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ROCK CARLING LECTURE: FADS IN MEDICAL CARE POLICY AND POLITICS: THE RHETORIC AND REALITY OF MANAGERIALISM

Introduction

It goes without saying that one is honored to be asked to give the annual Rock Carling lecture. I am grateful to the benefactors of this fellowship – especially John Wyn Owen and Sir Maurice Shock – for the opportunity. I am also grateful as an American who has had a forty-year history of education, friendship, and professional stimulation in Great Britain. This lecture provides me the chance to acknowledge my debt to those friends and colleagues, either as readers or auditors of this public lecture.

My topic tonight is Fads in Medical Care Policy and Politics: The Rhetoric and Reality of Managerialism.¹ I will introduce the broader topic of fads and then turn to how fashions in management commentary have shaped (and mis-shaped) understandings of medical care on both sides of the Atlantic ocean.

By fads I simply mean enthusiasms for particular ideas or practices. In clothing, we have no difficulty in identifying what is faddish. Either our adolescents or the press tell us what constitutes the current fad – or fashion. In the world of ideas, there are similar rushes of enthusiasm, though the character and pace of change of these fads differ greatly over time and space. There is a considerable sociological literature on the subject of fads in social practices. There are fads in names for children, items of home consumption, television soap operas, and the like. But the fads that interest me in this lecture concern fashionable managerial ideas, particularly ideas that in their dissemination are presented as panaceas for longstanding policy and organizational problems.

The Problem of Managerial Fads

My fundamental contention is that the managerial discussion of modern medicine's most prominent topics – cost, quality, access, and organization – is marked by linguistic muddle and conceptual confusion. Managerial jargon – and in the United States especially, marketing hyperbole – regularly threatens to drive out clear thought or reasoned argument.

One sees this most vividly as the managerial fads of one era give way to the enthusiasms of the next. As John Hunt of the London Business School put it, there is a “product cycle” in

1 The emphasis on the theme of what I call managerialism is but one of the fads I plan to address in the book manuscript Nuffield expects from its Rock Carling lecturers.

managerial fads.² New enthusiasms are promoted with high hopes, inflated rhetoric, and competitive zeal. The fads are also abandoned without much regret, with promoters escaping chastisement for their prior hyperbole. Managerial gurus shed failed models quite easily and embrace newer fashions promiscuously. Declarations of failure follow cycles of enthusiasm, as the scholarly literature documents. Both permit fame (and fortune) to be first made out of distributing the managerial equivalent of snake oil and then scholarly reputations out of discovering the pattern.³

Many in the audience will be familiar with some of the shifting fads in management—both for private and for public organizations. Let me briefly remind us of the shifts themselves. Twenty years ago or more, Management by Objective (MBO) and Zero Based Budgeting (ZBO) were the rage in boardrooms and bureaus. In recent years, the language of corporate seminars shifted to such expressions as “re-engineering” and “core competencies.” Quality circles were popular for a time soon to be displaced by an emphasis on synergy, mergers and acquisitions, and the like. At one point, big was better. Politicians as well as managers embraced larger scale operations, called conglomerates in the private sector and ‘super-agencies’ in the public sector. Within a few years, small became beautiful. Divestiture, devolution, decentralization, and specialisation became the watchwords of managerial correctness. One need not remind an audience in the United Kingdom about the cycles and recycling of managerial models.

There is already a great deal of contemporary discomfort with managerial fads, so I risk being accused of beating a dead horse. But perhaps the sort of discomfort that has given rise to the popular “Bullshit Bingo” circulating on the Internet indicates an audience receptive to more analytical discussion of why fads arise and what fads produce. Realism about what management can and cannot do might guard against swallowing the more dangerous panaceas offered by managerial gurus. Dissecting the linguistic modes of managerial fads highlights fallacies that are more serious in their effects than simple exaggeration. Some disciplined review may help moderate disappointment that good management has not (and will not be able) rid us of most of the world's evils. Here I want to elaborate the counter-argument that some have made about the effort this lecture represents.

Attention to the rhetoric of managerial thoughts is misplaced, I am told, because sophisticated audiences ignore the sloganeering and get on with the job. On this view, no one

2 John W. Hunt, “An appetite for ideas,” The Financial Times, May 3, 2001. Hunt’s analysis is very similar to my own. He reviews the research that identifies the “path” of managerial ideas “from invention through acceptance to disenchantment and decline.” And he emphasizes the speeding up of the fads, with chief executives, “exploiting and rejecting fashions within three or four years.”

