

Fads in Medical Care Policy and Politics: The Rhetoric and Reality of Managerialism

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I. Introduction

I am honored to be asked to give the annual Rock Carling lecture. I am grateful to the stewards 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 40-year history of education, friendship, and professional stimulation in Great Britain. This lecture provides me the chance to acknowledge my debt to these friends and colleagues — and most especially my Wadham College tutor of 1961, Pat Thompson.

My topic tonight is *Fads in Medical Care Policy and Politics: The Rhetoric and Reality of Managerialism*, or “managerialism in medical care.” I will introduce the broader topic of fads and then turn to how fads management commentary has shaped (and mis-shaped) understandings of medical care on both sides of the Atlantic.

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. In the world of ideas, there are similar rushes of enthusiasm, though the character and the 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.¹ There are fads in names for children, items of home decoration, 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.

II. The Problem of Managerial Fads, or Managerialism

My fundamental contention is that the discussion of modern medicine's most prominent topics — cost, quality, access, and organization — is marked by linguistic muddle and conceptual confusion. I want to distinguish two sorts of jargon within the broader category of business talk. Bottom lines, entrepreneurship, free competitive markets, M&A, which is now the Lingua Franca of globalism — the first jargon is the management jargon that comes out of B-schools and consultancies, and makes its way into the discourse via popular “business books.” The second is marketing jargon, or hype as I call it — a very different thing. My coinage, “managerialism,” covers both. It, to my mind, is a threat to clear thought or reasoned argument.

One sees this vividly as the managerial fads of one period give way to the enthusiasms of the next. As John Hunt of the London Business School put it, there is a “product cycle” in managerial fads.² New enthusiasms are promoted by author consultants and their publishers — with high hopes and inflated rhetoric. The fads are also abandoned even by their authors, when their consultant firms without much regret. Indeed, managerial gurus like Tom Peters shed failed models quite easily and embrace the newest fashions promiscuously. Declarations of failure follow cycles of enthusiasm, as the managerial journals and scholarly literature document.³ 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.⁴ I might mention in passing the corruption that goes on with consultancies buying up thousands of copies to get their author's book on the bestseller lists. The list makers are wise to this ploy now, but maybe you have never heard of it. I had not before investigating this copy.

Many of you 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

Best Selling Books Business

(Source: *The Wall Street Journal* Friday, October 26, 2001)

Rank	Title (Author)
1	Who Moved My Cheese? (Spencer Johnson)
2	Jack: Straight From the Gut (Jack Welch)
3	Good to Great (Jim Collins)
4	Fish! (S. Lundin, H. Paul, J. Christensen)
5	Rich Dad Poor Dad (R. Kiyosaki, S. Lechter)
6	7 Habits of Highly Effective People (Stephen Covey)
7	Side by Side Leadership (Dennis A. Romig)
8	Now, Discover Your Strengths (M. Buckingham, D. Clifton)
9	First, Break All the Rules (M. Buckingham, C. Coffman)
10	Gung Ho (K. Blanchard, S. Bowles)

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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 specialization became the watchwords of managerial correctness. One need not remind an audience in the United Kingdom about the cycles and recycling of managerial models. But, for visual clarity, take

note of the list an Australian management consultant provided me this summer:

Managerial Fads

1. Flatten the Structure – Eliminate Hierarchy
2. Empowerment – Leaderless Teams
3. TQ C/M/? – V A/B M/?
4. Vision, Mission, Values
5. Customer Focused / Service Organization
6. Trait Leadership
7. Continuous Improvement – Learning Organization
8. Process Re-engineering
9. Cultural Transformation

“Strongly held but largely unfounded beliefs and formulas about how to manage”

(Source: F. Hilmer and L. Donaldson. (1996) *Management Redeemed*, The Free Press)

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There is already a great deal of contemporary discomfort with managerial fads; so I risk being accused of beating a dead horse.

