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Exploring the neglected and hidden dimensions of large-scale healthcare change

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Abstract

Forms of large-scale change, such as the regional re-distribution of clinical services, are an enduring reform orthodoxy in health systems of high-income countries. The topic is of relevance and importance to medical sociology because of the way that large-scale change significantly disrupts and transforms therapeutic landscapes, relationships, and practices. In this paper we review the literature on large-scale change. We find that the literature is dominated by competing forms of knowledge, such as health services research, and show how sociology can contribute new and critical perspectives and insights on what is for many people a troubling issue.

Key words:
Large-scale change, Healthcare policy, Health services research, critical theory, governmentality

Regional 'reconfigurations' of clinical services, and other forms of large-scale change, are an enduring orthodoxy in health systems of high-income countries, despite limited evidence of either clinical or financial benefits (Bal 2017, Jones and Exworthy 2015, Fulop et al 2005). While some scholars have viewed these policies and programmes as a manifestation of managerialism, legitimated as originating in the private sector (Kitchener and Gask 2003), others have traced a longer history, surfacing an instrumental rationality that has attracted a confluence of clinical, economic, and techno-managerial interests (Jones and Exworthy 2015). For policy elites, large-scale change serves a performative function, showing, clearly, that 'something is being done' (Coid and Davies 2008), and yet that same visibility can generate opposition on the ground (Stewart and Aitken 2015, Barnett and Barnett 2003).

Despite the inherently political nature of healthcare planning, policy and planning texts often cast large-scale change as a technical intervention to address healthcare problems (Fulop et al 2012). Academic literature on the topic is dominated by instrumental evaluative research that presupposes the need for change and is concerned with judging the 'success' of changes that have been introduced in terms of clinical or economic outcomes. In contrast, sociological approaches understand that healthcare change occurs within contexts of organisations, communities and places. Health services employ local people, sit at the centre of communities, and act as a symbol of the wider health system. Sociological research can offer valuable perspectives on the macro, meso and micro-level processes through which services change, and on what is left behind.

We review the literature on large-scale change, following the narrative tradition within sociology (Waring et al 2016, Martin et al 2015, Davies 2003, Griffiths 2003, Learmonth 2003). Our analysis is thematic, aimed at describing, summarising and interpreting a diverse body of literature. It is also explicitly critical, asking questions about the nature of power, culture and practice, and identifying additional perspectives. Our aim is to articulate a sociological contribution to understanding large-scale change, with implications for the study of healthcare policy more generally. We ask, what might sociology contribute to an understanding of large-scale change? And how does the study of large-scale change extend our understanding of social processes? Our analysis develops sociological perspectives in three areas: local meanings, cultures and identities; leadership, co-optation and control; and framing, evidencing and strategies. We illustrate our analysis with examples from sociological research in a range of relevant areas, showing how the unique sensibilities and theoretical resources of sociology can enrich research, support public debate, and enlarge and rebalance healthcare policy.

Health services research and the 'technicist' impulse

Ferlie (2016) argues that there has been a decline in social science-based analysis of organisational change in the context of public policy. He attributes this to competing forms of knowledge, such as health economics, management consultancy, and health services research. Health services research is an applied field that has grown rapidly since the 1990s. In the UK this is partly an effect of funding - health services research has attracted substantial resources from the newly created (2006), government-funded National Institute of Health and Research. According to Black:

> The aim of HSR is to provide unbiased, scientific evidence to influence health services policy at all levels so as to improve the health of the public. It is not a scientific discipline but draws on and uses a wide range of methods from several disciplines including

> sociology, statistics, economics, epidemiology, psychology, and history. It also requires input from and an understanding of biology, medicine, nursing, and other clinical areas. (1997, p1834)

Ferlie describes health services research as having developed in a 'near clinical' manner 'with a predominant interest in microanalysis and the evaluation of discrete service interventions (e.g. a new model of service delivery). There is a strong focus on the specification of clinical outcomes and cost effectiveness, albeit combined with some interest in organizational processes'. (2016, p7).