3 I want to acknowledge two scholarly works were very helpful in identifying and documenting these developments. Staffan Furusten’s Popular Management Books, (London: Routledge, 1999) is a sociological study of the origins and dissemination of managerial ideas in the United States and Western Europe; Andrzej Huczynski’s Management Gurus, (London: Routledge, 1996) is more concerned with how particular marketers of management ideas promote the dissemination of their nostrums.

need worry about large numbers of misled and subsequently disappointed audiences. My topic, in short, could be thought of as an indulgence, a wasteful deflection of your time and mine.

I would respond that whether managerial gurus convince audiences or not, they take up time and energy, if only because their notions bewilder. I am reminded of a conversation in the waiting room at the Department of Health in Whitehall this past spring. A group of four from a regional health authority were, to use the jargon itself, “debriefing.” I listened as they tried to decipher the meaning of the bewildering terms used in the meeting from which they had just emerged. I could not help but hear their plaintive remarks and told them I was a student of managerial jargon and thought they would be better off if they proceeded with a more sceptical attitude. This appeared to give them some symptomatic relief. All too many audiences find themselves either fooled or furious about what turns out to be misleading, needlessly obscure, or downright fraudulent. At the very least, managerial obscurity directs discussion away from topics more worthy of the attention of those who provide medical care, receive care, pay for it, or manage those services.

Why Managerialism (and Market Enthusiasm) in Medical Care?

I want now to turn to the context that proved to be such a fertile setting for the transfer of business models of allocation and management to medical care. My contention is that the decade of the 1970s—marked by stagflation and intense fiscal pressure in all the industrial democracies — provided such a context. In that decade medical care policy leapt to the forefront of public agendas for one or more of these reasons. First, the financing of medical care became a major financial burden on the budgets⁴ of mature welfare states precisely when public finances fell sharply from prior forecasts. When fiscal strain arises – especially from prolonged recession – policy scrutiny (not simply incremental budgeting) is the predictable result. Secondly, welfare states, as Rudolf Klein argued in the late 1980s⁵, under almost all circumstances came to have less capacity for bold fiscal expansion in new areas. This meant managing existing programs (in new ways perhaps, but in changing economic circumstances) necessarily assumed a larger share of the public agenda. Thirdly, there was what might be termed the wearing down of the post-war consensus about the welfare state.⁶

4 Technically, this is not strictly true of course, as is evident in the sickness fund financing of care in Germany, the Netherlands, and elsewhere. But, since mandatory contributions are close cousins of 'taxes', budget officials must obviously treat these outlays as constraints on direct tax increases.

5 See R.Klein and M. O'Higgins, "Defusing the Crisis of the Welfare State: A New Interpretation," in Marmor and Mashaw, eds., Social Security: Beyond the Rhetoric of Crisis, (Princeton, N.J.: Princeton University Press, 1988), esp. pgs. 219-224.

6 The bulk of this ideological struggle took place, of course, within national borders, free from the spread of "foreign" ideas. To the extent similar arguments arose cross-nationally, as Kieke Okma has noted, mostly that represented "parallel development." But, there are striking contemporary examples of the explicit international transfer and highlighting of welfare state commentary. Some of this takes place through think tank networks; some takes place through media campaigns on behalf of particular figures; and, of course, some takes place through academic exchanges and official meetings. Charles Murray – the controversial author of Losing Ground (1984) and

Begun in earnest during the 1973-74 oil shock, sustained by stagflation, and bolstered by electoral victories (or advance) of parties opposed to welfare state expansion, critics assumed a bolder posture and mass publics came increasingly to hear challenges to programs that had for decades seemed sacrosanct.⁷ From Mulroney to Thatcher, from New Zealand to the Netherlands – the message was one of necessary change. The incentives to explore transformative but not fiscally burdensome options became relatively stronger. That, I would suggest, helps to explain the international pattern of welfare state review – including health policy – over the past two decades. And it also helps to explain why the appeal to market allocation and better management became so much more compelling.

Market Talk and Medical Care: the Impact in America on the Medical World and the Public

Not only was there a perceptible general increase during the 1970s in the attention paid to proposals to make medicine better managed and subject to market-like competition, but a dramatic shift simultaneously took place in the language of medical commentary. This transformation can be presented as a case study of what George Orwell might have called “the politics of the medical language.” To change thinking, one manipulates language. The traditional doctor-patient relationship becomes, in the language of competitive markets, provider-consumer, or buyer-seller, or supplier-demander. Medicine becomes just another business. The fallout from this refashioned language came to be a threat to the professional ethos of medicine, most obviously in America, but elsewhere as well.

