SEDIMENTED ARCHETYPE CHANGE IN PUBLIC SECTOR ORGANISATIONS

The Example of Managed Clinical Networks for Cancer

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Abstract
There has been increased interest in the United Kingdom in network-based modes of organising in the public services, as opposed to markets or hierarchies. Such multi-organisational working has also been seen in recent reforms in health and social services in Australian and New Zealand (Baehler et al. 2005; Considine 1999). This paper describes findings from five case studies of managed clinical networks for cancer in London and considers whether the network model represents a transformational change in the way that health services are governed in the UK.
Rather than representing radical or transformational change, these findings have been theorised as demonstrating *sedimented archetype change*. These findings have implications for future health policy development, both in the UK and internationally.

Keywords: health service, networks, governance, archetype change

INTRODUCTION TO POLICY CONTEXT

Networks are emerging as a new, innovative organisational form in the United Kingdom (UK) public sector (Pettigrew & Fenton 2000). The emergence of more network-based modes of organisation is apparent across many public services but has been particularly evident in the health sector. Cancer services represent an important and early example.

The managed clinical network (MCN) model, as developed within cancer services, has been defined as "linked groups of health professionals and organisations from primary, secondary and tertiary care working together in a coordinated manner, unconstrained by existing professional (and organisational) boundaries to ensure equitable provision of high quality effective services" (Edwards 2002: 63). These networks were developed initially as a means of streamlining patient care and fostering the flow of knowledge between professionals and organisations.

Note, however that these new networks evolved to be *managed* rather than taking their traditional informal and tacit form. They were to employ management teams and be responsible for meeting the key targets outlined in government policy (National Health Service 2000a). In this politically sensitive sector there have been central targets imposed (eg. waiting times) which have been monitored through performance management. There has also been a strong policy focus on organisational restructuring, with centralisation of specialist services in centres of excellence.

This development relates to a higher-level theme of modes of governance in the UK public sector. During the 1980s the UK public sector saw shifts towards vertically integrated organisations, governed by general management and emphasising command, control and performance management on an individual level. The early 1990s then saw the emergence of the internal market (or "quasi-market") model where the NHS was divided into purchasers and providers. These purchasers and providers were aligned through internally regulated contracting processes. This model represented a more market-like NHS, top driven through forceful implementation strategies.

When the Labour government was elected in the UK in 1997, following many years of Conservative rule, "modernisation" became the narrative for the package of proposed reforms. New Labour attempted to shift the focus towards greater collaboration between providers and towards holistic governance, partnership and networking (Hamilton & Redman 2003; Newman 2001). The proposed networks were seen originally as preserving substantial local autonomy, open to pressure from below and regulated only in a "light touch" manner. It is argued that networks should present a greater learning capacity than markets or hierarchies, be more able to diffuse evidence based knowledge and good practice across a complex system and translate knowledge into desired service change.

This shift in governance also reflects policy developments in Australia and New Zealand (NZ). Following considerable privatisation of public services in the 1990s, Australian and NZ public policy is now similarly moving towards a more collaborative mode of governance, centred on networks as a model to deliver health and other public services (Baehler et al. 2005; Considine 1999).

Archetype theory is a useful model for theorising whether or not there has been a radical transition from a hierarchical and market orientation, to a network-based model. Greenwood and Hinings' (1993; 1996) conceptualisations of archetype change provide a useful basis for extending our theoretical understanding of organisational change in health care.

ARCHETYPE THEORY AND ORGANISATIONAL CHANGE

The emergence of the MCN model could be reconceptualised and understood through consideration of the dynamics of "archetype" change (Greenwood & Hinings 1993; Greenwood & Hinings 1996) – with networked organisations representing a potentially emergent archetype in the UK public sector.

Archetypes are considered to consist of three core characteristics – a formal structure, a system of decision-making and an underlying interpretive schema (rules, values and norms). For successful transition to a new archetype, there must be a radical, quick and parallel change in each of these components – particularly in the interpretive schema – the changes in which are then reflected in the systems and structure.

Archetype change is most likely when there is a strong and coherent reform ideology. Greenwood and Hinings (1993: 1058) propose that "organizations that have structures and systems that are not manifestations of a single, underlying interpretive scheme will move toward archetypal coherence". As such, it would seem that an enduring mixed governance model is theoretically impossible using this model of archetype change. Greenwood and Hinings (1988) propose that a successful "track" (or outcome) of archetype change is dependent upon de-coupling from the initial archetype and re-coupling with the emergent archetype and there are a variety of potential outcomes of this transition. They present the following typology of potential outcomes.

