Structures of Control in Health Management

Rob Flynn

International Library of Sociology

ROUTLEDGE

Structures of control in health management

How has the National Health Service been restructured? Has professional medical autonomy been undermined by increased managerial control? In this timely and highly original study Rob Flynn explores these questions.

Using a variety of evidence the author documents the rise of general management, the application of new techniques to reduce medical costs and improve efficiency, and other methods to control use and evaluate clinical performance. The impact and significance of these developments is discussed, and illustrated in detail by original case study material and interview data about managerial strategies of rationalisation and retrenchment.

The book describes new systems of monitoring, regulation and surveillance applied to doctors and health workers, and argues that these threaten established power relations and institutional arrangements, by elevating managerial concepts for efficiency above professional definitions of need and citizenship demands for unrestricted access on the basis of need. Measures to create an internal market in the NHS are also analysed, and it is argued that current trends will intensify managerial influence and undermine professional medical power.

The contradictions and complexities of changes in structures of control in the NHS are examined in connection with critical assessment of theories about state restructuring and post-Fordism in the welfare state.

The book will be of interest to lecturers and degree level students in sociology, social policy, politics, public administration and health service studies.

'This is an excellent book, developing a theme which has not been explored in depth by any other writer. Flynn is able to bring together effectively ideas from a number of academic fields which often remain rather separate—organisational sociology, political science oriented policy analysis and social policy studies in the health field…an important contribution to a long-standing academic debate about professionals and health service management.'

Michael Hill, *Dept of Social Policy, University of Newcastle-upon-Tyne*

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To Gill, Sarah, Peter, Lilian and Michael, Harry, and in memory of Thelma

1 Restructuring health services

Health care is one of the most important, indeed vital, resources necessary in all social systems. It takes a variety of forms, and may be provided formally or informally through households or specialised institutions. It may be based on folk tradition as well as rational scientific theory, and comprises a range of different methods of assistance and intervention, corresponding to different concepts of health, illness and disease. Professionalised medical and surgical treatment, especially in hospital settings, is commonly regarded as the conventional model for modern health care systems, but this is only part of a more complex and differentiated pattern. The organisation of health care generally, and medical services in particular, differs between societies, reflecting their economic, political and ideological characteristics. It also varies over time, depending on the distribution of power and the outcome of social conflict between competing groups and interests.

Health care, because it is ultimately concerned with concepts of normality and pathology, with social reproduction, and with regulation and control of bodies and lives, is thus of fundamental importance in all societies. Similarly, it is of great sociological relevance, not simply for its intrinsic features and interest, but also because it reveals many aspects of societal, institutional and interpersonal processes. It can be studied in different ways and at different levels of analysis—for example, the phenomenology of illness, medical interactions and the political economy of health-care systems. Consequently, this poses challenging and difficult conceptual and theoretical problems which are unlikely to be cogently and exclusively explained within one theoretical framework (Turner 1987).

This book discusses the context and consequences of major changes in the organisation and management of health services in Britain during the 1980s. It is not intended as a contribution to the sociology of health and medicine as conventionally understood (Morgan *et al.* 1985; Stacey

1988) but, rather, is more generally orientated towards the political sociology of state intervention, and analysis of public policy (Ham and Hill 1984; Offe 1984). The focus is upon the implications of recent changes in the welfare state, and their effects on the budgeting, planning and delivery of medical services within the National Health Service (NHS). The central theme of discussion is the application of successively bureaucratic and managerial control structures in a formerly professionally dominated system, and the emergence of market and quasi-market rationality and practices. These developments are related to a diffuse but none the less systematic political strategy to restructure the economy and the welfare state.

RESTRUCTURING WELFARE

During the 1980s, in Britain and many other western capitalist societies, the welfare state became the site of intense political struggles. A period of relatively continuous economic growth and political stability from the late 1950s to the early 1970s coincided with the gradual expansion of state involvement in the collective financing and public provision of education, health, housing, social security and other forms of welfare. After the conflicts in the Middle East and oil price increases in the mid-1970s, governments in Britain and elsewhere were faced with the problem of dealing with economic recession, price inflation and rising unemployment.

Efforts to reduce public expenditure to deal with short-term crises were gradually consolidated in longer-term programmes to roll back the state. This shift was linked with other social and political trends—public dissatisfaction with economic management, and growing ideological disenchantment with the effectiveness and equity of welfare policies. In Britain, the Thatcher governments embarked on a series of measures designed to revive capital accumulation and enterprise, restrict or reduce the burden of taxation and public spending, and to move from a universalist to a selectivist model of welfare and social policy. The postwar social democratic consensus was overthrown, and New Right precepts were put into practice (Gamble 1988; King 1987a; Klein and O'Higgins 1985, *passim;* Papadakis and Taylor-Gooby 1987a).

The common assumption that during the 1980s there were large-scale cuts in state benefits and services is not entirely borne out by the evidence. Total public expenditure in Britain continued to increase, but there were important changes in its internal composition and its distributive effects. Very broadly, spending on defence, law and order, unemployment and social security rose, support for education and health was maintained, and public

expenditure on housing was reduced absolutely and relatively. While it is conceptually and methodologically difficult to operationalise and identify cuts in welfare, it is known that they occurred in a selective and uneven way, and that together with the effects of other changes in social policies and taxation arrangements, they were socially regressive (Duke and Edgell 1984; Edgell and Duke 1986; Flynn 1988a; Judge 1987; Robinson 1986; Taylor-Gooby 1989).

Instead of the radical dismantling of the welfare state expected by some, there has been a 'restructuring' of state activity in the economy and polity, linked with encouragement for competitive individualism, self-reliance and market mechanisms. Economic deregulation has occurred, government assistance for capital investment has expanded, trade unions' powers have been reduced, key nationalised industries and public sector monopolies have been transferred to private ownership, and privatisation has been applied in certain local government and health-service activities. Public sector bodies have experienced ever more stringent cash limits and financial controls, as well as measures to rationalise their organisational structures and improve efficiency.

The goal of reducing public expenditure which preoccupied the Thatcher governments proved difficult to achieve, mainly because increased spending was necessary to support growing numbers of unemployed, low-income and elderly retired households, and ever-increasing demand for services like health care. However other goals—promoting market forces in all spheres, encouraging competition among suppliers of public services, enhancing individual choice and minimising state provision—have been partly attained, or at least securely established as dominant objectives in the new political agenda.

In education, income maintenance, health, housing and personal social services, the institutions, policies and practices which had become part of the Keynesian social democratic consensus have been challenged. New Right doctrines about inefficient and paternalistic state bureaucracies and professional monopolies converged with New Left critiques and public disquiet about the quality and effectiveness of welfare provision, and this convergence has provided a firm platform for the advocacy of market solutions and consumerism in the public sector (Flynn, N. 1990).

The 'crisis' of the welfare state has not led to its catastrophic demolition, but rather to attempts to bring about its redesign. The economic and social structure associated with values of citizenship and collective provision has been derided, and liberal values of individualism and competition have been revived. While the amount of resources devoted to welfare programmes has not decreased significantly, there has been a fundamental change in the context of, and rationale for, social policy, and a move towards diversity, pluralism

and a mixed economy of welfare. In this new context, the state is expected to play only a minimal or residual role, to compensate for, or to supplement, the market. The state is being transformed from a provider to an enabler, and private sector organisational models are being used to reform its structures and methods of operation.

Many of these changes have been observed in other western capitalist societies, but they are most closely linked with Thatcherism in Britain. Despite adjustments caused by external economic events, and subtle shifts in ideological nuance and political emphasis, there is an identifiable pattern which allows us to describe Thatcherism as a systematic attempt to restructure the British economy and society. As Gamble (1988) has argued, this has comprised a New Right programme which has *attempted* to reform state institutions, preside over rules and inculcate a culture, in order to assist capital accumulation and individual freedom.

There has not been a completely consistent or coherent set of policies, nor has the Thatcherite project been 'hegemonic' or wholly successful to date. Ironically, it has involved a paradox in so far as the free economy requires a strong state: to achieve deregulation and liberalisation in some areas has necessitated *dirigiste* intervention and increased control in others. Moreover, it has encountered various forms of political opposition and institutional obstacles, in the form of continuing widespread public support for key components of the welfare state, and difficulty in implementing market reforms in relatively non-commodified sectors like education and health (Gamble 1988; Taylor-Gooby 1989).

Nevertheless, one of the dominant features of British society in the 1980s has been government determination to expand the role of the market, to reorganise the state and reconstitute the system of social relations. This book examines one aspect of this much broader set of processes—the restructuring of the NHS—and tries to analyse the means by which this has been attempted, as well as the implications of changes in the management and production of state-funded health care.

'Restructuring' is used here in a very general sense, to refer to a process by which significant changes are made in established arrangements in resource allocation, in the division of labour and organisational structure, and in the criteria and objectives of service provision. This raises the question about how significance is determined, and whether recent trends indeed constitute a radical departure from previous patterns. At this stage it will simply be asserted that, cumulatively and gradually, the NHS has been subjected to processes which have attempted to transform its structure, management and rationale. Later chapters will indicate the substantive importance of recent changes in comparison with earlier policies and reforms.

As already noted, there are several justifications for a sociological interest in these processes. First, the restructuring of health services can be used to gain a clearer understanding of New Right arguments, and the consequences which flow from them. Second, policies designed to extend managerial control over medical professionals, and/or to introduce an internal market within the NHS, pose questions about bureaucratic and professional power, and about medical autonomy and proletarianisation, which have wider relevance to important debates in the sociology of organisations and the professions.

Third, the trends discussed below may be expected to produce changes in the criteria of health-service provision (away from accessibility, comprehensiveness, equity, and treatment according to need) as well as changes in the social relations of production and consumption, and, through changes in distributive impact, directly affect life-chances. Fourth, as will be noted further below, NHS restructuring provides a useful point of entry for enquiry into the internal operations of the state—a topic usually shrouded in vague abstraction rather than empirical observation. The NHS in Britain receives the third largest amount of public expenditure, is an enormous organisation employing more than 1 million people, and for many represents the keystone of the modern welfare state. Major modifications in its structure and policy processes demand sociological analysis.

COST-CONTAINMENT IN HEALTH-CARE SYSTEMS

While it is correct to emphasise the distinctive character of Thatcherism in restructuring the welfare state, and important to recognise the particular significance of changes in the NHS in the 1980s, it must be noted that retrenchment and reform in health and and other social welfare policies have been common in other capitalist societies (Cameron, 1985; Friedmann 1987; Gillion and Hemming 1985; Moran 1988).

Many countries have adopted policies of cost-containment in health care, largely as a reaction to fiscal stress and economic recession which coincided with a large and rapid increase in demand. Governments have endeavoured to limit growth, and introduced cutbacks, irrespective of the structure of health service delivery and funding mechanisms. Some countries have a national health service model in which comprehensive services are provided free, financed from general taxation, and the state owns facilities and employs the majority of health-care workers. Others have adopted a social insurance model, with compulsory insurance paid by employers and employees, in which services are provided by a variety of public and private, for-profit and non-profit, institutions and professionals. Others have a private insurance or market model, where individuals purchase private

health insurance and receive care from a mixture of private for-profit and non-profit institutions and professionals. In fact, there are variations in the public/private mix within each system, but in virtually all countries controls on expenditure have become a major, if not dominant, objective (OECD 1987; Schieber and Poullier 1986, 1987, 1988).

Various methods of cost-containment have been applied, especially since the mid-1970s and the onset of inflation—preventing costs from rising in real terms, reducing costs in real terms, restricting the rate of growth as a proportion of gross national product. Changes in organisational structures, improved productivity, controls on staff costs (especially doctors' remuneration) and direct and indirect constraints on demand have been observed in most health systems (Abel-Smith 1984; Maxwell 1981). There has been increased scrutiny of medical efficiency and effectiveness, linked with political debate about the capacity of economies to absorb ever-expanding volumes of demand, given demographic shifts which add to the proportion of the elderly in the population; scientific and technological advances in medicine; and greater claims on and use of services.

Despite the methodological difficulties of international comparisons, the OECD (1987) concluded that systems originally intended to increase access and to extend provision had not achieved adequate levels of efficiency, and indeed had created allocational and distributional inefficiencies. The remedy recommended was cost control: further efforts to improve medical effectiveness and value for money, especially through market-oriented measures, were deemed necessary.

In many countries the entire basis of medical services has been reviewed, and a restructuring of health policy has taken place. As one observer has noted: 'Various forms of incentives for conservation of health care system usage and behaviour modification on a societal scale are now being implemented by many nations' (Virgo 1986:1). Severe budgetary restraints are being imposed to stabilise or reduce health expenditures, and in some countries there have been major shifts away from public finance, planning and co-ordination of supply towards private market or quasi-market mechanisms (Flynn and Simonis 1989; OECD 1990).

In Britain, government concern about the level of spending incurred by the NHS has been evident from its inception in 1948. Since that date there have been several official inquiries into health-service funding and numerous attempts to impose financial controls and measures to improve cost-effectiveness. In 1956 the Guillebaud Committee carried out an investigation into what were then regarded as higher-than-anticipated costs, and a Royal Commission on the NHS reported in 1979 on inadequacies in the use and management of financial and staff resources. It became evident

that there was no simple and unequivocal way of determining the 'correct' amount of funding necessary for the NHS because finance had to reflect continuous changes in demand, innovations and increases in supply, heightened expectations and political preferences (Office of Health Economics 1979; Klein 1983).

However, it was also clearly recognised that efficiency and effectiveness had to be improved. Cost-control was linked with other objectives— ensuring local adherence to central government policies for different components of health care, and achieving greater co-ordination among health-service agencies. Concern with finance and value for money inevitably merged with wider political demands for more accountability, better planning and management.

The administrative and structural reorganisations of 1974 and 1982 (and subsequent changes described in the following chapters) can be seen as stages in a long process of bureaucratisation and rationalisation. In this process, corporate planning and centralised control were introduced and extended to cope with an almost open-ended and professionally dominated health system. For successive governments (of all parties) the problem has been that of controlling costs, and securing an effective and efficient national health service. The crucial limiting factor in this is that the NHS is a system in which clinically autonomous medical professionals have ultimate power over the rationing and use of resources, delivering services according to professionally defined criteria of need. However, during the tenure of the Thatcher governments, committed to reducing public expenditure, rolling back the state, and challenging public sector and professional monopolies, this problem was tackled with new determination and vigour.

FINANCING THE NHS

As already noted, throughout the 1980s there does not seem to have been any dramatic reduction in NHS finance—instead there has been apparent continued growth. But this does not accord with popular perceptions, professional claims and independent analysis, which suggests that the NHS has been 'underfunded'. In the last decade there has been a prolonged media and parliamentary debate about the adequacy of funding, and complaints from health service professions and consumers about the effects of economy measures and cutbacks in services. During the 1983 and 1987 general elections, the future of the NHS was a significant political issue, and much argument surrounded the level of expenditure in the hospital sector.

Controversy about finance intensified because of a combination of factors. Annual growth in the NHS budget did fall, compared to the rates of growth sustained in the 1970s. In many districts there were reductions in their allocations, as a cumulative effect of the national mechanism for redistributing resources away from relatively well-provided areas to less-resourced areas. Tighter central controls on local spending, and rigid enforcement of cash-limits were reinforced by managerial reforms (the introduction of general management in 1983) and instructions to obtain efficiency savings and 'cost improvements'. This placed further pressures on local budgets, and led to numerous cash-saving measures including the closure of hospital beds.

Above-average inflation in NHS-specific costs (particularly drugs and equipment) and staff salaries was not fully covered by central government funds to local Health Authorities. In addition, there were more demands for patient services, and more rapid throughput of hospital patients, while at the same time hospital bed numbers were falling and waiting lists for consultation and treatment were rising. District health authorities found it extremely difficult (if not impossible) to stay within their government allocated budgets. Consequently, from about 1983 there was much discussion of a funding 'crisis', which reached a climax in 1987–88, and precipitated a wide-ranging government review of the NHS in 1988–89, leading to proposals for an internal market (see Department of Health 1989; Klein 1989; Social Services Committee 1988a, 1988b, 1989).

The dispute about funding is important, because it highlights some of the most important constraints encountered by New Right policies and partly explains the restructuring strategy adopted by the Thatcher government in the late 1980s. In order to appreciate the background to this argument, and the discussion which follows in later chapters, it is necessary to look in some detail now at the debate about NHS finance.

A report commissioned by a consortium of the Institute of Health Services Management, the British Medical Association and the Royal College of Nursing showed that in the period 1984 to 1986, real expenditure had not kept pace with increases in demand (Maynard and Bosanquet 1986). The finance allocated by government was insufficient to meet all the costs after allowances were made for pay and price inflation, medical technology and an increased number of elderly patients. In particular, the increase in funding available for the hospital sector was less than that for the NHS as a whole, so budgetary pressures were most severe in hospital medical services.

Similar conclusions were reached in another study, which observed that, although cash spending had increased by nearly 60 per cent between 1980/81 and 1986/87, growth in real terms (after allowing for inflation) was about

12 per cent (Robinson and Judge 1987). Current expenditure in the hospital and community health service was severely constrained during that period, and average growth was less than 0.5 per cent per year, while the family practitioner service grew at over 4 per cent per year in real terms.

Further confirmation that the effective purchasing power of NHS expenditure had increased only slightly was given in an authoritative report by independent analysts considering alternative options for future funding (King's Fund Institute 1988). The NHS was described as being in a state of turmoil, with 'spiralling demands and tight funding', creating a situation in which serious doubts had been raised about the feasibility of maintaining a tax-funded, universal service free at the point of use (King's Fund Institute 1988:5).

The report pointed out that by 1987/88 the cumulative shortfall in hospital and community health services' purchasing power (even when supplemented by so-called efficiency savings) was about £1.8 billion. It was estimated that to restore the purchasing power to 1981/82 levels, expenditure in 1987/88 needed to be £400 million higher than current allocations. The authors, acknowledging the scale of the shortfall in the hospital sector, presented a number of possible solutions, including income generation, increased patient charges, expansion of private insurance schemes, various efficiency measures, and an internal market in the NHS.

Faced with growing public criticism, and parliamentary pressure, the government allocated some additional funding, while asserting that more money was being spent on the NHS than ever before. Nevertheless, complaints that the NHS was underfunded continued unabated. The National Association of Health Authorities (NAHA) claimed that although total expenditure on the NHS had doubled between 1980/81 and 1989/90 (from £9.4 billion to £19.4 billion), real (rather than cash) increases in funding had only been on average 1.1 per cent per year. Government public spending plans indicated that increases in NHS and hospital sector finance to 1992 were also likely to be insufficient to meet expected demands and needs (NAHA 1989).

The spate of reports documenting chronic underfunding was significant not merely for identifying the scale and severity of the financial crisis, but also because it intensified the political controversy. Those committed to supporting the NHS in principle continued to raise sceptical questions about whether resources could be used more efficiently and effectively, while New Right critics disputed the viability of the NHS as currently constituted, and advocated variants of market reform and restructuring (see Maynard 1989). It was against this background that the Prime Minister carried out a review of the entire NHS system, and it was these pressures which influenced the

government's recommendation of another major reorganisation of the delivery system, and the creation of an internal market, described more fully in Chapter 7.

RESTRUCTURING THE STATE

Assailed by complaints about the inadequacy of NHS finance, and deepening disquiet about the effects of cutbacks in the hospital sector, the government faced a dilemma. Its customary preference for market solutions to an overgrown public sector could not be translated into a policy of complete privatisation of the NHS. Confronted by consistent and solid public approval for the principle of a tax-funded, comprehensive and needs-based free service, Conservative governments in successive elections assured voters that the NHS was 'safe'. However, the financial crisis persisted, and the clamour for radical reform continued.

A variety of public opinion polls and academic studies showed the depth and scale of popular support for the NHS and the citizenship rights it entailed. There were signs of dissatisfaction with waiting times for consultations and treatment, criticism of insufficient doctors and nurses, and some complaints about bureaucratic inflexibility in the NHS. There was also substantial support for a private sector in health (and education) but this view was held in combination with endorsement of the welfare state and NHS provision. While there was evidence of ambivalent and sometimes apparently contradictory attitudes, nationally representative sample surveys indicated very strong commitment to the NHS. The numbers of people expressing dissatisfaction with the NHS increased during the 1980s, but health maintained its position as the first priority for increased government spending (Bosanquet 1988; Papadakis and Taylor-Gooby 1987b; Taylor-Gooby 1985, 1989).

Public attitudes were thus an impediment to many of the New Right prescriptions. Indeed, political opposition to retrenchment in welfare has been identified elsewhere as a general phenomenon and constraint on radical marketisation. The growth of the welfare state has created powerful forces which sustain and stabilise public expenditure patterns, and help constitute new consumption sectoral interests (Dunleavy 1985, 1986). Beneficiaries of collective subsidies and clients of public services, together with the large number of producer groups (often highly unionised) employed in the state sector, have been shown to have sectoral interests which cross-cut those deriving from social class. There is thus a diverse but significant constituency for the defence and promotion of a variety of social policy and welfare provisions.

Contrary to some neo-Marxist arguments about state retrenchment as a necessary response to fiscal crisis, it has been shown that in most European societies, welfare states have been robust and resistant to major cutbacks. Although the rate of growth has slowed down, public expenditures have not been dramatically curtailed, and in some instances they have remained constant or marginally increased as a proportion of national output. Social citizenship rights may have been redefined and reduced, but conservative governments have not (so far) succeeded in displacing them by market values and practices (King 1987b; King and Gurr, 1988; Moran 1988, 1990).

What has occurred, however, is a policy of *selective* retrenchment in particular elements of social policy, in conjunction with measures leading to the internal reorganisation of the state. In Britain, programmes commanding broad popular support (for example, health) have been *relatively* protected, while those directed at stigmatised minorities (public housing, social security) have undergone substantial real reductions in resources (Taylor-Gooby 1989). At the same time, throughout the public sector—the civil service, nationalised industries, local government, the education and health systems and many other services—managerial discipline has been imposed, market-like mechanisms have been inserted, and organisational reform demanded.

This reorganisation or restructuring of the state has involved new corporate planning procedures, enforcement of cash limits, performance indicators, compulsory tendering for contracts, efficiency savings, management buy-outs and hiving-off of statutory agencies, and greater use of marketing and consumer relations techniques, in addition to a host of other innovations. In the absence of market prices and incentives to efficiency, public sector bodies have been required to devise proxies to stimulate cost-effectiveness and competition, and traditional bureaucratic hierarchies and systems of professional domination have been dislocated by limited forms of decentralisation and new-style managerialism. These trends have been accompanied by the evangelistic promulgation of the 'enterprise culture' in various welfare state organisations (see Flynn, N. 1990).

Writers from different theoretical positions agree that Thatcherism has comprised a number of complex and sometimes inconsistent attempts to alter the character of state-society relations. The corporatism of the 1960s and early 1970s was regarded as anathema; producer monopolies within the state, and the state itself, were to be subjected to market disciplines and 'managed competition'. For Gamble (1988), Thatcherism is distinguished by its attempt to reverse the decline in the British economy and political influence in the face of worldwide (capitalist) economic restructuring. To enable the adjustment and enhancement of accumulation, ideological and

institutional opposition had to be overcome, welfare dependency reduced and the authority of the state restored.

The paradox of increased state intervention in pursuit of a free economy has also been noted by Klein (1989: ch. 7), who has referred to a modernisation project consisting of contradictory trends towards both decentralisation and recentralisation of state power. Conservative governments successively (and successfully) confronted first the trade unions, then local government and education, and latterly the legal and medical professions in order to restrict their influence. For Klein: 'In a sense, the Conservative government can be seen as the equivalent of the Tudor monarchy asserting the power of the State in order to modernise a country previously dominated by feudal barons and corporate interests' (1989:198).

Thus a strategy of reorganising the state was simultaneously necessary to control (and if possible reduce) public expenditure, and, where privatisation was not feasible because of electoral risks, the only way of implementing key elements of the New Right programme. Substantial cuts in total NHS resources were not politically worthwhile, but improved management and increased efficiency, together with moves towards consumerism, were ideological objectives which could not be easily challenged. The process of restructuring, as we shall see, took a variety of forms, and brought about important changes.

ANALYSING STATE POLICY

As previously noted, these changes pose difficult theoretical problems. Explanations of the form, role and impact of state intervention are notoriously contested in the social sciences, since they hinge upon prior notions of power, decision-making and the representation of political interests. These issues, and the theories surrounding them are extremely complex, and can only be summarised briefly and very schematically here (but see Dunleavy and O'Leary 1987; Held *et al.* 1983; McLennan *et al.* 1984).

Neo-Marxist theories of the modern capitalist state offer plausible general accounts of contemporary politics, but rarely offer detailed explanations for modes of state policy-making and implementation. Neo-pluralist approaches focus our attention on the dispersion of influence through networks of competing interest groups, but may divert it from structural interests and non-decisions embedded in institutions and practices.

The pragmatic course is to recognise that each theory has inherent limitations, and for any specific question or problem there are different levels of analysis. In different spheres of state activity (production and consumption), there may be distinctive patterns of political representation,

ideologies, administrative structures and policy processes requiring different types of explanation. This suggests that we should avoid deterministic theories which assume complete capitalist domination of the state apparatus or imply that the state is a neutral arbiter or summation of citizens' preferences. We must recognise the specificity of the internal dynamics and operations of the state, and examine their effects on the policy process (see Alford and Friedland 1985; Cawson and Saunders, 1983; Dearlove and Saunders 1984; Saunders 1986).

This eclectic standpoint is both appropriate and empirically useful in analysing state policy, and is the approach favoured here in this account of changes in the NHS. Neo-Marxist theories of the capitalist state provide important vantage points for reviewing macro-level structures, but more broadly based organisational and occupational sociology enables us to gain insights into institutional processes and group action.

The state cannot be seen as necessarily reflecting, or consistently incorporating, capitalist interests. The 'anatomy' of capitalist society, Urry (1981) stressed, must recognise the importance of civil society and different types of social and political struggles. While the state attempts to maintain conditions for capital accumulation, commodity exchange and the reproduction of labour power, its form is contingently dependent on a variety of demands and pressures which are not reducible to production relations.

According to Navarro (1978), however, the emergence of the British NHS must be explained in terms of social class conflicts and political struggles outside of the medical sector. He dismissed the view that professionals were the controllers and managers of medicine, asserting that they simply administered the system in line with the needs of capital. The structure and composition of the health service reflected external economic and political forces rather than the inherent features of medical organisation and professional power.

Crises in capital accumulation, Navarro (1984) argued, led to a restructuring of the welfare state: the reorganisation of health and welfare were attempts to solve the crisis in terms which were favourable for capital. Referring mainly to the United States, Navarro (1986) described medicine as functional for capital in controlling the working class; even if medical provision was physically ineffective it was useful in terms of maintaining legitimacy. Thus health-care institutions and professions do not possess their own autonomy, but are subject to the ideological and political hegemony of capital (1986:243).

Although this approach may be a valid corrective to liberal accounts which explain the history of the NHS and other health systems as the outcome of humanitarian intervention by benevolent elites, or the result of rational scientific progress, and which focus solely on the activities of selected interest

groups, it has several weaknesses (see Turner 1987; Urry 1981). Navarro's analysis is both functionalist and deterministic. It assumes both a homogeneous capitalist class and a unified and consistent state. It tends to diminish the significance of organised labour, and neglects the practical achievements of the welfare state. It almost completely disregards the power of the medical profession and the institutional complexity of health-care systems, giving these factors only marginal or secondary significance in the explanation of policy-making. Evidently Navarro's argument is over-generalised, and is based on an instrumentalist concept of the state. To deal adequately with the contingency and variability of state-society relations, a different approach is necessary.

One useful framework for analysis can be built upon Offe's theories about the welfare state. Offe (1984) has argued cogently that the capitalist state is intrinsically characterised by contradictions. The state is not an instrument for capital: its constitutional and organisational arrangements must cope with both accumulation and legitimation. It attempts to assist the expansion of the market while attenuating some of the market's effects, where they threaten overall economic imperatives and/or political integration and social cohesion. The administrative and political system mediates and 'refracts' different demands, needs and interests.

Thus social policy

> consists of answers to what can be called the *internal* problem of the state apparatus, namely how it can react *consistently* to the twin poles of the 'needs' of labour and capital—in other words how to make them mutually compatible. The problem to which state policy development in the social policy domain reacts is that of the precarious compatibility of its own institutions and performances'.
>
> (Offe 1984:104; emphasis in the original)

In contemporary welfare states, in the face of these structural contradictions, governments adopt a number of different rationalisation measures —preventive social policies, citizenship entitlements or institutionalised welfare, reprivatisation, and what Offe terms the 'scientisation of politics' (policy-making controlled by experts, managers and professionals). State policy tries to underwrite market relations but does so through programmes (such as education, health and social services) which are ultimately incompatible with market criteria and forms. The welfare state and capitalism are simultaneously mutually interdependent yet antithetical, so public policy oscillates between competing objectives, and may generate contradictory outcomes. The execution of public policy mirrors these paradoxes and dilemmas, and state administrators and organisations exercise

some independent influence. However, the extent of this influence, and the 'concrete mechanisms and conditions of social implementation' (Offe 1984:114) are phenomena requiring sociological research.

One important line of enquiry implied by Offe elsewhere (Offe 1985: ch. 10) concerns the possibility of divergent modes and rationalities of administrative action. In what Offe terms modern, disorganised capitalism, state bureaucratic rationality cannot guarantee, and may actually conflict with, the 'functional' rationality of the political system. The socio-economic environment makes claims on the state, and 'binds' the state to specific modes of operation, but the state's performance may be inadequate. Increasingly, administrative policy and action are orientated towards a rationality of concrete results rather than formal bureaucratic rationality. Efficiency is judged by results rather than conformity with rules, and the state's 'steering tasks' are resolved in an *ad hoc* way.

Given the scale and complexity of state intervention, Offe argues, the tendency is for there to be a 'politicisation of administration'. Government agencies seek to achieve their goals by attempting to build political consensus, and by incorporating key strategic actors in the creation and execution of policy. Public administration thus involves the co-optation of institutions and groups, and state policy (in education, health, welfare and so on) is accomplished through 'co-production' and, in some instances, collaboration between producers and consumers.

This may lead to two outcomes. First, heterogeneous interests may obstruct or prevent the creation of a consensus. Second, the incorporation of client and producer interests within the state policy process may result in 'excessive' demands. The politicisation of administration therefore encounters the prospect of continued crises of political legitimacy and fiscal stress. Offe's conclusion is that the welfare state is apparently locked into a pattern of contradictions between different criteria, modes of action and rationality.

This rather abstract and general discussion of the welfare state is directly relevant, and broadly accurate as a means of understanding the recent restructuring of the state in Britain. It is also appropriate in reviewing many of the policy developments in the NHS described in the chapters which follow (see also Cawson 1982; Fitzpatrick 1987).

In the decades which followed the establishment of the NHS, economic growth enabled the rapid expansion of health-care facilities, and the medical profession played a decisive role in the formation and implementation of government policy on health care and priorities for resources. During the 1960s, the emphasis was on what Klein (1983) termed 'technocratic politics' —the emergence of rational planning and management, and growing centralisation of administration. Organisational changes attempted to

reconcile central control with delegated responsibility for the delivery of health care. Economic crisis and ideological conflicts after the mid-1970s were reflected in stronger government intervention to control expenditure, and to secure increased efficiency, as well as disillusionment with the dominance of medical professionals.

Throughout these periods, the politics of the NHS have varied in their intensity and nature, and conflicts have developed around a diversity of issues at different times. These have included the possibility of devising planned programmes for specific health-care needs; the balance between acute medicine and care of the elderly, mentally ill and mentally handicapped; the organisation of acute medical care; the national and regional redistribution of resources to equalise facilities and services; the scope of private medicine in NHS hospitals; the co-ordination of statutory agencies; tiers of administration and types of management; working conditions and pay levels for NHS staff; and cost-containment

Although there are distinctive political trends associated with particular governments and economic contexts, it is difficult to assign unambiguous causality to class relations and class conflicts as such. However, one consistent factor is the mediating influence of 'policy communities' composed of the civil service, health authority senior management and medical professional bodies (Ham 1985; Haywood and Alaszewski 1980; Lee and Mills 1982; Small 1989).

Historically, there have been tendencies towards both bureaucratic (hierarchical) and corporatist (co-optative) styles of intervention by government. There has also been a continuous struggle for control of resource allocation between medical professionals and administrators, in addition to a struggle between local Health Authorities and central government over policies, priorities and spending. As Cawson (1982) observed, there has been an overall dominance of producer interests, but the structure of producer interests, and their relative influence, has changed. In particular, there has been a 'succession of challenges to the dominant position of doctors and consultants by administrators' and others, and in hospitals, 'managers have come to play a more significant but not a dominant role' (Cawson 1982:91–2).

During the 1980s, as subsequent chapters will show in detail, there has been further bureaucratic encroachment on professional medical autonomy, manifested in renewed managerialism and increased central control of local Health Authorities. Government strategies of cost-containment and rationalisation have been pursued, but their limited impact, and public opposition to real reductions in health expenditure, reinforced New Right demands for more radical approaches to reform—such as the internal NHS market

Such trends appear to support Offe's model of contradictory state policies and divergent rationalities. In highly simplified terms, quasi-corporatist modes of policy-making in the 1960s coexisted with, and then were displaced by more bureaucratic forms of organisational control from the late 1970s. Executive-style management was introduced in the early 1980s, along with a series of measures which shifted the 'frontier of control' away from medical professionals and other health workers (Harrison 1988a; see also Cousins 1987).

Faced with the inexorable rise in demand for health care, and wishing to strengthen consumer choice and provider-competition, from 1989 the government attempted to restructure the supply-side through what became known as a managed market. Rational administrative efficiency became subsumed by market efficiency—money was to flow with patient referrals, and Health Authorities, doctors and hospital units were given incentives to achieve budget surpluses. Extending Offe's analysis, we can argue that the politicisation of administration was regarded by the New Right as responsible for excessive, indeed supplier-induced, demand. The remedy for the politicisation of administration became the marketisation of bureaucracy.

Marketisation, like the other processes, generates its own contradictions and paradoxes, as Chapter 7 indicates. Like other strategies too, its implementation threatened established interests and objectives: —local Health Authorities' delegated power, health-service staff and unions, fragmented client groups, service accessibility and comprehensiveness, and clinical autonomy. Control over the ultimate allocation of resources and service delivery—that is, medical decision-making—has been a continuing theme, and elusive goal, in successive government policies. Different types of intervention have been attempted, but (until the time of writing) they have not yielded the outcomes desired by central government—the crucial ones being a reduction in total expenditure, a transfer of resources from acute and high-technology medicine to community and primary care, and the subjection of clinical performance to managerial accountability. Marketisation may change that, but it must do so by overcoming institutional inertia, political resistance and professional power.

So we are returned to the analysis of state policy-making and the recognition that a number of different types of theoretical explanation will be valid and useful. Our understanding of macro-changes in state structures can only effectively be accomplished if realistic consideration is given to the importance of interorganisational relations and bureaucratic—professional conflicts, neither of which can be wholly accounted for within a neo-Marxist paradigm.

Organisations, like states, are not homogeneous machines pursuing coherent goals. State policies are formed and implemented through complex processes of inter- and intraorganisational bargaining and negotiation. Coalitions of competing interests struggle for ideological and substantive domination within agencies, and seek to modify relations of resource dependency with other bodies and groups. Decision-making within markets, networks and hierarchies usually depends on limited forms of delegation and discretion among both agencies and actors, so there are inevitable tendencies towards conflict as different groups seek to enlarge or minimise their sphere of action (see Barrett and Fudge 1981; Ham and Hill 1984).

Managerial and organisational control is thus always contingent and variable. Like the impact of 'structural' interests and exogenous factors on the relative autonomy of participants and institutions, the form and degree of control is an empirical question. In explaining state intervention and particularly health policy, institutions, organisations and professions matter, and cannot be simply regarded as mere epiphenomena of class hegemony.

The fact that organisational patterns themselves are constantly modified, and apparently adapt to new regimes of capital accumulation, does not weaken the argument for their specificity. If anything it reinforces it. Commercial firms and public sector agencies have patterns of working and organisational cultures which become 'outmoded' in changed economic and political conditions, but they are not transformed without difficulty and struggles. Elites and managers face a constant problem in securing worker compliance, but it becomes especially contentious in times of environmental turbulence and organisational innovation (see Chapter Eight, and also Benson 1982; Clegg 1989a, 1989b; Heydebrand 1983, 1989; March and Olsen 1984).

One possibility is that the changes documented below are another example of so-called 'post-Fordism'. Just as the commodity sector and commercial and industrial production systems have undergone restructuring due to changes in the domestic and international economy, so too it can be argued that the public sector has experienced a similar transition.

Disorganised capitalism, Lash and Urry (1987) argued, is characterised by transformations in economic production, spatial structure and cultural patterns. Multi-national corporations become more important, traditional industries and divisions of labour become redundant National collective bargaining and wage determination are superseded by company and local plant deals; work patterns and employment practices become flexible. The old polarised class structure is modified due to the growth of the service class, and fragmentation increases because of consumption, gender and ethnic

differences. Political struggles become sectional rather than predominantly class-based.

Organisationally, a shift takes place away from mass production, centralised bureaucracy, standardisation of output and Taylorist scientific management With new technologies, new products and new markets, diversification, specialisation, flexibility and decentralisation are necessary. Divisions of labour and the social relations of production are changed, with a fragmented workforce in a dual labour market, and control exercised through information technology and an entrepreneurial corporate culture.

There certainly appear to be some analogies with recent restructuring of the welfare state, and the 'post-Fordist' model may be relevant in understanding some of the organisational changes in the NHS, but there are difficulties with this approach too, as Chapter 8 will suggest. However, the point to be emphasised at this stage is that these structural transformations do not proceed automatically or evenly. They are likely to become political issues and sources of intra- and interorganisational conflict.

Other factors also make a direct transfer of the post-Fordist model to the public sector problematic. Welfare state activities, especially health services, have inherent features which may make such transformations difficult to implement. First, the 'product' demanded is to a large extent expected to be standardised at least as it serves universalist principles of need. However, at the same time, professional diagnosis and treatment of dependent clients is ostensibly based on particularised decisions, requiring substantial discretion. Second, the producers are highly differentiated, and the combination of public sector unionisation and professionalisation may be obstacles to 'flexibilised' working practices and management styles. Third, if decentralisation and flexibilisation expand, it is conceivable that there would be increased heterogeneity in local output and outcomes, thereby undermining central government's desire for budgetary and policy control.

Whether the restructuring of health services can be described as 'post-Fordist' or not, the task remains that of explicating *how* organisational change has occurred, and how far this has altered pre-existing modes of policy-making, management and service delivery. The argument of the following chapters is that recent developments *have* extended managerial power and reduced clinical autonomy. Whether marketisation will create more space for the reassertion of professional dominance remains to be seen. The likelihood is that it will not. Studies from the United States have shown that in a private health-care market, bureaucratic surveillance and control increased, as third party financers and state bodies found it necessary to regulate clinical practice to ensure cost control and effective

performance (Bjorkman 1989; Mechanic 1976; Starr 1982). The consequences of an internal market in the NHS for the supply and delivery of health care are beyond the scope of this book, but as Chapter 7 indicates, there will certainly be significant adjustments in the pattern of provision and important changes in the social relations of production and consumption.

RESTRUCTURING HEALTH SERVICES

During the 1980s, under the aegis of New Right government programmes, there have been numerous measures affecting the structure, financing and management of the NHS. It is argued here that cumulatively, these have altered the context within which health authorities operate, changed the balance of central-local power in favour of the former, and strengthened the influence of executive managers over medical professionals and other health workers.

This restructuring has been attempted through the introduction of ministerial accountability reviews; performance indicators; efficiency savings and cost improvements; the replacement of consensus management by general management; clinical budgets or resource management; compulsory contracting for non-medical ancillary services; support for private health care; underfunding in the hospital sector; and increased regulation of the family practitioner service. More recently it has also comprised the attempt to create an internal market with purchaser-provider competition, and the promotion of an entrepreneurial culture within the NHS.

These trends have begun a transformation in the public provision of health care, and are part of a much broader strategy of restructuring the welfare state. For those reasons, a sociological analysis of changes in NHS structures and processes seems necessary and worthwhile. Chapter 2 therefore examines the question of medical autonomy, and the implications of managerial encroachment for professional dominance. This deals with basic issues of bureaucratic-professional conflict, the application of scientific management and constraints on professional power. Chapter 3 explores the nature of management in the NHS in more detail. It describes changes in the organisational form of the NHS and the replacement of administration by a new type of general management, and reviews evidence about the impact of managerialism.

As already noted, finance has been a major and permanent problem for the NHS, and various efforts have been made to reduce or control costs, particularly in hospital services. Chapter 4 looks at recent developments in techniques to improve efficiency in resource use and to

limit spending. Clinical budgeting, resource management, diagnosis-related groups and medical audit are discussed, and their implications for clinical freedom and medical autonomy are assessed. The pursuit of value for money is closely connected with debates about efficiency, effectiveness and quality. Chapter 5 therefore considers a succession of policies and devices to obtain greater central control and planning of health authority activities and clinical practice. This deals with a number of forms of performance evaluation— performance indicators, efficiency savings, management audit—as well as the growth of interest in 'quality assurance'.

The NHS in the 1980s was dominated by controversy about the adequacy of funding, and discontent about rationalisation and retrenchment in hospital services. Chapter 6 looks at the impact of expenditure restraint on Health Authorities, and provides detailed empirical evidence about the practice of 'cutback management' at the local level. Findings from a study of six districts in one English region are presented and analysed, together with information from other sources. They show not only the severity of budget crises and the way in which reductions in services were achieved, but also the fundamental importance of retrenchment in consolidating managerial influence.

Moves towards an internal NHS market, as a solution to the financial crisis, are then outlined in Chapter 7. It argues that despite consumerist rhetoric, marketisation will not enhance consumer choice or influence. It may lead to a reduction in medical professional domination, but planned reforms will entrench managerial power, especially over the determination of demand, need and service effectiveness. Finally, Chapter 8 gives an overview of the significance of these trends, and relates them to similar developments in other parts of the welfare state and public sector.

Some caveats are obviously necessary. The book is concerned with one aspect of restructuring in the welfare state—health services—but in fact the analysis is restricted to Britain, and particularly the NHS in England. More specifically, while it tries to refer to aspects of change in the health-care system as a whole, it is mainly concerned with hospital medical services, and relatively little detailed attention is given to primary and community care.

Health-service provision is carried out by a wide range of diverse occupations and groups, but the focus of attention throughout the book is upon the relationship between doctors and managers at various levels. The argument that clinical autonomy is being eroded by bureaucratic and managerial control should not be inferred as either praise for professional dominance or criticism of 'illegitimate' managerial encroachment. The point is that whatever the quality and effectiveness of medical interventions, and

however paternalistic, monopolistic and unaccountable the medical profession might be, contemporary restructuring and managerialism will not necessarily remove those features from the system: they will simply transfer them to a different group within a different pattern of institutional relations.

One final introductory note, about sources of information. The material used in the following chapters is derived from various sources—original research, government reports and official publications, Health Authority documents, academic and professional journals, and the secondary literature. Many of the categories and terms used are peculiar to the British scene and NHS vernacular. Some basic familiarity with these, and with the evolution of the NHS, are assumed from the outset, but the meaning and relevance should be made clear in the context of the discussion.

2 Medical autonomy and managerial encroachment

Health-care services take a variety of forms, and medical services can be (and have been) organised in different ways. Here, the focus is on the recent organisation and production of medical (particularly acute hospital) services. 'Medical services' can be broadly defined as medical interventions in illness by state-licensed hospital doctors, general practitioners, nursing and paramedical staff, and are distinguished from long-term residential care, as well as self-medication, 'alternative' medicine, preventive health, and 'lay' treatment (see Busfield 1990a:93). Medical care has become institutionalised and professionalised, and its structure and form have been shaped by struggles between competing interests and contradictory objectives. In Britain, the creation and subsequent reorganisations of the NHS have been characterised by major conflicts between the government and political parties, local government, professional bodies and (perhaps less significantly) patient representatives (see Allsop 1984; Klein 1983; Levitt and Wall 1984).

As in all industrialised countries, the major issues of debate have concerned alternative systems of financing medical treatment (a private market, social insurance or tax-based collective funding); the employment, remuneration and regulation of medical and related staff (independent private practitioners, fee-earning contractors or salaried employees); the mode of provision and balance between types of care (hospitals, primary care and community/public health); criteria and mechanisms for planning, allocation and rationing of resources between competing demands and needs; and the degree of state involvement, and procedures for consumer and political accountability. In one country at different times, and in different societies, these issues are resolved in varying ways, reflecting changes in the influence of economic constraints and political-ideological pressures and struggles. However, what does seem evident is that the medical profession occupies a strategic position in virtually all debates about these issues, and that historically, in Britain and many other

industrialised countries, doctors have exercised significant influence over key decisions concerning those issues.

In any analysis of health systems and health policy, therefore, attention must be given to the nature and extent of professional power. There is a very large and complex literature about the role of professions in modern states, and especially about the medical profession, and there are continuing theoretical and empirical disputes about the identification and assessment of power. In this case, power (defined as the capacity to influence the actions, beliefs and values of others) can be effected through the possession of scarce expertise and skills (usually a monopoly of knowledge and resources for treatment), the definition of health and illness and specification of health policy, and influence over the organisation and control of the means of medical production and division of labour. Professional medical power is inextricably connected with the rise of rational scientific medicine, and the generalised authority and legitimacy sought by, and given to, experts. It is not merely expressed through the content of doctor-patient interactions, but embedded in a complex set of ideologies, institutional arrangements and societal relations (see Turner 1987).

Professional medical power and its corollary, medical autonomy, has many dimensions, and cannot be regarded as an absolute property: we cannot simply claim that it either exists at one time, or it does not. Rather, medical autonomy can be pursued (or restrained) in specific areas—for example, doctors' right to practise privately while contracted to the NHS, or insistence on performance evaluation only by professional peers, and so forth. Also, for different subsections of the profession, and for different 'external' groups, certain elements of autonomy are regarded as more important, and more open to dispute, than others.

Generally, at an abstract macro-level, autonomy can be thought of as an aggregate effect of social closure (discussed further below) where social groups compete to capture or maintain market advantages. At the institutional or meso-level, autonomy might be exercised by the inclusion of professional representative organisations in state policy-making machinery. At an individual or micro-level, autonomy may consist of the privilege to make unsupervised decisions on the treatment of patients. However it is defined, autonomy embraces a range of capacities, and it is socially constructed and politically contentious. Like all forms of human agency, medical autonomy is a *relational* attribute, having different manifestations, and subject to expansion and contraction under different conditions and social-structural constraints. Medical autonomy, then, is necessarily a form of occupational *relative autonomy*, as it refers to doctors' attempts to enlarge or protect their market for expertise, exclusive jurisdiction and prerogative of self-regulation.

This chapter addresses only some aspects of these wider capacities and processes. Its focus is upon recent attempts to modify the scope of medical autonomy within the NHS, and it considers the argument that throughout the 1980s, there has been a growth in bureaucratic intervention in medical services. It is argued that in a number of important ways, professional medical autonomy has been substantially, and increasingly, undermined by managerial encroachment. Later chapters provide detailed evidence about the policies and techniques involved in this erosion of doctors' power—the introduction of general management, the development of clinical budgeting and cost-controls, procedures for performance evaluation and quality assurance, and cutbacks in services—but first we must review some of the important arguments surrounding this shift in what has been aptly termed the 'frontier of control' (Harrison 1988a).

First we shall examine the conventional assumption of medical domination within the NHS. Next we shall look at recent NHS policies as examples of 'scientific management' and relate them to broader discussions of the labour process debate, ideas about the service class and the connection between professionalisation, deskilling and proletarianisation. In the third section, the nature of professional power is analysed in more detail, together with an account of what can be termed the 'bureaucratic-professional conflict' thesis. The significance of current managerial and other controls on medical activity is then assessed. Finally, these trends are placed in the context of similar developments occurring in other welfare state sectors, and questions are raised about whether recently evolved methods of managerial control are congruent with changed circumstances.

MEDICAL DOMINATION IN THE NHS

Most studies of the development and operation of the NHS have concluded that since its inception, doctors have exercised disproportionate influence over the content of health policy, the structure and organisation of the service and the rationing of resources. This view has now in effect become the conventional or orthodox view, based on a variety of studies by different authors. It will be argued here that this model of medical hegemony needs to be questioned, or at least modified, because of important organisational developments within the NHS and increasing challenges to professional authority over the last decade.

