ORGANISATION AND MANAGEMENT

Archetype change in the organisation and management of health care?

This paper examines long-term trends in the organisation and management of health care, and assesses whether there is evidence for an 'archetype' shift taking place in organisations that will develop over the next 20 years. Ewan Ferlie cites factors such as the change from a professionally dominated to a more managed and externally regulated system, a move to more private-sector-style organisations, and the promotion of business-like values that stress efficiency and entrepreneurship within the health care organisations in support of the shift. He also looks at the possible consequences of change. For example, what are the control and accountability implications of the expansion of the Private Finance Initiative (PFI), what new roles will ministers, politicians and local agents play in changed organisations, and what effect will changing value systems have on organisational style?

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Edited by Charlotte Dargie

This paper is part of a series written for the Policy Futures for UK Health Project, which examines the future environment for UK health, with a time horizon of 2015. The full series is listed below.

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Charlotte Dargie

FOREWORD

Since its inception the Nuffield Trust has identified individuals and subjects that would impact on health and health care policy in the United Kingdom, with notable examples being *Screening in Medical Care* [1], Archie Cochrane's *Effectiveness and Efficiency: Random Reflections on Health Services* [2], Thomas McKeown's *The Role of Medicine: Dream, Mirage or Nemesis?* [3], David Weatherall's *The New Genetics and Clinical Practice* [4] and Alain Enthoven's *Reflections on the Management of the National Health Service* [5].

In keeping with tradition and reflecting the more complex issues in health and health care policy today, the Nuffield Trust established a Policy and Evaluation Advisory Group (PEAG), supported by the appointment of a Nuffield Trust Fellow at the Judge Institute of Management Studies at the University of Cambridge, to provide a research and intelligence capability for the Trust.

The Policy Futures for UK Health Project stems from the work of PEAG. It involves examining the future environment for UK health, with a time horizon of 2015. The first environmental scan has resulted in a series of 10 technical papers, which cover the following areas[1]:

1. The Global Context
2. The Physical Environment
3. Demography
4. Science and Technology
5. Economy and Finance
6. Social Trends
7. Organisation and Management
8. Workforce
9. Ethics
10. Public Expectations

Each paper in the series is a stand-alone piece, but has also been used by the project to derive an overview report, which focuses on policy assessment in the light of the environmental scan. Entitled 'Pathfinder Report', the overview report is published separately and will be subject to external consultation[2].

The Policy Futures for UK Health Project and the work of PEAG are ongoing. Further reports and publications will appear in subsequent years. The technical papers will also be revisited and different subjects will be tackled.

The strength of the technical series is in providing a context for analysing health and health care policy for the United Kingdom. Each author has produced an independent piece of work that analyses trends and issues in their subject area, focusing on 2015. The papers enable one to read across the issues, in order to provide a general analysis of health and health care policy, which is lacking in the highly specialised debates that dominate the health world today. They have formed the basis for consultation and discussion as part of the Policy Futures for UK Health Project.

Finally, the Trust is grateful to the members of the PEAG, to Professor Sandra Dawson and Pam Garside of the Judge Institute of Management Studies and to the authors of the 10 technical papers. A particular thanks due to Dr Charlotte Dargie, Nuffield Trust Fellow at the Judge Institute of Management Studies, the author of the Pathfinder report.

John Wyn Owen CB
July 1999

ENDNOTES

1. *Screening in Medical Care: Reviewing the Evidence* A collection of essays with a preface by Lord Cohen of Birkenhead (Oxford: Oxford University Press for the Nuffield Provincial Hospitals Trust, 1968).
2. AL Cochrane *Effectiveness and Efficiency: Random Reflections on Health Services* (London: Nuffield Provisional Hospitals Trust, 1971).
3. T McKeown *The Role of Medicine: Dream, Mirage or Nemesis?* (London: Nuffield Provisional Hospitals Trust, 1976).
4. D Weatherall *The New Genetics and Clinical Practice* (London: Nuffield Provisional Hospitals Trust, 1982).
5. AC Enthoven *Reflections on the Management of the National Health Service: An American Looks at Incentives to Efficiency in Health Services Management in the UK* (London: Nuffield Provincial Hospitals Trust, 1985).
6. S Williams, S Michie and S Pattani *Improving the Health of the NHS Workforce* (London: The Nuffield Trust, 1998).

