrey, no drunks. And yet, within minutes of arrival, you feel you have been rolled in misery and grime. Everyone is frightened, everyone is suffering or watching someone else suffer. There is no privacy, and the panic is polyglot; notices offer interpreters, translators, signers, but in practice the staff just shout. It is an odd idea of ‘emergency’, this. No doctor comes. There is no pain relief. There is no information.

Hours pass. We draw the curtains around ourselves. We hold hands. Our breathing seems to synchronise. There is nothing to say or do. It is not appendicitis, as the GP suggested – the pain is moving to the wrong side. From time to time I push the curtain aside, collar someone. ‘Yes, yes’, they say. ‘Oh, I will.’ ‘Just coming.’ Then they disappear and I never see them again. A pain-killing drip is put up. Ten minutes later it’s taken down. He is rolled off the trolley, taken for X-ray. By now it hurts him to move. I think he might die. All around me, in the cubicles, the past is being folded away, lives collapsed like tents, and journeys beginning to the new camping grounds of sickness, disability, loss of self.

For two days in the intensive care unit the sick man is watched every minute of the day and night. He is in no pain. No one could be more attentive or competent than these nurses. I am weak with praising them. As he descends, in a few days, through the hierarchy, from intensive care to high dependency unit, from there to a surgical ward along the Green Mile, the care becomes more perfunctory, the rooms dingier, the staff more flippant and detached.

Nuns used to practise something called ‘custody of the eyes’. I see that modern nurses do it too, but for the nun’s downcast gaze they substitute a blinkered stare. It would be natural, coming into a bay of six patients, to cast a glance around in case anybody was about to roll out of bed, or vomit, or die. But these lasses march straight to their goal, whether to perform a procedure, pick up equipment, or write up a chart. If they looked left or right, they might see something that needed doing, something extra. They never, I notice, look at a relative or visitor, but around the edges of them, or above their heads; if these outsiders were acknowledged, they might want something; they might ask a question. I see a senior doctor, alight with irritation, rip into a gaggle of nurses, thrusting papers at them: ‘Who wrote this up? Who is responsible? I want to know.’ The nurses turn their shoulders and simper. They won’t look at him, won’t speak; they just smirk, darting amused glances at each other, until he gives up and steams away.

Money won’t mend this, I think: no redistribution of resources, no policy

revamp. This is about people. Is it possible that the failure is not in the healthcare system, but in the education system that has turned these people out? Or is the failure deeper than that? Do the nurses despise the patients (and their relatives) for their neediness? Are they secretly revolted by their work, and taking their revenge by pettiness, by the foot-drag and the eye-roll, the shrug? All week, my struggle is this: not to redirect my anger and distress to the wrong targets. Smiling obdurate patience must, I think, get me somewhere. But what kind of nurse dumps a patient, new to a ward, like a parcel on the nearest bed, without so much as a jug of water? Who 'forgets' to give the liquid morphine prescribed, and snaps 'He's had his pill!' when told a patient is in pain?

In the last few days much of the suffering I have witnessed and experienced has been caused not by the human body as it snakes towards death on its secret self-destructive paths, but by the blithe stupidity of the individuals I have encountered, and I don't know whether at the end of this process I, who am emerging whole and not a widow, will not also emerge a worse person, more cynical, more intolerant and more selfish, a woman who only looks out for her own. (Mantel, 2008)

After ten minutes, the discussion continued.

R: Could you respond to the Hilary Mantel story?

MC: I think it's utterly true. It's so sad. When I was nursing years ago, there was a hierarchy. There were the nursing officers, the ward sisters, the registered nurses, the state enrolled nurses and the auxiliary nurses. We'd all come into it for different reasons. It worked because we were all doing what we wanted to do. Then they took it all away. Everybody had to become a Registered Nurse. You lost that caring element because suddenly everybody wanted to be ward sister or specialism. Practical caring level just disappeared. That started when they brought in 'Nurse to the Book 2000'.

FCE: Hilary Mantel's article talked a bit about stupidity, but it's nothing to do with stupidity. The academic thing has been pushed so much, being able to write something well, being able to meet the targets in a way that's designed to fit the government targets and things. They can't do that bit but they can be a kind person who you would want at your bedside, and we haven't got that in the system anymore, it's gone. And that needs to be there and rewarded, and it isn't. I read this article and I can say "Well, that's to do with resources basically. When I was a young social worker, about 23 to 24 years

old, I used to go to a place in 59 Greek Street in Soho and it was a women's hostel. It had 40 women in it and these were severely mentally ill women who the mental hospitals couldn't cope with. It was run by a group of feminist women and men weren't allowed in there at all. I used to walk through the dining room and feel totally and utterly overwhelmed. I used to just feel the need from all around me. I could have spent several weeks sorting that woman out, because the needs were massive. The first time I came out of that place I just thought "I can't do this, I cannot do this job". So, I had to start sort of focusing. I either had to give it up or I had to focus down and pick one or two women that I could work with. That experience of feeling overwhelmed is what nurses feel in the busy wards.

MC: As a young social worker in that environment, you would feel overwhelmed, but in the National Health Service now that just seems to be the norm rather than the exception. I had an experience when my mum was ill. My mum was dumped on a ward, we were there for two hours before anybody even came and said "hello" and told us where we were and asked my mum's name.

And the nurses didn't even bother with her. As a nurse going back into the National Health Service for the first time in many years I was absolutely shocked and horrified by what I was seeing. I could remember when I was in the National Health Service being very proud of it and seeing the work that was done there and it was excellent. I had all faith in the National Health Service. With the experience that we had with my mum, I wouldn't want to go into one of our hospitals.

FCE: The government has got a lot more data than 20 years ago but it's not helped. The way they measure is not always accurate.

MC: It's also the data that's massaged because they have to fulfil these requirements to get certain amounts of money. In the A&E people have got to be seen within 4 hours. If they don't, they massage it so it looks like they're reaching targets.

FCE: Yes, because it is impossible to get some people through in 4 hours, they've opened a pre-admission ward, so there's somewhere to park people rather than in the A&E department because you can't actually shift them on in 4 hours.

A: Are you actually saying that things have got worse rather than better because everything we read suggests that actually the National Health Service is better, the service is better? What you're saying is that at ground level it's not any better...

MC: There's groundbreaking work that is better, medical and surgical procedures. But the actual work on the ground now is worse than it

has ever been. When I was nursing, your skirt had to be so many inches below your knee, you had to do things that maybe were a bit silly, but the actual control was in place because you are dealing with people's lives, it's the ultimate, and that control is gone.

FCE: We've put in targets and taken away the thing that really makes it work, good nurses, teachers, or leaders. But, as long as you've written that somebody is a caring teacher, it does not measure the fact that you are actually good at what you do.

A: Aren't we talking about an impossible situation, that the taxpayer wants accountability as a taxpayer and yet as a patient they are looking for something else. Because if, on the one hand you could say it's not sufficiently businesslike (or quasi businesslike...), and now what you're saying is that it's too businesslike. Is there a way of resolving this?

FCE: Possibly it will if it's put in the right way. It's not just money but it's about training and leadership and internal kind of values of people and nurturing those and valuing those and not killing that. We've killed that. Take my job. I was stifled to such a point that I had to leave the health service because I felt I would die in this atmosphere because I had to be the person who delivered on things that weren't important. Even after 33 years I am still that young social worker who wants to help. So that hasn't been killed.

A: [MC], you're still working with the National Health Service?

MC: I think it is too target driven. You have to fulfil these requirements, you are not allowed to give your own opinion, your creativity is gone and there's not that freedom. We've gone too far down the road to come back now. I think it will go down the private route. It will start to disintegrate. I don't think it can survive as such. People will purchase as they don't want to go into the hospitals that we've got at the moment.

A: There must be some positives though?

FCE: When I was with the Foundation Trust ... it was very good to be able to pull out the numbers and say "Oh, this team here seems to be costing us this much per unit, you know, the unit cost for running this team is lower than this team. What are we doing here that's better than here?" And that was very useful for me as a manager measuring the productivity of a team. But there were other teams you really couldn't measure the productivity of ... which they are still struggling to try and measure – a schizophrenic episode, or how much somebody with schizophrenia should cost you. But how the hell do you measure

one person's pain against another person's pain? It's very difficult to do that and seems pretty crazy.

R: You are sending out two messages because you're saying "It's impossible to measure" ... But then you were measuring things ... Have people sorted out ... the difference?

FCE: No, they think everything is easily measurable. But some things are sort of beyond measure. I think that there should be some measures, only a few. There are the 7 Better Standards for Health that you have to relate to. Trying to squeeze everything into them is really difficult. Underneath each one of them there are hundreds of different standards to reach, so if there's too many people can't keep their heads around them. What you really need is good leaders and there's something about a good leader that hasn't been bottled and sold very well.

A: Is there any resolution or have we just got an impossible situation where what you'll end up with is actually everything being privatised, or lots of things being privatised, and going back really to a two-tier system like you've got in the States where the poor are really ... if you're poor you've got a problem, if you're rich you can buy care?

MC: I think for me the solution is to go back to the grass roots and look at how it used to work. I think ... [FCO] is right. I think it's a lot to do with the leaders. You're getting people coming in that are bright and intelligent but don't have that passion for nursing.

FCE: But then the health service is absolutely littered with those people, but they're not valued and they're not grown. We just need to hold them and value them and grow them, which is what I did when I was in my job, but then of course I got squashed. What worries me is that the person going into my job would do that to his next layer, and they'll do it and you kill that passion. I think the Government's got something to answer for by pushing this business ethos too far. I think education's got something to answer for as well by misunderstanding what the public sector leaders need and the sector needs in terms of its leaders.

R: [FCE], could it be possible to say that the upper level of the National Health Service need to listen to staff, what *face workers* are trying to say?

FCE: The problem is hierarchy in the organisation. Senior managers have a far wider view of strategy, but service managers have their own view of reality, what is happening on the shop floor. They are also separated from what is going on the shop floor, required to tick the boxes, as part of performance management. But the performance management penetrates different areas of the organisation, so ticking

the boxes does not really show that. There is a problem of how to communicate and engage service managers. How to make them be more aware of the wider picture, but then there is the problem of too many changes in the health service. People do not have the time to sit down, to think about the problems, to absorb the new things.

We can make a few points about this discussion. To a great extent, however, it speaks for itself. One of the discussants, the National Health Service director, perceives that there is a misunderstanding at trust level about how networks operate. The social or organisational capital associated with trusts (although the terms are not used as such) is misunderstood. The networks of purchaser/supplier relationships should emphasise co-operation rather than competition. Management style has become intimidatory and overly 'macho'.

As in the earlier discussion, analysis is in the form of personal stories and metaphors. By analysing the discussions in this way, a general point about theory and methodology may be illustrated. People think in terms of their experiences and their stories, rather than in theoretical frameworks. In a sense, the theoretical frameworks provided by Value for Money and Net Present Value are as foreign to these respondents as they were to previous interviewees. However, the theory provides a framework in which to tell these stories.

What we can hear from the director's story is that it says that even when Value for Money is successful, it has severe drawbacks. In the long term, this is seen as spending large amounts of money on improving the services and people, but not really succeeding in doing so. It is also about the staff, who are afraid to say what they are seeing if it doesn't accord with what senior managers want to hear. Senior managers seem to be trapped in their own paradigm – a Value for Money paradigm – that can be applied in a bullying fashion. The talk is of the feeling of being a puppet, and the demand imposed that she must 'not share your secrets with other people' is counterproductive: the purchaser/provider split is seen as a partnership or an alliance, rather than a confrontation.

We can also observe the tone of the conversation. The commissioner recognises and assents to the director's view: 'some fantastic things have been done and real improvements where they were needed'. Then the discussion lapses into (what the researcher was tempted to perceive as) banalities about Margaret Thatcher, citing consequences such as having too many tiers between doctors and nurses. Although this seems journalistic or populist, we have to recognise that is how stories are told, with demonstrations of real feelings and real thoughts.

We also have to recognise that the same story was repeated frequently in the multi narratives. A feeling of loss emerged both in the multi narratives and in the panel data; a loss of something that was perceived to be present in the past. The researcher felt almost a 'sense of nostalgia'. She also felt that perhaps it did not matter whether she was detecting nostalgia for what might have or might not have been present in the past. What mattered was the sense of loss, the personal story. The researcher was perhaps detecting a personal goal, a rationale for entering the National Health Service in the first place, in which case this story is part of the social capital in the National Health Service. In an operational sense, this matters because it is the basis of trust. Trust according to transactions cost analysis (Williamson, 1981, for example), reduces all kinds of costs in organisations; this is well recognised, but it seems from our investigations, via panels and through multi narratives, that this recognition does not stretch to some parts of the management structure in the National Health Service.

Always the issue arises as to how far we can generalise from instances. In this case, the argument has to be that we do not know exactly how far we can generalise, so what we need to do is examine actual cases and incorporate findings from these cases into our design of Value for Money processes and procedures.

We have started to uncover a rich picture of emotional context. People are frustrated and anxious. Discussions expose frustration with the way the government runs the health service. They seem to be losing faith in the National Health Service. They

point at various problems: loss of control on the ground, services massaging their targets, discussion about the future, and so on. All these things clearly point towards issues of leadership and management. The current strategy is overly driven from the top down. A lack of quality in empathic leadership perhaps represents one of the major obstacles in our principal-agent problem. It would be true to say that too much centralised control stifles creativity.

A general point about the usefulness of this kind of methodology (and the Socratic Method) can also be illustrated. The emotional context of the story is sensed, and is difficult to map into the question boxes. The story approach offers the opportunity to capture this emotional context. People seem to be afraid of saying things that really do matter out loud. A veil of secrecy around how service managers massage their targets has been lifted; this was a shocking revelation to the researcher, a user of the National Health Service. The Royal College of Nursing highlights clinical staff critiques of 'management bureaucracy, unrealistic expectations, of a quick-fix attitude, a culture of rushing, of managers who were target driven and who pay lip service to dignity in care, who often had other priorities' (Royal College of Nursing, 2008, p.6).

We can learn a great deal from these stories about why the current strategy is not successful. The stories allow us to uncover serious flaws behind the targets. They tell us something that we should have known as users of services, but that we did not know. They reinforce the need for a more bottom-up orientation, and also reinforce the use of this research's story-telling, multi narrative approach for the effectiveness of a bottom-up strategy. This further supports the need to building this possibility into a bottom-up approach. This line of reasoning very much resembles the findings from the Darzi Review (National Health Service London, 2007). They reinforce the importance of introducing the Hawthorne effect (Mayo, 1949) in the National Health Service to induce CARE. The Hawthorne Effect is described as a situation which arose because people were 'singled' out for special treatment, or a 'special situation' was created where workers could feel free to air their problems. We illustrate the

importance of the Hawthorne effect below.

The company in question, the Hawthorne Plant of Western Electric in Chicago, decided to conduct a research study with the National Research Council into the relationship between work-place lighting and individual efficiency. The company began the study in 1924 by isolating two groups of workers in order to experiment with the impact of various incentives on their productivity. Both groups showed an increase in productivity, and output went up. Mayo (1949) searched for the reasons underlying these findings, and concluded that managers believed that industrial problems can be solved with technical efficiency. In contrast with these perceptions, however, Mayo also recognised that industrial problems were caused by to human and social factors. He argued that strict, formal rules and procedures generate informal approaches (human emotions, sentiments, problems and interactions), and that management should strive to create an equilibrium between these two approaches to work practice. Management should develop diagnostic and interpersonal skills such as counselling, motivation, leading and communicating.

In this sense, the above approach is of relevance to the National Health Service.

Conclusions

This chapter has further extended the Adapted Grand Narrative to include complex issues beyond the original framework. It may assist the reader if we summarise and reflect upon the issues that have emerged so far in this chapter. We go on to discuss the broader implications and some particular issues surrounding the principal-agent problem.

- a. The focus is on extending the analysis to consider the whole National Health Service, and providing an in-depth insight into the principal-agent problem
- b. Emotional issues are important. We provide evidence of this.

We introduce the evidence for thinking about the Adapted Grand Narrative in the context of the principal-agent problem. Again, we are calling upon our participants to construct the narrative themselves. From panel discussion 1, the emotional context started to emerge, in the sense of disillusionment and frustration on the part of participants. This gave us the opportunity to draw a distinct boundary line between quantitative and emotional aspects. The current management style (reflected by a top-down approach) is perceived to be too focused on creating a business leadership style, with the consequence of promoting secrecy and competitive behaviour rather than being CARE-oriented (with associated attitudes of sensitivity, compassion and empathy). Stories make these aspects explicit. They reinforce the need for a more bottom-up approach to managing services. We suggest that the use of the researcher's storytelling approach to make a bottom-up strategy effective would make sense. Such an approach allows us to elicit the emotional context that is otherwise difficult to see (Chapters 5 and 6).

From panel discussion 2, evidence also emerged about the current strategy being overly driven from the top down, and about a lack of quality leadership. This suggests that the government should focus on finding a way to stimulate empathic leadership. This again reinforces the argument for a bottom-up approach, where more consultation of people lower down the management hierarchy, and more flexibility to set their own targets, could be built into appraisals to a greater extent. In this sense, this story supports the idea that a bottom-up approach is essential to the survival of the National Health Service. There will always be a conflict between a top-down approach – the rationing policy – and those who implement it at the bottom level; this conflict includes taxpayers, whose expectations are grounded in strong moral and ethical principles.

It seems that the government walks a fine line in trying to balance these two scales. It faces a dilemma. We shall discuss this dilemma in the next and final chapter, the conclusion.

8. CONCLUSIONS AND RECOMMENDATIONS

Introduction

The concluding chapter is divided into three sections. Section 1 addresses the aims of the thesis, as set out in the introductory chapter (p.29) and the methodology chapter (p.117–121), and provides the set of recommendations and main findings as set out in Chapters 5 to 7.