Traditionally, much of the “income” doctors, nurses and other medical practitioners earned has been non-economic: self-esteem, respect from the community and idealization as selfless professionals. In casting medical care as no different from other industries, medical professionals are reconceptualized. They no longer deserve (and increasingly no longer receive) the non-economic benefits of public esteem, patient idealization, and the gratitude of families. The stereotype of the medical professional as a self-interested (selfish) agent of business feeds on itself. And, over the quarter century we are surveying, the American public's esteem for medical practitioners indeed fell sharply.⁸

co-author of The Bell Curve (1994) – illustrates all three of these phenomena. The medium of transfer seems to have changed in the post-war period. Where the Beveridge Report would have been known to social policy elites very broadly, however much they used it, the modern form seems to be the long newspaper or magazine article and the media interview.

7 This is the argument developed in Marmor, Mashaw, and Harvey, America's Misunderstood Welfare State: Persistent Myths, Continuing Realities, (New York: Basic Books, 1992), esp. ch.3. The wider scholarly literature on the subject is the focus of a review essay, "Understanding the Welfare State: Crisis, Critics, and Counter-critics," Critical Review, Vol.7, No.4, 1993, 461-77.

8 Public confidence in medicine and health institutions dropped from 73 to 33 per cent between the mid-1960s and mid-1980s. While all major American institutions experienced a loss of public support, the medical profession lost

Part of the decreased satisfaction with American medicine undoubtedly arose from worries over very high and rapidly rising costs. Although it is impossible to establish a clear causal connection between the demystification of the medical profession and the increased incomes of doctors, the phenomena have gone hand in hand. Despite sharp increases in the number of new physicians, doctors' incomes grew by 30 per cent from 1984 to 1989. (This contrasted with an average 16.3 per cent increase for other full-time workers over the same period.⁹ Physicians' fees for procedures were approximately 234 per cent higher in the United States than in Canada,¹⁰ and their take-home pay was more than 50 per cent higher than that received by Canadian doctors.¹¹ It should not be surprising that to the extent professional medical work was increasingly regarded as ordinary commercial activity, higher physician fees (and incomes) were increasingly understood as the result of market power or greed rather than a professional's just desserts.

External criticism and constraints on professional autonomy begat doctor dissatisfaction and the prestige of the American medical profession decreased over the 1970s and 1980s. Doctors complained that they no longer enjoyed the autonomy they once had. Rather, elaborate, intrusive and administratively expensive procedures proliferated, including utilization reviews, requirements for pre-admission certification and other forms of second-guessing. American Medical Association surveys in 1986, for example, found that 60 per cent of physicians strongly opposed third-party reviews of their hospitalization decisions.¹² In an often-quoted 1991 article in *The Atlantic*, Regina Herzlinger reported that despite increased incomes more than 30 per cent of current physicians said they would not have attended medical school had they known what their futures had in store.¹³

The language of industrial economics and competitive markets did not just affect doctors. Hospitals and hospital administrators recast themselves in new terms. The hospital administrator increasingly became the chief executive officer. Assistant administrators were refashioned as vice-presidents for their respective functions. These changes were not merely

support faster than any other professional group. Insofar as high levels of public trust are associated with altruistic behavior and sense of social mission of a profession, at least some of the lost support was no doubt due to the increasing commercialization in the medical profession. In his analysis of a host of survey data, Blendon found that while most (64 per cent of those polled) supported advertising by physicians, 58 per cent did not expect it to be truthful. Robert Blendon, "The Public's View of the Future of Medical Care," Journal of the American Medical Association, (1988) 259: 3587-93.

9 V.R. Fuchs, "The Health Sector's Share of the Gross National Product," Science, (1990) 247: 534-7.

10 V.R. Fuchs, and J.S. Hahn, "How does Canada do it?" New England Journal of Medicine, (1990) 323: 886.

11 R. G. Evans *et al.*, "Controlling Health Expenditures – the Canadian Reality," New England Journal of Medicine, (1989) 320: 572.

12 L. Harvey, *AMA Surveys of Physician and Public Opinion*: (1986) Chicago: American Medical Association, (1986).

13 Regina Herzlinger, "Healthy Competition," The Atlantic, (1991) No. 268: p71.

semantic exercises. Rather, they represented a fateful change in the way Americans were encouraged to think of medical care. The vision of a hospital as primarily a business – and the concomitant shift in administrative power away from medical staff and toward professional managers – inevitably affected the way Americans regard medical care. It would be wrong to assume unanimity on this and equally wrong to presume that American physicians and nurses think of themselves as simply business figures. The point here is narrower. Over time, the attack on the professional standing of medicine helped to deflate public confidence and to increase the probability of proposals threatening professional autonomy.

As hospital administrators gave way to chief executive officers (CEOs), so too did their incomes change. By 1990, hospital CEOs earned an average base salary of over \$103,000: those receiving incentive pay averaged \$125,000. Note that the salaries of these chief administrators increased by 8.5 per cent (on average) in 1989, while the Consumer Price Index grew by 4.6 per cent.¹⁴ And this took place in the midst of a supposed “crisis” in health spending.