Each of the papers in the series is available from the Nuffield Trust.

[2] C Dargie *Policy Futures for UK Health: Pathfinder* (London: The Nuffield Trust, 1999). The Pathfinder Report is for wide consultation and invited comment. You can email your comments to policyfutures@jims.cam.ac.uk. You can also send your comments to Dr Charlotte Dargie, Nuffield Fellow in Health Policy, The Judge Institute of Management Studies, Cambridge University, Cambridge, CB2 1AG. You can also find this Pathfinder Report along with other technical papers in the Policy Futures series at the Nuffield Trust website: http://www.nuffieldtrust.org.uk. Please respond with your comments by Friday 19 November 1999.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CEO	chief executive officer
CHI	Commission for Health Improvement
GDP	gross domestic product
GMC	General Medical Council
GPs	general practitioners
HIV	human immunodeficiency virus
HMO	health maintenance organisation
HQ	headquarters
HRM	human resource management
IPRs	intellectual property rights
IT	information technology
IVF	in vitro fertilisation
Mass.	Massachusetts
NHS	National Health Service
NICE	National Institute for Clinical Effectiveness
NPM	new public management
OECD	Organisation for Economic Co-operation and Development
PCG	primary care group
PFI	private finance initiative
PSOs	public services organisations
R&D	research and development
UK	United Kingdom
USA	United States of America

SUMMARY

This paper examines some long-term trends to the organisation and management of health care that may possibly unfold in the future (that is, over the next 20 or so years). It is based on a review of recent high-quality management literature, but includes an interpretive and indeed speculative component in trying to 'spot the future'.

Trends

This paper argues that health care organisations in the United Kingdom (UK) have, from 1948 to at least the early 1990s, been characterised by a stable organisational form or 'archetype' that can be defined in the following terms: the large scale, public sector based, professionalised bureaucracy. For fundamental change to occur, these basic parameters would have to shift. There is some early but as yet inconclusive evidence that such change is evident. There are five key parameters where significant change is possible (for more detail see table 1):

- There may be a move away from the traditional pattern of professional domination of decision-making to a more managed or externally regulated system.
- There may be a move away from a public sector base to more private-sector style organisations, given explicit public sector rationing and subsequent growth in private finance.
- A reduction is possible in the scope of health care politics and the high degree of political control so far evident over health care management.
- There may be a move away from large-scale bureaucratic forms (e.g. hospitals) to smaller-scale units of production (e.g. primary care settings).
- The erosion of a distinct public-service culture and set of values, which has stressed probity and due process, could shift towards more business-like values that stress efficiency and entrepreneurship.

Policy issues

We do not yet know whether these trends will materialise but, if so, they would have considerable policy implications:

- What would happen to health care strategy, control and accountability if the scale of private-sector finance such as the private finance initiative (PFI) begins to grow significantly?
- What are the likely outcomes and implications of current attempts to challenge the pattern of professional dominance (e.g. new systems of clinical governance)?
- Will ministers, politicians and their local agents (e.g. politically based non-executives) play less of a directive role in health care policy and management? Will traditional forms of political control be challenged by the rise of private corporations, of contracts enforceable in the courts and a technical-scientific apparatus (e.g. the National Institute of Clinical Effectiveness [NICE] and research and development [R&D])? Will the quality of the public policy discourse around health care management also be eroded as a result?

- Would any shift of services from large hospitals to smaller-scale primary-care settings trigger major changes of organisational style (e.g. more flexibility and innovative potential, but also perhaps a more costly production process)?
- Is there evidence of an erosion of the traditional public-service culture? What would be the likely impact of this on organisational style (e.g. more efficiency but lower trust levels)?

INTRODUCTION

This paper explores possible radical changes that may take place in the organisation and management of health care over the next 20 years or so. The intention is not to explore the short-term managerial agenda, where the likely themes (clinical governance systems and Primary Care Group formation) are well established. Nor does the paper examine the possible external sources of change (such as technology or demography) on health care organisations. The added value of this paper lies in the identification of broad organisational and managerial trends that may manifest themselves over a long time horizon. The discussion reviews recent high-quality academic management literature but also contains an element of interpretation and speculation, as would be expected in 'future spotting' writing. The task is a difficult one: to identify discontinuous breaks with the past rather than to extrapolate existing patterns into the future. For example, few of those writing in the late 1970s would have predicted the growth of management and internal markets that unfolded in the National Health Service (NHS) of the 1980s and 1990s.