Section 2 assesses the contribution of the thesis from both the academic and the practical perspective. It should be noted that these perspectives are not separate, but are interconnected. As Maynard Keynes (1936) pointed out, the connection is closer than is commonly imagined:

[T]he ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men, who believe themselves to be quite exempt from intellectual influences, are mainly the slaves of some defunct economist. Madmen in authority, who hear voices in the air, are distilling their frenzy from some academic scribbler of a few years back. (Keynes, 1936, p.383)

There can be no doubt that National Health Service policy, particularly the Value for Money strategy that is the subject matter of this thesis, has been profoundly influenced by contemporary economic and political thought. Taken together, both have profound implications for policy.

Section 3 presents an assessment of the thesis through a Socratic Dialogue between the researcher and an academic. The purpose of this section is to complete the phenomenological and deconstructive approach in the thesis by explicitly and reflectively examining the role of these participants in the research process. We complete this process with a postscript (p.254).

Findings in Relation to the Aims of the Thesis

We remind the reader that the general aims of the thesis, as set out in the introductory and methodology chapters, were to examine the ambiguities and complexities of obtaining Value for Money and to consider ways of obtaining it in the National Health Service. During the last fifty years, a trio of complementary strategies have been observed:

1. The introduction of internal markets
2. Extending public choice
3. Value for Money

The first two policies are concerned with introducing competition into the National Health Service by splitting the roles of purchasers and providers, and in doing so setting up an internal market. The movement towards internal pricing has been gradual, and allocation has been mainly through capital rationing in line with targets set by the Department of Health, filtered through the Strategic Health Authorities to the Primary Care Trusts, and finally passed on to the providers of health (hospitals, general practitioners and increasingly the business sector).

Successive governments have sought to increase the competitive element and the role of (internal) markets by increasing patient choice as to his or her provider, and by allowing Primary Care Trusts the discretion to choose between providers and to include business and voluntary services in their menu of choice.

Internal markets and choice as described in the previous paragraph operate on both the demand and supply side. The management teams of failing institutions in the health sector, i.e. those offering poor value in terms of cost or meeting targets, can and have been rejected by Department of Health appointees (e.g. the Healthcare Commission). Similarly, patient and purchaser choice is designed to increase the pressure of demands for efficiency. The Value for Money strategy is concerned with the supply side – the cost efficiency and effectiveness with which targets are met,

with efficiency relating mainly to unit cost and effectiveness relating to the standard at which targets are met.

Since Value for Money is concerned with value as well as cost, it also operates on the demand side. Referring to the quotation from Keynes (1936) above, we can, therefore, argue that “economists and political philosophers ... are powerful” (Keynes, 1936, p.383) in the design of National Health Service policy, since much of the foregoing summary could easily be found in the microeconomics section of an undergraduate economics text.

We should not neglect the influence of political philosophy. Health service provision is a critical element in winning or losing elections. There is also an economic aspect, as illustrated below:

Substantial challenges remain for health and social care services. Public expectations rightly continue to rise. People want care that is closer to home and tailored to their specific needs. Individuals need to be supported to take control of their own care, while services need to be provided where and when they are most convenient. In the long term, increasing life expectancy and lifestyle changes pose additional challenges. Future technological developments need to be grasped to further improve the quality of life people are able to enjoy. (Great Britain. Her Majesty's Treasury, 2007, p.205)

Ambiguity and Complexity

The problem with the value element of Value for Money, as the thesis has frequently pointed out, is that it includes monetary as well as non-monetary elements. Therefore, the policy maker in health has to deal with two problems:

- (a) The first is that of translating ‘health’ outcomes, costs and benefits that can be measured in monetary terms, into quantities or numbers
- (b) The second is the problem of dealing with non-monetary, qualitative outcomes that are difficult and perhaps impossible to measure. We have labelled these outcomes (e.g. compassion, empathy, sympathy) under the heading of CARE

The second set of issues is at least as important in the perception of the health service as the first. As the thesis has pointed out, these two issues are at the same time contradictory and complementary. Referring to the general aims of the thesis as set out in the opening paragraph, the “ambiguities and complexities of obtaining Value for Money” have many dimensions, many of which have been discussed above.

In summary, at this point these complexities include indentifying qualities, some of which may be non-monetary and difficult to define. Once they have been identified, there is pressure to transform them into comprehensive targets that reflect the top-down approach to delivering the strategy. There is also an issue of coping with the ever-present problem that the issues do not concern objects, or even services in themselves, but the perceptions of objects, such as hospitals and equipment, and services, such as the quality of CARE. Even when those objects and services are somehow measurable, perceptions about their quality may differ widely.

As the literature in Chapters 2 and 3 pointed out, classical economists and social theorists were aware of these issues. Fisher (1906, p.169) defines “physic income ... [as] ... the stream of consciousness of any human being. All his conscious life, from his birth to his death, constitutes his subjective income. Sensations, thoughts, feelings, volitions, and all psychical events, in fact, are a part of this income stream.” Fisher also believed that such psychic issues were “not directly measurable” (Fisher, 1930, p.7). In his terms, we see the National Health Service as providing ‘physic income’ from its capital, which provides a stock of services of CARE to the community, but we cannot assess the value of this CARE simply, either in terms of money or utility.

Perceptions also differ. However,, at the same time, society believes that the political system has responsibility for providing these services and, in spite of the conceptual difficulties of doing so, government has to justify the effectiveness and efficiency of its provision in terms of Value for (taxpayers’) Money. So there will never be a complete consensus as to how well Value for Money is achieved.

Other classical economists approached the problem through the concept of utility, via subjective utility theory, expected utility and the economies of welfare; some aspects of this work have evolved over time into decision theory. Marshall (1920), as noted earlier, deals with the fact that perceptions differ by assuming that everyone has the same capacity for enjoyment, and proposing that, on the whole, a more equal distribution of income is preferable to a less equal distribution (because the extra utility of an additional pound to a poor man or woman is greater than the extra utility of the same pound to a rich man).

Modern policy makers in the National Health Service have to contend with these complexities, but they have not followed the route suggested by the classical economists. On the one hand, they have favoured equality of opportunity rather than equality of income, hence the introduction of internal markets and choices into the National Health Service over the last thirty years. On the other hand, they have increasingly pursued Value for Money on the pragmatic grounds that this strategy allow the service to:

- (i) get more out of a given set of National Health Service resources
- (ii) get the same service out of fewer resources
- (iii) get resources in priority areas

In theory, the particular service to which resources are allocated is capable of making everyone better off. However, they still face the following dilemmas:

- a) Perceptions differ, and it is unlikely that everyone will agree that a policy or strategy has been successfully implemented, for example
- b) Perceptions are subject to emotions and moods, and are influenced not only by the experience of policy in one area but also by experience in a different area

These observations are related to the methodological approach used in the thesis. The approach is a thorough deconstruction, and a constant questioning of methods and

data. It has been emphasised that deconstruction is not a technique: “deconstruction is neither analysis nor a critique ... [it] is not a method ... the difficulty [with] all the defining concepts ... [are] also deconstructed” (Derrida, 1983, p.40). The problems facing the health service are at the same time urgent and intractable. Solutions must be sought, but there are no optimal solutions. Any policy can be deconstructed to show that in some respects it is not optimal. Therefore, we needed an approach like deconstruction, which is open to this contradiction. Since what matters is perception, a phenomenological approach is appropriate. The conceptual problem exists, but there is a parallel practical problem. We also have an example of this aspect of the National Health Service, using Keynes’s conception of a practical world ruled by ideas.

Getting Better Value for Money

As noted above, one of the methods of approaching the problem of health provision is through obtaining Value for Money. Table 8.1 (next page), reproduced from Chapter 1, shows how the Grand Narrative of Value for Money can be transferred into the Net Present Value framework.

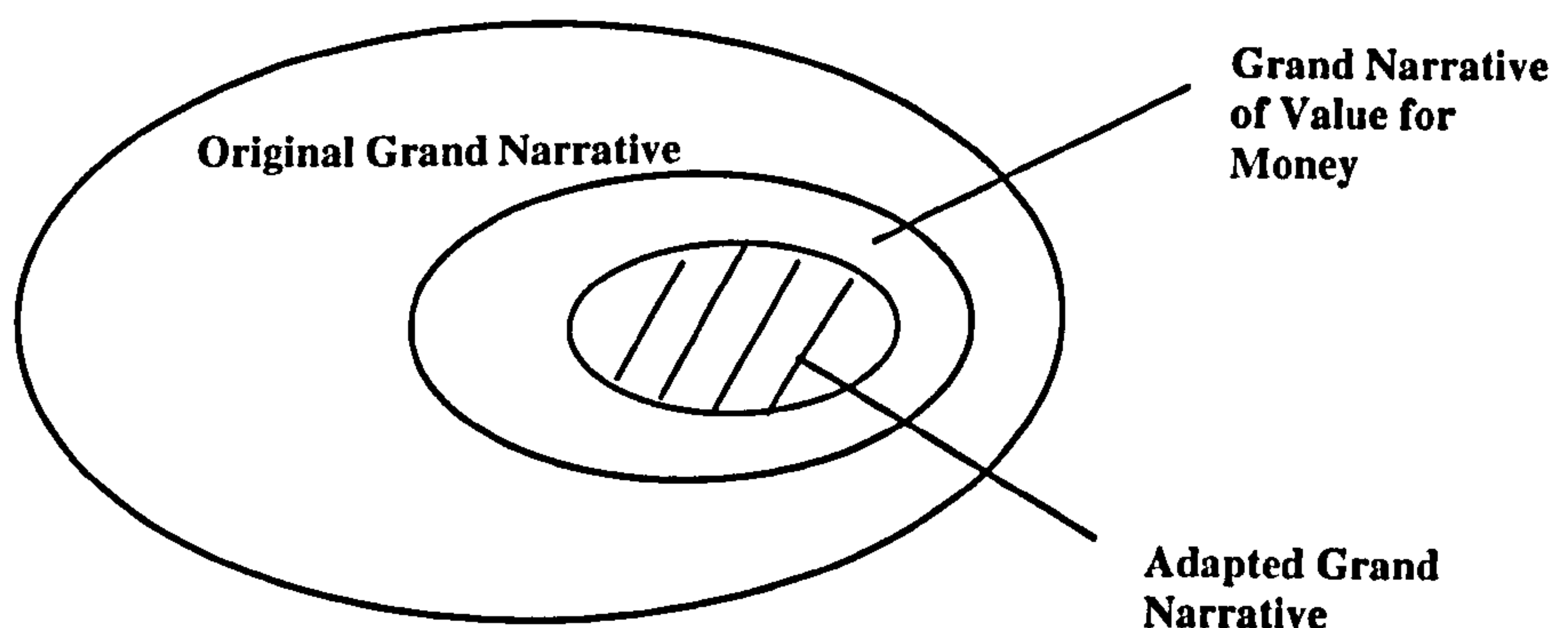
Table 8.1 Transferring the Grand Narratives, Archetype and Deconstruction into the Net Present Value framework

GRAND NARRATIVES AND ARCHETYPES	
FRANCOIS LYOTARD (1979, 1984) GRAND NARRATIVE (OGN)	Grand Narratives are defined as: - implying a philosophy of history of progress through scientific method.....used to legitimate knowledge (1979, p.24) - an “Enlightenment narrative” defined as “a possible unanimity between rational minds” (1979, p.23) - “the hero of knowledge [who] works toward a good ethical-political end – universal peace” (1979, p.24); a progress towards Socialism (the Marxist Grand Narrative) - globalisation; progress and growth through competitive markets, the pursuit of efficiency, with human beings treated as resources (1984, p.37); the Grand Narrative of capitalism
GRAND NARRATIVE OF VALUE FOR MONEY (GNVFM)	Investment decisions and efficiency measured in terms of Net Present Value and the categories of Net Present Value: rational choice; expected benefits and costs; the cost of capital; risk and attitudes to risk. Value for Money is a representation of Net Present Value in the National Health Service
ADAPTATION OF GRAND NARRATIVE OF VALUE FOR MONEY IN THIS THESIS (AGN)	If perception of the Net Present Value/Value for Money categories vary between implementers and designers of strategy, then outcomes may differ from the original intent
DECONSTRUCTION	
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (1)	Examination of the categories of the Adapted Grand Narrative in the context of an investment in training project. Extension of the study into National Health Service networks in addition to hierarchies.
DECONSTRUCTION OF ADAPTED GRAND NARRATIVE OF VALUE FOR MONEY (2) MULTI NARRATIVES	Examination of patterns excluded by the Adapted Grand Narrative: 1. Networks 2. Pure qualities 2. Dimensions of CARE omitted in Original Grand Narrative (and Grand Narrative of Value for Money, for example; compassion, empathy, sympathy. Incorporating new dimensions into the study in addition to the Adapted Grand Narrative; little narratives, local narratives, vignettes. The terminology used for such narratives in the thesis is multi narratives; they are less coherent, more diverse and more chaotic than Grand Narratives. Illustrative stories effect the transition from Adapted Grand Narrative to Multi Narratives
DECONSTRUCTION AND SOCRATIC DIALOGUES	
PANEL DATA 1	Re-examining and reflecting upon preliminary observations; building upon multi narratives.
PANEL DATA 2	Amplifying, reflecting and showing dimensions of CARE
DECONSTRUCTION OF THE PROCESS PANEL DATA 3 and 4	The role of the researcher in the research process, completing the dialogue. At each stage, described in the rows above, we gradually include what has been excluded in previous stages.

Value for Money can be seen as a subset of the Grand Narrative in the sense of Lyotard;s (1979, 1984) Grand Narrative, as one path to progress through efficiency while science, technology and competition provide complementary paths. Value for Money is also seen in the thesis as a representation of the Net Present Value archetype, which provides a set of categories under which the Grand Narrative of Value for Money can be deconstructed.

The relationship between these three grand narratives in the table is illustrated simplistically in the figure 8.1 (below).

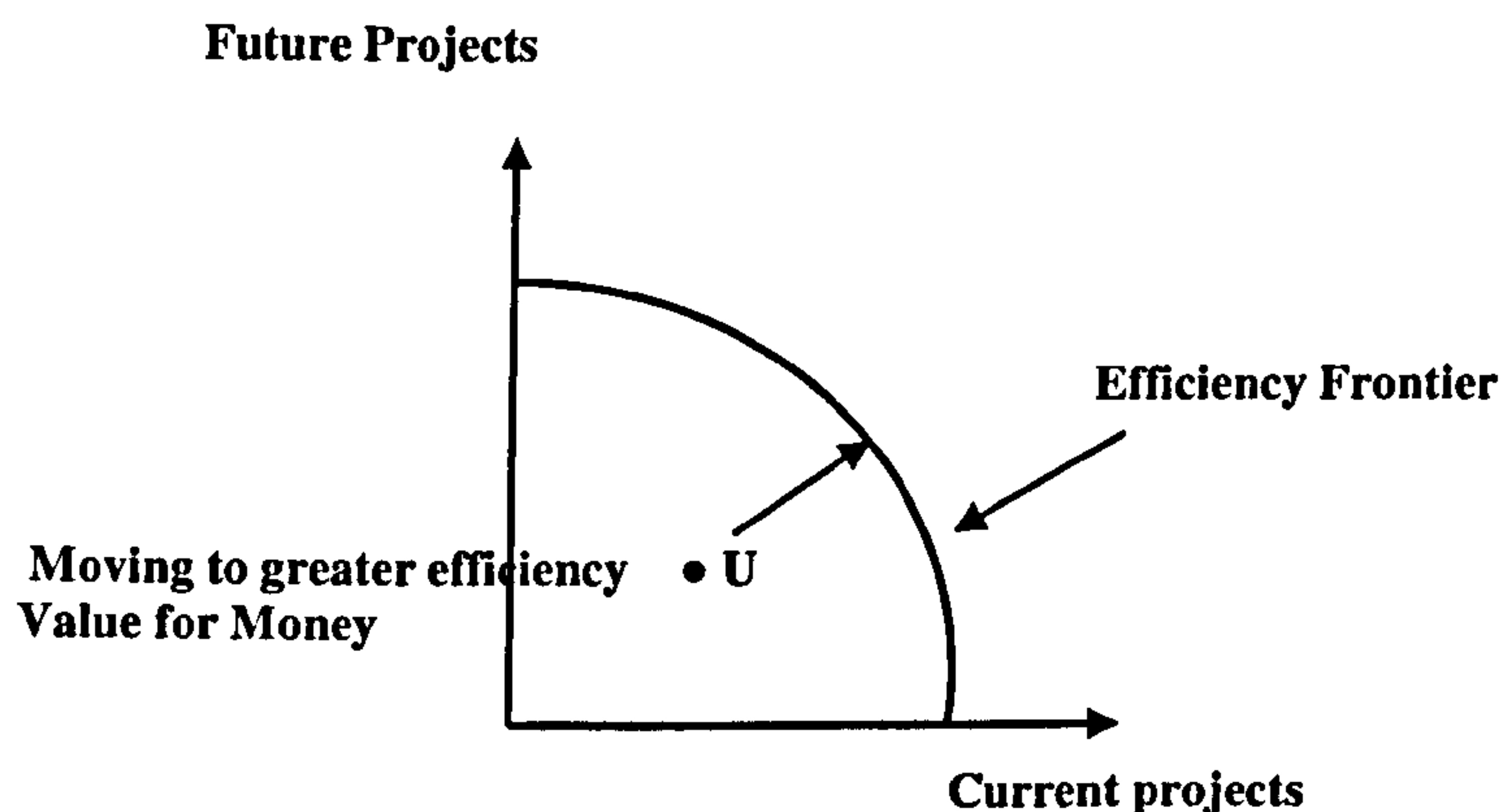
Figure 8.1 From Original Grand Narrative to Grand Narrative of Value for Money to Adapted Grand Narrative



The Grand Narrative of Value for Money is a subset of Lyotard's (1979, 1984) Grand Narrative, and in turn, the Adapted Grand Narrative adopted in the thesis is a subset of the Grand Narrative of Value for Money.