Our paper develops and extends a project aimed at fostering dialogue between those working at different positions on the 'translational spectrum' in healthcare research (Cribb 2018a). Whilst recognising the moral seriousness of research geared to the concerns of practitioners and policy, Cribb identifies a 'technicist' impulse, defined as a focus on identifying technical solutions to healthcare problems, underpinned by a means-end rationality, with the end defined in operational terms. Cribb acknowledges that the technicist orientation embodies some important values – it enables the measurement of effectiveness (important for professional account-ability), and facilitates communication and transparency. However, he argues that some values, perspectives and features of health care are neglected or obscured. The ethos is collaborative and inclusive. The aim is to expand and enrich healthcare research, debate and policy through greater attention to the social, cultural and political dimensions of healthcare. A recent example of this project is the Sociology of Health and Illness monograph on safety (Allen et al 2016). In a review of policy, practice and research on healthcare quality and safety, Waring et al (2016) identify an 'orthodox paradigm', which draws on clinical and behavioural sciences, and a broader 'sociological' paradigm. Although sociology has already made a significant contribution in this area, Waring et al identify addition contributions, both critical and complimentary, that enable a fuller understanding of quality and safety.

We extend this lens to large-scale changes to clinical services. Our analysis is informed by a review of research on this topic. For this review we defined large-scale change as:

> Policies, strategies or interventions that aim to transform the way multiple care services are coordinated at the inter- and intra-organisational level to address a single service areas (e.g. stroke) or integrated service domain (e.g. primary care).

We searched relevant databases (Pubmed, ProQuest, Scopus, Google Scholar) for research published in the last 10 years (since 2006) using a range of terms including 'healthcare' (health care), 'major system'; 'whole system'; 'service'; 'reconfiguration', 'change', 'reform', 'centralisation', 'regionalisation', 'implementation', 'policy process', 'leadership' and 'workforce'. We excluded clinical studies, studies of single organisations, studies from low and middle income countries, and macro-level studies of health system-wide restructuring. Limited resources meant we were restricted to English-language studies. This strategy produced 322 papers. We then read the abstracts of these papers, excluding those that did not meet our definition of large-scale change. This left 24 papers for our review. To these we added two reviews identified from the 'grey' literature (Immison et al 2014, Spurgeon et al 2010). Of these 26 studies, 6 were reviews of the international literature (Balasubramian et al 2016, Dalton et al 2015, Immison et al 2014, Perla et al 2013, Best et al 2012, Spurgeon et al 2010). The remaining studies were from England (Turner et al 2016, MacFarlane et al 2013, Greenhalgh et al 2012, MacFarlane et al 2011, Hunter et al 2014, Greenhalgh et al 2009, Barratt et al 2015, Morris et al 2014, Fulop et al 2012), Scotland (Jansen et al 2016, Farmer and Nimegeer 2014, Dattée and Barlow 2010), Canada (Evans et al 2015, Edwards et al 2011, Gilbert et al 2015), the United States (LaVela and Hill

2014, Tatman and Zauner 2014, Scott and Steinbinder 2009), Sweden (Nyström et al 2014), and South Africa (Schneider et al 2014).

The majority of studies identified from our search strategy were implementation or evaluation studies concerned with identifying 'barriers' and 'facilitators' to implementation and change. This literature is highly normative in that it assumes that change is necessary. For example, in the introductory framing of their paper, Scott and Steinbinder (2009) argue that:

> It is increasingly understood within the healthcare industry and the public domain that transformation of our healthcare delivery system is needed to achieve and sustain effective healthcare in the future. This transformation, or radical change, requires 2 large-scale efforts: (1) fundamental changes in the underlying beliefs and assumptions that perpetuate the current system and (2) a fundamental redesign of the multiplicity of diverse and complex subsystems that result in unpredictable aggregate behaviour and outcomes. (Scott and Steinbinder 2009, p335)

Here the suggestion is that 'the problem' is 'everything', and system effectiveness can only be realised by changing 'everything'.