There is an increasing debate in the management literature about the nature of so-called transformational change. Organisational transformation may be analysed at the level of a single organisation (i.e. a hospital) or across an organisational field (i.e. the health care sector). At the broadest level, there may be change to the underlying mode of production across the entire economy. Some have heralded a possible move from a 'Fordist' mode of organising (characterised by mass volume, invariant, routine, low cost production) to a 'post-Fordist' mode of organisation based on flexible specialisation, (lower volume, more differentiated, high value-added, faster changing product base) [1]. Moves to new 'network' forms of organisation have also been heralded, especially in the rapidly expanding knowledge-based industries (where the problems of managing the transition may have been underestimated) [2]. Large vertically integrated organisations are seen as downsizing, delayering and splitting up into more autonomous strategic business units. An extra premium is now placed on the development of organisational forms consistent with an enhanced rate of innovation, learning and change. The literature increasingly discusses radical or even transformational organisational change rather than incremental forms of change [3].

Public sector organisations (including the UK health care sector) may not remain isolated from such pressures, and recent managerial writing has emerged, assessing the extent to which 'organisational transformation' has taken place as part of the new public management (NPM) wave of the 1980s and 1990s [4][5] [6][7]. The NPM is seen as a process of deep restructuring away from the old public administration template to a more managerialised model, although there is debate about whether the new management models are crudely efficiency related or also include broader and 'softer' approaches such as organisational development techniques.

So has there been an organisational transformation in UK health care towards a more managerialised order? Ashburner *et al.* [7] assessed the degree of

organisational change already evident in health care as of the mid 1990s and concluded that a radical change strategy in health care had been successfully initiated, if not yet completed. More time was needed to assess whether changes to two key indicators (power bases and leadership groups; fundamental values and ideology) would consolidate. There were some signs of an ideological transition away from a full public service model, not to outright market models, but rather to the acceptance of a bounded and rationed public service. More bullishly, Kitchener [8] argued that there is already evidence that what he calls a quasi market transformation has already occurred within hospitals, including simultaneous and mutually reinforcing changes to structures, systems and underlying belief systems, achieved over a relatively short time scale. This paper represents an opportunity to build on these small-scale empirical studies and take a broader sweep across recent high-quality management literature.

CHARACTERISING THE OLD NHS ARCHETYPE

In order to understand the new, one has to define the old. Moreover, it is important to have a conceptual basis rooted in the analysis of organisations for such comparative classification. The underlying theoretical concept of an 'organisational archetype' has been explored by Greenwood and Lachman [9] in their analysis of how change processes occurred in a category of organisations that they defined as professional service organisations (organisations run by a cadre of senior professional workers). Their data were drawn from accountancy firms (traditionally dominated by their partners), but much of the logic also applies to highly professionalised health care organisations.

Such 'archetypes' are theoretically seen as consisting of three distinct components or dimensions, which have been adopted in this paper to orientate the discussion:

- the formal structure
- systems of decision-making
- underlying interpretive schemas, which include core values, beliefs and ideology.

These concepts have been used in the empirical analysis by Kitchener [8]and by Denis *et al.* [10]. For there to be a successful transition from one archetype to a succeeding archetype, simultaneous and reinforcing change is needed along all three of these dimensions. Such archetypical transition is rare and difficult, but it is periodically possible.

So can we use these concepts to define the dominant health care archetype that persisted throughout the 1948-90 period? After 1990, it came under a top-down challenge, although we do not know how strong its defensive capabilities remain. The following formulation is based on the author's understanding of the literature and should be seen as only one possible interpretation. The basic parameters presented are, however ,well grounded in a number of major works on health care management.

It is suggested that the old NHS archetype can best be defined as a *professionalised, public sector, large-scale bureaucracy,* characterised by the following five underlying dimensions:

- professional dominance
- a public sector base
- the 'hyper-politicisation of health care decision-making
- large-scale bureaucratic forms
- distinct public-service culture and values.

