Debate & Analysis

Street-level bureaucracy:

an underused theoretical model for general practice?

INTRODUCTION

Street-level bureaucracy (SLB) is a sociological theory that seeks to explain the working practices and beliefs of front-line workers in public services and the ways in which they enact public policy in their routine work. Developed by an American, Michael Lipsky,[1,2] it examines the workplace in terms of systematic and practical dilemmas that must be overcome by employees, with a particular focus on public services such as welfare, policing, and education. The theory is based on the notion that public services represent 'the coal mines of welfare where the "hard, dirty and dangerous work" of the state' is done.'[3] According to Lipsky,[1,2] that is because:

- demand from clients will always outstrip supply due to finite resources (cost, time, or service access). Most clients are unable to obtain similar services elsewhere (such as private alternatives to state organisations). As a result, employees must resort to 'mass processing'[2] of excessive client caseloads.
- extensive personal discretion is a critical component of the work of many front-line public sector employees, particularly those who undertake private, face-to-face interaction with clients to assess the credibility of cases. Employees must use their personal discretion to become 'inventive strategists' by developing ways of working to resolve excessive workload, complex cases, and ambiguous performance targets.[4]
- employees compromise the quality of their work by 'creaming off'[2] cases that are likely to be straightforward or to have a positive outcome. Alternatively, workers may act as an 'advocate'[2] for clients who are perceived as being at the tip of an iceberg of social vulnerability. Because workers are unable to offer all services to every individual they may be forced to 'deny the basic humanity'[2] of other clients. These pragmatic micro choices ultimately become the *de facto* policy of the organisation, which may contrast starkly with its official stated aims.

This theory has implications not just for the individual employee but also the overall system. In particular, Lipsky suggests that the extensive unmet demand from clients means that even substantial expansion of staff and budgets are unlikely to decrease workload pressures. Instead, he predicted that increased capacity would result in ongoing expansion of the *same level of service quality at a higher volume*.

> *"The theory is based on the notion that public services represent 'the coal mines of welfare where the "hard, dirty and dangerous work" of the state' is done.'"*

Although Lipsky's original research only considered in depth those working in non-medical services, there have been calls for its wider application to the healthcare sector.[5] Despite this, only limited attention has been paid to the approach of SLB to physician behaviour[6] and general practice in the UK.

STREET-LEVEL BUREAUCRACY AND GENERAL PRACTICE IN THE UK

Where evidence exists, this has focused on GP attitudes and behaviour towards service uptake and workplace targets. For instance, one study of the commissioning process in relation to coronary heart disease in an English primary care group found that aspects of GPs' working behaviour were consistent with Lipsky's theory, in particular that GPs were able to exercise 'huge' discretion in their professional role.[7] This was evident in diverse adherence to guidelines on prescribing statins, to lower cholesterol and inconsistent patterns of referral to new secondary care services for patients with ischaemic heart disease. Where such hospital services were taken up, this tended to be because they offered 'avenues down which to send 'problem patients' who took up large amounts of GP time'.[7] Such pragmatism and diversity is consistent with Lipsky's notion of policy being made at the front line. This, however, was not considered to be a purely negative finding as McDonald concluded that, restricting the powers of individual GPs to allocate resources at their own discretion would undermine the overall ability of the system to manage gaps between supply and demand.

These findings are consistent with another study which concluded that GPs consider clinical guidelines to be too complicated and that, even where GPs held positive attitudes towards guidelines, they had little effect on behaviour.[8] This was because new guidelines were adopted *before* their formal introduction because they were already perceived as 'making the job easier'.[8] To this end, official policy was simply being 'enacted' by GPs on the ground. While recognising aspects of SLB in these working patterns, Checkland concluded that GPs were, at least in part and for the time being, protected from the full operation of SLB due to their professional power and status as independent contractors. Nevertheless, she highlighted that this could be undermined by moves towards a workforce of salaried GPs, rather than the current dominant model of the independent contractor. That concern, however, did not appear to be important in one study of GPs' perceptions of Quality Outcomes Framework (QOF) in the North of England.[9] Here, salaried GPs reported a belief in the inherent value of clinical targets by dint of their evidence base and

> *"SLB shows us that change to primary care policy must operate in ways that support front-line general practice, otherwise GPs will continue to adapt and bend rules in ways that they perceive best ..."*

"... despite good intentions, the function of public services may ultimately be construed as one that serves to maintain established divisions and inequalities within society."

benefit to patients. As a result, Cheraghi-Sohi concluded that Lipsky's framework was of limited value to understanding GP behaviour in relation to QOF. Salaried GPs' faith in QOF may, however, be explained by Lipsky's 'myth of altruism': although many workers seek to be 'advocates' for needy populations they may, in practice, only be able to implement this for a small number of their most vulnerable clients.