The process of getting better Value for Money can also be illustrated with an amended view of Fisher's (1930) Efficiency Frontier, illustrated in Figure 8.2 (next page) .

Figure 8.2 Grand Narrative of Value for Money as adapted from Fisher (1930)



The issue becomes one of moving toward the efficiency frontier. However, as we pointed out in the literature review, according to Georgesu-Roegen (1971) the efficiency frontier is likely to be an indeterminate band rather than a line, since it will always be possible to squeeze some more efficiency savings and Value for Money out of a system.

The problem with the diagram is that the stakeholder analysis means that the vector of other activities is very complex and indeterminate. It excludes the more emotional elements, which have emerged as an important element in this research. Decisions involve an emotional aspect that is invisible in strategy but is an implicit part of it.

The emphasis on targets and a top-down approach is in danger of being counterproductive; people are scared of giving weight to the kinds of emotional aspects needed in health services, and this needs to be rectified. Bearing in mind that decisions are negotiated through networks of relationships, decision makers must make certain trade-offs, and act according to their own pay-off function. Again, we are back to the need for a bottom-up approach (a recommendation that emerges from the findings in Chapters 5 to 7).

Findings of the Thesis in Relation to Chapters 5–7

The starting point of the analysis was the Grand Narrative of Value for Money. Viewing strategy as a process of search, choice, implementation and adaptation, the initial question was whether those implementing the strategy actually shared the same perceptions of key strategic variations as those designing the strategy. Our account of the Grand Narrative of Value for Money focused on the transition between two stages of the strategic process:

- a) search for the right strategy (in this thesis, search for efficiency or Value for Money); and
- b) choice and implementation of the strategy

The former (a) is decided by the top managers, and the latter (b) is decided by implementers at a lower level of the decision making hierarchy. However, there is an inevitable complication. As we point out in earlier chapters (Chapter 6, for example), we should view decision making in any complex or networked organisation as a parallel process (p.200). Strategy as defined at any one time consists of a collection of decisions made a by large number of individuals. To some extent these decisions are coordinated, but in other aspects they are chaotic, made in a complex web of networks of relationships.

As a result of taking these issues into consideration, the findings from Chapters 5 to 7 represent an extension of the Grand Narrative of Value for Money in the National Health Service, forming the Adapted Grand Narrative.

As we showed in the first empirical chapter (Chapter 5), the Grand Narrative of Value for Money, especially as it was applied to the first stage of the empirical work, provides a useful framework. Value for Money inevitably involves a consideration of the various elements governing individual investment choices in general, such as: the expected stream of revenues and costs from projects; the timing of expected revenues and costs – both short- and long-term considerations; the appropriate rate at which

they should be discounted; and the risks involved. Capital rationing is a key component, but it has the consequence that too little choice is available to the bottom level decisions makers. In spite of all the targets, implementers seem to be very vague and uncertain about exactly what education and training is supposed to achieve.

A further set of findings emerged from Chapter 6. The government has so far been efficient in implementing a top-down strategy. However, we learned that top-level decision makers can map their views of the National Health Service into targets only in an approximate fashion. Their motivation is purely strategic, insofar as meeting those targets reflects the success of a particular policy. Those people implementing the decisions (*face workers*) face specific situations rather than the very general situation viewed by top-level decision makers. *Face workers* have to map these top-level targets into the specific variables that they face in their own particular jobs. They might also have different day-to-day motives than those setting the top-down targets. These differences illustrate a dilemma associated especially with obtaining Value for Money.

Many measurable qualitative variables are involved, so that it is impossible to map decisions precisely into Fisher's (1930) efficiency frontier. Targets may be met, but only at the expense of quality of service as perceived by the client, which results in new set of trade-offs. Perhaps the situation was dealt with insensitively. Perhaps it was unavoidable that the client should feel the service was flawed – lacking effectiveness or sympathy, for example. This dilemma results from the nature of the demand for the National Health Service.

Further, the very notion of Value for Money cannot capture all the variables in the National Health Service. The variables we refer to may be classified in general terms as CARE, including compassion, empathy, and sympathy for others. To further complicate the situation, however, these variables are possibly experienced very differently by the participants or stakeholders in a particular situation, and this lead

us to examine this aspect further in Chapter 7.

In Chapter 7, we arrived at some interesting insights about Value for Money and CARE. Government is, to a large extent, afraid of losing centralised top-down control. Given the complexity of the National Health Service it is necessary to have such control, but, as the findings indicate, this has come at the cost and expense of CARE. The practical nursing level of providing CARE is disappearing. Nursing is not what it used to be – caring, compassionate and empathic. Too much target-driven control, concerned with introducing incentives and rewards based on educational qualifications, has caused more damage than it has added value. Leaders are not nurtured but suppressed. The need for leadership that feels compassion, empathy or sensitivity is not seen as a priority. Instead, the National Health Service management has adopted the habit of thinking in terms of tough business management. *Face workers* consider that empathy and compassion play an important part in their decision making processes, but they are afraid to speak up about these problems. Somehow, we need to reconcile these two aspects of strategy, indicating the need for a bottom–up approach.

The deconstruction of the multi narratives and stories in Chapters 5 to 7 points to a set of recommendations:

- a) A greater emphasis on the case
- b) Slack exists in the system, recorded by general agreement with the Value for Money strategy, but the emphasis is placed more heavily on this policy than it should be
- c) The way to achieve more CARE in the system is to pursue strategy setting in a more traditional manner, in terms of transferring from a top-down to a more bottom–up approach

Evolution of the General Aims

The aims should be seen from an evolutionary point of view. They evolve as the result of the development of the research process. Deconstruction is a key approach in the thesis. It suggests moving from the Grand Narrative, to multi narratives, and then to storytelling, in a sequence of four empirical stages:

- Stage I Deconstruction of the Grand Narrative of Value for Money
- Stage II Multi narratives
- Stage III Panel Data
- Stage IV Socratic Method

The research begins with an examination of the Grand Narrative of Value for Money in the context of a training and education project, 'Team Leadership Effectiveness' (see Appendix 2), initiated by the commissioner of the study (London Development Centre for Mental Health). Clearly this represents an academic perspective, and generally speaking, an attempt to address the specific principal-agent problem in the National Health Service. Also, as the study was commissioned to provide a report, this is a practical aim for the Doctorate of Business Administration.

Then a richer picture of the implementers of the strategy emerged in the form of multi narratives. We looked at the variety of responses, rather than trying to squeeze everything into a Grand Narrative. We looked at the issues involved with obtaining Value for Money, and we looked at the process of making choices and the allocation of funds between projects. Chapter 5 focuses on the categories of the Adapted Grand Narrative, and Chapter 6 extends the discussion of the Adapted Grand Narrative to multi narratives.

We also considered three extensions:

- a) Networks need to be taken into account. Broader groups of individuals are included, and trade-offs among these groups are examined.
- b) We need to consider the quality of the outcomes, rather than measuring

them in terms of unit productivity.

- c) Issues of compassion, empathy and CARE also needed to be introduced.

Therefore, we developed a panel data approach using in-depth, open-ended interviews. The purpose was to test the above-mentioned complex issues that we found we were not able to examine in multi narratives. We constructed three different panels with carefully chosen members and experts (p.135). A member of one of the panels of experts was involved in the original commissioning of the project.

Panel 1 was introductory, and was designed to test the approach. The findings related to the Adapted Grand Narrative were re-confirmed. A preliminary discussion about the complexities and ambiguities of obtaining Value for Money started to emerge. It was felt afterwards that this was an exploratory panel interview, requiring further development.

Therefore we introduced panel 2. We extend the discussion of the Adapted Grand Narrative to explore the complexities and ambiguities of obtaining Value for Money, and develop a critique of the current top-down target driven approach to strategy in the National Health Service from the experts' viewpoints. We introduced the dimensions of CARE (empathy, compassion and sympathy) using novelist Hilary Mantel's (2008) story to get panel reactions and elicit emotions. Then we linked the importance of CARE to the overall strategy; that is, balancing the hard and soft sides of the elements of the strategy. This is reported in Chapter 6 (p.200–201) and followed up in Chapter 7 (p.221–223).

Finally we constructed the last interview (employing the Socratic Method) using panel 3, comprised of an academic supervisor and the researcher herself. Here we can we point to two important issues:

1. Recognition of the fact that the researcher has a critical role in determining and shaping the research process. This needs to be made

transparent.

2. The researcher here comes at the problem from a particular perspective – sense making. First, the researcher views herself as both a client and a researcher, and this introduced the focus on CARE and compassion. Second, the researcher has a hearing sensitivity, which means that she has a distinctive listening style. These considerations were discussed in the final Socratic dialogue at the end of this chapter.

In concluding, Stages I and II, although fundamental to the thesis and to the Adapted Grand Narrative that emerges from the literature review, were stimulated by the practical considerations of providing feedback to managers of the training project. As the reader will also see, the results of the Value for Money investigation in Stages I and II were reported back for preliminary feedback and to get the respondents' own views of CARE and compassion, which were followed up in Stages III and IV.

The results of Stages I and II (and to some extent also of the later stages) can conveniently be summarised in Figure 8.3 (below).

Figure 8.3 Dilemma of obtaining Value for Money

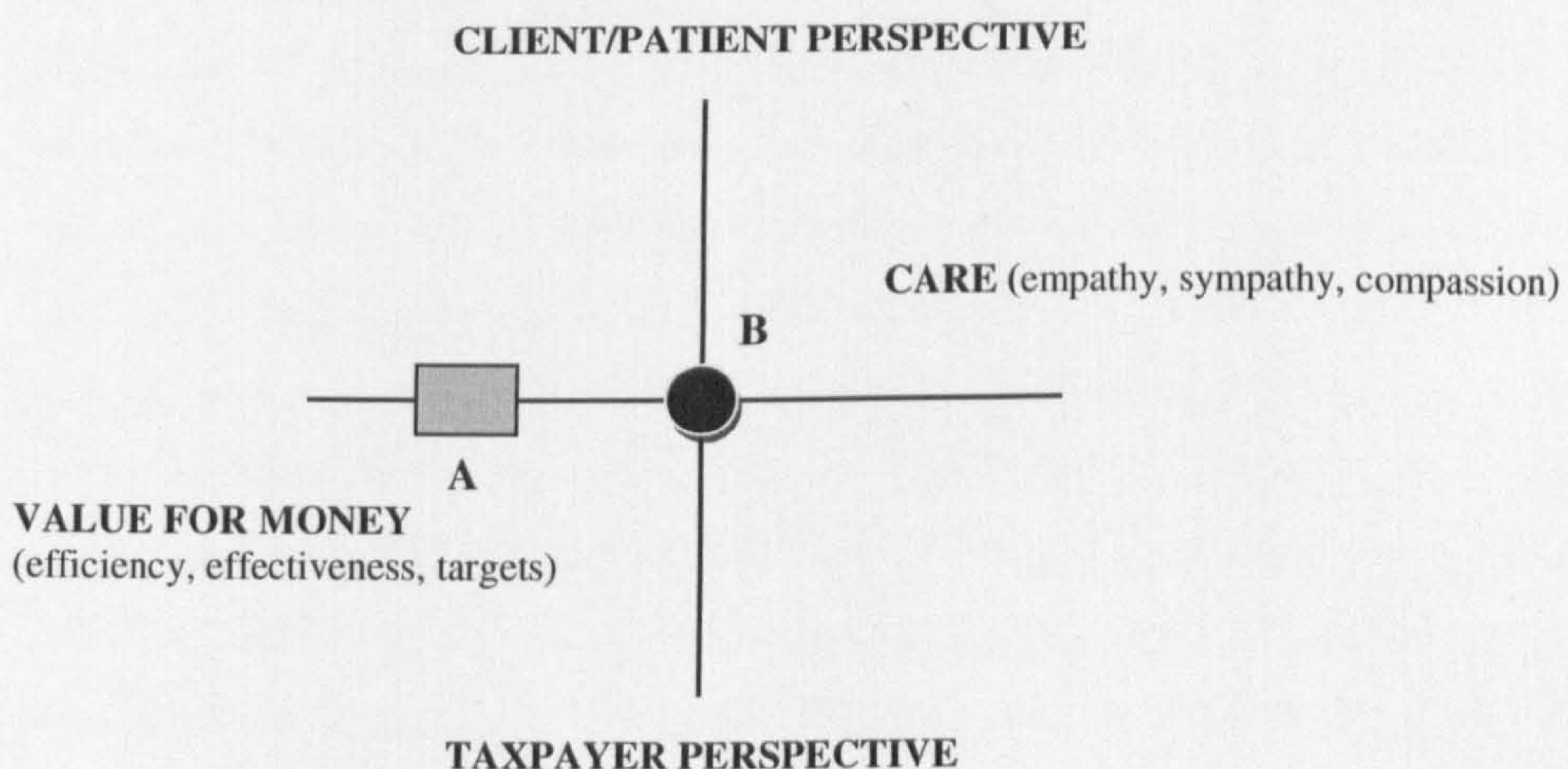


Figure 8.3 as it is presented earlier is a simplification, following from the empirical analysis in Chapters 5 to 7. It would be useful to explain to the reader the assumptions behind the diagram. The diagram has two axes. The vertical axis represents the possible trade-offs between the client and the taxpayer. The client/patient presumably wants excellent service, and may have limitless demands for this kind of service. The taxpayer presumably wants to minimise, or at least optimise, tax payments without compromising the quality of CARE. The horizontal axis represents rational and emotional trade-offs between Value for Money (efficiency, effectiveness, economy and the Net Present Value rule) and empathy, CARE and compassion. As we move from left to right on the horizontal axis, Value for Money is sacrificed in favour of CARE. As we move down the horizontal axis the patient/client interest is sacrificed in favour of the interests of the taxpayer, who we presume is interested in a lower tax bill.

The two ends of each spectrum compete only to a certain extent. All decision making has both a rational (or intellectual) perspective as well as an emotional perspective. However, these two perspectives do compete with each other, at least to some extent. A rational decision maker adopts the Value for Money perspective, while an emotional decision maker is more likely to adopt a feeling attitude, focusing on aspects such as empathy, compassion or sympathy. It is quite likely that any individual will focus on one or other perspective at some time in his or her life, and in the case of some decisions. The same person at different times (or even at the same time) is likely to be both a client and a taxpayer. Similarly, most individuals are both clients of the National Health Service – users of the service at some point in their life – and taxpayers. As a taxpayer, the focus is likely to be on Value for Money. As a patient or client, the emphasis is likely to be more on the quality of health services. This is reported in Chapter 7 (p.206–209). It might not be altogether misleading to say that in some circumstances – where, for example, life is threatened – the demand for the service is infinite. In reality, capital rationing is a way of putting a brake on this infinite demand. This is reported in Chapter 6 (p.175).

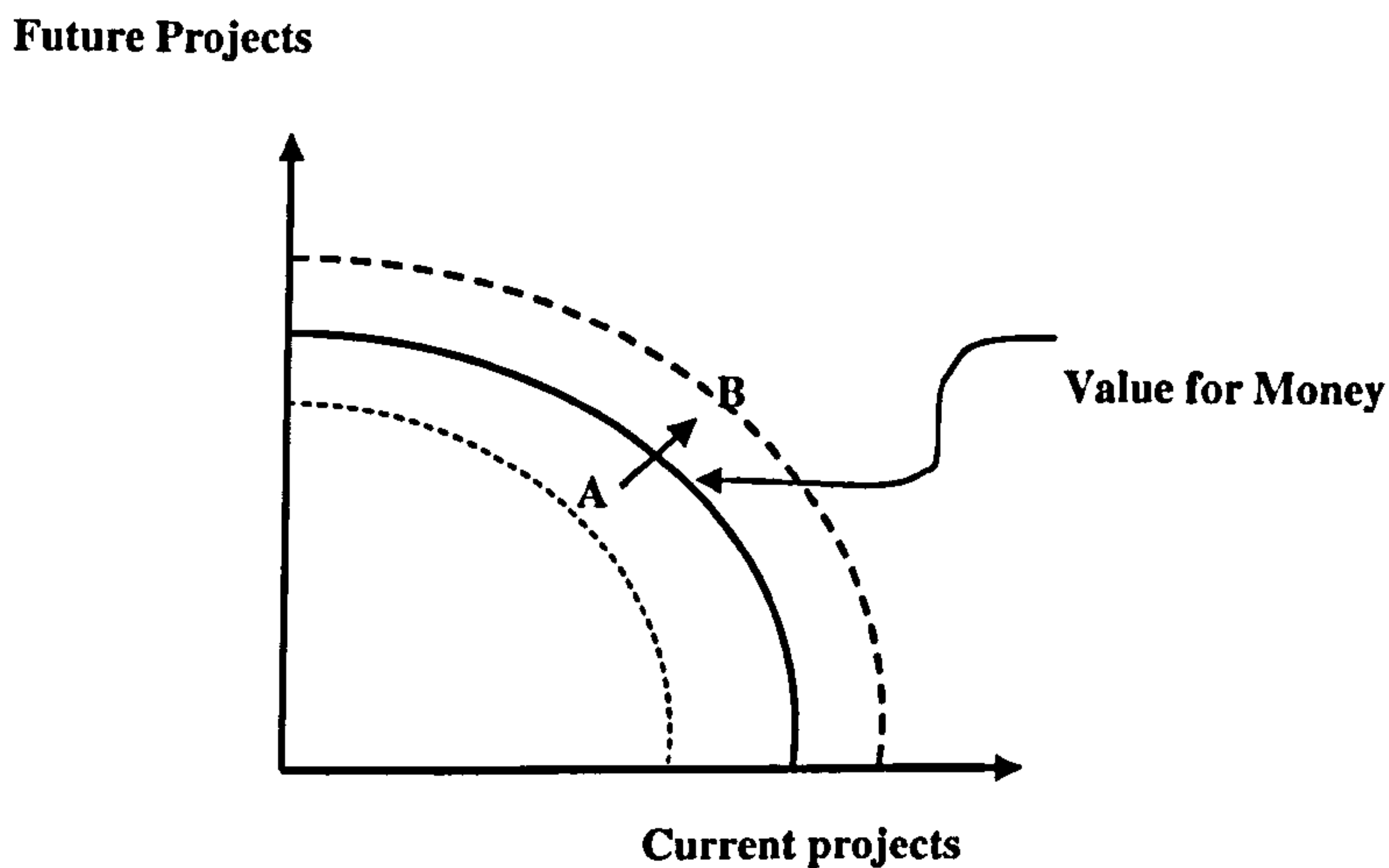
No doubt the government concern with Value for Money also includes a consideration of CARE. Results seem to show that recent policy has achieved Value for Money to a great extent, but the level of disquiet among the panel participants (and also expressed in the press) indicates that the situation is now at point A in Figure 8.3 (p.238). A balance needs to be achieved between Value for Money and CARE, represented by point B in Figure 8.3 (p.238).