Professional dominance

The old archetype was highly professionalised - that is, power over decision-making was largely in the hands of professional groups. The vast range of health care professions negotiated amongst themselves for 'jurisdiction' over turf. They could be divided into elite professions (such as medicine) and mass professions (such as nursing). The basic theory of professional dominance has been recently outlined in Hinings et al[l 1], in reference to partners as power holders within accountancy firms, but much of the original work was drawn from medicine, notably by Freidson [12].

Professional dominance was assured by three structural factors:

- control over entry into and exit from the labour market
- claims to autonomy backed by legislation and enshrined in the judicial system
- possession of a body of esoteric and valued knowledge that commanded respect.

From this flowed institutionalised systems of self-regulation (e.g. Royal Colleges and the General Medical Council [GMC]) and protected contractual positions (e.g. self-employed status for general practitioners [GPs]). Self-regulation and the retention of autonomy were major objectives of the professions, secured in return for the promise of trustworthy behaviour.

By contrast, health care users were usually passive and subordinated in nature. Lay management ('administration') had a modest facilitative role, combined with occasional negative veto power when professionally generated demands for expenditure exceeded the political willingness to supply. The self-regulatory control system within these professionalised organisations tended to be informal and collegial in nature with a stress of sapiential authority (that is, professional eminence) rather than formal role power. Systems of external regulation were weak, with government and courts reluctant to intervene. This raises the question of how organisational change takes place in such professionalised organisations. Hinings et al's analysis of successful resistance to proposed change from partners in accountancy firms emphasised that groups of senior professionals remained key power holders who could block changes that they found threatening [11].

A public sector base

Since 1948, UK health care has been clearly located within a public sector base and system of financing, with about 85 percent of the UK health spend in 1997 coming from the public purse (compared to a Organisation for Economic Co-operation and Development [OECD] average of 75 percent and 45 percent in the United States of America [USA]) [13]. There has been a strong consensus that health care should in public choice terms be seen as a 'merit' good (where society would be concerned about low levels of consumption, particularly among disadvantaged or excluded groups) rather than a private good. As a merit good, health care was rightly located within the public sector and insulated from market forces. As a result, there were few private property rights, there was little small-scale private insurance, and only modest amounts of private finance flowed of into what remained throughout this period a taxation-based system. Along with this came direct governmental oversight of the health care system with a tight control over levels of resources (both revenue and capital) by the treasury and the use of NHS monopsony (that is, monopoly buyer) power in order to secure value for the taxpayer in purchasing decisions. The mode of ownership may then have exerted powerful effects on patterns of behaviour within the health care system.

The strong public sector base has had a number of specific effects. In terms of human resource management (HRM), a reliance on national collective bargaining and 'Whitley'-style arrangements was evident, with complex demarcations between different occupational groups. There were few individually negotiated job contracts and systems of performance appraisal were tacit and implicit. In the 1960s and 1970s, a wave of unionisation radicalised many of the low-paid blue-collar employees in the public services, notably in the Winter of Discontent (1978-9). Flows of public capital into the system were scarce, with the result that much of the NHS estate became badly neglected.

The 'hyper-politicisation' of health care decision-making

Decision-making in health care has been subject to a high degree of politicisation. Many would feel that it is right and proper that policy issues in such an important field as health care should be subjected to public scrutiny and debate, but a pattern of 'hyper politicisation' has also been evident.

The high political sensitivity - and therefore desire for effective political control - of health care management has been evident in a number of ways - for example, in the manner that proposals for local hospital closures generate intense political controversy. Indeed such proposals - if contested - go to ministerial desks for final decision. Health care is an issue about which voters feel strongly, reporting a continuing attachment to the NHS, and this creates fertile ground for opposition parties. Within this period, there were relatively few non-governmental actors (for example, few private funders) that lay largely outside the political system, with the exception of the professions.