Let me use a visual aid to get us to “Bull... Bingo,” and a more analytical discussion of fads and what they produce.

More seriously, 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. But let me elaborate the counter-argument that some have made about the effort this lecture represents.

My cautious warnings about the rhetoric of managerial thoughts are misplaced, I am told, because sophisticated audiences ignore the sloganeering. They simply get on with the job. On this view, no one needs to worry about large numbers of misled and subsequently disappointed audiences. In short,

Bull**** Bingo

Do you keep falling asleep in meeting and seminars? What about those long and boring conference calls? Here is a way to change all of that!

How to play: Check off each block when you hear these words during a meeting, seminar or phone call. When you get five blocks horizontally, vertically or diagonally, stand up and shout **BULL****!!**

Synergy	Strategic Fit	Gap Analysis	Best Practice	Bottom Line
Revisit	Bandwidth	Hardball	Out of the Loop	Benchmark
Value-Added	Proactive	Win-Win	Think Outside the Box	Fast Track
Result-Driven	Empower [or] Empowerment	Knowledge Base	Total Quality [or] Quality Driven	Touch Base
Mindset	Client Focus[ed]	Ball Park	Game Plan	Leverage

Testimonials from satisfied players:

"I had only been in the meeting for five minutes when I won." – Jack W. – Boston

"My attention span at meetings has improved dramatically." – David D. – Florida

"What a gas. Meetings will never be the same for me after my first win." – Bill R. – New York City

"The atmosphere was tense in the last process meeting as 14 of us waited for the 5th box." – Ben G. – Denver

"The speaker was stunned as eight of us screamed 'Bull****' for the third time in 2 hours." – Kathleen L. – Atlanta

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my topic could be thought of as an indulgence, a wasteful deflection of your time and mine.

My response: 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 much better off if they regarded the jargon much more skeptically. 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 language. 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. At worst. . .

III. Why Managerialism (and Market Enthusiasm) in Medical Care

So, I want now to turn to the context that proved to be such a fertile setting for the transfer of business models of management to medical care. The decade of the 1970s — marked by stagflation and intense fiscal pressure in all the industrial democracies — provided just such a context. In that decade medical care policy leapt to the forefront of public agendas. First, paying for/medical care became a major burden on the budgets of mature welfare states precisely when public finances fell sharply from prior forecasts.⁵ When there is a fiscal strain, policy scrutiny is the predictable result. Accordingly, welfare states, as my friend, Rudolf Klein argued in the late 1980s, had less capacity for bold fiscal expansion in new areas.⁶ This meant managing existing programs necessarily assumed a larger share of the public agenda. Tight welfare budgets foreclosed expansive reform? Lastly, there was what might be termed the wearing down — some people would say, “wearing out” — of the post-war consensus about the welfare state.⁷

Having begun in earnest during the 1973–1974 oil shock, sustained by stagflation, and bolstered by electoral victories (at least or advance) of parties opposed to welfare state expansion, these critics assumed a bolder posture. Mass public came increasingly to hear challenges to social programs that had for decades seemed sacrosanct.⁸ 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 stronger. That context, I suggest, helps to explain the international pattern of welfare state review — including healthcare policy — over the past two decades. And it also helps to explain why the appeal to market mechanisms and business-like management became so much more compelling: they were more sellable to more business-minded constituencies.

IV. Market Talk, Management, and Medical Care: The Impact in America on the Medical World and the Public

Here is where you pick up on the “business discourse” distinction you made at the outset.