There are, of course, advantages to treating hospitals more like a typical business. Improved capital budgeting, financial and accounting systems are all vital in getting better value for health expenditures. Nor can one pretend medical practitioners are all selfless workers concerned only for the welfare of their patients. Clearly economic motives are important. Indeed, many of the concerns of those who subscribe to pro-competitive strategies are identical to my own. Asymmetries of information and bargaining strength between doctors and patients *do* require attention. Likewise, uncertainty about the efficacy of alternative treatments and the problems of moral hazard and adverse selection all need to be addressed whatever one's personal philosophy of entitlement to medical care.

But the rhetoric of the competitive market helped to disguise what sets medicine apart from other industries and it was that broader development that made it possible for a Democratic president like Bill Clinton to marry ideas of universal health insurance to “pro-market” ideology. No one can make sense of the Clinton embrace of his reform plan of “managed competition” without appreciating just how much the celebrations of markets and management had depleted faith in ordinary public administration. It is worth noting that managed competition is itself an example of double talk, the holding of two contradictory ideas at once. A managed system is one whose parties control operations by various managerial techniques – for good or for ill. By contrast, the results of a competitive market are largely up for grabs. Under idealized competitive conditions, individual actors pursue their own interests without central direction. Whatever coordination occurs is not by managerial design, but as a consequence of individual adaptation. The results are not planned and may not be desirable. We regulate competition, well or poorly. And we manage resources, well or poorly. What we do not do is manage competition.

In arguing against governmental provision of medical care, pro-competitive advocates regularly claim that governments are not competent as managers. The inevitable concessions of

¹⁴ Regina Herzlinger, *op. cit.*

the political process, it is argued deplete resolve and efficiency so that programs over time bear less and less resemblance to their initial design and purpose.

Ironically, from the 1970s to the present, pro-competitive advocates proposed a variety of detailed government programs, laws and regulations designed to address and eliminate the market failures that occur in unregulated medical markets. The dilemma hardly faced in most public discussion of competition in medical care, arises precisely here. What happens to the logic of pro-competitive proposals when government incompetence contaminates the efforts to reform medical markets? How desirable can a plan for “managed competition” be when only half of its provisions get enacted and implemented, when insurance companies are not required to offer specific types of plans, when the government increases, rather than eliminates, the tax deductibility of medical insurance? What happens if experience rating is allowed (insurers can offer lower premiums to low risk groups) but the government sets up no provision for high risk groups who find it difficult to get insurance at all?

The answer is that most pro-competitive plans were not robust in precisely this crucial respect. They would not perform well unless conditions were just right. By the very detailing of the government actions required to eliminate market failures, backers of pro-competitive reform implicitly acknowledged that without these remedies, a competitive system does not work very well.

The characterization of medical care as just another business also had implications for the way in which the potential for improvement from government intervention came to be judged. The dichotomy drawn between private competition and public regulation invoked free choice and well-functioning markets on the one hand, and failed socialism on the other. But the dichotomy was, and is, artificial and misleading. The properties of the medical sector are such that regulation of some kind has always been regarded as inevitable by every serious writer on the subject. Ironically, the most popular pro-competitive schemes have all entailed a myriad of regulatory restrictions on practitioners and patients alike.

From Idealized Markets to Misleading Managerialism: The Case of Managed Care

I want now to return to the connection between market enthusiasm and managerial fads. I have in mind the tendency to express ideas through misleadingly persuasive linguistic devices. Consider, for example, medical expressions like “managed care” or more general public management labels like “joined up” government. These are slogans, persuasive terms that imply success by their very use. Consider this feature. In every case of such a slogan, the opposite has no appeal. So, for example, the appeal to integrated systems has no defenders of “disintegrated” ones. Disease management is set against the non-management of disease, a null category. Even that familiar slogan in research circles – evidence-based medicine, policy, or whatever – has no credible antonym.

Precisely because so much of the language used to describe medical care today is meant to convince rather than to describe or to explain, even thoughtful observers often end up endorsing claims whose validity they should be assessing. I cannot think of a better illustration of this process than the widespread appeal to “managed care” in medical reform circles.

The expression “managed care” – much like that ubiquitous reform phrase of the early 1990s, “managed competition” – is actually a product of market sloganeering, aspirational rhetoric, and managerial jargon. Insofar as it is an incoherent notion, most claims about managed care will suffer from incoherence as well. Although the exact provenance of “managed care” is uncertain, the term came into widespread usage only in the 1990s. The expression does not appear once, for example, in Paul Starr’s exhaustive 1982 history *The Social Transformation of American Medicine*. The phrase first appeared in *The New York Times* in 1985 but surfaced in only a handful of articles during the decade. In the 1990s, however, *Times* articles mentioning the phrase exploded, increasing from 27 in 1990 to 287 in 1994 to 587 in 1998. Because “managed care” has become something of a household term, it is difficult to recognize how recently it entered medical discourse.