Anticipating our conclusions, we argue that it is precisely this ‘feel for the situation’, or culture of CARE (compassion, empathy and sympathy toward patients), that needs to be encouraged in the National Health Service, alongside the inevitable targets associated with Value for Money. This balance, we argue, can only be achieved by adopting a bottom-up approach to management. Some ideas for what this inevitable generalisation and bottom-up approach might mean in practice are:

- a) achieving control and promoting targets; and
- b) compassion should be seen explicitly as a complex trade-off

In this sense, the Value for Money strategy would involve choices in terms of quality of CARE (compassion, empathy and sympathy) and quality of leadership. It could make members of both groups better off than they were before (De Scitovszky, 1941). The diagram in Figure 8.3 (p.238) also extends Figure 8.2 (p.232) of Fisher’s Efficiency Frontier to encompass broader issues. This is illustrated in Figure 8.4 (next page).

Figure 8.4 Moving the Efficiency Frontier to include issues of CARE



Earlier in the thesis (p.53) we mentioned and emphasised the great importance Georgescu-Roegen (1971) and Fisher (1930) placed on psychic factors such as enjoyment and satisfaction. In the specific situation discussed in the thesis, the efficiency frontier should include issues of CARE, compassion and empathy – in general, it should include the emotional context. One can invest in both, at points A and B in Figure 8.3 (p.238), but this requires a reliance on goodwill because sometimes CARE and Value for Money are complementary. The study examines these key results of the research in terms of the Adapted Grand Narrative and in terms of storytelling, suggesting a number of recommendations:

- (i) The need for policy makers to take a bottom-up approach to strategy
- (ii) As part of this bottom-up approach, the need to set targets through a process of consultation, both with those delivering the service and with those receiving the services
- (iii) Again as part of this bottom-up approach, the need to find a way of incorporating the emotional aspects of decisions and implementation within the National Health Service into the strategic process
- (iv) This may involve the adoption of the storytelling approach outlined in this thesis

Contribution

We can divide the contribution of the thesis into two areas. This section should also be seen in relation to the recommendations listed below.

- i. Academic contribution
- ii. Practical contribution

The requirements for obtaining a Doctorate of Business Administration (DBA) are that the research must be traditionally (academically) sound, but it also has to have practical contributions:

The distinctive characteristic of the DBA, as a professional doctorate, is that holders of the qualification have demonstrated their ability to make an original contribution to the way in which theory is applied, or to the nature of practice within professional or business and management contexts. (Regulations for the Award of Doctor of Business Administration, 2004, pp.16)

For convenience purposes, we separate the academic contribution from the practical, but we should bear in mind the quotation from Keynes (1936) at the beginning of this chapter, in which he points out the intimate relationship between theory and practice. The models and concepts used in the thesis have developed in an evolutionary way, but at every stage they have been influenced by the literature. The Adapted Grand Narrative was influenced by the literature surveyed in Chapters 2 and 3; later, in the evolution of the research process, ideas associated with deconstruction were very influential.

The search for a better understanding of decision making also continues in the twenty-first century (p.58). This thesis contributes to a better understanding of the role of behavioural factors, emotions and the complexities of decision making in the public sector, especially healthcare.

i. Academic Contribution

The academic contribution of the research can be demonstrated in two ways:

- (i) The thesis extends the academic literature into the practical domain of achieving better Value for Money in the National Health Service
- (ii) It represents a new application of existing theory. The theoretical constructs in the Adapted Grand Narrative draw on the extensive literature in a novel way, to investigate obtaining Value for Money in the National Health Service

In relation to i), emphasis is placed on the complexities of achieving Value for Money in the National Health Service, especially with respect to its hierarchical structure, as well as its formal and informal networks of relationships. Special attention is paid to trade-offs, setting priorities and the separation of strategic decision making and implementation in the National Health Service.

Thus, principal-agent theory is applied in a novel and complex setting, i.e. the National Health Service. In an era where corporate governance and attention to the stakeholder is becoming of increasing relevance in the business (especially the financial) sector, the findings in this thesis, although they relate specifically to the National Health Service, might equally well be applied fruitfully in the business sector. The root of the principal-agent problem is in fact contained in the Adapted Grand Narrative of this thesis. In other words, the Adapted Grand Narrative restates the principal-agent problem in a more general form, thus making a further contribution to the theoretical understanding of the application of the theory to practice.

In relation to ii) we have made two statements frequently throughout the thesis:

- (i) The research process has been evolutionary; and
- (ii) Some of the concepts critical to the thesis can be shown, but not precisely defined (deconstruction, Différance, CARE)

We began by deconstructing the Adapted Grand Narrative empirically into a series of categories (i.e. cost, benefit, discount rate, and risk). As a result of this deconstruction it was realised that the Adapted Grand Narrative was an insufficient framework for understanding the Value for Money strategy in the National Health Service. The aspect of CARE was always present, as indicated by the multi narratives which we began to include, by the stories (stories 1 to 6) which were recounted in the thesis, and by the panel data which was used as a reflective device. This evolutionary process in fact represents deconstruction in action. It demonstrates what is meant by deconstruction.

Further, the deconstruction revealed the difficult notion of Différance and applied it in a novel setting. Thus, we might make a modest claim to have clarified the complex relationship between deconstruction and Différance and then later to have incorporated the notion of Socratic Dialogue.

ii. Practical Contribution

Here we should restate our conviction that the academic and the practical contributions cannot in fact be clearly separated, but that the nature of the Doctorate of Business Administration thesis might require that we attempt to do so. However, this is part of a reflective process, and a doctoral thesis should contain:

- a) A set of distinctive outcomes
- b) A novel application to practice
- c) A set of recommendations

a) A set of distinctive outcomes

In relation to (a) above, the thesis does contain distinctive outcomes. We remind the reader that part of the thesis, in fact that part of the research process that initially gave access to the National Health Service, was commissioned by a government

agency, the London Development Centre for Mental Health. As a result:

- (i) A short presentation was delivered to the commissioner of the project.
- (ii) An extended presentation of a selection of findings was delivered to a conference. The title of the paper was: “Deconstructing evaluation metrics in healthcare: Value for Money and CARE”. This paper was presented at the International Conference and Doctoral Consortium on Evaluation Metrics of Corporate Social and Environmental Responsibility, ISEOR, University of Lyon, France, 9–11 June 2009. (A summary of the presentation is given in Appendix 7)
- (iii) As result of ii), the researcher has been invited to give a presentation at a number of further conferences:
 - 2nd Transatlantic Congress: Accounting, Auditing, Control and Cost Management in a Global and Harmonized Economy, International Federation of Scholarly Associations of Management (IFSAM), Paris, 8–10 July 2010;
 - 3rd International Conference and Doctoral Consortium “Organizational Development and Change”, ISEOR, University of Lyon, France, 14–16 June 2010; and
 - 19th Standing Conference for Management and Organisational Inquiry (sc'MOI), Alexandria, Virginia, 25–27 March 2010. (see Appendix 8 for correspondence)

b) Novel application to practice

In relation to point (b) above, in the author’s view this is the first application of a deconstruction method in health provision. The methodology of the thesis provides a blueprint for the design of bottom-up or two-way strategic decision making in the National Health Service. Anticipating one of the recommendations of the study – the adoption of a bottom-up approach to the strategy – it is vital to take account of the patterns that emerge from multi narratives and a story approach in this respect.

The contribution of the storytelling methodology is that it provides a framework for achieving a balance. It is important to encourage policy makers to take account of how their own perceptions influence their judgement. In other words, an implication of the storytelling approach is that it is important to take into account of the multiplicity of narratives that exist in any situation, especially in the case of designing policy.

c) A set of recommendations

In relation to (c), the reader is reminded of the recommendations discussed above, and repeated below for convenience in an abbreviated form:

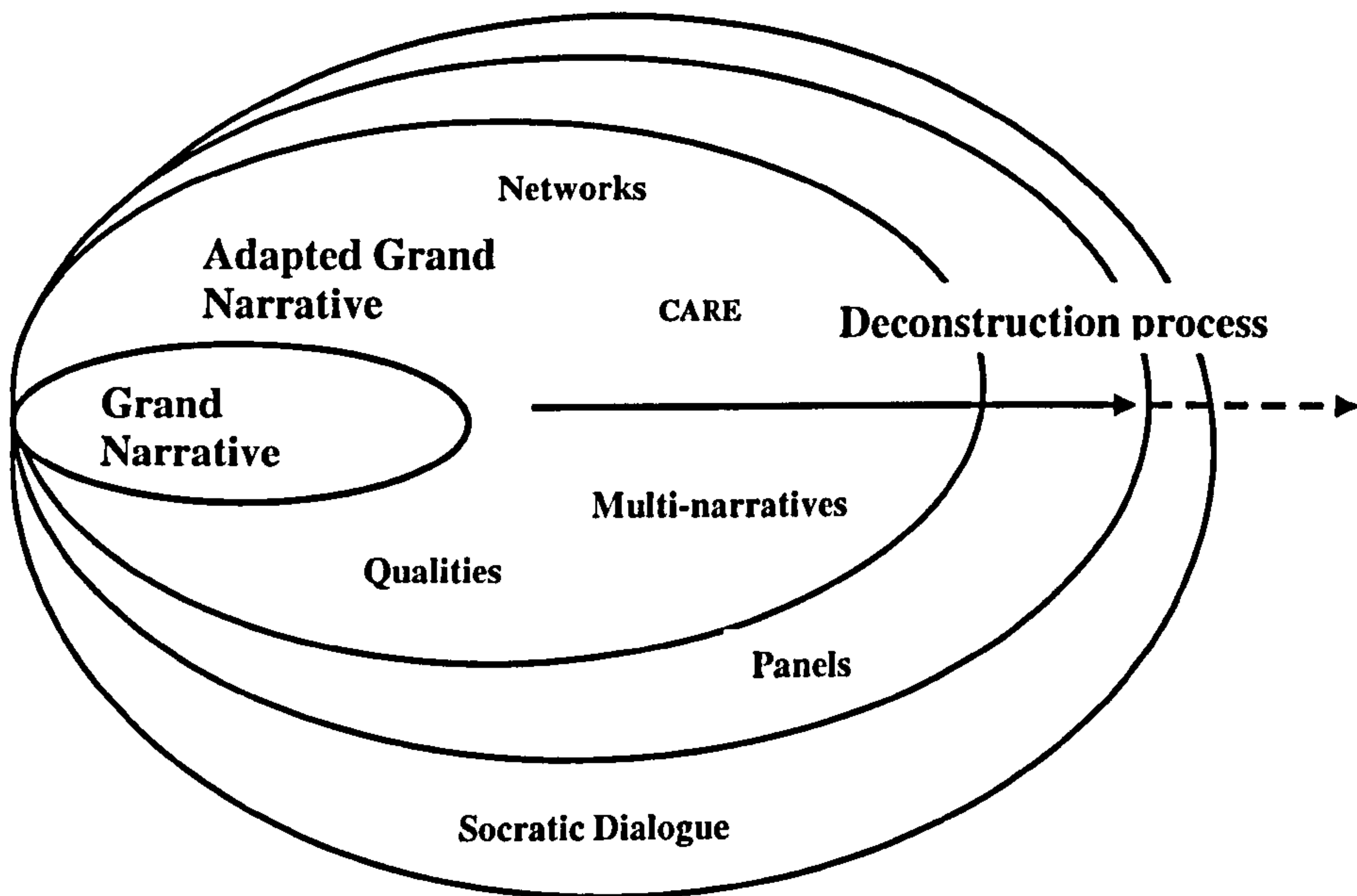
- (i) The need for policy makers to take a bottom-up approach to strategy
- (ii) As part of this bottom-up approach, the need to set targets through a process of consultation with both those delivering the service and those receiving the service
- (iii) Also as part of this bottom-up approach, the need to find a way of incorporating the emotional aspects of decision making and implementation in healthcare services into the strategic process
- (iv) This may involve the adoption of a storytelling approach such as the one outlined in this thesis.

Socratic Dialogue 2

At the end of this long thesis, the entire process of which could be described as a deconstructive process, it is appropriate to end with a picture and a dialogue.

Figure 8.5 (next page) summarises the deconstruction process used in the thesis, via a gradual inclusion of what has been previously excluded in the analysis.

Figure 8.5 Deconstruction process



The deconstruction process, indicated by the arrow, is a process of discovering the ‘*Other*’ that was always present but was excluded in the earlier narratives.

What follows below is a final Socratic dialogue between the academic supervisor (A) and the researcher (R), reflecting on the process that the picture describes.

A: We arrive at the final stage of your work – your reflection. You say that Socratic Dialogue is essential to the method that you have used. In what way is it essential? Because the idea of using deconstruction, using differences, is very much something that you have come up with ... and the Socratic Method is something that is particularly your innovation in this research. What was it that made you think that it was a good idea to approach this research in this way?

R: My first thought was that this was an alternative way of confirming findings. Second, it is useful as a tool of deconstruction. We did self-reflective interviews. We were challenging our ways of thinking, why

have we done the things in the particular way. You mentioned once that we are in fact doing the interviews in the form of Socratic dialogues. So I started thinking about it deeply.

A: ... [D]o you think your research is useful in a practical sense?

R: I think that this research is useful as practical ... The topic, Value for Money, is challenging. If you are looking at interviews, we had interviews with senior decision makers who had been in the National Health Service for over twenty-five years. They have a different interpretation of Value for Money. I wanted to use their stories because this is how they communicated their views to me, through stories.

A: Yes, I am just thinking aloud for a bit. One of the things it seems to me that comes out of your thesis is that actually researchers need to listen more to what people are saying ... In some extent, it [Value for Money] is being pursued quite successfully in the National Health Service ... that seems to be what you are saying. We have reached a stage that there are so many ambiguities in the concept that we need to listen to what people are saying about it and listen to how they interpret it, if we are going to move to another level ... to higher standards of delivery ... [in the] National Health Service. It strikes me that when people come to do research, very often they have a model in mind, and they approach their research too single mindedly through that model.

R: I agree. I started with a theory, a brilliant piece of Fisher's work. But when you start to look at it and deconstruct it and you see that people see it differently and that they can't relate to it and they say "What is she talking about?", you are starting to think, not so much that the model is wrong, but how is it perceived? ... Because we could not feed all the data back into the model ... we had to think of a different way of interpreting ... That reminds me ... when you approach research you have already had a certain approach (positivistic or phenomenological) in your mind. What I was concerned with was that I could not follow any of these views strictly. You have to start thinking on your own ... you need to find your own niche...

A: Moving on, one of the things you decided is to go from the Grand Narrative to the multi narratives, then panel data to check your interpretation ... You have said your own story is important. Could you say more about that? What is the essence of your story insofar that it has affected your research?

R: I think that the story approach has allowed me to focus on my strengths not my weaknesses. My weaknesses are not to be able to

hear well, and therefore fear of not being able to understand what people mean when they say something ... The story approach allowed me to use my mind in a more creative way. I think this is the reason why I thought, 'hold on, maybe my story will help me to develop my own way of expression'. It made me realise that there are other ways of presenting findings. It is a difficult question [my disability] ... because it affects you in many different ways on many different levels. You are only aware when you get into a situation...

A: It is a very difficult question. The way I interpret your research process is that it has gone something like this: you start off with the Grand Narrative; then you move into looking at multi narratives, then you move into a process of collecting reflection, when you discuss your interpretations with panels of people (experts); and then in this last stage what you are saying is that it is impossible for the researcher to be completely transparent ... It is necessary to really try to open up the work and make the researcher ... more transparent. I could put it another way. We cannot report other people completely objectively. It is always filtered through our own hearing, our own mindsets and in a way, what you might be saying is that we all have a disability in one sense. Could you say a little bit more about your disability?

R: With hearing impairment you have a few weaknesses: you have a problem with your speech, the way you express yourself. It may have an impact on people's understanding of the situation. They think: "What does she mean by that?" I had to use people's feedback to correct myself. It also has to do with my confidence, to be able to hear what people are trying to tell me. So again I had in my mind a sort of conflict of logic; this is what people tell you, but are you sure? How can you be sure? I think this is why I like narratives, especially stories ... you can confirm what they are saying. Then you actually write down what they are saying and reflect on it. Stories are so reflective. I think this is how I became more confident with using the storytelling approach ... it enabled me to provide transparency ... I wanted to report things as people said them. I was not interested in reporting what I think they told me, I needed to report exactly what they said because ... that is the real story.

A: Maybe it is a good idea if all researchers include something of this kind in their research, some self-reflective piece rather than pretending to an ideal objectivity, which they cannot possibly obtain. Could I just ask you one question, which is really how people treated you with a hearing disability? What do you feel about it?