There was a perceptible increase during the 1970s in proposals to make medicine better managed and subject to market-like competition. Simultaneously, a dramatic shift took place in the language of medical commentary, a case study of, following Orwell, “the politics of language.” To change thinking, one manipulates language. The traditional doctor–patient relationship becomes, in the language of competitive markets, provider–consumer, buyer–seller, or supplier–demander relationship. Medicine in this way 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 earn has been non-economic: self-esteem, respect from the community, indeed 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) as much of the non-economic benefits of public esteem and gratitude. 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. Public confidence in medicine and health institutions dropped from 73 to 33 percent between the mid-1960s and the mid-1980s. While all major American institutions experienced a loss of public support, the medical profession lost support faster than any other professional group.⁹

Part of the decreased satisfaction with American medicine undoubtedly arose from worries over our 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 went hand in hand. Despite sharp increases in the number of new physicians, doctors’ incomes grew by 30 percent in the 5 years from 1984 to 1989 — twice that of the increase of full-time workers over the same period.¹⁰ It should not be surprising that, to the extent professional medical work was increasingly regarded as ordinary commercial activity, higher physician 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 begot doctor dissatisfaction. Doctors complained bitterly about the losses of discretion. Elaborate, intrusive, and administratively expensive procedures proliferated, including utilization reviews, requirements for pre-admission certification, and other forms of second-guessing. In an often-quoted 1991 article in *The Atlantic*, Regina Herzlinger reported that despite increased incomes more than a third of physicians in their 50s said they would not have attended medical school had they known what their futures had in store.¹¹

The language of business management — and competitive markets — did not just affect doctors. Hospitals and hospital administrators recast themselves as businesses and began speaking the language of business in new terms. The hospital administrator increasingly became the chief executive officer (CEO). Assistant administrators were refashioned as vice-presidents for their respective functions. These changes were not merely semantic exercises. Rather, they represented a fateful shift 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 how Americans regarded 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 business figures. The point here is narrower. Over time, the managerial attack on the dominance of medical professionalism helped to deflate public confidence and to increase the probability of proposals threatening professional autonomy.

As hospital administrators gave way to CEOs, so too did their incomes increase. By 1990, hospital CEOs earned an average base salary of over \$103,000; those receiving incentive pay averaged \$125,000. The year 1990 was in the midst of a supposed “crisis” in health spending. And, by 2000, those figures had increased sharply.

There are, of course, advantages to treating hospitals more like a typical business firm. Improved capital budgeting, financial monitoring, and accounting systems are all vital in getting better value for health expenditures. Nor can one pretend that medical practitioners are all selfless workers concerned only for the welfare of their patients. Clearly, economic motives

are important, as they are for professors too. Indeed, many of the concerns of those who subscribe to pro-competitive strategies are identical to that of mine. Asymmetries of information and bargaining strength between doctors and patients do require attention.

But the rhetoric of the competitive market — and the rhetoric of managerialism — helped to disguise what sets medicine apart from other industries. 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” managerialism. 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 the very term managed competition is itself an example of an oxymoron. 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. Individual actors pursue their own interests without central direction. No single actor can determine the outcome. The occurrence of coordination is not by managerial design, but a consequence of individual adaptation to market conditions. The results are not planned and may not be desirable. We regulate competition, well or poorly. And we manage resources, well or poorly. What no one does is manage competition.

In arguing against governmental provision of medical care (or the financing of it), traditional business advocates predictably argue that governments are not competent as managers. The inevitable concessions of the political process, they claim, deplete resolve and hamper efficiency so that programs over time bear less and less resemblance to their initial design and purpose.

Ironically, from the 1970s to the present, advocates of competition have proposed a variety of detailed government programs, laws, and regulations designed to address and to eliminate the market failures that occur in unregulated medical markets. The dilemma hardly addressed in public discussion of competition in medical care arises precisely here. What happens to the logic of competitive proposals when government incompetence contaminates the efforts to reform medical markets?

The answer is that most competitive plans are not and were not robust precisely in 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 competitive market reform implicitly acknowledged that without these remedies, a competitive system does not work very well in medical care.

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 choice and well-functioning free markets on the one hand, and failed government programs on the other. But the dichotomy was, and is, artificial and misleading. The properties of the medical sector are such that substantial regulation is inevitable, as every serious writer on the subject has noted. Ironically, the most widely disseminated schemes of market competition in medicine have all entailed a myriad of regulatory restrictions on practitioners, patients, and program managers alike.