What exactly managed care is, however, has never been entirely clear, even among its strongest proponents. To some, the crucial distinguishing feature is a shift in financing from indemnity-style fee-for-service, in which the insurer is little more than a bill-payer, to per capita payment methods. Yet there is nothing intrinsic to fee-for-service payment that requires that reimbursement be open-ended or insurers passive. Many, if not most, American health insurance plans that are labeled “managed care” do not rely primarily on capitation. To others, the distinctive characteristic is the creation of administrative protocols for reviewing and sometimes denying care demanded by patients or medical professionals. But such micro-level managerial controls are not universal among so-called managed care health plans either. In fact micro management may be obviated by payments methods, like capitation or regulated fee-for-service reimbursement, that create more diffuse constraints on medical practice. Finally, to some, what distinguishes managed care is the establishment of integrated networks of health professionals from which patients are required to obtain care. Yet some so-called managed care plans have no such networks. And what is called a network by many plans is little more than a list of providers willing to accept discounted fee-for-service payments – hardly a radical break with the past. In short, what constitutes the subject matter of managed care is utterly obscure.¹⁵

15 Even thoughtful critics of managed care face confusion. Donald Light’s essay, “Managed Care: false and real solutions,” *The Lancet*, Vol.344, October 29, 1994, described managed care as “the hot new export from the United States, promoted by major consultants as the most efficient way to integrate primary care, sub-specialization, and everything in between.” He goes on to suggest that “these days [1994], the term managed care means any of several institutional arrangements,” but then goes on to employ the expression even though it is not clear which of the “several” arrangements constitutes the relevant noun. It reminds one of the joke that if you don’t know where you are going, any road will get you there. So, with managed care. If it has no settled meaning, conversations about it are certain to be misleading.

A more sensible interpretation of “managed care” is that it represents a fusion of two functions that had once been seen as separate: the financing of medical care and the delivery of medical services. This, at least, provides a reasonably accurate description of the most familiar organizational entity that marched under the managed care banner in the early 1980s: the health maintenance organization (HMO). When the majority of American health insurers used fee-for-service payments and placed few restrictions on patient or provider discretion, it was at least possible to identify a small subset of health plans that existed outside this insurance mainstream, however poorly the expression “managed care” described the organization of such plans or what they did. Today, however, that is decidedly no longer the case. Only two percent of private health plans in 1997 conformed to the traditional model of fee-for-service indemnity insurance. Another 16 percent use fee-for-service payment but employ some form of utilization review.¹⁶ Thus between 80 and 98 percent of today’s private health insurers appear to fall into the general category of managed care. The category does not, in other words, offer any guidance as to how to distinguish among the vast majority of contemporary American health insurance plans.

Conflating organization, technique, and incentives leads to unnecessary confusion. When contrasting health plans we are often comparing them across incommensurable dimensions (arguing, for example, that an HMO is somehow more “managed” than a fee-for-service plan with utilization review even when the latter may use much stricter controls on individual treatment decisions). It means, too, that we are tempted to presume necessary relationships between particular features of health plans (such as their payment method) and specific outcomes that are alleged to follow from these features (such as the degree of integration of medical finance and delivery) – even though such outcomes usually result from a complex of financial, organizational, and administrative factors. And finally, it encourages a wild goose chase of efforts to come up with black-and-white standards for identifying plan types. As health plans employ increasingly diverse payment methods and organizational forms, the search for the “essence” of a particular plan will become all the more futile.

The “managed care revolution” is really a set of related trends, few of which are accurately captured by the blanket term. When these trends are distinguished from one another, the evidence suggests that American health insurance has moved simultaneously in several different, perhaps even contradictory, directions in recent years and that many of the changes are longer standing than the rhetoric of managed-care celebrants implies.

The rapid changes taking place in American medical care place a special burden on analysts to be precise about the criteria and considerations that underlie their empirical evaluations and, ultimately, their judgments and assessments. Labels and categories are indispensable, but they should be designed to elucidate the techniques, organizational forms, and incentives that characterize alternative health plans, rather than to confirm or deny the claims of industry friends or foes. “Managed care” fails that test, and although I hardly expect my words

16 HIAA, Source Book of Health Insurance Data 59 (1998).

to be heeded, I think that it – and other terms like it – should be banished from the medical care lexicon for good.