Studies often adopt prevailing policy framings that represent large-scale change as the means to stated policy objectives. For example, in a review of 84 studies from the international literature on 'large-system transformation' (2012), this framing is incorporated as part of the definition used for the review:

> Large-system transformations in health care are interventions aimed at coordinated, system-wide change affecting multiple organizations and care providers, *with the goal of significant improvements in the efficiency of health care delivery, the quality of patient care, and population-level patient outcomes.* (Best et al 2012, p422, emphasis added).

Some studies employ theory to guide their analysis, particularly complexity theory (e.g. Nystrom et al 2014, Schneider et al 2014, Dattée and Barlow 2010), diffusion of innovation theory (e.g. MacFarlane et al 2011), and realist evaluation (e.g. Greenhalgh et al 2009). Sociological themes, such as political influences, professional power and cultural differences, are widely acknowledged, but the focus is largely instrumental (how can we make it work?) with little attention to the dynamics of social power. For example, the focus of the Best et al review is on formulating recommendations for successful implementation:

> Our rapid realist review identified five "simple rules" of LST that were likely to enhance the success of the target initiatives: (1) blend designated leadership with distributed leadership; (2) establish feedback loops; (3) attend to history; (4) engage physicians; and (5) include patients and families. (2012, p 421)

One deviant case is a study of community participation in healthcare planning in rural and remote areas in Scotland (Farmer and Nimegeer 2014). Farmer and Nimegeer distinguish between 'top down' approaches to healthcare planning, that use rational, algorithmic models and prescribe standardised service designs; and 'bottom up' approaches, that incorporate community participation in discussing local priorities, and customise services to local context. Drawing on broader social-science theories, and applying community-based participatory action research, the paper describes four case studies of community participation in healthcare planning, describing the different methodologies, and the range of service models that were produced.

Overall, however, the literature reinforces dominant policy arguments, for example, that centralising hospital care (providing services in fewer, larger units) is good for patients, standards and resources. Few studies question this orthodoxy, or offer a more critical interpretation of the governing rationalities of reform and the implicit imperatives for resource constraint and control. It is premised on a rational and technocratic model of planning and change, leaving unspoken questions about how centralisation reinforces the status and power of established tertiary centres, the nature and implications of super-specialisation, and new forms of professional hierarchies.

A more sociological perspective suggests a number of questions that can be asked of the extant literature. Taking the Best et al (2012) review as an exemplar (Learmonth 2003), we ask, how does the use of 'simple rules' frame phenomena or influence the reader? Why is large-scale change assumed to be a good thing? Why are professions and publics seen as oppositional or problematic? Why are issues of politics and power excluded from analysis or reduced to formal institutions? In asking these questions sociology can uncover the governing rationalities that underlie research and policy in this area. Sociology can also contribute to an understanding of large-scale change by bringing in alternative issues, perspectives, paradigms, and values. This will not only provide new insights but will make research 'better' - 'ethically, politically, empirically and theoretically' (Janssens and Steyaert 2009, p144).

In the remainder of the paper we suggest ways in which sociology can contribute insights to our understanding of large-scale changes to healthcare, using examples from empirical and theoretical research in a range of areas to illustrate. We suggest that sociology can contribute important insights under the following themes: local meanings, cultures and identities; leadership co-optation and control; and framing, evidencing and strategies. This ordering framework was derived in an interpretive manner, inevitably reflecting our experience of fieldwork, areas of interest, and theoretical proclivities (Yanow et al 2012). The examples have been chosen to illustrate the sociological contribution to large-scale change in terms of additional and alternative questions and perspectives, and potentially fruitful theoretical resources.