The most common track is *inertia*, where structural consistency is maintained over long periods of time and changes that do not comply with the existing archetype will be suppressed. Alternatively, some attempts at archetype change will fail where there is only limited de-coupling from the existing archetype (what Greenwood and Hinings (1988) refer to as *discontinued or aborted excursions*), some will partially work where there is incomplete de-coupling and incomplete re-coupling (*unresolved excursions*) and others will be successful (*successful reorientations*). Successful reorientations are the most difficult to achieve and a number of facilitating forces must be evident.

Movement between archetypes can occur, but the process of this movement is not well explored in the literature. Many studies focus on change within organisations, on successful change and on inertia – why organisations do not change. However, there is only limited research on aborted or unresolved excursions – that is, why some organisations are not completely successful when they do attempt change (Greenwood & Hinings 1988).

Kitchener (1998; 1999) used Greenwood and Hinings' (1993) model of archetype change to explain the introduction of the quasi-market in the UK. Kitchener suggests that the quasi-market example does not represent transformational archetype change, but rather the "co-existence of new structures and systems with a hybrid interpretive scheme that maintains established values and attitudes".

Similarly, Stokes and Clegg (2002: 226) conducted an ethnographic study of an Australian government department, and proposed that traditional bureaucratic and more enterprising governance models create new and differing power relations with contradictory and unresolved dualisms. New organisational forms see senior management fighting for power, and others struggling to retain "remnants of bureaucratic meaning". The department studied by Stokes and Clegg failed to meet the hopes of the reformists or allay conservative anxieties.

These and other findings (Cooper et al. 1996; Hinings et al. 1999; Kitchener 1998; Kitchener 1999; Kitchener & Harrington 2004; McNulty & Ferlie 2002; Stokes & Clegg 2002) provide a starting point for our empirical understanding of organisational change in health and social care, however this understanding can be further theorised to provide a coherent picture of archetype change in the public sector, professionalised organisational context.

RESEARCH QUESTION

Based on Greenwood and Hinings' (1988) archetype model and "tracks of change", the findings from five case studies presented here will provide the basis for beginning to understand whether attempts to introduce a network model of governance in the UK public sector represents a successful archetype change, or rather a more hybrid interpretive scheme.

This paper will review the findings from five case studies of MCNs for cancer in London, and consider how these theoretical findings can be reconceptualised within a broader theoretical

framework of archetype change. Does the network model represent an emergent archetype (that is, a consistent set of structures, systems and overriding ideology) in the UK public sector to replace existing hierarchical or market archetypes?

METHODOLOGY

Comparative case studies were utilised to provide an in-depth understanding of the five MCNs for cancer across London and the organisations and professional groups involved. These London networks are comprised of multiple teaching and local district hospitals, as well as service commissioners and health authorities – each contained within a relatively small geographical area.

This study examined three specific issues (or 'tracers') in order to gain some insight into power relationships in the newly formed MCNs for cancer. These tracers were: centralisation of specialist services; budget / resource allocation, and; education and training activities.

Case Studies – Triangulation

Three methods were combined to gather data – semi-structured interviews, document analysis and observation at meetings. Multiple data sources were used to address a wide range of issues, and provide a more convincing and robust contextual account. One hundred and seventeen semi-structured interviews were conducted with representatives from a range of organisations and key professional groups involved with the London cancer networks. Table 1 outlines the range of professional groups to which these interviewees belong.

Table 1. Interviewees by network and professional group[*]

	Network A	Network B	Network C	Network D	Network E	Total
Medical	2	7	9	9	10	**37**
Nursing	3	4	4	3	5	**19**
Managerial	1	4	3	3	0	**11**
Network Management	5	6	4	5	5	**25**
Strategic Health Authority	1	1	2	2	1	**7**
Primary Care	2	0	0	1	1	**4**
Palliative Care	1	1	1	2	0	**5**
Commissioners	1	1	3	2	2	**9**
Total	**16**	**24**	**26**	**27**	**24**	**117**

Key organisational documents were also analysed to provide a historical narrative of the development of the cancer networks and a textual indication of communication and accountability arrangements

[*] Networks are anonymised and referred to as "Network A", "Network B", etcetera.

between the organisations and groups within the networks. Network meetings were also attended to observe and gain further insight into how the groups relate in a professional environment.