V. So, How Can We Move from Idealized Markets to Misleading Managerialism: The Case of Managed Care

Now I want to return to the connection between market enthusiasm and managerial fads, including language fads like persuasive definitions. Consider, for example, medical expressions like “managed care” or more general public management labels like “joined up” government or “integrated delivery systems.” All of these are slogans, persuasively defined terms that imply success by their very use. Also consider this feature. In every case of such 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

Slogans / Antonyms

- | | |
|------------------------------|----------------------------------|
| ■ Managed Care | ■ NON-Managed Care |
| ■ Integrated Delivery System | ■ DIS-Integrated Delivery System |
| ■ Joined Up Government | ■ DIS-Jointed Government |
| ■ Empowerment of Employees | ■ DIS-Empowerment of Employees |
| ■ Evidence-Based Medicine | ■ NON-Evidence-Based Medicine |
| ■ Customer Focused | ■ NON-Customer Focused |
| ■ Learning Organization | ■ NON-Learning Organization |

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thoughtful observers often end up endorsing claims instead of assessing their validity. I cannot think of a better illustration of this process than the widespread appeal to “managed care” in medical reform circles.¹² (And here I want to warn you... United States)

The expression “managed care” is actually a product of marketing sloganeering, and managerial jargon. Insofar as it is an incoherent notion, most claims about managed care suffer from incoherence as well. 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 (i) 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 reimbursement to be open-ended or insurers passive. Many, if not most, American health insurance plans that are labeled “managed care,” in fact, do not rely primarily on capitation. (ii) To others, the distinctive characteristic is the creation of administrative protocols for reviewing and sometimes denying care demanded by patients or preferred by medical professionals. But such microlevel managerial controls are not universal among so-called managed care health plans either. In fact micromanagement may be obviated by payment methods, like capitation or regulated fee-for-service reimbursement, that create more diffuse constraints on medical practice instead of their means. Finally, to some, what distinguishes managed care is the establishment of integrated networks of health professionals from

whom 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. In short, what constitutes the subject matter of managed care is utterly obscure. Even thoughtful critics of managed care face confusion. Donald Light's essay, "Managed Care: False and Real Solutions," in *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."¹³ 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 do not 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.

Conflating organization, technique, and incentives leads to serious confusion. When we contrast health plans we often compare them across incommensurable dimensions (assuming, for example, that an HMO is somehow more "managed" than a well-controlled fee-for-service plan). 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 when not true. And finally, it encourages a wild goose chase of efforts to come up with black-and-white standards for identifying plan types. As health organizations 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, 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.

Labels and categories are indispensable, but they clarify, not simply amplify hyperbole. “Managed care” fails that test. And I wish I could get it — and its cousins — banished.

From this extended American example of linguistic and conceptual muddle, let me turn to the use of managerial jargon in the UK context. But first, let me contrast the cross-Atlantic contexts. In the United States, the language of medical managerialism — and managerial practices more generally — has produced a backlash, a sense of outrage. The recent disputes about the patient’s bill of rights, for example, reveal this.¹⁴ 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 dismayed at managerial changes that are recurrently imposed in the name of slogans, but with the force of budgetary authority. In the United States, where no one is in charge of a national system of medical care financing, obscurantism more easily leads to disperse rage and a search for scapegoats in the face of distress whose sources are not simple to identify. In the NHS context, where somebody is indeed in charge of policy, perhaps excessively so, sullen resentment appears a more common response to managerial excess.