Historically, it is well known that the political compromise which allowed the establishment of a nationalised health service in 1948 gave concessions and a privileged position to hospital consultants and general practitioners. According to Klein (1983), GPs were effectively able to maintain their *status quo ante* position (as independent contractors), while consultants' particular

interests and clinical freedom were accommodated in the new system. In both cases, their power was essentially obstructive, but they were accorded a monopoly of legitimacy in decisions about the shape and content of the NHS. Subsequently, although doctors' incomes were depressed, 'the medical profession permeated the decision-making machinery of the NHS at every level and achieved an effective right of veto over the policy agenda' (Klein 1983:54). As a result of this position, throughout the 1950s and early 1960s, the medical profession's power was sustained through its capacity to select issues and policies for public and governmental debate, and its ability to determine the boundaries of professional expertise and to resist efforts to change them.

Efforts to introduce rational planning and improved management structures from the mid-1960s to the mid-1970s did relatively little to weaken the domination of the medical profession. Various attempts to devise national planning targets and priorities for specific programmes, and the redistribution of resources between different areas of the country and away from acute medicine to other care groups, met with only limited success. Opposition centrally from the representatives of the medical profession, and local insistence on clinical freedom in everyday practice, served to frustrate many of these plans and policies. As Ham (1985:161) observed: 'centrally determined health policies are mediated by a range of interests at the local level, among which the medical profession is the most influential'.

Other studies also support this claim. Ham (1981:198) argued that although policy processes in the NHS were incremental and pluralistic, characterised by bargaining and compromise, nevertheless 'the distribution of power was weighted heavily in favour of the professional monopolists'. Similarly in Lee and Mills's (1982) account of policy-making and planning, they stressed that there was a multiplicity of interests and influences (and conflicts) in decision-making, and much local variation in the implementation of central policies. However, they also noted that despite reorganisation and new formalised planning systems, 'resistance to change in the pattern of services suggests that the informal political structure and the stability through time of accustomed relationships and styles of behaviour have diminished the likelihood of large-scale change in medical priorities' (Lee and Mills 1982:181).

Haywood and Alaszewski (1980) documented the emergence of a centralising and managerial perspective as the economic crisis of the mid- and late 1970s impinged upon the NHS. But they also emphasised that the core activity of managers was the management of process rather than directing developments. Medical providers were shown to be powerful actors locally, and managers performed a 'servicing', 'mediating' or 'brokerage' role, rather

than controlling decisions on service development. Consequently, the medical profession, especially acute hospital specialists, maintained effective power, and there was 'continuing medical hegemony in important decisions within the NHS' (Haywood and Alaszewski, 1980:135).

Thus there seems to be substantial empirical evidence of professional power exercised in different ways and at different levels. Some commentators have highlighted the corporatist character of state-medical relations, and the preponderance of doctors' representatives in national, regional and local decision-making bodies (Cawson 1982; Klein 1977; Saunders 1985). They have also pointed to the more prosaic but fundamental fact that the quantity and quality of health services are determined through specific clinical judgements of need and individual doctors' decisions on treatment. So, according to Saunders, 'a "medicalised" ideology of health care, reflecting the views and interests of the hospital doctors, became entrenched throughout the management structure of the NHS', and at the Regional Health Authority level, 'producer' influence was pervasive (Saunders 1985:158).

Klein, and Cawson, also using a corporatist framework of analysis, have both indicated the historical contingency of medical dominance, and imply that it is not a fixed or inevitable feature of the government of health. Klein (1977) noted that despite (or because of) the medical profession's traditional domination of the NHS, a number of threatening trends had emerged: disputes over salary levels had exacerbated sectionalism and fragmentation within an already divided profession; increased complexity and specialisation in clinical practice had weakened the authority of hospital consultants; and rigid expenditure controls and efficiency measures posed problems for clinical freedom. Similarly Cawson (1982) argued that although medical professional interests had played a crucial role in the formation and implementation of policies, the history of the NHS revealed a succession of challenges to their dominance, and, more recently, greater determination by managers (as agents of central government) to reduce costs and require greater medical accountability.

As we shall see in more detail in later chapters, a combination of factors (most notably the Thatcherite aims of restraining public spending and restructuring the state) precipitated a series of government measures during the 1980s to enhance central control over local Health Authorities' expenditure and service priorities. Mechanisms for monitoring and evaluating performance, to ensure cost-effectiveness (efficiency savings) and compliance with ministerial directives (for example, on 'privatisation' or compulsory tendering of non-medical services), were introduced or made more stringent. Systematic attempts were made to regulate clinical resource use (through clinical budgeting or resource management), and to assess clinical practice

(through medical audit). Most significantly, the traditional system of consensus management within Health Authorities was replaced in 1983 by 'general management', with increased powers for bureaucratic executives at each level (discussed further in Chapter 3). In 1989 the Conservative government (after an unprecedented crisis and public concern over NHS under-funding) published proposals to reform the health service by introducing an internal market, with reinforced emphasis on cost-efficiency, consumer awareness and an extension of managerial controls over clinicians and general practitioners.

Cumulatively, these changes constitute a fundamental transformation in the policy system of the NHS, and have given managers at all levels a mandate and an imperative to challenge medical professional dominance. Harrison (1988a) has documented the various phases of this process historically. From the 1950s to 1980, health authority administrators (*sic*, now 'managers') functioned basically as 'diplomats', servicing the professional demands of doctors. From about 1982 to 1984, amid central government anxiety to impose its spending and other policy objectives, managers were 'scapegoated' for allowing inefficiency to persist. Then, after about 1985, managers were instructed to become more assertive and directive, as agents of government, and the 'frontier of control' between doctors and managers was shifted in favour of the managers.

These trends, and the 1989 White Paper *Working for Patients* (Department of Health 1989), have also been described by leading commentators as the 'beginning of a new era', intended to 'change the managerial and professional culture of the NHS through the 1990s' (Day and Klein 1989: 1, 3). Recent developments have crystallised around the need for closer regulation of medical output and quality, and the necessity for increased managerial authority over doctors in hospitals and in primary care.

The White Paper's management proposals (see Chapter 7) comprise, as Day and Klein (1989) suggest, elaborations of measures that have been evolved over the last ten years, and they reflect wider international trends towards the subjection of professional definitions of efficiency and effectiveness to managerial criteria. Most importantly, these policies, as Day and Klein cogently argue, 'represent…the ideology of Weberian bureaucratic rationality', and despite claims to champion competition and consumerism, current government plans represent 'the apotheosis of rational, bureaucratic paternalism' (Day and Klein 1989:27, 3).

Of course it is an empirical question as to whether this process of bureaucratisation and managerial encroachment takes place consistently, and whether it indeed does undermine medical dominance. Later chapters provide further evidence that the process has taken place, and indicate that there are reasonable grounds for expecting it to intensify.

Previously, doctors had virtually unrestricted clinical freedom to define medical need, prioritise demand and prescribe treatment, within notionally fixed financial allocations. But cash limits were overridden by the expansion of demand, the growth of medical technology and by cost inflation, while the pattern of medical services, clinical resource use and outcomes, failed to meet central government expectations and targets. Medical autonomy had become identified as a source of inefficiency, and as a device for opposing external quality control and accountability. From the early 1980s it became clear that this tradition of medical hegemony was to be broken.

The point which must be emphasised, therefore, is that the long-held assumption of medical domination of the NHS can no longer be accepted unproblematically. Instead, much closer attention must be given to the ways in which professional medical autonomy is increasingly diminished by structures and means of management control.

Moreover, it is argued here that to understand this shift in the balance of power, we need to relate it to much broader social and political movements affecting the welfare state—in particular, the application of 'scientific management' and quasi-market mechanisms to public sector service organisations, and general changes in the composition and functions of the service class, leading to a form of deprofessionalisation.

SCIENTIFIC MANAGEMENT?

In all complex societies and organisations, roles and tasks are differentiated, and a division of labour emerges. In industrial, commercial and welfare organisations, despite (possible) differences in goals, there are common problems of devising appropriate degrees of specialisation and methods for co-ordination. Resources must be obtained, worked on and processed, and there are (minimal) needs for continuity and predictability in output. Productivity, quality, cost and revenue are universal preoccupations for dominant coalitions in organisations, whether they wish to maintain a 'steady state', to survive external threat or to expand.

On recounting these truisms, it is assumed that all (or most) organisations entail hierarchy and potential conflict among members—quite obviously because task specification, co-ordination and scrutiny of performance involve the exercise of power (or authority) by superordinates over other staff. In simple terms, the participation of employees can be obtained through various modes of coercion or compliance. Whatever the pattern, employers encounter continuing problems in achieving reliability and standardisation of output, in securing workers' commitment and in obtaining their conformity with managerial directives and requirements.

The acceptance and enforcement of managerial authority is a question which has dominated industrial and organisational sociology (and debates about social class relations), but most of the discussions have concerned capitalist enterprises geared to profit There are by contrast very few accounts of state or welfare agencies, and non-profit organisations. Much attention has been given to the treatment of manual (usually male, and industrial) workers. Administrative, clerical, managerial or non-manual occupations have only been examined relatively recently, and even this work has concentrated on the 'contradictory' class location of the so-called property-less or 'new' middle class, or 'intermediate strata' (see Abercrombie and Urry 1983; Clegg and Dunkerley 1980; Marshall *et al.* 1988).

However, as Cousins (1987) has clearly established, it is both valid and useful to apply theoretical ideas about the labour process to welfare state organisations, especially as they refer to questions of managerial strategy. For Cousins, the absence of capital accumulation or profit maximisation as an immediate objective does not necessarily mean that the labour process and management activity in state agencies are entirely different from capitalist enterprises.

Following recent neo-Marxist analysis, and suggestions by Offe (1975, 1984), Cousins convincingly argues that the labour process in public and private sector organisations *is* similar, although such organisations may operate according to different 'logics' or 'rationalities'. This arises because welfare state agencies, while not necessarily seeking profit, are nevertheless constrained by political requirements to be efficient and cost-effective, because they derive their resources from tax revenues (public expenditure is regarded as a deduction from private capital).

Further, because they are usually engaged in what Offe and others term the reproduction and legitimation of capitalist social relations, welfare organisations therefore attempt to reconcile competing demands. State agencies and their policies thus reflect constant struggles between contradictory ideologies of citizenship, social need or universalism, and of commodification, competitive individualism and productive efficiency (see Cawson 1982; Cawson and Saunders 1983; Saunders 1986).

Although it is mistaken to believe that state or public sector agencies are directly analogous to business corporations, there are common features, particularly in the internal enforcement of (or perhaps more accurately, the attempt to impose) bureaucratic authority. In principle at least, in most welfare state services, demand is met by non-price rationing. Usually, needs are assessed according to formalised criteria and/or professional judgement, decisions are ostensibly governed by impersonal procedures, and actions or treatment are determined by rational-technical rules or expert knowledge. Administrative discretion or professional autonomy may be a necessary

feature of service delivery, but they are also necessarily circumscribed and regulated. At a minimum, public employees are expected to behave in ways which fulfil state-defined objectives, and to remain within budget: but these requirements beg many questions about practice.

Most public sector organisations are therefore subject to external scrutiny and internal surveillance, to ensure local conformity with central government policies, to demonstrate value for money and to check on accountability. Since the 1960s, the British civil service, local government, NHS and other welfare state services have been advised and instructed to adapt their working practices and organisational structures, to make them more 'business-like'. Corporate planning and associated management methods developed in commercial and industrial settings have been imported and adapted (see *inter alia,* Dearlove 1979; Gray and Jenkins 1985; Ham and Hill 1984; Hambleton 1986).

Irrespective of their degree of 'success', there are similarities in key aspects of the management ideologies and structures of control found in state agencies and capitalist corporations. Such similarities are likely to increase, of course, as a consequence of more government pressure to make public bodies more 'commercial' —that is, to reduce costs, increase productivity and quality, and become more responsive to consumers.

The argument here is that, as a consequence of the contradictory nature of the welfare state in capitalism (Offe 1984), in the public sector generally, and within the NHS in particular, there has been a gradual, erratic but sustained attempt to implement a variety of techniques and arrangements designed to limit spending, restrict discretion and extend managerial control. This in itself may not be an original or surprising observation. What is claimed, however, is that especially in the acute hospital sector of the NHS, a form of 'scientific management' has been applied recently with increasing vigour. Moreover, its implementation constitutes a major transformation in the position and power of medical professionals, and consequently, bureaucratic-professional conflicts are likely to intensify.

'Scientific management' refers to a set of ideas about organisational design and manager-employee relations in capitalist production enterprises initially proposed by F.W.Taylor in the United States in 1911. According to Clegg and Dunkerley (1980:96–7):

> At its base, scientific management is concerned with the question of organisational/managerial control…the production process is so tightly controlled that the possibility of employee discretion is almost non-existent…. Taylorism, in modified forms, has become the orthodox doctrine of technical control in contemporary industrial capitalism.

They argue further that scientific management facilitates administrative or management control over the labour process in non-capitalist state organisations, including NHS hospitals, and that it has been extended to incorporate 'white-collar' or non-manual work.

Essentially, scientific management or Taylorism consisted of the deliberate fragmentation of the division of labour, work measurement to optimise effort, discrete and standardised tasks, and the separation of planning from the process of production itself. 'Management' became a specialised activity (a form of socio-technical engineering), and managers assumed the right to co-ordinate and command workers. Scientific management is, as Clegg and Dunkerley (1980:82) and Littler (1982:58) suggest, a form of bureaucratisation of the structure of control.

There seems to be general agreement that scientific management has had profound consequences for industrial work patterns and management practices, but there is disagreement over the extent to which it has necessarily resulted in the 'deskilling' (or 'degradation') of work and workers, and whether it has enabled complete managerial domination of the workforce to take place. Various writers have criticised Braverman's (1974) account of Taylorism for exaggerating the extent of deskilling; for overestimating the coherence of managerial strategy and the cohesion of management; and for underestimating worker resistance and struggle (see, *inter alia:* Littler and Salaman 1982; Thompson, P. 1983; Wood and Kelly 1982).

Such criticisms have been valuable precisely because they direct our attention to the *variety* of methods and strategies commonly used to achieve employee consent and managerial legitimacy. They do not, however, diminish the importance of recognising the centrality of attempts by managers to institutionalise order, discipline and control by inscribing them in organisational structures and operating procedures.

It is these attempts, as they have evolved recently in the NHS, which form the core concerns of this book. Here, so-called scientific management is regarded as a generic movement comprising a number of interrelated aspects. Its main aim is to increase workers' productivity, and remove workers' craft control of the work process by vesting power in managers and in the production arrangements themselves (in industry, it is of course closely associated with 'Fordism' —assembly-line continuous production, standardisation and the creation of a mass market).

Since 1948 there has been a constant stream of measures (carried out by Conservative and Labour governments) designed to make the NHS system more 'rational' and efficient, including two major structural reorganisations in 1974 and 1982. Various schemes for the control of detailed planning and budgeting (the Hospital Plan of 1962, Resource Allocation Working Party

1976, NHS Planning System 1976, revised 1982, and so on) have been used to estimate needs, plan services, allocate resources and limit expenditure. Cumulatively, they have reinforced other trends towards the specification and regulation of tasks and roles within local Health Authorities, and within units such as hospitals. Only a few examples can be referred to here, but later chapters give much more detail.

In the medical profession, the so-called 'Cogwheel Reports' of 1967–74 introduced a system of hospital medical organisation by specialty 'divisions'. This was a response to ministerial criticism of medical inefficiency in resource use, and represented a means of exerting managerial control, albeit indirectly through senior consultants as chairmen of Medical Executive Committees. 'Cogwheel' was seen by many doctors as a threat to their clinical autonomy, and was met with some resistance (see Levitt and Wall 1984; Manson 1977).

In 1983 consensus management teams (Health Authority and hospital management teams comprising chief officers of equal status—administrator, treasurer, and medical and nursing representatives) were abolished. General managers were given new powers, and executive responsibility, to improve efficiency and performance, and there was a major initiative to gain control over clinical activity and clinical resource use. 'General management' signalled the explicit application and endorsement of commercial management methods and styles at all levels, and to all types and grades of staff. Not surprisingly, managers encountered opposition and hostility among many doctors, because general management posed a serious threat to professional medical dominance in the NHS, as described further in Chapter 3 (see also Harrison 1988a; Strong and Robinson 1990).

Nursing has been subject to a number of important managerially induced changes over several decades (Stacey 1988; Strong and Robinson 1988). In 1966, the Salmon Report brought about the creation of functional specialisation and an elaborate hierarchy among nursing staff, with a special designation for nurse managers. As both Carpenter (1977) and Manson (1977) have shown, this 'new managerialism' involved the application of work study techniques and productivity criteria, differentiation into 'skilled' and 'unskilled' nursing work, and reinforced latent conflict between ward-level and senior nurse managers.

The implementation of general management from 1983 has apparently demoted the most senior nursing managers within the corporate management structure, and caused further problems because 'non-professional' managers at unit and district level have overall responsibility for the activities, budgets and performance of all nurses (Harrison 1988b). These developments, of course, have taken place against the background of continuing disputes and crises over nursing pay and conditions.

Like nursing, the wages, terms and conditions of employment of NHS 'ancillary' workers have also been the source of intense conflict and numerous government measures to improve productivity and reduce labour costs. Indeed strikes and industrial relations disputes with NHS ancillary staff have figured on the national political stage since the 1970s (Klein 1983). From the late 1960s, there have been a variety of bonus schemes and productivity agreements with different staff groups, but employee discontent has persisted, and management have continued to seek greater efficiency from the workforce. Conservative governments after 1979 introduced a large-scale programme of compulsory tendering ('privatisation', or 'contracting out') in some NHS ancillary services—most notably catering, domestic cleaning, and laundry services, and more recently it has been extended to other services. This led to a number of important political and trade-union disputes, but has nevertheless gone ahead, resulting in considerable financial savings through changed working practices, job losses and tighter managerial control of task performance through contract specification (see Harrison 1988b; Key 1988).

In addition to these important changes in the structural arrangements and working practices of key staff groups in the hospital sector of the NHS, there have been other interrelated developments, designed to increase output while restraining expenditure, and aimed at institutionalising a 'management culture'. Throughout the history of the NHS, successive governments have worried about increases in spending, and have endeavoured to contain costs. Conservative governments in the 1980s intensified these efforts, while introducing substantial changes in the apparatus of central control and accountability. A number of different, but linked, policies and measures were geared to strengthening local managerial power over clinicians, nursing and ancillary staff, increasing cost-efficiency and medical resource use, and enlarging the scope for external central monitoring and surveillance of output and performance.

Thus the setting up in 1982 of annual 'Accountability Reviews' between ministers, civil servants, and Regional and District Health Authority chairpersons, and then between general managers at each level down to the local units, can be seen as direct evidence of government determination to ensure the full implementation of its polices through hierarchical control. At each level, managers are employed on short-term contracts, are given specific 'key tasks', targets and deadlines in their review meetings with superordinates, and their performance is appraised annually (in most cases 'performance-related pay' is added to basic salary). Health Authority chairpersons are appointed (and removed) by the Secretary of State for Health, and general managers' appointments are also subject to ministerial approval.

Associated with this 'review system', a complex set of 'performance indicators' (PIs) was devised and formally introduced in 1983. These included norms and averages expressed in statistical terms for hospital inpatient days, patient turnover and bed use, and so on, for each clinical specialty, as well as comparative figures for different types of hospital, and for comparisons of different districts. Other PIs also incorporated data related to personnel, finance and property functions of Health Authorities. Local managers were expected to make better judgements about resource use and efficiency on the basis of this information, and regional and central authorities had a means for appraising the relative success or failure of different districts and units. PIs thus provided a technique for enhanced internal managerial control, and a mechanism for external inspection and evaluation (see Chapter 5, and Birch and Maynard 1988).

The so-called 'Cost Improvement Programme' (CIP), and 'Rayner Scrutinies' were initiated by central government in the early 1980s, and represent another element in the overall strategy of applying the disciplines of the commercial market to the public sector. The aim of these measures was to reduce waste and inefficiency in all aspects of the NHS: 'efficiency savings' could then be redeployed to offset pressure on finances.

Districts and Units were instructed to achieve specific target savings within their budget: these economies included the 'rationalisation' of patient services, 'competitive tendering' of ancillary services, and savings in estate, fuel and supplies. This coincided with a period of growing political debate about the crisis of NHS funding, and attempts to obtain savings sometimes resulted in real reductions in hospital services (see Chapter 5). Again the important point to note is that, as well as stringent central regulation of local Health Authorities, the CIP and other efficiency measures permitted (indeed, demanded) managerial intervention into hitherto professionally dominated areas and activities.

Other important examples of the sustained impact of managerialism and scientific management include the emergence of clinical budgeting or 'Resource Management' (discussed more fully in Chapter 4), and increasing attention given to medical or clinical audit (see Chapter 5). These are complex issues not amenable to easy summary, but their significance lies in the fact that they represent serious challenges to traditional professional monopolies of authority over resource use and the quality of service.

Hospital doctors are now required to identify, and justify, the resources used in clinical practice, and procedures of peer review are being extended and amended to permit more managerial scrutiny of medical performance. A large-scale investment in computerisation and information technology within the NHS (the Körner programme), and rapid development of clinical costing through Diagnostic Related Groups, have provided the means for

detailed managerial inspection of medical procedures, working practices and resource use. The 1989 White Paper *Working for Patients* has given added impetus to these trends, and further entrenched managers' capacity to intervene in the production of, and 'quality assurance' in, medical services, thereby potentially eroding professional medical autonomy.

The main difficulty obstructing the full adoption of commercial line management systems in the NHS is clinical responsibility for patient care. As one commentator has emphasised:

> those on the shop-floor who commit resources and make decisions on their use are the *major* determinants in the system and not the minor ones envisaged in a traditional line management structure. They are the clinicians, who determine the levels of production (the number of patients), what is produced (the types of patients given care and treatment) and how it is produced (the methods of treatment and care given). These are not decisions normally taken by those at the 'end of the line'.
>
> (Steele 1985:78)

Recent measures in the hospital sector (and to a much lesser extent in the family practitioner service too) have thus been aimed at amending this 'inversion' of ordinary line management: central and local managers are seeking to define the limits of doctors' clinical freedom, previously entirely a matter for professional jurisdiction.

It seems reasonable to conclude at this stage that there has been a long-term, systematic, though uneven and variegated imposition of 'scientific management' within the NHS. This is partly explained by governments' desire to contain public expenditure and to ensure efficiency, as well as more widespread political demands to subject producer monopolies to greater public accountability. The outcome—managerial encroachment on medical autonomy—raises other questions about professional power which can now be addressed.

PROFESSIONAL POWER

The conceptualisation and explanation of professional power is an enduring problem in sociological theory and research (see Abbott 1988; Crompton 1990; Fielding and Portwood 1980; Johnson 1977, 1982; Saks 1983). There seems to be general agreement that professionalisation should be analysed as an occupational strategy for the control of work, and as a way of institutionalising and regulating expert knowledge. Neo-Weberian writers focus on struggles for occupational control as examples of attempts at collective mobility and social closure. Neo-Marxist writers stress the functions

of professions in the management and reproduction of exploitative class relations, and ask whether professionals are members of the dominant class or whether they are becoming 'deskilled' and 'proletarianised'.

However, just as it is necessary to recognise that professionalising occupations compete for exclusive jurisdiction and state-licensed monopoly within a political economy which defines the market for expertise, so too it is necessary to recognise that not every aspect of professional organisation and practice can be reduced to the overarching functional pre-requisites of capital. The 'service class', which consists of a diverse, indeed heterogeneous, set of administrative, managerial and professional occupations, does have a contradictory class location, and may engage in activity which cannot be wholly explained by the appropriation and realisation of surplus value (see Abercrombie and Urry 1983; Crompton 1991; Goldthorpe 1982). Rather than seeking an all-encompassing theory to explain all aspects of professionalisation, especially in the field of medical care and health services, it may be more prudent to use some elements of different theories for different levels of analysis (see Turner 1987).

In his now classic discussion, Freidson (1970) argued that the core of professionalism consisted of the possession of autonomy, and the nature of control over practice. Professionals constantly seek to gain public acceptance and state recognition of their authoritative expertise, and professionalisation involves a particular form of organised autonomy. Doctors historically have been very successful in obtaining autonomy—the right to determine the content and terms of work. Medical professionals' power became institutionalised as doctors gained the authority not only to direct and evaluate their own work, but also that of other health workers, and the division of (medical) labour.

Larson (1977) insisted that this account neglected the class dimension of professionalism: professional producers try to constitute and control a market for expertise which reflects dominant class interests and which maintains social inequality. Professions flourished in modern capitalism through incorporation within enterprises and state bureaucracies, but their 'autonomy' was (and is) conditional and dependent upon the objectives as well as the process of incorporation. Professional groups may benefit from a protected market, and this allows them to operate with increasing independence, but they are not immune from external control, and may find their privileges restricted or undermined.

Theoretically, these and other scholars distinguish between what can be termed institutional and work autonomy. The former basically refers to the state's recognition of an occupation's professional competence and jurisdiction (the terms of its work), whereas the latter refers to specification

of tasks, and evaluation and regulation of quality (work content). What remains in dispute is whether current developments in industrial capitalism and the welfare state represent a fundamental expansion in *heteronomy*, so that both the terms and the content of professional work are more strictly circumscribed by external bodies.

From different theoretical positions, Freidson (1970) and Johnson (1982) have both stressed the variation, cross-nationally and historically, in state-professional relations, and the limited and contested nature of autonomy. At different times, professions enjoy varying kinds of 'structurally determined' economic and political power.

Johnson makes the valuable point that, although autonomy 'consists of a specific structural context where access to organisational, economic, political and technical resources provides the conditions for independent action', nevertheless 'Autonomy has meaning…only when posed at the level of action' (Johnson 1982:189). Similarly, as Freidson observed:

> For professional workers the issue is whether they are able to exercise control over their work and its outcome, and what methods of control they use. Control over work performance is of course the basic prize over which occupation and administration contend in particular work settings.
>
> (Freidson 1971:33)

What, then, are the implications for the organisation and provision of medical services? In the United States, Starr (1982) described the rise and gradual decline of 'professional sovereignty', and charted the ways in which commercial market pressures in corporate medicine had diminished American doctors' autonomy. In Starr's view, physicians were not likely to become completely proletarianised by corporate medicine (defined as total loss of control over conditions of work and levels of remuneration) because medical enterprises were ultimately dependent on medical professionals' expertise. Nevertheless, Starr predicted more regulation of the pace and routines of work, more performance evaluation, more 'corporate' quality control. Hospitals and doctors would be faced with increased heteronomous influence over the rules and standards of medical work (Starr 1982:446).

McKinlay and Arches (1985) have argued that these trends were more developed and more significant than Starr suggests. They stress that with increased bureaucratisation and commercialisation of medicine, doctors *were* in the process of becoming proletarianised. This entails the loss of control over prerogatives in the determination of entrance criteria and training, and loss of autonomy in the terms and content of work. It also means that the profession loses control over the commodities/services produced and clients

served, the machinery and equipment used, other means of labour (land, buildings), as well as remuneration. As hospital and primary care become more subject to business disciplines of work standardisation, routinisation, hierarchical control and evaluation, a process of deskilling occurs among salaried doctors. Bureaucratic encroachment, and scientific management of workloads, output and costs, weaken the exclusivity and monopoly traditionally claimed by doctors.

Paradoxically, this process of proletarianisation linked to the corporatisation of American medicine appears to be mirrored in the state-bureaucratised system of the NHS in Britain. However, as Elston (1977, 1991) has shown, the concepts of medical autonomy, proletarianisation and deprofessionalisation are problematic theoretically and empirically.

Elston (1991) correctly points out that autonomy is never absolute, and that it can be disaggregated into a number of components. Autonomy may be thus a property of individuals, and of the professional body; it may comprise economic (remuneration), political (authoritative expertise) and clinical or technical elements (the right to set standards and controls over performance). She argues that changes in one type or level need not necessarily produce changes in others. Until recently, British doctors (reluctantly) accepted state-imposed constraints on incomes and general conditions of employment, while retaining significant degrees of control over clinical activity. There have been more examples of managerial intervention into certain aspects of medical practice, Elston acknowledges, but she argues that current proposals for reforms of the NHS will allow for the continuation of doctors' technical autonomy.

Elston's claim that doctors will endeavour to capture or co-opt the procedure for medical audit, for example, rather than accede to state and managerially defined mechanisms, is partly supported by Dent (1990a, 1990b). He also makes a distinction between what he terms 'organisational control' and 'institutional control'. The former refers to rules imposed by the state bureaucracy which impinge on doctors' work autonomy; the latter refers to the professional bodies' ability to control the content of the work process.

As he notes, this distinction is not clear-cut—indeed, it can be argued to be confused—but the main point Dent makes is that so far, most of the policies adopted in the NHS have been concerned with 'organisational' control. Since the 1960s the medical professional groups have pursued strategies which have sought to pre-empt external efforts to devise schemes for medical audit and quality assurance. With retrenchment and the prospect of an internal market in the NHS, however, the state has tried to involve itself much more in the content of medical practice, and Dent anticipates far more managerial evaluation and inspection, despite (or rather because of) professional obstruction.

Both Elston and Dent suggest that in the British situation, medical professionals (so far) have not undergone a process of proletarianisation as such. They both indicate that doctors have benefited from a kind of state 'sponsorship', and that the conditions of that sponsorship are being disputed and renegotiated. Using Derber's (1984) model it can be argued that NHS doctors as state employees have experienced only a limited form of proletarianisation. Unlike deskilled industrial workers, doctors have maintained control over the technical content of their work. Such control may consist of influence over ideological (concerning policy and objectives), bureaucratic (authority over the division of labour), productivity (scheduling and workload), and technical (skills and knowledge) aspects of work.

Following Derber, Dent and Elston each argue that NHS doctors have been more vulnerable to state control of the first two rather than the others. Nevertheless, both also acknowledge that this may change with the implementation of proposed market reforms. Interestingly, Derber predicted an intensification of managerial controls on costs and medical practices as the power of 'third parties' increases (health maintenance organisations in the USA, compare NHS self-governing hospitals, Health Authorities and GP firms as purchasers of services).

BUREAUCRATIC-PROFESSIONAL CONFLICT

Recognising that there are different levels or components of autonomy, and that conflicts may be played out in different spheres of control, we still have to consider whether doctors do indeed have different interests and objectives from bureaucrats and managers. The bureaucratic-professional conflict thesis is a well-worn argument in the literature. It stems from the Weberian concept of legal-rational authority and obedience to superior officials, and its apparent incompatibility with esoteric expertise and allegiance to a collegial peer-group. Without giving a complete inventory of the arguments (for a succinct discussion, see Larson 1977: ch. 11), we must simply note that most attention has been focused on the probability that professionals, trained and socialised to practise with full responsibility for treatment of a client, subject only to peer regulation, will be frustrated by and resistant to, employers who attempt to subject them to organisational control and corporate objectives based on different values. Professional autonomy is presumed to be antithetical to bureaucratic authority.

There are, however, disagreements about the existence and importance of such a structural and normative divergence between bureaucracy and professions. There are many values and principles which are common or complementary, and professionalisation and large-scale burcaucratisation were historically interdependent and to some extent mutually reinforcing.

Many (indeed most) professionals are salaried employees, often working in large multi-purpose organisations.

In welfare state organisations particularly, professional work is shaped by what Johnson (1972) termed 'state mediation', where the clientele and needs are effectively prescribed by the state. Bureaucratic professions, as Fielding and Portwood have shown, vary in terms of their dependency on the state for the provision of clients, facilities and remuneration. Consequently:

> In relation to deprofessionalisation our argument is few professions have lost status, social position and autonomy by virtue of state heteronomy, and that for most professions the interdependent processes of bureaucratisation and professionalisation have been to the benefit of both themselves and the state.
>
> (Fielding and Portwood 1980:48)

We must be cautious then, about the assumption of an inherent and inevitable contradiction between bureaucratic authority and professional autonomy. In one case-study of NHS hospital consultants and administrators in Scotland, Green found little direct evidence of a conflict about goals or about control. The main source of conflict was disputes over resources and procedures, but differences among medical professionals (internal divisions between specialties) were more important than disagreements between consultants and administrators (Green 1975). Similarly, Davies (1972, 1983), in her accounts of NHS hospital organisation, has dismissed the bureaucratic-professional conflict thesis as empirically inadequate.

Of course it is quite possible to qualify these rejections of the thesis by noting that they are based on experience in organisational settings and financial circumstances which are very different from those prevailing today. The most pragmatic course is not to exclude the notion of bureaucratic-professional conflict in its entirety, but to recognise that professional autonomy coexists with, and may be contingently limited by, administrative and organisational constraints. At different times there will be variations in the degree of employee discretion and managerial control.

Here we can usefully return to labour process theory, and parallel ideas of 'responsible autonomy' and 'direct control' (Armstrong 1984; Littler and Salaman 1982; Thompson, P. 1983; Wood and Kelly 1982). The former is said to exist in certain industries requiring high levels of skill and employee discretion: managers maintain their authority by persuading key workers to identify with corporate goals, and by allowing them to work with a minimum of supervision. By contrast, with processes involving routinised production

by an unskilled workforce, managers can impose their authority directly and/or by Taylorist principles.

However, these are not totally opposed methods of managerial control, and in changed conditions there may be shifts between them. Control is thus rarely absolute or comprehensive; it is precarious, and involves a variety of different strategies and techniques, reflecting external conditions (market pressures) and internal struggles (worker opposition). As Storey (1985) has argued, there may be interpenetrating layers of managerial control, with a cluster of devices and practices. During one period, one form (for example, responsible autonomy) will be attempted, but then, without it being totally replaced, other forms (for example, bureaucratic discipline) may be introduced—the dynamics and outcomes, at all stages, are shaped by group struggles.

Assuming this to be a reasonably plausible view, what will those struggles be about? In the case of medical services, the sources of dispute between doctors and administrators/managers are quite varied, but usually revolve around the use of resources. As Klein (1977) pointed out:

> The administrator of health services must clearly be concerned to maximise the availability of care to the greatest number; the doctor, equally clearly, is concerned to maximise the availability of care to the individual patient in front of him or her. There is a fundamental contradiction between these two approaches, and it is this which makes it unlikely that the debate about cost control and professional autonomy can be easily resolved. Indeed if the rhetoric of cost effectiveness is to be translated into practical managerial action, then a head-on collision with the medical profession is unavoidable.
>
> (Klein 1977:174)

It is clear from the context of his remarks that Klein, in referring to administrators' goals of maximising the availability of care, in fact relates this to the growing problem of scarce resources, and disputes about whose decisions should influence expenditure restraint and rationing. It is also obvious that since the date of those comments, pressures to economise have increased significantly. In conditions of economic retrenchment, the delegated discretion represented by clinical freedom is regarded as both the source of ever-increasing claims on resources, and as an obstacle to 'rationalisation' in the pattern of service delivery and resource use.

As Larson (1980) observed, in public sector or human service organisations, underfinancing and overload are exacerbated by the fiscal crisis of the state, and efforts to rationalise and reorganise the professional labour force are common. Thus, 'Under financial pressure, the focus of managerial

policy is clear, however undecided or unpredictable its strategies: costs must be reduced and/or productivity must be increased. This imperative inevitably threatens the prerogatives of privileged workers' (Larson 1980:163).

Three major strategies are frequently used, she claims: first, a more fragmented and rigid division of labour, with greater specialisation and delegation of tasks to lower level workers; second, the intensification of labour, speeding-up production, involving heavier workloads; third, routinisation and codification of high-level tasks to facilitate intervention by non-expert managers. Within the NHS it is difficult to identify all of these strategies precisely, or all aspects of them, but there is sufficient evidence to regard them as real tendencies. For several decades there has been an expansion and diversification in the work undertaken by nursing and paramedical staff, and stratification between senior hospital consultants and junior doctors. More recently there has been a significant increase in hospital patient throughput during a period of rising caseloads and a fall in total beds, and several government campaigns to clear up excessive waiting-lists for hospital treatment (see NAHA 1989). Finally, there have been a series of different measures (performance indicators, clinical budgets and resource management, Diagnostic Related Groups) which have paved the way for managerial evaluation, surveillance and standardisation of clinical activity.

We can assume then that there *are* real differences between doctors' and managers' objectives and interests, and that especially in a period of retrenchment, managers will attempt to exert stronger influence over the scope and content of medical practice. Again Klein has given a cogent account of the problem of accountability and control in the NHS: 'While the bureaucratic experts may be charged with increasing efficiency, the professional experts are intent to safeguard their autonomy: the values of bureaucratic rationalism and professional mystique are in conflict' (Klein 1983:160).

In the United States, administrators have used scientific management techniques to fix medical workloads and output in accordance with both commercial insurers' and federal welfare agencies' demands for cost-containment. This, and other evidence about the position of professionals in employing organisations, led McKinlay and Arches (1985:182) to conclude that there are 'fundamental and possibly irreconcilable differences between professional and bureaucratic types of authority'.

We do not have to share the deterministic view that conflicts between bureaucrats and professionals are inevitable; as already noted, there are complex patterns of interaction between them, and fluctuations in their influence. However, it can be argued that in the case of health service managers and doctors, beneath some agreed general commitment to provide

'adequate' health-care, there are important structural (and perhaps normative) factors which will predispose them to pursue different objectives.

There is some empirical evidence of distinctive coalitions routinely engaged in organisational conflict. For example, Thompson (1987) has described separate, competing coalitions based on 'practitioner interests', and an 'administrative ethic', as well as a (then-nascent) 'general management coalition'. Such groupings may form and dissolve over particular issues, but they represent different and stable sets of values. The professional providers' (practitioners') basic concern was with clinical freedom and individual patient needs, whereas the administrators/managers were concerned with the overall distribution of resources between different categories of need, and with cost-effectiveness or efficiency. These differences are also evident in qualitative data from a recent study by the author (Flynn 1988b) discussed in Chapter 6.

Organisationally, of course, managers are subject to direct instruction within the NHS hierarchy, and are required to comply with government policy directives and budget restrictions. Hospital consultants currently have contracts with (Regional) Health Authorities, and GPs are independent contractors; neither are (currently) directly accountable to managers, and are only subject to discipline by their professional body and by legal actions for malpractice. As a result, it can be inferred that doctors' and managers' interests and objectives may not always be congruent. Moreover, as already noted, they can be expected to diverge even more in conditions of financial austerity. Bureaucratic-professional conflict may not be inevitable, but is is highly likely as cost-controls limit the volume and method of service delivery, and as managers try to limit medical autonomy.

LIMITED AUTONOMY

The idea that managers have been able to mount effective challenges to medical domination has, however, been questioned. Indeed, Harrison (1988a) contradicts the view expressed here, and specifically rejects Klein's argument, that doctors and managers have conflicting values. According to Harrison's review of the literature, and his own studies, there has been a 'remarkable homogeneity' of culture in the NHS. Doctors and managers were said to inhabit a world of common, shared values, and managers have been passive agents in alliance with doctors (Harrison 1988a:54). This consensus, in fact, refers to perceptions of status attached to medical specialisms and acute medicine generally, and, as Harrison makes clear, was observed during a period of relative growth in NHS expenditure. It should not therefore be thought of as a permanent feature of medical-

managerial relations, and has probably been displaced because of retrenchment and reform.

To repeat, the scope of medical autonomy is variable historically, and nationally. Harrison and Schulz (1989) compared clinical autonomy in the United States and Britain, and on the basis of interviews and secondary sources, concluded that NHS doctors possessed more autonomy although their budgets were fixed. They noted, however, that in both countries, reductions in finance and increased managerial intervention had begun to affect the detailed process of clinical decision-making, and they anticipated further incursions by, and the possible ascendancy of, 'corporate rationalisers'.

In other work, Harrison has been more cautious about the impact of managerialism. Documenting the recent rise of a more centralised bureaucracy and a more assertive management style in the NHS, Harrison (1988a) argued that the 'frontier of control' had shifted away from doctors towards managers, but that this had affected the form rather than the substance of relationships. He stressed that doctors' structural monopoly as gatekeepers and resource allocators remained secure; that the complexity and unpredictability of clinical work prevented close managerial planning and control; and that the doctrine of clinical freedom is a way of rationing which insulates managers and government from criticism. Consequently, Harrison claimed, professional medical dominance remained intact.

In a larger study of the implementation of general management in Health Authorities, Harrison *et al.* (1989) acknowledged that recent initiatives (limits on drug-prescribing, performance indicators, general management itself, and so on) do constitute actual or potential challenges to medical autonomy. However, in their interview survey, they found that the majority of respondents believed that general management had *not* increased management influence over doctors. Changes in relationships were observed, but these were explained by respondents as caused by financial restrictions rather than managerial reforms. Managers were largely perceived as 'diplomats' or facilitators, rather than as executive directors.

What must be emphasised in both cases is that these conclusions were reached prior to the severe expenditure crisis of 1988/89, and prior to the government's 1989 proposals to restructure the NHS and extend managerial responsibilities. As Harrison (1988a:129) noted, 'the frontier of control is currently more unstable than ever before in the history of the NHS', and therefore his observations must be regarded as provisional. Further, Harrison *et al.* (1989:44) reported that 'our research provides little evidence of behavioural change…*except in so far as it has been enforced by a tight financial situation.*… Managers rarely challenge the doctors *except when obliged to do so by financial exigencies'* (sic; emphasis added).

It is argued here, and shown in more detail in later chapters, that such financial exigencies have become normal rather than exceptional, and that future changes in the NHS will accentuate managerial preoccupations with, and influence over, cost-effectiveness. In situations of both retrenchment and a purchaser-provider market, medical autonomy will be regarded by managers as a constraint on efficiency. In addition, it can be argued that, contrary to Harrison's (1988a) claims about the maintenance of medical autonomy, existing instruments and planned mechanisms will reduce clinical autonomy.

Thus, for example, general practitioners may remain as gatekeepers, and consultants continue to make independent decisions on resources, but this is true in only a limited sense. GPs have until recently been unaffected by cash-limited budgets, but that is likely to change under current government plans. Hospital consultants have been expected to try to remain within their unit budgets, but through existing resource management or planned clinical budgets they face the prospect of real finite limits on finance. Clinical work may be complex and difficult to plan, but performance indicators, medical audit, quality assurance and resource management are already beginning to provide the means for detailed managerial control. So attempts are being made to constrain and redefine the limits of medical autonomy, and we should continue to expect conflict and tension between doctors and managers, whether in a bureaucratised or a marketised NHS.

The trend towards an ever-increasing bureaucratisation of medicine in quite different health systems is largely explained by 'third-party' (either government or insurers') attempts to control cost increases caused by expansion in demand and supply aided by demographic change and technological advance. Mechanic (1976, 1978, 1981) regarded the bureaucratisation of medicine in the United States as inevitable, and as a threat to the concept of physician responsibility for the best interests of individual patients. Rationing of scarce resources in medical services was also inevitable, Mechanic argued, and there were historical shifts in modes of rationing, in the organisation of health-care delivery systems, and in the role of medical professionals. There was an observable movement from systems of rationing by fee through a stage of 'implicit' rationing, to a final stage of 'explicit' rationing (Mechanic 1978).

In the first stage, there is a private market (between fee-earning professionals and fee-paying clients) for medical care, which becomes unacceptable because of high costs and unmet needs. The second stage evolves with an insurance system run by third parties, but health professionals decide which types of patient to accept and treat, and access to services is limited by waiting-lists and other restrictions. In the final

stage, fixed limits are placed on total health expenditure, and it becomes necessary to devise 'rational' criteria and procedures for the allocation and distribution of resources between different types of care, facilities and areas, and for the establishment of minimum standards. Accordingly, in this process, 'the role of the physician shifts from entrepreneur to bureaucratic official, and medical practice from a market-oriented system to a rationalised bureaucracy' (Mechanic 1978:328).

This model, despite its context and date, does seem to have a close resemblance to the evolution of the NHS. Moreover, it also seems to give an appropriate description of the changes in role relations and types of influence on medical professionals. Thus in the stage of market-rationing, doctors are effectively entrepreneurs controlled by client demand. Under third-party finance, implicit rationing occurs, and doctors are basically experts controlled and regulated by professional colleagues. When a system of explicit rationing develops, doctors are subject to bureaucratic control, and their role becomes that of an official.

Mechanic stresses that these changes are complex and subtle. In the United States, he suggests, explicit rationing is most likely to be imposed on the total framework of services and rather less on individual doctors' decisions, but others have subsequently disputed this, claiming that detailed intervention has occurred and is likely to grow (see Starr 1982). In the British NHS, it can be argued that the move to an explicit rationing system was a rapid one, but vestiges of the implicit mode and collegial control have persisted until the 1980s. Now, a variety of techniques and measures to regulate efficiency and effectiveness are emerging which are being imposed on doctors, and as Mechanic predicted, are causing conflicts between professional providers and administrative controllers.

Thus the scarcity of resources, and the prevailing system of rationing, will be important constraints which limit the scope of professional medical autonomy. It is the power to allocate resources which is crucial in determining the capacity for organisational influence, and it is precisely this power which is being displaced from professional providers and claimed (some doctors might say arrogated) by managers.

As Freidson (1986) argued, professional employees possess technical autonomy (the right to use discretion and judgement in their work), and to exercise it they must have policy-making and supervisory authority, and they must select the work they do and how they do it. However, they can only exercise these responsibilities *within limits* and those limits are fundamentally resource constraints set by management. In one sense professionals are autonomous, but only relatively so: 'they are helpless and dependent because they have no control over the "economy" of the organisation that employs them' (Freidson 1986:155).

Decisions on caseloads, client eligibility or need, task specification, working practices and performance evaluation are all dependent on professional judgement, but that judgement is conditioned by the availability of resources, and wider political demands and influences, both of which are directly expressed through government policy. Professionals with technical autonomy need not be organisationally impotent, though, and as Freidson (1986) argues, they not only attempt to resist managerial intrusion into matters like technical standard setting and supervisory scrutiny, but they also engage in coping strategies to deal with resource restrictions. The problematic and contentious issue remains: whose criteria are to be used in the selection of priorities and prescription of work volume and content— clinicians' and general practitioners', or managers'?

Conventionally, within the NHS, clinical freedom has been regarded as the ultimate principle for deciding these questions. In the official manual used after the 1974 NHS reorganisation (the so-called 'Grey Book') this was explained as follows:

> The management arrangements required for the NHS are different from those commonly used in other large organisations because the work is different. The distinguishing characteristic of the NHS is that to do their work properly, consultants and general practitioners must have clinical autonomy, so that they can be fully responsible for the treatment they prescribe for their patients. It follows that these doctors…work as each other's equals and that they are their own managers. In ethics and law they are accountable to their patients for the care they prescribe, and they cannot be held accountable to the NHS authorities for the quality of their clinical judgements so long as they act within the broad limits of acceptable medical practice and within policy for the use of resources.
>
> (Cited by Stacey 1989:13)

Since at least the beginning of the 1980s, this pattern of accountability has been regarded as outmoded and unacceptable by successive governments and all-party House of Commons Social Services Committees, because it is thought to have encouraged inefficiency in resource use and a lack of attention to quality and 'customer relations' (see Social Services Committee 1988b; Social Services Committee 1989). As a result, political pressure in support of enhanced managerial control over professional autonomy has grown. The exercise of clinical freedom is now to be explicitly subordinated to resource constraints, and doctors are expected to become accountable to managers.

Thus, in the proposals to create an internal market of purchasers and providers within the NHS, the government White Paper observed that: 'The decisions taken by consultants are critical to the way in which the money

available for the NHS is used. It is therefore important to ensure that consultants are properly accountable for the consequences of those decisions' (Department of Health 1989:39). A 'proper balance' had to be struck between two legitimate pressures—individual consultants' professional responsibilities, and managers' responsibility 'to ensure that the money available…buys the best possible service for patients' *(ibid).*

In the accompanying working paper about the role of hospital consultants in a reformed NHS, this view was strengthened:

> Consultants are increasingly responsible for the direct or indirect commitment of substantial levels of resources. Their working patterns also have a major impact on the work of other staff and the overall effectiveness of the NHS. Ministers therefore consider it essential that District managers should have a clear understanding of the work… undertaken by consultants and be in a position to make changes following discussions with them. In other words, there is a need for an improved process of accountability.
>
> (Department of Health 1989: Working Paper 7, para 2.1)

Clearly, then, professional power is always contingent and variable, and a source of continuing dispute. It is also evident that in the last decade in the NHS, there has been an intensification of the bureaucratisation of control, and a process of managerial encroachment on medical autonomy. It seems reasonable to expect that these trends will continue in the 1990s, and that market reforms will serve to strengthen managerial power. Consumerism, clinical audit, quality assurance and value for money will become ever more important concerns for managers, and thus will necessarily have practical consequences for professional activities, whatever the financial and organisational regime. Medical autonomy is always relative, and limited, but its constraints and limits will increasingly be defined and enforced by managers and a bureaucratised structure of control.