From this extended American example of linguistic muddle, let me turn to the use of managerial jargon in the UK context. First, let me contrast the cross-Atlantic contexts. In the United States, the language of medical management – and managerial practices more generally – has produced a backlash, a sense of outraged anger. The disputes about the patient’s bill of rights, for example, reveal this. The critics of the managers of health insurance plans portray them as greedy profiteers who extracted funds from the health insurance pools to line their pockets and obscured what they were doing under misleading labels like managed care, integrated delivery systems, and the like. To turn to the NHS, the complaint is much more likely to be dismay at managerial changes that are recurrently imposed in the name of slogans but with the force of budgetary authority. In the US, where no one is in charge of a national system of medical care financing, obscurantism more easily leads to dispersed rage and a search for scapegoats in the face of distress whose sources are not simple to identify. In the NHS context, sullen resentment – not diffuse rage – appears the more common response to managerial excess.

NHS Management: Styles And Responses

Visitors from abroad should, in my view, adopt a posture of hesitant certitude in commenting on the complexities of policy and management in another country. For every Tocqueville, there are scores of others whose observations waste paper. So, what might this outsider say prudently about the reactions not only to the newly announced policy of dispersing managerial authority but also the style of policy making and management in the NHS more generally? Here the outsider has considerable help from a number of scholars who have written about what can be called the new public management in the United Kingdom. I have relied on that literature in first understanding the type of managerial rhetoric dominant now and to make sense of why reactions to managerial fads are often so hostile.

My guides to what is called the new public management in Britain are the writings of Michael Barzelay, Christopher Hood, and Michael Power. Power has brilliantly summarized the central ideas, suggesting that the new public management “consists of a cluster of ideas borrowed from the conceptual framework of private sector management.” Among the ideas most emphasized are

cost control, financial transparency, decentralization of management authority, the creation of market and quasi-market mechanisms separating purchasing and providing functions and their linkage via contracts, and the enhancement of

accountability to customers for the quality of service via the creation of performance indicators.¹⁷

It does not take exhaustive research to see just how widely these ideas have spread in the world of the NHS. So, for example, consider this brief survey of faddish presentation of managerial ideas in recent years. In December of 1997, the white paper announcing the “New NHS” promised dramatic changes in the way Labour would manage things. “Integrated care” would replace the internal market of the Thatcher reforms, building on “what has worked, but discard[ing] what has failed.” This, we were told, would save huge amounts of red tape and put “money into frontline patient care.” Here we have the familiar appeal to a persuasively defined action – integration. The world of clinical audits promised wondrous improvement in patient care, but has hardly experienced embrace from those whose professional performance is the object of improvement. Performance targets, quantitative measures, monitoring, and evaluating—these became watchwords of NHS reforms. But the reality appears to contain more variability than these expressions suggest. As Christopher Hood has argued, the new public management is more a story of successive shifts in approach over the last twenty years than steady reinforcement of a single trend. Indeed, Hood suggests over the 1980s a shift in emphasis “from efforts to...equip ministers to be effective managers of their departments...to the effort to take management away from ministers...by the creation of executive agencies at arm’s length from the departments.” The drumbeat of changing fads is evident in Hood’s depiction of the themes of managerial innovation. So one notes the “move from the stress on ‘results’ or ‘outputs’ that were the catchwords of public management reformers in the early 1980s to the stress on ‘governance’ (a euphemism for ‘process’) as the hot topic of the mid-1990s.” Rather than a coherent doctrine, these persistent adjustments in doctrine might be regarded, Hood notes, as “ceaseless activity to grapple with the unacknowledged consequences of yesterday’s mistakes.”¹⁸

It is to the “ceaseless activity” that I want to call attention. It is striking to the visitor how unanimous NHS commentators are in both their criticism of and their cynicism about proposed NHS shifts in policy and management. Rudolf Klein, in discussing a “much advertised” speech about devolution by the Secretary of State for Health, predicted that “the first reaction to Mr Millburn’s speech is...likely to be cynicism.” In published reactions to the Milburn policy during the summer of 2001, it seems, both analytical rage and policy skepticism was dominant. And this is true from observers as different as Nicholas Bosanquet and Charles Webster, and across a wide spectrum of general political views. To this observer, it seems plain that Bosanquet and Webster are not ideological cousins, but they both find nothing to recommend in

17 Michael Power, *The Audit Society: Rituals of Verification*, (Oxford: Oxford University Press, 1997), p.43. See also, Michael Barzelay, *The New Public Management*, (Berkeley: University of California Press, 2001) and Christopher Hood, *The Art of the State*, (Oxford: Oxford University Press, 1998).