Local meanings, cultures and identities

Sociology can contribute to an understanding of large-scale change by exploring the experiences and perspectives of patients and recipients of care, which are largely missing from the extant literature (Dalton et al 2015). The sociological analysis of Lawton et al (2005) focuses on the meanings and understandings patients attach to the kinds of services they receive and to the types of healthcare professionals they encounter as part of their care. Lawton et al explored how patients with diabetes perceived and experienced changes aimed at shifting care from hospital to community settings. They found that patients did not always value a transfer of care. Some patients associated the care provided by specialists located in hospitals with quality, while others assumed that a transfer of care meant that their condition was not serious, or that they were better. Their analysis recognises the dynamic interplay between patients and the healthcare system. The context of health service delivery shapes patient perceptions, and these, in turn, influence patient expectations and preferences for health services. For medical sociologists, Lawton et al's analysis highlights the importance of the context of health service delivery, and the broader political economy of healthcare, in explaining the perceptions and behaviours of patients.

Sociology can also provide a nuanced analysis of the role and influence of professional identities and boundaries. Huby et al (2014), for example, show how large-scale change shapes, and is shaped by, negotiations about professional boundaries. They found that fierce resistance to change from senior hospital doctors was not a 'barrier' to change but did alter the character of the change. In this case, from a collaborative venture between clinicians, to a management driven initiative which addressed primarily the commissioner's concern for limiting costs and control of hospital resources. Huby et al argue that the senior doctors' strategy of entrenchment was detrimental to their position because it led to their isolation and prevented their involvement in service developments that could benefit them. In their case study, medical staff who participated as change agents were also the most successful in protecting and expanding their professional boundaries.

A key contribution of Huby et al's sociological analysis is in underlining the importance of professional and organisational hierarchies. They develop an analysis of professional hierarchies through the lens of social capital. They found that nurses lacked the cross-boundary 'linking' relationships that helped GPs and consultants exert influence and effect change. These relationships can have a 'dark side' (Currie, Finn and Martin 2008), benefiting those in higher positions in organisational hierarchies and excluding other actors from participation.

Importantly, sociological scholarship can enhance an understanding of large-scale change by illuminating the multiple meanings attached to healthcare facilities. Healthcare facilities are often important to local communities, embodying a 'sense of place' (Eyles 1985). Hospitals, in particular, often hold important symbolic properties (Kearns and Joseph 1997, 1993). In addition to providing support for local needs, healthcare facilities may represent a significant source of local employment, and embody the political identity of an area, fostering a sense of community ownership. Brown (2003), for example, suggests that in the UK the district general hospital is often symbolic of the foundation of a post-war 'welfare state', through which the idea of communality or common citizenship has been defined, and of an ideological commitment to the provision of a comprehensive national health service. Meanings and attachments may, however, vary between facilities, explaining, in part, variation in the extent of community resistance to closure (Brown 2003).

Competing conceptions of space are central to many intractable policy controversies, not just in healthcare, but other sectors, such as education and the environment. These can be found in the discourses of political actors, both those used to 'sell' healthcare policies to the public and those of resistance. In political contests over hospital closures spatialized language is an important tactic, especially invocations of 'the local' (Moon and Brown 2001). In a study of government plans to close 'Barts', a prominent and historic London hospital, Moon and Brown (2001) show how the political contest involved the mobilization of competing representations of the same space. The geometric analysis of travel times and catchment populations presented by government agents was countered by three alternative representations, broadly associated with different stakeholders: a local hospital serving a deprived population (managers); an international centre of medical expertise (clinicians); and a tangible expression of London's cultural heritage (public groups, politicians, and the London and national media). Central to this notion of the hospital as a monument was the historical legacy of the hospital and its association with significant events, such as the Great Plague, the Fire of London, and the Blitz. Moon and Brown argue that the government's rational planning analysis neglected the 'dual significance of the hospital as a site of therapeutic care able to support the citizens of London in times of particular need and a site which symbolises the capital city's many heroic struggles' (2001, p54). The isochronic maps produced by government agents presented the spatial as transparent and unproblematic, a view that 'excluded the possibility that the spatial exists at the level of social

imagination and impacts upon the everyday lives of individual people' (2001, p54). Moon and Brown show how in political contests over service closures hospitals emerge as 'more than mere sites of medical expertise, they are material objects that hold particular symbolic significance and act to unite individuals in an otherwise fragmented urban landscape' (2001, p 56).