CONCLUSIONS

This chapter has tackled a number of large and complex issues posed by professional medical power, and dealt in a limited way with only some of them. The main argument is that during the 1980s in the NHS, medical autonomy has been subject to managerial encroachment. Medical autonomy can be conceptualised at different levels and in different forms—the degree of social closure and state regulation, representation and influence within state policy-making, and the terms and content of work practice are the most significant elements. The discussion in this chapter has focused on the latter

dimension because, as Rueschemeyer (1983:48) pointed out: '[The] irreducible core of autonomy in the actual delivery of expert services remains a resource of power and influence that can become the springboard for more extended institutionalised independence and other privileges.'

It is argued that a number of changes associated with 'scientific management' can be observed in the NHS, and that these have weakened medical dominance, through managerial challenges to clinicians' control of resources and patterns of service delivery. As in most large-scale organisations, managers are concerned with maintaining control over the production process and labour productivity, but in medical services there are great difficulties in dealing with professionals' technical indeterminacy— the discretion which constitutes clinical freedom. Throughout the 1980s, however, a series of linked measures and policies—general management, performance indicators, clinical budgeting, resource management, medical audit, quality assurance—associated with drives for greater cost-effectivenesss and efficiency, have provided the means for extending managerial influence.

Models of either complete proletarianisation or complete medical dominance are both inaccurate and inappropriate, since there are constant struggles and conflicts over the nature and extent of professional autonomy. Indeed, as labour process theory recognised, managerial control strategies are varied and multiple, and meet with worker opposition and resistance. Further, as the debate about bureaucratic-professional conflict indicated, although it is mistaken to assume an inevitable incompatibility between these forms of occupational structure, there is evidence of contradictory interests and objectives among doctors and managers, and medical autonomy has become even more contested during a period of economic retrenchment.

Attempts have been made, and are continuing to be made, to place limits on medical autonomy, as managers seek to constrain the use of resources, whether in a cash-limited bureaucratised NHS or in a future marketised NHS. The process, and the outcomes, are still in dispute, so we must wait for detailed evidence. Nevertheless, this chapter, and subsequent ones, argue that the tendency during the last decade has been towards an erosion of professional dominance in the face of increased central government intervention and managerial power.

Of course these changes have not occurred in an economic and political vacuum, and they are not unique to Britain and its nationalised health service. The fiscal crisis of the welfare state, and New Right governments have led to reductions in the rate of growth of public expenditure, and in the UK have prompted reforms and rationalisation in the funding, organisation and scope of education, health, housing, social services and social security, as well as

other public sector programmes (see Cousins 1987; Flynn, N. 1989). Cost-containment, and efforts to restrict medical autonomy, have become common in many different types of health-care system (see Freddi 1989).

What is interesting is that recent government policy for the NHS does represent a fundamental shift in the structure of control, and that this is connected with a number of interrelated economic, ideological and political goals. Conservative policies have been simultaneously concerned with controlling public spending and obtaining better efficiency, applying business methods to the public sector and challenging so-called producer monopolies to become more accountable to consumers and taxpayers. The trends outlined in this chapter, and described in more detail in later chapters, have to be seen in this wider context.

Analysing managerial encroachment on medical autonomy in terms of the application of a form of scientific management poses two general questions which can only be dealt with briefly. First, as we have seen, it contradicts the long-held orthodox view of medical dominance in the NHS. The solution is simply to recognise that there are, historically, fluctuations in the balance of power between competing interest groups, and that further empirical case studies will provide evidence to assess the claims made here.

Second, it might appear that 'Taylorism' in the NHS lends some support to Navarro's claims about bourgeois domination of health systems and the illusion of professional claims to autonomy. Navarro (1978, 1986) disputed the suggestion that the growth of health spending and decline of medical effectiveness were simply explained by professional monopoly. He argued that the nature and functions of health services reflected structural forces within capitalist society, and that the professional's power is always a 'delegated' power—doctors merely 'administer' medicine in ways compatible with the needs of capital accumulation and legitimation. For Navarro, then, the bureaucratisation of medicine is an inevitable aspect of commodification in the health sector, and attempts at organisational rationalisation and control must be related to the crises of capitalism.

This approach, however, appears to be both unacceptably deterministic and functionalist, and disregards the very real significance of previous medical domination and the peculiar and important nature of the political conflicts which shaped the creation of the NHS and which have arguably prevented its full-scale privatisation recently. It is more realistic to assume that there are a number of competing structural forces which influence the health-care system in general, and the production of medical services in particular. Scientific management may be more or less systematically applied, and with varying degrees of 'success', but once again this is likely to be a source of bureaucratic-professional (as well as inter- and intraprofessional) conflict, and entail worker resistance.

This point seems to be more easily accommodated within Offe's framework for the analysis of contradictions within the welfare state (Offe 1975, 1984, 1985). The welfare state in capitalism, he argued, must attempt to reconcile the competing demands of capital accumulation and political integration, and the divergent rationalities of efficiency and legitimacy. In both allocative and productive activities, the state adopts various modes of operation which create their own problems for both legitimacy and efficiency. Thus bureaucratic modes tend to be over-rigid; purposive-rational modes lack explicit and agreed criteria for effectiveness; and democratic participation leads to excess demand and fiscal crisis.

Consequently, various elements of the state move between different modes of internal organisation and policy-making. So, for example, welfare services are frequently defined and produced through professional organisations, but these in turn may pursue interests and strategies which conflict with wider state goals, and may precipitate other techniques of state intervention.

We do not have to identify an exact correspondence between Offe's categories and specific practices in the NHS in order to accept the more general point that, in the welfare state, we can expect a continuous movement between alternative principles and systems of policy-making. The corporatist form of professional production which emerged in the NHS until the 1970s was subjected to increasingly bureaucratic forms of control, and during the 1980s this was accompanied by efforts to introduce market rationality. However, the introduction or extension of scientific management, and attempts to restrict professional medical autonomy, have not gone unchallenged organisationally and politically. Moreover, they are likely to encounter fundamental difficulties in the regulation of technical indeterminacy and standard-setting, as later chapters show.

The appropriateness and relevance of a strong managerialist culture within the NHS is also thrown into question by recent developments in commercial management theory and practice. One of the central arguments about disorganised capitalism is that Taylorism and Fordism have become outmoded, and industries have adapted to new world markets and new technologies by adopting flexible organisations and processes. Management itself may be transformed as moves towards worker participation, quality circles, and decentralisation of decision-making take place within large 'post-modern' enterprises (see Heydebrand 1989; Lash and Urry 1987).

Some emulation of these trends is apparent in the public sector, particularly in local government (Stoker 1989), and in certain respects they are mirrored in proposals for an internal market in the NHS. The paradox is that centralised control becomes even more problematic as devolved management and

entrepreneurialism are encouraged, and as more emphasis is placed on the quality of service delivery, which is determined by professional providers using clinical discretion.

The wider implications of these trends will be discussed later in Chapter 8, but for the moment it is worth noting that bureaucratic rationalisation of medical work processes and managerial intervention in the content of health service delivery, *and alternatives to them*, will continue to be arenas of conflict, because they involve either accommodation to, or subordination of, professional autonomy. Important aspects of such conflicts are already evident from the experience of introducing general management in the 1980s, as we shall see in the next chapter.

3 Administration or management?

The NHS is generally regarded as one of the core components of the British welfare state. It provides comprehensive health care universally on the basis of need, and is financed out of general taxation and national insurance. It is one of the largest employers in the country, and is a major consumer of public expenditure. If we ask who 'owns' it, the answer seems simple enough: the NHS is 'owned' by all British citizens and taxpayers collectively. If we ask who controls it, the answer seems straightforward initially, but becomes more complicated if we examine the details, because the nature and structure of control is disputed, and changing.

In this chapter we shall examine this complexity, in order to show that recently there has been a fundamental transformation in the nature of management within the NHS, and that this has significant implications for the pattern of health service provision in general, and for the scope of professional medical autonomy in particular. There has been a shift in the relationship between national government and local Health Authorities, and between administrators and doctors, in which central state power has increased, and professional discretion has been subjected to bureaucratic control. There has been a move from public administration to general management, and this entails a change in values and organisational culture which may alter not merely staff working practices and relationships, but also the basis upon which services are planned, budgeted and delivered. In order to discuss these themes, we must first look at the present structure of the NHS, and review some of the important historical factors in its development. Then we can analyse the significance of the introduction of 'general management' and its practical consequences, and finally consider likely some of the outcomes of 'marketisation' and their impact on managerial control. Some caveats are necessary, however: a full account of the changes in the structure and internal arrangements of the NHS cannot be given here, and this discussion concentrates almost entirely on the acute hospital sector (for further details

on the history of the NHS, and about other sectors, see *inter alia*, Allsop 1984; Ham 1985; Klein 1983; Levitt and Wall 1984).

THE ORGANISATION AND STRUCTURE OF THE NHS

The NHS owes its existence to legislation, and ultimately is subject to parliamentary regulation, exercised through the Secretary of State and Ministers of Health. Although it is a national service, its delivery is decentralised through special local agencies: the Health Authorities and Family Practitioner Committees (now Family Health Services Authorities). Centrally, ministers are supported by a large civil service department, including scientific and medical staff, and by a group of officials and advisers at various times called a 'supervisory board', 'management board', or 'executive'. Locally, the budgeting, organisation and provision of health services differs by sector. Most primary care is provided by general practitioners working solo, in partnerships, or in group practices in communities and neighbourhoods. GPs are independent contractors with the NHS, and in England their work (like that of dentists, opticians and pharmacists) is financed and regulated through ninety local Family Health Services Authorities (FHSAs). These bodies are appointed, not elected; the Minister appoints a chairperson and members, who are deemed to be representatives of the local community.

Most acute, specialist and long-stay intramural care is provided through the hospital service, which is administered by local Health Authorities. Following two reorganisations in 1974 and 1982, the current structure in England consists of fourteen Regional Health Authorities (RHAs) and 190 District Health Authorities (DHAs; districts comprise populations from 90,000 to 860,000) (DHSS 1987). The RHAs are made up of members appointed by the Secretary of State with a chairperson directly appointed by the Secretary of State. Each RHA has its own full-time administrative and professional staff. The functions of RHAs are primarily the co-ordination and approval of DHAs' plans for local services and the preparation of regional strategic plans. They evaluate DHA bids for capital and revenue expenditure, monitor their performance against national and regional policy objectives, and allocate finance for their annual programmes.

DHAs are responsible for hospital and community health services. The members of DHAs are appointed by the RHA after consultation with local statutory bodies and interest groups, but the chairperson is appointed directly by the Secretary of State. Each DHA has its own full-time administrative and professional staff and since 1983 executive responsibility has been vested in a District General Manager. Annual short-term plans and budgets, and

medium term strategies, are prepared by staff and approved by Health Authority members. Day-to-day responsibility for running hospitals and related services is delegated to Unit General Managers (units are large hospitals, or groups of hospitals, or specific client-group services).

There is liaison between DHAs and FHS As over some aspects of primary care, and with local government authorities over personal social services and community care (for the mentally ill and mentally handicapped, and for the elderly). However, Health Authorities are not electorally accountable to their local populations. There are bodies which represent 'consumer' interests—Community Health Councils—but half of the (approximately twenty) members are nominated by local authorities, about one third are recommended by voluntary bodies, and the others are nominated by the RHA. Community Health Councils monitor standards of care provided by hospitals and by GPs, can attend DH A meetings and make representations on service plans, and act as advocates to pursue complaints from patients.

This structure is the result of various reforms and changes, and the outcome of one Royal Commission, numerous government inquiries and reports, and much legislation on funding, organisation, staffing and management arrangements. From its inception in 1948, the NHS has been the subject of continuous political debate, and government policies have reflected wider controversies about its costs, functions and form. There was a tripartite structure after 1948, reflecting the political compromises necessary to secure agreement for a nationalised health system. Three components were amalgamated in a loose federation. The GPs in the Family Practitioner Service maintained their independent status as contractors with the NHS. Local government lost control of its hospitals but retained control over many preventive, domiciliary and public health services. Various different types of hospitals were taken over by Regional Hospital Boards (appointed by the Minister of Health), and were administered locally by Hospital Management Committees.

Throughout the 1950s and 1960s there was increasing awareness that expenditure on health was rising much faster than anticipated or planned; that there was a lack of co-ordination and integration between the different sectors; that the provision of facilities and resources across the country was uneven; and that there was inadequate planning for different categories of illness and care groups. This first phase of the NHS was characterised by considerable local variation and autonomy, significant growth in the importance of the acute hospital sector, and the entrenchment of professional medical influence on local and national policy-making (see Klein 1983). Proposals to reform the basis of local government widened the debate about the need for a reorganisation of the NHS in the early 1970s; these were

connected with a broader movement to import concepts and techniques from private sector management into the public sector generally (see Dearlove 1979). Two sets of proposals to reorganise the NHS were made by a Labour government, another set were put forward by a Conservative government and enacted, but the 1973 Health Service Act was implemented by the Labour government in 1974.

According to Ham (1985), the main objectives of the 1974 reorganisation were to unify the fragmented sectors, to improve co-ordination between Health Authorities, and between them and local government, and to introduce better management at all levels. The new structure included recommendations by management consultants as well as academic organisation theorists; for some commentators, this was the zenith of managerial ism, because the reforms were based on 'scientific management' and a concern with achieving efficiency (Haywood and Alaszewski 1980). Under the new arrangements, there were three 'tiers' below central government. Regional Health Authorities were created, appointed by the Secretary of State: they superseded the Regional Hospital Boards, and took over responsibility for strategic planning and financial allocation for all services except primary care. Below the RHAs were ninety Area Health Authorities, coterminous with local government authorities, and responsible for detailed planning and liaison between them and the third, operational tier (Districts), as well as being responsible for appointing the members of Family Practitioner Committees.

Teams of permanent paid officials, and professional medical and nursing staff, carried out the day-to-day running of services locally, and advised lay members of the RHAs and Area Health Authorities on policy. At the regional level, the senior officials formed a 'Regional Team of Officers' (RTO) consisting of an administrator *(sic)*, a medical officer, a nursing officer, a treasurer and a works officer. Area Health Authorities were served by an 'Area Team of Officers' (ATO) comprising an administrator, a medical officer, nursing officer and treasurer. The number of Districts within an Area depended on local population size; each one corresponded to the catchment area of a district general hospital and was served by a District Management Team (DMT) in which there was a district administrator, finance officer, community physician, hospital consultant, general practitioner and nursing officer (Stewart *et al.* 1980).

For each level it was assumed that doctors would be directly involved in the management structure, and that, given the size and organisational complexity of the NHS and its numerous types of staff, it was necessary for there to be an emphasis on multi-disciplinary teams. The distinctive and fundamental principle underlying this arrangement was that policies were to be formulated and implemented through 'consensus management'. Consensus

management meant that all corporate decisions had to be mutually agreed between all of the professionals and officers in a management team: no single team member had any statutory authority over the others, but in the event of irreconcilable disagreements, issues were to be referred to Authority members for resolution (NAHA 1987a).

Overall, the changes in structure and administration reflected a continued series of attempts to combine contradictory goals and interests. As Klein (1983:99) has perceptively commented:

> Essentially…the 1974 reorganisation can be seen as a political exercise in trying to satisfy everyone and to reconcile conflicting policy aims: to promote managerial efficiency but also to satisfy the professions, to create an effective hierarchy for transmitting national policy but also to give scope to the managers at the periphery.

Government policy documents referred to a health system in which there was maximum delegation downwards, and maximum accountability upwards. In practice, however, the system experienced many difficulties born of these contradictions, and pressure for further reform increased, coinciding with a period of economic crisis and industrial relations disputes within the NHS.

Before describing the next phase of reorganisation, we must briefly consider the debate about the relative balance of power between Health Authorities and central government, and between health authority members, administrators and medical staff. There have been numerous studies documenting the changing relationship between central government and local Health Authorities. One continuing theme in these studies is that despite complete control over the allocation of finance, a direct chain of command from centre to units, and firm policy directives, there has nevertheless been considerable diversity in policy implementation, and a consistent failure to shift resources away from the acute hospital sector towards the care of the mentally ill and mentally handicapped, and the elderly.

Local Health Authorities have enjoyed some limited discretion in interpreting national policy objectives, although the trend has been towards increased restriction and centralisation. Hay wood and Alaszewski (1980) stressed that Health Authorities in England possessed room to manoeuvre, but that their capacity to exercise devolved autonomy varied according to economic and political circumstances. Klein (1983) documented the fluctuations and tensions in central-local relationships, and showed that for both financial and policy objectives, the tendency was for government to insist on greater accountability and bureaucratic control. Lee and Mills (1982), Ham (1985) and Stoten (1982, 1985), among others, have also indicated that organisational complexity, medical

dominance, multiple interest groups and the dispersion of political authority in a decentralised system have created conditions in which, in the view of successive governments, central priorities were not achieved, expenditure increased in an apparently uncontrolled way, sectoral integration was poor, and service planning was inadequate. It is against this background that demands for structural reorganisation, and the need for better management, emerged.

A related theme in various studies is the relative weakness of health authority members in the policy-making process, the persistent dominance of professional medical groups and the gradual assertion of managerial power by administrators. In his case study of one Regional Hospital Board, Ham (1981) demonstrated that within an ostensibly pluralist decision-making framework, the influence of lay members was very limited, and that the distribution of power was weighted in favour of doctors. Medical professionals obstructed policy changes, and also ensured that incremental changes benefited the acute hospital sector. However, most policy making 'typically took place in the interstices of the Board's committee system and in negotiations with officers' (Ham 1981:199).

In a more recent case study of two District Health Authorities, and an extensive review of the literature which supports his own findings, Ham (1986) has shown that members exercise very little influence over Health Authority policy. In dealing with central government policy initiatives, and in making decisions about local capital investment and hospital service rationalisation, members played a marginal role. Their influence was generally limited to approving, endorsing or ratifying proposals made to them by officers and the authority chairperson. Moreover, members acknowledged their limited role, and the effective power enjoyed by the chairperson and district administrator. Thus, members' influence 'was exercised within a framework over which they had little control and in response to ideas developed principally by officers and professional advisors' (Ham 1986:51).

In their study of the members' perceptions of accountability in three districts, Day and Klein (1987) showed that members had difficulty in defining their district objectives, and difficulty in obtaining information and evaluating it. Members were effectively dependent on the officers, especially the District Management Team, who were seen to monopolise expertise, particularly in financial matters. Day and Klein report that members were confused over their accountability, were frustrated about their limited role in authority policy, and acknowledged their sense of powerlessness. The professional power of doctors was largely taken for granted, and the members surveyed were preoccupied with the DMT's command over information, rather than the effects of medical dominance.

The importance of medical professionals, and particularly hospital specialists, in NHS decision-making has been highlighted by various writers. National policies and strategies have always had to deal with the entrenched position of acute and curative medicine and the high status enjoyed by the major teaching hospitals and medical technology. Doctors, and especially consultants, have not only driven demand for services and determined the nature and scale of service provision, but more fundamentally, it has been their assumptions and values about appropriate forms of care and medical organisation which have shaped policy debates, and influenced resource allocation (see Haywood and Alaszewski, 1980; Ham 1985, 1986, Klein 1983). According to most commentators about the NHS in England, medical professional interests have dominated the agenda of national and local decision-making: doctors have enjoyed an almost hegemonic influence, and in many Health Authorities (until recently) they have been the most powerful and even dominant coalition (Cawson 1982; Harrison 1988a; Rogers Hollingsworth 1986; Stacey 1988; Thompson 1987).

However, recently this position of dominance by what Alford (1975) termed 'professional monopolisers' has been challenged more frequently, and more vigorously, by government demands for higher efficiency and conformity with central objectives, and by the accretion of bureaucratic power among the 'corporate rationalisers' —local administrators/managers. In order to assess the evidence for this, we must return to the post-1974 structure and management arrangements, and look at the factors which led to another reorganisation in 1982.

During the 1970s, corporate planning and other structural reforms were introduced throughout central and local government, and in the NHS. A new NHS planning system was introduced by the Labour government in 1976, and in the same year a new method for the allocation and redistribution of resources (Resource Allocation Working Party—RAWP) between different areas was established. A statement of government priorities and objectives for different health needs and care groups was also published in 1976, and Health Authorities were required to plan service provision in accordance with those objectives. However, a number of different problems emerged which led to widespread disillusionment with the structure. Perhaps more significantly, the oil crisis caused a slowdown in the rate of growth of NHS expenditure, and the imposition of stringent financial controls exacerbated local and national political disputes about priorities.

There was much confusion and conflict in operating the 1974 system, and widespread dissatisfaction with the new arrangements among most staff groups. In particular, the respective roles of, and relationships between, Regions, Area Health Authorities and Districts caused uncertainty and

frustration: medical professionals, officers and members at each level complained about unnecessary duplication, excessive delays, unwarranted interference and the blurring of responsibilities. At the same time, coinciding with other industrial relations disputes associated with high inflation and economic crisis, many groups of NHS workers pressed their claims for improved wages and conditions, and action was frequently taken by increasingly militant and unionised ancillary workers. Doctors too took unprecedented action over salary levels in 1975, and from 1974 to 1976 hospital consultants fought a bitter struggle with the Labour government over the terms of their contracts, specifically over private practice and pay-beds within NHS hospitals.

In addition, the complex structure and rational planning system were built on the assumption of continued resource growth, but from 1976/77, cash limits were introduced for the first time, and there was virtually no growth in NHS finance after allowing for inflation. Consequently, many of the plans and programmes devised at local level were deferred or disrupted, and this added to the feelings of disillusionment and resentment reported among most staff groups, and to public disquiet. Together, these factors combined to create a profound sense of discontent, and led to the establishment of a Royal Commission on the NHS (set up in 1976, reporting in 1979) and thus to pressure for further reform (see Allsop 1984: Ham 1985; Kinston 1984; Klein 1983; Levitt and Wall 1984).

The election of a Conservative government in 1979 accelerated the movement to reorganise the NHS. There was broad acceptance of the Royal Commission's view that there should be simplification in the structure, and a government White Paper in 1979 and subsequent legislation required the removal of the Area tier of administration, the strengthening of District functions, and independent status for the Family Practitioner Committees. From April 1982, AHAs were abolished, and DHAs took over many of their responsibilities, with operational administration delegated to 'units' at local level.

In reforming the NHS, the government had initially stressed the need to reduce bureaucracy, and to decentralise decision-making. However, this emphasis diminished after ministerial changes in 1981/82. The devolutionist trend was reversed because of the government's determination to control public spending and to increase efficiency. In addition, there was growing parliamentary concern about large variations in service provision, and discrepancies in performance between DHAs, and calls for stronger central management (see Parston 1988; Scrivens 1988a, 1988b). From 1982, there were annual review meeetings in which the Minister called RHA chairpersons to account for their progress (or lack of it) in meeting objectives and targets, and RHA chairpersons

repeated the procedure with the DHAs. There was also sustained government pressure to introduce competitive tendering for catering and domestic services, and for Districts to obtain better value for money in all services. The chain of command was thus tightened once again, despite the earlier devolutionist rhetoric.

THE EMERGENCE OF 'GENERAL MANAGEMENT'

In late 1982, the then Secretary of State, Norman Fowler, invited a group of businessmen to advise him on the use of manpower, management and resources in the NHS. Initially, this group and its advice were intended to remain confidential, but following leaks and press speculation, its terms of reference, and eventually its report, were made public. The team consisted of Sir Brian Bailey (Chairman of Television South West and of the Health Education Council), Mr Jim Blyth (group finance director, United Biscuits), Mr Michael Bett (board member for personnel, British Telecom), and was chaired by Mr (later Sir) Roy Griffiths (deputy chairman and managing director of Salisbury's, the retail supermarket company) (Carrier and Kendall 1986). Instead of carrying out a type of inquiry like a Royal Commission and producing a detailed report based on evidence, the team (after carrying out various site visits and unspecified investigations) submitted a twenty-five page letter to the Secretary of State in October 1983 recommending major changes in the management system of the NHS. The so-called Griffiths Report (NHS Management Inquiry) was in fact not a report, but advice, a statement intended for 'management action' not for debate (DHSS 1983). The Griffiths Report's observations led to significant and fundamentally important changes within the NHS, and it is important therefore to review some of the major points.

First, Griffiths stressed that the differences between the NHS and business enterprises could be exaggerated, and that management systems and skills from the private sector could be appropriately applied to the delivery of public health care. The NHS was criticised for lacking continuous evaluation of its performance against predetermined standards and objectives. Precise management objectives were rarely set; health outputs were not often measured; clinical evaluation of medical practices was uncommon, and economic evaluation 'extremely rare'. Second, one of the most serious deficiencies observed was that there was a lack of a clearly-defined general management function at all levels of the NHS. General management was defined as: 'the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance' (DHSS, NHS Management Inquiry 1983:11).

Griffiths pointed out that at DHA and RHA level, consensus management teams gave each officer a power of veto, and that centrally, within the Department of Health and Social Security, there was no clear management structure. As a result of this (in a now well-known comment): 'In short if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge' (1983:12). There was 'no driving force seeking and accepting direct and personal responsibility' *(ibid.)* for developing plans, ensuring their implementation and monitoring achievements. The devolution of responsibility down to units was much too slow, and the centre was involved in inappropriate matters, giving many directives but little direction. Change was seen to be extremely difficult to achieve, but was increasingly necessary because of the growing pressure on resources.

A 'strong' general management process was advocated in order to secure 'leadership', and to 'stimulate initiative, urgency and vitality' among NHS staff. It would also be necessary to bring about 'a constant search for major change and cost improvement' so that constant levels of care could be delivered more efficiently at lower cost, or a superior service provided at the same cost. General management was also a means of motivating staff: responsibility would be linked with incentives, rewards and sanctions, to promote overall efficiency. Existing consensus management arrangements had led to duplication, excessive meetings and a fragmented and divisive approach to tasks. To remedy the weaknesses of functional specialisation, professional functions should be 'effectively geared into the overall objectives of the general management process' (*ibid.:* 14): a line management system should be established in which the general manager sets the priorities and programmes for functional managers. Finally, by business standards, the consultation processes of the NHS were 'labyrinthine' and contributed to 'institutional stagnation': by implication, the introduction of general management would overcome these defects, and speed up decisions.

The Griffiths Report consequently proposed a number of interrelated measures to introduce general management in the NHS. At the centre, within the Department, a Health Services Supervisory Board and full-time NHS Management Board were recommended. The former was to be chaired by the Secretary of State and include Health Ministers, the Permanent Secretary, Chief Medical Officer, the chairman of the Management Board and some external non-executive members. The NHS Management Board was to be accountable to the Supervisory Board, and would plan the implementation of policies, 'give leadership' to the NHS, control performance and 'achieve consistency and drive' (*ibid.:* 3). In fact it was composed of senior civil servants from the Department of

Health, senior officials from the NHS, and members appointed from business and industry.

General Managers were to be appointed within each of the RHAs and DHAs, and eventually at Unit level, 'charged with the general management function and overall responsibility for management's performance in achieving the objectives set by the Authority' (*ibid.:* 5). Hospital doctors were to be involved more closely in management, consistent with the requirement for clinical freedom, because clinicians must participate fully in decisions about priorities in the use of resources—doctors were also expected to participate in the development of management budgeting (see Chapter 4). In addition, there were to be more systematic management arrangements for personnel, and property, a simplification of consultation procedures, and the expansion of 'market research' and consumer relations work to monitor the views of patients.

The background to these recommendations included the team's view that, with a coherent general management process and 'tight budgetary system' in place, local managers should be enabled to get on with their tasks, and the role of the centre would be restricted to strategic policy rather than detailed intervention. Moreover, at RHA, DHA and Unit levels, where consensus management had previously led to 'lowest common denominator decisions' and delays, general managers would assume responsibility as final decision-takers, especially in issues crossing professional boundaries and likely to cause disagreement. Urgent management action was necessary at unit level, the team argued, to bring about the real devolution of decision-taking promised by the 1982 reorganisation, and again, doctors would have to accept management responsibility for the effective use of resources.

Reaction to these recommendations within the NHS varied from outright opposition, and rejection of the Report's assumptions, to acceptance of the broad critique but reservations about the specific details of implementation. The House of Commons Social Services Committee welcomed the report but acknowledged that, among NHS staff, the response had not been very enthusiastic, largely because the Griffiths proposals were interpreted as a criticism of staff, a threat to clinical freedom, and as damaging nursing management (Social Services Committee 1984). While accepting most of the recommendations, the committee none the less pointed out that Griffiths had not appreciated the distinctive nature of the NHS arising from the control of service delivery by medical professionals, and that therefore line management arrangements could not be easily applied. However, the committee supported the development of clinician involvement in budgeting and management, and shared in the Report's criticism of the previous consensus management regime.

The British Medical Association representing doctors, and the Royal College of Nursing, voiced protests at some aspects of the Griffiths reforms which encroached on their professional autonomy, but, being unable to dispute the goal of greater efficiency and better use of resources, eventually acceded to the introduction of general management. In June 1984, the Secretary of State announced his decision to implement the Griffiths Report recommendations fully in England. By 1986 the majority of general managers had been appointed at RHA, DHA and Unit level. Most of those appointed were already employed within the NHS, predominantly as administrators: only about 15 to 20 per cent were 'outsiders', originating from the private and public sectors, and also the military. There were relatively few medical professionals appointed as General Managers; among Unit General Managers, only 10 per cent were former nurses, and 20 per cent doctors (see Carrier and Kendall 1986; Petchey 1986).

Under the new arrangements, there were major changes in internal management structures. Many former chief officers, and especially consultant, GP and community health doctors, as well as directors of nursing, found their roles redefined, and their influence reduced. General Managers were no longer *primus inter pares* in a team—they enjoyed executive authority, and were empowered to take decisions on the *advice* of professionals and functional administrators, who could no longer insist on 'consensus' agreement for those decisions.

District Management Teams were superseded by a multiplicity of executive groups, policy boards, management boards, and these were served by new 'directorates' of finance, personnel, quality assurance and so on. The managers of these directorates, and Unit General Managers (running large hospitals, groups of hospitals or related services) were held individually responsible for achieving prescribed tasks, and were subject to individual performance appraisal. In turn, the general managers were appointed on rolling short-term contracts with performance-related pay, and were held directly accountable to their superior line manager, and relevant Authority chairperson.

Thus general management established, for the first time in the history of the NHS, a direct and explicit hierarchical chain of command in which managers at each level assumed personal responsibility for the execution of bureaucratic control. As Harrison (1988a) has stressed, this constitutes an unprecedented degree of centralisation, with managers effectively becoming agents of ministers, through direct line management accountability from Unit General Managers to District General Managers to Regional General Managers to the chairman of the NHS Management Board. Moreover, these developments have made the status of Health Authority members in local

decision-making, and the policy-making role of Health Authorities, even more ambiguous than before (see Stoten 1985). Overall, the consequences have been profound.

FROM ADMINISTRATION TO MANAGEMENT

It is generally agreed among most commentators that the Griffiths Report has had a major impact not only on organisational arrangements and staff relationships, but also on the operational objectives and *ethos* of senior non-clinical staff. According to one leading policy analyst and NHS educationist, general management has had an immense effect, and it is difficult to overestimate the importance of the changes it has brought about. The NHS has been 'transformed from a classic example of an administered public sector bureaucracy into one that increasingly is exhibiting the qualities that reflect positive, purposeful management' (Best 1987:4). The transition has been away from a uniform structure and procedures, a reactive stance in relation to the environment, traditional administrative style and insensitivity to consumers, towards more flexibility and variety in service delivery, performance evaluation, individualised responsibility, and more consumer awareness, Best argues.

General management was implemented through a new division of labour, but also required a fundamental change in attitudes and values; the rhetoric and vocabulary of 'management' became a new orthodoxy, buttressed by training courses, conferences and a constant stream of publicity. The national body representing hospital and health service administrators argued that traditional ways of thinking and acting were limiting, and should be removed. In their place, general management offered a more relevant and effective set of ideas and practices. General management, it was noted, requires (a management style typified by strong and dynamic leadership…that encourages innovation and calculated risk-taking…[and] an overall philosophy of "getting things done"' (IHSM 1985:7).

Consequently,

> the single greatest achievement of Griffiths and its precursors has been to thrust management and management preoccupations to the very centre of NHS thinking. Management ideas now provide the dominant intellectual framework within which the NHS thinks about itself and its role in society. They have begun to foster a regime in which particular kinds of activity are valued while others are pushed to one side.
>
> (Davidson 1987:46)

This entails a dominant concern with efficiency and cost-control, monitored through performance indicators and value-for-money appraisals,

rather than a concern with clinical effectiveness, equity and access, for example, as discussed further in Chapters 4 and 5. It has taken the form of what Strong and Robinson have termed a 'moral crusade' to bring about a total change in organisational culture: 'Mere administration was abolished. In its place came management' (Strong and Robinson 1988:56). This so-called 'new model management' involved the subordination of the clinical professions to managerial control, but more than that, it endorsed the ideology of 'permanent revolution' —the acceptance of a need to question and modify existing arrangements continuously, in order to meld fragmented and autonomous professionals into an integrated organisation pursuing corporate goals.

This shift from an administered to a managed service necessarily created, therefore, significant amounts of organisational turbulence in which there was not simply a rejection of 'consensus management' but also a rejection of the consensus about objectives (Ferlie and McKee 1988). The scenario described by Ferlie and McKee is one in which management imperatives increasingly predominate, clinical supremacy is being challenged and other professional power blocs may be broken up. While this may not proceed without some conflict and opposition, there is no doubt that managerial language and rhetoric are being matched by action.

For example, Cousins (1988) has shown how managerial prerogatives have been asserted through a more authoritarian style in the enforcement of staff discipline and the handling of industrial relations problems. Among the managers in her case study, Cousins observed that managers regarded the NHS as a set of commodities (staff, equipment, plant) to be rationalised in order to achieve least-cost efficiency. Not surprisingly, this approach, together with problems caused by the demotion of nurse managers, disagreements with doctors over clinical budgeting and conflicts over 'contracting out' ancillary services, led to considerable demoralisation among NHS staff, and prompted local challenges by trade unions, Community Health Councils, and medical, paramedical and nursing groups.

Evidence about managers' own perceptions of these changes is also available from a number of other studies. In one nationally based research project, twenty District General Managers were interviewed periodically over a two-year period to monitor the implementation of general management (NHSTA 1987—otherwise known as the Templeton series). Among the many findings, a number of key results stand out. First, there was enormous diversity in the roles and influence of District Health Authority chairpersons, and General Managers had very different ideas about the kind of role and relationship necessary for effective management (NHSTA 1987: no. 1). Second, there was much confusion about the appropriate role for HA members under the new system, and many DGMs

found their Authority members unsatisfactory or ineffective. Members themselves felt squeezed between central pressure and general managers' influence (NHSTA 1987: no. 3). Third, despite official affirmations, there was widespread confusion about the 'quality initiative', although there was an acknowledgement that the quality issue had only arisen as a consequence of the Griffiths Report (NHSTA 1987: no. 2).

The fourth main conclusion concerns relationships with doctors. Managers had great problems drawing clinicians into management, and these problems were traced to basic differences in approach, outlook and methods of working. General managers believed that hospital consultants did not think about the resource implications of their decisions. The resulting 'disharmony' between corporate planning and financial control on the one hand, and clinical practice on the other, was linked to a strong contrast in cultural norms and values, and was a source of frustration to managers. Some DGMs wanted to curtail what they regarded as the excessive power of doctors, while others wished to 'co-opt' them (NHSTA 1987: no. 5).

The range and form of local decentralisation varied, but District General Managers were united in their attitude towards their respective Regional Health Authorities. Most DGMs had neutral or unfavourable views about the role of Regions, and criticised their intrusion in district matters. Regions were regarded as too close to central government, and failing to act as advocates for their constituent districts (NHSTA 1987: no. 6). Within districts, there was again diversity in the amount of delegation given to Unit General Managers, especially about finance and planning, and explicit awareness of the stresses and tensions which existed between district management and unit management (NHSTA 1987: no. 7).

Overall, District General Managers differed greatly in their sphere of influence, how they did their job, and the pace of change in introducing general management locally. For these managers, their greatest achievements were in speeding up decision-making and in starting a 'de-tribal-isation' among NHS staff—that is, breaking down professional barriers which had formerly led to a fragmented service. Their main disappointments concerned the trend towards more centralisation; financial stringency; their lack of influence over doctors; and the slow progress in converting other staff to the philosophy of general management (NHSTA 1987: no. 8).

Very similar findings have been reported in an interview survey of Unit General Managers and other unit staff in two regions (Banyard 1988). Respondents believed that there had been improvement in budgeting and costing arrangements, and there had been more devolution of responsibility to Units from District headquarters. It was generally agreed that there was now a clearer responsibility for decisions, and lines of authority were better

defined. There were mixed reactions to the existence of short-term contracts, with some staff alleging that managers acted more 'ruthlessly'. Among all respondents, there was a very small majority (53 per cent) who believed that Unit general management had been a worthwhile innovation. The UGMs claimed that they had become more involved in setting clinical targets, but regretted that their influence was still very small; the main constraints were their inability to exercise direct control over doctors, and the difficulties caused by inadequate resources.

Unit managers recognised that general management had had an important impact at unit level, but identified two major problems—a failure to improve staff morale and motivation, and greater formality and rigidity (hierarchy) within Units, and between Units and Districts. Significantly, Banyard's survey showed that most 'direct-care staff felt that general management had *not* been beneficial overall for patients. In particular, trade-union members and medical staff regarded general management negatively. This was a reflection of both structural trends in the NHS, and a reaction to specific local circumstances. The implications of these views will be discussed again later, but they are underlined by Banyard's observation that: 'Certainly, the strength of personality and individual management style of a particular UGM now tend to be of proportionately greater influence than in the pre-Griffiths era, when matters were largely conducted in a consensus-seeking fashion' (Banyard 1988:917).

Other evidence about managers' perceptions of their role and the local impact of general management is available from a study conducted by the author in the spring of 1988. As part of a research project on 'cutback management' in health care services, involving case studies of six District Health Authorities in one English region, semi-structured interviews were held with the DGMs, Directors of Finance, Directors of Planning, UGMs and representatives of senior medical staff (Flynn 1988b, 1991a). The next sections describe the views held by each of these groups about general management: further details and findings are discussed in Chapter 6.

All of the DGMs were enthusiastic and positive about the introduction of general management. Four particularly stressed the increased speed of decision-making, and the improvement gained by having personal responsibility and accountability at different levels. They compared this favourably with the old system of consensus management However, they all claimed that the delegation promised by Griffiths had been undermined by recent restrictions on expenditure, and they complained about regional and central directives reducing their discretion. They all emphasised that general management had still to be worked out fully to have its proper effect, and that there was resistance from medical and some non-medical staff.

One DGM regretted that appropriate changes in organisational culture had yet to be achieved, and criticised 'unrealistic attitudes' among some staff, especially doctors, who were seen as hostile to general management. Another DGM complained that the 'political dimension' of the NHS, and the 'mish-mash of different pressure groups', posed great difficulties for effective management. This DGM, and two others, pointed out that their biggest problem was extending managerial authority over clinicians; doctors were said to be not interested in management issues at all, and medical and nursing practices were seen as obstacles to increased efficiency.

The Directors of Finance (Treasurers) were equally enthusiastic about general management, although they varied slightly in their assessment of its effects. Five of the six interviewed believed that general management had already had a profound impact on the running of their district's affairs. They all stressed that there had been clear improvements in the process of decision-making: most of them used the cliché of 'sharpening-up' decision-making. More co-ordination, less duplication and confusion over responsibility, and fewer delays were mentioned by all respondents as the main benefits over consensus management. One Treasurer approved of the changes, but felt that they had not yet gone far enough: he believed that many staff were reluctant to accept managerial authority.

Several pointed out that Griffiths had led to real delegation of financial responsibility from District headquarters to Units, but that this had created some inter-organisational tensions, which became problematic because of budgetary crises. Some unit accountants were reported to be 'protective' of their 'own' unit and resistant to district headquarters' influence. However, most respondents claimed that general management had given much greater importance to the finance function at all levels, and that this was a necessary and useful development.

The most emphatic comments about general management concerned opposition from doctors. Finance Directors insisted that it was necessary to change clinical practices, to control resource use and enhance efficiency, and that this required extending managerial control over clinicians. Although they all stressed this point, they all equally acknowledged that there were continuing difficulties in obtaining the change in organisational culture which treasurers believed was desirable.

While day-to-day executive responsibility for running DHAs is vested in District General Managers, and strategic financial and operational budgetary control is the function of Directors of Finance, Directors of Planning also play an important role in policy-making. Most districts have a senior manager responsible for co-ordinating, preparing and monitoring service plans for all units, and for devising the annual or short-term plan

for capital and revenue expenditure. It is useful, therefore, to examine the views of Directors of Planning (PDs).

Most PDs believed that general management had made a significant difference to the way their District operated, and they praised improvements in clarification of staff functions and speed of decision-making. They derided the previous consensus management system, in which, they claimed, there was confusion, debates 'dragged on', and 'issues were fudged' or never resolved. Three PDs were cautious about the effects of general mangement. One was unsure whether it was possible to identify and separate the effects of general management from the impact of expenditure restraint. Another said that he was cynical, suggesting that the stress on rapid results and urgency was counterproductive—staff were worried about the pressure to reach targets and take decisions quickly, and this sometimes lowered what he described as the 'quality' of decisions. Elsewhere the PD thought that there had been real changes in what he termed 'the organisational culture', but he had personal reservations about whether these changes were desirable.

Two important sources of difficulty were mentioned by all six respondents: relationships with medical and nursing staff, and relationships with Units and UGMs. For example, one PD said that the 'negative' aspect of general management was that it had 'clipped the wings' of medical and nursing advisers, and this had led to tensions. In his district, managers had tried to foster better relationships with doctors—'some of them [managers] say bringing them [doctors] to heel' —to try to control resource use, but there were still problems. Planning directors also referred to the need for careful handling of District-Unit relations.

In some DHAs, the senior managers involved UGMs directly in district Management Board meetings and discussions, whereas in others, UGMs were distanced or even excluded from headquarters decision-making, or invited to participate only when Unit-specific items emerged. PDs pointed out that Units had to be persuaded or cajoled to adhere to District service plans and budget limits. It was recognised that Units sometimes tried to obstruct or veto headquarters' demands, and that they often made bids for improved services or new developments which could not be approved within the District global budget.

Twelve UGMs (mainly managers of acute hospitals) were also interviewed about their experience of, and attitudes to, general management at the front-line of service delivery. Their views are especially interesting and important, since it is at this level that day-to-day resource allocation takes effect, and where relationships between managers and all types and grades of staff have most consequence for patient care. All of the UGMs considered that general management had a

major impact on the running of their DHA and on their Units. Ten argued forcefully that general management had a beneficial effect, by improving decision-making within the Unit and District headquarters. There was, they claimed, greater urgency, more individual responsibility for tasks and responsibility for actions, and a welcome stress on leadership. Unfavourable contrasts were drawn with the previous system of 'consensus management', in which indecision and delay compounded problems, and in which responsibility was said to be diffuse, and issues were 'fudged'. In the words of one acute Unit manager, 'the previous hospital management team was a kind of unholy deadlock', but that situation had now changed.

Some reservations about the extent of general management were expressed by two UGMs. One (a manager of a large mental illness and mental handicap unit) argued that there had not been any obvious improvement because hospital consultants and other medical staff were still not accountable to managers. The other UGM (who had been appointed from private sector industry to manage a large district general hospital) asserted that general management had not yet gone far enough. In his opinion, managers were subject to interference from too many sources, too many people demanded to be consulted, and many medical staff did not acknowledge the chain of command. According to this UGM, 'many [NHS employees] seem to think we can run the hospital as a kind of workers' co-operative', a view which he dismissed as unacceptable. For these two Unit Managers, general management was necessary and worthwhile—their criticism was that it had not been implemented sufficiently rigorously. In fact these reservations were expressed by most of the other UGMs, but two gave them much more explicit emphasis in their interviews.

All UGMs mentioned the constraining influence of financial stringency and budget crises on their capacity to run their units and provide services in the way they preferred. They also emphasised the importance of professional medical power, and other staff attitudes, as significant constraints on their own authority. Regarding finance, it was argued that financial stringency had soured relationships between UGMs and many unit staff. Four UGMs were especially concerned about their lack of influence over doctors, and expressed their desire to extend managerial control over hospital clinicians. One UGM admitted it was hard to 'bring difficult consultants into line', and claimed that consultants could 'subvert' unit managers' decisions—'they [doctors] are aware of their power, and often use it to undermine policies they disagree with'. Another UGM claimed that although most other staff had adapted well, doctors had not come to terms with general management, because they did not want to be accountable to managers. A manager of a large acute hospital criticised

consultants' 'shroud-waving', but admitted that he had to rely on persuasion to obtain clinicians' co-operation over difficult decisions; a similar view was also expressed by a UGM elsewhere.

Two Unit Managers claimed that general management had resulted in a shift in the balance of power away from doctors to managers, and approved this change. One reported proudly that he had successfully persuaded doctors in his Unit to become clinical sub-unit managers, to take on 'real' managerial responsibility for resource allocation and specific hospital services. A manager of a mental illness unit expressed pleasure in his claim that 'the balance of power has moved away from doctors'.

Five UGMs specifically referred to difficulties with non-medical staff, and particularly their 'outmoded' attitudes, as a serious problem for managers. They complained about the disparate nature of occupational groups in the NHS, and some criticised senior nurses' unwillingness to change procedures and practices. Most of those interviewed spontaneously mentioned that the change in organisational culture associated with general management had not yet permeated through the entire Unit. For most UGMs, this was a cause for regret. Several argued that it was necessary to instil a new set of attitudes among all Unit staff, to break down 'rigid professionalism', 'to get people to think as managers', and to encourage more individual responsibility, innovation and risk-taking.

All of the UGMs noted that financial retrenchment, leading to cutbacks and 'rationalisations' in services, had intensified the problems of management, and some referred to declining morale among staff. But they were all equally confident that this situation could only be dealt with satisfactorily by a system of general management.

The former system of consensus management was regarded as incapable of resolving the dilemmas posed by budget restraint There was a common concern to increase cost-effectiveness and improve efficiency, and to seek greater flexibility in the organisation and delivery of services. Longstanding priorities were being reassessed, and conventional practices questioned, they claimed. Consultants and other medical staff were now being required to explain and justify their decisions and use of resources, to stimulate cost-consciousness, and were being asked to consider alternative arrangements and procedures.

UGMs were aware of the opposition from medical and other staff to changes and especially reductions in hospital services resulting from budget cuts. They also accepted that UGMs occupied a contradictory role, dealing with conflicting demands from different interests, but claimed that this was an inevitable and defining characteristic of the management task, and one which they were willing to undertake. Nevertheless, they all replied in terms which indicated a strong determination to press on with general management,

and displayed a notable commitment to extend managerial control over clinicians, and to intensify the search for more efficiency savings in clinical as well as non-clinical services.

Interviews were also carried out with a small number of senior medical staff in five of the case-study Districts—two senior consultants (chairmen of the Medical Executive Committee), one District medical officer, and two medical assistant District General Managers—and their views provide an important contrasting perspective. Most of the doctors were sceptical about, and critical of, the introduction of general management. One consultant stated that he and his colleagues were cynical about it, arguing that if there had been greater speed in decision-making this was the result of urgent and imposed budget cutbacks rather than better management. The basic problem, this consultant claimed, was that although the Griffiths Report advocated devolution of responsibility to the shop floor, no one had defined where that shop floor was. He insisted that ultimately, responsibility for medical services lay with doctors, and should remain so. Another consultant said that his colleagues had taken a conscious decision not to participate in general management Most of his medical colleagues were not prepared to give up their clinical time 'to act as administrators'; instead, 'managers must do the management'. He believed that in principle general management offered a form of 'benevolent dictatorship', but because it was introduced at a time of financial constraint, managers were more dictatorial than benevolent.

The senior doctors who were formally members of the District Management boards had slightly different views. According to one, general management had a major beneficial effect on the running of the DHA, and was better than 'obstructive' consensus management. His colleague in a different District agreed, but noted that although decision-making had been tightened up, there was 'still no real control over clinicians'. This remark seems paradoxical in the light of this doctor's subsequent comments that he was personally committed to the medical profession, and that despite his membership of the Management Board, he did not regard himself as a manager. Nevertheless, his opinion was that 'administrators' were still working under inappropriate constraints, and that 'real management' could not proceed unless clinicians were accountable to managers.

Another senior doctor claimed that there had been a deterioration in relationships between managers and members of the medical and nursing professions as a result of general management. There had been an increase in antagonism and suspicion because medical officers and chief nursing officers had 'lost out', and now occupied ambiguous positions. They held advisory rather than executive responsibility, and this caused problems in their relationships with both District and Unit General Managers. It was

clear therefore that medical professionals recognised the challenge to their power posed by general management, and acknowledged that the struggle for control was continuing.