This high political sensitivity reflected itself in strong reporting lines upwards to the Department of Health and ultimately to ministers. The politicisation went well beyond the discussion of local policies, although this type of debate

(which many would see as legitimate and indeed welcome) also intensified in 1990s with the drive to develop explicit rationing decisions at local level (a policy later abandoned on grounds of territorial inequity or dislike of 'postcode rationing'). Local disputes (such as the closure of local hospitals) or even the handling of individual cases (such as the case of Child B and the enquiries into murders committed by discharged psychiatric patients) could also quickly move into the political arena with a culture of adversarial debate. Party and chamber-based forms of politics - with a low level of technical expertise - was dominant and cross-party forms of scrutiny (e.g. by the Select Committee on Health) far less visible.

Intense media interest in the failures of health care led in turn to the development of news management techniques within the Department of Health, which became increasingly sophisticated and assertive, as a defence against the parliamentary question that could provoke intense political interest in questions of micro management. Senior civil servants defined their primary role as helping to protect their ministers within parliament and cabinet and as managing 'bad news', rather than offering managerial leadership.

Another chain of command operated at local level - and only in a semi-visible fashion - through the ranks of the governing political party, which could offer the power of patronage. Senior party political figures often assumed local leadership roles on the boards of health authorities and trusts, with some figures (such as regional chairs) operating as significant political figures in their own right. Under the Conservative government, appointments favoured local business representatives, whilst under the Labour Party, local councillors (usually Labour Party councillors) flourished. Alongside the formal managerial chain of command, therefore, lay a less visible (but also important) political chain of command.

The high degree of politicisation had other effects. Ministers made their political names by proclaiming high-impact policy 'initiatives' (such as Norman Fowler's initiative on human immunodeficiency virus [HIV] and acquired immune deficiency syndrome [AIDS] in the late 1980s for which he became well known globally as a progressive minister of health). The growth in the number of junior ministerial posts and a typical two- or three-year ministerial appointment cycle helped create a pattern of 'initiative upon initiative', which led to change overload. This intense politicisation also led to a culture of short-term political crises and panics that distracted from long-term strategic change efforts and clear priority setting. Large-scale reorganisations in 1990 and 1998 just as those undertaken previously, reflected ideology and electoral mandate rather than empirical evidence (despite the current rhetoric of 'evidence based policy').

Large-scale bureaucratic forms

Throughout this period, much health care was delivered through large, integrated organisations under a unitary chain of administrative command (although the professional and political elements created alternative power systems, as has been noted). Indeed, the NHS was famous for being one of the largest single organisations in the world, with about 850,000 whole-time

equivalent staff as of the early 1990s. While in some ways this unitary organisational status was a fiction, as the NHS was comprised of a number of autonomous subunits, at local level the old district health authorities planned across their patches with the various hospital management teams reporting up to district. In the 1960s and 1970s, the rise of the very large district general hospital further marked the triumph of large organisations. At regional level, corporate staffs and functions began to proliferate, with the growth of strategic planning or information technology (IT) systems.

The outcome was an intense bureaucatisation process within the administrative sphere of operations, with few devolved operational responsibilities and a proliferation of rules, regulations and due procedures (such as the Capricode process for planning new hospitals). The advantages of this bureaucratic model should not be forgotten and included impartiality, due process, probity and an arm's-length relationship from politicians. The NHS also enjoyed major buying power, economies of scale and specialist advice as a result of its scale. However, bureaucratic pathologies were also evident including a lack of problem ownership, little interest in securing value for money, few incentives to improve performance and a low level of administrative learning and innovation.

Distinct public service culture and values

In terms of its fundamental value base, the management of the old NHS was characterised by a distinct public service belief system and ideology, reinforced by the existence of a largely separate labour market. There was little crossover of personnel from the private sector, as graduates tended to join the NHS at the age of 21, spending a lifetime in the NHS and therefore developing little cross-sectoral experience. There was a strong public service orientation, with a belief that public service was a vocation and essentially different from the private sector. These were often 'high-commitment organisations' with a strong underlying set of motivating values. Hood [5] suggests that this was a 'progressive era' (early twentieth-century) model designed to protect the public interest through ensuring elaborate procedures that would protect against the abuse of political position and the employment of a cadre of 'ascetic zealots' to ensure probity.

Key values included the following:

- the belief that access to health care should reflect need (as assessed by a professional) rather than the ability to pay
- the belief that the NHS should offer a 'cradle to grave service' that was truly comprehensive in scope
- the belief that the NHS should offer a high-quality service radiating out from a nucleus of teaching hospitals
- trust in the generally altruistic orientation of clinical professionals.