Data Analysis

Interviews were tape-recorded and transcribed verbatim. Interview transcripts, documents and meeting notes were examined and coded using *QSR NVivo* software, to organise and manage the resulting data. Codes were developed to provide a basis for categorising and analysing data and the coding structure was then checked and validated by another researcher. The data was then scanned for specific cases that illustrated and provided evidence for the themes.

CASE STUDY FINDINGS

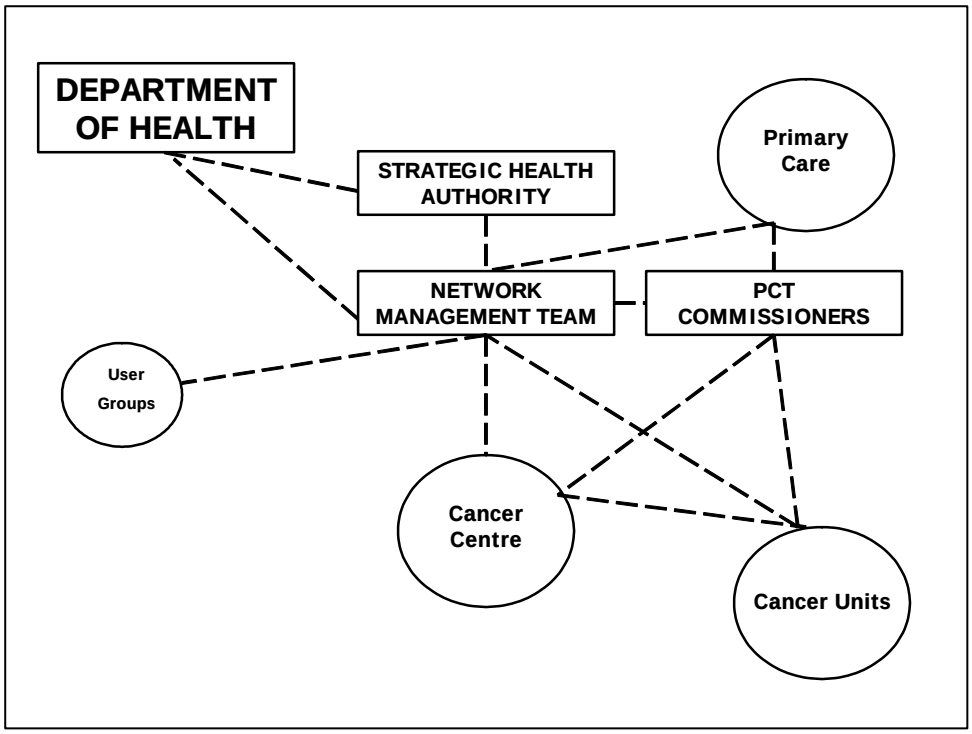
Due to the necessity to follow the national policy agenda, each of the five networks were structured in similar ways and governance arrangements followed a similar pattern across the case studies. As such, this section presents an amalgamated narrative of the case study findings, with vignettes from particular networks as appropriate. The following section will consider the networks in relation to the three identified tracer issues, followed by a discussion of the governance arrangements surrounding these networks – and whether the findings provide evidence for a move towards a network archetype.

Each of the five MCNs were managed by a Network Management Team, typically comprised of four core staff – a manager, lead clinician, lead nurse and a service improvement lead. The role of the Network Management Team was to facilitate communication between the professional groups and organisations that comprised the network. However, their function was frequently disputed by network members.

The MCNs more broadly consisted of various Tumour Groups, which were committees of representatives from primary, secondary and tertiary care – including acute service managers and clinicians (medical and nursing), primary and palliative care representatives, Strategic Health Authority stakeholders and cancer commissioners. Broadly speaking, the Tumour Groups were the substance of the networks and were responsible for establishing joint protocols for their particular tumour types. The Tumour Groups were also designed to establish arrangements for joint and compatible systems for data collection and audit.

Figure 1 provides an illustration of the stakeholders and relationships within a typical MCN.