18 Hood, op. cit., 201.

the NHS's mode of policy making. Bosanquet's claim that "there never has been a greater gap between the view of solutions at the center and the realities as they appear day to day at the local level" should, if true, worry the Blair government greatly. And that critical stance is common to David Hunter (emphasizing the dismay of managers) to Charles Webster (emphasizing the secret and detached quality of the Blair government's policy making in healthcare) to Bob Sang's invocation of high managerial doctrine in lamenting what the NHS debate lacks. Only Jennifer Dixon saw a "chink of light," itself an qualifying metaphor for Dixon's effort to explain the "gripes" about what she describes as New Labor's "tendency towards hierarchy and centralism." Hierarchy and centralism – that is the common theme of the criticism here and the explanation of why these analysts were so cynical about the NHS plan to shift the balance of power.¹⁹

What the outsider wonders about is whether there is any reason to think this 2001 plan is any more than another centralist move in decentralist clothing. The NHS appears to have been on a centralizing mission for decades now, masking that for a time with one or another reorganization. And the reorganizations themselves have sapped morale and disturbed lives enough to make managers more likely candidates for psychotherapy than corporatist cooperators with central office. None of these commentators find much to say about announced aims of *Shifting the Balance*. Since paying more attention to "local level" actors – providers, patients, and payers – is what most of the commentators applaud, this inattention to the stated policy goals is striking testimony to the distrust of the NHS and its policy making modes.

There are good grounds for that distrust in the reviews of NHS history since the 1970s. First, as Webster notes incisively, the rhetoric of local level decision making goes back to 1979, but the reality of both the Thatcher and Blair policies have not "been conducive to such decentralisation of power." David Hunter emphasizes, as do others, what he calls "control freakery" and concludes that managers at the local level have been "unwilling to say what they think" about proposals like Mr Millburn's on shifting the balance. And most of the comments converge on disbelieving the commitment to devolution, whatever the rhetoric. They believe the history, the Blair (and Thatcher) style of policymaking, and the structure of British government support their cynical reaction.

While appreciating these grounds, I want to offer two somewhat different perspectives on this evaluation. First, I want to call attention to the more general trends in national health decision-making that are not at all the topic in this NHS debate. From Australia to New Zealand, from the US to Canada, from Holland to Germany, and from Sweden to Denmark, dismay about modern medical care financing, quality, and management is apparent. The attack on medical errors and the distrust of physician self-government are trends that are cross-national in the OECD world. What is more, the claim that good science, proper information, and appropriate monitoring can raise the quality of health care among industrial democracies is an article of faith among the devotees of what could be called the "new public management" in medical care.

¹⁹ Across the Great Divide: Discussing the Undiscussable," in *British Journal of Health Care Management*, 2001, Vol 7, No. 10.

These views are neither new nor restricted to public management. They inform not only the development in the United States of new agencies of government devoted to the improvement of quality standards as well as the rise of private firms advertising their capacity to separate good from bad hospitals, competent from incompetent physicians, and worthy from worthless drugs. A UK audience will think of NICE, a Canadian audience will think of the Center for Health Information, and others will find their own acronyms. But the common element is distrust of collegial authority and either celebration of market means or government hierarchies as the right measure for a lamentable state of “local self-government” of clinical matters.

What distinguishes the NHS is the degree of centralism in the day-to-day mode of policymaking. As David Hunter rightly notes, a non-political NHS is a fantasy, a goal that will not (and could not) be entertained in a democratic society. But the extent of the political control has varied across time in the UK. There were decades when central budgetary control combined with considerable medical and managerial discretion about how to live within budgets. Not so for more than the last decade.

This brings us back to the question of whether this new turn of policy is to be taken seriously. The only grounds for doing so is to see the connection, as Rudolf Klein did, between the "corset of control" that the Blair government has already established and a new freedom justified by the conviction that it will not be a “license for poor standards or inadequate performance.” This interpretation rests on the premise that no British government could ignore inappropriate variation in care standards. But, if the new Modernization Agency could count on prior constraints, then its posture could be one of promoting good practice and not hectoring.

This is the most generous interpretation one could make of the logic of the Blair government's newest policy. It puts my sense of realism at the limit. But it also suggests a way of discussing such policy initiatives: namely, to add to justified criticism and cynicism a set of indicators of what would count as evidence that the new policy was being carried out. Without that, commentary stays girdled by past disappointments and leaves little opportunity for those within government to show they mean what they say.

A Return to Realism: Why Sensible Management Requires Modesty, Not Zeal

The review of these cynical responses to the most recent shifts in NHS managerial directives does not mean I endorse all the criticism (or cynicism). But it does remind one of both the persistence of organisational changes and the weariness of those whose lives are thereby affected. At the same time, the prominence of cynical commentary reminds one of the costs of massive gaps between what is claimed and what is true. And that in turn leads me to comment on the incantation throughout contemporary management talk about the importance of having clear, measurable, and limited organisational objectives. An unfortunate consequence of the injection of managerial fads into medical care is the suggestion that there is some one right way, some panacea, for rationalising the delivery of decent, affordable medical care.