R: I do not want to talk about myself. My research stands up by itself. But, I do want to make a general point about disability of this kind and research. Two things come up. I have been disabled all my life, so

I have learnt to use body language, and people don't realise that I'm actually deaf until I start to talk or to use phrases differently; my own language clues. They think that she may not speak good English or use good language, or maybe they think something is wrong but they do not know what it is. I do not want to be critical about it but some supervisors try to learn something about disabilities of this kind because it affects the process, especially the length of the process. Because we may have the problem of not getting the point across and they think we ... got it. The problem is that we are working on different wavelengths in terms of thinking. Then there should be an adjustment. The point is you [the academics] want them [or us] to deliver ... to make a journey, and you should, I think, make some adjustments ... people develop in different ways and I have learned a lot about this and about me during the research process. That is one important part of it, I learnt about me, how I think, how and why I think ... this or that ... As we have all kinds of disability we should be able to learn, because the purpose of having the research is that you develop, to learn. It is not about rushing to finish it within three or four years, as the academics want you to, but to make sure that you fulfil your potential...

A: It is another story, but attitudes are changing. We have disabled athletes, and what we say is that there is a lot to be gained from their efforts, from their energies. Similarly, because research is done by someone who is not hearing very well, it doesn't mean that it's worse research. It is different and we should be encouraging the difference.

R: When I started research, I did not think about that.

A: How did it come up? When did you first notice it explicitly as an issue? Tell me when...

R: It was when we started thinking in terms of multi narratives, because I realised that I am comfortable with this way of understanding the data. Perhaps it is something to do with the way I perceive the things, how I construct the reality, the big picture. I pick up little cues...

A: Are we saying something like this? Putting it in an academic framework, that Derrida has this notion of Différance and essentially, as you have written in your methodology chapter, what this really refers to is the fact that in any conversation there is always the unstated, the implicit, the background, the multi narrative, the thing that doesn't quite fit into a Grand Narrative. Are you saying that actually because of the way you work and the way you hear, that actually you are more sensitive to the '*Other*', to the undisclosed?

R: Yes, I may be more sensitive to what people try to say in their own

way. People can talk by saying things in different ways, using different language, so I am able to pick up the cues. When you are talking to me and listening to me, or when I am talking to you and listening to you, I hear a message, I hear words, but I also see you. I see what you look like, I pick up your body language, I pick up when you're uncomfortable, I pick up when you're thinking, I pick up when you're detached, I pick up when you don't want to answer the question, I pick up all kinds of non-verbal cues. ... I may for example be sensitive to the very tone of the voice you are using, whether this higher, lower, deep voice or higher, I can feel these things which you do not pay too much attention to. You pay more visual attention but I can pick up these other things.

A: How is this then, this facility, the sensitivity that you are describing, how has this influenced your research? My thoughts, what I observed when you were talking about the first set of interviews and you were talking about the Grand Narrative, the idea that if people who carried out strategies had a different view than people who are designing strategies, then this gave rise to a principal-agent problem, and that's your Grand Narrative ... I got the impression that actually you were uncomfortable with that, partly because you were hearing different things, you were hearing that these people were uncomfortable with the Grand Narrative, you were hearing that they had other things to express, and that led you into looking at the multi narratives ... Again, it would be nice to think that actually your disability led you in a way to looking at multi narratives, and again it led you to another stage where you felt "Well, what I've got to do is I've got to check my perceptions using some kind of panel data because I'm picking up all kinds of non-verbal cues and these are appearing in my thesis...

R: Also, I have emphasised that the real issue for the National Health Service is to think more about CARE. CARE has a lot to do with noticing, picking up signals, things that are unstated, deconstructing and noticing the '*Other*'.

Following the Socratic Dialogue, a number of limitations arose which may help to guide the direction of future research.

Limitations

Some of the limitations of the research in the thesis resulted from time factors; others from the multidisciplinary nature of the thesis, and others from the evolutionary development of the methodology. Still others followed from what Simon (1982) calls bounded rationality, or may we modestly call the bounded capability of the researcher.

Clearly, it would have been advantageous to do more interviews, particularly with patients and nursing staff. These groups were introduced through stories 1 and 2 (p.2–3); stories 3 to 5 (p.196–199); story 6 (p.212); and the multi narratives. One of the assumptions was that CARE could be shown, but not precisely defined. It involves sympathy, empathy and compassion, and it could be shown very clearly with more examples, more stories, more multi narratives and creative writing. The time factor was a limiting constraint, but every attempt was made to be as transparent as possible.

The thesis is multidisciplinary, drawing on post-modernist theories such as deconstruction, Derrida's (1983) *Différance*, Matthews' (2008) grammar and Boje's (2001) storytelling, and also on economics, demographic issues and health care service policies. We cannot pretend to do justice to all those areas. In future a bigger research team might attempt to revisit this area of research in more depth. Perhaps the author's own post-doctoral research will serve this purpose. The methodology of the thesis was described in detail in Chapter 4 (p.116, Table 4.1).

It can be seen that the thesis moved from a formal Net Present Value approach to a much more qualitative storytelling approach, as the researcher herself had to adapt to the research environment. Clearly, the storytelling aspect could have been developed, enriched and placed in a conventional business research framework, demonstrating further its distinctive contribution.

Herbert Simon (1982) writes of bounded rationality. In addition to human limitations of intellect and information processing, the researcher worked with a severe hearing

disability. We cannot help feeling that doctoral programmes could be enhanced by a greater sensitivity to both the limitations and the advantages that a hearing disability brings to research. This is particularly important and relevant when the ability to listen, watch and perceive body language and invisible clues can provide deeper information about CARE in health service research generally.

Future Research

We are aware of more limitations than we have cited above. However, the limitations we have noted suggest a number of directions for future research. The idea of CARE is critical to the health services worldwide, and Value for Money policies have resulted in distinct improvements in the National Health Service. The thesis does not wish to underestimate or undervalue these achievements as a result of the Value for Money strategy. So far, health service managers have made huge contributions in this area. However, the thesis argues that the next step involves getting a bottom-up, decentralised multi dimensional picture of CARE. We are trying to show that CARE has been unintentionally crowded out as a result of placing too much emphasis on centrally constructed targets.

The ideas of Hayek regarding decentralised decision making could be applied in the National Health Service. Hayek (1945) pointed out that central planners lack local information:

...central planning based on statistical information by its nature cannot take direct account of these circumstances of time and place and that the central planner will have to find some way or other in which the decisions depending on them can be left to the "man on the spot" ... [We] cannot expect that this problem will be solved by first communicating all this knowledge to a central board which, after integrating all knowledge, issues its orders. We must solve it by some form of decentralisation ... [We] need decentralisation because only thus can we ensure that the knowledge of the particular circumstances of time and place will be promptly used ... But the "man on the spot" cannot decide solely on the basis of his limited but intimate knowledge of his immediate surroundings. There still remains the problem of communicating to him such further information as he needs to fit his decisions into the whole pattern of changes of the larger economic system. (Hayek, 1945, pp.524)

This is exactly the case with CARE in the National Health Service. We argue strongly in the thesis that a storytelling approach, particularly involving CARE workers and patients narrating their experiences, is a way forward to enhancing the Value for Money approach and including the more human qualitative aspects of CARE, along with inducing the Hawthorne Effect (p.221).

Postscript

We finish the thesis in true post-modern fashion with the brief ongoing academic dialogue presented below.

R: Could we add a postscript to the Socratic Dialogue approach reflecting a further conversation?

A: Yes. As a result of these further comments, what do you think are the limitations?

R: I have included a section in the thesis on this issue (p.252). I can think of different reasons for leaving the word limitation out of the study. First, we have not avoided it but have 'deferred' for the moment ... because we use deconstruction as a research approach and ... if we recall Boje's (2001, p.1) definition of deconstruction: ..."story deconstruction is all the constructing and reconstructing processes happening all around us ... The point of doing the deconstruction analysis is to find a new perspective, one that resituates the story beyond its dualisms, excluded voices, or singular viewpoint" ... So I have learned deconstruction never stops ... we can keep doing it forever but at some point we have to stop and reflect on how far do we really need to go; so that is, I think, a true limitation of applying the deconstruction ... [the] researcher has to make this important decision.

A: Yes ... there must be some kinds of limitations ... they are always present they are not necessary a bad thing...

R: I agree. There ARE always some limitations. I just did not think of them in a conventional way ... As Simon (1985) pointed out the process does not allow you to optimise due to the constraints

imposed on the process. I was not interesting in optimising; in fact we know this is impossible. There will always be some kind of constraint, in the form of time, resources or input ... we have to accept this as a reality of doing business research...

A: So there are some kinds of unconventional limitations. What about future research? What would you do differently if you could repeat the study?

R: At the onset of the study I wanted to include nursing staff and patients into my analysis; but for confidentiality and ethical reasons I could not do that. This could be perhaps done in the future research. So there is a scope for improvement.

A: Perhaps there is scope for improving the storytelling approach too?

R: Definitely. The fact that I have used a negative image to explore the emotion of the participants, for example – novelist Mantel's (2008) story acted as a catalyst for exploring the emotions. This perhaps suggests that I could in future perhaps enrich the current storytelling approach; for example, to give the participants two different stories, one negative and one positive ... and in this way ensure the balance that examiner talked about...

A: Moving on to the issue that came up during the discussion ... the issue of incorporating CARE into the National Health Service ... could you tell us what else could be done?...

R: Incorporating the methodology – CARE – into the National Health Service is important one ... One of the routes of doing so is to develop an educational programme so as to educate staff in understanding the complexities of CARE. We strongly argue that it involves intangible elements, that it varies from person to person and that it means all those little things that we as human beings desire when we are sick – making us comfortable, feeding us properly, ensuring that we do not miss the medication, looking out for our mental wellbeing, not discriminating against disabled patients, respecting our right to privacy and so on. All these things mean CARE. However, to be successful the programme will need to be designed in such a way as to reach out to people in a non- confrontational way ... to elicit emotions just like we did in the panel data interviews, where we talked about the problem of aggressive leadership and the need for nurturing the leaders and not losing them due to business-style management ... I think that we need a different kind of approach to teaching people what is meant by CARE, so

a programme designed in this way may be one way of re-introducing CARE back into the National Health Service system...

A: I feel that I have learned a lot personally from working with you on this research. Do you?

R: Absolutely. Research is a two-way learning process, and I feel that I have learned something precious from you ... I have changed the way I see my own disability, in a very positive way, and learned to harness it rather than exclude or to hide it ... so it has become a unique research capability – a bounded capability
....

REFERENCES

- Abdel-Kader, M. and Dugdale, D. (1998) 'Investment in advanced manufacturing technology: A study of practice in large U.K. companies', *Management Accounting Research*, 9 (3), pp.261–284.
- Adler, M. and Ziglio, E. (1996) *Gazing into the oracle*. Bristol: Jessica Kingsley Publishers.
- Agrawal, A. F. (2001) 'Kin recognition and the evolution of altruism', *Proceedings of the Royal Society of London, Series B*, 268 (1471), pp.1099–1104.
- Akalu, M. M. (2003) 'The process of investment appraisal: The experience of 10 large British and Dutch companies', *International Journal of Project Management*, 21 (5), pp.355–362.
- Al-Ali, J. and Arkwright, T. (2000) 'An investigation of UK companies practices in the determination, interpretation and usage of cost of capital', *Journal of Interdisciplinary Economics*, 11, pp.303–319.
- Alkaraan, F. and Northcott, D. (2006) 'Strategic capital investment decision-making: A role for emergent analysis tools?: A study of practice in large UK manufacturing companies', *The British Accounting Review*, 38 (2), pp.149–173.
- Allais, M. (1953) 'Le comportement de l'homme rationnel devant le risque: Critique des postulats et axiomes de l'ecole americaine', *Econometrica*, 21 (4), pp.503–546.
- Apostolou, B., Watson, S. R., Hassell, J. M., and Webber, S. A. (2001) 'Accounting education literature review (1997–1999)', *Journal of Accounting Education*, 19 (1), pp.1–61.
- Armstrong, J. S. (1978) *Long-range forecasting*. New York: John Wiley.
- Arnold, G. C. and Hatzopoulos, P. D. (2000) 'The theory-practice gap in capital budgeting: Evidence from the United Kingdom', *Journal of Business Finance and Accounting*, 27 (5), pp.603–626.
- Arnold, G. C. (2006) *Corporate Financial Management*. 3rd edn. London: Financial Times / Prentice Hall.
- Arrow, K. J. (1951) 'Alternative approaches to the theory of choice in risk-taking situations', *Econometrica*, 19 (4), pp.404–437.

- Arrow, K. J. (1963) 'Uncertainty and the welfare economics of medical care', *American Economic Review*, 53 (5), pp.941–973.
- Arya, A., Fellingham, J. C. and Glover, J. C. (1998) 'Capital budgeting: Some exceptions to the net present value rule', *Issues in Accounting Education*, 13 (3), pp.499–508.
- Asthana, S., Gibson, A., Moon, G., Dicker, J. and Brigham, P. (2004) 'The pursuit of equity in National Health Service resource allocation: Should morbidity replace utilisation as the basis for setting health care capitations?' *Social Science and Medicine*, 58 (3), pp.539–551.
- Aumann, R. J. (1974) 'Subjectivity and correlation in randomized strategies', *Journal of Mathematical Economics*, 1 (1), pp.67–96.
- Axelrod, R. and Hamilton, W. D. (1981) 'The evolution of cooperation', *Science*, 211 (4489), pp.1390–1396.
- Axelrod, R. (1984) *The Evolution of Cooperation*. New York: Basic Books.
- Barnes, J. E. (1954) 'Class and committees in a Norwegian island parish', *Human Relations*, 7 (1), pp.39–58.
- Batson, C. D. (1994) 'Why act for the public good? Four answers', *Personality and Social Psychology Bulletin*, 20 (5), pp.603–610.
- Beardsworth, R. (1996) *Derrida and the Political*. London: Routledge.
- Becker, G. S. (1968) 'Crime and punishment: An economic approach', *Journal of Political Economy*, 76 (2), pp.169–217.
- Becker, G. S. (1971) *The Economics of Discrimination*. 2nd edn. Chicago: University of Chicago Press.
- Becker, G. S. (1981) *A Treatise on the Family*. Cambridge: Harvard University Press.
- Becker, G. S. (1993) *Human Capital: A Theoretical and Empirical Analysis, with Special Reference to Education*. 3rd edn. Chicago: University of Chicago Press.
- Bentham, J. (1843) The Works of Jeremy Bentham. *The Online Library of Liberty* [Online]. Available at: <http://oll.libertyfund.org/title/1925> (Accessed: 03 February 2009).
- Bentham, J. (1907) *An Introduction to the Principles of Morals and Legislation*. Oxford: Clarendon Press.

- Berger, D. M. (1987) *Clinical empathy*. Northvale: Jason Aronson.
- Bernoulli, D. (1954) 'Exposition of a New Theory on the Measurement of Risk', *Econometrica*, 22 (1), pp.23–36.
- Bevan, A. (1952) *In Place of Fear*. London: MacGibbon and Kee.
- Böhm-Bawerk, E. von (1890) Capital and Interest: A Critical History of Economic Theory. Translated by William Smart. *Library of Economics and Liberty*. [Online]. Available at: <http://www.econlib.org/library/BohmBawerk/bbCI.html> (Accessed: 24, January 2009).
- Boje, D. (2001) *Narrative Methods for Organizational and Communication Research*. London: Sage
- Borrill, C. S., Wall, T. D. and West, M. A. (1996) *Mental Health of the Workforce of the NHS Trusts, Phase 1: Final Report*. Sheffield/Leeds: Institute of Work Psychology, University of Sheffield, and Department of Psychology, University of Leeds.
- Borrill, C. S., Carletta, J., Carter, A. J., Dawson, J. F., Garrod, S., Rees, A., Richards, A., Shapiro, D., and West, M.A.(2001) '*The Effectiveness of Health Care Teams in the National Health Service: final report for the Department of Health.*', Aston Centre for Health Service Organisational Research, University of Aston, Human Communications Research Centre, Universities of Glasgow and Edinburgh, Psychological Therapies Research Centre, University of Leeds
- Borrill, C. S., Carletta, J., Carter, A. J., Dawson, J. F., Garrod, S., Rees, A., Richards, A., Shapiro, D., and West, M. A. (2002) 'Team working and effectiveness in health care: findings from the health care team Effectiveness project', Aston Centre for Health Service Organization Research, University of Aston and Birmingham
- Brackenborough, S., McLean, T. and Oldroyd, D. (2001) 'The emergence of discounted cash flow analysis in the Tyneside coal industry c.1700–1820', *The British Accounting Review*, 33 (2), pp.137–155.
- Brenner, S. N. and Cochran, P. (1991) *The stakeholder theory of the firm: Implications for business and society theory and research*. Paper presented at the 2nd Annual Meeting of International Association for Business and Society, Utah: Sundance, 21–24 March.
- Brockhoff, K. (1975) The performance of forecasting groups in computer dialogue and face to face discussions, in Linstone, H. and Turoff, M. (ed.) *The Delphi method: techniques and applications*. London: Addison-Wesley
- Bruner, R., Eades, K., Harris, R. and Higgins, R. (1998) 'Best practices in estimating the cost of capital: Survey and synthesis', *Financial Practice and Education*, 8 (1), pp.13–28.