VI. 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. So, what might this outsider say prudently about the reactions not only to the newly announced policy of dispersing managerial authority,¹⁵ but also to 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 understanding the type of managerial rhetoric that is now dominant and in making sense of why reactions to managerial fads here 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 — and Rudolf Klein.¹⁶ 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

- (i) cost control, financial transparency, and decentralization of management authority,
- (ii) the creation of market and quasi-market mechanisms separating purchasing and providing functions and their linkage via contracts, and
- (iii) 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 1997, the white paper announcing the “New NHS” promised dramatic changes in the way Labour would manage things.¹⁸ “Integrated care” would replace the internal market of the Thatcher reforms, building on “what has worked, but discarding 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 slogan, integration (also, the promise that clinical audits would produce wondrous improvement in patient care. But that aim has hardly experienced embrace from those whose professional performance is the object of improvement). Performance targets, quantitative measures, monitoring, and evaluating became watchwords of NHS reforms.

But the reality appears to contain more variability than what these expressions suggest. As Christopher Hood has argued, the new public management is more a story of successive shifts in approach over the last 20 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 a “ceaseless activity to grapple with the unacknowledged consequences of yesterday’s mistakes.”¹⁹

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 the “much advertised” speech about devolution by the Secretary of State for Health Alan Milburn in 2001,²⁰ predicted that “the first reaction to Mr. Millburn’s speech is... likely to be cynicism.”²¹ In published reactions to the Milburn policy during the summer of 2001, both analytical rage and policy skepticism were wide spread. This seemed 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 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 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 a qualifying metaphor for Dixon’s effort to explain the “gripes” about what she describes as New Labor’s “tendency toward hierarchy and centralism.” Hierarchy and centralism 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.²²

What the outsider wonders about is whether there is any reason to think this 2001 plan was any more than another centralist move in decentralist clothing.²³ 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 a striking testimony to the distrust of the NHS and its policy making modes.

There have been 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 decentralization of power.”²⁴ 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.²⁵ 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 the British government support their cynical reaction.

While appreciating the grounds of these critiques, 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 United States to Canada, and from Holland to Germany, 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. Moreover, 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.

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 but also the rise of private firms advertising their capacity to separate good from bad hospitals, competent from incompetent physicians, and worthy from worthless drugs. A United Kingdom audience will think of NICE, a Canadian

audience will think of the Canadian Institute for Health Information, CIHI, and others will find their own acronyms. But the common element is the distrust of collegial authority and celebration of either 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.²⁶ But the extent of the political control has varied across time in the United Kingdom. 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.”²⁷ 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 without missionary zeal.

This is the most generous interpretation one could make of the logic of the Blair government’s newest policy. 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.

VII. A Return to Realism: Why Sensible Management Requires Modesty, Not Zeal²⁸

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 organizational 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 organizational objectives. An unfortunate consequence of the injection of managerial fads into medical care is the suggestion that there is some right way, some panacea, for rationalizing the delivery of decent, affordable medical care.

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

What is the Purpose of a Hospital?

1. A hospital is designed to contain the spread of contagious diseases.
2. A hospital is a place that provides hygienic surroundings for otherwise dangerous interventions.
3. A hospital is designed to economize on the cost of access to expensive technology.
4. A hospital provides respite from normal social roles that are producing physical or mental breakdown (strain) in patients.
5. Hospitals are intended to economize on the transmission of information and the process of learning among professionals who have clinical responsibilities and require multiple clinical encounters to validate their procedures.
6. Hospitals are designed to centralize medical activities sufficiently to achieve economies of scale in different healthcare tasks.
7. Hospitals provide symbolic reassurance that social effort is being devoted to the health of citizens in a culture with considerable faith in technological remedies.
8. Hospitals are institutions designed to improve the health of the population.

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same period, one might answer that hospitals serve various purposes such as:

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 healthcare tasks,
7. provide symbolic reassurance that social effort is being devoted to the health of citizens in cultures with considerable faith in technological remedies, and
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 spend the rest of their life in the ER.

A second observation about managerial technique is the truism that every upside has a downside. 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 professionals. 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 the “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. On the one hand, there are technological recommendations based on improved structures, processes, and technologies and, on the other, cultural ones 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 cost containment standpoint. 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 judgments. 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.