Thus it can be reasonably concluded from this brief review of findings from the author's own study that the results confirm and reinforce the observations made by other researchers. Certainly the language and rhetoric of management described by Best (1987) and the Institute of Health Services' Management (1985) seems to have become well established, and as Davidson (1987) noted, managerial ideas have become the current orthodoxy among NHS administrators. There were clear signs of what Strong and Robinson (1988) term a 'moral crusade', and desire for a 'permanent revolution' to bring about a change in organisational culture, among most if not all of the respondents.

There is also other case-study evidence, described in Chapter 6, supporting interviewees' claims to have taken on a more assertive and directive role, and this is in line with Banyard (1988) and Cousins (1988). This survey provides further evidence to back up Cousins' observation that managers have begun to regard NHS staff, plant and equipment essentially as commodities and resources, and see their own role as attempting to maximise efficiency in resource use. Similarly, and most importantly, the interview data indicate the widespread concern among managers to challenge medical dominance, and to overcome staff resistance to the new managerial ethos.

CONCLUSIONS

There is sufficient evidence to indicate that there *has* been a fundamental change in attitudes and values, and in practices and procedures, as a consequence of general management. Although the rate of diffusion is variable from place to place, and there are constraints of varying severity, general management has become well established. There *has* been a major transformation in the internal operation of the NHS, and a far-reaching shift from administration to management.

Support for these views is derived not merely from practitioners' and proponents' claims, but from observable actions and policies (described in more detail in subsequent chapters) and academic research reviewed above. The staff magazines and professional journals for and about the NHS have become dominated by articles advocating and explaining the adoption of 'managerial' concepts and techniques. There is a thriving academic and private sector industry of management consultants and training agencies, and an extensive programme of 'management development' schemes, designed to enhance managerial skills and promote managerial thinking at

all levels. The norms and jargon of business management have begun to permeate health-service administration, and there are frequent and admiring references made to the sayings of private sector management gurus concerning corporate goals, the pursuit of excellence and leadership qualities.

Recent public declarations by NHS managers about their role and objectives illustrate and emphasise this. For example, in the 1988 annual address to the Institute of Health Services Management, the then president spoke approvingly of the success of general management and the profound changes associated with it. Local-level management was praised for achieving better value for money and providing opportunities for developing an entrepreneurial spirit. Management was about maintaining high rates of change, and the NHS managers were said to be 'changing from a somewhat passively administered bureaucracy to a purposeful, customer-oriented business, eager to maximise results' (Bowden 1988:64).

Such views are particularly important because they anticipated (and closely mirror) the ideas contained in the government White Paper *Working for Patients* (Department of Health 1989). The proposals for an NHS 'internal market' will involve significant reorganisation, so that 'purchasers' and 'providers' will negotiate contracts for the provision of services, and revenue will depend on efficiency and quality determined by regulated competition. In this market, Health Authority managers will play a crucial role in setting the specification for contracts, in negotiating prices and tariffs and in evaluating quality. In self-governing hospitals, managers will acquire much stronger powers over medical and other staff, and be able to fix local salary levels and working conditions. The implications of these developments are discussed more fully in Chapter 7. For present purposes the point to be stressed is that NHS managers are being required to adopt the attitudes, values and practices of private sector managers, in the name of improved cost-effectiveness and responsiveness to consumers.

According to one management consultant, the NHS internal market proposals can be seen as 'part of the continuing development and strengthening of a business culture in the NHS which began with the introduction of general management' (Wigley 1989:252). Consequently, he argues, it is necessary to obtain a shift in organisational culture, and to stimulate more business-like attitudes, behaviour and motivation among staff. So-called 'Individual Performance Review' can be used to inculcate appropriate attitudes and to enlarge 'managerial competency', which will be even more relevant in the new regime where the highest value will be placed on entrepreneurial skills. The successful entrepreneurial manager, we are advised, 'tends to be very high in need for achievement, below

average in need for affiliation, and moderately high in need for power' (Wigley 1989:254).

It remains to be seen whether, and how, these 'needs' will be successfully met, and indeed whether 'success' will be gauged in terms of effectiveness or efficiency. As one commentator has indicated, many managers' current objectives (especially within the existing Individual Performance Review system) are confined to short-term efficiency, controlling and reducing costs (Flanagan 1989). It is very unlikely that this would change in a competitive purchaser-provider market.

The Chief Executive of the NHS Management Board has stressed that the key objective for all NHS staff is to provide better quality and greater choice of services for patients. In accomplishing this, he stressed several subsidiary tasks for managers: 'positive leadership' to create a 'climate for delegation and change'; the search for value-for-money as a continuing responsibility; and the need to establish incentives and rewards for performance (Nichol 1989). In a similar but more critical vein, Sir Graham Day (a member of the NHS Policy Board, and chairman of Rover Group plc and Cadbury Schweppes plc) has recommended a reduction in the number of layers of management within the NHS, but above all, a commitment to continuous organisational change, and to dynamic leadership—features which have hitherto been uncommon (Davidson 1989). Clearly then, the message from the top of the NHS hierarchy is that new management action, styles and values must become prevalent throughout the system.

It would be a mistake, however, to believe that this process is already complete, or that it will proceed without difficulty. We know from recent studies of the impact of general management that there is considerable variation in local managerial roles and objectives, and that there is no single, homogeneous 'general management culture' (see NHSTA/ Templeton College 1987; Pettigrew *et al.* 1989; Stewart 1989; Williams and Dopson 1988). Thus for example, Pettigrew and his colleagues reported that one of the most striking findings of their case studies in eight DHAs was the diversity in models and varying interpretations of general management They argue that there were 'many "general managements" and its implementation has not been at all "general" but rather highly context-specific and coloured by the history, culture, politics, values and traditions of individual localities' (Pettigrew *et al.* 1989:29).

Nevertheless, despite this pattern of diversity (which can be partly explained by the fact that general management was in its infancy at the time of this research) there are common themes. Williams and Dopson observed that District General Managers expressed a strong preference for a hierarchical model of organisation, while Stewart was struck by significant changes in

attitudes among managers interviewed regularly over a two-year period—DGMs appeared ready to consider, indeed welcomed, the adoption of a more entrepreneurial approach to the provision of health care.

Recent events in NHS funding and policy, and the proposed internal market reforms, will have encouraged these tendencies. The future implementation of purchaser-provider competition, with trading of services between Health Authorities, and contracts between GPs, DHAs and self-governing hospitals, hinge upon an increased role for health service managers, and the acceptance of market ideology and disciplines. Clinicians can expect to see their professional autonomy challenged, as managers come to exercise greater influence over the determination of priorities, the allocation of resources and the auditing of performance and quality. In a 'marketised' NHS (discussed more fully in Chapter 7) the structure of control will inevitably be one in which managers rather than consumers or producers are the dominant actors.

Throughout the 1980s there has been a fundamental transition from a system in which administrators facilitated the provision of services within a medically dominated decision-making framework, towards a system in which managers are attempting to subject clinical activity (and clinicians) to quasi-market criteria and managerial objectives. The methods by which this is being accomplished, and the context within which this is occurring, are described in the chapters which follow.

4 Budgeting and the costs of medical autonomy

We have seen how the issue of professional medical autonomy has always been contentious, in most health systems. However, as the pressure on resources has intensified, governments and funding bodies have sought to exercise more control, across the entire apparatus of health-care delivery systems generally, but also more specifically over medical practice. For those agencies wishing to limit or reduce health expenditure, the fundamental problem is that resources are ultimately committed and consumed by clinicians. It is medical and surgical practice, and all the associated paramedical, diagnostic and therapeutic services generated by it, which determine staffing, equipment and pharmaceutical costs. As patient demand has grown, and expectations risen following advances in medical treatments and technology, the production of clinical services has expanded, leading to a continuous rise in expenditure.

Various methods of cost control, at different levels, have been introduced to regulate demand and limit supply. In this chapter we shall examine some of the most important developments in the management of resources used by clinicians in the intra-mural acute sector. We shall assess the impact of these developments—clinical budgeting, resource management, diagnosis-related groups and medical audit—on professional medical autonomy, and consider the argument that clinical freedom is being eroded by managerial and organisational imperatives.

CLINICAL BUDGETING

Ever since the inception of the NHS there were problems in identifying and measuring costs within hospitals, but by the late 1970s and early 1980s the measurement of costs and efficiency became a major source of concern for government. Health Authority revenue budgets from 1976 were cash-limited—that is, financial allocations had a statutory fixed spending ceiling —and all activity had to be financed out of a predetermined annual prospective

budget. As central government attempted to contain health-service spending, tighter controls were applied to local Health Authorities; in 1982 special emphasis was given to improvements in efficiency, and DHAs were required to make 'efficiency savings' in their budgets.

From 1984/85 such savings became institutionalised in annual financial programming, and districts were compelled to fund 1 per cent of their revenue expenditure through specific 'Cost Improvement Programmes'. Local Health Authorities were expected to increase productivity—maintain or increase output for the same or smaller amount of input. Resources released by improved labour productivity and other cost savings could then be redeployed locally. Reductions in direct patient care were not permitted in these schemes, so most Cost Improvement Programmes applied to the hotel and ancillary services in hospitals—catering, laundry, cleaning, portering and related services. From 1983 there was a compulsory procedure for Health Authorities to seek tenders for the supply of these services, and a government requirement to make contracts open to external commercial competition. In fact some contracts were privatised, but many were given to in-house groups; in both cases, however, working conditions and practices, and wage rates, were changed, and in some instances staff redundancies occurred (Harrison 1988b; Key 1988).

Cost improvements or efficiency savings in the clinical sphere have not, to date, been established, but there have been systematic attempts to devise techniques for measuring and evaluating medical output, and intensive efforts to develop better accounting, budgeting and costing procedures. A major and long-standing difficulty in the NHS, largely due to the absence of market pressures, is that clinical costs were rarely the subject of detailed investigation, and budgets were (until very recently) increased incrementally. One other basic problem, particularly in hospitals, is that there are several different ways of identifying and classifying costs. As a consequence, it is often hard to ascribe responsibility for expenditure to one discrete sub-unit of the organisation, or even to one form of activity.

Budgets (quantified operational plans showing how resources are committed to achieve defined objectives and activities within a specified period) and expenditure can be analysed in different ways. Within a hospital, for example, costs can be assigned to subjects such as medical and nursing salaries, drugs and so on; or by function or department, such as pharmacy, radiology, pathology services; or by patient group, or clinical specialty (geriatric medicine, thoracic surgery, and so forth). In practice NHS accounting has been based on subjective and functional expenditure, but as government has demanded evidence of value for money and performance indicators of efficiency, more efforts have been made to define specialty costs.

There are immense technical problems in categorising and tracing the various cost elements of medical and surgical activity for accountancy purposes (see Brooks 1986; Perrin 1988). There have also been difficulties in standardising 'patient activity' statistics, and workload and manpower data, which led to the creation of an official working party inquiry, and recent implementation of its recommendations about health-service information (the so-called Körner Reports: DHSS Steering Group on Health Services Information, 1982–84).

One major problem is thus identifying the originators of, and assigning responsibility for, costs at different stages of a patient's treatment. How, for example, should the radiology, pharmacy, pathology, physiotherapy (and overhead) costs be apportioned and recharged, and charged to whom? To individual consultants, or groups of doctors within a specialty? Individual hospital consultants decide which of their patients referred by GPs to admit, and what treatments they shall receive, and consultants' decisions then have important resource consequences for other staff and the use of facilities: operating theatre schedules, nurse staffing, skill mix and work rotas, drugs, dressings and other supplies.

However, conventionally, doctors have not been budget-holders as such; individual clinicians work in 'firms' or teams within specialties, headed professionally by consultants who are not accountable to district authority managers. Their workload, case-mix and throughput, and the costs incurred, are primarily determined by their own clinical judgement about both priorities among patients and about forms of treatment and length of stay. Although they practise within an environment of resource constraint, their clinical decisions are guided by professional criteria and peer-review, including advice from local Medical Executive Committees consisting of the representatives of divisions and specialties.

Ethically, doctors have a duty to provide the best treatment for their patients regardless of costs, and many believe that consideration of the resource effects of their decisions is irrelevant and inappropriate. But individual responsibility for expenditure is precisely what is deemed essential for effective cost-containment and for evaluation of efficiency. Recent government policy has sought to establish the principle that clinicians must be made aware of the costs they generate, not least so that they might compare their productivity and 'value for money' with other colleagues, and improve their performance. This move constitutes a profound change in the culture of medical professionals in the NHS, and is regarded with caution by many doctors, and outright hostility by others. So, in addition to technical accounting problems, there are major problems in subjecting medical professionals to managerial and budgetary controls.

It is in this context that we can begin to appreciate the significance of clinical budgeting, management budgeting, resource management and other techniques for involving doctors in what they had hitherto regarded as 'administrative', or more latterly, 'management' issues. The momentum for these initiatives stemmed not only from the Körner reports but more especially from the Griffiths Report—the 1983 NHS Management Inquiry —and earlier experimental work done by researchers at the King's Fund, London. The latter group initiated a series of projects in 1979 to involve hospital doctors and nurses in budgeting and financial control, under the rubric of CASPE (Clinical Accountability, Service Planning and Evaluation). The evolution of these initiatives, and the interrelationships between CASPE, Griffiths and Körner, are extremely complex and confusing, even for NHS insiders (see Ashmore *et al.* 1989; Perrin 1988).

The CASPE experiments were based on groups of hospital doctors (and nurses) planning future service provision, with forecasted workload and resource consequences then being formalised in a 'clinical budget'. So-called 'PACTS' (planning agreements with clinical teams) were agreed between doctors and managers, and information on current activity and costs given routinely to clinicians, so that they could decide what changes in workload and performance were necessary to remain within the budget for which they were responsible. There is some disagreement about the success of these trials in various hospitals, but it seems generally agreed that clinicians were not wholly convinced of their utility, partly because of the quality of the information (and information technology), partly because there were no obvious incentives, and partly because of scepticism about involvement in 'management' (Prowle 1988; Pollitt *et al.* 1988).

Nevertheless, the idea that consultants should take on some managerial responsibility for clinical resources and spending within their control had gained ground. Moreover, it was explicitly approved (even demanded) by the Griffiths Report in 1983, although this introduced the slightly different concept of 'management budgeting'. Griffiths had identified a number of weaknesses in the structure and management of the NHS. Indeed, it was implicitly suggested that there was little if any effective 'management' as understood in the private sector.

According to Griffiths, there was little concern with the setting of precise objectives and monitoring performance, and virtually no economic, let alone clinical, evaluation of services. To improve performance all round, and to secure better value for money and efficiency, the NHS had to adopt the principles of 'general management'. This entailed in particular ensuring that individuals assumed direct responsibility for implementing specific tasks, and for monitoring activity, resources and outcomes. The changes in bureaucratic arrangements and

organisational culture this required have been described in Chapter 3. What is relevant here is Griffiths' presumption that general management should, as a matter of necessity, apply to *all* staff working at all levels, doctors as well as administrators.

The report recommended that clinicians should participate fully in decision-making about priorities in the use of services, and therefore should become involved in 'management budgeting' (MB). It was axiomatic that, since doctors' decisions 'largely dictate the use of all resources…they must accept the management responsibility which goes with clinical freedom. This involves active involvement in securing the most effective use and management of all resources' (DHSS 1983:18). As Perrin has pointed out, the Griffiths Report uses the terms 'management budget' where it might seem that 'budget' would be sufficient, precisely because of the view that conventional NHS budgets did not facilitate real managerial control and evaluation of cost-effectiveness in resource use (Perrin, 1988:97).

General management therefore inevitably required clinicians to become aware of the costs of services they authorised, and for doctors to become 'budget holders' with consequent managerial accountability for resources and performance. As Griffiths argued: 'The nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the *natural managers*' (DHSS 1983:19; my emphasis).

MB, according to Griffiths, was intended to be characterised by an emphasis on management rather than accountancy. In practical terms this meant that, at Unit level, hospital doctors were expected to assess the relationship between workload, manpower and finance, and most notably full overhead costs, so that progress in achieving defined service objectives could be measured. In order to put this new scheme into effect, in 1983 four District Health Authorities (and subsequently more) agreed to participate in 'demonstration projects'.

Experience with MB led, not unexpectedly, to various difficulties, but before we can review them, it is important to describe the differences between MB and clinical budgeting (CB). These are important, because they reveal some of the sources of medical professional resistance to managerial supervision and financial constraint. It must be noted that these differences, and their significance, seem arcane and complex, even (or especially) to expert practitioners (see Ashmore *et al.* 1989). There are major problems in the operationalisation of costs, and identification of executive responsibility for expenditure.

According to one leading expert, whereas CB is concerned with spending on direct patient care, MB includes overhead costs. Clinical budgets allow for some *virement* by clinicians (that is, adjusting or transferring resources between budget heads within fixed financial limits) but with MB there may

be no such flexibility or delegation of spending authority. Clinical budgets are intended to apply only to the providers and users of clinical and paramedical services, whereas MB is inherently comprehensive, comprising all budget-holders (Coles 1986).

The Griffiths Report, in endorsing MB, saw CB as essentially a much-needed *management* tool, as a technique which could, and should, be incorporated in much broader corporate objectives. Thus in MB, budget-holders are not only responsible for expenditure under their direct control but also for 'indirect' spending recharged from other departments to cover the cost of services. So, for example, a consultant might be charged for the cost of pathology tests incurred by the consultant's team, as well as other clinical and paramedical services, plus some element of other general overhead (lighting, heating, and other) costs. For perhaps the first time in the NHS, clinicians would be faced with objective information about the impact of their clinical decisions on expenditure, and they would have the opportunity to consider alternative patterns of resource use, and even changes in medical practices. For the first time too, doctors would be inextricably caught up with the process of accounting for (literally, in both senses) the financial results of their activities. At the same time of course, managers and other budget-holders in units would also be able to see the aggregate picture of resource use, and could begin to evaluate, and even challenge, clinical outputs.

The principal argument for introducing MB, at least in the Griffiths managerial ideology, is the need for integrated financial planning and management control. The subsidiary argument, often used to justify its extension to medical and nursing staff, is that it makes the allocation of resources more objective and rational. It is widely known that all doctors practise some form of rationing in deciding which types of patient should receive what kind of treatment when. CB and MB, proponents argue, potentially can provide better data about resources and comparative information about the cost of different treatments. Consultants, it is presumed, will be convinced that CB/MB will provide the basis for more rational decisions (to optimise the use of resources), and therefore can be persuaded to co-operate in their adoption (see, for example Coles 1986; Forte 1986; Perrin 1988; Pratt 1986). However, consultant 'attitudes', 'motivation' and 'behavioural problems' have proved to be important obstacles to the widespread application of CB and MB.

Following investigation of experience in the various pilot or trial sites, by government-appointed management consultants, it became evident in 1984/85 that in addition to accountancy, computing and other technical difficulties, there were signs of hostility by clinicians, or at least a reluctance by them to become fully committed to these new systems. Commentators have pointed

to problems over the reliability and validity of workload data, continued uncertainty over the basis for cost apportionment and vagueness about doctors' 'managerial' accountability, as important constraints (see Coles 1986; Pollitt *et al.* 1988; Prowle 1988).

According to one expert, the failure of MB could be explained by a combination of factors. There was 'organisational turbulence' due to the uneven introduction of general management throughout the NHS; the variety and complexity of hospital activity could not easily be assimilated in standard commercial MB techniques; basic data recording was inadequate; and there were insufficient qualified staff with the requisite training. Moreover, there had been an overestimation of the speed 'at which professional independence could be supplanted by a disciplined management culture', and a 'failure to interest, involve and commit the large majority of clinical staff needed to enable CMBs [clinical management budgets] to have a major, positive impact on improving resource utilisation' (Perrin 1988:109–10). Despite, or perhaps because of this, in 1985/86 the experiments were extended, with modifications, to fourteen other units, including community health services.

RESOURCE MANAGEMENT (RM)

Discussions about progress (or lack of it) with these schemes were held between the NHS Management Board and representatives from the British Medical Association's Joint Consultants Committee and Royal College of Nursing in order to overcome some of the continuing criticisms and difficulties. Most importantly, agreement was reached about a revised system, and new sites for 'demonstrations' and testing of a new model of CMB. This initiative incorporated substantial changes, and was marked by significant change in terminology: Clinical Budgeting and Management Budgeting were to be replaced by 'Resource Management' (RM). It is widely acknowledged that this evolution reflected official acceptance that medical and nursing staff had been antagonised by earlier experiments, and therefore had to be persuaded to participate in a budgeting system which was tailored to their needs, and accommodated their interests.

A notice was issued by the Department of Health in November 1986 announcing the details of this new model. It stressed that RM projects should only take place where doctors and nurses were already participating in the management structure; that the new information and data systems had to meet medical and nursing users' requirements; and that more effort would be given to developing patient case-mix costing and planning (including experiments with diagnosis-related groups—DRGs) (DHSS 1986). Various sites in acute hospitals and community health units were selected for this

revised programme, with the expectation that more Health Authorities would adopt and adapt RM in due course. Fifty hospitals were subsequently added to the original six, and after the 1989 White Paper the government proposed the extension of the Resource Management Initiative to a further 260 hospitals.

In order to appreciate the importance of the changes contained in the RMI, and their implications for medical autonomy, we must look in more detail at how RM has been developed. One management consultant has observed that the emphasis had shifted away from CB towards an approach which gets clinicians to examine their clinical practice more critically. The aim was to improve effectiveness and efficiency, and this required giving information about case-mix on a DRG basis, rather than merely comparing actual with budgeted expenditure (Prowle 1988). Different ways of doing this are being attempted. One RM experiment in South Lincolnshire Health Authority gives valuable insights into current practice, and it is useful to examine it here at some length (Flynn and Roberts 1988).

There, according to the local project managers, efforts were made to construct a budget system which recognised cross-charging between different services, diagnostic and facility departments, and which linked this with the 'frontline users', the medical staff, so that they were charged for the services and resources used as a result of their clinical decisions. Each department in a hospital was regarded as a business unit within a group (the hospital). A business unit (for example, radiology) buys services (staff and/or materials) and sells them to users of that department (for example, consultants requesting X-rays). By using standard costs, variations in efficiency, volume and price can be measured. The project managers noted that MB did not produce caseload information for consultants or nurses, and this deficiency made it difficult to persuade them to become involved. However, it did facilitate the production of better clinical and cost information, which was then used in the new RMI. Medical and nursing staff were now routinely provided with relevant data about resource use.

Having established patient categories which reflected clinical perceptions and type of treatment, the use of resources by clinical category could be measured. For nursing staff, this allowed nurse managers to devise and change patient care plans and patient dependency ratings, and helped in setting staff rosters. A computerised case-mix database held all information about patient activity, operating theatre, pathology, X-ray, pharmacy, physiotherapy and occupational therapy and other services, as well as nurse management, and was linked to individual patients. Thus a continuous picture was built up of the treatment a patient received, and the costs incurred at each stage, using clinically defined

patient groupings which could be converted into DRGs. According to this experiment's project team, RM is essential in order to use existing resources more efficiently, and nurses and clinicians will be able to take more informed 'management decisions', leading to better quality patient care (Flynn and Roberts 1988).

This returns us to the issue of professional discretion and managerial constraint. According to the one-time Director of Financial Management in the NHS Management Board: 'The resource management programme is principally about changing attitudes and encouraging closer team work in managing resources among patient care professionals and between such professionals and other managers' (Mills 1987, cited by Ham and Hunter 1988:18). At a national conference, a Unit General Manager from one of the original 'pilot' sites stressed that RM was about gaining the commitment and involvement of people, changing the organisation's culture, and extending the Griffiths style of management (Davies *et al.* 1989). Ham and Hunter have argued that whereas MB was more narrowly concerned with expenditure, RM is more broadly concerned with 'making doctors more management conscious and accountable for the resources they use' (Ham and Hunter 1988:19). It is also intended to produce accurate information for clinicians to compare their practices and costs with colleagues in their own hospital and elsewhere.

However, in their review of evidence about progress so far, Ham and Hunter note that clinicians have not been completely won over: their commitment and support for RM is variable and weak. Further survey evidence indicates that hospital consultants are often cynical about and critical of CB and RM. They are extremely sceptical about the accuracy and validity of data; they suspect that the primary objective is cost-cutting; they do not have the time (or sometimes the training) to evaluate the information; and there is a fundamental objection to moves to allow managers to discuss clinical workloads (Pollitt *et al.* 1988:226).

Evidently, then, all the different schemes, under different rubrics—Clinical Budgeting, Management Budgeting, Resource Management—have encountered major problems in securing the changes in attitude, behaviour and culture that their advocates promote. The enduring issue is that of clinical autonomy versus managerial control. All of these experiments and initiatives necessarily involve significant changes in the role of hospital doctors, and each of them requires the incorporation (and possibly subordination) of professional medical staff in the management process. Not only are doctors faced with information about their clinical activity, the resources used and their costs, but they are now invited to take an active part in evaluating cost-effectiveness, and making trade-offs between alternative activities.

For some, possibly the majority of doctors, financial and resource considerations are of secondary importance: their priority is to provide the best available treatment for their patients. If they become actively engaged in resource allocation and budgetary decisions, this certainly involves a change in the traditional boundary between professional clinical freedom and bureaucratic line management. Accepting responsibility for a limited budget means precisely that: clinical decisions must be made in the full knowledge of financial and resource constraints. Ultimately, if all the resources budgeted for are consumed, then the medical staff must stop providing services. The criteria for medical or surgical intervention remain valid, but they are no longer the only, or dominant, criteria in medical decision-making. Doctors thus become accountable not just for the treatments they authorise, but also for the spending which results from those treatments.

For many clinicians there is a dilemma. If they accept the validity of RM and similar programmes, and become actively involved in their implementation, they *may* be able to 'optimise' resource use through more 'rational' planning and perhaps improve their clinical practice. They might also be enabled to make claims for *more* resources. But in doing this, they thereby open up the entire sequence of medical decision-making to inspection and questioning by non-medical managers. Decisions about admission, about length of stay, about operations and other treatment required, and so on, can be subjected to professional peer review, or clinical audit. But because there is a continuing preoccupation with cost-effectiveness and efficiency (and especially variations between consultants in the same specialty in one hospital, or between hospitals, or between Health Authorities) clinical audit may become subsumed by financial auditing and scrutiny by managers. RM is thus a platform for possible managerial intervention in clinical practice, and can be linked with medical audit, because efficiency and effectiveness cannot be assessed without some evaluation of quality, and outcomes.

We shall examine this in more detail below when we consider medical audit separately. However, it is worth noting here that government policy treats medical audit as one element in an overall strategy to secure greater efficiency, and assumes that managers will attach more weight to it in future. In the 1989 White Paper, *Working for Patients*, great importance was given to the need to develop a comprehensive system of medical audit to cover primary health-care, community health services and the hospital sector. Audit was necessary, it was argued, to provide doctors, patients and managers with reassurance that the best possible quality of service is achieved within the resources available. However, while the practice of medical audit was regarded as essentially a professional matter,

'management too has significant responsibility for seeing that resources are used in the most effective way', and managers would therefore need to ensure that the system of audit was effective (Department of Health 1989: Working Paper No. 6, 6).

Budgeting, therefore, in all its forms, represents an arena in which the struggle for professional control is most contentious, because it is inevitably linked to the assessment of value for money, effectiveness, and therefore the evaluation of outcomes. For example, one consultant in charge of a departmental budget in one of the CB pilot schemes observed that although new budgeting systems would be used to challenge clinical working practices, at the same time they could also be used by consultants to exercise more influence on the allocation of resources (Elvin 1986). There were, he suggested, clear incentives for consultants to co-operate: clinicians are directly involved in setting the budget, can influence other resource allocation in other departments and services, and may have the possibility of *virement* to redeploy savings. There were also important constraints: the fact that some important elements of the budget are not within clinicians' control, and that clinicians might have to share budgetary responsibility with non-medical colleagues, were undoubted disadvantages.

From the perspective of one DGM, the purpose and implication of CB and RM were straightforward: the work of clinicians is an integral part of the management process, and doctors must share the responsibility and accountability for resource allocation. For this manager, clinical requirements, 'while still shaping the service, can no longer be considered as paramount and inviolable. *They become negotiable in the way that all objectives are*' (Kaye 1986:180: my emphasis). Here then we see clearly that CB and its derivatives can function as a means of inserting bureaucratic modes of control into spheres formerly characterised by professional dominance.

Such views about the subordination of clinical freedom to organisational and resource constraints have now become the established orthodoxy for government and NHS management. The House of Commons Social Services Committee's report on the future of the NHS gave strong support to the extension of RM (Social Services Committee 1988b). It was noted that there was often mistrust between doctors and managers, particularly because consultants were used to being in complete charge of patient care and were free to diagnose and prescribe treatment without considering resource implications (paragraph 40). However, the committee argued it was now necessary to question doctors' right to commit resources without regard to NHS funding constraints. Doctors should be involved in management decisions about the allocation of resources, and be accountable to Health Authorities and managers for the use of those resources. The co-ordination

of CB and RM was necessary to obtain better use of resources, and this required the full participation of doctors (paragraphs 69 and 199).

Two issues had to be tackled if NHS resources were to be used more effectively, the committee argued. Better means of costing treatments and procedures, and measuring outcomes, had to be evolved. But more fundamentally, 'doctors' hitherto virtually untrammelled freedom to determine treatment has to be recognised to be a recipe for potential inefficient use of resources and…clinical freedom, in the absence of accountability, is not necessarily in the best interests of either individual patient or health services as a whole' (Social Services Committee 1988b: paragraph 191).

This argument is now taken for granted in government policy, and is reflected in most of the current RM projects. The first purpose of the RM initiative listed by the NHS Director of Resource Management was to demonstrate 'how doctors and nurses can be involved *such that they are committed to the management process, responsible for their use of resources and able to take better decisions regarding service quality and patient care'* (cited in Social Services Committee 1989, paragraph 2,51; my emphasis).

In the RM initiative pilot sites, experiments are underway not just to evaluate computer systems and databases, but also to try different ways of linking doctors with management roles. In some Districts, doctors are also part-time UGMs; in others, consultants become 'medical managers' in charge of a specialty, or clinical sub-unit managers. Guy's Hospital, London, is recognised as one of the leading pioneers of RM and devolved clinical management. Following severe financial crises in the mid-1980s and cutbacks in services, Guy's consultants decided to take a greater part in the management of the hospital. Clinical directorates were created, with nurse managers and business managers under the control of doctors, and each clinical director became wholly responsible for service provision, costs and medical audit.

The Guy's endeavour is now often held up as an example for other NHS Units to emulate, but it has not been without its problems. Ham and Hunter (1988) have noted that clinical directors have not been able to exercise full management control over their consultant colleagues. Community Health Council representatives have complained that although Guy's system of devolved clinical management and budgets have provided useful financial and management targets, objectives and outcomes in terms of patient care have been neglected (O'Kelly 1989). An observer with detailed knowledge of Guy's Hospital has argued that the basis for the organisational changes at Guy's is the acceptance that one person must be responsible for keeping the cost of service provision within the annual cash allocation. However, there

are continuing difficulties with the clinical director role: ambiguity about whether this is a representative, or executive function; problems in representing a wide range of clinical specialties and medical services; and the disjunction between the formal status of directors and the high levels of informal power and influence in the organisation (Mumford 1989).

Thus the attempt to introduce bureaucratic management in medical organisation continues to be problematic. This is particularly significant for the implementation of the 1989 White Paper proposals, as discussed in Chapter 7. Following the announcement of plans to introduce self-governing hospitals and an internal market in the NHS, the government also decided that the Resource Management Initiative should be accelerated and extended to other areas.

However, these plans encountered criticism from Health Authority managers and doctors because information technology and expertise were still inadequate, and medical staff commitment was variable (Moore 1989). Consultants' representatives criticised the enlargement of the RMI: it had not been evaluated, costed, nor shown to improve patient care, so was 'counter-productive' and likely to antagonise medical and nursing staff.

In April 1989, leading consultants at five of the six major pilot sites for RM wrote to the Health Minister protesting at the linkage of RM with government plans for self-governing hospitals. These consultants were in effect complaining that RM was being used as a 'Trojan horse' by government to introduce self-governing hospitals, and they were angry that their original agreement to participate in the scheme was being regarded as support for self-government (see Social Services Committee 1989, paragraph 2.55).

Their fears were probably well founded. For the NHS internal market to operate, there must be a fully developed costing system to price contracts, and managerial capacity to rationalise the hospital production process—resource management potentially provides one of the the necessary instruments. This was recognised in the 1989 White Paper (Working Paper 2) and re-emphasised by the Social Services Committee (1989: paragraph 2.49). RM is a precondition for itemising costs reliably, and for fixing prices, both of which are necessary for the internal market to work, for providers and purchasers buying and selling services.

Uncertainty about the practical feasibility of RM, and concern about the lack of medical professionals' commitment to it, continued to be reported in 1989. An evaluation study conducted by researchers at Brunel University concluded that in the six original RM pilot sites, there was no evidence that the new information would improve efficiency or benefit patient care. Service providers (that is, doctors, nurses and paramedical staff) were described as remaining agnostic, and the researchers pointed to the need for local politically powerful 'champions' to promote RM and

the changes in organisational culture necessary for its implementation (Millar 1989). The House of Commons Social Services Committee's report on the 1989 White Paper fully endorsed the RM initiative, but noted a number of problems with the scheme so far, particularly difficulties in getting staff commitment. The co-operation of doctors was said to be crucial, and likely to be forfeited if RM was perceived by them as a management tool to contain costs and establish costing and billing systems (Social Services Committee 1989: paragraphs 2.49–2.64 and 3.4).

Notwithstanding these difficulties, the RM initiative remains an important part of the current restructuring of the NHS. An investment of £43 million was allocated in the 1989/90 NHS budget, mainly to provide comprehensive computer information systems, and the government is unlikely to be diverted from its intention to secure the widespread diffusion of RM. As noted above, data on workload, costs and resource consumption are needed not simply to monitor medical productivity and efficiency, but will also be essential in the negotiations between providers and purchasers in the marketised NHS.

DIAGNOSIS-RELATED GROUPS

With or without an 'internal market', the measurement of output, and more importantly the measurement of outcomes, has become acknowledged as vital by those concerned with estimating the effectiveness of health services. In order to compare the performance of doctors or hospitals for comparable types of work—an objective shared by those who wish to promote professional peer review and clinical audit, as well as those interested in cost-containment—some method must be agreed for describing the types of cases treated, and their complexity or severity. 'Diagnosis-Related Groups' (or DRGs) are one means of doing this, but, it will be argued, they also comprise another mechanism for the imposition of managerial control on medical autonomy.

Basically, DRGs are a way of classifying acute hospital patients in terms of their diagnostic characteristics. DRGs were originally developed in the United States, first to define more precisely the output of a hospital, and secondly, as a device to standardise costs for reimbursement in the federal Medicare programme. Although they are quite well established in the USA, DRGs are still the subject of investigation and development in Britain. Currently there are 467 separate DRG categories based on clinical definitions of diagnoses, surgical procedures, patient's age and sex, and condition on discharge. Each group therefore contains patients with similar diagnoses and treatments, and similar workload and pattern of resource use.

DRGs are especially interesting to those wishing to monitor and reduce costs, because they provide a *standardised* unit for comparing the output and unit costs of different clinicians and hospitals. Simple statistics about hospital admissions or treatments do not give realistic descriptions of clinical workload. Within and between specialties there are variations in the severity of patients' conditions and complexity of treatment ('case-mix') which determine resource use, and thus costs. DRGs permit detailed assessment of the effects of case-mix on output and resources; information about costs per case is made more meaningful by referring to differences in the type of case treated. In the USA, hospitals claiming reimbursement under the government Medicare programme after 1983 were paid a fixed price for each DRG. If their actual costs were less than the standard DRG cost (price), they retained the surplus; if not, they were forced to review their efficiency and become more cost-effective.

According to one of the originators of the DRG system, it became evident in the 1960s that hospital productivity could be enhanced if hospitals adopted industrial control methods conventionally used in manufacturing industry. The problem, he argued, was how to define hospital 'products' operationally. DRGs provided a way of doing this in a clinically coherent way, and they also enabled hospital clinicians and administrators to think in terms of product selection and design, cost accounting and quality control (Fetter 1987). The use of DRGs in the USA is reported to have led to a fundamental change in the management style of acute hospitals. Fetter claims that DRG-based payment has stimulated managers to think about the use and cost of hospital services in terms of a 'product-line approach'. Doctors are expected to act as product managers producing a package of services for patients, and are responsible for the resources used, therefore they are required to be accountable for their output, and must be able to justify variations in expenditure compared to standard costs/tariffs.

It is important to look in more detail at the context within which DRGs were introduced in the USA. The federal government, in the face of rising inflation in hospital expenditure, adopted a prospective payment system based on DRGs. Hospitals were only paid according to a predetermined fixed price for the 467 DRG categories, despite opposition by the American Medical Association, which objected to the rationing of medical care on grounds of cost control. Nevertheless, the system was implemented, and linked with a new set of arrangements for professional standards review organisations to monitor clinical practices and treatment patterns. According to commentators, the government's objective, and the result, was simply cost-cutting. DRGs were an essential device in reducing the technical autonomy of physicians, and thereby placing a limit on medical spending (Bjorkman 1989; Dohler 1989; Harrison and Schulz 1989).

According to Margaret Heckler (then US Secretary of Health and Human Services), DRGs were necessary devices to deal with rising expenditures caused by open-ended reimbursement of hospital costs. In her view the DRG-based prospective payment system had reduced costs because there was a reduction in hospital stays, less use of ancillary services, better co-ordination of inpatient care, faster throughput and earlier discharges. This was achieved, she claimed, without any decline in the quality of patient care (Heckler 1986).

Other US commentators are less sanguine. Bradford, for example, stresses that the real purpose of the Medicare DRG system was simply to reduce the rate of increase of government's payments to hospitals, without reducing the coverage of the Medicare programme. It succeeded in cutting payments, but, Bradford argues, at the expense of lowering the quality of services to all patients. Diagnosis related groups 'transform a hospital from an entity perceived as a conglomeration of tests, rooms, and services, to an entity that provides very specific products' (Bradford 1986:184).

These products (DRGs) are treatments of cardiac arrests, respiratory problems and so on, with assumed levels of resource use. Doctors are under pressure to produce 'competitive' service lines, by reducing their operating costs to below the standard or average DRG cost, and by expanding 'profitable' DRG procedures. Rosko and Broyles also claim that the Medicare DRG structure penalises those hospitals with higher-than-average intakes of severely ill patients, and that the financial system may reduce access to services and use of services once admitted (Rosko and Broyles 1986).

DRGs are thus inevitably linked with cost-containment measures, and with monitoring performance. Using DRGs, over a period of time a profile of typical or average resources and costs can be built up. Doctors can be asked to specify the medical, nursing, paramedical staff time, diagnostic tests, drugs, theatre time and length of stay for particular DRGs, and standard treatment costs can then form a baseline for budgeting and service planning. 'Discrepancies' between actual and standard resource use, and variations in treatment procedures, can be identified. It is largely for these reasons that in Britain DRGs have recently been associated with CB and RM because they appear to permit accurate and reliable bases for estimating workloads and spending, and for 'pricing' cases (see Perrin 1988; Sanderson 1987; Wickings 1987).

They can also be used in debates about priorities. Bardsley and Coles have suggested that DRGs, in conjunction with CB, can help managers when they have to arbitrate between competing claims for resources, and when trade-offs between service provision for different patient groups must be made. For example, in discussions of waiting lists for elective surgery, case-

mix and DRG information would be valuable in comparing the resource implications of different treatments, and for comparing local performance with regional or national norms. For Bardsley and Coles, DRGs would be helpful in making more rational choices over whether, for example, more hip replacements should be carried out, and other forms of elective surgery given lower priority. General Managers in Health Authorities, it is suggested, can use DRG-based data including costs, to discuss changes in the level of provision or type of treatment (Bardsley *el al.* 1987).

Diagnosis-related groups thus have enormous appeal to managers and third-party payers for medical services because of their potential versatility and because of their seemingly objective, technical nature. As some of their proponents have correctly observed: 'The description offered by DRGs can be used both as a vocabulary for determining the range and volume of care the hospital should provide and for monitoring performance against desired organisational goals' (Bardsley *et al.* 1987:162). DRGs therefore provide a kind of algorithm which facilitates direct managerial assessment of clinical output and resource use, and which provides a benchmark for extra-professional scrutiny of clinical activity.

In addition to their function in cost-containment, and external bureaucratic surveillance, DRGs can also be used in internal professional peer review of clinical practice (medical audit) and as a possible basis for 'quality assurance'. This is yet another important development in the apparatus of formal regulation and inspection applied to medical practitioners in the acute and primary care sectors, and another example of the changing nature of the structure of control.

MEDICAL AUDIT

Medical interventions in human life can be enormously beneficial, or potentially disastrous. The history of the professionalisation of medicine demonstrates a continuing struggle over who should confer the licence to practise, and how practitioners should be educated and regulated (see Freidson 1970; Larson 1977; Stacey 1988). The issue is in fact vital—deciding whether an occupation should be permitted to make decisions which may improve, or injure, clients' health, and creating a framework of rules and procedures to outlaw charlatanism, promote good practice, and punish unethical and incompetent behaviour. Medicine has become increasingly affected by scientific, pharmacological and technological advances, and more people experience (and demand) medical and surgical treatment, but the likelihood of mistakes does not diminish. Indeed, with the growth of medical consumerism, litigation and the recognition of 'iatrogenic' illness, doctors are now more open to challenge over their

diagnoses, and the outcomes of treatment, and are having to confront the consequences of 'medical errors' (Richman 1987).

It is in this context, as well as the pressures for cost-containment and improved efficiency, that the medical profession has had to deal with demands for 'audit' and 'quality assurance'. Patients, managers and governments (and, presumably doctors) are seeking confirmation not just that the health service has treated more people, but that it has done so successfully, and/or provided primary, preventive and community medicine which removes or reduces the need for acute and inpatient care. Health is about outcomes and not just activity levels, and therefore more attention is being given to the measurement of benefits achieved by medical intervention, and to assessment of the *relative* advantages of different forms of treatment, and their value for money.

According to Maxwell (1985), compared to the United States, in Britain the medical profession has been slow to adopt a formal system of medical audit, and current arrangements are arbitrary, fragmented and incomplete. There are a number of different mechanisms for assessing the quality of medical care in the NHS. The Royal Colleges and professional bodies inspect educational and training institutions, and specify standards of practice for accreditation. There is a Health Advisory Service and national development team which inspect hospitals, particularly long-stay institutions, and advise the Minister about necessary improvements. A national quality-control scheme for bacteriology, haematology and pathology laboratories maintains a constant check on analysis procedures and tests.

Nationally and locally, performance indicators allow for comparisons of hospital activity, outputs and waiting-lists. The Royal College of General Practitioners set up an auditing scheme in 1980 to define and evaluate standards of primary care. There is a long-standing reporting system for monitoring maternal deaths—the Confidential Inquiry into Maternal Deaths. Finally, under the auspices of the medical services group of the Royal College of Physicians, since 1977 a series of investigations has been carried out into 'avoidable deaths', and recommendations made for improving practice.

It is widely known that among some medical professionals there is suspicion about, and criticism of, attempts to inspect and evaluate their activities, even by their professional peers. The question is whether informal collegial discussion and criticism should be transformed into a formal auditing system, and whether such a system might impose inappropriate conformity and standardisation, so undermining the doctrine of individualised treatment of every patient (see Alment 1981). To date, reliance has been placed on voluntary, informal and confidential studies, without sanctions for 'poor

performers': description of anonymised and general deficiencies or weaknesses is believed to stimulate better performance.

However, accounts of some medical audit studies (in various clinical specialties, psychiatry and primary care) have shown not merely the very great methodological and technical problems encountered, but also considerable unease among doctors about the purpose and effects of audit. Dollery concluded his study of deaths due to malignant hypertension by indicating possible improvements in clinical and general medical practice, but pointed out that the two major British medical journals were unwilling to publish the research results, from which he inferred that the profession was not interested (Dollery 1981). One of the reasons for this reluctance to discuss audit and quality publicly may indeed be doctors' unwillingness to countenance what McColl advocated in his study of clinical outcomes—the development and application of national standards for measuring and comparing performance (McColl 1981).

In the face of doctors' anxiety and caution about the impact of medical audit, hospital physicians have none the less been encouraged by their professional body to establish regular reviews and meetings to analyse all the factors relating to the death of patients, and to participate in routine self-assessment and internal peer review (see Clarke and Whitfield 1981). Medical audit, then, is basically regarded as a matter of professional pride and continuing education and training. Outright malpractice and negligence are presumed to be detectable by conventional means, and subject to customary professional investigations of complaints, civil legal actions and, if relevant, criminal prosecution. As more audit studies and schemes have been set up and reported, and as the medical professional bodies have recognised increasing threats to impose auditing, resistance has been waning.

There are, as we have already noted, various alternative forms and methods of audit. Indeed there is some confusion over terminology: clinical audit, medical audit, peer-group review and evaluation. It seems generally agreed that it (or they) comprise regular systematic study and critical analysis of patient care by doctors. According to the 1989 White Paper *Working for Patients:* 'Medical audit can be defined as the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient' (Department of Health 1989: Working Paper 6, 3).

Ham and Hunter (1988), in discussing the raising of professional standards, have given a useful summary of many of the most important recent attempts at audit in the NHS. Among the examples they cite is CEPOD— the Confidential Enquiry into Perioperative Deaths. This study,

started in 1986 by the Royal College of Surgeons and Association of Anaesthetists, investigated all deaths occurring within thirty days after surgery, in three English regions. Doctors prepared reports on each of these deaths, and these reports were then independently examined by professional experts, who determined cases of 'avoidable' deaths, and identified factors contributing to them. Recommendations for improvements in clinical care were then made. Subsequently, CEPOD was extended to all the English regions.

Internal clinical review, as another description of medical audit terms it, has several components (Black *et al.* 1989). It is voluntary, confidential, involves only medically qualified professional peers and does not entail sanctions. Medical standards for practice should be defined and actual practices should be compared with these standards: changes would then be made to bring current practices up to standard.

However, as Black and his colleagues argue, there are a number of difficulties with this approach. First, methodological problems: medical interventions consist of complex and multiple procedures, and the results of treatment are affected by the patient's age, the stage of illness and disease, and presence of complications. Isolating the exact causes of changes in a patient's condition, and measuring the effect of interventions on eventual outcome, is extremely difficult. Second, and consequently, setting standards and obtaining agreement for clinical protocols, is contentious, both technically and politically within the professions. Third, many clinicians are suspicious of audit, because the data are sensitive; because audit requires a change of attitude to allow questioning by peers; and because some doctors perceive it as a threat to their independence, especially by managers.

Nevertheless, the pressure to introduce and extend formal medical audit has increased, despite (or perhaps because of) signs of indifference or opposition to it among doctors (see Ham and Hunter 1988). The most significant aspects of this pressure are that it is directly linked to concerns about cost-effectiveness, and that it implies disquiet with internal self-regulation. Medical audit constitutes one of a series of measures which can be used to subject the medical profession to external control, and for making clinicians justify their use of resources in relation to quality of outcome. This is very evident in recent parliamentary reports on the NHS, and in the 1989 White Paper.

For example, the Social Services Committee Fifth Report (1988b) stressed that it was vital to assess performance, through peer review and self-audit *and/or by appraisal by management,* when monitoring quality and standards of medical and nursing care. The report commented on the slow progress of appraisal so far, and argued that the capacity to audit the process of health

care (how the treatment is provided) and its outcome (benefit to patients) was required urgently (1988b: paragraph 57).

It went on to make a direct connection between medical audit (and quality assurance) and improving the use of resources. Measurements of effectiveness and patient outcomes are regarded as indispensable if more rational means of resource allocation and use, such as Resource Management, are to be attempted, as the committee recommended (1988b: paragraphs 192–198). Moreover, the committee doubted whether the issue of audit and quality was best left to internal medical debate, and suggested the formation of national or regional Peer Review Organisations (to provide independent verification of performance standards and outcome evaluation) as well as other forms of accreditation to ensure conformity with good practice.

Similar views were more forcibly expressed in the *Working for Patients* White Paper (Department of Health 1989:39–41) and the supporting working paper (no 6) on medical audit. In the former, the government expected that by 1991, all hospital doctors should take part in medical audit. Ensuring that the quality of medical work meets acceptable standards as defined by peer review of practice was acknowledged as Essentially a professional matter'. While accepting that medical audit was based on the principle of peer review, the government nevertheless stressed that Health Authority managers were responsible for ensuring the effective use of resources, and that management had a responsibility to ensure that medical audit became firmly established at local level.