- Buchan, J. and Evans, D. (2007) *'Realising the benefits? Implementing Agenda for Change'* London: King's Fund.
- Buchanan, J. M. (1969) *Cost and Choice: An Enquiry in Economic Theory*. Chicago: Markham Publishing.
- Burt, R. S. (2000) 'The network structure of social capital', *Research in Organizational Behavior*, 22, pp.345–423.
- Burton, B. K. and Dunn, C. P. (1996) *Stakeholder Interests and Community Groups: A New View*. Paper presented at the 7th International Association for Business and Society Annual Meeting. New Mexico: Santa Fe, March.
- Camerer, C. F. (1997) 'Progress in behavioral game theory', *Journal of Economic Perspectives*, 11 (4), pp.167–188.
- Camerer, C. F. (2003) *Behavioral Game Theory: Experimental Studies of Strategic Interaction*. Princeton, N.J.: Princeton University Press.
- Camerer, C. F., Loewenstein, G. and Rabin, M. (2004) *Advances in Behavioral Economics*. Princeton, N.J.: Princeton University Press.
- Canadian Institute for Health Information (2008) *National Health Expenditure Trends, 1975–2008*. [Online]. Available at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1595_E&cw_topic=1595&cw_rel=AR_31_E (Accessed: 26 June 2009).
- Carvel, J. (2008) National Health Service Nurses to be rated on how compassionate and smiley they are. *The Guardian*, 18 June [Online]. Available at: www.guardian.co.uk/society/2008/jun/18/nhs60.nhs1 (Accessed: 12 July 2009).
- Chiswick, B. and Mincer, J. (1972) 'Time-series changes in personal income inequality in the United States from 1939, with projections to 1985', *Journal of Political Economy*, 80 (3), pp.534–566.
- Cigdem, Z., Gurgur, J., Luxhoj T. (2003) Application of chance-constrained programming to capital rationing problems with asymmetrically distributed cash flows and available budget, *The Engineering Economist*, 48 (3), pp. 241–258.
- CIMA (1996) *Management Accounting Official Terminology*. London: Chartered Institute of Management Accountants.
- Clarkson, M. B. E. (1995) 'A stakeholder framework for analyzing and evaluating corporate social performance', *The Academy of Management Review*, 20 (1), pp.92–117.
- Coleman, D. P. (1995) *Emotional Intelligence: Why It Can Matter More Than IQ*. New York: Bantam Books.

- Collier, P. M. and Berry, A. J. (2002) 'Risk in the process of budgeting', *Management Accounting Research*, 13 (3), pp.273–297.
- Comte, A. (1852) *Catéchisme positiviste*. Paris: self published, Reprint: Garnier Freres, 1966.
- Corbacho, A. and Davoodi, H. (2002) *Expenditure Issues and Governance in Central America*. Washington, D.C.: International Monetary Fund. [Online]. Available at: <http://www.imf.org/external/pubs/ft/wp/2002/wp02187.pdf> (Accessed: 26 June 2009).
- Cornish, E. (1977) *The study of the future*. Washington, D.C: World Future Society:
- Critchley, S. J. (1992) *The Ethics of Deconstruction*, Oxford: Blackwell
- Culyer, T. J. (1990) *The internal market: an acceptable means to a desirable end*. Discussion Paper No. 67. University of York: Centre for Health Economics.
- Dahlgren, G. and Whitehead, M. (1991) 'What can be done about inequalities in health?' *The Lancet*, 338 (8774), pp.1059–1063.
- Dawkins, R. (1990) *The selfish gene*. Oxford: Oxford University Press.
- De Bernières, L. (1994) *Captain Corelli's Mandolin*. London: Secker and Warburg.
- De Man, P. (1986) *The Resistance to Theory*. Minneapolis: University of Minnesota Press.
- De Scitovszky, T. (1941) 'A note on welfare propositions in economics', *The Review of Economic Studies*, 9 (1), pp.77–88.
- Debreu, G. (1959) *The Theory of Value*. New York: Wiley and Sons
- Delbecq, A.L., Van den Ven, A.H. and Gustafson, D.H. (1975) *Group Techniques for Planning. A Guide to Nominal Group and Delphi Processes*. Glenview, Illinois.: Scott, Foresman and Company.
- Department of Health (2000) *Maximizing Value For Money In The National Health Service* [Press release]. 20 July. [Online]. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4005063 (Accessed: 8 July 2009).
- Department of Health (2004) *The NHS Improvement Plan – Putting people at the heart of public services*. London: Her Majesty's Treasury. (Cm 6268) [Online] Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084522

- Department of Health (2007) *Further developments in measuring quality adjusted healthcare output*. [Online]. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_079021 (Accessed: 9 July 2009).
- Department of Health (2008) *Departmental Report 2008*. London: The Stationery Office. (Cm7393). [Online]. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_084908 (Accessed: 26 June 2009).
- Derrida, J. (1982) *Margins of Philosophy*. Translated by Alan Bass. Chicago: University of Chicago Press, 1985.
- Derrida, J. (1983) 'The time of a thesis: punctuations' in Montefiore, A. (ed.) *Philosophy in France Today*. Cambridge: Cambridge University Press, pp.34–50.
- Dixit, A. K. and Pindyck, R. S. (1994) *Investment Under Uncertainty*. New York: Princeton University press.
- Dixon, A. and Mossialos, E. (2001) Funding health care in Europe: recent experiences. in: Harrison T. and Appleby, J. (eds.) *Health care UK Autumn 2001: the King's Fund review of health policy*. London: King's Fund, pp.66–77.
- Donaldson, T. and Preston, L. (1995) 'The stakeholder theory of the corporation: Concepts, evidence, and implications', *Academy of Management Review*, 20 (1), pp.65–91.
- Donnelly, L. (2009) 'Patients forced to wait hours in ambulances parked outside A&E departments'. *The Sunday Telegraph*, 30 May. [Online]. Available at: <http://www.telegraph.co.uk/health/healthnews/5412191/Patients-forced-to-wait-hours-in-ambulances-parked-outside-AandE-departments.html> (Accessed: 08 September 2009).
- Drummond, M. F., Sculpher, M. J. and Torrance, G. W. (2005) *Methods for the economic evaluation of health care programmes*. Oxford: Oxford University Press.
- Durán, A., Lara, J. L. and Waveren M. van (2006) *Health Systems in Transition: Spain Health system review*. European Observatory on Health Systems and Policies. [Online]. Available at: <http://www.euro.who.int/Document/E89491.pdf> (Assessed: 26 June 2009).
- Dye, J. (1996) Socratic Method and Scientific Method. [Online] Available at: www.niu.edu/~jdye/method.html (Accessed: 15 September 2009).
- Edgeworth, F. Y. (1881). Mathematical Psychics: An essay on the application of mathematics to the moral sciences. *American Libraries*. [Online]. Available at: <http://www.archive.org/stream/mathematicalpsy01goog#page/n7/mode/1up> (Accessed: 30 June 2009).

- Edwards, J. R. and Warman, A. (1981) 'Discounted cash flow and business valuation in a nineteenth century merger: A note', *The Accounting Historians Journal*, 8 (2), pp.37–50.
- Egerton, R. A. D. (1960) *Investment Decisions under Uncertainty*. Liverpool: Liverpool University Press.
- Eisenberg, N. (2002) 'Empathy-related emotional responses, altruism, and their socialization' in Davidson, R. J. and Harrington, A. (eds.) *Visions of compassion: Western scientists and Tibetan Buddhists examine human nature*. London: Oxford University Press. pp.131–164.
- Eisenhardt, K. (1989) 'Agency theory: An assessment and review', *Academy of Management Review*, 14 (1), pp.57–74.
- Elster, J. (1977) 'Ulysses and the sirens: A theory of imperfect rationality', *Social Science Information*, 16 (5), pp.469–526.
- Ellsberg, D. (1961) 'Risk, ambiguity, and the savage axioms', *Quarterly Journal of Economics*, 75 (4), pp.643–669.
- Epstein, R. S. and Sherwood, L. M. (1996) 'From outcomes research to disease management: A guide for the perplexed', *Annals of Internal Medicine*, 124 (9), pp.832–837.
- European Observatory on Health Care Systems (1999) *Health Care Systems in Transition: Luxembourg*. [Online]. Available at: <http://www.euro.who.int/document/e67498.pdf> (Assessed: 26 June 2009).
- Fama, E. F. (1980) 'Agency problems and the theory of the firm', *Journal of Political Economy*, 88 (2), pp. 288–307.
- Fama, E. F. and Jensen, M. C. (1983) 'Agency problems and residual claims', *The Journal of Law and Economics*, 26 (2), pp.327– 349.
- Fetter, F. A. (1905) *The Principles of Economic*. New York: The Century.
- Fisher, I. (1906) *The Nature of Income and Capital*. New York: Macmillan.
- Fisher, I. (1930) *The Theory of Interest. Library of Economics and Liberty*. [Online]. Available at: <http://www.econlib.org/library/YPDBooks/Fisher/fshToI.html>. (Accessed: 30 June 2009).
- Fisher, R. A. (1936) "The use of multiple measurements in taxonomic problems", *Annals of Eugenics*, 7, pp.179–188.
- Fisher, K. and Statman, M. (1999) 'A behavioral framework for time diversification', *Financial Analysts Journal*, 55 (3), pp.88–97.

- Ford, J. L. (1983) *Choice, expectation and uncertainty: an appraisal of G.L.S. Shackle's theory*. Oxford: Robertson.
- Ford, J. L. (1987) *Economic choice under uncertainty: a perspective theory approach*. New York: St. Martin's Press.
- Ford, J. L. (1990) *Shackle, G. L. S: Time, expectations and uncertainty in economics: selected essays of G.L.S.* Aldershot, UK: Edward Elgar Publishing.
- Fowles, J. (1978) *Handbook of futures research*. Connecticut: Greenwood Press
- Francaro, K. E. (2007) 'The consequences of micromanaging', *Contract Management*, 47 (7), pp.4–8.
- Frank, A. (1977) 'Capital, interest, and rent: Essays in the theory of distribution' in Rothbard, M. N. (ed.) Kansas City: Sheed Andrews and McMeel.
- Freeman, R. E. (1984) *Strategic Management: A Stakeholder Approach*. Boston: Pitman.
- Freeman, R. and McVea, J. (2001) 'A stakeholder approach to strategic management', Working Paper No. 01–02. University of Virginia: Darden Business School.
- Friedman, A., L. and Miles, S. (2002) 'Developing stakeholder theory', *Journal of Management Studies*, 39 (1), pp.1–21.
- Gallop, D. and Plato (1999) *Plato*. Oxford: Oxford University Press.
- Georgescu-Roegen, N. (1971)) *The Entropy Law and the Economic Process*. Cambridge, MA: Harvard University Press.
- Gindis, B. (1995) 'The social/cultural implication of disability: Vygotsky's paradigm for special education', *Educational Psychologist*, 30 (2) pp.77–81.
- Giraud, P. (1995) 'The equilibrium price range of oil: Economics, politics and uncertainty in the formation of oil prices', *Energy Policy*, 23 (1), pp.35–49.
- Glenngård, A. H., Hjalte F., Svensson, M., Anell, A. and Bankauskaite, V. (2005) *Health Systems in Transition: Sweden*. European Observatory on Health Systems and Policies. [Online]. Available at: <http://www.euro.who.int/Document/E88669.pdf> (Accessed: 10 July 2009).
- Graham, J. R. and Harvey, C. R. (2001) 'The theory and practice of corporate finance: Evidence from the field', *Journal of Financial Economics*, 60 (2–3), pp.187–243.

- Greenson, R. R. (1960) 'Empathy and its vicissitudes', *International Journal of Psychoanalysis*, 41, pp.418–424.
- Guardian (2008) The Prime Minister's speech to the Labour Party conference in Manchester today, *Guardian*, 23 September [Online]. Available at: <http://www.guardian.co.uk/politics/2008/sep/23/gordonbrown.labour1> (Accessed: 25 June 2009).
- Gurgur, C. Z. and Luxhoj, J. T. (2003) 'Application of chance-constrained programming to capital rationing problems with asymmetrically distributed cash flows and available budget', *The Engineering Economist*, 48 (3), pp.241–258.
- Hanson, W. H. and Ramani, N. (1988) 'Technology forecasting: a hydroelectric company experience', *Technology Management Publication*, 1 (3), pp.266–270.
- Harris, E. (1999) 'Project Risk Assessment: A European Field Study', *The British Accounting Review*, 31 (3), pp.347–371.
- Harsanyi, J. (2004) 'Games with incomplete information played by "Bayesian" players, I–III', *Management Science*, 50 (12), pp.1804–1817.
- Harsanyi, J. (1968) 'Games with incomplete information played by "Bayesian" players', *Management Science*, 14 (5), pp.320–334.
- Harsanyi, J. (1968) 'Games with incomplete information played by "Bayesian" players, part iii. the basic probability distribution of the game', *Management Science*, 14 (7), pp.486–502.
- Harsanyi, J. (1967) 'Games with incomplete information played by "Bayesian" players, I–iii', *Management Science*, 14 (3), pp.159–182.
- Hartman, G. (1981) *Saving the text: literature, Derrida, philosophy*. Baltimore: Johns Hopkins University Press.
- Hayek, F. A. (1945) The Use of Knowledge in Society, *American Economic Review*, 35 (4), pp.519–530.
- Hayes, J. W. (1989) 'Dual variables in pure capital rationing linear programming formulation', *Engineering Economist*, 34 (3), pp.255–260.
- Heald, D. A. (2003) 'Fiscal transparency: Concepts, measurement and UK practice', *Public Administration*, 81, pp.723–725.
- Helmer, O. (1977) 'Problems in futures research: Delphi and causal cross-impact analysis.' *Futures*, pp. 17–31.

- Her Majesty's Treasury (2002) *Securing our Future Health: Taking a Long-Term View: Final Report*. London: Her Majesty's Treasury. [Online]. Available at: http://www.hm-treasury.gov.uk/consult_wanless_final.htm (Accessed: 25 June 2009).
- Her Majesty's Treasury (2007) *Pre-Budget Report and Comprehensive Spending Review*. London: The Stationery Office. (Cm7227). [Online]. Available at: http://www.hm-treasury.gov.uk/d/pbr_csr07_completereport_1546.pdf (Accessed: 26 June 2009).
- Her Majesty's Treasury (2008) *Value for money and the valuation of public sector assets*. [Online]. Available at: [http://www.hm-treasury.gov.uk/d/9\(2\).pdf](http://www.hm-treasury.gov.uk/d/9(2).pdf) (Accessed: 8 July 2009).
- Hertz, D. (1964) 'Risk analysis in capital investment', *Harvard Business Review*, 42 (1), pp.95–106.
- Hill, C. W. and Jones, T. (1992) 'Stakeholder-agency theory', *Journal of Management Studies*, 29 (2), pp.131–154.
- Hilless, M. and Healy, J. (2001) *Health Care Systems in Transition: Australia*. European Observatory on Health Care Systems. [Online]. Available at: <http://www.euro.who.int/document/E74466.pdf> (Accessed: 10 July 2009).
- Hillier, F. S. (1971) 'A basic model for capital rationing of risk investments', *Engineering Economist*, 17 (1), pp.1–30.
- Hirshleifer, J. (1958) 'On the theory of optimal investment decision', *Journal of Political Economy*, 66 (4), pp.329–352.
- Hirshleifer, J. (1964) 'Efficient allocation of capital in an uncertain world', *American Economic Review*, 54 (3), pp.77–85.
- Hirshleifer, J. (1965) 'Investment decision under uncertainty: Choice-theoretic approaches', *Quarterly Journal of Economics*, 79 (4), pp.509–536.
- Hirshleifer, J. (1966) 'Investment decision under uncertainty: Applications of the state-preference approach', *Quarterly Journal of Economics*, 80 (2), pp.252–277.
- Hirshleifer, J. (1970) *Investment, Interest, and Capital*. Englewood Cliffs, N.J.: Prentice-Hall.
- Hirshleifer, J. (1978) 'Competition, cooperation, and conflict in economics and biology', *American Economic Review*, 68 (2), pp.238–243.
- Hirshleifer, J. (1985) 'The Expanding domain of economics', *American Economic Review*, 75 (6), pp.53–68.

- Hirshleifer, J. (1993) 'The affections and the passions: Their economic logic', *Rationality and Society*, 5 (2), pp.185–202.
- Ho, S. and Pike, R. (1992) 'Adoption of probabilistic risk analysis in capital budgeting and corporate investment', *Journal of Business Finance and Accounting*, 19 (3), pp.387–405.
- Hoffman, M. L. (1987) 'The contribution of empathy to justice and moral judgment' in Eisenberg, N. and Strayer, J. (eds.) *Empathy and its development*. Cambridge: Cambridge University Press. pp.47–80.
- Horne, J. von (1966) 'Capital-budgeting decisions involving combinations of risky investments', *Management Science*, 13 (2), pp.84–92.
- Horne, J. von (1969) 'The analysis of uncertainty resolution in capital budgeting for new products', *Management Science*, 15 (8), pp.376–386.
- House of Commons (2007) *Workforce Planning: Fourth Report of Session 2006–07: Volume 1*. London: The Stationary Office. (HC171-I). [Online]. Available at: <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/171/17102.htm> (Accessed: 30 June 2009).
- Husserl, E. (1927) *Phenomenology*, Translated by Palmer, R. Reprint, Oxford: Journal of the British Society for Phenomenology. 1971.[Online]. Available at: <http://www.hfu.edu.tw/~huangkm/phenom/husserl-britanica.htm> (Accessed: 10 July 2009).
- Jensen, M. C. and Meckling, W. H. (1976) 'Theory of the firm: Managerial behavior, agency costs and ownership structure', *Journal of Financial Economics*, 3 (4), pp.305–360.
- Jevons, W. S. (1871) *The Theory of Political Economy*. 3rd edn. London: Macmillan, 1888. *The Online Library Liberty* [Online]. Available at: <http://oll.libertyfund.org/title/625> (Accessed: 30 June 2009).
- Jones, R. (2002) 'Declining altruism in medicine', *British Medical Journal*, 324 (7338), pp.624–625.
- Jung, C. (1968) *The Archetypes and the Collective Unconscious*. London: Rutledge.
- Kahneman, D. and Tversky, A. (1979) 'Prospect theory: An analysis of decision under risk', *Econometrica*, 47 (2), pp.263–291.
- Kalu, T. C. U. (1999) 'Capital budgeting under uncertainty: An extended goal programming approach', *International Journal of Production Economics*, 58 (3), pp.235–251.