“High-minded theory yields to the basics of running a good company”

“Something funny happened on the way to the future of business. It turned out to be hard work. Technology is not magical. There is no single catch phrase, whether “re-engineering” or “business-to-business software,” that can automatically transform the nuts and bolts of how companies operate. And chief executives with “visions” cannot necessarily ride in on their white horses to save organizations single-handedly.

If the latest offerings from management gurus are any indication, the whole focus of business is shifting from theory to practice, and it has nothing to do with terrorism or recession. It appears that the euphoric days of “revolutionary” and “radical” change in business are giving way to the painstaking and detailed work of reshaping companies, department by department and division by division.”

(Source: *The New York Times*, Sunday, November 25, 2001)

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Endnotes

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¹To understand the “emergence, diffusion, and decline” of fads, see Carson, P. P., P. A. Lanier, K. D. Carson, and B. N. Guidry, “Clearing a Path through the Management Fashion Jungle: Some Preliminary Trailblazing,” *American Academy of Management Journal*, 43.6 (2000): 1143–1158.

The diffusion or rejection of technologically inefficient fads is discussed in Abrahamson, E., “Managerial Fads and Fashions: The Diffusion and Rejection of Innovations,” *Academy of Management Review*, 35.3 (1991): 596–612.

The stages in the life of a fad are discussed in Meyerson, R., and E. Katz, “Notes on a Natural History of Fads,” *American Journal of Sociology*, 62.6 (1957): 594–601.

The psychology behind fads is examined in Krugman, H. E. and E. L. Hartley, “The Learning of Tastes,” *Public Opinion Quarterly*, 24.4 (1960): 621–631. For a more specific case study of what counts as a fad and why people participate, see Aguirre, B. E., E. L. Quarantelli, and J. L. Mendoza, “The Collective Behavior of Fads: The Characteristics, Effects, and Career of Streaking,” *American Sociological Review*, 53.4 (1988): 569–584.

For an examination of how language helped create and sustain the dot-com boom, see Shister, N., “South Park: New-Economy Drivel Leaves a San Francisco Neighborhood High and Dry,” *Boston Review*, February/March 2002.

²Hunt, J. W. “An Appetite for Ideas: US Research Shows That the Life Cycle of Management Fashions are Getting Shorter,” *The Financial Times*, 16 May 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 product cycle of fads, with chief executives “exploiting and rejecting fashions within three or four years.”

³As Richard Freeman has pointed out in Letters to the Editor in the *British Journal of Health Care Management*, 8.2 (February 2002): 69–70, one of the intriguing aspects of fads is that they are not just rhetorically superficial, but also — by definition — short-lived. Still, the very process by which they are created helps ensure their danger later on. Fads arise, he postulates, through competition between management consultants and business schools, and then later, political competition (government officials looking to be viewed as “change makers”). Sadly enough, the very managerialism of medical care exacerbates this problem, since, as Freeman aptly puts it, managerialism serves as “an institutionalised cadre dedicated to the consumption and reproduction of the fad,” thus allowing fads to feed off of and perpetuate themselves. See also Carson, *supra* note 1.

⁴Two 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.