I want to challenge that contention directly and forcefully. It is obvious to me is that the objectives of any institution are multiple, shifting, and often contradictory. It would be quite surprising if any single managerial approach could cope effectively with differing objectives, let alone with changes in priority among different objectives over time. To make this point clear, consider for a moment just how one might answer the following question: "What is a hospital's purpose?" At different periods, and often during the same period, one might answer that hospitals:

1. Contain the spread of contagious diseases.
2. Provide hygienic surroundings for otherwise dangerous interventions.
3. Economize on the cost of access to expensive technology.
4. Provide respite from normal social roles that are producing physical or mental breakdown in patients.
5. Economize on the transmission of information and the processes of learning among professionals who have clinical responsibilities and require multiple clinical encounters to validate their procedures.
6. Centralize medical activities sufficiently to achieve economies of scale in different health care tasks.
7. Provide symbolic reassurance that social effort is being devoted to the health of citizens in cultures with considerable faith in technological remedies.
8. Improve the health of the population.

Hospitals, in short, serve quite varied purposes, all of which cannot be pursued through the same internal authority structure, with the same information technology, or on the same scales. They give rise to starkly different images of what counts as a well-managed hospital. For example, emphasizing purposes 1 or 4 implies a relaxed approach to length of stay; stressing purposes 3 or 6 might mean treating longer hospital stays as evidence of managerial failure. Purpose 5 suggests a team approach to management, with authority centralized among the professionals; purpose 3 bolsters hierarchical forms of bureaucratic authority. Purposes 1 through 7 suggest allocations of authority within the hospital as a separate institution: purpose 8 suggests a much broader structure of authority, one including outside stakeholders with the power to define and redefine the institution's primary mission.

What should one make of this? The first lesson here is a simple one. Institutions such as hospitals have multiple tasks which imply different managerial approaches. Good management is not what slogan the administrator has emblazoned on the tee shirts of employees but how well the manager's particular approach balances the different demands of the multiple purposes of the institution. I would not belabor this simple point but for the overwhelming evidence that it is often, if not usually, forgotten. Indeed, when some clone of managerial guru Tom Peters next says to health care managers that to have multiple objectives, or even two objectives, is to have no objectives at all, he or she should be condemned to pursue one objective for the rest of their lives.

A second observation I would make about managerial technique is the homily that every upside has a down side. For instance, when moving into a world of managerial cost containment, we should reflect on what can be lost as well as gained. Cost containment in practice stresses the reduction of questionable doctor/patient encounters, diagnostic procedures, and treatments. The bureaucratic routines required to implement these actions may or may not contain costs. But they may very seriously reduce the choices, morale and satisfaction of both patient and health care professional. Different managerial techniques and different organizational configurations will be required if old values are not to be unduly sacrificed to mindless cost control. Moreover, the managerial techniques imposed in the name of reducing costs do little to encourage innovation, patient control, or professional autonomy. Repeating the mantra of TGM or “integrated systems management” every day will not eliminate the stress built into serving different purposes and clienteles with multiple objectives. Good management requires multiple approaches to balance the “goods” and “bads” of each approach. In other words, there are no managerial panaceas available —now or ever.

Finally, there is a deep ambivalence in managerial theorizing about the effectiveness of, very broadly speaking, technological as opposed to cultural solutions to managerial problems. Management theorists, ever since the so-called "scientific management" movement prompted hostility for treating people and machines interchangeably, have oscillated in their recommendations for change. On the one hand, there are recommendations based on improved structures, processes, and technologies and, on the other, those based on learning, motivation, and culture. One cannot decide which managerial strategy to believe in because both work some of the time, but neither works all of the time.

The same is true in the reorganization of health care systems. It is hard to believe that a cultural approach will be appealing from the standpoint of cost containment. Managing costs is mostly about information systems, the determination of what is cost-effective, and the delivery of incentives or coercion to act on those judgements. On the other hand, if there is cultural vision of the caring medical professional, there will be a need for internal structures that emphasize professional autonomy, team effort, group responsibility, and patient involvement in an overall culture of humane care. Under such circumstances, managerial arrangements will to some degree work at cross-purposes. The technology of cost containment confronts the professional culture of patient care. Good managers balance these perspectives in ways that cope with our conflicting purposes and necessarily inconsistent desires.

Management is not a solution to seemingly intractable stresses. Rather it is a means of coping with and sometimes improving only marginally tractable situations. This more modest vision of management has much to teach those in the reform business about the appropriate level of aspiration for anyone engaged in re-forming complex systems. But management thinkers cannot teach others that lesson until they give up the quasi-religious adoption of one management slogan after another as the solution to getting management right. There is no best management theory, technique, or slogan. In particular contexts, some are better than others. But that must

be shown, not glibly claimed by persuasive definitions that presume saying so makes something so.