The specific requirements were that every consultant should take part in some form of audit agreed locally between managers and the medical professions. Local medical audit advisory committees, chaired by a senior clinician, would run this system, but District managers would review the committees' work regularly and frequently. In addition, although the findings of peer reviews of particular cases would remain confidential, 'general results' would be available to local management, and 'lessons learned' would be published widely. Moreover, local managers were to be empowered to commission *independent* professional audit, 'for example where there is cause to question the quality or cost-effectiveness of a service' (*Working for Patients*, paragraph 5.8).

The Working Paper enlarged on the government's reasons for medical audit, and gave more details about how it was to be implemented. Starting from the premise that the primary concern for any patient is that a correct diagnosis should be made and effective treatment provided, medical audit was deemed to be central in any programme to improve the quality of patient care. Audit would also reassure doctors, patients and managers 'that the best possible quality

of service is being achieved *within the resources available*' (Working Paper No. 6, 3; my emphasis). Although the detailed work of medical audit was a professional responsibility, general results must be examined by local managers 'so that they may be able to satisfy themselves that appropriate remedial action is taken where audit results reveal problems' (*ibid.:* 6).

A 'proper organisational framework' was deemed necessary in order to carry out medical audits systematically, within both the District Health Authority and the Family Health Service spheres. Different arrangements were suggested for hospital and community health services, and primary care, and amendments to consultants' and GPs' contracts were proposed, to ensure their participation in local audit schemes. As a further stimulus (or sanction), it was noted that in the new internal market, arrangements for audit would be taken into account in allocating contracts between self-governing hospitals, and in making contracts with GPs. The Working Paper concluded by observing that the government did not underestimate the challenge likely to be faced in making these major changes, and anticipated substantial discussion and negotiation with various representative bodies in the medical profession and with other interests.

In its response and commentary on the White Paper, the Social Services Committee gave its strong support to the government's plans for medical audit, but criticised the conflation of clinical audit with value for money audit (Social Services Committee, Eighth Report 1989). In doing so, it highlighted a possible tension between between objectives—between high quality care and lowest possible cost, and between medical professional and managerial interests. The committee argued that these might not be mutually exclusive, but that there were potential conflicts.

This view is predictably optimistic, but it is mistaken, because it implicitly denies that there is an inevitable conflict between fundamentally contradictory, irreconcilable interests. Referring to evidence from two medical professionals concerning the 'confusion' between financial and medical concepts of audit, the committee urged that the government should make medical audit more explicitly focused on procedures, standards and outcomes of treatment. This, it was believed, might provide some reassurance to clinicians, and secure their enthusiasm and support. The committee recognised that 'to some extent quality of care is dependent on the resources available' (*sic; ibid.:* 26), and hoped that doctors' involvement in resource management would improve their awareness of cost-effectiveness. Medical accountability in the future, the committee argued, would also be improved through linking the systems for medical audit and resource management.

But this view assumes that clinicians are predisposed, or can be persuaded, to consider value for money in resource use when making clinical judgements and decisions. In practice, NHS doctors' have always had to provide services within a constrained budget, and implicit rationing has occurred. However, their decisions on diagnosis and treatment have been regarded as *entirely* a matter for professional judgement—clinical autonomy—and any moves which restricted their freedom to decide how to treat patients would be regarded as an unacceptable interference with their professional prerogative (see Harrison and Schulz 1989). Medical audit by itself represents a considerable extension of peer control over doctors, which may or may not be accepted willingly, but its linkage with cost-control and managerial inspection of cost and quality in outcomes poses a significant threat to clinical autonomy, as argued in Chapter 2.

CONCLUSIONS

It is clear from this discussion of medical audit, RM and DRGs that recent and current government policy has tried to make cost-efficiency a central part of medical decisions. As Ham and Hunter (1988) have pointed out, improved quality of patient care is necessary, but another aim of audit must be to reduce unnecessary or inappropriate practices to avoid wasting scarce resources: 'efficiency as well as quality is thus a *key* aim of audit' (Ham and Hunter 1988:10; my emphasis). However, there are likely to be prolonged disputes about how medical audit schemes will be implemented, and how far they intrude on traditional professional autonomy. Although ostensibly professionally driven, medical audit facilitates the extension of local managerial and central bureaucratic control over the delivery of services, and will form a main axis of conflict in the reorganised NHS.

Clinical budgeting, resource management, diagnosis-related groups and medical audit all represent important attempts to introduce new, or strengthened, methods of control and regulation of medical activity, premised on rational-economic and calculative approaches to efficiency in resource allocation. Second, they all entail, explicitly or implicitly, doctors' recognition and acceptance of their *managerial* responsibility. In the Griffiths model of general management, doctors are the 'natural managers' of the health service, and must take individual responsibility for resource use and expenditure arising from their actions. Clinical budgeting and resource management are extensions of this principle, and both are based on the assumption that clinical freedom must coexist with management accountability. All the other recent schemes have stressed the necessity for doctors to become committed to the management process, to view their clinical activities in the broader 'corporate' context, and to

adopt tools and techniques which might enhance productivity and permit evaluation of performance.

Third, all of these developments have a common concern with changing the traditional form of professional accountability. If they are successful, then they will achieve a substantial shift in the balance of power away from professional domination in favour of managerial control. With clinical budgets, resource management, DRGs and medical audit, the conventional monopoly enjoyed by individual doctors to determine the content and scope of treatment for patients is weakened, perhaps even removed. There are two dimensions to this: the kinds of criteria used in medical decision-making, and the types of actors involved in making and monitoring those decisions.

Hitherto, doctors have claimed that the only (or at least the primary) criteria governing medical interventions were based entirely on professional judgements about clinical need. Recent policies, however, have continually insisted that doctors must give greater, or equal, consideration to costs and resource constraints, and made it clear that organisational and managerial objectives are expected to impinge directly on individual medical decisions. The change in 'organisational culture' demanded by general management is intended to lead to a change in doctors' frame of reference, so that they fulfil their obligation to manage resources effectively.

Professional discretion or clinical freedom is no longer an accepted privilege, but is now to be made more open for external monitoring. The effect of all the measures described above is to make clinical activity and medical working practices open to scrutiny and challenge, not only by other medical professionals, but also, more importantly, by health-service managers and central government. Clinical work thus becomes *negotiable* at all levels of the NHS organisation, in contrast to traditional arrangements, in which the medical professions dominated all or most aspects of policy-making and resource allocation.

Although medical audit is regarded as 'essentially' a professional matter for peer review, it is nevertheless evident that managers are to be involved in approving local audit systems, and evaluating the results of enquiries. The development of clinical guidelines and protocols may lead to increased standardisation of treatment, but this also allows extra-professional interests to attempt to enforce stricter compliance with organisational goals and performance objectives, and begs the question of how the cost-quality trade-off is to be made, and by whom.

There are, of course, two counter-arguments which need to be considered. The first is that medical professionals' dominance will not be undermined by these managerial measures, because clinical work is extremely complex and subject to great uncertainty, and therefore inherently difficult to control

and plan, especially through bureaucratic regulation. Moreover, doctors may be able to evade controls on their performance, not least because of the technical difficulties in obtaining and evaluating information on procedures, costs and outcomes. This is an empirical question on which evidence is awaited. In the meantime, NHS doctors will encounter increasing efforts to co-opt them in, or subject them to, hierarchical line management and accountability.

The second point is that the discussion here may have exaggerated the importance of professional notions of 'clinical freedom'. It can be claimed that this aspect of professional autonomy is a myth, because NHS doctors have always worked within limited and often rigid budgets, and that the measures described above simply change their informal practices of 'implicit rationing' into explicit and formal mechanisms. There is some strength in this argument, but much depends on how the constituent elements of clinical freedom are defined.

The important sociological questions here are not whether rationing occurs, but what form of rationing, with what criteria, and which interests and groups are involved? From this standpoint, clinical budgets, resource management, DRGs, and medical audit do facilitate increased managerial intervention in and bureaucratic surveillance of activities (including rationing), which were formerly the domain of medical professionals. How this will affect rationing, the pattern of service provision, and the position of doctors in policy-making and resource allocation, remains to be seen. Moreover, rationing and the efficient use of resources is not the only focus of managerial concern: there has also been increased managerial determination to influence service performance, quality and standards, as we shall see in the next chapter.

5 Assuring performance, quality and standards

The extension of financial and management controls to clinical practice reviewed in Chapters 3 and 4 is clearly part of a much broader and more long-term attempt by successive governments to make public sector organisations more efficient. Central government departments, nationalised industries, local authorities and other welfare state agencies have faced continuing demands to improve their organisational structures, management arrangements and delivery of services. This began with the advent of management-by-objectives, planning-programming-budgeting, and corporate planning in the 1960s and 1970s. During the 1980s, amid economic crisis and government determination to 'roll back the state', the disciplines and procedures of private sector management were applied to many areas of government activity, not least to control and reduce public expenditure.

Concern with getting better value for taxpayers' money, and with allowing more consumer choice, led to various initiatives to reform paternalistic public bureaucracies and challenge professional monopolies. The emergence of performance indicators, the search for efficiency savings, the expanded role of the National Audit Office, and recent adoption of quality assurance methods in the NHS must be seen against this background. This chapter will examine some of these instruments and policies, and discuss their implications for the structure of control in health.

In order to appreciate the importance of these recent trends, it is first necessary to consider some of the major changes in NHS organisation, and to discuss the perennial issue of central control versus local delegation. We shall examine some of the main features of the NHS planning system, and other means for exerting influence on Health Authorities' service provision.

NHS ORGANISATION AND REORGANISATION

We noted earlier that since its foundation in 1948 the NHS has undergone two complete reorganisations and several major inquiries because of

continuing government concern about its functions, finance and effectiveness. It became evident in the 1950s that elements in the original tripartite structure were not collaborating very well, that acute medicine and the hospital services were expanding in an unplanned way, that other sectors of the NHS appeared to be slow to develop, that there were considerable regional disparities in provision, and that expenditure was significantly in excess of planned budgets. A *laissez-faire* regime had contributed to a lack of co-ordination and integration between different parts of the NHS, and to the relative neglect of certain groups and areas.

Various proposals to reform the system were made by Labour governments in the 1960s, focusing on the need to create area boards of administration to manage the multiplicity of local bodies, and to secure better liaison with local government, which was itself undergoing reorganisation. Although there was a change of party in government, the idea of creating regional and area level agencies was built into legislation, leading in 1974 to a reorganisation in which the NHS became administered by the Secretary of State through fourteen Regional Health Authorities (RHAs), ninety Area Health Authorities (AHAs) and 200 Districts (DHAs).

According to Allsop, the 1974 scheme was a logical culmination of central government attempts to increase control, improve efficiency and achieve national priorities and standards. This reorganisation, Allsop argued, represents the zenith of managerialism and was 'based on the notion of the essential unity of the NHS and [was] designed to transform it into a more efficient and effective service through a change in structure, the strengthening of management and the introduction of a planning system' (Allsop 1984:60).

In addition to seeking better co-ordination and integration, the reforms also introduced a strong emphasis on management and planning. Management consultants and operational researchers were influential in the adoption of new arrangements and procedures at each level. In each tier of the NHS, management teams (with strong representation from the medical professions) were to take responsibility for planning and policy implementation across the range of local services. Most importantly, the relationships between government and the Health Authorities were to be based on a principle of maximum delegation downwards and maximum accountability upwards. Within a framework which stressed the virtues of consensus decision-making and corporate management within local Health Authorities, efforts were nevertheless made to establish a vertical hierarchy of command.

A formalised planning system was set up in 1976—authorities were required to produce strategic plans and annual operational plans—linked to a government statement on policies and priorities for specific care-groups

and needs, and an allocation formula (RAWP) for redistributing resources between different areas and regions. Ham (1985) has argued that the NHS Planning System (as it was termed) appeared to be an attempt to challenge the dominant interests of acute medicine and hospital services, and was opposed locally by some medical professionals. This opposition was partly responsible for the move away from detailed targets and objectives towards general guidelines in the modified planning system adopted in 1982.

However, there were also more fundamental problems with the entire structure. There were many indications of dissatisfaction in operating the 1974 arrangements, and widespread criticisms of delays, administrative duplication and other difficulties. This coincided with a period of economic crisis, and industrial disputes involving ambulancemen, ancillary staff, and hospital doctors and nurses, and provided the impetus for a Royal Commission on the NHS, appointed in 1976 and reporting in 1979. The report criticised the cumbersome and complex 1974 system, and recommended simplification by removing one tier in the organisation. The incoming Conservative government accepted many of the recommendations for structural reform; following a White Paper, another reorganisation took place in 1982 (Klein 1983).

Area Health Authorities were abolished, and the day-to-day running of hospital and community services became the responsibility of 191 DHAs, while most primary care was to be administered by ninety local Family Practitioner Committees. The fourteen Regions retained their supervisory and monitoring functions, and the job of allocating centrally determined finance between DHAs. Accompanying these changes was a rhetoric of devolution or decentralisation—the Districts, and within them 'Units' (for example, large hospitals or groups of smaller hospitals or services) were empowered to carry out the planning, development and delivery of services within a set of broad central guidelines and cash-limited resources.

However, the balance between local discretion and central control was not simply a question of organisation or policy; finance became overwhelmingly important, and central government sought other means of exercising a constraining influence. As part of its broader project of reducing public expenditure, the Conservative government indicated that there would be low growth in NHS spending, and increased restraint on service development.

Local autonomy was to be limited through stronger mechanisms of monitoring and stricter accountability. The planning system was altered to give more emphasis to the achievement of costed proposals within specified time periods. Such District 'short-term programmes' were expected to include 'cost improvement' schemes to realise efficiency savings. In addition, and partly also in response to criticism by the parliamentary Public Accounts

Committee that there was insufficient ministerial control over NHS policy and expenditure, 'Accountability Reviews' were introduced (discussed below in more detail). After 1982, 'whilst policies related to more efficient use of limited resources were maintained or intensified, the emphasis on local autonomy and reducing intervention from the centre was abandoned' (NAHA 1987a:11).

PLANNING

The implementation of national policies by local Health Authorities has always been problematic, because of the diversity of local needs and variations in circumstances, and because local coalitions and pressure groups modify central objectives. One of the dominant concerns in various forms of planning in the NHS has been to obtain greater local conformity with ministerial goals and priorities, and greater consistency between different regions. The NHS Planning System, introduced in 1976, represented the first systematic attempt to introduce rational comprehensive planning, based on defined 'care-groups' or categories of need.

Centrally, the Department of Health issued guidelines about priorities and resources which local Health Authorities had to embody in their plans. An annual programme budget allocated expenditure between different care-groups: general, acute and maternity hospital services; primary care; services for the elderly; mental illness and mental handicap; services for the physically handicapped; services for children; and so on. Regions, AHAs and DHAs were required to prepare 'strategic plans' setting out their policy goals over a ten- to fifteen-year period, and detailed annual 'operational plans' indicating specific actions to be taken to achieve these strategic objectives and national priorities.

This approach was a product of the general application of PPBS (planning, programming, budgeting systems) in government, and is regarded as a clear example of an attempt to use the techniques and assumptions of rational-comprehensive planning (see Hambleton 1983, 1986; Lee and Mills 1982; Stolen 1982). It was to be rational in so far as it was based on evaluation of information about existing provision, and objective assessment of needs through a formalised set of procedures to evaluate alternative options. It was to be comprehensive in that the entire range of health-care client groups and needs were considered by planning teams.

In practice there were numerous difficulties, and important changes in the economic and political context, which led to its modification. There were problems in producing the strategies and operational plans due to inadequate skills, confusion and conflicts between authorities, and mismatches between strategies and operational, budgeted plans. In the

period of increasing restraint on public expenditure (cash limits were imposed in 1976), industrial relations problems, a Royal Commission inquiry, and subsequent change of government, official views about NHS planning changed. The 1976 system was criticised for being excessively bureaucratic and complex; it was recognised that priorities expressed in specific and quantitative terms could not be achieved uniformly; and it was tacitly accepted that national policy to shift resources away from acute hospital services to the 'Cinderella' services (the elderly, mentally ill, mentally handicapped) was politically and professionally unpopular (see Ham 1985).

Consequently, a reformed planning system became effective in 1982. National priorities were expressed in broad terms, without precise targets. DHAs were given the primary role in devising service plans: comprehensive operational plans were superseded by more limited 'short-term programmes'. Regions and Districts were still expected to produce a strategic plan covering perceived needs and expected developments over a ten-year period. However, District annual programmes were to specify actions to be taken in the next financial year, and planned developments for the following year. Regions would assess the aggregate of District proposals in making annual resource allocations, and evaluate their implications for Regional strategies and national priorities. One important element in this cycle of planning is continuous monitoring of subordinate tiers by superordinates, through the annual review process, discussed further below.

After problems with Health Authority overspending in 1987, modifications were made to strengthen such monitoring by linking the planning and budgeting cycle more closely, and to align Districts' service developments and expenditure with Regionally approved objectives (see National Audit Office 1989:11). These arrangements remained broadly unchanged until the government's proposals for an internal NHS market in 1989. The *Working for Patients* White Paper recommended changes in the basis upon which budgets and service plans are to be made, but their effects on planning are as yet uncertain.

ACCOUNTABILITY AND PERFORMANCE INDICATORS

The planning system after 1982 was to remain dominated by a 'top-down' approach to policy implementation, and by a particular concern with achievement and performance. From 1982, the government introduced a new procedure to ensure that Health Authorities at each level were pursuing national policies and objectives. 'Annual Review' meetings were held, at which the Secretary of State and senior departmental officials would discuss with RHA chairmen and senior officers their progress (or lack of it) in meeting

objectives. The Regional chairmen and officers would repeat this exercise with District chairmen and officers, and they in turn would review the performance of Units in each District.

The purpose of these meetings was to assess performance, and to agree a list of 'action tasks' for the coming year, with specific deadlines. They were explicitly designed to increase the accountability of Regional and District authorities to the Minister, and to Parliament (see Ham 1985; Rathwell and Barnard 1985). One paradoxical aspect of this pursuit of accountability has been that Health Authorities, or rather their members, have seen their policy-making role further reduced, and that of chairmen (and district administrators/managers) increased. Another was that, in contrast to developments in the planning system which moved away from prescribed norms, the Annual Review process increasingly focused on specific norms and targets for services (for example, staff numbers). The effect was to make the chain of command even tighter, to give government the capacity to supervise detailed implementation of local policies, and thereby to increase other trends towards centralisation of control (Day and Klein 1985; Stolen 1985). Accountability was thus explicitly defined in terms of local conformity with central directives.

However, in order to determine how far Health Authorities had achieved their objectives and complied with ministerial advice, some measurements of performance were necessary. Performance Indicators (PIs) were an integral part of the government's search for greater efficiency in resource use, and in strengthening its influence over local resource allocation and service provision. Like the review procedure, they were developed in response to severe (and repeated) criticism of the Department of Health by the Public Accounts Committee and other parliamentary committees, for failing to assess efficiency and monitor performance against objectives (see Committee of Public Accounts 1984: paragraphs 24–31; Klein 1982a).

Health Authorities were required to justify their activities not only because this was regarded as essential to maintain accountability and efficiency, but also because the government's overall economic and political strategy was geared to cost-containment and value for money. The first set of PIs (announced in 1983) were part of a 'centre-run exercise focused on a narrow, finance-dominated notion of performance' and were 'imposed from above' (Pollitt 1985:9). Planned public expenditure on health entailed a reduction in its rate of growth, so proposed developments in services would have to be funded from savings made through better productivity, using existing resources more efficiently. PIs would enable local managers to compare their Districts and Units with others, and identify areas where performance could be improved. The recurrent theme of official statements promulgating PIs was cost-control and efficiency (Allen *et al.* 1987).

So what are the NHS PIs and how are they used? Originally, PIs were devised by a group of academic researchers to examine variations in hospital services between areas of the country, but were then adapted and extended by the Department of Health and Social Security. Quantitative information, based on routine and specially collected NHS activity, cost and staffing statistics, was collated and analysed in order to show the position of individual District Health Authorities in relation to Regional and national profiles. Data on clinical activity, staffing, finance and estate management were categorised initially into seventy indicators, but subsequent work has yielded more complex and sensitive indices combined in a package of 450 PIs in 1988, and a possible 2,700 separate codes based on Körner information (Social Services Committee Fifth Report 1988b: paragraph 36; Social Services Committee Eighth Report 1989: paragraph 5.18).

Clinical indicators (on inpatient admissions, average length of stay, throughput, turnover interval, bed use, admission waiting-lists, and so on) are classified in terms of major hospital specialties (general medicine, obstetrics, general surgery, trauma and orthopaedics, gynaecology). Financial indicators include, for each type of hospital, cost-per-day and cost-per-case, as well as catering, cleaning and domestic costs. Staffing indices include numbers and ratios of different grades and types of medical and nursing staff by district. Tables of statistics show the position of specific Districts, and Units, relative to others, and are supposed to be used as a 'management tool' to prompt enquiry into the reasons for apparent 'anomalies' or extreme variations from the average. Statistical outliers are, in effect, regarded as deviant cases, and *prima facie* indications of possible inefficiency in resource use: 'If, for example, the district's average length of stay in a particular specialty were well above the national norm, suspicion would arise concerning the efficiency of performance' (Birch and Maynard 1988:52).

There is, not surprisingly, some discrepancy between the formal purpose of PIs, and their actual use. Although officially they were not supposed to be used to create a rank order or league table, but instead to stimulate close scrutiny of existing activities, the background to their introduction, and their implementation, suggests that PIs *are* being used as instruments of cost control, and to enforce compliance with national objectives through the ministerial-RHA, and RHA-DHA review process. 'Below-average' or 'above-average' performers, because they are 'atypical' for certain measures, will undergo particularly intensive investigation, and PI information may be used in decisions about future resource allocation.

Allen *et al.* (1987) have shown in their study of three Districts in one English Region that, contrary to original DHSS guidance, the Regional Health Authority explicitly used PIs to set targets for improvement, and

required Districts to explain progress or inability to meet such targets in the annual review meeting. This occurred although the Districts showed that some of the PIs were invalid because they did not compare like with like, and that the data were inaccurate. Notwithstanding these objections, Districts undertook many initiatives to improve their PI ratings, including in one case the closure of beds in a Special Care Baby Unit. The Unit's low occupancy rate was explained by staff shortages, but in order to conform with PI norms, the number of available cots was reduced to match existing inadequate staffing levels. Variations from Regional and national averages can be explained by specific local factors, but one of the effects of PIs is to induce local managers to seek ways of conforming with what might be spurious norms.

Moreover, as Birch and Maynard (1988:54) have argued, 'under pressure to achieve the arbitrarily-determined cost improvements, performance indicators may have in some cases been used as a basis to initiate action without due regard to outcomes'. They note that to improve performance, three options are open: reduce service costs without commensurate reductions in service outputs or health outcomes; increase service outputs without increasing service costs; or increase outputs while lowering costs. Performance indicators, they stress, are crude measures of inputs (resources used) and throughputs (activities), and do not refer to outputs or outcomes. Comparisons of activity levels and resource use do not indicate anything about effects on patients' health, and cannot be used as valid proxies for 'performance' relative to outcomes *per se.* They are used, nevertheless, and used especially to implement cost-improvement targets or efficiency savings which may have deleterious consequences.

Thus reductions in length of stay, increased inpatient throughput and other clinical indices *may* be evidence of higher activity levels in a formerly 'below-average' hospital, but these 'improvements' in efficiency might be achieved by reducing the quality of care provided, or at the expense of premature discharge leading to complications and subsequent readmission. The accountability review procedure, and cost-improvement initiatives, give PIs enormous managerial importance. But these PIs have created, as Birch and Maynard (1988) have shown, 'perverse incentives' to economise by making cuts in services, and to standardise both in order to comply with national averages and to conform with line management directives.

Performance evaluation thus necessarily raises fundamental political and technical questions which are interrelated. As Klein (1982b) has correctly observed, the very concept of 'performance' is a contested one, because it begs questions about values and objectives: performance can only be assessed in terms of desired goals, which themselves may be conflicting, multiple and vague. Health care as a policy arena, Klein argues,

is characterised by ambiguity, complexity, heterogeneity and uncertainty, and these features render the process of defining evaluation criteria inherently problematic.

Further, evaluation is potentially an instrument for enforcing organisational and political power, since it will influence resource allocation. Recently in the NHS, PIs have emerged as a means for extending central control through detailed scrutiny of local Health Authorities, and has intensified the managerial pressure to make clinicians justify their activities. PIs are extending the process of bureaucratisation in two ways. First, in the name of public accountability, the delegation supposedly built into an ostensibly decentralised service is strictly regulated, perhaps removed, by increasingly detailed norms, standards and targets expressed through PIs, and policed through the review procedure. Second, in operationalising performance criteria for inputs, process and, if possible, outcomes, medical professionals face regulation and standardisation, and probable threats to clinical autonomy.

Health Authority chairmen and managers are placed under contractual and legal constraints to implement accountability reviews and performance evaluation. The constraints imposed on NHS doctors, though, are indirect but none the less real. PIs have been used primarily as a means of identifying variations in resource use, and in comparing patterns between specialties and Districts. But managers face problems in trying to 'remedy' apparently anomalous PI scores, because the delivery of services and decisions on resource use are controlled by medical professionals. Managers evidently cannot control clinical performance, although moves are underway to involve doctors in Resource Management, and to involve managers in medical audit, as described in Chapter 4.

PIs provide 'evidence' for managers to challenge established medical working practices. Doctors are reportedly sceptical about the validity and purpose of PIs. There are undoubted technical objections, arising from inaccuracies in the basic data and non-comparability. There are even more fundamental difficulties if attempts are made to assess performance in terms of outcomes, because the measurement of health and changes in health status due to medical interventions is notoriously problematic, conceptually and methodologically. In efforts to specify criteria for evaluating inputs, process and outcomes, clinical definitions, customs and practices are questioned, and this represents a significant threat to professional dominance.

The proponents of PIs recognise the technical and political obstacles, but nevertheless recommend continued development of performance evaluation in order to secure better efficiency and quality, as well as professional accountability. Harley (1988), for example, claimed that doctors and Health

Authority managers are sometimes apprehensive about PIs, and make defensive comments and reservations in order to excuse apparently poor performance. Nevertheless, Harley argues, clinicians should be more closely controlled and monitored, not least because there are such gross variations in performance that cannot be explained by data-error (see also Yates and Davidge 1985). If consultants can be shown their performance compared with consultants in similar specialties elsewhere, managers can have legitimate grounds for criticism of clinical practice, and can demand changes to improve productivity and performance.

Accountability reviews and PIs are thus closely linked, and are integral elements in the general management structure discussed in Chapter 3. Together they are part of a larger process of increased centralisation and detailed intervention by central government in Health Authority activities, and in regulating and controlling medical professionals, as discussed above. What they are both concerned with is evaluating conformity with national policies and priorities, efficiency in the use of resources and, in a more indeterminate way, assessing performance and quality. In an era of retrenchment, the connection between cost and quality is crucial: efficiency may seem to be increased if unit costs decrease, but reductions in costs can be achieved by allowing standards and quality of service to fall. To examine this further, we must next consider the debate about the continuing pursuit of efficiency in more detail, by reviewing evidence about the Cost Improvement Programme and related initiatives. Having done this, we shall then look at other mechanisms for extending audit and quality assurance.

COST IMPROVEMENTS AND EFFICIENCY SAVINGS

The election of the first Thatcher government in 1979 heralded a number of important and related changes in a wide range of social welfare policies. These were designed to reduce public expenditure and allow private enterprise and individual responsibility to flourish. 'Privatisation' became both a means and an end in a process of transforming the welfare state: nationalised industries and some public sector services were to be deregulated and/or transferred to private ownership. Wherever possible, the disciplines of the competitive market were to be applied to the civil service, the NHS and local government in order to secure greater efficiency.

One of the first manifestations of these moves was the creation in 1979 of a special efficiency unit within the civil service, under the direction of a businessman, Sir (now Lord) Derek Rayner. So-called Rayner Scrutinies examined all aspects of Whitehall departments' operations, including the NHS, investigated inefficient and wasteful practices and procedures, and made recommendations to improve their effectiveness (see Gray and Jenkins

1985). As a result of Rayner inquiries, in 1982 NHS residential property holdings were reduced significantly, and changes were recommended in the collection of charges and payments, catering services, recruitment advertising and transport.

Although private contractors had long been used for the supply of various goods and services to the NHS, in 1983 the government decided that 'competitive tendering' for contracts was to be extended. Domestic, catering and laundry services were to become subject to bids from NHS staff and private contractors, in order to improve efficiency and value for money. One of the other unstated but significant reasons for this was the government's determination to curb the power of NHS ancillary workers and their unions after the crisis in industrial relations of the 'winter of discontent' in 1978/79. District Health Authorities were instructed to introduce competitive tendering, and to submit schemes for RHA and ministerial approval. Many were reluctant, and opposed the demand to 'contract out' their ancillary services, but were eventually forced to comply by threats of financial penalties and ultimately warnings of compulsory legal direction by the Secretary of State.

Despite union resistance, competitive tendering proceeded. Although the majority of contracts were awarded to 'in-house' bids, there were staff redundancies, changes in working conditions and practices, and complaints about poorer wages for both NHS and private contractors' employees. There are no reliable data to indicate the extent of real savings resulting from competitive tendering (some estimates indicate only a 10 per cent-saving on domestic services), but overall since 1982 there has been a 30 per-cent reduction in ancillary staff (see Key 1988; NAHA 1988a).

However, the main point to be stressed here is that competitive tendering represents a very clear example of increasingly detailed intervention and control by central government, and that it was part of a much wider economic and political strategy to restructure the welfare state. Criticism, from whatever quarter, was deflected by insisting that in order to maximise the resources available for patient care, efficiency and productivity among non-clinical services and staff had to improve. This was connected with other efforts to obtain 'efficiency savings' throughout the NHS.

The idea of efficiency savings emerged in the 1981/82 financial year: Health Authorities were required to save a percentage (rising to 1 per cent) of their annual revenue budgets by providing constant or increased levels of service at reduced cost. In fact the aggregate savings obtained in each of the successive years fell below the target set by the Department of Health and Social Security, and there were doubts about whether the 'savings' were actually the result of improved efficiency. The 1983 Griffiths Report recommended that better efficiency could be achieved

by adopting a systematic 'cost improvement programme' (subsuming Rayner Scrutinies and efficiency savings measures) linked to output and performance measurement and general management at all levels of the NHS. From 1984/85, therefore, Health Authorities were required to submit Cost Improvement Programmes (CIPs) for regional and departmental approval, as part of their annual short-term plans. District performance in achieving CIP targets was monitored in the accountability review procedure.

Cost improvements were officially defined as actions which released cash or manpower by getting the same service output for less resources, or improved productivity through increased output for the same or less-than-proportionate increase in inputs. They were not intended to be the outcome of service reductions. However, there has been considerable argument about the precise content of some cost-improvement measures, about the accounting devices used, the scale of financial savings, and about whether cuts in services have taken place (see King's Fund Institute 1988; Robinson and Judge 1987; Social Services Committee 1988a).

Generally, most CIPs have included measures described as rationalisation of patient services, competitive tendering, reductions in labour costs, Rayner Scrutiny savings, supplies, fuel and other cost savings. Together, they have 'released' about 1.5 per cent of total current expenditure on hospital services, and have been important in offsetting the short-falls in NHS funding, and in balancing local budgets (NAHA 1987b, 1988a, 1988b; National Audit Office 1989).

One study has provided further evidence to question the accounting and recording procedures used by Districts to quantify savings, and to confirm the suspicion that (contrary to Department advice) cuts in services have taken place in order to meet prescribed savings targets. It also indicates that health-service managers have, because of line management accountability, performance review and pressures to balance budgets, made strenuous efforts to conform with CIP plans. The emphasis, at all levels, is on meeting overall savings targets, and the expectation among local managers is that CIPs are a permanent task: 'Districts are reconciled to the fact that the RHA, the DoH and Ministers expect them to cope with future increases in costs as part of their search for greater efficiency' (King's Fund Institute 1989a:30).

Managers are faced with a contradictory set of demands: to remain within cash-limited budgets, to reduce costs and improve efficiency, and to maintain the level and quality of services provided. Some Health Authorities and Units have found themselves in an 'efficiency trap': because they have increased hospital productivity (through decreased lengths of stay and increased turnover), they are able to treat more patients, but the extra costs lead to

overspent budgets, and possible financial penalties for exceeding their cash-limit (Social Services Committee 1988a: paragraphs 24 and 35).

There is also some evidence to indicate that, because of CIP targets and lowered budgets, gains in efficiency have been obtained not only by withdrawing services but also by reducing the standard of care provided (see King's Fund Institute 1989a; Robinson and Judge 1987:6–7; Social Services Committee 1988b: paragraph 23). Thus, it can be argued that health-service managers are confronted with 'perverse incentives': under pressure from accountability reviews and PIs they seek to maximise efficiency, but this conflicts with effectiveness.

The difficulty stems from the problem of defining 'efficiency' and 'effectiveness' in health care. Efficiency is a contested concept, and as Brooks (1985) shows, there are various ways of operationalising it—allocative, distributive, dynamic, and managerial. In practice, within the public sector generally, and the NHS in particular, it is the 'managerial' concept of X-efficiency which seems to prevail: the ratio of inputs to outputs which produces the least-cost means of provision. 'Economy' implies minimising the consumption of resources, but 'efficiency' involves a direct relationship between inputs and outputs. Higher efficiency is achieved by increasing output while keeping inputs constant, or reducing them, or alternatively, maintaining outputs while reducing inputs (see Perrin 1988:10).

However, this begs the question of efficient for what, and for whom? Efficiency cannot be discussed without some reference to goals and values, and, therefore, the quality and outcomes of services provided. 'Effectiveness' refers to these latter criteria—how inputs and outputs yield desired outcomes at a defined level of quality. In the health service, it is notoriously difficult to measure outcomes (improved health status and quality of life) and this, together with demands for retrenchment, has meant that there has been a preoccupation with cost-effectiveness.

The pursuit of efficiency has been characterised by a managerial concentration on cost-reduction and increased productivity. But this value-for-money approach, as soon as it leads to changes in the pattern of hospital bed-use, nursing rotas and skill mix, and patient throughput, as well as to longer waiting-lists if Unit budgets are overspent, inevitably raises questions about the quality of services, about standards of care and about the outcomes for patients. Ultimately, there are diminishing returns from cost-improvements in non-medical services, and significant cost-reductions can only be obtained by closing hospital beds and wards, and by shedding staff. The price of improved productivity may be a decline in clinical care.

Economy and efficiency are principal elements in the ideology of centralisation and bureaucratic control, but they necessarily conflict with

other fundamental NHS goals: effectiveness, equity and quality (see Green and Harrison 1989; Robinson 1988a, 1988b). As Flynn *et al.* (1988:36) argue: 'economy, efficiency and effectiveness within the public sector cannot simply be regarded as technical terms or managerial tools because they are, in practice, structured by the political context in which they are operationalised'. This conflict of goals, and the influence of the political context, can be seen in another example of central government's detailed and extensive involvement in the running of the NHS: the growing importance and changing form of financial and managerial audit.

AUDIT

In the last decade, there has been a significant expansion in the audit function within the NHS. Traditionally, audit has been concerned with scrutinising Health Authorities' accounts of income and expenditure, and inspecting their procedures for financial control. Recently, however, this role has been enlarged to include a concern with efficiency, value for money and effectiveness. New organisational arrangements have been introduced which strengthen parliamentary and government influence on local audit.

Directors of Finance within local Health Authorities maintain constant checks on spending, and both District and Regional authorities carry out continuous budget reviews. Internal auditors work in Health Authorities, checking accounts and other financial information to establish their accuracy, and to establish probity. The Department of Health also appoints statutory auditors (from the Ministry, or contracted private chartered accountants) who have the power to examine all Health Authorities' accounts and procedures, to ensure conformity with public expenditure allocations and objectives. In addition, inquiries are also carried out by the Comptroller and Auditor General and National Audit Office, who review all government departments' spending, and report direct to Parliament, particularly through the Public Accounts Committee. At all levels the stress has shifted from certification of the integrity of financial accounts to increased evaluation of efficiency and 'value for money' (see Henley *et al.* 1986; Perrin 1988).

From 1982 onwards, central government, reacting to regular criticism of the NHS by the Public Accounts Committee, gave more emphasis to internal and external audit. The Comptroller and Auditor General's report in 1987 pointed out a number of deficiencies and weaknesses in NHS internal audit (National Audit Office 1987). The Public Accounts Committee stressed these shortcomings, and urged more investment in audit not only to monitor Health Authorities' spending but also to check on their

stewardship of taxpayers' money and to increase their commitment to value for money (Committee of Public Accounts 1987).

The 1989 White Paper *Working for Patients* argued that to pursue this commitment to value for money, responsibility for audit should be transferred to a body which was 'demonstrably independent of the Health Authorities and FPCs, and of the Health Departments' (Department of Health 1989:20). The government therefore proposed that all statutory external audit should be done by the Audit Commission, but that the National Audit Office (and Comptroller and Auditor General) would continue to examine and certify NHS expenditure.

The significance of this change lies in the government's judgement that previous accounting arrangements had been inadequate to monitor efficiency and effectiveness. The Audit Commission had been set up in 1983 to investigate economy, efficiency and effectiveness in local government in England and Wales. It produced reports, for example on social services and care for the elderly, and care for the mentally handicapped, and it developed PIs for other local authority services.

In the government's view, it was necessary to establish an independent agency concerned with value for money, good practice and improved quality in the NHS, and the Audit Commission (AC) was accordingly charged with this new responsibility. Thus, in addition to general management and RM, PI and CIPs, and all the other instruments for intervention and regulation recently imposed on the NHS, it was nevertheless still deemed necessary to create another mechanism for external evaluation and control.

These developments are evidently connected with other long-term trends in government policy towards the public sector in general, and the NHS in particular, with their paradoxical combination of attempts to increase central state control and measures to stimulate quasi-market performance criteria. Such a conflict of goals can be seen in the functions of the Audit Commission. Nominally autonomous of government, but reporting to ministers, the AC will investigate economy, efficiency and effectiveness in the NHS.

However, as we have seen, not only are each of these concepts problematic, but they are also in important ways contradictory: 'efficient' hospitals actually lead to increased costs, and cost-improvements may be obtained by lowering standards and quality of service. Although the AC's auditors in local government are under instructions not to seek savings at all costs (Social Services Committee 1989:24), in social services for example, 'the AC has tended not so much to ask whether a service is satisfactory, but rather whether the same service could be provided in a different, cheaper form' (Hudson 1989).

Extending financial audit in this way in the NHS inevitably means assessing performance in relation to outcomes, but measuring quality of service and outcomes is highly complex and controversial. Moreover, as we saw in Chapter 4, medical professionals are extremely sceptical about, and hostile to, the involvement of Health Authority managers in medical audit, and are likely to oppose further direct incursions into the monitoring of medical effectiveness by a quango concerned solely with value for money.

Nevertheless, the government has given the Audit Commission powers to investigate the NHS, and the Commission will certainly try to examine costs and quality in its search for improved effectiveness through detailed local studies and the development of outcome measures. How this will affect central government relations with Health Authorities, and with medical professionals, remains to be seen, but it is likely to be another source of inter- and intraorganisational conflict.

QUALITY ASSURANCE

At the same time as these attempts to strengthen and extend the role of audit in the NHS have emerged, there have been other efforts to apply some techniques from the commercial market to the public sector in order to assess 'customer satisfaction' and to standardise quality. The main impetus for these moves was the Griffiths Report (DHSS 1983), but the burgeoning interest in 'consumerism' is also connected with wider demands for greater community participation in health policy-making, the advocacy of patients' rights, and public dissatisfaction expressed in complaints.

The apparent novelty of concern about customer satisfaction with health services must be placed against the fundamental structure and ethos of the NHS. Unlike health systems in which there is a large private sector and a competitive market (where suppliers seek to attract customers, and thus presumably must engage in commercial practices to maintain or increase their market share and profit levels), the NHS is a collectively funded, non-profit service, in which eligibility for treatment is professionally defined. Historically, the medical profession has dominated decision-making about the content and quality of service provision, and 'customer satisfaction' was primarily a matter of good professional practice in encounters between individual doctors and patients, and the avoidance of complaints and malpractice litigation.

In the view of many commentators, patients' interests have not been explicitly articulated, and community representation in Health Authority policy-making has been marginal or ineffectual (see Day and Klein 1987; Ham 1985; Levitt and Wall 1984). It has been argued that the welfare state

model of health is based on a paternalist culture in which medical experts define client needs and prescribe treatment. It is not surprising, therefore, that the NHS had given little attention to the measurement of client satisfaction, because the incentive, and the constraint, of 'consumer demand' was absent, or only vaguely mediated through central government man-dates, non-elected Health Authorities and weak Community Health Councils.

However, the impact of New Right ideology and Thatcherite policies for the welfare state has led to an urgent search for methods of incorporating consumer views into the planning and delivery of health services, and for means to devise standards to monitor quality. This was signalled by Griffiths' claim that 'Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question' (DHSS 1983:10). Since this pronouncement, Health Authorities have been required to demonstrate that they are engaging in 'market research' and 'consumer relations', as well as other formal programmes of 'quality assurance' (QA). There are many problems, however—considerable diversity in schemes, methodological difficulties and conflicting interests and values—affecting their implementation.

Evidently there is some confusion as to what 'quality assurance' means, and how arrangements and procedures can be designed to monitor and improve service quality. It seems to be implicitly assumed that quality refers to process and outcome, to clinical treatment as well as the standard of nursing care, and 'hotel' provisions in hospitals. Surveys of patient satisfaction may deal with all of these, but the results may not be easily converted into management action. As we saw in Chapters 2 and 4, medical professionals reserve the right to determine the boundaries of clinical autonomy, and insist on peer review in medical audit. The quality of medical decisions is an issue contested between managers and doctors, and thus the involvement of managers, let alone 'consumers', in the evaluation of clinical practices and outcomes is highly controversial.

Nevertheless, advocates of QA have devised various schemes for assessing patients' opinions, for setting up 'quality circles' among staff within hospital and community units, and for stimulating the 'cultural' changes appropriate for a more consumer-responsive service (see Dalley 1989; Kerruish *et al.* 1988; Morgan et al, 1988; Pryce-Jones 1988).

Arguments continue about the validity and reliability of survey techniques and data, about arrangements and responsibilities within Units between different types of staff, and about whether, and how, to create codes and protocols which define standards to monitor performance. One recurrent theme is the recognition that QA entails the specification of objectives, and

that the quality of service provision must be evaluated in relation to outcomes as well as process. However, as we have already noted, objective-setting and outcome measurement are not merely technically complex, but are also inherently value-laden and contentious.

The QA issue demonstrates once again the fundamental conflict of interests and values confronting the NHS, and the struggles for control internally and externally. It is clear, first, that the recent preoccupation with QA stemmed not just from a sudden conversion to consumerism for its own sake, but more from the relentless search for greater efficiency and effectiveness under conditions of retrenchment. The overriding concern with demonstrating value for money and accountability leads inevitably to investigation and evaluation of quality of outputs. Cost control, and cost reduction, necessarily require closer managerial control over the determination of service standards and objectives, and more stringent monitoring of performance. As Pollitt (1987) has observed, the development of QA in the United States was closely connected with the decision by purchasers and third-party payers to restrict medical expenditures, and similar imperatives have emerged in the NHS.

Quality assurance initiatives are linked to two distinct pressures—for more accountability and for greater efficiency—and there is a potential conflict between attempts to standardise treatment quality, and attempts to define standards of performance within specified cost-limits. Thompson (1988:113) has argued that QA must be distinguished from quality cost-control, and has claimed that 'Problems inevitably arise when costs are seen as an integral part of quality assurance, and optimum quality standards are subjugated to the vagaries of the budget'. Thus beneath the rhetoric of consumer protection and the maintenance of high standards, there is another objective—budgetary control and cost-reduction—and the pursuit of this may only be possible at the expense of other goals and values.

Second, it is also obvious that whatever QA methods are adopted, they constitute challenges to professional medical dominance, both by national governmental agencies and by local managers. Some writers have discussed the possibility of establishing national frameworks for QA linked to medical audit systems and formal machinery for accreditation (see Ham and Hunter 1988). One possible development is the creation of schedules and protocols to define minimum professional standards for clinical practice, as well as for nursing and other aspects of service delivery. Inspectors and surveyors could evaluate institutions and certify that they complied with agreed standards (see Brooks 1989).

This represents another form of bureaucratisation and regulation which will constrain medical professionals, and has been tried extensively in the USA and other health systems with market or near-market structures. In the context of a

future NHS 'internal market', some form of quality surveillance and accreditation is necessary, to allow purchasers and providers to trade competitively. The pressure to extend such systems will almost certainly continue.

By their very nature, such moves entail bureaucratic encroachment on territory previously controlled entirely by doctors and their professional bodies. PIs, clinical protocols and quality control devices all pose threats to the doctrine of clinical freedom precisely because they seek to establish 'average', 'routine', 'typical' or 'preferred' norms and standards for particular cases and treatments, and the minimisation of variation from national or local agreements. Unless these have been designed and approved by the professional medical bodies they will be perceived as an interference in individual doctors' right to determine the most appropriate form of treatment for patients according to their specific circumstances and needs. Pollitt (1987) has argued that, in contrast to the United States, the struggle for control over the medical domain, and the challenge to medical sovereignty, was not so evident in Britain. However, recent events and policies have changed the situation, and accelerated the trend towards external managerial control of professional medical autonomy.

Moreover, the introduction of general management has provided the rationale and the mechanism for extending bureaucratic control. As Scrivens (1988b) has correctly stressed, given the pressure on resources and demands for greater consumer awareness, managers will no longer allow doctors to be the sole arbiters of service provision and quality. The quality slogan and patient satisfaction surveys enable Health Authority and unit managers to question and criticise consultants legitimately, in ways that were impossible previously. Doctors' traditional monopoly of expertise is being eroded, and one of the methods available to managers is to co-opt them by appealing to a value that they cannot possibly dispute: the pursuit of quality.

However, there is some doubt about the extent of participation by consumers in QA. According to Scrivens:

> The 'customer relations movement' …which is held to be the corner-stone of general management by many general managers, is beginning to attract criticism, for it does not of itself award communities and consumers the right to determine the nature and quantity of health-care made available to them.
>
> (Scrivens 1988b:184)

Levels of investment, product lines and cost/quality trade-offs are not matters in which ordinary health-service clients ever had much influence, because they were ultimately doctors' prerogatives, exercised under the global constraints of cash-limited budget allocations.

Under current and probable arrangements, however, consumers' demands are still unlikely to be directly translated into resource allocation and policy. None the less, they are likely to be used vicariously by managers, to justify reductions in clinical autonomy in the name of accountability, efficiency and quality. QA is therefore another plank in the platform of managerialism; medical dominance and paternalism may be challenged by consumerism and quality control, but these are to be defined and articulated by managers exercising bureaucratic authority.

CONCLUSIONS

Accountability reviews, performance indicators, cost-improvement programmes, audit and quality assurance are all part of a general phenomenon in recent government policy: a determination to secure improved efficiency in, and greater control over, public sector outputs. It must be acknowledged that these objectives can be observed throughout the history of the NHS, and that there has long been a movement towards pervasive centralism as well as the application of a managerialist ideology (see Haywood and Alaszewski 1980). What is important about these goals in the past decade is that they are connected to a fundamentally different model of state intervention, and arguably both a stronger commitment to them, and greater capacity to obtain their implementation.

The policies described in this chapter are integral elements in a broader programme of civil service reform started by the first Thatcher government in 1979. Central departments operate within a system known as the Financial Management Initiative, which emphasises cost-consciousness, value for money, output evaluation and managerial accountability to ministers. This system, according to Gray and Jenkins (1985), is primarily a financial code dominated by economic, and to a lesser extent, technical rationality. Within the civil service, as a result, there has been a shift in values and rationalities in favour of cost-efficiency rather than effectiveness.

The other significant feature has been the salience of the market, both as a method of accountability and as a guide to evaluation:

> The reassertion of the market concept, which has been a hallmark (but not exclusively so) of Mrs Thatcher's Administration since 1979, has not only promoted economising as a mode of reasoning but intensified the use of the market as a framework of accountability in the sense of subjecting activities to *market forces*. The test of good practice is now seen as the ability to compete in the market place.
>
> (Gray and Jenkins 1985, 159–60)

Within this wider movement, of course, there are constraints, both technical and political, on the full application of market rationality. In the particular case of the NHS, there are fundamental obstacles to its extension— notably the explicit undertaking to provide comprehensive services according to need, funded out of general taxation, and a delivery system dominated by medical professionals not directly accountable to managers. However, the apparently uncontrollable growth in public expenditure on health services prompted successive Conservative governments to impose a limited form of privatisation ('contracting out' or competitive tendering), to apply proxies for market influences more rigorously than before and to propose structural reorganisation leading to an 'internal market' in the NHS.