More recently, Ivanova et al (2016) explored the multiple ontologies of 'carescapes' in an ethnographic study of a nursing home facing closure on a Dutch island. In this case, the ontology of care embodied in national healthcare governance (as defined by quality standards and protocols) combined with local understandings of the nursing home. This building was 'home' to the residents. As the only recognisable health facility on the Island it was, at the same time, 'hospital' and 'mortuary' to the small community. It was also central to the Island's economic future and continuing existence as a 'real place'. These multiple ontologies interacted to shape the practice of care in this setting. Ivanova et al remind medical sociologists that 'care and place cannot be practically or analytically separated' and that 'places have identities, purpose, and real effects' (2016, p1346).

Leadership, co-optation and control

Evaluation and implementation studies of large-scale change stress the importance of 'leadership' in realising healthcare change, both in terms of top-level strategic leadership for shaping strategy and culture, and 'distributed leadership' through engaging clinicians in change (e.g. Turner et al 2016, Best et al 2012). These studies adopt the categories and vocabulary of senior managers and, for the most part, are orientated to their needs. Sociology can offer more critical perspectives on the increasing emphasis on leaders and leadership in research and policy. Sociological analyses have sought to look beyond the seductive 'common sense' appeal of this discourse, treating it instead as an object of analysis, rather than as an explanatory framework (Knights and Morgan 1992). From this perspective the discourse of leadership is both an effect and a vehicle of power (Foucault 1980). In this vein O'Reilly and Reed (2010, 2011) see the discourse of 'leadership' as an extension of managerialism. They argue that 'leaderism' has developed as a set of discourses and practices (such as leadership development courses) that enhance managerial control by harnessing the agency of professional actors previously resistant to managerialist norms and practices. In the context of large-scale change, this discourse assumes a unitarianism, erasing the inherent tensions between different stakeholders. At the same time it locates accountability with leaders, rather than with politicians. It also supports and lionises a particular form of 'strong' leadership that enforces radical change, as opposed to negotiated compromise or incremental change.

O'Reilly and Reed's (2010) analysis draws our attention to the way that health services research adopts prevailing political framings, in particular the 'cascade of change'. This narrative positions large-scale change as a rational, and inevitable, response to exogenous drivers:

> The 'cascade of change' narrative is used to legitimate the need for public service reform, and in this particular instance it is also used to create an onus on leaders and leadership as the form of agency by which these pressures and changes are addressed and new services are developed. (2010, p967)

Sociological analyses have interpreted efforts to engage clinicians as leaders as co-optation in the interests of policy-makers, and a means of realising service change in the face of professional resistance (McDonald 2004, Martin and Learmonth 2012, Waring 2014). Martin and Learmonth (2012), for example, argue that efforts to engage clinicians as leaders in the delivery of reform are

best understood as a way of reconstituting these actors' subjectivities as a means of 'governing at a distance'. In their ethnographic study of hospital planning, Jones and Exworthy (2015) draw on Waring's (2014) theoretical development of professional restratification to show how clinical leaders, at both national and local levels, were enrolled to 'sell' controversial plans to the public and secure the agreement of local clinical staff. In their empirical settings these efforts were recognised by other stakeholders as strategic and perceived to be manipulative.