Figure 1. Organisational structure and patterns of communication in an MCN



Centralisation of Specialist Services

One of the predominant initiatives of these newly formed MCNs was to designate the segregation of tumour-specific specialist cancer services. The National Institute of Clinical Excellence (NICE) is the clinical and technical advisory body to the NHS and the body responsible for supporting the implementation of the NHS cancer policy (National Health Service 2000a) and producing guidelines for centralisation of specialist cancer services. Adhering to these guidelines has become a key priority for MCNs in London and is an example of the top-down autocratic approach to the structural configuration of these networks.

The requirement for centralisation was determined on a national level – by the Department of Health through NICE – however the localised configuration decision was dominated by a sub-group of medical professionals in each of the networks.

Medical professionals from acute teaching Trusts dominated decision-making to achieve the ultimate objective of their organisation becoming a cancer centre. Of these networks, medical dominance was most evident in Network B where powerful clinicians from the specialist cancer Trust acquired control of enacting policy and distributing resources, due to an under resourced and ineffective Network Management Team and an inattentive Health Authority. In this case in particular, a sub-group of medical professionals exerted their influence over other stakeholders – especially cancer unit clinicians – to acquire resources and ultimately the coveted designation of cancer centre status.

Budget and Resource Allocation

Initially Network Management Teams believed that they would be assigned responsibility for commissioning some – if not all – cancer services within their individual network. One view is that these networks require direct responsibility for funding, as the organisations within may have competing and incompatible objectives and priorities and will be unable to make funding decisions on a network-wide basis. Instead, commissioning responsibilities have been reallocated to Primary Care Trusts (PCTs), reflecting the government's intention to devolve decision-making and financial responsibility to a local level (Department of Health 2001), whereby PCTs now control up to 75% of the NHS budget (Le Grand 2003) – including the delivery of cancer services.

While PCTs were ultimately responsible for commissioning health care in the NHS, the role of Health Authorities was to provide leadership to ensure delivery of improvements in health and health services (Department of Health 2001). Health Authorities are the localised representatives for the Department of Health, and broadly responsible for performance management of the health service "on the ground". Health Authorities are responsible for ensuring that all aspects of the health economy – primary, community, secondary and tertiary care – work together to deliver on health policy (National Health Service 2000b), as well as having a strong performance management role. "With performance management delegated mainly to StHAs [Health Authorities] they will in effect be responsible for managing NHS locally on behalf of the Department [of Health]" (Department of Health 2002:10).

Education and Training

Initially policy documentation (Calman & Hine 1995: 7, 11) recommended that medical professionals involved in the proposed networks should take part in "professional education, development and audit so that the current knowledge is rapidly available and disseminated" as a means to "deliver a uniform standard of high quality care to all patients". The report further stressed the importance of multidisciplinary consultation and management. By 2000, policy (National Health Service 2000a) largely focused on the structural configuration of services, performance targets and workforce planning. However reports did maintain the focus on multidisciplinary education and training. In 2001, the NHS Confederation (2001: 3) reiterated that these MCNs were an appropriate model for coordinating clinical services, where "members of the network need to surrender sovereignty to achieve shared objectives" – focusing on the centralisation of specialist services.

Although MCNs were initially conceptualised by clinicians as a novel and professionally acceptable method of sharing knowledge across professional and organisational boundaries, the model is under increasing control by the Department of Health as the activist centre. The key MCN priority is to adhere to centrally driven targets and guidelines, such as delivering key policy targets.

Initial policy stressed the importance of professional education and development, and multidisciplinary consultation and management. A decade since the initial cancer network policy, this focus on sharing and spreading knowledge across cancer service providers has virtually disappeared.

Governance and Accountability

The intended composition of membership across the five MCN Boards generally followed a similar pattern – PCT commissioners, Trust CEs, senior clinicians and Network Management Team representatives. Network D drew attention to problems associated with attendance being delegated to less senior representatives from the acute Trusts, which hindered decision-making. The frustration was felt by members of the Network Management Team, as well as those in less senior roles who were required to attend the meetings. In particular, lack of senior representation on the Board resulted in problems in decision-making on the centralisation process, as the appropriate personnel were not present to make the necessary decisions, with the Health Authority threatening to intervene in order to resolve the conflict. The Chair of the Board felt that referring decisions from the network Board reflected badly on the ability of the organisations involved to make decisions, which may then impact on clinical engagement in network activities.