To observe that this has happened is not to assume that it has been consistent, continuous or entirely successful. These trends are varied and variable, and often opposed locally and nationally by different interest groups. But attempts to measure performance, to assure quality and standards, and to monitor efficiency and accountability are not mere ideology: they are institutionalised at all levels of the NHS and are being inserted into areas previously considered immune to such intervention.

The impetus for this is clearly the adoption of New Right ideas by each Thatcher government, and a shift from a Keynesian to a Liberal model of the state and welfare. Within the rubric of 'public choice' theory, state bureaucracies are seen as inefficient, dominated by bureaucrats and professionals whose interests are maximised by over-supply, and incapable of responding to consumer demand. Among the basic remedies are the reduction of state intervention, decreases in public spending, increased competition among providers of public goods and services, increased choice for consumers, and the enlargement of market forces in public finance, management and provision (see Flynn, N. 1989; Green 1988; King 1987a).

One of the ironies of these moves to mimic the market and espouse consumerism, however, is that within the NHS it has entailed massive centralisation of power, and reinforced bureaucratic control. Despite challenging doctors to become more accountable (because professional self-regulation is regarded as a form of monopolistic restrictive practice), mechanisms for audit and quality assurance have not (so far) enhanced users' demands, because consumer choice and sovereignty are mediated by professional medical definitions of need, constrained by Health Authority managers working within government financial allocations.

At the same time, performance evaluation has been accomplished through 'top-down' methods and has effectively reduced local autonomy. Performance Indicators and associated instruments are a means of enlarging central control over policy (and expenditure) while maintaining a

decentralised system of service delivery—they represent a form of remote, or 'hands-off control (Carter 1989). Whatever view is taken about the possibility of combining criteria which measure efficiency and effectiveness (and quality), the devices and techniques discussed in this chapter are best seen as tools for central control and surveillance, rather than devolved or consumer-led services (Smith 1987).

Thus the developments reviewed here illustrate in another way how the structure of control has changed, and is changing. The insertion of quasi-market mechanisms and disciplines in the NHS is the outcome of state restructuring. Efficiency, performance and quality in a market are assumed to be regulated by consumer choice and supplier competition. In the absence of these incentives, and in a system in which services are produced through allocation based on need and effective rationing, other means must be used. Recent government policy has been based on the view that the consequences of a producer monopoly and local discretion in the NHS are unacceptable, and there has been a consequent increase in central control over local Health Authorities, attempts to standardise costs, outputs and quality, and further managerial encroachment on medical autonomy.

The effect of these trends is uncertain, not least because they are contested and therefore the source of continuing struggles. Performance, standards and quality cannot be 'assured' in any unproblematic way, because they are the core of all conflicts within organisations, and cannot be separated from broader questions of values and interests. Their importance becomes manifest especially in situations of retrenchment, when cuts and 'rationalisations' of services are demanded. The next chapter therefore describes such a situation, and examines the practice of cutback management in a number of District Health Authorities.

6 Cutback management

In previous chapters we have seen how a combination of factors has changed the structure of control in the NHS. The introduction and extension of general management, the development and application of financial techniques to secure efficiency in the use of medical resources, and attempts to devise bureaucratic systems to evaluate performance, standards and quality, have all changed the framework within which medical services are planned and provided. These measures have been part of a much broader movement in which central government has increased its control over local Health Authorities, and medical professionals' traditional dominance in policy and service delivery has been constrained and reduced by the extension of managerial power. As already noted, these trends were an integral part of the wider Thatcherite programme of reforming the public sector and restructuring the welfare state. They also emerged in response to an expenditure crisis in the NHS, and became entrenched during the late 1980s as cost-controls and service reductions were imposed, especially in the hospital sector.

It is important to examine not only changes in structures, and the general context of these developments, but also their impact on local managerial attitudes and practices. There are, unfortunately, relatively few recent case studies of policy formation and implementation in Health Authorities (but see Cousins 1987; Ham 1986; Harrison 1988a; Pollitt *et al.* 1988; Strong and Robinson 1990).

However, some relevant evidence from a study conducted by the author in 1987–88 gives useful insights into managers' views and actions during a period of budgetary crisis (Flynn 1988b; 1991a)[1]. Obviously there are limits on the generalisations which can be made from this study, but it does provide detailed qualitative data which allow us to make reasonable inferences about managers' objectives and priorities, and about the implications of their increased power.

This chapter therefore looks closely at the findings of the research project carried out by the author, and relates those findings to the argument about managerial and bureaucratic encroachment on medical autonomy. First the financial situation of the case-study Health Authorities is described. Then the views of different types of managers about strategies for cost-containment and service reduction are analysed. Before presenting the results, however, it is necessary to supply some background information about how the study was done, and to stress some methodological caveats.

COPING WITH CUTBACKS: A CASE STUDY

As part of a comparative study of retrenchment in health-care services in England and the Netherlands (Flynn and Simonis 1989, 1990) the author conducted a case study of six District Health Authorities and one English Regional Health Authority, from August 1987 to July 1988. Documentary materials such as Health Authority committee papers, reports and minutes, together with annual plans and budgets, and other internal official documents were obtained and analysed for the period August 1986 to July 1988. In addition, an interview survey was carried out with senior managers and a sample of medical professionals, in the Districts and in the RHA, between January and May 1988, a period in which there was unprecedented national political debate (and industrial action) about health-service funding and the effects of local cuts in services.

Attention was focused on the hospital and community health services, and particularly the acute and general hospital sector, because they consumed the largest proportion of NHS expenditure and had been subject to continuing resource constraint. Chairpersons, lay members of the Health Authorities, lower-ranking officers, junior doctors and nurses were not interviewed. This was largely due to time and resource limitations, but also because it was well established in the literature that, especially since the introduction of general management, senior managers had executive responsibility and power, and comprised key strategic actors in DHA policy-making.

The region chosen for study was one of the largest in population and among the biggest spending authorities *per capita* in England, and also contained a large number of Districts with varied characteristics. Information about expenditure and service provision was derived from the Regional Strategic Plan and other official documents, from which it was possible to determine whether specific Districts were planned to have increases or decreases in hospital acute and general beds, revenue spending and staff. Districts were then categorised into three types: those expected to have expansion; those where only slight growth was planned; and those where

real reductions in resources were planned. From this sampling frame a number of different DHAs were selected, representing different types of District—some inner city, some metropolitan, some mixed urban and rural. Certain Districts were included because they were 'teaching' Districts, containing university medical and nursing education and hospitals with regionally (or nationally) designated specialties.

Two Districts from each of these three categories were selected for research, so that the study would not be distorted by only looking at areas undergoing contraction and retrenchment. Six Districts agreed to participate in the project, comprising areas of different socio-economic and demographic characteristics, and varying levels of service provision. These DHAs contained populations ranging from 125,000 to 245,000, and in 1986/87 had annual revenue budgets from £13 million to £80 million; they all had Units for acute and general hospitals, mental illness and mental handicap, and community health services. On this basis, then, it is reasonable to assume that the Districts chosen for case studies were as 'representative' as possible of the range of different types of DHAs, and funding patterns, found within the NHS in England in the late 1980s.

One further caveat must be emphasised, concerning the reporting of data from the case studies and interviews. None of the DHAs (or the RHA) or personnel can be named. In order to obtain co-operation and permission to do the research, it was agreed that anonymity would be given to DHAs and officials participating. As a consequence of this, data and findings have to be presented in ways which safeguard that anonymity. It is not possible, therefore, to give comprehensive descriptions and exact details of DHA budgets, financial measures, and policies. Nor is it possible to supply contextual material juxtaposed with the interview data, because this might enable informed observers and analysts to identify the DHAs and individual respondents. This restriction also prevents precise inter-District comparisons. Given the problem of persuading Health Authorities to grant access for the research, and given the sometimes controversial nature of some of the policies locally, the maintenance of anonymity was, and is, essential. Readers must judge the validity and reliability of the qualitative data analysed below for themselves. Quotation marks in the text below indicate verbatim comments recorded during interviews or found in official documents.

FINANCIAL PROBLEMS AND RETRENCHMENT POLICIES

Before looking at the views of managers about changes in the structure of control, and the management of cutbacks in the NHS, we must set the scene by describing the financial context of the Region and each of the

case-study DHAs. Throughout the financial years 1986/87 and 1987/88, an expenditure crisis developed in the Region, and many DHAs encountered severe difficulty in balancing their budgets. Some idea of the scale of the problems, and official reaction to them, can be gained by reviewing information taken from RHA and DHA agenda papers, and claims made in their 'short-term plan' or 'annual programme' documents. The latter are policy statements prepared to show how much expenditure is required to maintain services, and to bid for resources for increased or new services, and must be framed in ways which relate local services to national and Regional strategic priorities and targets. The documents set out the link between planned activity levels and resources (finance, staff, equipment and estate and so on), and also indicate how 'efficiency savings' and cost improvements are to be obtained.

The Regional short-term plan for 1987/88 acknowledged that there had been 'severe financial difficulties' caused by increased workloads and rising costs, and that this had resulted in considerable problems for DHAs when preparing their plans. Noting that demand was likely to increase further in 1987/88, especially in the acute hospital sector, the RHA reported that some DHAs were having to take 'urgent action' to balance their budgets, and were identifying ways of achieving additional savings. The RHA stressed that it was Districts' responsibility to manage services within the resources already allocated to them, advised DHAs that the RHA would strengthen its monitoring of their performance, and instructed DHAs to obtain cash-releasing efficiency savings of at least 1.4 per cent of their total revenue allocation, plus productivity increases.

Reports and minutes record the growing scale of financial problems across the region. By September 1987, Districts were told that if they could not achieve a balanced budget in terms of income and expenditure, they would be permitted to obtain a cash balance. However, DHAs which did not agree a budget which balanced recurrently were not allowed to receive any money for new developments. Shortfalls in funding were regarded as causing 'continuing serious problems'. Aggregate expenditure continued to rise, and this 'overcommitment' gradually worsened.

By the end of 1987, the Regional cash-position was described as 'extremely volatile', and tighter financial controls were applied. Several Districts were identified as having particular problems (including two of the case-study DHAs), and all districts were urged to take 'corrective action' to stop overspending their allocations. The Regional Health Authority admitted that its finances were 'under considerable strain', and that cash-limits were under pressure—the RHA wrote to the Department of Health to express their concern. In three of the case-study Districts, budget deficits were reported to the RHA as being especially problematic.

Against this background of continued financial crisis, the RHA announced that it would not permit more overspending by Districts, and the RHA approved a penalty mechanism. Any overspending by a DHA was carried forward and deducted from its allocation in the next financial year, plus a special penalty of 5 per cent of its revenue, uprated to cover inflation. Three of the case-study Districts were singled out for mention as posing particular difficulties staying within cash-limits. By the spring of 1988, RHA reports on financial problems were dealt with in the closed *confidential* sections of meetings, and minutes were not available.

However, other documentary evidence was obtainable (for example the Regional short-term programme for 1988/89) which showed a gradually worsening picture. Various measures were adopted, including securing special non-recurrent funding from central government, using reserves, delaying payments to creditors, and other 'cash-management' methods, to achieve a 'break-even' at the Regional level.

Nevertheless, there was, in official terminology, an 'overcommitment' (that is a recurrent deficit) of £17 million, which had to be solved by further 'cost-improvement programmes', more service 'rationalisations' and service reductions (through hospital bed and ward closures) at District level. All of the Districts were issued with revised planning guidance by the RHA, which required them to balance their own budgets, but also to devise extra 'cost improvements' and more service reductions over and above those recently approved. The RHA threatened to withhold allocation and development money from Districts unless they took 'appropriate' action. By May 1988, four of the case-study Districts were noted as overspending, and some other DHAs were said to have included real service reductions in their 'cost improvment programme', contrary to government advice.

This, then, was the global situation from the Regional standpoint There was a serious expenditure crisis in most of the Region's constituent Districts, and a sense of desperate urgency to control overspending of cash-limited budgets by different means. Given this background, we need to look at the circumstances of the six case-study DHAs, so that we can get a full appreciation of the interview material analysed in detail below. The next sections therefore set out the main factors and problems encountered by the six DHAs, simply referred to as *Districts A to F.*

In *District A*, there were major financial problems. A deficit of about £2 million in 1987/88 had already led to the 'reluctant' closure of some hospital beds. The DHA adopted what it referred to as 'desperate short-term measures' to deal with the expenditure crisis, and lobbied the RHA for extra funding. Threats were made to refuse to treat patients referred from outside the District's catchment area. But this strategy proved unsuccessful

in winning extra money. The DHA eventually agreed, unwillingly, to a package of reductions in hospital clinical services, to remain within their allocated budget.

In *District B,* the short-term plan stressed that resources were already inadequate for existing, let alone projected, hospital caseloads, and noted that there was a recurrent overspending of £1 million. Health Authority minutes and other documents repeatedly referred to financial problems, and members and officials seemed totally preoccupied with the consequences of deficits. In one of the Treasurer's reports it was noted that the District's net current liabilities exceeded its current assets by a sum which was 'substantially in excess of normal levels of acceptability'. In January 1988, after protracted debate, the DHA approved hospital-bed and ward closures, and various other measures to reduce clinical services, to ensure financial stability.

District E forecast in 1988 that it would overspend its budget by £1 million in the next financial year, unless 'overcommitments' were reduced. The Health Authority found itself 'forced' to make 'unavoidable' service reductions. One entire acute hospital ward was completely closed, and other cost-saving measures were planned. Further deterioration in the District's finances subsequently led to more closures, and other attempts to find extra 'efficiency savings'.

District F stated explicitly in its short-term plan for 1988/89 that the resources provided in previous years were 'totally inadequate' to meet local demand. The DHA passed a resolution that it was unable to maintain services at existing levels of provision, and 'with regret', planned various reductions in clinical and other services. In early 1988 the DHA was told that there was a recurrent overspend of more than £1 million, and members later acknowledged that the shortfall in funding made service reductions 'inevitable'. One official report noted that existing services were 'functioning at bare minimum levels of acceptability', but accepted that more cutbacks in medical activity were necessary.

The two other case-study Districts were expected to be in relatively more favourable financial positions, because they were planned to undergo resource expansion (including major capital developments with new hospitals). In fact, however, both had budget problems in 1987/88.

In *District C,* there were deficits and overspending in all Units. Financial problems were described as serious and urgent, and these led to 'unpalatable' but 'unavoidable' measures to reduce the volume of services in 1988, including bed and ward closures in different hospital specialties. *District D* Health Authority members were advised by managers that it was becoming increasingly difficult to generate the required level of savings without affecting the quality and level of services. Unit overspending

continued through 1988, and led to the adoption of more revenue-saving schemes as well as cuts in clinical activity.

Thus in all of the case-study Districts, there was an expenditure crisis, and all of them implemented retrenchment measures, and policies to obtain higher-than-planned efficiency savings. In each DHA, budget deficits were debated with great anxiety. As pressures got worse, then initial preferences for 'across-the-board' cuts were superseded: substantial targeted decreases in the volume of clinical activity (inpatient and day-patient admissions for diagnosis, surgery and medical treatment) were approved. Very similar cutback methods were adopted in each District: limits on and reductions in staffing; 'cash-management'; the use of reserves; the use of five-day wards to reduce hospital activity; restrictions on operating-theatre time; and selected bed and ward closures.

From documentary sources it was evident that officials and DHA members were all very aware of the negative effects of cuts on hospital waiting lists and on patient services. Cutbacks were universally referred to as 'last resort' solutions to the inevitable constraints of cash-limits and NHS underfunding. In many Districts there were acrimonious arguments about the necessity and the scale of retrenchment measures, and in most DHAs, members and managers complained publicly (and privately) about the financial crisis. There was much evidence of representations about, and objections to, cuts in hospital and other services by groups of consultants, other medical and nursing staff, paramedical and ancillary workers, trade unions, and local Community Health Councils. Minutes of Health Authority meetings frequently recorded that approval of plans for service reductions was given reluctantly, or even under duress.

It is against this background that the attitudes and perceptions of local managers take on their relevance and importance, and from which we can obtain some insight into what Harrison (1988a) has termed the 'shifting frontier' of professional-medical and bureaucratic-managerial control.

COPING WITH CUTBACKS: MANAGERIALISM IN PRACTICE

In this section we examine the findings from an interview survey carried out in the six Districts, and in the Regional Health Authority, between January and May 1988. Forty-three respondents were interviewed in their private offices by the author, using a semi-structured schedule. The interviews lasted between one and one-and-a-half hours: verbatim notes were made during the interviews, and transcribed immediately afterwards. In each District interviews were completed with the District General Manager (DGM), the Director of Finance (Treasurer), the Director of Planning, Unit general managers (UGMs), and wherever possible with

senior medical and nursing members of the Management Team (Consultant Chairmen of the local Medical Executive Committee, and Chief Nursing Officers). After fieldwork in the Districts, interviews were also held with the Regional General Manager (RGM), and Regional Directors of Finance, Planning and Personnel.

During the interviews, respondents were asked a series of questions about the impact of general management; retrenchment strategies; and the implementation of cost-improvements, rationalisation and service reductions. The main survey findings about general management were presented in Chapter 3. The next sections therefore describe managers' perceptions of the impact of retrenchment, and their views about the implementation of cutbacks. For ease of presentation, the narrative will deal with particular groups of managers' and their responses to each issue.

District General Managers

(1) The impact of retrenchment

All of the DGMs referred to the overwhelming importance of financial problems as the primary concern in their organisations. They all argued that government underfunding of the NHS together with increased demands had precipitated a situation in which fundamental reassessments of services were necessary. Improvements in efficiency were said to be a continuing requirement, but there was also recognition that rationalisation and restructuring were needed. However, this involved the extension of managerial influence over clinicians, which was acknowledged to be difficult

One DGM commented that until recently the NHS had been a 'professionally driven' (that is medically dominated) service, but now it was being driven by financial priorities and targets. Previously, he claimed, the manager's function was simply to provide administrative assistance to clinical staff, but this had changed: 'Now *we* are setting priorities…. The more that finance is the problem, the more important management's role in the manipulation of resources.'

In another District, the DGM pointed out that there were problems in trying to influence medical services, because of complex hierarchies of professional authority. For him, the biggest problem in the NHS was the need to extend executive authority over clinicians, in order to influence resource use, but consultants, he complained, were unable to accept a chain of (managerial) command.

For another DGM in a District where there had already been notable advances in the development of 'resource management', and where doctors

were designated as 'clinical sub-unit managers', clinicians' involvement and commitment was nevertheless described as patchy and sceptical. Consultants generally were reported as being 'not remotely interested in management is sues at all'.

Similar views were given by other DGMs in other Districts. One manager insisted that it was necessary to get better value for money, and this entailed getting doctors integrated in management. Another claimed that budget problems could be eased by better management of caseloads and hospital-bed usage, and reduced lengths of stay. But this involved challenging the customs and conventions of clinicians, and getting doctors to change their working practices. While it was seen to be difficult, it was none the less regarded as a priority task for managers.

(2) Cost improvements, rationalisation and service reductions

A variety of approaches was found in making strategies and plans for changes and reductions in services. One DGM said that his approach to making cuts in clinical services was incremental rather than 'zero-based'. Targets for savings in the cost improvement programme were not made *pro rata* to Unit budgets, but made after reviewing District-wide needs, and then determining units' contributions. In some Districts there was a 'top-down' approach, especially in relation to the competitive tendering of ancillary services. However, one DGM claimed that he had 'protected' non-acute units from the full effects of the search for economies. There was some variation in attitudes concerning the necessity for a permanent programme of efficiency savings. Some DGMs believed this was an automatic part of good management, while others argued that there were diminishing returns, and that quality and standards could be driven down.

All DGMs stressed that it was essential to reduce levels of clinical activity in order to cope with the prevailing crisis in expenditure. Most of them suggested that Health Authorities had gone as far as they could in improving efficiency and making savings in non-clinical areas, but medical practices still had to be tackled. One DGM suggested that 'resource management' or clinical budgeting was the best way of controlling costs and regulating activity, but he regretted that doctors were reluctant to participate.

Another DGM claimed that managers were only just beginning to control clinical services; ideally he wished to compare and alter clinical practice between different consultant teams, but this was difficult because only doctors could challenge other doctors in their professional peer group. Like the other managers, he was convinced that inefficient medical practices contributed to an unacceptable waste of resources, and there was much

managerial support for the concept of medical audits. A DGM in one District suggested that there was 'enormous scope' for improved efficiency in medical practice. In common with the other managers interviewed, he believed that recent retrenchment, and particularly the closure of hospital beds, had been necessary and useful in forcing doctors to reconsider their role in the use of resources.

Directors of Finance

(1) The impact of retrenchment

As a result of both general management and expenditure restraint, there was a widespread recognition of the importance of financial issues at all levels, respondents claimed. Treasurers/Directors of Finance consistently mentioned that there were both technical and political problems in financial planning and budgeting under conditions of retrenchment Short-term plans were contingent upon Regional allocations, and subject to central government decisions on funding. There had been delays, changes and uncertainties which had complicated the annual budget and planning cycle. Service plans had to be prepared well in advance of notification of funding, and 'resource assumptions' were subject to modification by the Regional Health Authority. People were unwilling to anticipate the need for economies and closures until budgets were firmly established, the Treasurers claimed, but this delay exacerbated the problem of overspending cash-limits.

District Directors of Finance nevertheless asserted that retrenchment had brought about greater 'realism', in contrast to what one described as the 'blue-sky' planning assumptions of the 1960s and 1970s. Several pointed out that having to work within cash-limits was in itself a necessary and worthwhile discipline, but the severity of recent financial problems posed new difficulties. In most Districts consideration had been given to the posssibility of a 'zero-based' budgeting approach, in which all services and facilities are required to justify their *raison d'être* and argue their case for continued funding.

However, in practice the Directors reported that complete, fundamental reviews of costs and services were not possible, largely because substantial elements of Health Authorities' work was predetermined and prescribed by central government and Regional policies. In effect, a form of zero-based budgeting was adopted in the competitive tendering exercises, because every contract needed a detailed specification and itemisation of costs. This enabled managers to carry out a scrutiny of working practices, and make trade-offs between efficiency and effectiveness.

In several Districts, Treasurers pointed out that budget crises had forced them to ask whether particular services were really necessary, and that this had led to attempts to rationalise service provision. To their evident dismay and frustration, they found that 'political' factors hampered this process. For example, in one District, a Treasurer complained that Health Authority members had been very reluctant to take decisions about ward closures and competitive tendering. Their stance was intended to pressurise the RHA for additional funding, but it led to worsening financial deficits, and thereby exacerbated their difficulties.

Elsewhere, members were said to have tried to ignore or circumvent central government directives, and had attempted to maintain or even increase levels of service provision, but again this intensified the budget deficit In all cases this appeared to strengthen Treasurers' resolve to carry out more thoroughgoing reviews of services, and a re-evaluation of priorities.

The most significant problem facing Treasurers was the need to regulate clinical activity in order to reduce costs. Two respondents mentioned that Unit managers were sometimes slow to respond to the call for cutbacks, and noted that UGMs occasionally tried to defend their own Units. Overall, however, Treasurers regarded opposition from medical staff to demands for service rationalisation and reduction as a major constraint. According to one Finance Director, it was vital to involve doctors in resource management and clinical audit, but he regretted that this was an 'uphill task': it was essential to completely reduce the level of clinical activity, but it was proving difficult 'reining-in consultants and changing their working practices'.

Most of the other Directors made similar comments, and insisted on the importance of examining and controlling clinical workloads, while acknowledging that this was opposed by doctors. Despite this resistance, the Treasurers firmly believed that (to paraphrase one respondent) consultants had always worked within constraints, but what they needed to recognise was that there had to be a change in who makes the constraints, and how they are defined.

(2) Cost improvements, rationalisation and service reductions

Various techniques were used in the case-study Districts to find efficiency savings through the cost-improvement programme. In some, a Districtwide target was reached, and there was an across-the-board strategy. In others, there were targets *pro rata* to Unit budgets, while in a few cases, major savings were made by imposing rationalisation and competitive tendering schemes on particular Units

or sections. These measures were inadequate to meet the growing financial deficit in most Districts, so reductions in services were planned and introduced.

For most Treasurers, the seriousness of the situation demanded urgent cutbacks in clinical services through hospital-bed and ward closures, as well as reductions in other areas. This was acknowledged to be a contentious and problematic process. In one District, the director criticised a short-term approach in which *ad hoc* measures were taken, but more fundamental reappraisals were avoided because of local political opposition and medical staff resistance. He wanted to analyse hospital-bed use and under-occupancy, patient throughput and length of stay, as well as asking consultants to spell out in detail the content of their activities, but this was proving difficult.

All Treasurers mentioned that there was significant opposition to service reductions among doctors, and that there had been extensive discussions and negotiations about the nature and scale of cuts in clinical services. In some Districts, consultants had objected to plans through the Health Authority, and had voiced their criticisms in public and to the press. Most Directors of Finance argued that a change of 'culture' was overdue, especially among consultants, to facilitate better productivity and cost-effectiveness.

Treasurers were obviously very concerned to balance DHA budgets and make services fit the available finance (rather than allowing incremental drift), and they were determined to challenge professional medical assumptions about service provision and particularly clinical working practices.

Directors of Planning

Day-to-day executive responsibility for the running of District Health Authorities is vested in District General Managers. Since the implementation of the Griffiths Report and, simultaneously, the increasing significance of budgetary problems, Directors of Finance have occupied key roles in policy-making. Most Districts also have a senior manager designated as a planner, who is responsible for co-ordinating, preparing and monitoring service plans for all Units within the area, specifically the annual programme or short-term plan covering both capital and revenue expenditure. Given these functions, the views of Directors of Planning (PDs) about retrenchment and service reductions are important and relevant, and we shall examine them in the sections which follow.

(1) The impact of retrenchment

All six PDs referred to the fact that underfunding had created a climate in which it was difficult to prepare service plans. Planning was said to be subordinated to short-term crisis management, because the first priority was tackling budget deficits. One respondent argued that retrenchment had brought with it the opportunity for a radical reorganisation of services in the District, but the immediate problem of making savings to balance the budget restricted the scope for innovation and rationalisation.

In several Districts, PDs mentioned that delays and uncertainties about the level of government funding, and Regional allocations, often meant that decisions and policies were 'rushed'. More importantly, for some PDs, consultation processes had become truncated and devalued, or even redundant, and this aggravated problems of staff morale. As expenditure problems worsened, District-level managers and planners found it necessary to intervene much more in what UGMs and others regarded as detailed operational matters, and this led to resentment among Unit staff. Several respondents believed that financial restraint had brought planning into dis-repute—Unit staff were expected to prepare plans for improvements or new developments only to discover that these could not be funded *and* that they must make further savings in their existing budget.

In these circumstances, PDs were aware that to cope with increased demands and financial constraints, the only strategy was a crude one of controlling clinical workloads, and reducing hospital beds. This was known to be unpopular or unacceptable among doctors. As one PD observed, in solving this problem there were incompatible responsibilities: doctors are responsible for patients, and managers are responsible for money, so consequently 'the problems of prioritising demands are horrendous'. This PD claimed that his role was to try to 'play the honest broker' in mediating between medical and managerial interests, but he believed that planners and managers were 'working in a different intellectual framework [from doctors] …we are more analytical, but the clinicians are not into this way of thinking'.

In another District, it was said that planning had been thrown into disarray by a severe budget crisis, and by the adoption of a package of cuts in hospital services. The PD noted that financial pressure had forced them to adopt a different, more 'authoritarian style of management': decisions had to be taken quickly to plan bed and ward closures, so there was little possibility for debate or discussion. There had been rows with consultants because senior managers took urgent decisions without consultants' prior knowledge or consent.

In a different District similar problems developed. The Director of Planning asserted that due to financial pressure, managers were much more concerned with 'getting returns on investments'. Previously, the PD claimed, managers traded-off demands with clinicians, agreeing to fund developments desired by doctors in exchange for other changes wanted by managers, but this was no longer possible because of lack of resources. Retrenchment had brought about a 'fundamental questioning of what clinicians do', and among managers there was 'greater realism and increased concern with effective results'. Managers and planners were said to find it difficult to establish overall priorities when faced with cuts, but this PD believed that many consultants had an 'irresponsible attitude' towards the allocation of resources. In his view, doctors make the real decisions on the use of resources, 'but they do not think about it that way, and many of them are reluctant to discuss costs or evaluation of clinical outcomes'.

Restrictions on medical autonomy were said to be especially necessary under conditions of retrenchment by most of the PDs interviewed, and there was a common view that consensus management was inappropriate in the new circumstances. In all Districts, clinicians were described as being slow to recognise and accept the new situation of resource restraint and general management

(2) Cost improvements, rationalisation and service reductions

What was the PDs role in selecting areas for efficiency savings, rationalisation and cutbacks, and how were these accomplished? In fact a variety of roles and practices were reported; in some Districts there were consultation exercises and widespread discussion among staff about possible strategies, whereas in others there was said to be no conscious, explicit strategy, but a series of *ad hoc* measures. The cost-improvement programme was recognised as an integral element in the annual planning exercise in most Districts, but PDs claimed that it was becoming difficult if not impossible to find savings continuously without affecting standards of care and levels of provision. Most respondents argued that they had gone as far as they could with cost-improvements in the non-clinical areas, and acknowledged that in practice, efficiency measures were sometimes actual cuts in service or quality.

In devising cash-saving measures, the PDs reported that they had encountered significant opposition from Units and especially from medical staff. In several Districts, Units were said to be fighting among themselves in efforts to resist cuts, and were trying to transfer the burden to other Units. Moreover, as one respondent claimed, 'Clinicians cannot

talk rationally about service reductions and closures. Clinicians are not into the business of making direct comparisons and evaluations of each other's work.'

In most of the Districts, planners emphasised that they had now begun to review the entire basis of clinical services, and this entailed an examination of clinical practice too. Doctors had so far remained outside the cost-improvement process; many were said to have refused to participate in management, arguing (according to one PD) that they 'want to be left alone to practise medicine without thinking about the wider issues of finance'. It was clear from planners' replies that they regarded this stance as unsupportable, and there were strong indications that planners, like other managers, believed it was necessary to challenge professional medical dominance.

Unit General Managers

So far we have described the views of key senior executives at District headquarters level, whose primary responsibility is for strategic policy and overall financial management. The delivery of services—acute hospitals, community services and services for the mentally ill and mentally handicapped and so on—is performed by numerous staff located in 'Units' (usually based administratively in a large general hospital or group of hospitals). With the introduction of general management, UGMs were given considerable delegated powers and limited discretion in matters of finance, staffing and service provision, as discussed in Chapter 3.

In reality these UGMs, and Unit medical, nursing, paramedical and ancillary staff, are the 'front-line' workers of the NHS. They have day-to-day responsibility for, and contact with, patients, and it is their decisions which determine the use of resources. Unit General Managers occupy a fundamentally important position in controlling expenditure and implementing District policies. Thus if we wish to gain a full appreciation of the changes in managerial control within the NHS, we must examine the ideas and priorities held by UGMs.

The following sections outline the main findings from interviews with twelve UGMs, comprising both managers of acute and general hospitals, as well as community and mental illness/mental handicap hospitals. Most of the UGMs had been appointed from within the NHS (many from within their present District) but two had formerly worked in the private sector (manufacturing), one was a hospital doctor, and some were formerly nursing professionals.

(1) The impact of retrenchment

All of the UGMs stressed that retrenchment had become the dominant issue in the management of their Units, but they varied in their estimations of its specific effects. Some pointed to increasing conflicts between Units: each Unit was reported to be seeking to maximise its own resources, was very protective of them, and angry if required to transfer savings to other 'inefficient' Units to balance the District budget.

Several UGMs spoke of their role as one of 'damage limitation'; some referred to the difficulty and unpopularity of decisions when coping with cash limits, efficiency drives and cuts. One believed that the District put excessive pressure on UGMs to solve overspending, arguing that this was an 'abdication of responsibility' by senior managers. Other UGMs mentioned that their loyalty to the Unit and to the District as a corporate body was often placed under strain as a result of budget restrictions. One stated that until recently there had been moderate incremental resource growth, but 'now the competition [among units] is for shrinking resources…the fight is over how little you can lose'.

Most of the UGMs also pointed out that expenditure problems had caused them to begin fundamental reassessments of local priorities, and had led to a much greater concern with cost effectiveness. Several UGMs referred to exercises under way in which they had questioned the necessity for particular services, and asked whether existing modes of provision could be justified in value-for-money terms. Others explained a variety of income-generating schemes and rationalisation measures which created or released resources to be used for high-priority services in the Unit.

These managers stressed the importance of persuading staff to be innovative and flexible, and to consider changing existing arrangements and practices. One UGM suggested that shortage of money was often used as an excuse by staff who did not wish to envisage change. In his view, cutbacks were inevitable, and staff had to adapt to new circumstances. However, he observed, that 'It's a bit like turning around an ocean-going supertanker, to change the culture of the organisation and alter people's frame of mind'.

All the respondents agreed that it was essential to obtain doctors' support, if change and innovation were to be secured. Some UGMs went further and insisted that consultants' contracts of employment must be changed in order to make them directly accountable to managers. Productivity generally had to be raised, argued one UGM, but this entailed managerial control over consultants and the costs they generated. In another Unit which had already started resource management, and had clinical sub-unit managers, the UGM wished to set up a system of clinical audit to back up clinical budgeting. This

manager wanted to convince consultants that they could adjust their caseload and throughput, and wanted doctors to modify current working practices (for example use of operating theatres, outpatient sessions and so on) to increase efficiency in resource use.

In different Districts, managers of community and mental illness Units pointed out that in recent cutbacks and cost-improvement schemes, non-medical staff and nursing staff had borne the brunt of changes, redeployment and redundancies, while doctors had been 'immune'. These UGMs referred to professional 'tribalism' and the power of consultants as constraints on much-needed reforms. Most of the other UGMs (especially those in acute Units) also laid great stress on the need to change consultants' ideas and practices, and indicated that they had experienced difficulties in getting doctors to recognise the necessity of making 'realistic' choices and priorities within and between services with reduced funding.

Consultants' exemption from managerial control was regarded as a fundamental organisational weakness in the NHS. As one acute Unit manager argued, 'There has been vastly increased pressure on general managers, but so far it hasn't been applied to doctors. Greater managerial authority over consultants is needed…[so that] consultants can be *instructed* to carry out so many operations, or vary their workload.'

(2) Cost improvements, rationalisation and service reductions

As noted above, in all Districts, in addition to established cost improvement programmes, service reductions were implemented to deal with Unit overspending. UGMs were asked how they went about planning and introducing these measures.

According to most UGMs, they were simply instructed by their District General Manager to achieve a CIP target Various methods were used. One community Unit manager holding un underspent budget was told to make cuts by removing money previously earmarked to cover incremental salary drift, rather than try to reduce non-staff costs which were directly connected with patient care, and were therefore more sensitive politically. Efficiency savings were also achieved by trying to change staff working practices, by installing modern labour-saving equipment, and by rationalisation of activities, particularly in domestic services, catering and laundry.

In one District, a manager of an acute Unit noted that cost-improvement measures were imposed 'from above', and were 'led by the accountants'. Another UGM in the same District confirmed that he had merely been told what his savings target was by the District General Manager, and that he then had a series of meetings with Unit staff to select ideas for further economies. Most UGMs reported that there was much debate about whether

efficiency savings, and service reductions, should be based on targets *pro rata* to Unit budgets, or whether there should be a more selective programme in specific areas. This was obviously a source of disagreement and some conflict between Units in most Districts.

The closure of hospital beds, or entire wards, for periods of weeks or months, or permanently, was regarded as the only option to deal with continuing financial deficits. Unit general managers indicated that they regarded these measures with disquiet, but also as inevitable. One acute Unit manager, faced with District requests to reduce services, claimed that he knew from experience which hospital wards were 'under pressure' (in terms of bed-occupancy rates, waiting-lists) and which were not, and this knowledge enabled him to recommend certain ward closures. However, there were further requests from the DGM to make more cuts, which he opposed. The DGM intervened and *instructed* him to make further closures in medical and surgical wards, ignoring the UGM's objections.

In another District, an acute Unit manager was told to find £200,000 through service reductions. This necessarily entailed ward closures, but the UGM attempted to minimise the impact by 'rotating' temporary closures between different specialties. A UGM in a different District reported that at the first stage of making cuts, Unit staff had suggested savings from non-staff items and consumables which yielded significant sums, but then another round of cuts became necessary. The District management team had asked the UGM to agree to the loss of fifteen nurses, but he had objected, and the argument about nurse staffing levels was continuing.

UGMs described consistent and widespread opposition by doctors to proposed service reductions. In one Unit, ward closures were planned to cope with a very large budget deficit, and according to the UGM, after much debate, medical and nursing staff accepted the need for cuts 'grudgingly'. However, one senior consultant in the Unit objected to the closures, and told the manager that he would criticise the policy in public and contact the press. The UGM said that 'managers must accept this—the doctors know that it [the closures] is not the personal responsibility of the managers'.

In another District, the acute Unit manager described how savings were made by closing two wards completely, and by reducing admissions in others. He acknowledged that the decision had been 'very unpopular with consultants, and now they're not very co-operative'. He went on to complain that consultants tried to get around bed closures, were obstructive by lengthening waiting-lists, or by reducing the amount of emergency cover they provided. The UGM argued that although doctors claim that they cannot influence the volume or flow of patients, and are not responsible for overhead costs, they must nevertheless be made to realise that clinicians are responsible for the resource consequences of their decisions.

Similar views were expressed in most other Units, and UGMs spoke of their frustration in persuading doctors to agree to packages of cuts. One manager of a very large acute hospital referred to conflicts arising from a plan to make selective cuts in some specialties in order to fund developments in others. The plan, he regretted, was 'not acceptable on the medical side. On the non-medical side, …you take the autocratic line and say "This is your budget. How are you going to manage it?" But this is not feasible on the medical side.' In this District, the Medical Executive Committee had voiced its total opposition to all cuts and cost-improvements, and according to the acute Unit manager, doctors would only accept 'equal misery for all' if cuts were imposed. At the time of the interview, negotiations between the UGM and medical staff about bed and ward closures, and the 'rationalisation' of operating theatre use, were still proceeding.

UGMs also recognised that the distinction between 'cost-improvements' in order to make efficiency savings, and real cuts in services, was difficult to sustain, and that this too had caused disagreement and tension within Units. Eleven out of twelve UGMs believed that the CIP could *not* be continued indefinitely. The one exception argued that the drive for efficiency should be continued permanently, so that money could be recycled to fund new developments.

The majority of Unit managers claimed that any previous 'slack' resources had been used up, and that further cost reductions could only be obtained by reducing the quantity and quality of services. As one UGM described it: 'We've reached the point at which patient services will be affected.' In his Unit, half of the total budget was spent on nursing staff, and he argued that economies were only possible if staff were laid off and wards closed. Elsewhere, the manager of a large mental illness and mental handicap Unit commented, after a prolonged series of economy measures: 'Enough is enough. Service quality is bound to be affected as nurses are overstretched and staff sickness and absenteeism increase. We are constantly being asked "Can we shave a bit off here and there?" I believe that now we must say "No, we cannot!".' In his view, 'real' savings could only be made by closing acute wards and reducing operating theatre sessions, but this was 'politically very difficult'. Continued pressure to make cost-reductions would lead to a fall in the quality of care and particularly threaten nursing standards.

Most Unit managers emphasised that the scope for making further savings was now very limited, and that there were diminishing returns from economy measures. One UGM stressed that he was under constant pressure to look for additional ways of reducing expenditure, and that the CIP was 'really a misnomer for service cuts'. He claimed that after the first round of competitive tendering for ancillary services (catering, cleaning) there had been genuine

improvements in efficiency, but that there were now very few areas in which substantial gains could be made. As a result, this respondent had reluctantly come to accept that locally 'we are into a phase of real cuts, re-examining priorities, not just planning at the margins but looking at the totality of services'. In the same District another UGM endorsed his colleague's views, stressing that 'in reality, increasingly, efficiency savings are subtle reductions in the quality of service'.

Senior medical staff

The research described here focused on the views of Health Authority managers because of their recently increased powers and significance in the NHS. For practical reasons—access, money and time—it was not possible to carry out an extensive study of the views of doctors (or Authority members and chairmen). Nevertheless, interviews were carried out with a small number of senior medical staff in five of the case-study Districts. Two senior consultants (both chairmen of the local Medical Executive Committees), one District medical officer and two assistant District general managers (for medical services, and for community medicine) were asked about their experiences of, and responses to, retrenchment, and the implementation of cutbacks. To protect their anonymity, they will be referred to as senior doctors or consultants.

(1) The impact of retrenchment

Both consultants were critical of the effects of cash limits and government underfunding of the NHS. One complained angrily that hospitals had become more efficient and were treating more patients more quickly, but the increased throughput breached cash limits, and they faced penalties for overspending inadequate budgets. As an example, he cited one large acute hospital where annual patient turnover had risen by 11 per cent, but the hospital subsequently only received a 4 per cent rise in revenue. In other sectors of industry their productivity would be acclaimed, the consultant argued, 'but all we are told is that we should stop seeing so many patients'. Reductions in the level of clinical services were being urged by managers to deal with budget deficits, but this conflicted with government policy to reduce hospital waiting-lists. Doctors were therefore placed in a dilemma, but, 'In practice acute cases cannot be refused….You cannot simply tell patients to go away or refuse to treat them.'

For this consultant it was medically and ethically negligent to refuse admission to cases referred by GPs, but that was the probable implication of demands to reduce expenditure. This was even more of a problem in Districts

containing designated Regional specialties and centres of research and teaching: such Units received large numbers of non-local referrals, and they were unable to prevent patients from being referred to them.

The other consultant had virtually identical views. The most important point to be stressed, he argued, was that clinicians cannot and would not refuse to treat patients on financial grounds. He expressed this graphically by saying, 'We cannot put up a sign outside the hospitals saying "Sorry, we have run out of money for this financial year".' In his opinion most doctors saw the financial crisis of the NHS as a result of deliberate underfunding of pay awards and prices. He acknowledged that health care was 'obviously a bottomless pit' and that clinicians must be expected to use their resources effectively and efficiently, but insisted that 'we are not like a retail enterprise'. The NHS had to be run by 'administrators', he observed, but it was their job to find the resources and distribute them equitably 'so that we can provide decent levels of care… It's their job to sort out the funding.'

According to a senior doctor in another District, 'dreadful constraints' on resources were increasing the antagonism between managers and medical and nursing staff, particularly over which Units and which specialties would be cut. Often, he claimed, managers' decisions were made without adequate discussion and consultation, because managers were 'seeking desperate solutions to a desperate situation—simply trying to keep afloat'.

Another senior doctor in a different District remarked that trying to select priorities between Units and various types of service had become more difficult because of the cash crisis. An acute Unit had a problem of chronic overspending, which had led to other Units having to make extra savings to balance the District budget, and created resentment However, reductions in hospital services had what were described as 'kick-back effects' on community services. The examples cited were where earlier hospital discharges actually increased the workload of community nurses, and reductions in the number of available hospital beds resulted in demands for more treatment and nursing in the community sector. For this doctor it was evident that retrenchment had placed contradictory demands on everyone in the NHS, and he noted that 'morale among front-line staff is beginning to slip'.

A slightly more positive outlook was adopted by a senior doctor elsewhere, who argued that the financial situation had forced them to tackle the problem of priorities more seriously, and this was long overdue. Conventional service planning had been upset by unfavourable allocations, so there was now a growing recognition that they needed to define objectives more precisely, and examine outcomes more closely. In his view, there was an unarguable case for altering the pattern of medical service provision, and for controlling clinical activity and workload. These were based on historical custom and

practice by consultants, who were reluctant to change their arrangements, but they had to be revised to meet new circumstances.

(2) Cost improvements, rationalisation and service reductions

Most of the doctors interviewed stressed their awareness of the *negative* effects of efficiency savings and service cuts. There were slight variations in their accounts of the problems in different Units and Districts, but the overall view was one of anxiety and reluctant acquiescence to externally imposed economies.

One consultant said that he was not aware of there being any *strategy* to determine priorities for rationalisation or ward closures. Usually, he observed, doctors and managers looked at caseloads in different specialties, but in practice doctors could not refuse to treat acute referrals. What disturbed him and medical and nursing colleagues was the fact that they faced a *series* of continuing cuts, and that so-called efficiency savings were affecting the quality of care. For example, within some Units, he claimed, there was continual pressure to economise on nursing staff, and this had already had a negative effect on standards of nursing care. Nursing costs are a large element in Unit budgets, so, in order to reduce spending, beds and wards were closed. However, there was an increased workload for the remaining nursing staff, as patient turnover and throughput increased, and because of the intense pressures, safety standards were also threatened.

His consultant colleague in another District endorsed this account. There, the District Management Board had recently debated proposed cost-reductions and hospital-bed closures. As the senior consultant he had been mandated to tell the Board that every consultant was opposed to *any* cuts in the quantity and quality of patient care. Medical staff believed that prior cost-improvements had already removed 10 per cent of local resources cumulatively, and that this was additional to the underfunding of pay and prices. Doctors argued that this extent of cut was 'really as far as it can go', and advised managers and the Health Authority members that more service reductions were unacceptable.

Elsewhere a senior doctor said that staff were only just beginning to realise the full impact of financial deficits. Doctors had taken part in some 'brainstorming' sessions with Unit managers to suggest items for improvements in efficiency, but the task of identifying areas for more savings had become more difficult, and they had reluctantly had to face the prospect of closing hospital wards.

In a different District, a senior doctor acknowledged that 'The impact of the cuts is severe. Everyone deplores them, but recognises that little can be done about them.' It was well understood that waiting-lists for surgery

and other treatment would inevitably lengthen, so clinicians tended to argue that the 'less popular' services should receive the greatest cuts, and disagreements persisted about which activities should be reduced. As for cost improvements, these were regarded as 'a constant annoyance', causing more disputes. This respondent concurred with the opinion of a senior doctor in a different District, who claimed that, 'We have gone as far as we can with efficiency savings. Great efforts have been made, but now we've reached the end.' For him and for all those doctors interviewed, existing budgets were simply inadequate to meet existing needs and demands, and the consequences of 'economies' and service reductions were professionally anathema.

Clearly all the personnel at District level had been forced to come to terms with a new financial climate and organisational culture. Generally, they adopted similar strategies and displayed similar attitudes. The particular issues and problems confronting Districts, and managers' and doctors' reactions to them, indicate the effect of constraints imposed by central government, as mediated by Regional Health Authority influence. It is necessary, therefore, to look briefly at the standpoint of the case-study Regional managers.

Regional Health Authority managers

As these District responses show, and as noted in previous chapters, Regional Health Authorities occupy an important position in the structure of control. They transmit central government directives to local Districts, decide the amount of financial allocations each DHA will receive, set strategic 'Regional' objectives and targets, and monitor their constituent Districts' performance. To understand the context and process of cutback management at the local level, we must also examine the Regional managers' perspective.

The next sections therefore describe the views of the case-study Regional General Manager (RGM), and Regional Directors of Finance (RDF), and Planning (RPD), who comprise the key executives responsible for Regional affairs. In analysing the interview data, it became evident that respondents did not make a clear separation between general aspects of retrenchment, and specific features of cutback measures. This is probably explained by the fact that *District* respondents were preoccupied with the very detailed substantive consequences of rationalisation and service reduction, and gave much greater salience to them, whereas Regional managers were concerned with broader, global issues.

In presenting Regional managers' views, therefore, the format must be slightly different Responses about retrenchment and cutback management

are discussed first, followed by their views about cost improvements and efficiency.

Regional General Manager

(1) Retrenchment and cutback management

The RGM explained that until about 1986 the Region was a beneficiary of RAWP finance, but then serious underfunding had forced them to review their Regional strategy and sub-Regional allocations. Their major concern had become balancing the books, while the NHS 'creaked under the strain' of increased demand and further government-imposed tasks. Delays and uncertainties over the amount of central funding compounded these difficulties, and caused frustration for Regional and District staff and members. The RGM noted that in dealing with this situation 'the big question is can managers manage?'. Thus, for example, while Regional members had given RHA managers considerable delegated powers, District managers were constrained by local political factors, and pressure from doctors and nurses, which might obstruct decisions to close inefficient hospital Units.