While the above authors explore the discourse of clinical leadership as a mode of governing, Latimer and Monro ask 'who benefits from endless reform?' (2015, p428). They draw attention to class relations and the way that the discourse of distributed leadership appropriates labour in the interests of elites. While Huby et al (2014) find that engaging with service change benefits some groups, such as professional elites, Latimer and Monro argue that:

> the sheer numbers of persons making themselves 'available' and 'response-able' today leads not to them benefitting from what they deliver, but rather to further losses in solidarity for the many and the greater advancement of the few. (2015, p427)

Latimer and Monro's analysis suggests that reconstituting clinical staff as 'leaders' may also 'drive out discretion from the front-line' (2015, p248). Front line staff are expected to be orientated to the objectives and interests of the organisation, which may not be same as those of patients.

One line of sociological analysis questions the dominant research conventions employed in the mainstream literature on management practices, such as value neutrality and objectivity, surfacing the underlying assumptions and rationalities of these conventions and exploring their consequences (Learmonth 2003). Learmonth stresses that this is not to suggest that the research is ill-intentioned or without rigour, only that it is often from the perspective of senior managers, which may be different from other groups, such as middle and junior managers, and those providing and receiving care. In appearing disinterested the research bolsters the interests of one particular group. Moreover, the tendency for research to be focused on the needs of the 'people in charge' results in an analytical neglect of certain organisational phenomena, such as domination and oppression.

Applying this lens to the extant literature on large-scale change illuminates the way that management is portrayed as 'a set of technical activities, only problematic to the extent it might be difficult to perform' (Learmonth 2003, p99). It also reveals that underlying seemingly neutral terms such as 'system leadership' there is a managerial conception of healthcare as a system that can be managed. This language may camouflage coercive and punitive forms of performance management. For example, in the study by Turner et al (2016) of large-scale changes to clinical services in England, a service commissioner describes their strategy for managing stakeholder differences as 'not letting people out of the room if I thought they were actually disagreeing but they weren't disagreeing in the room' (Turner et al 2016, p161). Another strategy was for regional managers to link their organisational goals to the appraisal (and by implication, employment) of subordinate staff (Fraser et al 2017). Looking at the data in this way affirms Latimer and Monro's insight that 'for all the emphasis on reform, hierarchy remains the main mechanism at work along which credit and rewards travel upward while blame and responsibility are divested down' (2015, p 427).

Framing, evidencing and strategies

While policy texts often represent large-scale change as a technical issue (Fulop et al 2012, Spurgeon et al 2010), Jones' (1999) sociological study of the centralisation of renal services in London reveals the political dimensions. Drawing on Habermas, Jones analyses the interaction of powerful interests, including the different renal units, each vying to be designated a specialist centre. He describes the way a review group, (comprising specialist clinicians, managers, and a patient representative) promoted a particular solution (centralisation). He goes on to describe a review process consisting of a series of meetings that were 'less a means of arriving at a set of healthcare decisions and more a means of legitimising decisions that had, more or less, already been taken' (1999, p94):

> The outcome of the planning process favoured the more powerful groups. For example, precedence was given to academic standing over patient access. Both doctors and managers engaged in strategic action, including the mobilisation of particular and restricted understandings of 'need'. For example, doctors were able to use evidence of 'unmet need' to argue for more resources and justify decisions that protected vested interests.

Jones provides a rich, detailed, ethnographic account, capturing, at one point, a near farcical response to the politics of healthcare change through an extended consideration of nomenclature:

> The definitional problems seem to centre on the need to distinguish between units in a hierarchical sense, without introducing terms that could be construed as demeaning to a unit. Terms such as 'secondary', 'subsidiary' and 'lesser' were introduced but were clearly unacceptable. (1999, p96)

Jones shows how management is accomplished through rhetoric (Hughes 1996), including the rhetoric of rational planning. Importantly, he shows how health services research plays an important role in strategic 'depoliticisation':

> Hard political choices are transformed into technical solutions through focusing on mechanistic rational forms of health service research, thus imposing a rational scientific framework on what in reality is more complex, contested and ambivalent. (Jones 1999, p130)