This administrative ideology allied itself with dominant professional ideologies and together they comprised the founding ideology of the Bevanite NHS. Commitment and trust levels were generally high amongst senior

medical and administrative staff, but there was also a mass of badly paid manual staff that represented the other face of the public sector.

SHIFTS AWAY FROM THE NHS ARCHETYPE

In order to examine the extent of any shift away from this old NHS archetype, each of the five key parameters needs to be considered in turn.

Radical deprofessionalisation?

The deprofessionalisation of health care has long been held up as an alternative scenario for the future [14]. Will the professional dominance of health care evident since the mid-nineteenth century continue? Certainly a noteworthy feature of the late 1980s was the apparent rise of general management as an alternative power base within the NHS and the cutting back of some professional power (for example, the 1990 contract that was imposed on GPs).

In the late 1990s, however, this trend to strong general management has not continued and there has been some cutting back in both the number of general managers and in their roles (the so-called reduction in M2 costs) following central intervention. A subgroup of clinicians has been moving into part-time managerial roles (clinical directors, GP fund holders and primary care group [PCG] members) and acquiring an additional managerial knowledge base, so that managerialisation may still be occurring but through more subtle medico-managerial channels. The most plausible threat to clinical autonomy in the late 1990s may lie in the development of more assertive systems of external regulation as part of the clinical governance movement. But are the fundamental conditions of a deprofessionalisation process in place?

There is a more general theoretical debate about whether we are seeing a shift of power to cognitive elites (such as leading professionals) as part of the rise of the knowledge-based society (and this could reinforce professionally dominated systems of clan control) or whether professionals are being ground down by managerialisation and marketisation processes. Reed [15] argues that sharper market forces lead to a greater division between professional groups with a deskilling of lower-level professional groups (such as nurses). Higher level groups (such as doctors) may however form an alliance with other dominant elements, including the senior managerial cadre, in order to protect their position. This theoretical position would indeed predict the emergence of clinico-managerial hybrids as representing an alliance between two elites. Ackroyd [16] sees the prospect of less change than this and argues that professionals are able to maintain a high level of autonomy and occupational closure, even when they operate within large-scale organisations rather than on a individual 'fee for service' basis. In relation to the experiments of the early 1990s, Whittington *et al.* [17] found that some clinicians enjoyed the possibility of more autonomy brought in by the quasi market, rather than seeing it as a threat, and quickly adapted their roles.

The characteristic mode of control in professionalised organisations is 'clannish' and through peer review and self-regulation rather than through systems of external regulation. Such control is often relatively informal in

nature, with explicit procedures being invoked only in the last resort. Critics argue that such systems of self-regulation are ineffective and collusive and have called for the development of more explicit and transparent procedures of clinical governance. Calls for externally driven clinical governance procedures rest upon a distinct theory, namely that it is possible to codify such professional knowledge - and monitor its application - although others would see such knowledge as tacit, contested and provisional in nature.

The ability to secure new systems of external regulation may well be contingent on a reduction in the power base of the professions. Greenwood and Lachman [9] argue that there is still a contemporary tendency for professions to increase in their size and scope. Nevertheless, they argue that non-profit professionals may face challenges with the reduction in the scope of government and the corporatisation of health care functions, as they have in the USA.

In some areas, pressure from users or their representatives for more active involvement in health-service decision-making has increased. Sometimes this is associated with the presence of active lobbying groups: women's services, services for people with HIV/AIDS and mental health services would be good examples of such trends. This has led to a shared care model, where the patient is well informed about possible treatment options and plays a fuller role in deciding on the treatment plan. There are other sectors where the rise of user involvement has been far more modest. The exercise of user voice in a planned and bureaucratic system - rather than one led by market-based choice - remains problematic and may favour those with political or social skills that they can exert on providers.