There needed to be a wider recognition among the public and NHS staff that the future would consist of low or no growth, the RGM argued. Resources must be used more effectively, and costs must be controlled or lowered through better management. However, clinical practices were 'the real issue yet to be tackled': reviews of clinical practices were a necessary part of the strategy to contain health-service costs, but consultants were reluctant to get involved with resource management. It was essential, the RGM insisted, to change consultants' contracts to give explicit recognition to managerial accountability and resource constraints: 'Yes, a doctor should provide the best possible treatment for his patients, *but within the resources available.*'

(2) Cost improvements and efficiency

The Region had previously been used to continued resource growth, but inflation and underfunding had created a serious shortfall in finance, and this gap had to be filled by the CIP. According to the RGM, there should be a continuous CIP, because this was a natural part of management: efficiency measures were integral to good management, part of 'doing our business better'. This required considerable pressure on Districts to achieve their targets. He acknowledged that Districts had felt aggrieved at what they saw as the Region's 'centralism', but he stressed that because of the imperative

need to ensure that DHAs balanced their budgets, 'close intervention' had become necessary. Nevertheless, it was for Districts to make their own decisions in coping with financial difficulty: some DHAs had in effect tried to ask the RHA to take decisions on ward or Unit closures, but this was entirely the Districts' responsibility.

Regional Director of Finance

(1) Retrenchment and cutback management

The Regional Director of Finance (RDF) stressed the long history of central government control of health-service spending, and the fact that Health Authorities had become 'dominated' by cash limits. Treasury control had increased even more because of tighter regulation of public expenditure. Many NHS finance professionals had complained and protested about the current system of budgeting, but to no effect. Locally, efforts were usually made to 'elicit the maximum freedom' within the current financial system. It was against this general background that regional policy had to be understood: the RHA had become very 'centralist' in its dealings with DHAs, and this had intensified because of the underfunding crisis. Ministerial review procedures and NHS Management Board directives were 'compelling necessities' which governed the Region's attitude to District spending (and overspending).

(2) Cost improvements and efficiency

Cost-reduction and improved efficiency were regarded as necessary to cope with underfunding, but also as an automatic part of management. The RDF argued that although increased importance had been given to the CIP, he believed that measures had not yet gone far enough. In his view in some Districts, substantial savings could be obtained, but decisions were 'fudged' because of 'internal organisational opposition' and probable industrial relations difficulties. The region would continue to pursue a strong line on District CIP targets, and monitor and audit their schemes closely. Efficiency measures were essential, but the RDF believed that there was a lot of potential for further reductions in costs. The scope for savings could be significantly enlarged if clinical practices were revised. According to the RDF, hospital consultants 'in effect are like small private firms' so that there are built-in conflicts when trying to control medical costs, but more efforts would have to be made to deal with professional vested interests.

Regional Director of Planning

(1) Retrenchment and cutback management

The RDP explained that until recently, the allocation of finance to Districts had been based on a system which linked client-care group plans at the Regional level with DHA annual service plans and proposed expenditure. Efforts were made to connect spending with specific Regional strategic objectives and targets (based on Regional average unit costs). This had led to a redistribution of resources between the local Districts. After initial allocations were decided, CIP targets were identified and given to Districts. Originally cash savings made locally were 'clawed back' by the Region, put into a reserve fund, and redistributed to finance new developments. However, because of the extent of underfunded inflation in 1987–88, the RHA decided it could not use Districts' CIP money for growth, but had to allow them to retain their efficiency savings to balance their budgets. Financial pressures had also coincided with a regular review of the Regional strategic plan, and proposed rationalisation of acute service provision, so the Region and the Districts all faced significant changes in circumstances.

There had been an important shift historically in the method by which the RHA had attempted to influence local policy and expenditure. From the late 1970s, sub-Regional resource allocation was based on a modifed form of RAWP procedure (relating funds to objective measures of need), but many Districts disputed their 'share' of the allocation. In the mid-1980s there was a move to a system in which finance was reserved for special schemes, and Districts had to bid for 'pockets' of money to finance new developments. This too led to tensions and District dissatisfaction.

More recently, because of this experience, the RHA was considering a move back to a 'formula-based' approach, but much of this was expected to be 'top-sliced' (that is, predesignated for specific purposes) by central government, so difficulties were likely to continue. Overall retrenchment, the RDP observed, had simply reinforced the necessity for Districts to justify their need for growth or development money—DHAs were required to demonstrate their entitlement or eligibility for funding. Economic restraint had increased tensions between the Region and the Districts, especially over the methods and criteria to be used in evaluating DHA plans and bids for resources.

(2) Cost improvements and efficiency

Like his finance colleague, the RDP pointed out that, since cost-improvement targets were one of the PIs used by the Department of Health, the RHA was

very concerned to monitor local District schemes. In his view, the CIP should continue indefinitely, because everyone should constantly be seeking efficiency, and claims for increased resources could only be honoured if Districts demonstrated that they were using existing resources to good effect: 'Clearly, before you can assess what extra you need you must assess what you're doing now and whether it can be improved. That's what the CIP is about, so it's integral to planning.'

He argued that it was no longer acceptable for Districts to presume incremental growth in resources, so there was a need to 're-jig and reallocate resources within a constrained environment'. However, while value for money and tight expenditure control was inevitable, he acknowledged that there had been increased tensions between the Region and Districts, and that this was likely to continue.

CONCLUSIONS

The purpose of this chapter has been to provide case-study evidence about some of the effects of changes in the structure of control, and about the simultaneous impact of retrenchment in the NHS, and to examine the views of local managers. Some important general observations can be made on the basis of the documentary material and interview data described here.

First, it is clear that despite differences in their initial financial positions, needs and organisation, the impact of retrenchment was severe in *all* of the case-study Districts, and each DHA undertook significant, unprecedented reductions in, and 'rationalisation' of, services. There is no reason to suppose that the case-study Districts were in any way exceptional in confronting the problem of retrenchment most English DHAs were unable to remain within their cash-limited budgets and more than a third of all Districts had planned real reductions in services during the period of the research (see NAHA 1988b). The severity of budget deficits and crises over cuts in services varied slightly between Districts, but their overall situation was similar.

Secondly, there was similarity in the pattern of District responses to underfunding/overspending, and a noticeable convergence in the ideas and priorities expressed by managers during interviews. For all Districts, and all levels of manager, dealing with the consequences of retrenchment and demands for rationalisation had become their overwhelming preoccupation. Their plans and remedies for coping with cutbacks were very similar, reflecting both government and Regional directives, as well as conventional wisdom about the feasibility of different methods of cost-containment

Thirdly, and parallel to this cross-District convergence, there was a noticeable similarity in the attitudes of most managers, irrespective of their rank or function. Evidently the 'cultural revolution' of general management appears to have been effective. Although there are variations in nuance, there is broad consistency, and managerial orthodoxy, in the views presented by District General Managers, Finance Directors, Planning Directors and Unit managers.

The most obvious and repeated theme was the urgent need to reconsider current patterns of service provision (because of increased demand but reduced resources) and linked to this, the necessity to control clinical practice and medical costs. All of the managers interviewed stressed the need to limit clinicians' autonomy. The DGMs referred to consultants' unwillingness to accept managerial authority; the Finance Directors wished to evaluate and improve clinical activity levels and cost-efficiency; Planners criticised doctors' opposition to any questioning of the rationale for particular services; and Unit Managers complained that doctors were not yet subject to managerial direction, and should be made accountable for the resource effects of medical decisions. Unsurprisingly, those doctors interviewed expressed grave disquiet about the results of retrenchment, and most of them rejected the notion of subjecting their clinical freedom to managerial control.

There is no simple and unequivocal way of knowing whether the views described above are specific reactions to a particular crisis in local funding, or whether they reflect the successful diffusion of the general management ethos and the power of central government to impose constraints and objectives on Health Authorities and their staff. In reality, they are obviously interconnected. Just as increased central intervention and monitoring was a necessary part of a strategy to limit expenditure and to implant the need for efficiency in the NHS (through general management, resource management, performance evaluation and so on) so too were cost-improvement programmes and service reductions a means of coping with budget deficits but also a step towards more extensive bureaucratic regulation of medical practice.

Retrenchment had thus required drastic action, but it also legitimated the extension of managerial control over medical professionals. Paradoxically, budget crises could only be dealt with by managers challenging what had hitherto been the domain of medical prerogative—the basis of service provision, clinical resource use and medical autonomy—but doctors had been opposed to such moves, and had attempted to resist managerial incorporation. Nevertheless, the necessity for cutbacks and rationalisations eventually prevailed, and was being used as a mandate for more fundamental changes in the relationship between clinicians and

managers. In retrospect it can be seen how important this was as a prelude to the creation of an 'internal market' in the NHS, discussed in the next chapter.

NOTE

1 The evidence discussed in Chapter 6 is derived from a study conducted by the author, funded by the Netherlands National Hospital Institute from 1987 to 1989. It was part of a comparative research project undertaken in collaboration with Dr J.B.D.Simonis (University of Utrecht). I wish to acknowledge the support of both the funding body and my colleague Jan Simonis.
Much of the qualitative data is also reported in Flynn (1991a). The help and co-operation of Health Authorities and interviewees is acknowledged with thanks. None of the material reported here is intended to imply any criticism of particular Districts or individuals.

7 Marketisation and management in the National Health Service

Earlier chapters have shown how, in the last decade, there has been a gradual change in the structures of control within the NHS, reflecting New Right economic and political demands for reductions in state expenditure, limits on professional power, and greater efficiency and effectiveness in the public sector. One central element in implementing these changes is the extension of bureaucratic and managerial control over medical professional autonomy. This has involved, among other developments, the introduction of budgeting and performance evaluation techniques which require medical participation in management, and which permit managerial encroachment on clinical activity.

Throughout the 1980s continuous increases in NHS expenditure occurred despite government cash limits, and by the late 1980s, annual crises of overspending (or 'underfunding') led to programmes of rationalisation and retrenchment in most Health Authorities, resulting in the measures described in Chapter 6. Widespread public and political criticism of hospital service cutbacks and lengthening waiting-lists prompted a review of the NHS by the Prime Minister in 1988, and a White Paper proposed radical reform—*Working for Patients* (Department of Health 1989). The main objective of the proposals was to introduce market mechanisms within a health system which remained collectively financed and which continued to provide comprehensive services free at the point of consumption.

While the immediate context of this attempt to marketise the public provision of health care was a period of cost-containment and retrenchment, it was very much part of a broader strategy of rationalisation and restructuring of the welfare state. The Thatcher governments embraced a firm economic and ideological commitment to restraining public spending, challenging producer monopolies, and expanding individual consumer freedom and choice. These key aspects of the New Right political platform were embodied in legislation which denationalised or 'privatised' the

electricity generation, gas, and telecommunications industries (among others); deregulated public transport; severely restricted local government finance and autonomy; expanded owner-occupied housing while reducing social rented housing; and introduced quasi-market mechanisms in education and personal social services. These, and a variety of other policies, represented the overthrow of the postwar welfare state consensus based on citizenship, and endorsed liberal doctrines of individualism, competition and self-reliance (Gamble 1988).

The National Health Service, as the largest public employer in Britain, as one of the largest spenders of public finance, and as one of the clearest examples of a producer and professionally dominated public service, became an obvious candidate for reform. However, given the very high levels of public support for the principle of a comprehensive, universal and tax-funded health system (see Bosanquet 1988), the government recognised that wholesale privatisation was politically unacceptable (Klein 1989). Instead, it recommended a reconstruction of the NHS based on the application of market principles to the *supply* of services within a state-financed system.

This chapter will examine current plans to create a so-called internal market within the NHS, and will discuss their implications for the structure and processes of control. It will be argued that despite a rhetoric of consumerism, patient choice and influence will not be enlarged, because crucial decisions about demand, need and service quantity and quality will be taken by Health Authority managers and (appointed) executive members with no accountability to local communities. Moreover, the regulation of competition between purchasers and providers will necessitate, and intensify, increased managerial influence over General Practitioners in primary care, and over hospital consultants and other medical, nursing and paramedical staff. Marketisation will thus reinforce managerialism.

However, as we shall see, the creation of a market requires hospitals and other units to opt out of direct Health Authority management, and involves the clear separation of suppliers of services from funders. More local delegation and discretion will be necessary, if units and managers are to compete for contracts on price, quality and volume. Faced with the likelihood of more variation in levels and standards of service provision between areas, Health Authorities and the government may be pressed to adopt regulatory measures which constrain local entrepreneurialism.

An effective internal market will undoubtedly raise questions about whether traditional objectives of accessibility, comprehensiveness and equity can be sustained when managerial goals of least-cost efficiency become institutionalised. Central government may be confronted with politically unpopular actions taken by local managers, and may be tempted to reintroduce

strong hierarchical controls. Managers striving to maintain their Unit's market niche and share will be dependent on the co-operation of doctors and other staff, but will endeavour to limit their autonomy, and so may encounter opposition. Therefore the transition from a centrally controlled bureaucracy to a locally managed market will inevitably reveal the contradictions inherent in attempting to combine fundamentally different systems of allocation premised on opposed values.

The NHS internal market will entail significant changes in the funding and production of primary medical care, hospital services and community (long-term non-medical) care. This chapter will focus on the likely changes in the primary (General Practitioner) and hospital sectors, and will assess the implications of those changes for the management of medical services. First it is necessary to place the plans to restructure the NHS in context by considering the 'external' aspect of the internal market—its relationship with the private or independent health sector—as well as other attempts to apply market disciplines and mechanisms. Then, in the next section, the arrangements for, and relationships between, purchasers and providers in a marketised NHS will be described. Some of the most important effects of these reforms on producers and 'consumers' will be outlined in the following section, and finally some assessment of their wider implications will be made.

THE MIXED ECONOMY OF HEALTH

In discussing moves to insert market forces within the NHS it is important to remember both the history of health-care provision in Britain and the current position of the private sector. Briefly, we must note that prior to 1948, health care was characterised by fragmentation, heterogeneity and extreme social and spatial inequality in access and provision. Limited forms of primary medical aid were available for those insured through occupational, trade union or voluntary schemes, and hospital treatment was provided in a variety of independent, municipal and charitable institutions. The Beveridge Report on social security and a national health service, and subsequent Labour government legislation, was opposed by the medical profession, mainly because doctors, who were independent professionals, were resistant to increased state regulation and completely opposed to becoming state employees.

The political compromise which enabled the establishment of the NHS gave significant concessions to the medical profession. Thus, for example, General Practitioners were permitted to remain independent contractors with the NHS, the major teaching hospitals maintained their semi-autonomous status, hospital consultants were allowed to practise privately

in NHS hospitals, and the medical profession (though internally divided) secured an influential position within the decision-making machinery at all levels (Klein 1983).

Although the national health system became the dominant source of most forms of medical care, private consultation and treatment has always been possible. GPs and hospital consultants contracted with the NHS have always been allowed to have private fee-paying patients, and a small but important private (or 'independent') hospital sector has continued to exist, and indeed has expanded in the 1980s. The NHS did not eliminate a private market in health-care: it has coexisted with it, and some would argue, fostered its survival.

There are several aspects to this. First, proponents of a fee-paying health sector maintain that the NHS cannot meet all the demands placed on it, and that patients who are able and willing to pay should be enabled to receive the type of care they prefer, at a time of their choosing, in high-quality facilities, rather than being forced to wait for appointments and treatment, receive less-personalised attention, and endure less-comfortable amenities (see Green 1988; Letwin and Redwood 1988).

Critics of the private sector in health argue that doctors may have a vested interest in keeping NHS waiting-lists long in order to create demand for early private treatment. They also point out that not only do private hospitals employ doctors and nurses who have been trained entirely by the NHS without incurring the costs, but they (and the private insurance companies) avoid and exclude the most expensive and complex medical conditions and treatments, and long-term care, leaving them to be dealt with by the NHS and paid for by collective funding (see Griffith *et al.* 1987; Watkins 1987).

Disputes about whether the private medical sector is parasitic on the NHS, and whether it relieves the NHS by freeing hospital beds for other NHS patients, have fuelled a long-running political controversy. It reached a crisis in conflicts over so-called 'pay-beds' and the scope of private practice during the 1970s. From 1974 to 1976 the Labour government attempted to restrict private practice within NHS hospitals, and was opposed by consultants and their professional bodies. Local strikes and other action by trade unions added to the dispute. After bitter and protracted negotiations, a compromise agreement was reached which required the separation of private hospital beds and facilities from NHS units, and reduced the total number of private beds through a phased programme, but which guaranteed the right of doctors to continue to practise privately as well as in the NHS. Along with other changes in structure linked to a 1979 Royal Commission report on the NHS, the incoming Conservative government countermanded these arrangements.

The phasing out of pay-beds in NHS hospitals was cancelled, new contracts with consultants enabled them to practise privately without any financial penalty, and tax relief for employer-based insurance schemes encouraged a growth in private health insurance (Klein 1983).

During the 1980s, Conservative governments have given consistent support to the growth of private medical services. Town planning legislation was relaxed to facilitate construction of new private hospitals, and minimum-size thresholds were also relaxed; tax incentives to employers gave a stimulus for private health insurers; other financial incentives were available for investors in private hospital developments; and NHS consultants' contracts were made more flexible and gave them more scope to engage in private practice. Health Authorities were explicitly encouraged to co-operate more with the private sector, and were instructed to include the level of local private provision when making their own service plans. These trends, Mohan (1985) observed, indicated that the boundary between the public and private medical sectors was being redrawn in favour of the latter.

The expansion of the private sector brought its own problems, however. Although there was a significant increase in the number of private health insurance subscribers, the growth in subscriptions levelled out, and failed to meet the expectations of for-profit and non-profit insurers and private hospitals. There was considerable spatial unevenness in the location of private hospitals (concentrated in London and the south-east), and problems of overcapacity, lower-than-anticipated profits/surpluses, and rising costs (Mohan 1986). There had been a 'boom' in private health insurance and medical care from the late 1970s through the early 1980s, but this expansion slackened off as increases in claims precipitated increased premiums and reduced cover. The private sector became preoccupied with how to control costs, and how to maintain a viable balance between prices and premiums (Rayner 1986).

The market itself underwent significant changes on the supply side. Between 1975 and 1985 there was a 35 per cent increase in the number of private acute hospitals, a 54 per cent increase in the number of private acute beds, and a doubling of the numbers covered by private insurance. An already fragmented sector based on independent non-profit institutions found itself threatened by commercialisation and invasion by North American for-profit enterprises (insurers and hospitals). Consequently, private medicine was transformed from a cottage industry to big business (Higgins 1987, 1988) but with all the difficulties of maintaining its market share and profit levels.

Undoubtedly the private medical sector has flourished, partly as a result of dissatisfaction with NHS waiting-times and quality of service. But the

rise in private insurance is mainly explained by corporate subscriptions: company schemes became popular as perks and subsidies to employees, as well as having taxation advantages. Individual subscribers are a small minority of all private health insurance consumers (Busfield 1990a). Indeed, far from demonstrating the virtues of individual choice and consumer sovereignty, Busfield has argued that individuals experience little effective choice in private medicine, and confront a market dominated by powerful corporations (Busfield 1990b). There are a variety of motives for the decision to participate in private health insurance, and as one recent study has shown, private subscribers have a high regard for the NHS and have ambivalent attitudes towards their own use of the private sector (Calnan and Cant 1990). We cannot, therefore, assume that the growth of private health insurance and treatment are simply a reflection of consumer preferences *per se.*

Nevertheless, the scale of the private market is significant, and its very success has been used as a justification for criticism of the NHS, and as a model for reforms. Estimates about the size and importance of private medical services vary. One report indicated that independent hospitals (non-profit and for-profit) treated 500,000 inpatients and day cases in 1986 (the largest element of this caseload was abortions) which represented 6 per cent of all NHS inpatients and day cases. There were about 3,000 private beds in NHS hospitals in 1986, and about 200 private hospitals, with over 10,000 private acute beds (Appleby 1989). The government White Paper *Working for Patients* claimed that 5.34 million people, or 9 per cent of the UK population, were covered by private health insurance in 1989. The private hospitals contained 6 per cent of all acute beds, carried out 17 per cent of all elective (that is non-urgent) surgery in England, and private nursing homes provided almost all long-term residential care for the elderly (Department of Health 1989).

The 1989 White Paper praised what it termed the independent health sector, for relieving pressure on the NHS, for increasing the options available to patients and doctors, for providing cost-effective treatment of NHS patients through special contracts, and for responding 'flexibly and rapidly to patients' needs' (1989:67). The government recommended more use of private hospitals by Health Authorities through contracts for specific services, more joint ventures and partnerships for shared facilities, and more local co-operation between NHS units and the private sector. Clearly, then, private health insurance and medical services are seen as complementary to the NHS, and the government has encouraged the continued growth of the private sector and a mixed economy of health.

One further important aspect of marketisation is the policy of competitive tendering or 'contracting out' of NHS non-medical services, which emerged

in the 1980s. Linked to a series of measures intended to stimulate increased efficiency and cost-effectiveness, from 1983 Health Authorities were compelled to go through a procedure of seeking tenders for contracts for hospital catering, cleaning and laundry services. Bids from in-house staff groups had to be assessed against bids from private contractors, and there was strong government pressure to award contracts to the private sector. As noted in previous chapters (and particularly Chapter 5), this approach was an integral element in the introduction of general management, but it was also a political reaction to long-running industrial relations disputes with ancillary staff and their trade unions.

The overall result has been that although many contracts were awarded to the private sector, most (85 per cent) were obtained by in-house staff. Within Health Authorities, working practices have been modified and some redundancies have occurred. Certainly there have been substantial improvements in productivity—'efficiency savings' from competitive tendering have formed a significant element in the Cost Improvement Programme (which yields about 1 per cent of all Health Authority annual revenue), although there are disagreements about the accuracy of the accounting (see Key 1988; King's Fund Institute 1989a, 1989b).

According to government estimates in 1988, competitive tendering in catering, domestic cleaning and laundry services had produced annual savings of £120 million in the United Kingdom, comprising about 17 per cent of previous costs. Competition was regarded not only as a source of financial savings, but also led to 'clearer performance criteria, improved productivity, innovative ideas and techniques, and better management' (Department of Health 1989:69).

There are continuing disputes about the scale of privatisation, and about its effectiveness. According to one hostile commentator, the initial dominance of private contractors in 1984/5 was reversed in the second round of competitive tendering—by February 1990, 77 per cent of all contracts had been won by NHS teams. It was claimed that in hospital cleaning and catering, private contracts are controlled by one or two companies, and that there has been much evidence of falling standards and failures to perform to contract specification. At the same time, 10,000 NHS jobs have been lost, and wages and conditions for private contractors' employees have been poor (McGregor 1990).

This view has been challenged by a representative of the contractors' association. He has argued, to the contrary, that in 1990 private contractors were winning a growing share of NHS domestic services, that evidence of declining standards was exaggerated, and that private staff conditions and wages are better than those found in the NHS. Most importantly, however, he suggested that

> from a management standpoint, competitive tendering has been a huge bonus to those prepared to use it. They have been allowed to introduce a root and branch reform of methods of work at a stroke. They were also spared hours of tortuous negotiation with the trade unions.
>
> (Hall 1990:847)

This viewpoint illustrates very clearly the main significance of privatisation or competitive tendering in so-called ancillary services. Whatever the amounts gained in productivity and efficiency savings, it facilitated a new style of NHS management, and made possible the application of market disciplines and criteria. Having introduced competition to the provision of non-clinical services, it then also became possible to extend it to the medical and paramedical areas; thus, for example, the government have suggested that Health Authorities should consider competitive tendering in hospital pathology and pharmacy services.

In a similar way, all Districts and Units have been encouraged to explore new ways of obtaining extra revenue to supplement their Treasury allocation and any cost-improvement savings. 'Income generation' and NHS enterprises have become increasingly important not simply as a way of offsetting the effects of central underfunding but also in establishing a business orientation among Health Authority staff. Income generation comprises a number of different elements: charges to hospital patients, sales of clinical services to private hospitals, leases and sales of land and property to the private sector, sales of non-medical services, and so on.

National Health Service hospitals have always been able to charge private patients for clinical and 'hotel' services provided through pay-beds, and since 1987, Districts have been permitted to fix their own price for pay-beds. In 1986/87, charges to persons using hospital services yielded £91 million (Health and Personal Social Services Statistics for England 1988: 14). In 1988 it was estimated that pay-beds produced an annual income of £60 million, but by 1990 revenue from private patients rose to £73 million (King's Fund Institute 1988:14; Robinson 1988a:52; Laing's Review 1990). The expectation is that this will increase as NHS hospitals attempt to expand their market share of private patients by competing more aggressively against the private hospitals.

In addition to pay-bed income, some Health Authorities have begun selling other services to external customers. NHS catering and laundry services have obtained contracts with non-NHS organisations, hospitals have sold or leased sites to banks, retail shops and other commercial companies, and agreed to advertising and sponsorship deals. Some Districts have contracts to sell pathology, X-ray and diagnostic facilities, pharmacy

and other paramedical services to private hospitals. Others have negotiated agreements with private companies to finance new medical units and capital investments, to be shared between NHS and private users. Land and property sales have also become more frequently used as a means of raising extra funding (see King's Fund Institute 1988:12–14; Social Services Committee 1988b: paragraphs 115–25).

The overall impact of income generation on NHS finance is not large: the King's Fund Institute estimated that all schemes combined would only produce revenue equivalent to just over 1 per cent of the total national budget for the hospitals and community health service (King's Fund Institute 1988:12). Questions have been raised about the economic efficiency and social equity of income generation schemes: do they misuse so-called 'spare capacity' in the NHS, and does the accident of inherited land or other capital assets give an unfair advantage to some Units and Districts? However, the key points to be stressed here are that since the mid-1980s the government has consistently encouraged Health Authorities to raise external (non-Exchequer) revenue, and that income generation is another clear example of the importation of commercial techniques and market values in the public sector.

The impact and significance of income generation within the NHS is thus not merely financial; its sociological and political importance lies in the changes it represents in organisational culture. While public sector organisations may strive for efficiency and value for money, the New Right assertion is that they are inefficient and wasteful. Consequently, the optimal use of productive resources can only emerge if market disciplines of competition and profit-seeking are applied. But this constitutes a novel and major departure from conventional practices in public administration, and especially in a service hitherto dominated by assumptions that its objectives and methods of operation were governed by *non-economic* criteria.

Thus we can see that through the maintenance of private practice and pay-beds within NHS hospitals, through competitive tendering, and through income generation and collaboration with the private sector, the NHS has become increasingly linked with (and partly enmeshed in) the private health-care market, and has been increasingly required to mimic the market and adopt entrepreneurial practices and values. The government, in line with its other policies for state restructuring, has attempted to shift the balance between the public-private mix in health towards the private sector. Moves towards the complete marketisation of the NHS are to be found in the government's 1989 White Paper, *Working for Patients*, which advocated the adoption of an internal market The next section therefore examines those proposals.

THE INTERNAL NHS MARKET

As Chapter 6 showed, from about 1986 a major financial crisis emerged in the NHS, and there was extensive publicity and parliamentary debate about hospital waiting-lists, cutbacks in hospital services, and demoralisation among health-service staff (see Klein 1989; Small 1989). There was much political argument about the need for reform in the NHS, and a series of publications giving critical assessments of the successes and failures of the NHS on the fortieth anniversary of its foundation. One theme became predominant: urgent structural changes were necessary, and those changes should include consideration of market-like mechanisms.

Several New Right organisations made proposals for radical measures in the financing, organisation and delivery of health-care. Butler and Pirie (1988) from the Adam Smith Institute accepted that there was a general malaise but denied that this was a result of inadequate funding: the structure of the NHS itself was faulty. Among the deficiencies of the system, Butler and Pirie highlighted the lack of a customer-orientation, excessive centralisation, lack of awareness of real costs among both patients and staff, and the absence of incentives to seek efficiency. They referred to public choice theory, and the likelihood of distortion in resource allocation and use caused by producer dominance and bureaucratic inertia. They reviewed a number of possible reforms: better management, more charges to patients, more involvement by the private sector in insurance and service provision, more contracting-out of NHS functions, and the use of an internal market for NHS hospitals to trade spare capacity.

Other more radical options were also suggested: universal private health insurance, a voucher system, and health maintenance organisations (HMOs provide complete health-care packages for fixed prepaid annual premiums). Butler and Pirie favoured a modified version of the HMO which they termed health management units, which would introduce a market system within the NHS. Funding would reflect patients' expressed preferences, and producers would be motivated to adopt cost-effective procedures under such a system. Butler and Pirie noted that combining this with tax-funding and free consumption would be difficult, but they pointed to other current market reforms such as those being implemented within the state education sector as an indication that market influences could secure more choice, efficiency and variety.

In a widely publicised pamphlet, Goldsmith and Willetts (1988) from the Centre for Policy Studies criticised poor management and long hospital waiting-lists in the NHS, and advocated adaptation of North American-style solutions such as HMOs and preferred provider organisations (PPOs). Problems in the NHS were explained not as a result of insufficient finance,

but as the consequence of the large size of the organisation and the absence of competition between its constituent parts. A break-up into competing units was necessary to improve efficiency: in particular, it was essential to separate responsibility for *funding* health-care from responsibility for *providing* it. Goldsmith and Willetts therefore recommended an internal market based on 'managed health-care organisations', combining the existing functions of Family Practitioner Committees and District Health Authorities, and enabling these organisations to purchase health-care by making contracts with various providers.

Other New Right critics also bemoaned the inefficiency of the NHS. Letwin and Redwood (also of the Centre for Policy Studies) described the NHS system as a 'bureaucratic monster' which neglected patients' interests and allocated resources irrationally (1988:4). Hospital waiting-lists were a clear example of the failure of a centrally planned and collectivised system, which could not match supply and demand. Bureaucratic overload added to the problem, they argued, so a fundamental reappraisal was needed to remedy the basic defects of the system. They reviewed a number of alternative measures—joint NHS-private sector ventures, extensions of charging, health-tax credits, an insurance scheme, making the NHS an independent trust—and urged the government to consider all of them as realistic possibilities for reform.

These and other suggestions for radical reform of the NHS clearly had some influence on the government, and stood in stark contrast to the public protests about inadequate finance and professional bodies' lobbying about the need for extra funding (see Klein 1989:232–6). A new orthodoxy had emerged which favoured the adoption of a so-called 'internal market' within the NHS, and this orthodoxy secured a key position in the 'review' of the NHS announced by the prime minister in January 1988.

Ideas about an internal market had spread, and were approved cautiously, or enthusiastically, by a variety of analysts (Green 1988; Robinson 1988b), following publication of a paper by Enthoven, a North American academic who suggested that NHS efficiency could be enhanced if Health Authorities and hospitals traded with each other, buying and selling clinical sevices to earn revenue (Enthoven 1985). Faced with the political reality of entrenched public support for the maintenance of a comprehensive, universal, collectively tax-funded health service free at the point of consumption, the government eschewed fundamental radical reforms (such as switching to private health insurance), and instead endorsed proposals for an elaborated version of the internal market idea.

The White Paper *Working for Patients* and its associated series of working papers (Department of Health 1989) was published in January 1989, and most of its proposals were incorporated in subsequent

legislation (principally the NHS and Community Care Act 1990). According to Day and Klein (1989) the White Paper signalled a process of modernisation and transformation in the NHS, and was the beginning of a new era involving unprecedented change. The government did not explicitly address demands for increased NHS finance: instead, the basic system of government funding was retained, but the organisation and delivery of services was changed.

The White Paper asserted that there was a need for change because demand had risen and there was disquiet about performance in the delivery of health care. Two main objectives were initially identified—to secure more choice for patients, and more satisfaction and rewards for NHS employees; and three aims were listed: to extend patient choice, delegate responsibility and obtain value for money.

The way in which finance is allocated to the hospital and GP service is to be changed. In future, GP practices and Health Authorities will be funded on the basis of their resident population (weighted for age and morbidity), and the previous system of redistribution to equalise resources between different parts of the country is to be ended.

For the first time in the history of the NHS, GPs (initially those with 11,000 patients on their list) will be given a fixed, cash-limited budget. They will be expected to negotiate contracts with hospitals for the supply of diagnostic, medical and surgical services for patients on their list. These contracts can be made with NHS or private hospitals, and can be based on a block contract for defined services, case-numbers and waiting-times; or on a cost and volume arrangement in which hospitals receive payment for a basic level of activity but supplementary work is charged for at a higher rate; and cost-per-case, where items not covered by ordinary contracts attract additional charges.

At the same time, new contracts between Family Practitioner Committees (now known as Family Health Service Authorities) and GPs will require doctors to expand the range of their services, and make their practices more flexible and consumer-friendly. Targets for ante-natal care, immunisations, health screening and so on, as well as medical audit, will make possible the monitoring of medical perfomance. Annual indicative drug budgets will be set for each GP practice, and doctors will be expected to adjust their prescribing to this allocation.

The belief is that efficient and successful practices will attract more patients (and thus revenue), and doctors' incomes will be related much more to actual services provided rather than registrations alone. Practices which attract the most customers will receive the most money, and competition between GPs will give real incentives to improve performance, and better value for money.

In the hospital sector, suppliers of health care are expected to compete to provide services under contract for GPs and Health Authorities. The larger acute general hospitals will be able to opt out of direct management by a District Health Authority, and become self-governing trusts or self-governing hospitals (SGHs). Other hospitals and community units may also choose to follow this route but remain within the NHS system. SGHs will earn their revenue from contracts for the provision of specific types and quantities of clinical and diagnostic services. They will be able to raise capital on the commercial financial market, set their own staff salaries and conditions of employment, and act as trading businesses, albeit within financial limits fixed annually by central government. Hospital consultants' contracts are to be amended to make them directly accountable to Unit managers and SGH executives, and doctors are to be given managerial responsibility for the use of clinical resources. Procedures for medical audit will be extended and formalised, with managers involved in the review of performance monitoring.

The District and Regional Health Authorities will carry out co-ordinating and regulatory functions. Districts will decide what the 'core' of basic services comprises, which each SGH must provide to patients in its locality. Districts will set the framework for negotiations about terms and conditions of contracts between GPs, SGHs and private hospitals, and will exercise quality control supervision over suppliers. The composition of Health Authorities will be changed to make them more 'business-like' —by reducing the number of lay members, by removing local authority representatives, and by creating boards consisting of a small number of senior executive managers and several non-executive members under a non-executive chairperson.

The intention behind these changes is to create conditions for a market between purchasers and providers of health services, and to stimulate competition among various suppliers. This is expected to engender greater cost-effectiveness and responsiveness to consumers. Districts and GP budget-holders will have more influence over the range and standard of hospital services, because money will 'flow with the patients'. GPs will be in competition with one another to attract and retain patients. Self-governing hospitals will have more autonomy and will have financial incentives to improve efficiency and quality. In general, it is assumed that patients as consumers will benefit through reductions in waiting times for consultations and treatment, and through enhanced standards, and because higher levels of productivity will permit better use of NHS resources.

IMPLICATIONS OF AN INTERNAL MARKET

The publication of these plans gave rise to much media, public, professional and parliamentary discussion, and some controversy. Considerable confusion surrounded the feasibility of implementing them, and at the time of writing there is still some uncertainty about the detail, scale and timetable for some of the reforms. There was sustained and vociferous opposition to the proposals by the British Medical Association, and by some of the other medical, paramedical and nursing professional bodies, as well as notes of caution voiced by Health Authority representatives and some segments of the health-service management (see Social Services Committee 1989). However, although there has been some minor revision, and adjustment of the schedule for implementation, the government's plans for an internal market remain in force, and can be expected to shape the immediate future of the NHS. Precise outcomes are difficult to predict, but there is broad agreement among several authoritative commentators about the likely implications and effects of the internal market (King's Fund Institute 1989b; Maynard 1989; Robinson 1990; Williams 1989).

GP budget-holders will have incentives to seek surpluses and avoid overspending. As a result, doctors can be expected to become more selective in accepting or keeping patients with high-cost or high-risk medical conditions, because they might absorb disproportionate amounts of time, drugs and treatment. There is a possibility of adverse selection, in which patients with very complex and chronic problems, and those needing continuous and expensive forms of treatment, are regarded as placing too great a burden on the GP fixed budget, and so may be avoided or excluded.

Given the constraints on finance, primary care doctors may wish to safeguard their budget by 'under-treating' and by minimising the number and type of patients referred to hospitals under contract. Some patients may not be referred to hospital specialists, and GPs may attempt to treat them within their own practice. The indicative drug budget, however flexible, still places a resource limit on GP prescribing, so there may be a tendency to under-prescribe. Traditionally, GPs were able to refer patients to any specialist and any hospital in the NHS, but with contracts in place, this professional privilege will be severely curtailed: patients must go to those hospitals with whom the GP or Health Authority has arranged a contract. It is also likely that the range of hospital services available locally will diminish, as economies of scale and specialisation reduce the clinical services on offer, let alone accessible, to local communities.

Greater competition between GPs for patients may force improvements in primary care—more services, better appointment systems, better facilities. But it is equally possible that there will be (indeed, it is almost axiomatic

that there must be) increased variation in GP care, which has long been unequally distributed and heterogeneous (Wilkin *et al.* 1987). Due to demographic and socio-economic factors, and differences in morbidity, mortality and consultation rates, there are variations in local needs and demands, and thus variations in the potential to experience budget deficits and surpluses. Further, as Maynard (1989) has observed, GPs may be able to accumulate budget surpluses in areas with affluent populations and patients able to subscribe to private health insurance, whereas, conversely, GPs risk deficits in areas with disadvantaged populations. The social and spatial inequality of health, and health-care, may thus be reinforced.

Providers in the hospital sector face different pressures in a competitive market Self-governing hospitals must seek custom from GPs and Health Authorities, and will presumably seek to maximise their income. District authorities will define minimal core services which every hospital must provide, but beyond that hospitals will be free to develop their services in cost-effective and revenue-expanding ways. All-purpose general hospitals may lose some of their conventional specialties, as economies of scale and concentration favour certain units over others. Some hospitals may market particular expertise, and attract customers from outside their catchment area at higher-than-average prices. Both of these trends may distort the pattern of local provision and accessibility. It is unclear whether managers will be completely free to expand profitable services at the expense of less profitable ones, but this must be one corollary of a market system.

Since money will flow with patients, and since competition is presumed to yield efficiency, it must be the case that efficient hospitals will prosper, and less efficient ones must adapt or, ultimately, close. Whether this would be permitted politically is unclear, but there are practical difficulties. Both complete closure and major expansion involve decisions on large-scale capital investments, which are complex, time-consuming and not easily resolved. If less-efficient hospitals try to overcome their problems, the most likely strategy is to reduce costs, and this may entail reductions in standards and poorer quality of services (King's Fund Institute 1989b).

A related and crucial aspect of these changes is pricing policy, which has hitherto been almost irrelevant in the NHS. Because of the absence or unsatisfactory nature of data on costs and resource use in the NHS, there is insufficient or unreliable information to allow purchasers to make price-quality trade-offs. Massive investments in information technology, resource management and costing systems have been made, but the relationship between contract prices, tariffs and quality has yet to be agreed between competing purchasers and providers. Within hospital units, there may be conflicts between departments and specialties about the apportionment and

recharging of costs, and disputes between 'efficient' and 'less-efficient' units over perceived subsidies.

Hospitals with large elements of research and teaching may have above-average costs which must be passed on in higher prices. Hospitals occupying expensive city sites and having major capital investments will (because of the requirement to charge for the use of capital assets) also have to levy higher charges. To attract and retain scarce health service staff, SGHs may have to offer advantageous salaries and conditions, thereby pushing up labour costs, and tariffs. The consequences of all of these innovations are as yet unknown, but once again they constitute radical departures from traditional financial practice in the NHS.

The internal market will undoubtedly reinforce the power of Health Authority managers, because they are to be given the key role in negotiating and supervising contracts between purchasers and providers, and in monitoring quality and regulating competition. Although GPs will play a role in setting the basic terms and conditions for contracts with hospitals, this will be done under the aegis of Family Health Service Authority managers in negotiation with District Health Authority managers, overseen by the Regional Health Authority. Health Authorities are unelected and arguably unrepresentative (being appointed by the Secretary of State), and their business is likely to be guided very firmly by executive managers. Inside hospitals, SGH executive boards are expected to exercise stronger control over clinicians, and managers will have greater power over strategic policy and resource allocation. Consultants will be directly accountable to managers, responsible for clinical budgets, and subject to audit in which managers are involved.

In all of these emergent changes, despite the rhetoric of consumerism, it is evident that the internal market will be a managed market Power may shift away from professional medical interests, but only to be arrogated by Health Authority managers acting as brokers, intermediaries and financiers (see Flynn, R. 1991b; Day and Klein 1989).

The Deputy Chief Executive of the NHS was reported as emphasising the commissioning role of managers in the new contract system: in his view, commissioners and providers had to recognise that the market would be a managed one, but one where the commissioners acted as proxies for market forces (Millar 1990). Thus for example, in drawing up specifications for contracts, it is the managers' responsibility to determine quality requirements, and to ensure compliance with specified standards. Much discussion has centred on the extent to which it is feasible to define quality for clinical processes and outcomes. But under the planned arrangements, *managers* will define 'demand', and evaluate contractors' performance.

Indeed, managers are expected to construct what some writers have described as 'epidemiologically-based business plans' *(sic)* so that purchasers can assess their local population's needs and the effectiveness of provision (Buchan *et al.* 1990). Similarly, purchasers of health care will wish to be assured not only that the exact number of treatments were undertaken at an agreed price, but also that they conformed with specified clinical standards of performance and outcome. Assuming that the methodological and technical problems can be resolved (or simply ignored), this type of activity significantly enlarges the scope for managerial intervention in health-care planning and delivery, and gives managers unprecedented power.

This power is unlikely to go unchallenged by clinicians, and there are also inter- and intraorganisational constraints which may lead to difficulties. At the core of these is the potential conflict of roles and interests between purchasers and providers, which results from the separation of funding from provision. Purchasers will estimate their needs and service requirements and draw up contract specifications; providers will attempt to forecast demand, define service requirements and estimate costs. They will then negotiate detailed contracts, agree tariffs and proceed to produce the services.

The first issue that arises is how far District Health Authorities as purchasers will be able to influence supply; in reality the providers (SGHs and directly managed units—DMUs) may attempt to dictate the pattern of service provision. Districts as purchasers must relinquish key areas they formerly controlled—the allocation of real resources and actual service delivery—to provider SGHs and DMUs, and units in a competitive market may endeavour to secure contracts with a variety of alternative purchasers (Meadows 1990). Thus the internal market cannot be presumed to function on the basis of identical or shared interests. Bargaining is inherent in a competitive system, and an internal market may exacerbate the conflict and fragmentation between Units and Districts which often exist in the NHS.

Since revenue will depend on patient referrals and the quality of treatment provided, it is assumed that purchasers will be in a dominant position, but it is unclear how far financial incentives can bring about significant change in the type or range of services. The practice of contract purchasing is said to be based on a concept of 'leverage': buyers use their financial power to change suppliers' behaviour (Flux and Best 1990). This idea is central to the plan for GP budgets and Health Authority purchasing of hospital services. However, hospitals may only be able and willing to make marginal adjustments to their 'product'. Moreover, because of the coexistence of overlapping and uncoordinated Health Authorities and GP

groups buying care for patients, there is the possibility of confusion about market demand. The leverage placed on suppliers therefore may not be direct, or sufficiently large.

Confusion and contradiction may also characterise the role to be played by District General Managers in the new internal market. The major responsibility of DGMs will be to ensure that their Health Authorities obtain effective and efficient contract compliance by providers. But most DGMs will remain responsible for those units which have not opted out of Health Authority control—DMUs. The latter will expect to be awarded block contracts and will probably wish to maintain or expand their own services. But DGMs' allegiances to their own Units will be strained by the necessity to award contracts through the competitive market.

If Districts discover lower prices and/or better quality for a fixed volume of caseload in Units outside their area, will local hospitals be artificially protected from competition, or allowed to decline, or be forced to adopt stringent cost/quality measures? Should the DGMs remain deliberately remote from the operational management of local DMUs, in order to be insulated from such conflicts, even though the DGM is held accountable for the overall performance of all Health Authority units?

Various options have been outlined as possibilities (Crump *et al.* 1990). First, DGMs may try to have a close involvement with their DMUs, but this runs the risk that the Health Authority receives what the units produce, rather than what the local residents need. Second, DMUs could be treated as if they were self-governing, although they are not. They would be forced to take appropriate action to compete: if successful, they could become truly independent trusts, if unsuccessful, presumably they would be 'rationalised'. Again, however, DGMs are responsible to the Health Authority and to external purchasers if Units fail to meet finance and quality targets, so they might not want to be distanced from Unit management (see Plummer 1990).

Third, all Units could be encouraged to become fully self-governing as soon as possible, but this might not be feasible in practice because of the composition and functions of Units, and might not be welcomed by all managers and staff. One final option is to contract out the purchasing function to another agency, and concentrate on service provision, but this might be seen as an abdication of managerial responsibility, and further weakens the already fragile and tenuous chain of local accountability.

Clearly the drafting, operation and monitoring of contracts will not only be technically difficult but also politically problematic, as purchasers and providers attempt to secure the most advantageous market position. Thus there are inevitable conflicts of interest within Health Authorities, between Health Authorities and external suppliers, and between GP groups and hospitals. It might be observed that similar conflicts of interest exist under

pre-market conditions, but this would disregard the importance of an accountable unitary Health Authority, and the fact that a market system will lead to greater fragmentation in health-service provision, and, through financial incentives, positively demands competitive and surplus-maximising behaviour.

The result, according to one commentator, is likely to be two countervailing tendencies: first, a significant increase in opportunistic behaviour and collusion (cartels) among suppliers; and second a selective tightening of central government controls, as ministers attempt to regulate contract disputes, market failures and cost escalation (Hughes 1990).

The probability of purchaser-provider conflicts, fragmentation and market failure has also been indicated by a simulation exercise involving senior health service personnel (Liddell and Parston 1990). Participants acted out the main decisions for contracting hospital and GP services in one region over a notional three-year period, with data and information based on real Districts. As the simulation proceeded, Health Authority purchasers formed a consortium with the Family Practitioner Committee and GP budget-holders. Gradually, GP budget-holders effectively controlled the whole of the finance for elective admissions, and Health Authorities had little leverage over the hospitals. Community units were overwhelmed by early discharges of patients from hospitals, the hospitals were only able to accept emergency admissions, and the Region was forced to plan reductions in the GP budgets.

Eventually, as a result of these pressures, 'Purchasers began to compete for limited hospital services; being unable to adjust volume or price, purchasers actually pressed providers to lower quality in order to meet contracted caseloads and stay within their budget' (Liddell and Parston 1990:731). The simulation exercise showed that actors pursued divergent strategies, that outcomes, quality and benefits to patients were not as hoped, and that in its third year, the market crashed.

Whether this scenario is an accurate prediction of the future NHS market remains to be seen. What does seem clear is that in the new system, managers will undertake fundamentally new roles and responsibilities, and that in the drive towards a competitive market, substantial changes must take place in traditional arrangements for the planning, budgeting and delivery of services. 'Business planning' will become essential, as managers identify markets and demands, as they sell their products, win contracts against competitors and generate income (Elphick and Dillarstone 1990).

Managers will attempt to become, in the current jargon, 'proactive', and they will challenge medical professionals' conventional assumptions about health needs and patterns of provision. At the same time, despite

affirmations about extending patient choice and customer orientation, it is not clear how a system formerly predicated on medical professionals' dominance but now to be transformed by a managed market, will enhance consumer influence.

There is, of course some dispute about whether the term 'consumer' is appropriate or valid in relation to patients receiving health care from professionals, and ambiguity about who the consumers of marketised health services are: patients, GPs, Health Authorities, self-governing hospitals are all users (see Flynn 1991b). Patients and prospective patients are highly differentiated and cannot be regarded as having similar demands or as seeking identical commodities (see Social Services Committee 1989: 34–6). In addition, the 'consumption' of health care is like very few (if any) other market transactions, because of the inherent unpredictability of illness, patient dependence on expert knowledge and skill, and important externality effects (Mooney 1986). Nevertheless, accepting that the use of the term 'consumer' (referring to patients) and the advocacy of consumerism has considerable ideological and political currency, it is still difficult to show how the planned internal market will improve patient choice or consumer influence.

As we have already noted, it is budget-holding GPs who will act as the guardians and gatekeepers for their patients. They will decide on the content of primary care they make available, and will play a major role in the specification and placing of contracts for hospital services, under Health Authority supervision (Maynard 1989). Patients may in future be able to compare GP services and transfer from one practice to another more easily, but the scope for consumers to penalise unsatisfactory doctors, or to object to inadequate contracts, is unlikely to be large.

At the level of the Health Authorities, consumer representation is notable for its virtual absence, apart from the weak (and declining) role of statutory Community Health Councils (CHCs). The number of Health Authority lay members is to be reduced, non-executive members will be appointed by the Secretary of State by virtue of their personal qualities and experience, and there will be no representatives from local government The statutory right of CHCs to be consulted over major changes in service provision is to be restricted, and self-governing hospitals and budget-holding GPs may be exempted from CHC oversight. Thus even existing token forms of consumer representation are likely to be further emasculated (Jobling 1990; Sheldon 1990).