- Keynes, J. M. (1921) *A Treatise on Probability*. London: Macmillan.
- Keynes, J. M. (1936) *The General Theory of Employment, Interest, and Money*. London: Macmillan.
- King, P. (1975) 'Is the emphasis of capital budgeting theory misplaced', *Journal of Business Finance and Accounting*, 2 (1), pp.69–82.
- King's College (2007) *New report predicts soaring cost of dementia* [Press release]. 30 July. [Online]. Available at: http://www.kcl.ac.uk/news/news_details.php?news_id=525&year=2007) Accessed: 8 July 2009).
- King's Funds (2005) *An Independent Audit of the National Health Service under Labour (1997–2005)*. London: King's Fund.
- Kingston University (2004) 'Regulations for the Award of Doctor Of Business Administration'
- Kingston University (2004) 'Guide to good research practice' [Online]. Available at: http://www.kingston.ac.uk/aboutkingstonuniversity/howtheuniversityworks/policiesandregulations/documents/research_good_practice.pdf (Accessed: 1 June 2009).
- Kingston University (2007) 'Ethics: Guidance and Procedures for Undertaking Research Involving Human Subjects' [Online]. Available at: <http://student.kingston.ac.uk/C1/YourStudies/Document%20Library/Guidance%20and%20Procedures%20-%20Sept%202007.doc> (Accessed 2 June 2009).
- Knight, F. H. (1921) *Risk, Uncertainty and Profit*. Boston and New York: Houghton Mifflin.
- Kohut, H. (1984) *How Does Analysis Cure*. Chicago: University of Chicago Press.
- LeGrand, J. and Bartlett, W. (1993) *Quasi-Markets and Social Policy*. Basingstoke: Macmillan.
- Levine, D. K. (1998) 'Modelling altruism and spitefulness in experiments', *Review of Economic Dynamics*, 1 (3), pp.593–622.
- Lintner, J. (1965) 'The valuation of risk assets and the selection of risky investments in stock portfolios and capital budgets', *Review of Economics and Statistics*, 47 (1), pp.13–37.
- Lister, S. (2006) 'Breast cancer drug on National Health Service in weeks'. *Times Online*, 25 May. [Online]. Available at: <http://www.timesonline.co.uk/tol/news/uk/health/article725622.ece> (Accessed: 25 March 2007).

- London National Health Service (2007) *National Health Service London Annual Report 2006/07*. [Online]. Available at: http://www.london.nhs.uk/webfiles/Corporate/NationalHealthServiceL_Annual_Report_2006-07.pdf (Accessed: 30 June 2009).
- Lyotard, J. F. (1979) *La Condition Postmoderne: rapport sur le Savoir*. Paris: Editions de Minuit.
- Lyotard, J. F. (1984) *The Postmodern Condition: A Report on Knowledge*, Manchester: Manchester University Press.
- Mantel, H. (2008) 'In the Waiting Room', *London Review Books*, 30 (16) [Online]. Available at: http://www.lrb.co.uk/v30/n16/mant01_.html (Accessed: 12 July 2009).
- Markowitz, H. M. (1952) 'Portfolio selection', *Journal of Finance*, 7 (1), pp.77–91.
- Marshall, A. (1920) *Principles of Economics*. 8th edn. London: Macmillan. *Library of Economics and Liberty* [Online]. Available at: <http://www.econlib.org/library/Marshall/marP11.html> (Accessed: 13 July 2009).
- Martino, J. P. (1983) *Technology Forecasting for Decision Making*, New York: Elsevier Science Publishing
- Matthews, R. (2002) 'Competition archetypes and creative imagination', *Journal of Organizational Change Management*, 15 (5), pp.461–476.
- Matthews, R. (2004) Capitalism Correspondences and The Impossibility of Thinking That, in Alkafaji, A. and Gardner, C. (ed.) *Business Research Yearbook: vol. XI*. Michigan: Saline. McNaughton and Gunn Inc.
- Matthews, R. (2006) 'Identity, Synchronicity and Correspondences in Kronos Capitalism', *Tamara*, Vol. 3 (5).
- Matthews, R. (2007) *The Enneagram Methodology*. Moscow: Institute for Economic Strategies.
- Matthews, R. (2008) Legal Fictions: Critical Theory Criticality and the State of Economics and Management, in Boje, D. (ed.) *A Critical Theory Approach to Organizational Ethics*. Information Age Publishing.
- Maynard, S. J. (1982) *Evolution and the theory of games*. Cambridge, New York: Cambridge University Press.
- Mayo, E. (1949) *Hawthorne and the Western Electric Company, The Social Problems of an Industrial Civilisation*. London: Routledge and Kegan Paul.

- McLaney, E., Pointon, J., Thomas, M. and Tucker, J. (2004) 'Practitioners' perspectives on the UK cost of capital', *European Journal of Finance*, 10 (2), pp.123–138.
- Mendas, Z. and Matthews, R. (2009) '*Deconstructing evaluation metrics in health care: Value for Money and Care*' Paper presented at the International Conference and Doctoral Consortium on Evaluation Metrics of Corporate Social and Environmental Responsibility (ISEOR), University of Lyon, France, 9–11 June.
- Menger, C. (1871) *Principles of Economics*. Translated and edited by Dingwall, J. and Hoselitz, B. F. 1976. *Ludwig von Mises Institute* [Online]. Available at: <http://www.mises.org/etexts/menger/principles.asp> (Accessed: 30 June 2009).
- Michael, P. (1997) *The Audit Society: Rituals of Verification*. Oxford: Oxford University Press.
- Miller, J., H. (1976) 'Stevens' Rock and Criticism as Cure', *Georgia Review*, 30, pp.330–348.
- Miller, P. and Napier, C. (1993) 'Genealogies of calculation*1', *Accounting, Organizations and Society*, Volume 18 (7–8), pp.631–647.
- Mincer, J. (1958) 'Investment in human capital and personal income distribution', *The Journal of Political Economy*, 66 (4), pp.281–302.
- Mises, L. von (1966) *Human Action: A Treatise on Economics*. 3rd edn. Chicago: Henry Regnery.
- Modigliani, F. and Miller, M. H. (1965) 'The cost of capital, corporation finance, and the theory of investment: Reply', *American Economic Review*, 55 (3), pp.524–527
- Morris, S. and McGuire, A. (2002) 'The private net present value and private internal rate of return to becoming a nurse in Great Britain', *Applied Economics*, 34 (17), pp.2189–2200.
- Mossin, J. (1966) 'Equilibrium in a Capital Asset Market', *Econometrica*, 34 (4), pp.768–783.
- Nancy, J-L. (1982) *Le partage des voix*. Paris: Galilée.
- Naslund, B. (1966) 'A model of capital budgeting under risk', *Journal of Business*, 39 (2), pp.257–271.
- Nash, J. (1951) 'Non-cooperative games', *The Annals of Mathematics*, 54 (2), pp.286–295.

- National Audit Office (2001) '*Educating and training the future health professional workforce for England*' report. HC: 277 2000–2001. [Online]. Available at: <http://www.nao.org.uk/idoc.ashx?docId=742a0078-b783-4cac-ae7a-a9d12f096ddb&version=-1> (Accessed 8 July 2009).
- National Health Service Confederation (2005) '*Money in the National Health Service: the facts*'. [Online]. Available at: <http://www.welshconfed.org/companyData/1898/resources/UK%20Finance.pdf> (Accessed: 9 July 2009).
- National Health Service London (2007) '*A Framework for Action*'. [Online]. Available at: <http://www.healthcareforlondon.nhs.uk/assets/Publications/A-Framework-for-Action/aFrameworkForAction.pdf> (Accessed 14 April 2010).
- Neumann, J. von and Morgenstern, O. (1947) *Theory of Games and Economic Behavior*. 2nd edn. Princeton, N.J.: Princeton University Press.
- Newell, A. and Simon, H. (1972) *Human Problem Solving*. Englewood Cliffs, New York: Prentice-Hall.
- Office for National Statistics (2005) *Atkinson Review: Final report: Measurement of Government Output and Productivity for the National Accounts*. [Online]. Available at: http://www.statistics.gov.uk/about/data/methodology/specific/PublicSector/Atkinson/downloads/Atkinson_Report_Full.pdf (Accessed: 26 June 2009).
- Office for National Statistics (2008) *Public service productivity: Health. Care: Summary* [Online]. Available at: http://www.statistics.gov.uk/articles/nojournal/HealthCare_290108.pdf (Accessed: 9 July 2009)
- Ogilvie, J. (2006) *CIMA Official Learning System, Strategic level, Management Accounting – Financial Strategy*. London: Elsevier.
- Organisation for Economic Co-operation and Development (2004) *The OECD Health Project: Towards high performing health systems: Summary Report*. [Online]. Available on: <http://www.oecd.org/dataoecd/7/58/31785551> (Assessed: 26 June 2009).
- Organisation for Economic Co-operation and Development (2008) *OECD Health Data 2008*. [Online]. Available on: http://www.oecd.org/document/27/0,3343,en_2649_34631_40902299_1_1_1_1,00.html. (Accessed: 26 June 2009).
- Pareto, V. (1935) *The Mind and Society: A Treatise on General Sociology*. New York: Harcourt, Brace. Reprint, New York: Dover Publications, 1963.

- Parker, R. (1968) 'Discounted cash flow in historical perspective', *Journal of Accounting Research*, 6 (1), pp.58–71.
- Pascal, B. (1670) *Pensées*. Translated by Kraitsheimer, A. London. Penguin, 1966.
- Piaget, J. (1926) *Language and Thought of the Child*. New York: Harcourt Brace & Co.
- Piccart-Gebhart, M. J., Procter, M., Leyland-Jones, B., Goldhirsch, A. (2005) 'Trastuzumab after adjuvant chemotherapy in HER2-positive breast cancer', *The New England Journal of Medicine*, 353 (16), pp.1659–1673.
- Pigou, A. C. (1928) *A Study in Public Finance*. London: Macmillan.
- Pigou, A. C. (1932) *The Economics of Welfare*. 4th edn. London: Macmillan.
- Pike, R. (1983) 'The capital budgeting behavior and corporate characteristics of capital-constrained firms', *Journal of Business Finance and Accounting*, 10 (4), pp.663–671.
- Pike, R. (1996) 'A longitudinal survey on capital budgeting practices', *Journal of Business Finance and Accounting*, 23 (1), pp.79–92.
- Preston, S. D. and Frans, B. M. de Waal. (2002) 'Empathy: Its ultimate and proximate bases', *Behavioral and Brain Sciences*, 25 (1) pp.1–20.
- Price, G. R. (1972) 'Fisher's 'fundamental theory' made clear', *Annals of Human Genetics*, 36 (2), pp.129–140.
- Putnam, R. D. (1993) The prosperous community-social capital and economic growth, *The American Prospect*, 21 March [Online]. Available at: http://www.prospect.org/cs/articles?article=the_prosperous_community (Accessed: 14 July 2009).
- Rabin, M. (1998) 'Psychology and economics', *Journal of Economic Literature*, 36 (1), pp.11–46.
- Rabin, M. (2006) 'The experimental study of social preferences', *Social Research*, 73 (2), pp.405–428.
- Radner, R. (1968) 'Competitive equilibrium under uncertainty', *Econometrica*, 36 (1), pp.31–58.
- Radner, R. (1972) 'Existence of equilibrium of plans, prices, and price expectations in a sequence of markets', *Econometrica*, 40 (2), pp.289–303.
- Rand, A. (1996) *Atlas Shrugged*. New York: Signet.

- Reynolds, T. M. and Wierzbicki, A. S. (2000) 'Improvements in survival may be an illusion', *British Medical Journal*, 321 (7274), pp.1470.
- Rogers, C. R. (1959) 'A theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework' in S. Koch (ed.) *Psychology: A study of a science: Study 1. Conceptual and systematic: Vol. 3 Formulations of the person and the social context*. New York: McGraw Hill. pp.184–256.
- Santry, C. (2008) 'Watchdog chair to get tough on obeying NICE rules', *Health Service Journal*. 13 August. [Online]. Available at: <http://www.hsj.co.uk/watchdog-chair-to-get-tough-on-obeying-nice-rules/1796360.article> (Accessed: 10 July 2009).
- Schafer, R. (1959) 'Generative empathy in the treatment situation', *The Psychoanalytic Quarterly*, 28, pp.342–373.
- Schelling, T. C. (1960) *The Strategy of Conflict*. Cambridge, MA: Harvard University Press.
- Schultz, T. W. (1961) 'Investment in human capital', *American Economic Review*, 51 (1), pp.1–17
- Schultz, T. W. (1963) *The Economic Value of Education*. New York: Columbia University Press.
- Seelig, B. J. and Dobelle, W. H. (2001) 'Altruism and the volunteer: Psychological benefits from participating as a research subject', *American Society for Artificial Internal Organs*, 47 (1), pp.3–5.
- Selten, R. (1975) 'Re-examination of the perfectness concept for equilibrium points in extensive games', *International Journal of Game Theory*, 4 (1), pp.25–55.
- Sharpe, W. F. (1964) 'Capital asset prices: A theory of market equilibrium under conditions of risk', *Journal of Finance*, 19 (3), pp.425–442.
- Sharpe, W. F. (1970) *Portfolio theory and capital markets*. New York: McGraw-Hill.
- Sigmund, K. and Nowak, M. A. (2001) 'Tides of tolerance', *Nature*, 414, pp.403–405.
- Simon, H. A. (1982) *Models of Bounded Rationality*. Cambridge: MIT Press.
- Simon, H. A. (1986) 'Rationality in psychology and economics', *Journal of Business*, 59 (4), pp.S209–S224.
- Simon, H. A. (1992) *Economics, Bounded Rationality and Cognitive Revolution*. Aldershot: Edward Elgar.

- Simon, H. (1997) *An Empirical Based Microeconomics*. Raffaele Mottioli Lectures. Cambridge: Cambridge University Press.
- Smith, A. (1759) The Theory of Moral Sentiments. *The Online Library of Liberty*. [Online]. Available at: <http://oll.libertyfund.org/title/192> (Accessed: 22 June 2009).
- Stein, E. (1989) *On the Problem of Empathy*. Washington D.C.: ICS Publication.
- Stiglitz, J. E. (2000) *Economics of Public Sector*. 3rd edn. New York: W.W. Norton and Company.
- Thaler, R. H. (1994) *The Winner's Curse: Paradoxes and Anomalies of Economic Life*. Princeton: Princeton University press.
- The Green Book (2003) *Appraisal and Evaluation in Central Government*. [Online]. Available at: http://www.hm-treasury.gov.uk/d/green_book_complete.pdf (Accessed: 30 June 2009).
- The Orange Book (2004) *Management of Risk – Principles and Concepts*. [Online]. Available at: http://www.hm-treasury.gov.uk/d/orange_book.pdf (Accessed: 8 July 2009).
- The Royal National Institute of Blind People (2008) *Justice for thousands facing blindness* [Press Release]. 27 August. [Online]. Available at: http://www.rnib.org.uk/xpedio/groups/public/documents/PublicWebsite/public_pr270808.hcsp?printPage=1. (Accessed 12 June 2009).
- The Sainsbury Centre for Mental Health (2003) *The economic and social costs of mental illness*. [Online]. Available at: http://www.scmh.org.uk/pdfs/costs_of_mental_illness_policy_paper_3.pdf (Accessed 10 May 2010).
- Treynor, J. L. (1962) 'Toward a Theory of Market Value of Risky Assets' in Korajczyk, R. A. (ed.) *Asset Pricing and Portfolio Performance: Models, Strategy and Performance Metrics*. London: Risk Books, pp.15–22.
- Tversky, A. and Kahneman, D. (1986) 'Rational choice and the framing of decisions', *Journal of Business*, 59 (4), pp.S251–S278.
- Tversky, A. and Kahneman, D. (1991) 'Loss aversion in riskless choice: A reference-dependent model', *Quarterly Journal of Economics*, 106 (4), pp.1039–1061.
- United Nations (2008) Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat. *World Population Prospects: The 2008 Revision*. [Online]. Available at: <http://esa.un.org/unpp/p2k0data.asp> (Accessed: 22 June 2009).

- Veblen, T. (1899) *The Theory of the Leisure Class: an economic study of institutions*. New York, London: Macmillan.
- Wagner, E. H., Austin, B. T. and Korff, M. von (1996) 'Organizing care for patients with chronic illness', *Managed Care Quarterly*, 4 (2), pp.12–25.
- Wanless, D., Appleby, J., Morrison, A. and Patel, D. (2007) *'Our future health secured? A review of National Health Service funding and performance'*, London: King's Fund.
- Waterfield, R. and Plato (2008) *Republic*. New York: Oxford University Press.
- Wieser, F. von (1889) Natural Value. *An Online Library of Radical Libertarian Classics*. [Online]. Available at: <http://praxeology.net/FW-NV-I-5.htm> (Accessed: 22 June 2009).
- Williams, A. (1978) 'Need – an economic exegesis', in Culyer A. J. and Wright, K. G., (ed.) *Economic aspects of health*. London: Martin Robertson. pp.32–45.
- Williamson, O. E. (1981) 'The Economics of Organization: The Transaction Cost Approach', *American Journal of Sociology*, 87 (3) pp. 548–577.
- Wissema, J.G. (1982) 'Trends in technology forecasting' *R & D Management*, 12 (1) pp. 27–36.
- Vygotsky, L. (1978) *Mind in Society*. Translated by Cole, M. Cambridge, MA: Harvard University.
- Vygotsky, L. S. (1983) *Sobraniye Sochinenii [Collected Works]*, Vol. 5. Moscow: Pedagogika Publishers.

APPENDIX 1 Research Introduction



The research project

‘What constitutes ‘value’ in team leadership and effectiveness training programme for health and social care teams?’