In his ethnography, and in his later chapter on healthcare decision-making (2001), Jones demonstrates the utility of critical theory for analysing the interaction of powerful groups in large-scale change. Foucault's analytics of power also offer a range of resources for analysing the politics of healthcare change, particularly the role of knowledge and expertise. Of particular salience are his perspectives on discourse and governmentality. This work draws our attention to the relations of power that are immanent in knowledge, and the way that knowledge and the activities of experts play a central role in contemporary systems of governance (Foucault 1979, 1990, 1991 Miller and Rose 1993, Johnson 1993).

Jones and Exworthy (2015) combine Foucauldian perspectives on discourse and governmentality with the political science concept of 'framing' (Rein and Schön 1993). They show how national policy makers and implementation elites strategically reframed plans to centralise hospital services, using dominant discursive resources such as 'evidence' and 'safety'. Although the persuasive power of the framing was limited, in the sense that other stakeholders were unconvinced of the need for change, Jones and Exworthy identify a more insidious form of power in the way the framing disguised the political nature of the issue by defining it as a clinical

problem. The strategic re-framing had the effect of restricting the extent to which alternative courses of action could be considered, and undermined public participation in healthcare decision-making. This discursive strategy had very real effects in the material world. In one instance the ability of local commissioners to define plans as 'clinical best practice' allowed them to avoid pubic consultation at the same time as government policy established a range of new mechanisms and structures for involving the public in decisions about service change.

Fraser et al (2017) also employ Foucauldian perspectives in a study of the London reconfiguration of stroke services, showing how practices of stakeholder consultation were manipulated to serve powerful interests. They found that within ostensibly participative forums management consultants were able to control how problems were understood and which solutions were adopted. This is illustrated by the following excerpt from their study. The excerpt is from an interview with a management consultant involved in running the stakeholder consultation workshops. In this account the strategic use of these participation forums is explicit:

> We had our first pan London conference and that was attended by representatives across London…and we mixed everyone up and we eventually workshopped ideas…but we kind of had the answers in our back pocket…And we were able to guide that conference to an answer that we had already, I suppose, decided on… (Fraser et al 2017, p45).

The above work problematizes many of the recommendations of evaluation and implementation research, such as 'engage physicians' and 'involve patients and families', showing how, in practice, these have been used as cooptive devices. Moreover, to the extent that these strategies are recognized by other stakeholders they are likely to 'backfire' by eroding trust (Jones and Exworthy 2015).

Foucauldian perspectives on healthcare policy show that, beyond the often quite obvious use of rhetoric, power operates in policy practices in ways that are often difficult to see. Central to these processes are knowledge and expertise which serve to frame the debate, shaping how the problem is understood, which solutions are considered (and which are not) and who is included in decision-making. To the extent that research is orientated to problems as defined by policy elites, academic researchers are implicated in these processes.

Discussion

In our review of the existing literature on large-scale change we have highlighted the dominance of implementation and evaluation studies that are, overall, highly normative, and although theoretically informed, orientated to generating recommendations for realising change. We show how sociology can contribute to an understanding of large-scale change by surfacing underlying assumptions and providing additional lines of analysis on the social, cultural and political dimensions.

A focus on large-scale change can also contribute a wider and deeper understanding of the core concerns of medical sociology - medical knowledge, the practice of medical work, and the experience of receiving or giving medical and health care - by linking micro and meso practices to macro-level social processes. Sociological perspectives on large-scale change bring the healthcare landscape, often the backdrop to studies in medical sociology, to the fore, showing how this infrastructure shapes and supports working relations, interactions and practices. From this perspective the healthcare landscape is simultaneously a system of social relationships and a system of ideas. This stance reveals the configuration of the healthcare landscape to be an