One area where it is indeed recognised to be very difficult for GPs to fulfil policy expectations is unscheduled care for patients with long-term conditions. Here, SLB theory has highlighted GP behaviour to promote the safety of individual patients that was counter to targets designed to reduce use of unscheduled care.[10]

CONCLUSION AND FUTURE APPLICATIONS

Despite limited application, the above-mentioned studies suggest that SLB theory can help develop understanding of GPs' behaviours towards guidelines and targets and how these affect patient care. The SLB approach is increasingly relevant given the expansion of GP commissioning and referral management in England. One reason is because SLB highlights a need for primary care policy to promote whole-system change rather than reliance on individual professionals to introduce changes into their clinical practice.[10] Ways forward include even greater consideration in policy making of the perspectives of patients and front-line clinicians as well as acknowledgement that good care outcomes in general practice may be hard to measure. SLB shows us that change to primary care policy must operate in ways that support front-line general practice, otherwise GPs will continue to adapt and bend rules in ways that they perceive best meet the needs of patients, especially those who are vulnerable or disadvantaged.

Alongside that, the SLB perspective can offer insight into the effect of reduced GP autonomy on workforce morale. Finally, future research should also consider how SLB can be used to explore the origins of inequalities in primary care delivery, as, inherent in Lipsky's notion of mass processing of clients is the application of selective barriers to limit demand, be they practical (for example, appointments, queues and fees) or symbolic (for example, imposing offices that lack privacy). SLB research should consider how the attitudes and prejudices of primary care workers influence selective (and unrecognised) rationing of access, particularly where workers belong to different demographic backgrounds from their clients. This is important because Lipsky suggests that despite good intentions, the function of public services may ultimately be construed as one that serves to maintain established divisions and inequalities within society. This is of particular importance at a time when austerity measures are differentially impacting on those in more disadvantaged positions, resulting in greater workload and demands on general practice.

Maxwell JF Cooper,
Senior Lecturer in General Practice, Division of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton.

Sangeetha Sornalingam,
General Practice Facilitator, Division of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton.

Catherine O'Donnell,
Professor of Primary Care Research and Development, General Practice and Primary Care, Institute of Health and Wellbeing, University of Glasgow, Glasgow.

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

DOI: 10.3399/bjgp15X685921

ADDRESS FOR CORRESPONDENCE

Maxwell JF Cooper
Division of Primary Care and Public Health, Brighton and Sussex Medical School, Room 322, Mayfield House, Falmer, East Sussex BN1 9PH, UK.
E-mail: m.cooper@bsms.ac.uk

REFERENCES

1. Lipsky M. Street-level bureaucracy and the analysis of urban reform. *Urban Aff Rev* 1971; **6:** 391–409.
2. Lipsky, M. Dilemmas of the individual in public services. In: Lipsky M, ed. *Street-level bureaucracy. Dilemmas of the Individual in Public Services.* 2nd edn. New York, NY: Russell Sage Foundation, 2010.
3. Bovens M, Zouridis S. From street-level to system-level bureaucracies: how information and communication technology is transforming administrative discretion and constitutional control. *Public Adm Rev* 2002; **62(2):** 174–184.
4. Moore ST. The theory of street-level bureaucracy: a positive critique. *Administration and Society* 1987; **19(1):** 74–94.
5. Thompson F. Street-level bureaucracy: dilemmas of the individual in public services. *J Health Polit Policy Law* 1983; **7(4):** 968–970.
6. Dunham ACA. Primary care and mental health: does the financing and organization of health care affect the treatment of depression? [Masters dissertation]. Charlotte, NC: University of North Carolina, 2006.
7. McDonald R. Street-level bureaucrats? Heart disease, health economics and policy in a primary care group. *Health & Social Care in the Community* 2002; **10(3):** 129–135.
8. Checkland, K. National Service Frameworks and UK general practitioners: street-level bureaucrats at work? *Sociol Health Illn* 2004; **26(7):** 951–975.
9. Cheraghi-Sohi S. Contractual change and UK general practitioners: still a case of street-level bureaucrats? [PhD thesis]. Manchester: The University of Manchester, 2011.
10. Drinkwater J, Salmon P, Langer S, *et al.* Operationalising unscheduled care policy: a qualitative study of healthcare professionals' perspectives. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X664243.