INTRODUCTION

The emerging picture of London mental health services is characterised with a low morale, low job motivation and high turnover among multidisciplinary health and social care teams. It is estimated that the cost of mental illness in England adds up to £77.4 billion (The Sainsbury Centre for Mental Health, 2003, p.12) while mental illness costs London about £5 billion a year (National Health Service London, 2007, p.56). London spends annually over £1 billion on NHS mental health services. To tackle the problem, it has been agreed that development of multidisciplinary team working in mental health service is a key to improving the efficiency of mental health services. The training and education needs of the mental health workforce thus represent an enormous challenge facing the National Health Service. London Development Centre for Mental Health and NHS Leadership Centre, in association with Leeds University, designed a training programme for promoting and implementing team leadership and effectiveness. The ‘value’ of this programme is seen in improving the team effectiveness of multidisciplinary health and social care teams. While the ‘value’ of this programme can offer to teams is clear, very little is known about how ‘value’ is seen from the perspective of the decision makers, those who make the decision to invest into this type of programme. Often, they ask the question: ‘What ‘value’ can this programme offer to us?’ This has prompted a need for research into ‘What constitute ‘value’ in training programme for health and social

care teams?’ from the decision-makers’ perspectives. The London Development Centre for Mental Health, NHS Leadership Centre, and the Kingston University agreed to conduct this research.

WHAT IS IT ABOUT?

The overall aim of this research is to have an insight into the perceptions of decision-makers, involved in making decisions about investing into training programme, and how the decision making process itself happens.

HOW WILL IT BE TACKLED?

The objective is seen as an attempt to establish: Who are those decision-makers? How do they go about making decisions in relation to training? Why they make decisions in a particular way?

HOW WILL IT BE CARRIED OUT?

The research will be carried out by Zrinka Mendas, a researcher from Kingston University, under instructions of Margo Fallon from London Development Centre for Mental Health, over a period of 3 months. During this period, the researcher will conduct in depth interviews with a number of participants. It is anticipated that interviews will take an hour. The interviews will be recorded for research purpose. The researcher will abide by the codes of ethics provided by Kingston University. This will ensure that the interviews will be treated with strict confidentiality and anonymity. For participants, who may have concerns about the interviews and research, and who wish to contact the researcher or her supervisory team, the contact details are provided below. The time and the place will be agreed between researcher and participants. To ensure that participants benefit from interviews, a full report and recommendations will be distributed to them after the completion of the research by post.

HOW WILL PARTICIPANTS BENEFIT FROM THIS RESEARCH?

Participants in this research shall be given the unique opportunity to express their own views and add their expertise to important aspects that make up a decision making process. In this way, they shall make a direct contribution to better understanding of what drives and aids decision-makers in their decisions concerned with investment into training programmes. From a broader perspective, this research will offer a welcome opportunity for mutual private and public sector learning about decision making related to investment into training programmes and improving the delivery of 'value'. It is hoped that this study although based on investment into training will also provide a more general insight into the broad category of decision making in the NHS.

CONTACTS

Prof. Robin Matthews
Faculty of Business
Kingston University
Kingston upon Thames
Surrey KT2 7LB
Tel. 020 547 7443 (Office)
07775 895 710 (mob)
R.Matthews@kingston.ac.uk

Dr Thérèse Woodward
Tel 020 8547 7310 (Office)
T.Woodward@kingston.ac.uk

Zrinka Mendas
ZrinkaMendas@aol.com
Mobile: 07930301239

APPENDIX 2 Introductory letter from London Development Centre for Mental Health



The research project: 'What constitutes 'value' in team leadership and effectiveness training programme for health and social care teams?'

Dear participant,

Providers of mental health services are under enormous pressure to improve performance. To enable them to do so they need to identify which service development tools and techniques are best suited to their local context. The London Development Centre for Mental Health is keen to understand and learn more about how organizations make these types of decisions. It is therefore collaborating with a PhD student from Kingston University to research 'the process of decision making and talking specifically around the adoption and or commissioning training for an organization'.

The focus will be on the **Team Effectiveness and Leadership Training Programme**, one of several service development tools that the London Development Centre for Mental Health has made available to Mental Health organizations in London. As with all the service development tools individual organizations have the option to either implement the team training programme or to reject it. Some are currently delivering the training locally, others for a variety of reasons have decided not to implement it.

You have been identified, by Margo Fallon, as a person whom might be willing to participate in this research. I would strongly emphasize that it does not matter whether you chose to implement the Team Effectiveness Training or not. There is potential learning with both scenarios.

Participation would entail a structured interview, of approximately one hour, with the researcher. They can either come to your work place or alternative arrangements can be made for both of you to meet at the London Development Centre for Mental Health based at the Kings Fund building in Central London.

I hope you are agreeable to being part of this research. Please find attached a brief

outline further detailing the underlying thinking behind the research. If you wish to participate in this or have any queries please contact Hayley Barlow on 020 7307 2431 or email Hayley.barlow@londondevelopmentcentre.org by 21st January 2005.

Thank you for taking the time to read this request.

Yours sincerely



*Gemma Hughes
Programme Director
London Development Centre for Mental Health.*

APPENDIX 3 Relationships between Policy, Targets and Output

BOX 7: EXAMPLE 'EXPANDING VOCATIONAL TRAINING'

OVERALL POLICY OBJECTIVE

'To address the major skills deficiency in the UK by increasing training to be reflected in the numbers of people holding vocational qualifications'.

See Box 4 for the rationale for government intervention.

Examples of outcomes, outputs and targets:

Outcomes	Outputs	Targets
A socially optimal level of training	Human capital as a share of GDP	The number of training places that will be provided by a certain date
Higher productivity for both trainees and co-workers	Proportion of workforce with vocational training	Reduction in the percentage drop-out rate by a certain date

Source, Green Book (2003, p.15)

APPENDIX 4 Example of activities to be measured to achieve targets

Service Lines		Activity 000's (Spells/attendances)	Examples
Elective medicine	Complex	40	PCI, hepato-biliary procedures
	Non complex	165	Neuropathies, sleep disorders, scoping, renal, haem
	Long-term conditions	6	Planned admission for asthma, diabetes
	Under 17s	16	
Non elective medicine	Complex	60	Acute MI, stroke
	Non complex	260	DVT, pneumonia, pulmonary embolus
	Long-term conditions	46	Emergency admissions for asthma, diabetes
	Under 17s	12	
Elective surgery	Complex	126	Major GI procedures, transplants, neurosurgery
	High throughput	344	Cataracts, arthroscopy, hernia
	Minor procedures	73	Vasectomy, skin lesions
	Under 17s	53	
Non elective surgery	Complex	39	Trauma, major GI procedures, burns
	Non complex	147	ENT, fractures
	Minor procedures	2	Minor skin procedures
	Under 17s	19	
Obstetrics	Deliveries	114	Normal delivery, assisted delivery, caesarian section
	Antenatal admissions	103	Antenatal admissions
Paediatrics*	Paediatrics	89	Cystic fibrosis, neoplasms, epilepsy
	Neonatology	107	Neonates with major/minor diagnoses
Outpatient		8,255	New and follow up outpatient consultations
A&E**	Major	1,436	Emergency admissions, trauma
	Standard	581	Fractures
	Minor	1,832	Minor illness and injury
Community care		8,197	Health visitors, podiatrists, district nurses etc.
Primary care	GP & Nurse consults	27,836	GP and Nurse consultations
	Direct access diagnostics***	933	CT, MRI, ultrasounds, radiographs, etc

* HRGv3.5 Chapter P. Children assigned non-chapter P HRG are included in other service lines
** Based on national HAS 05/06 returns, split by Major/standard/minor proportions derived from St George's Healthcare Trust Feb-Aug 2006
*** GP direct access diagnostics estimated as 16% of 5.8m total tests in London - proportion derived from representative sample SHA data

Source: National Health Service London (2007)

APPENDIX 5 Benefit Categories

BOX 24: BENEFIT CATEGORIES		
Benefit		Example
Financial	Quantitative	Operating cost reduction, revenue increase
Non-financial	Quantitative	Number of customer complaints, reduction in road accidents, percentage of government on-line
Non-financial	Qualitative	Staff skills, staff morale
Outcome	Quantitative and Qualitative	Improved standard of healthcare

Source: The Green Book (2003, p.4)

APPENDIX 6 Types of Risk

BOX 4.3 GENERAL TYPES OF RISK

Availability risk	The risk that the quantum of the service provided is less than that required under a contract
Business risk	The risk that an organisation cannot meet its business imperatives
Construction risk	The risk that the construction of physical assets is not completed on time, to budget and to specification
Decant risk	The risk arising in accommodation projects relating to the need to decant staff / clients from one site to another
Demand risk	The risk that demand for service does not match the levels planed, projected or assumed.
Design risk	The risk that design cannot deliver the services at the required performance or quality standard
Economic risk	Where the project outcome are sensitive to economic influences For example, where actual inflation differs from assumed inflation rates
Environmental risk	Where the nature of the project has major impact on its adjacent area and there is a strong likelihood of objection prom the public

Source: The Green Book (2003, p.82)

APPENDIX 7 ABSTRACT FOR LYON CONFERENCE 2009**ABSTRACT****DECONSTRUCTING EVALUATION METRICS IN HEALTH CARE:
VALUE FOR MONEY AND CARE****Zrinka Mendas****Robin Matthews**

The paper describes the methodological approach of a Doctoral dissertation (and commissioned research) into Value for Money in the United Kingdom National Health Service; a vital issue, given population trends, public aspirations and scrutiny of taxation, and now, pressures of global debt.

Value for Money strategies have had success but the approach has been overly *top down*, target driven, too focused on quantitative outcomes; neglecting qualitative aspects especially care: sympathy, compassion and empathy, which are essential to health care but complex. The paper suggests a practical methodological approach to Value for Money that includes deconstruction, narratives, and (i) narratives, storytelling and the Socratic Method.

Evaluation in the National Health Service should involve an entire stakeholder perspective, outcomes should be derived bottom-up; vital, difficult to measure, capture or achieve qualities such as care, compassion, empathy can be achieved by the methodology we describe. People delivering and receiving care feel target driven. Value for Money has crowded out such qualities to the extent that, for example, nurses, seeing this happening, are afraid to speak out on the issue, so contrary has it become to the current, flawed Value for Money discourse.

APPENDIX 8 Correspondence Letter

David Boje [dboje@nmsu.edu]

Sent: 12 June 2009 04:24

To: Mendas, Zrinka

Cc: ocler@iseor.com; Henri Savall [savall@iseor.com] ; Marc Bonnet [bonnet@iseor.com] ; Matthews, Robin

Hi Zrinka,

The feedback is that I thought your approach to narrative and story was very exciting, groundbreaking, and innovative. You were able to apply ideas from the 2001 book on narrative methods, and go beyond them, using the Socratic Method. Ken Baskin and I have a book coming out on the Socratic Circle conference held in Las Cruces that Robin attended. I think the way you used the Socratic dialogue as a way for you and Robin to engage in reflexivity and to analyze the grand narratives and multi-perspective stories is an interesting approach. It seems to extend kinds of reflexive sense making that is only partially developed in my 2008 book, *Storytelling Organizations*, and the work of John Shotter, and Ann Cunliffe (reflexive practitioner). Perhaps you can keep working with your study and do some kind of article for QROM (Qualitative Research in Organization and Management), or *Journal of Management Inquiry*, or *Narrative Inquiry*.

I am letting the conference organizers know that you did a terrific job in your presentation.

All the best to you, and please visit us at the <http://scmoi.org> annual conference.

J. David M. Boje, Ph.D.
Endowed Bank of America Professorship,
College of Business,
New Mexico State University

Send correspondence to home address:

David Boje
4700 Dunn Drive
Las Cruces, NM 88011

Contact:

Email dboje@nmsu.edu
575-532-1693 voice
575-646-1372 fax

<http://business.nmsu.edu/~dboje> home <http://peaceaware.com/vita> and articles on line
<http://tamarajournal.com> journal
<http://scmoi.org> annual conference

Appendix 9 Stages I and II: List of participants from the National Health Service in study

Title	Organisation	Role
Training Lead for St. Georges Trust	Kingston University	My role is Senior Lecturer within the School of Nursing and within that, if you like, I'm a specialist teacher so I just teach one aspect which is course viability. I teach pre-registration students as well as continuing professional development students and the medical students. I'm the key liaison lecturer for the faculty so I liaise with St. George's Hospital which is mainly to do with the pre-registration students
Training Lead for Kingston Hospital Trust	Kingston University	I am a principle lecturer, but one of my roles is Course Director of the Diploma in Nursing programme. It is a three year programme with students leaving with a diploma in higher education and a registered nurse qualification. My responsibilities are to coordinate the foundation programme and all the branch programmes which are adult, child, mental health and learning disabilities. Roughly twelve groups of students, around 1500 students. Because our programme is 50% theory, 50% practice, they're not just staying in the schools. I represent Kingston Hospital as a key liaison. We meet here once a month in a formal meeting to look at issues with student placements, learning in practice, mentorship
Education Development Manager	North West London SHA, NHS Workforce Development Confederation	I am involved in commissioning education and training for primarily nurses, midwives, health visitors and speech and language therapists. I do the nursing and I take a lead in various care groups, and most of that education is pre-education, but when it comes to care-groups, it moves into post-registration as well. I lead on mental health and I am involved in working with representatives from each of the trusts in the Strategic Health Authority to look at what their requirements are for pre and post-registration education and training and how that might be influenced.
Finance Director	South West London SHA, Workforce Development Federation	My job is to invest the National Health Service's educational trust's money in South West London, in the workforce of the National Health Service. We have contracts with universities to train student nurses.
Head of Capital Investment	South East London SHA	My main responsibility is to provide technical advice and support around investment, the development of business cases for our investments, for the 14 National Health Service organisations which the Strategic Health Authority has responsibility for performance managing.
Director of Service Improvement and Strategy, Executive director	St. Georges NHS Trust	I am Director of Service Improvement and Strategy and I'm an executive board director for St George's National Health Service Trust. So, it's kind of two jobs rather than integrated into one. I'm also the Executive Director responsible for South West London's Improvement Academy. So for the Academy I'm representing the whole sector, making sure that the whole sector of 15 different organisations, Primary Care Trusts, Acute

South West London Academy		Trusts, Ambulance Service, ensuring that they're all getting what they need from the Academy, but my St George's job is very different, working for the interests of St George's Trust.
CEO	Kingston Hospital NHS Trust	I am accountable to the Department of Health for the financial probity of the organisation and the whole of clinical services within the organisation of delivering safe and effective services for the population base that we serve. I see my role very much as a leadership role in leading and guiding my team of executive directors, and also in terms of horizon scanning, being politically aware of the changing environment the health service operates within, so that Kingston Hospital can be responsive to that for now and for the future.
HR Director		I see my role as informing the Board of workforce considerations, and generally contributing to the Board. Also trying to ensure that decisions that we make are of benefit to the Trust workforce.
Service Manager	Camden Islington NHS Mental Health Trust	I manage health in adult care in the south of Islington. The ranges of services I manage are: community mental teams, crisis teams, early intervention teams, psychological outpatient day treatment. In terms of strategic role, I take a lead in the borough in personality disorder, early intervention service, and clinic liaison.
NHS Trust Training Facilitator	Tees and North East Yorkshire NHS Trust, NIMHE	My job role is I do leadership training and, I also do team working training. That will involve training more managers around their leadership skills, it will involve senior managers, and working with the whole team.
Trust Senior Organisational Lead, and Programme Lead at NIMHE	Bedfordshire and Luton Community Mental Health Partnership Trust	I work for Bedfordshire & Luton Community Mental Health Partnership Trust, located in Luton. With the Trust, my job role in the National Health Service is a Senior Organisational Development Lead, but I work for the Eastern Region for NIMHE, where I am the Programme Lead for Team Effectiveness and Leadership.
Section Manager	City and East London Mental Health Trust	I am a Section Manager. I manage different sections of adult mental health services, so I manage managers really. I manage the west of the borough, so that's both mental health teams, and the wards. A lot of my role is liaising with these managers, communicating around my area. I manage the budgets for these services, and I manage mental health and social care, so I manage the social workers as well. So there is a developmental part of the job, and a planning part of the job, although that sometimes gets lost in the day to day operation stuff. I'm part of the senior management team – I participate in the wider planning of our development of wider services, as well as development of the immediate services that I manage. I may also be on trust-wide or steering group.
Leadership Programme Co-ordinator, Service Manager	LDC, Hillingdon Primary Care Trust	I am the manager of the Occupational therapy service and the rehabilitation service and I also, I'm currently looking after the older people service as well. I'm also professional lead for the occupational therapists because that's my profession. So I'm responsible for the day to day running and delivery of the services, and managing the staff that do that. Occupational

		Therapy service is my primary responsibility but it's sort of evolved to take on more responsibilities: including inpatient wards, community teams, managing budgets, looking at business planning, looking at staff development, performance.
Service Manager	St Anne General Hospital, London	I am service manager at mental health wing at St. Anne General Hospital, and responsible for running secure psychiatric ward.
Programme Director	LDC	My responsibility is to set up development programmes in those work areas, which means identifying what's needed, coming up with solutions and ideas, finding out if people that are going to take part in those programmes find them useful. So consultation, identifying the needs, the outcomes and delivery of the programme.
Programme Director	LDC	I am one of 5 programme directors at the London Development Centre for Mental Health, directly managed by the Chief Executive Officer. Each of us has a portfolio of things that we do. Mine happens to be a lot of practice development work. I've got all the community teams assorted outreach crises, teenage teams, work on new guidance coming out like the personality disorder guidance, and eating disorders network. I lead on the carers' issues for the development centre, and a variety of things which tend to be about how mental health staff in the care system are working. Each programme director has a geographical patch, mine is South East London. That means I link with the Strategic Health Authority of South East London. Together we make sure that we cover the development needs of that sector.
National Development Lead	NHS Leadership Centre	I am with the National Development Lead for the team and network leadership workgroup at the National Health Service Leadership centre, which is part of the organisational area of the Department of Health.