important site of political contestation, illuminating how beliefs and ideologies are manifest in the distribution of healthcare facilities, how plans for change privilege particular visions and versions of health care and advance the interests of certain groups, and how the disruption of the therapeutic landscape invokes reflection on values and identity, and provokes collective social action. Sociological perspectives on large-scale change are attuned to the way that territory is discursively rendered in systems of governance that include forms of knowledge and the practices of professionals. We suggest that future research might benefit from ethnographic approaches that 'follow' a policy through multiple practices at different levels (Ball 2016, Shore and Wright 1997, Marcus 1995). These approaches are well-suited to the way that contemporary healthcare governance involves the knowledge and activities of multiple actors and organisations, across international, national, regional, and local levels.

The findings from our review support Ferlie's (2016) assertion that there has been in decline in social science-based analysis of organisational change in the context of public policy. Ferlie's assessment echoes broader concerns within sociology that the support from government agencies for competing forms of knowledge, such as conventional economics, has led, in part, to the marginalisation of sociological perspectives in social knowledge (Brown and Spencer 2014, Burawoy 2015, Sorokin 2017). Health services research can be considered instrumental in cases where the questions are not defined by the researcher. In such cases the values and the goals of the research are supplied by external funding and policy agencies, and the focus is on 'providing solutions to predefined problems, the means to predefined ends' (Burawoy 2004, p1606). Learmonth (2003) observes that, in some cases, the vocabulary of senior managers is reproduced in the wording of specifications from funding agencies. These tendencies are likely to be intensified by features of contemporary academic research practice, such as the increasing number of early-career social scientists reliant on fixed term contracts funded by government agencies, and the expectation that resultant research will be 'co-produced' with senior service managers.

Scambler (1996) argues that studies funded by government departments are not intrinsically undesirable, but represent particular interests. He advocates critical theory as offering sociologists studying healthcare change an orientation that acts as a corrective to the dominance of economic and state imperatives in research agendas. Critical perspectives are important because of the way that large-scale change is, for many, a 'troubling' issue (Willmott 2015). Large-scale change disrupts clinical teams, care practices and therapeutic relationships, and fractures individual and collective identities. It can also disrupt the relations between local institutions and the communities they serve (Brown 2003). Large-scale change reconfigures state-citizen relations at the same time as it redistributes resources. And behind euphemistic reference to 'system leadership' and 'hands on facilitation' is the suggestion of coercion and domination. It also invariably consumes vast amount of public resources in the pursuit of change that is often never realised. In a rare effort to cost the process, Wistow et al (2015) found that in one locality in England a programme cost £24.9 million in the first three years, without any change to services. In the first two years £7.9 million was spent on management consultants alone.

For critical sociologists the role of sociology in relation to healthcare policy is to promote a broader range of values in research, and a wider spectrum of topics and questions in public discourse. Scambler (1996), for example, advocates a sociology guided by the goals of inclusion and participation, but always vigilant to the potential for these processes to be co-opted. Both critical theory and Foucauldian perspectives suggest an emancipatory role for sociology. From the perspective of critical theory this is accomplished by exposing, with a view to alleviating, oppression. In contrast, Foucauldian scholarship seeks to 'unsettle the certainties and orthodoxies that govern the present' (Shore and Wright 1997, p17) so as to support public

debate, and create room for alternative policy options (Wedel and Feldman 2005). Sociology can also contribute to public debate by articulating alternative and subaltern logics and versions of healthcare. These can help to expand and rebalance healthcare policy. In the case of large-scale change this could mean an alternative conception of healthcare planning 'as less about picking from a menu of competing interventions and more about the enlargement and balancing of competing conceptions and visions of healthcare' (Cribb 2018b, p7).

We have sought to open up new lines of analysis and suggest additional and complementary insights on large-scale healthcare change. We believe that by including a wider range of values and voices, offering critical perspectives, and articulating potential futures, sociology can enrich future healthcare research, debate and policy - empirically, theoretically, ethically and politically.

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