- ⁵Technically, 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.
- ⁶See Klein, R. and M. O’Higgins, “Defusing the Crisis of the Welfare State: A New Interpretation,” in Marmor, T. and J. Mashaw (eds.), *Social Security: Beyond the Rhetoric of Crisis* (Princeton, New Jersey: Princeton University Press, 1988) esp. pp. 219–224.
- ⁷The 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 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* (Basic Books, 1984) and coauthor of *The Bell Curve* (Free Press, 1994) — illustrates all three of these phenomena. The medium of transfer seems to have changed in the postwar 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.
- ⁸This is the argument developed in Marmor, T., J. Mashaw, and P. 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*, 7.4 (1993): 461–477.
- ⁹Insofar 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 survey data, Robert Blendon found that while most (64 percent of those polled) supported advertising by physicians, 58 percent did not expect it to be truthful. Blendon R., “The Public’s View of the Future of Medical Care,” *Journal of the American Medical Association*, 259 (1988): 3587–3593.
- ¹⁰Fuchs, V. R., “The Health Sector’s Share of the Gross National Product,” *Science*, 247 (1990): 534–537.
- ¹¹Herzlinger, R., “Healthy Competition,” *The Atlantic*, 268 (1991): 71.
- ¹²The following section draws on an article written with Hacker, J. S., “How Not to Think About Managed Care,” *Michigan University Journal of Law Reform*, 32.4 (Summer 1999): 661.
- ¹³*The Lancet*, 344 (29 October 1994).
- ¹⁴See news reports from around the US, for example, Hotakainen, R. and G. Gordon, “Patients Testimony Helped Bill in Senate,” *Minneapolis-St. Paul Star Tribune* (2 July 2001): A1; or Kurtz, H., “Some GOP Hopefuls Echo Democrats on Health Care,” *The Washington Post*, (29 July 2000): A7.

- ¹⁵Milburn, A., "Shifting the Balance of Power in the NHS," Speech delivered on 25 April 2001. <http://tap.ccta.gov.uk/doh/intpress.nsf/page/2001-0200>. For a critique of the Milburn Plan, see Klein, R., "Milburn's Version of a New NHS: Adopting the Missionary Position," *British Medical Journal*, 322 (5 May 2001): 1078–1079.
- ¹⁶See Power, M., *The Audit Society: Rituals of Verification* (Oxford: Oxford University Press, 1997); Barzelay, M., *The New Public Management* (Berkeley: University of California Press, 2001); Hood, C., *The Art of the State* (Oxford: Oxford University Press, 1998).
- ¹⁷Power, *Id.* at 43.
- ¹⁸*The New NHS: Modern. Dependable: Beyond the Internal Market*. Department of Health 1997. Published by the Stationary Office.
- ¹⁹Hood, *supra* note 16 at 201.
- ²⁰Milburn, *supra* note 15.
- ²¹Klein, *supra* note 15.
- ²²Bosanquet, N., J. Dixon, T. Harvey, D. Hunter, A. Pollock, B. Sang, A. Wall, and C. Webster, "Across the Great Divide: Discussing the Undiscussable," *British Journal of Health Care Management* 7.10 (2001): 395–400; Hunter, D. J. "Policy-Making in the NHS," "Across the Great Divide: Discussing the Undiscussable," *British Journal of Health Care Management*, 7.10 (2001): 397; Webster, C., "Brave New NHS," "Across the Great Divide: Discussing the Undiscussable," *British Journal of Health Care Management*, 7.10 (2001): 399–400. Sang, B., "Confronting Machiavelli's Dilemma: Are Managers Part of the Solution, or Part of the Problem," "Across the Great Divide: Discussing the Undiscussable," *British Journal of Health Care Management*, 7.10 (2001): 398–399; Dixon, J., "Why the Gripes," "Across the Great Divide: Discussing the Undiscussable," *British Journal of Health Care Management*, 7.10 (2001): 396.
- ²³Milburn, *supra* note 15.
- ²⁴Webster, *supra* note 22.
- ²⁵Hunter, *supra* note 22.
- ²⁶Hunter, *Id.*
- ²⁷Klein, *supra* note 15.
- ²⁸This section of the chapter has appeared in different forms in two other articles: Marmor, T. and J. Mashaw "Rhetoric and Reality," *Health Management Quarterly*, 15.4 (Oct.–Dec. 1993); Marmor, T. R., "Hope and Hyperbole: The Rhetoric and Reality of Managerial Reform in Health Care," *Journal of Health Service Research & Policy*, 3.1 (January 1998).