In effect, members of the new, more 'business-like' (*Working for Patients* 1989:65) Health Authorities will act as corporate trustees for local populations, without any electoral mandate or direct accountability. Health Authorities, according to some leading analysts, will in future become the

local agency of the NHS management executive, and 'strengthening the managerial role of HAs means downgrading their role in providing a channel for local public participation in the NHS' (Ham and Best 1990: 483). Most of the key decisions will be taken by executive managers, and the job of non-executive members will be to monitor and evaluate their success; how this is to be done remains as yet unknown.

Consequently, the prospects for consumers are not good: patients' dependency on professionals will remain, and professional dominance may simply be displaced by managerial control, with even more complexity in the social relations of production. Patients are not likely to be given access to discussions about clinical outcomes and assessments of quality, and they will not be involved in provider-purchaser negotiations over contracts.

Health-service users are not going to be 'empowered' in the internal market, because patient choice will be exercised vicariously through a new 'managerial paternalism' (Pollitt 1990:1). As the director of the Greater London Association of Community Health Councils has argued: 'The shift of power to managers and the concomitant weakening of professional power does not enhance the status of patients' (Winkler 1990:5). She points out that managers are unwilling to share decision-making with users' representatives and are resistant to the idea that their own actions should be subject to external consumer scrutiny.

If consumers/users are not empowered in the marketised health service, what about the position of employees in the new entrepreneurial, flexible system? The White Paper gave two objectives: better health care and greater choice for patients; and greater satisfaction and rewards for those working in the NHS 'who successfully respond to local needs and preferences' (Department of Health 1989:3–4). Again it is too early at the time of writing to give any detailed information about the effects of a market on health service salaries and working conditions. However, there are some indications of probable developments, which again point to the strengthening of managerial control.

The important starting point which must be noted is the enormous size of the NHS as an employer, and the expenditure on staff costs. In 1989/90 staff costs accounted for three quarters of total NHS costs: about £17.5 billion was spent on the wages and salaries of 1.25 million employees and contractors (such as GPs and dentists). In 1988 there were, for example, more than 44,000 medical and dental staff, 403,000 nursing and midwifery staff, 116,000 thousand administrative staff, and 107,000 ancillary staff (NAHA1989:11).

For most staff, the basic framework for establishing terms and conditions of employment, and salaries and wages, has been a national statutory system of bargaining arrangements known as the Whitley Councils. These were

composed of staff organisations' representatives and NHS management representatives appointed by the Secretary of State, and consisted of ten 'functional' councils covering administrative, ambulance, ancillary, dental, medical and other groups (NAHA 1987a).

Throughout the history of the NHS, and especially since the mid-1970s, there have been a series of industrial relations conflicts and disputes over pay and conditions for virtually all staff groups. In the 1980s, after intense and protracted disputes (involving limited forms of strike action in some cases), the government agreed to establish separate review bodies and additional negotiating procedures to settle doctors' and nurses' annual pay claims. This has led to outcomes which have not been fully accepted by all of the staff groups, and so NHS wage bargaining and industrial relations have continued to be a source of political controversy; one notable example was the bitter dispute and strike over ambulance officers' pay in 1989–90.

The White Paper's proposals must therefore be discussed against this background. The government indicated that in the reformed NHS there is to be greater flexibility in conditions and wages: managers are to be permitted to relate pay rates to local labour markets, and to reward individual performance (Department of Health 1989:17). This appears to apply to all types and grades of staff. Self-governing hospitals in particular will be allowed to determine their own tailored ('Taylored'?) contracts and 'employment packages' with consultants and other medical, nursing and other staff. Whether this change will be accepted by and yield benefits to all employees is uncertain.

In a leaked report on personnel policy in the marketised NHS, one Regional Health Authority has indicated that it may adopt an aggressive and confrontational style towards trade unions. The report, among other ideas, suggested dividing hospital workforces into core and non-core staff. The former (doctors, nurses, paramedics and senior managers) would be offered attractive remuneration packages (including performance-related pay, company cars, sabbaticals), whereas the latter (hotel services, laboratories, portering, pharmacy, supplies) would probably be contracted out to the private sector. The report also allegedly referred to getting rid of staff described as renegades, subversives and opposers of the new arrangements (Moore 1990a).

The abandonment of national collective bargaining was also proposed in a report undertaken for the NHS management executive in 1989–90. This suggested that individual managers should have the power to determine pay and conditions, and should have increased discretion in the management of staff discipline, with an end to the practice in which Health Authority members conduct appeals on grievances and discipline. It also recommended that

doctors' conduct, work patterns, performance and pay should be subject to local management control (Moore 1990b).

Clearly then the introduction of an internal market is likely to entail substantial changes in employment practice and wages policy. Various outcomes are possible, not all of which conform with the expressed intentions (greater satisfaction and rewards for employees) behind the reforms. Greater flexibility in salaries and conditions will mean variation between self-governing hospitals, between SGHs and DMUs, and between hospitals in different cities and regions, with substantial disparities between high-wage, high-cost labour markets and other areas. Opted-out trusts will be in competition to attract and retain all types of staff, and as a result may offer superior wages and conditions (see Social Services Committee 1989: 69–71).

The results may be that overall labour costs rise, some Health Authorities may be unable to afford to make contracts with certain SGHs, and differentials may lead to a more uneven distribution of nursing and medical specialists across the country. In addition, local flexibility in wages and wage bargaining is likely to exacerbate the already weak position of the ancillary, non-nursing, non-medical workers. Deregulating the NHS pay structure and personnel policy may thus create new inequalities, and intensify existing grievances among many staff groups. Further, it transfers power away from national collective bargaining procedures, and places it firmly in the hands of local managers, who are charged with the responsibility to secure the efficient use of resources, especially staff.

Thus it can be seen that the internal market will result in greater fragmentation, heterogeneity and possible inequality among producers as well as consumers. Indeed, these are the inevitable consequences of competition and flexibility. Moreover, in order to bring about a process of marketisation, managers must be given enhanced powers and more local autonomy. In negotiating contracts, in acting as proxies for market demand and as brokers between purchasers and providers, and as direct employers, managers will occupy crucial strategic and operational roles in the marketised health service. This represents a fundamental transition from a formerly bureaucratically administered system to a more mixed economy of health, and will alter the social relations of production in significant ways, by expanding managerial influence.

CONCLUSIONS

The application of market principles and practices to the NHS was part of a systematic attempt by the Thatcher governments to restructure the welfare

state. Continued moderate growth in public expenditure was unable to meet the real costs of increased demand for health care, an expansion in the elderly population, advances in medical technology and inflation. Cumulative underfunding led to cutbacks in services, provoking intense public and professional pressure for more state finance. In 1988 the Conservative government was forced to undertake a review of the NHS, and serious consideration was given to radical changes in the financial system as well as the organisational structure.

Faced with the risk of widespread lack of political support, the government edged away from full-scale privatisation of health care and health-care finance, and instead accepted the compromise of an internal NHS market. Efficiency and choice could be achieved within a state-funded system, it was argued, if producers were exposed to the discipline of competition and incentives, and if providers were separated from purchasers.

At the time of writing, the impact of these proposals has yet to be experienced. However, as we have seen, expert commentators have predicted a number of likely trends which cast doubt on whether the marketisation of the NHS will actually improve consumer choice and influence, and indeed whether it will produce better value for money. There have also been questions raised about whether the measures will diminish the comprehensiveness and accessibility of Health Services to local communities (Robinson 1990; Social Services Committee 1989).

It is also evident that the majority of the reforms will depend on, and at the same time expand, managerial power. Managers, through their role as brokers, commissioners and quality-controllers of contracts, will undertake new and fundamentally important tasks which were previously diffuse or the province of medical professionals alone. Managers will be key actors both as executives within purchasing agencies and in provider units, and will exercise regulatory functions as well. In these capacities, they will be charged with overall responsibility to secure efficient and effective health-care delivery, and will be given enlarged powers to manage resources and personnel. Health Authority chairpersons and members will play an important role in local decision-making, but the whole point of government plans is to make those Authorities more business-like, and to give executive managers more discretion: 'Local management must be allowed to get on with the task of managing, while remaining accountable to the centre for its delivery of the Government's objectives' (Department of Health 1989:12).

As we noted above, the NHS has always had a close relationship with the private health-care market and, through competitive tendering, income generation and pay-beds, has been required to imitate some of its features. Marketisation, especially through self-governing hospitals, will attempt

to make the planning and delivery of NHS health care much more like a competitive market. Managers, and all staff, are being encouraged to become more entrepreneurial, and to adopt the techniques and strategies of business enterprises. Whether this will lead to a more consumer-oriented service, or to improved conditions and wages for employees remains to be seen. However, what is clear is that for 'consumers', this ideological and organisational shift raises doubts about the continued viability of former NHS objectives and values of comprehensiveness, equity and need. Competitive individualism and commodity values are not easily reconciled with values of citizenship and welfare (Turner 1990; Williams 1989).

Similarly, there are other paradoxes and contradictions contained in these developments. In the White Paper *Working for Patients*, much emphasis was given to improving consumer choice, but equal emphasis was given to efficiency and value for money. There is no necessary link between these: indeed, more consumer choice (and demand) may lead to increased expenditure. Perhaps ironically, evidence from the private sector in both the United Kingdom and the United States suggests that cost-containment is a principal if not the dominant preoccupation among funders.

One study of the private health insurance industry in Britain has shown that insurers have had to pursue a variety of techniques to limit and control costs (from 'excessive' consumer claims and expectations as well as medical treatment charges), and that this has become more difficult (Laing *et al.* 1988). In a review of health care in the USA, one analyst concluded that competition did not necessarily lead to cost-containment: the private market could produce higher costs and inequitable distributions (Pauly 1988; see also Robinson 1990).

Nevertheless, the government's plans to marketise the NHS assume that competition will improve efficiency, and despite the frequent references to consumers, much weight is attached to the better use of resources. As Day and Klein have noted: 'whenever there is a possible conflict between containing costs and increasing [patient] choice, the Review invariably comes down in favour of the former' (Day and Klein 1989:28).

Another paradox is that if the NHS internal market does begin to operate like a competitive commercial market, there are likely to be some GP budget-holders, self-governing hospitals, directly managed hospitals, and Health Authorities which are successful in obtaining revenue surpluses, and which maintain or even expand services, and others which do not. In this process, there are two possible political constraints: how far cost-quality trade-offs will be allowed to reduce standards, and how far efficiency and rationalisation measures will be permitted to lead to a reduction in accessibility and comprehensiveness. Basic regulatory mechanisms have

been devised, but the difficulty is that the more extensive the regulation, the less incentive there is for purchasers and providers to pursue competitive strategies.

Similarly, all of these trends are based on an assumption of more local delegation or decentralisation of decisions about types of demand and appropriate levels of service provision. However, central government still retains crucial powers to determine the overall finance available, will still set the policy framework by approving general strategy and objectives, and will monitor NHS effectiveness and performance. The White Paper *Working for Patients* stressed that there was to be a 'clear and effective chain of management command running from Districts through Regions to the Chief Executive [of the NHS Management Executive] and from there to the Secretary of State' (Department of Health 1989:13). Consequently, there may be an internal market, but purchasers and providers will only enjoy a very limited form of relative autonomy. The limits will reflect wider political struggles about the consequences of marketisation in health and welfare, in particular how much variation and inequality will be condoned by government and tolerated by consumers.

If there is to be more diversity and fragmentation, this raises a further question about the possible erosion of professional medical power, and managerial encroachment, discussed earlier in Chapter 2. The NHS internal market will continue to depend on the active participation and co-operation of medical, nursing and other staff. But as we have noted above, the reforms entail contradictory elements which have implications for the changes in the 'frontier of control'.

On one side GPs and hospital doctors are expected to respond to competitive market pressures and incentives to increase their productivity and improve quality. On the other, doctors are to be subjected to stricter employment conditions and formalised audit and performance evaluation. In self-governing hospitals and directly managed units, managers will be wholly dependent on doctors to fulfil contract specifications and to adapt to changing market circumstances. Medical professionals may use the vestiges of their monopoly position to maintain their clinical autonomy, but alternatively, if threatened by rationalisation or closure of their units, they may acquiesce in managerial direction, as suggested in Chapter 6.

In general, the introduction of the NHS internal market requires the consolidation and expansion of managerial influence over professional medical activity. Conventional beliefs about health-service organisation and production, traditionally the prerogative of doctors, have been challenged, and managerial concepts of efficiency and effectiveness are about to be institutionalised and given pre-eminence. As Day and Klein (1989) pointed

out, the reformed NHS will be a managed market, not a consumers' market, and in many ways the changes simply comprise a shift from professional to managerial paternalism. The nature of managerial objectives and values, the extent to which they will reflect bureaucratic responses to central government directives, and the degree to which they displace and supplant medical dominance, are among the many uncertainties surrounding the impact of marketisation.

8 Structures of control in health management

Forms of medical care, and arrangements for their provision, reflect the dominant cultural, economic and political assumptions and relations in society. They are the outcome of ideological conflicts, social struggles and competing rationalities. In Britain, as in most western capitalist societies, the modern system of scientific medicine is institutionalised and professionalised, and doctors enjoy relatively high levels of reward and status. In contrast to many other countries where a private market or social insurance mechanism is used to allocate resources and regulate demand and supply, the British NHS has been based on collective, tax-based funding, universalist criteria for access, and massive state intervention in the planning, financing and organisation of medical services. It has also been based on a set of compromises between governments and medical professionals which gave general practitioners and hospital doctors extensive clinical autonomy. Further, the administration and delivery of services has been largely delegated to local agencies, subject to central budgetary constraint and national policy directives.

State control of this system has been effected through a number of different mechanisms and strategies, which themselves changed in response to changes in policy objectives and limits on expenditure. As previous chapters noted, there has been a series of attempts to design a 'rational' organisational structure, to secure greater co-ordination between different components of the health-care system, and to achieve greater local conformity with centrally prescribed goals. There has also been a longstanding preoccupation with controlling the growth of public expenditure, and with improving the efficiency with which resources are used in medical services. In the 1980s, with lower rates of economic growth, and determination by Conservative governments to roll back the welfare state, there has been a decisive shift in the extent and mode of control.

Earlier acceptance of decentralised decision-making, professional dominance and consensus management has been displaced by *dirigiste* policy-

making, strict enforcement of cash limits, and the rigorous pursuit of efficiency and effectiveness by non-medical managers. Concepts, methods and values characteristic of commercial enterprises have been extolled as remedies for health-service production and administration. Medical autonomy has been increasingly circumscribed by the extension of bureaucratic and managerial authority. Professional prerogatives and technical discretion are no longer taken for granted: accountability is more than ever defined in terms of corporate objectives, defined, translated and enforced by state-appointed executives.

The introduction of an internal market will further strengthen general managers' capacity to challenge medical professionals' actions and traditional divisions of labour. It is also likely to change the basis on which facilities and services are made available to patients, since there will be competition between purchasers and providers. Assumptions and conventions which evolved in an earlier period of economic prosperity and political consensus about welfare spending and citizenship rights have come under attack. Consequently, comprehensive health services, universally provided solely on the basis of medically defined need, *and* the organisational and professional infrastructure which attempted to deliver them, are no longer sacrosanct

An unprecedented battery of measures and techniques for audit, evaluation, monitoring and surveillance now exists. These constitute the principal devices through which the structure of control in health is accomplished. They also represent a radical departure from previous arrangements concerning professional autonomy, because they entail managerial encroachment on the determination of work content, productivity, resource use and quality standards.

These trends represent a significant change in the structure of control in health management. As in other organisations, changes in the structure of control in welfare state agencies and institutions reflect changes in the labour process and relations of domination (Clegg and Dunkerley 1980). All formally rational organisations share common characteristics in so far as they seek to achieve desired outcomes by co-ordinated action. Resources (material and symbolic) must be acquired, processed and converted into activities and products (including services). A division of labour must be established, roles and tasks specified, and a minimum degree of workers' co-operation or compliance must be secured. To ensure the maintenance or expansion of any system of production, the social relations of production must be maintained and reproduced. This necessarily involves the creation and execution of control by dominant coalitions, elites and managers.

Such groups usually seek exclusive rights to define the nature of corporate aims, and endeavour to impose that definition on other organisational

members by regulating their behaviour. In practice there are many different strategies and methods of control exercised by managers, manifested in the design of the organisation itself, in beliefs and ideologies, and in disciplinary and reward systems. There are different levels and types of control, corresponding to interorganisational, intra-organisational and task-specific problems, and they may be direct or indirect, personal or impersonal. As Reed (1989) has emphasised, the dynamics and means of control are multiple and contradictory, they are variable, and subject to social conflict. Collectively, all those practices and policies which attempt to specify rules and norms for tasks and productivity, the division of labour, the assessment of performance and accountability, are regarded here as comprising a complex structure of control. This structure of control will inevitably be contested because it embodies relations of authority and power which are themselves negotiated and conflictual.

In the context of NHS history, it is evident that the devolutionist approach adopted by government during periods of economic growth and the expansion of welfare was gradually replaced by systematic attempts at rational planning and tighter financial restraint Local Health Authorities became subject to much stronger centralisation despite official rhetoric about delegation. The employment conditions, wages and status of ancillary, nursing and paramedical hospital staff have undergone continuous 'rationalisation' and reorganisation, and such staff have become subordinated to more direct management control. With the onset of fiscal crisis and consolidation of New Right programmes, medical professionals' relatively privileged position in a quasi-corporatist policy-making system, and their exemption from local managerial accountability, have been undermined by managerialist interventions and surveillance techniques.

This is most clearly visible in the introduction and impact of general management As Chapter 3 showed, central government insistence on improved cost-effectiveness and efficiency in the NHS prompted a fundamental critique (the Griffiths Report) of existing management arrangements. It led to the abolition of multi-professional consensus management and its replacement by executive managers working within an explicitly hierarchical chain of command. Commentators agree that this heralded a new ethos within Health Authorities, with some describing it as leading to a new organisational culture; staff were assigned new tasks and responsibilities, sanctioned by direct personal responsibility for resource use and overall performance.

Although retaining clinical freedom, hospital doctors found their previous dominance weakened, as general managers were mandated to obtain better cost-control, service improvements and value for money. Various empirical evidence indicates that both doctors and managers

recognised that the success of general management depended on the extension of managerial control over clinicians. It also suggests that what Harrison (1988a) described as the frontier of control has shifted in favour of managers. Moves towards an internal NHS market (as with the impact of recent retrenchment and pressure for service reductions) will provide further demands for, and legitimation of, an increasingly assertive and entrepreneurial style of NHS management, and the proliferation of controls over clinical workloads and standards.

One crucial aspect of all these developments is doctors' routine decisions on diagnoses and treatment, and the resources required to provide specified levels of service. While there has always been government concern about the growth of NHS expenditure, there was, until the 1980s, little sign of measures intended to restrict clinical freedom as it affects resource use. However, as Chapter 4 showed, a number of different methods are now being used to identify clinical and associated costs, and to assess the efficiency and effectiveness of particular medical procedures and nursing patterns.

Clinical budgeting or resource management is one of the most important innovations, because not only are hospital doctors required to define and specify the elements to be costed, but they are also expected to assume direct responsibility (managerial accountability) for the resources they use. Quite apart from methodological and technical problems, the diffusion of resource management has been slowed by opposition by many hospital doctors. It is evident that doctors are cautious and sceptical for a variety of reasons, perhaps the most significant being that many of them believe that resource management compromises their professional ethics and clinical freedom.

Similarly, experimentation with Diagnostic Related Groups (DRGs) and medical audit also originated with attempts to control costs and a 'value-for-money' approach. With DRGs, there is an attempt to measure output and compare performance for standardised types of case and procedures. There is also an emphasis upon improved efficiency and productivity, and the possibility that managers will be able to select preferred 'products' (and reward or penalise consultant teams or units) on a unit-cost basis. The allocation of resources might not be determined by professional judgements about relative needs and priorities, but by managerial assessments of cost effectiveness and financial rates of return.

Doctors are thus increasingly being compelled to justify their procedures, their costs and their effectiveness. Medical audit and quality assurance projects have attracted growing attention in the last decade. While internal professional concern and external consumerism are part of the explananation, government and managerial pressure are especially relevant influences. Again, in addition

to methodological problems in measuring and comparing clinical processes as well as outcomes, there is medical opposition to such performance evaluation. Many doctors are critical of appraisal mechanisms which render them vulnerable to assessment by non-medical managers. There is also some confusion over accountability in medical audit, and doubts about the possible blurring of medical and financial criteria when judging the efficacy of treatments.

The broader context of these issues was highlighted in Chapter 5. Although a locally delivered service, the NHS is a national system, and most governments have attempted to improve coherence, impose conformity with central policies, and seek cost-containment. These goals have become even more important during the decade of New Right reform. More local accountability to the centre has been demanded. Units experience close, detailed supervision by Districts; Districts are overseen by Regions, and they in turn must carry out ministerial and NHS Executive instructions. Performance indicators and other means are used to ensure compliance with directives. Financial mechanisms reinforce this; the cost-improvement programme, competitive tendering exercise and financial audit involve stringent discipline at all levels.

In addition, investigations into efficiency and effectiveness have been extended by the 'quality assurance' and 'customer relations' movements. These, like value-for-money approaches, audit (medical and financial) and contract specification, have all led to an unprecedented questioning about objectives, work practices and outcomes. Attempts have been made to devise minimum standards for medical and nursing care, and there are moves to establish protocols and schedules for treatment So, in parallel with a national system of bureaucratic regulation of local agencies there is an interlinked system of managerial surveillance of clinical practice. Medical decision-making is now perhaps more than ever subject to growing pressure from external challenge and inspection. The possible erosion of professional autonomy is directly connected with increased centralisation within the NHS, which itself is connected with wider changes in the political economy of the welfare state.

Despite professional resistance, resource management, DRGs, medical audit and quality assurance are all under way, firmly endorsed by central government. To repeat, their importance lies in the fact that they facilitate extra-professional scrutiny and managerial control. Non-medical managers and accountants are able to question existing medical practices and clinical activity levels and propose alternatives. Moreover, although many doctors, nurses and paramedical staff may subscribe to measures designed to improve standards, they are suspicious that non-professional criteria (efficiency and effectiveness defined financially) will gain in prominence, and thus these innovations are sources of conflict.

Some confirmation of the impact of the new managerialism and bureaucratic surveillance can be derived from the evidence presented in Chapter 6 about cutback management in six Health Authorities. Clearly, the severity of the budget crisis enabled local managers to implement major changes in hospital and community service provision. It also legitimated much closer intervention in the organisation of clinical activity. Doctors and managers agreed that the process of making cuts and service rationalisations inevitably rendered medical autonomy problematic. Managers almost without exception insisted that a new financial climate demanded a major reorganisation of services and a review of medical working practices. Clinicians were aware that arguments about efficiency and productivity were ultimately disputes about their professional authority, and were largely dismissive about suggestions that they should become accountable to local managers. Nevertheless, in the case-study Districts, the majority of cost-saving reforms and real cuts *were* put into effect, albeit under duress.

Under a quasi-market regime, as Chapter 7 argued, it is likely that managerialism will expand and professional medical dominance will be further challenged. Controls over the performance of all the workforce will necessarily increase, as Health Authorities adopt commercial methods to cope with a business environment There have already been moves to secure the 'flexibilisation' of the NHS labour force, working conditions and pay. Doctors' contracts will probably be amended to make them accountable to local managers, and arrangements have been made to enable managers to participate in the review of clinical effectiveness.

In the hospital sector, Unit survival and growth will depend on income generation and revenue gained by selling services, rather than being determined by planned allocations. As a result, managers, in their new role as contract-makers and quality-controllers, will insist upon having stronger powers to direct personnel, including doctors and nurses. A newly marketised NHS may, paradoxically, improve the bargaining position of some medical and paramedical staff (those in high-demand specialties) but the overall effect is likely to enhance managerial control over clinicians.

It is clear therefore that major changes have taken place in the range and form of bureaucratic regulation within the NHS, and that current trends will reinforce managerial control across different types of service and over all grades and types of staff. It is also evident that there have been a number of apparently contradictory trends—apparent endorsement of local delegation (latterly entrepreneurialism) combined with tight central restrictions on spending and policies—which are unlikely to produce consistent or uniform consequences. Theoretically, such changes

may be usefully explained in terms of Offe's analysis of state policy-making outlined in Chapters 1 and 2. They also appear to coincide with recent accounts of 'post-Fordism' in the welfare state.

POST-FORDISM AND THE RESTRUCTURING OF THE WELFARE STATE

Some writers have tried to explain the interdependent development of industrial capitalism and the modern state in terms of regimes of accumulation and modes of regulation. Systems of commodity production and capital accumulation are said to have corresponding social and political institutions, and changes in the political economy are reflected in changes in state activities and form, as well as patterns of consumption (see Bonefield 1987; Jessop 1988). The restructuring of the welfare state may thus be part of a much broader set of processes associated with 'post-Fordism'.

Fordism is synonymous with the period of economic growth, the emergence of assembly-line mass production, gigantic corporations, economies of scale and the promotion of mass consumption of goods and services. Taylorism became its corollary as the dominant mode of organising the division of labour and controlling the workforce. Work itself was fragmented, routinised and deskilled, products were standardised and management was bureaucratised. To secure the reproduction of labour-power and minimal levels of social integration, a Keynesian welfare state provided basic elements of collective consumption and social security.

However, since the late 1970s widespread economic crisis prompted adaptation in both the economy and polity. In certain sectors, new, more flexible, methods of production and organisation evolved. New products and markets emerged alongside computerisation and new technologies. The trend was towards increased diversification and specialisation, segmented markets, and the break-up or decentralisation of large organisations. The workforce became increasingly polarised between relatively well-rewarded high-skill employees and marginalised unskilled workers in the secondary labour market At the same time, welfare state intervention was reduced or removed, and commodification and privatisation were introduced into public services.

There are some significant parallels between recent developments in the welfare state and 'post-Fordism' in the wider economy (see Geddes 1988; Hoggett 1987; Stoker 1989). In the sphere of British local government, for example, standardised universal services have traditionally been provided through centralised hierarchical bureaucracies. However, New Right

governments have ensured that local municipal services, like other public sector monopolies, have been challenged and reorganised. Attempts have been made to impose flexible work practices, greater cost-effectiveness, decentralisation and competitive contracting in a variety of services. Local authorities are increasingly regarded not as the providers or suppliers of services, but as enablers or facilitators for other, more flexible, agencies. The content, scope and availability of services are also becoming more restricted and selective.

Public bureaucracies are being reconstructed and forced to become more 'entrepreneurial' and 'customer-orientated'. Their services, workforce and production methods have become subject to criteria and disciplines usually found in for-profit enterprises. Cost-centre management, cash limits, proxy measures of value and productivity, product differentiation and the weakening of electoral representativeness, collective bargaining and trade union influence have all hastened the transformation of conventional public administration.

These trends are repeated in a number of welfare state services: education, housing, transport and, as we have seen, health. Delivery systems, management methods, organisational structures and the basic determinants of access are being modified to accommodate the requirements of a welfare state undergoing commodification and marketisation. They have been particularly evident in the provision of income support and social security (Berthoud 1987; Bradshaw 1987; Lonsdale and Byrne 1988); in the 'de-municipalisation' of public rented housing (Kemp 1989; Whitehead and Kleinman 1989); in various reforms of the education system, including local financial management of schools and the possibility of opting out of local authority control (Kogan 1987; Wilcox 1989); and also personal social services and community care (Baldwin and Parker 1989; Flynn, N. 1989, 1990).

Many of these developments do appear to support claims made about the evolution of post-Fordism in the economy and the state. The shift from Fordism and Taylorism towards greater 'flexibilisation' is seen as an integral part of contemporary 'disorganised capitalism' (Lash and Urry 1987) and as signifying the collapse of the social-democratic consensus in welfare states (Gamble 1988). Citizenship rights, public services and forms of political representation appropriate to Keynesian economic management and social policy have been regarded by the New Right as impediments to post-modern capitalism, in need of radical reform.

In Britain, Thatcherism has embraced a combination of economic and political reform strategies. These have consisted of the deregulation of private capital, public sector privatisation and the application of quasi-commercial criteria to state activities. They have also involved a reduction

in collective welfare provision, transfer of functions to unelected and special agencies, and increased concentration of power within central government. For Jessop *et al.* (1988) these state strategies are attempts to establish social, spatial and political relations which favour flexible accumulation, and will lead to a 'two-nations' polarisation within civil society. Stoker has also argued that recent changes in the role and functions of local government have been intended to 'make its activities, organisation and orientation compatible with the flexible economic structures, two-tier welfare system and enterprise culture' endorsed by Thatcherism (Stoker 1989:141).

Although these accounts are generally plausible, and can be applied to the restructuring of health services, there are some difficulties with a post-Fordist explanation. There are many problems concerning determinism and functionalism implicit in post-Fordist theories—for example, about the causal connection between accumulation regimes and modes of regulation, and about the relation between structural factors and group action and political strategies (see Bonefield 1987; Jessop 1988). There are also problems in identifying the precise content, configuration and dynamics of 'Fordism' and 'post-Fordism' within the economy, and in locating their comparable equivalents within the state and public services (see Cochrane 1990; Stoker 1989).

For example, as Stoker has observed, the Fordist production methods common in industrial settings were never wholly transferable to local government. There were, however, emulation of private sector organisational models and corporate planning, and attempts to create mass standardised services delivered through hierarchical bureaucracies. But, as Stoker acknowledges and Cochrane emphasises, in practice local government services were not uniform, there was much variation, and service delivery reflected administrative and professional discretion as well as local political influence.

It must be recognised therefore that apparently 'post-Fordist' changes in local government and in the NHS do not completely conform with post-Fordist theory. Thus, contrary to some projections of more decentralisation and less direct supervision, the contracting-out and competitive tendering of public services may reinforce authoritarian and hierarchical management. Moreover, especially in Health Services, there are contradictory moves to allow for greater consumer-responsiveness and product-differentiation, but simultaneous efforts to secure much more central (managerial) control over, and standardisation of, clinical processes and outputs.

In many ways, efforts to establish managerial control over NHS medical services and hospital clinicians are better described as Fordist/Taylorist rather

than post-Fordist. The argument in previous chapters is that until the emergence of ideas about an internal NHS market, most developments in the 1980s can be regarded as attempts to *increase* and extend bureaucratic (Taylorist) control structures and processes. Within an overall set of policies designed to improve efficiency (ostensibly maximising local delegation and endorsing, paradoxically, both managerial discretion and professional medical autonomy), a battery of measures have tightened central influence over Health Authorities and enhanced managerial surveillance over doctors and other health workers. As Chapter 7 also suggested, even within an entrepreneurial, marketised NHS there are likely to be extensive regulation, and close bureaucratic/managerial monitoring of productivity, quality and cost-effectiveness.

Finally, of course, moves to secure more flexibilisation in the public sector are likely to encounter various constraints—technical difficulties in the application of information technology and modern methods of production in medical and social services; obstruction by staff, particularly by unionised and semi-autonomous workers and professionals; and broader political opposition.

Consequently, the post-Fordist account of state restructuring is best regarded as providing a heuristic framework requiring much more detailed specification (Jessop 1988; Jessop *et al.* 1988). It does offer a systematic way of linking a variety of societal changes, the interconnection between economic and political structures and their impact on social welfare policies. However, the nature of those linkages, and their expression in concrete processes, have yet to be analysed fully.

In the public sector, some of the contradictions in the transition from Fordism to post-Fordist organisation may be partly explained by an inherent tension within New Right ideology. Thus the conflict betwen centralism and consumerism reflects deeper conflicts between 'liberal' and 'conservative' variants in New Right politics (King 1989). The uneven and incomplete incorporation of both Fordist and post-Fordist methods in welfare services is a consequence of these ideological conflicts as well as the constraints outlined above.

It is also a result of the fact that public goods and services are produced, allocated and delivered according to a variety of bureaucratic, professional and quasi-market mechanisms. Welfare systems, organisation and management reflect these competing rationales and thus assume hybrid forms (see Hoggett 1987). Accordingly, state restructuring must be analysed as a complex, contested and contingent strategy, rather than as a coherent, structurally determined and inexorable pattern.

However we define contemporary changes in the organisation of health and social welfare, it is undoubtedly the case that the major axis of change

lies in managerial systems and structures of control. Heydebrand (1983, 1989) has argued that economic crisis has generated pressure for a new type of management and new organisational forms, especially in health and welfare services. Governments try to cope with rising client demand and budgetary restraint by different methods of rationalisation, including the creation of what Heydebrand (1983) terms 'technocratic strategies of administration'.

These consist of a new type organisational control structure based neither on bureaucratic nor professional principles. Technocratic administration attempts to mediate the contradictions between bureaucratic and professional authority, and between productive work and administrative regulation. It involves de-bureaucratisation in so far as it entails greater functional decentralisation and task complexity. Management policies are orientated more towards objectives and results rather than rules and procedures. It also involves deprofessionalisation, with a reduction in technical autonomy and increased managerial influence over productivity, terms and conditions of work. Technocratic strategies of administration claim to provide depoliticised technical-rational solutions to the problems of public sector retrenchment. They are, nevertheless, inherently unstable and conflictual: they are contested tendencies rather than established systems of control.

Heydebrand's account of new types of managerial control, and their problematic status, is useful in understanding many of the recent changes in NHS management described above. It connects well with Offe's discussion of the politicisation of administration and the existence of divergent rationalities within state policy-making. It also helps us make some links between abstract theory about civil society, the state and the economy, and concrete institutional and organisational arrangements. This then brings us back to more detailed consideration of the nature of public sector management, and the significance of managerialism in health services.

PUBLIC SECTOR MANAGERIALISM

The evidence discussed above does suggest that there has been a significant increase in the role of management, and the scope for managerial power, in the NHS. In concluding this analysis of health services, three important questions remain. First, is public sector management and the structure of control distinctively different from private commercial management? Second, can we identify discrete interests, values and objectives held by health-service managers? Third, are the management practices likely to be adopted within a marketised NHS incompatible with medical dominance, and will they undermine clinical autonomy?

The first issue immediately raises long-standing arguments in economics, sociology and political economy about the nature of ownership and control in capitalist enterprises, and whether executive managers engage in profit maximisation or satisficing behaviour. This debate is too complex to be rehearsed fully here. Whether private sector management is defined as a set of neutral, technical and organisational skills, or as a set of practices which are functional for capitalist accumulation and class exploitation, its immediate objective must be the realisation of a surplus and the maintenance of production relations.

Clearly, it is possible to describe management generically. Reed (1989: 25), for example, sees management as 'a loosely connected set of mechanisms, processes and strategies directed at the assembly of other practices concerned with the production of goods, services and ideas that transform the environment'. The point, however, is that formal rationality may serve a number of different substantive goals and objectives, and capitalist enterprises are by definition driven by market competition and profit.

By contrast, in the public sector, resources are not allocated according to market conditions of price-regulated supply and demand. Certain goods and services are deemed to be collective or public goods because of their positive or negative externalities (for example, public health), and political choices are made about the relative *needs* of different groups for specific services. Some form of bureaucratic or professionally determined rationing is virtually inevitable, and as a consequence of this and the necessity of collective finance, questions of accountability and equity play a major role in shaping policy and service delivery.

Public sector managers are subject to constraints and pressures that have no direct equivalent in the commercial world. Their agency's activities may be statutorily prescribed, they cannot easily jettison 'loss-making' services or seek out new 'customers', and their behaviour is probably open to much greater political criticism and scrutiny than that experienced by managers reporting to shareholders.

Thus, while there are many common management tasks and principles (see, Gunn 1988, 1989), in practice it must be recognised that the production and delivery of social welfare goods and services does presume a distinctive form of management (Flynn, N. 1988, 1990; Stewart and Ranson 1988).

There is nevertheless much emulation of commercial management ideology and techniques throughout the public sector. Indeed, a major theme of previous chapters is the rapid expansion of 'business-like' management methods and control strategies within the NHS. As we also noted above, however, there are many different, sometimes contradictory,

means and types of management control in capitalist organisations, and they are subject to dispute and struggle; a similar situation exists within the welfare state. New Right governments have, with some success, sought to establish analogues for commercial management and corporate control inside the NHS, but the process has been controversial, and is as yet incomplete.

We can conclude, then, that within the NHS, while there will be systematic efforts to impose and extend 'managerialism', it too will comprise complex and contradictory elements, and these will continue to be a source of internal conflict. Structures of control and management methods originating in the private sector will continue to be imposed on the NHS, but their implementation will be contentious and partial. This is because of the inherent features of public sector management; the political saliency of the NHS; organisational complexity; and professional dominance in the organisation and delivery of medical services.

Given the increased significance attached to health-service managers in an era of retrenchment and market reform, what interests and objectives are they likely to pursue? This cannot be answered easily, because of the lack of direct empirical evidence, but previous chapters (especially Chapters 2, 3 and 6) have described relevant findings from earlier studies and the author's own recent research.

In summary, it can be inferred that Health Authority managers do perceive their role as controllers of resources, and as wishing to direct other personnel, especially medical, nursing and paramedical staff, towards the achievement of 'corporate' goals. Of course those goals are initially defined politically and their execution is monitored bureaucratically—managers have become increasingly constrained by ministerial directives and their performance is subject to evaluation, reward and penalty by superordinate executives.

Local delegation and entrepreneurialism is permitted, even encouraged, but only within financial, ideological and political limits set by central government Translating such imperatives into priorities and programmes of action necessarily leads managers into negotiation with a variety of local interest groups. Managers have sought, and have been mandated to seek, much closer control over the production and delivery of medical services, and they now have potentially more means of enforcing such control over medical, nursing, paramedical and other health workers.

As in all organisations, there has always been bargaining and negotiation between coalitions and groups at all levels of the NHS. However, compared to earlier periods, managers are now in a much stronger position to set the local agenda for decision-making. Conventional assumptions about the pattern of medical services, clinical activity levels and most operational

aspects of health-care delivery are now being continually and fundamentally challenged by managerially defined concepts of efficiency and effectiveness. Again, those very concepts are contested, and likely to provoke intense debate among 'front-line' workers, but there is extensive evidence of determination among managers to extend their control, and greater capacity to do so.

The degree to which current structures of control and managerialism will undermine medical dominance and threaten clinical autonomy remains uncertain, since much depends on the outcome of the 'market' reforms still being introduced at the time of writing. The main thesis of previous chapters is that recent restructuring and the proposed internal market arrangements will further intensify managerial power over NHS doctors and other health workers.

As we saw in Chapter 2, professional autonomy has different dimensions, is variable, and is a contingent outcome of interactions between technical, institutional and societal factors. It can be argued that the ultimate, essential components of professional autonomy are the ability to define the content of work and the prerogative of peer-evaluation of performance. However, it is precisely those aspects of medical practice which will become more vulnerable to managerial intervention, especially as doctors are made managerially accountable for clinical budgets. Resource limitations are likely to become even more severe constraints on primary care and hospital services, and managers will demand a more prominent role in discussions of rationing and priorities, and will insist on more detailed appraisal of medical cost-effectiveness.

Managerial intervention is likely to grow in the family practitioner service as GPs' budgets and performance are regulated as part of purchaser-provider competition. In the hospital sector too, the managed market will entail more managerial influence over decisions about resources for different specialties, and clinicians' workloads.

So-called clinical management experiments have already begun in NHS hospitals, and more attempts will be made to co-opt doctors into functional management of divisions and units. As one study observed, doctors commit most of the resources but they are the only hospital staff not subject to managerial controls. Clinical management is therefore explicitly seen as an attempt to 'overlay the medical staff organisation on the management hierarchies' (Disken *et al.* 1990:5).

The authors of that report noted that there was substantial professional scepticism about, and opposition to, the introduction of clinical management Doctors hostile to it were said to fear limitations on their clinical freedom, and were resistant to what they perceived to be attempts by accountants and managers to reduce resources. Such evidence is generally consistent with

other studies described in earlier chapters, and tends to support Coombs' (1987:401) conclusion that doctors and managers 'inhabit sharply different cultures with different values and perspectives. The language of symptoms, treatments and prognoses does not translate easily into the language of budgets and efficiency'.

The provisional conclusion must be that changes in the structure of control and management practices are incompatible with conventional arrangements for NHS medical organisation, because they facilitate managerial incursion into decisions and practices which have been traditionally the monopoly of doctors alone. Retrenchment, restructuring and market reforms have at the same time enabled and legitimated health-service managerialism, and a systematic reduction in professional medical autonomy. It is unlikely that medical dominance in the division of labour and policy-making will be completely undermined, but it is undergoing significant transformation, and the changes will undoubtedly generate important consequences for the provision of health services.

Such a view is provisional because these changes are still happening, because there is much variation in local circumstances, and especially because they are, and will continue to be, contested.

STRUCTURES OF CONTROL

As Paul Starr emphasised in his classic study of North American medicine,

> The organisation of medical care cannot be understood with reference solely to medicine, the relations between doctors and patients, or even all the various forces internal to the health care sector. The development of medical care, like other institutions, takes place within larger fields of power and social structure.
>
> (Starr 1982:8)

This book has attempted to show the relationship between important recent developments in the British welfare state and their implications for the organisation and management of medical care in the NHS. The focus, however, has been on the mechanisms and processes by which bureaucratic and managerial control have been created and implemented. It has been argued that New Right government policies of restructuring welfare and social policy have involved the erosion of citizenship rights, a reduction in local political influence, and the insertion of quasi-market criteria and commercial methods in state agencies. The 1980s have been a decade of radical reform within the NHS, with a series of attempts to transform a professionally dominated service into a managerially driven, flexible corporation.

Collectively and cumulatively, the measures discussed in previous chapters can be seen as orientated towards the consolidation of new structures and techniques of control. These have emerged at all levels, affecting individual doctors' clinical decisions; nursing, paramedical and ancillary staff working conditions and salaries; the amount of responsibility delegated to Unit, District and Regional Health Authorities, and so on. Initially, cost-containment was the dominant objective in setting up new schemes to improve efficiency, but this was superseded by policies concerned with changing the internal functioning of the NHS, and establishing a corporate culture compatible with the economic and political priorities of a putative enterprise state.

It is a mistake to assume that these phenomena and trends have been entirely coherent, consistent and complete. We must recognise that there is no automatic or unproblematic translation of structural imperatives into organisational practices and policies. All social structures are relatively stable sets of patterned relations in action and meaning which reciprocally influence behaviour and are moulded by that behaviour. Structures are socially and politically produced, but may be simultaneously experienced as constraining. As Giddens has insisted, the relationship of action and structure is one of duality: structures are both the medium and the outcome of social practice. The capacity for individual and group action—and thus power—is defined by contingent relations of autonomy and dependence. Consequently, power is embedded in relationships and structures, and in all social systems there is a 'dialectic of control' over the disposition of resources, and relations of autonomy and dependence (Giddens 1982:32). The resolution of this dialectic is a continuing, and empirical, question.

Several implications flow from this. First, explanations which argue that institutional and organisational arrangements reflect class hegemony or structural logics are inadequate because they ignore or neglect inter- and intraorganisational conflict, and the everyday reality that management control is never total (Clegg 1989a; Reed 1988). In particular, state institutions and organisations matter: they are not simple, homogeneous machines which merely respond to exogenous forces. Policy implementation is the result of bargaining and conflict between competing interests and coalitions. In health and social welfare systems, service delivery is dependent on administrative discretion and professional autonomy, and this gives such groups important, independent, though variable influence (see Ham and Hill 1984; Hjern and Hull 1982; March and Olsen 1984).

Second, as we have noted throughout this book, state policies and organisational practices are frequently (perhaps always) complex and contradictory. Certain values and objectives may achieve prominence over others, and specific procedures introduced, but they coexist with, and

sometimes contradict both other new 'reforms' and previously established conventions. As Offe (1984) has argued, state policies are refractions of different demands and pressures, and contain multiple, often competing objectives, administered in divergent ways.

The tension between consumerism and state centralism, a recurrent problem in New Right ideology and legislation, is one example of such a contradiction. Thus in the marketised NHS, there will still be an immense degree of bureaucratic regulation of statutory health-care purchasers and providers. Managers will not only be required to demonstrate achievement of balanced budgets (surpluses) but also delivery of specified amounts and levels of patient care. It is possible that for hospital units to compete and trade services for revenue successfully, and to secure more patient referrals, *more* rather than less clinical autonomy will be demanded by doctors, and managers may have to accede to continued medical dominance. Therefore the structures of management control associated with state policies cannot be viewed as deterministic and unidirectional.

Third, although one of the major functions of any system of management is the control and disciplining of organisational actors, the extent of control is variable and is itself a source of conflict and resistance. One of the conclusions drawn from the labour process debate referred to earlier was that management control is rarely completely effective or hegemonic. Workers of all grades and types usually attempt to maintain or enlarge their own autonomy; they may also challenge managerial authority, or seek out pragmatic ways of accommodating managerial supervision.

Following Clegg (1989b), organisations should be conceptualised as 'locales of politics', where contestation, negotiation and struggle between different groups and rationalities is a routine occurrence. In both the commercial and state sectors, organisations have increasingly devised new mechanisms of power, especially what can be referred to as disciplinary practices of surveillance. Drawing on the work of Foucault, it is argued that all organisations are characterised by the embodiment of power. Disciplinary power is pervasive, and reproduced through everyday routines: similarly, surveillance is built into all relationships and meanings. Although originally concerned with prisons and medical knowledge and practice, the metaphor of surveillance has been reified, quite literally, in all organisational life (see Armstrong 1983; Burrell 1988).

Such surveillance has various forms, based on direct personal supervision and formal (often computerised) systems for the evaluation of staff performance, as well as cultural rules and moral values. Control over employees' behaviour is attempted through surveillance, but employers' inevitable reliance on minimal levels of discretion and trust renders this problematic.

It is this paradoxical aspect of employee discretion and trust which constitutes an important basis for the exercise of agency within any structure of control (Armstrong 1989; Reed 1988) and is especially significant in the analysis of medical professionals in a state health service. Performance of complex tasks requires considerable delegation and dependence on individual competence and skill: professional work is probably the extreme case where technical indeterminacy (or social closure and the monopoly of competence) legitimates substantial autonomy.

Managers may thus be forced to allow professional-employee discretion, but the organisational costs may become unacceptable if the actions of those professionals 'distort' corporate objectives or consume 'excessive' resources. To 'correct' this situation, more performance monitoring and surveillance takes place, but this is likely to antagonise and frustrate front-line professionals and intensify disciplinary conflicts. Medical professionals possess (or rather, claim) expertise which leads them to expect lay deference and a superordinate role in the medical division of labour; they are unlikely to acquiesce in managerial encroachments which threaten those arrangements and expectations.

Thus again, structures of control should not be regarded as totally constraining. Organisational members, particularly those claiming or granted discretion in the execution of tasks, cannot be easily controlled, and indeed are likely to dispute the exercise of managerial supervision and surveillance. In the case of the NHS, as we have seen, medical professionals are currently facing probably the most significant and systematic attempt to subject them to bureaucratic and managerial control. How they cope with these pressures, and how far they seek to mobilise support inside and outside the NHS, will depend largely on the (as yet unknown) impact of market reforms, and the political struggles surrounding them.

ANALYSING HEALTH SYSTEMS

Clearly, the restructuring of health services will have a number of diverse outcomes for the range and type of medical care provided, and for the conditions under which it is available. It will also modify the social organisation of production and delivery, and therefore influence power relationships among participants. Generally, these issues have been the subject of study by medical sociologists, and economists and sociologists of health. Their focus has frequently been on the nature of medical knowledge, the form and content of medical encounters and lay beliefs about illness and health, and the social distribution and costs of disease and care. Some writers have also examined the significance of professional

power, the bureaucratisation of medicine and the governance of health policy in different types and stages of political economy.

However, as Hunter (1990) suggests, what seems to have been relatively neglected, or perhaps underdeveloped, in Britain is the detailed institutional and organisational analysis of health systems in practice, and studies which relate such analysis to broader changes in the welfare state.

Obviously it is interesting and important to investigate the phenomenology of sickness, lay-professional interactions, and questions about the overall determination of levels of care, but the challenge, and the difficulty, as Turner (1987) argued, consists in linking them theoretically. Although this book does not even begin to attempt such a synthesis, it has indicated the relevance of approaches which attempt to analyse the organisation, structure and management of health systems in the context of societal change.

In a medicalised society, health has become politicised, and will continue to be an arena for ideological and social conflicts. To understand some of the key dynamics of those conflicts, we have to understand the internal structures of control in health systems, and their relationship to wider struggles over citizenship, markets and welfare, as they are expressed in state policy.

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