Overall, the Health Authorities and Boards assumed a more "hands off" role, rarely becoming involved in operational decision-making. Typically, the Board and Health Authority adopted a more removed "signing off" function, with minimal operational contribution. This had the added consequence of ensuring that service providers did not feel overly performance managed on a clinical level by the network model and Health Authority. However, this is not meant to indicate that they did not feel controlled by the Department of Health policy direction. Service providers from all networks felt that increasing top-down control was not necessary or appreciated.

Decision-making regarding service reconfiguration in most networks did involve different stakeholders, but was considerably medically dominated – especially amongst those from the cancer centres. Management were responsible for developing the business cases, but ultimately considered the network to be reliant upon clinical cooperation to carry out any organisational change. There were thought to be too many clinicians on the network Boards who "dominate the agenda". The Health Authority of Network C described a Board meeting as consisting of "clinicians around the table…all arguing their own corner". There was no evidence of cooperative decision-making in many instances, and instead communication was characterised by considerable conflict and medical dominance. There did not appear to be significant decisions made through this forum.

Although the Department of Health were ultimately responsible for developing the MCN agenda, they were considerably removed from actual enactment. Health Authorities were the localised representatives for the Department of Health, and broadly responsible for performance management of the health service "on the ground". However, as the Health Authorities were more localised, they were

required to interact and negotiate more closely with a multitude of stakeholders and their influence was not as definitive or direct as that of the Department of Health on national strategic development.

Broadly, the Department of Health is demonstrating top-down control over the London MCNs through (i) the imposition of performance targets focusing in particular on waiting times, and (ii) structural reconfiguration. Information regarding performance targets is fed to the Department of Health (via the Health Authority) on a Trust-by-Trust basis, which is then displayed on the Department of Health website. The Department of Health approach individual Trusts if there are any failures to meet the targets, otherwise the data does not appear to be used in any way. Given the additional focus on structural reconfiguration, there were no resources or time to collect or analyse any additional data that did not form part of the core performance management target reporting.

The explicit understanding within MCNs is that lack of compliance with the reconfiguration recommendations will impact on the performance measures of the individual Trusts, which in turn will have financial implications. There were no avenues for negotiation or discussion regarding these edicts. Therefore, the *guidance* is not so much based on recommendations, but on directives – there is no option but to comply.

As such, the rise of the Department of Health and Health Authority as a combined power source, responsible for steering MCNs, represents a new and noteworthy finding. To reiterate, Health Authorities were to provide leadership and ensure delivery of improvements in health services (Department of Health 2001). Health Authorities are responsible for ensuring that all parts of the health sector work together to deliver on policy recommendations – this is largely achieved through a process of performance management.

The above discussion conceptualises the emerging role of the Department of Health and Health Authorities as a combined national and local authoritative entity, responsible for defining the structure and function of MCNs in the UK. For that reason, one could ask how well the MCN model represents a network, or whether it actually bears characteristics more similar to a bureaucratic hierarchy. This question will be considered in the following section.

DISCUSSION

The context illustrated here presents a case for exploring why the NHS was unable to successfully transform to a collaborative, network archetype. Greenwood and Hinings (1993; 1996) suggest that successful archetype change requires de-coupling from the existing archetype and re-coupling with the emergent archetype. However, it could be argued that the NHS has failed to successfully de-couple from either of the two orientations that preceded post-NPM governance and that the resulting hybrid of archetypes is enduring over time.

The findings presented propose that the dichotomous nature of archetypes is insufficient for examining the complexity of the health system. Greenwood and Hinings acknowledge that an organisation may be "between" archetypes and their tracks of change represent the temporal association between archetypes. However, they do not consider that an organisation may continue to embody hybrid elements of a range of archetypes with only limited movement between the dominance of each at different points in time.

Successful archetype change requires a fundamental shift in the three core identified components – formal structure, decision-making system and underlying interpretive schema. For successful transition to a new archetype, there must be a change in each of these components (Greenwood & Hinings 1988). It will now be argued that there has not been a fundamental shift in each component, but rather a complex and inconsistent movement among a limited sub-set of these characteristics.