Possible propositions include:

- Radical deprofessionalisation of health care remains unlikely in the UK context. There may well be more pressure from users, government and third-party payers but this is unlikely to be severe enough to fracture existing professional dominance.
- However, mass professions (such as nursing) may be more vulnerable than elite professions (such as medicine).
- Management may also be engaged in a major professionalisation project in its own right and there may be an alliance emerging between rising clinico-medical subgroups and a rather smaller general management core.
- Attempts to codify tacit clinical knowledge and adopt external systems of regulation will largely fail, at least in research-rich settings such as teaching hospitals and practices.

Downsizing the scope of the public sector?

A second parameter in archetypical change is a reduction in the role of the state. Over the last 20 years, the UK public sector has retreated in a number of functions, mostly economic ones, but also in a few social policy functions (for example, in the provision of social housing). As a percentage of UK gross domestic product (GDP), public spending (widely defined to include transfer payments) peaked in 1975-6 at about 49 percent and now appears to be stable

at the 40-percent level [18]. There is a political consensus that there is widespread voter resistance to substantial increases in the level of taxation but the NHS retains political support. Any shrinkage is likely to be covert rather than overt, and in the face of political denial.

Since the 1940s, UK health care has been largely financed through taxation rather than insurance and with a very modest private sector. It was not privatised in the 1980s and any contracting out has so far been limited to peripheral functions such as cleaning, although this may be extending to clinical support services such as pathology. Public sector health care provision has been slowly declining in a few fields such as dentistry and long-term nursing care. There is increasing talk within the NHS of rationing and of providing a bounded public sector service, rather than the old model of universal provision, and insurance companies are marketing new products (e.g. for long-term social care). NICE is likely to engage in more explicit rationing of new drugs, and may well seek to expand its role over time beyond this bridgehead. Demand for health care remains high and wealthy consumers may be concentrated in certain areas (e.g. London and the south east), leading to pronounced regional variation in the pattern of private sector growth.

There are some signs that the flows of private money into the health care system are now accelerating, even with the change of government. The Private Finance Initiative is taking off in the hospital sector with some very major schemes now planned, and the Primary Care Act experiments allow for a wider range of organisational forms - including limited companies - within primary care. There is an emergence of novel public/private organisational hybrids with major implications for the distribution of property rights, opaque accountability regimes and shifts of decision-making power. These are potentially major changes that have been under-explored. Such changes will reinforce the use of the contract as a key vehicle for co-ordination [19]. While contracts within the NHS internal market were 'inward facing' and subject to internal systems of regulation (with no right of access to the courts), contracts with external players will increase the role of outside judicial review.

One proposition is that the gradual shrinkage of the scope of the NHS will slowly continue, with a transfer of property rights and effective control into the private sector. Such processes are likely to be highly variable, both by condition (where the emergency core is most likely to resist such change) and by region where the growth of the private sector is likely to be fastest in London and the south east. It is unclear whether such processes will have only a marginal impact on the health care system as a whole, or whether there is a point at which they quickly develop a self-generating momentum.

Depoliticisation of health care?

A third key parameter would be any process of depoliticisation. This could in principle arise as a consequence of reduced public sector provision and with the rise of private sector finance, provision and control. In public choice terms, health care could then be perceived as less of a public or a merit good and more as a private good (where decisions are best left to the market), especially in elective services. Decisions (e.g. about the siting and closure of hospitals

and choice of levels of insurance cover) would begin to shift out of the public domain and become more of a matter for corporate or private decision, admittedly subject to regulation but with little direct public sector intervention.

Depoliticisation could also result from increasing levels of autonomy being accorded to operational tiers of management through the NPM [6]. While the centre retains strategic control through an agreed contract, operational decisions - such as the handling of individual cases - fall increasingly within a managerial arena and are less subject to political debate or review. Agencies in the style of Next Steps have been set up to handle the management of politically sensitive social policy functions (such as the Benefits Agency), but not yet in health care. The need for resolution of contractual disputes also opens the way to increased judicial interventions through recourse to the courts, which further limits the power of politicians.

The continued rise of scientific and highly technical knowledge also poses a challenge to traditional politically derived notions of accountability through debate, scrutiny and the giving of persuasive accounts. Day and Klein [19] argue that, not only has the welfare state grown in scale and complexity, but there is increased reliance on expertise and professionalism in service delivery. Within this web, individual citizens find increasing difficulty in holding expert decision makers to account. The growth of applied social science (the so-called evaluative state [6]) further adds to the extent of expert control over decisions previously undertaken on political grounds.