The findings presented here indicate that attempts at radical change in the health care setting can be considered to concentrate almost exclusively on the transformation of *formal structure*. The MCNs were instructed to, and became preoccupied with, adhering to the Department of Health's requirements for structural reconfiguration, to the detriment of other collaborative knowledge-sharing activities. Considerable attention was assigned to where services are to be delivered, and resulted in much conflict between stakeholders – detracting attention from the initial remit of sharing and spreading best practice across organisational and professional boundaries.

To a lesser extent, there were some limited attempts to transform the *systems of decision-making* through networks with Network Management Teams appointed to manage network activities and Boards appointed to oversee localised network development. However, in practice these groups had minimal decision-making influence within a prevailing bureaucratic structure. Although the espoused logic was to decentralise decision-making, such power was ultimately ascribed to PCTs rather then MCNs – with Health Authorities as an intermediate tier. Centralised guidelines, stringent standards for network formation and function, a national peer review programme and performance management targets have all ensured that network stakeholders only have limited scope for making any strategic decisions at all.

The third (and considered to be the most significant) characteristic of an archetype, the *underlying interpretive schema*, was the most notably omitted feature in the MCN model. Although the model was intended to represent a familiar manner of working to clinicians, service providers and managers continued their loyalty to their individual organisations, and their ideas, beliefs and values were not aligned with those of the Network Management Team or the broader network as a whole – indicating that the MCN ideology was weak. Ultimately, the most fundamental characteristic for successful archetype change was absent from attempts to transform the delivery of public services under New Labour.

The same argument could be made for understanding the introduction of the internal market model in 1991. Amongst these attempts at reform of public services in the UK, the government have been unable to transform the underlying interpretive schema away from bureaucratic governance. Any attempts to devolve accountability to a local level have been consistently superseded by a continued emphasis on centralised accountability, through a bureaucratic hierarchy.

As such, the findings presented here demonstrate that elements of hierarchical, market-oriented and network archetypes each exist simultaneously within a complex and conflicting organisational framework of accountability. The enduring hybrid archetype formation can be explained by limited successes in challenging the prevailing, and potentially conflicting, underlying interpretive schemas of professional dominance and bureaucratic hierarchy. Rather than simply being "between" archetypes, the NHS instead embodies elements of a range of archetypal structures and values to varying degrees, at varying points in time. Table 2 provides an overview of how this range of archetype characteristics is demonstrated in the British health care system.

Table 2. Examples of the Range of Archetype Characteristics Evident in the NHS

Mode of Governance (archetype)	**Archetype Characteristics**		
	Structures	**Systems of Decision Making**	**Interpretive Schema**
Hierarchy	Centralised structural reconfigurations mandated by the State and enforced on a local level	Centralised performance management and national targets	Professional dominance Bureaucratic accountability
Market	Purchaser-provider split Commissioners contracting for services	National guidance requires individual hospitals to "bid" for resources, against others in network	Preferred emphasis on centralisation of services and resources
Network	Establishment of multidisciplinary and cross-organisational tumour groups	Network Board and management team empowered to make some decisions on network activities	Continuation of informal networking and referral patterns

These findings instead suggest that the dynamics of archetype change in the UK public sector cannot be characterised in such a dyadic manner, but that the complexity of the context needs to be taken into consideration. The temptation to reduce the organisation of public sector governance into "either/or"

categories – or even to consider the "tracks of change" to be moving in a particular definitive direction – fails to appreciate the complicated and incongruous nature and delivery of health policy in the UK.

This rejection of Greenwood and Hinings (1988; 1993) approach to archetype change instead leads the way for a theoretical reconceptualisation of sedimented archetype change, that extends on work in other professionalised organisations (Cooper et al. 1996; Hinings et al. 1999) and explores why there has not been a move towards a coherent and stable archetype as Greenwood and Hinings predict.

Sedimented Archetype Change

As explained, Greenwood and Hinings' (1988) tracks of archetype change have shown to be inadequate for understanding organisational change in professionalised organisations. Instead, it is proposed that archetype change is non-linear and non-transformational, and could be instead regarded as "sedimented" – whereby different archetypal structures, systems and interpretive schema are layered, providing a competitive and conflictual organisational environment.

Sedimented change can be conceptualised in contrast to transformational change. While transformational change is considered to be radical and dyadic, sedimented change is characterised as a more gradual, non-linear and hybridised process whereby features of multiple archetypes are layered in a sedimented manner, resulting in an organisational model that is based on a series of potentially contradictory and competing characteristics. Early theorising of archetype change in organisations (Greenwood & Hinings 1988; 1993; 1996) focused on hybrid states as transitional and temporary, however sedimented archetype change would instead suggest that these hybrid states are enduring. In the case presented here, sedimented features of hierarchical, market and network archetypes are each present in an oscillating, but nevertheless, enduring state – focused simultaneously on competition, a purchaser-provider split, collaboration and centralised accountability. Characteristics of both market and network archetypes maintain dominance at different points in time, but continue to operate concurrently within an overarching and enduring bureaucratic hierarchy.

Previous studies of archetype change in law and accounting firms (Cooper et al. 1996; Hinings et al. 1999) indicate that market forces operate as a motivator for the adoption of a new archetype. Alternatively, public sector organisations provide a distinct institutional setting, where a range of strong professionals are somewhat insulated from these market forces and globalisation that affect law and accounting firms. Further, while law and accounting firms are dominated by the principal professional group, the health care setting is comprised of a range of stakeholders – one of which is the dominant medical profession, another of which is the dominant state. These present multiple enduring and competing fields, where pressure from the state regarding organisational form continually oscillates.

The prevailing and competing dominant interests of the medical profession and the state have ensured that transformational change in the health care setting has not been evident. The health care setting

provides a unique organisational example of a professionalised industry, regulated by the state. Private sector organisations are not subject to the degree of external and centralised regulation that is evident in the public sector. While accounting and law firms respond to market forces, public sector organisations respond to state control and professional dominance.

Although the NHS was to operate within a quasi-market and then a collaborative network model, the state failed to engineer reinforcing cultural change of the underlying interpretive schema, rather focusing primarily on formal structures and systems of decision-making to a lesser extent. Both the quasi-market and network archetypes have focused on structural change, which can be most clearly seen in the example of MCN development presented here. Both archetypes have also espoused decentralised systems of decision-making, whereby local authorities are given responsibility for allocating funds. However, in reality these decision-making systems are still constrained in their agenda by top-down control and direction of government policy.

Throughout these state-initiated attempts at archetype change that focus on transforming the formal structure of the health care setting, the underlying interpretive schema has continued to be characterised by professional dominance. The medical profession continues to resist attempts at archetype change that threaten and do not legitimate their privileged position. Both the quasi-market and managed network approaches conflict with their privileged status, as they are both focused on increasing the prominence of non-medical stakeholders.

CONCLUSION

The major theoretical contribution of this paper lies in the reconceptualisation of these conclusions into a theory of archetype change in professionalised public sector organisations. Early considerations of archetype change suggest that organisations which do not embody a consistent collection of structures and systems will attempt to move towards a common archetype (Greenwood & Hinings 1993). However, analysis of the current context demonstrates partially formed, overlapping and conflicting archetypes, which generate confusion and frustration within an organisation. However, these tensions continued over a long period of time and were not resolved through a return to a coherent archetype.

Rather than representing radical or transformational change, these findings from a professionalised organisational context have been theorised as demonstrating sedimented archetype change. A hybrid interpretive scheme has prevailed, whereby the characteristics of a range of conflicting archetypes coexist. Examples from other professionalised organisations (Cooper et al. 1996; Hinings et al. 1999) emphasise the significance of market forces in archetype change. However, the health care setting as a public sector, professionalised context highlights the combined and conflictual impact of state command and control and medical dominance in generating sedimented archetype change.

These findings not only have implications for policy makers in the UK, but also resonate with reforms in Australia and NZ where public services have undergone major restructuring over the past several decades. In Australia and NZ, recent attempts at collaboration and knowledge-sharing in health services (particularly in primary care) similarly coexist alongside a continued focus on performance management and a purchaser-provider division (Baehler et al. 2005; Considine & Lewis 2003).

Distrust of professional self-regulation and the responding dominance of managerialisation have emerged as continuing considerations in health policy development. These continual attempts to undermine professional autonomy (Ferlie & Pettigrew 1996) have largely failed to penetrate the dominance of an elite sub-group of medical professionals within a given context. However, the prevailing focus on structural reconfiguration has damaged many long-standing clinical relationships and their attempts at knowledge sharing and collaboration. Heavy-handed attempts at structural reform increase the divide between local providers and policy makers. An effort should be made by policy makers to actually put into practice the espoused rhetoric of decentralised decision-making.

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