Smaller-scale, post-bureaucratic forms?

There is empirical evidence in the private sector of a shift to smaller-sized and post-bureaucratic organisations, with large corporations retreating into 'core competencies' in order to improve efficiency and ensure (at least rhetorically) shareholder value [21]. Divestitures, demergers and management buy-outs are common techniques for achieving such downsizing.

Within health care, it is possible that large hospitals may downsize into a high-tech core (especially with technological change), with some functions shifting into less complex primary and community care settings. For example, the very large psychiatric hospitals of the Victorian period are now virtually extinct and much mental health care is now provided from smaller-scale and less institutionalised settings. Some health care sectors (e.g. primary care) exhibit a pattern of hyper regulation (such as the red book) at present, and this may well come under pressure for increased flexibility.

What are the likely effects of decreasing organisational size? McKinley [22] takes a pessimistic view of decreasing organisational size as a response to decline, which he sees as leading to more formal procedures (formalisation). However, Sutton and D'Aunno [23] argue to the contrary and suggest that decreasing organisational size should lead to a reduction in rigidity and the extent of bureaucratisation. There might also be a reduction in the degree of formalisation (e.g. deregulation and the culling of procedures) and an increase in levels of integrative working (e.g. greater emphasis on horizontal processes across a health care facility).

Ideological change and erosion of a public service culture?

In the last 20 years, the scope of markets within society has increased substantially and with it market-based roles and forms of thought. Individuals are more likely to define themselves as customers and less as citizens, with a decline in levels of political participation (for example, as measured by membership levels of political parties) or ideological alignment.

Alongside changes to structure and control systems, shifts in organisational and managerial values, beliefs and ideologies are a key parameter in an organisational archetype (indeed, they represent the most profound expression of organisational identity and meaning). We suspect that collectivist ideologies have been in retreat at a societal level and careers within public sector organisations are seen as both less attractive and distinctive than 20 years ago. Time is increasingly seen as a priced commodity by successful professional workers, with a decline in altruistic behaviour. The old metaphor of the 'NHS family' becomes less convincing, and with it the possibility of clannish methods of control.

Some writers [24][25]see the rise of the NPM as opening the way to the colonising of the public sector by private sector models of management, although this is a controversial view. So-called entrepreneurial management styles [26] may imply a set of personal character traits and norms of conduct. Du Gay asks whether there are dangers in this entrepreneurial project and whether we are in danger of losing the old public administration values of due process and probity [26]. This may appear alarmist, as there is little evidence of any systematic increase in corruption, but it does raise the possibility that the new management styles could increase efficiency and innovation, but also lead to a decline in vocational or trustworthy behaviour. This would in turn fuel the need for even more developed audit and scrutiny mechanisms. It would also mean that the managerial and clinical labour markets would be increasingly determined by the operation of strong market forces (pay led) rather than being underpinned by strong public sector values.

The ideological base of the health care sector and its relation to the changing human resource base is then of great interest. Will recruitment and retention difficulties emerge and will the type of people coming into the sector change? Will pay levels have to float upwards in order to attract and retain good-quality staff? Will the underlying ideology and value base of the service change and what are the implications for the realignment of control systems? How are management selection, education and development interventions framed?

By way of concluding this section, five key parameters that make up the present NHS 'archetype' have been identified and possible changes discussed. Should there be substantial evidence of major shifts emerging along most or indeed all these five parameters, then the possibility of archetypical change within the health care sector increases. But if we know what we are shifting from; what may we be shifting to?

THREE POSSIBLE NEW ORGANISATIONAL FORMS

In this section, three new organisational forms already apparent in other sectors are outlined and their possible relevance to the health care sector discussed. Although three alternative forms are presented, the categories are not entirely mutually exclusive as there are some overlapping characteristics.

Post-Fordist organisations

The possible transition between a Fordist (routine, mass volume and efficiency led) and a post-Fordist mode of production (more varied, knowledge based and with a greater premium on rapid adaptive capacity) has been discussed by a number of writers. A classic early statement is contained in Piore and Sabel (27) who argue that, increasingly, firms will wish to produce high value-added costs where innovation rather than cost control is the key consumer issue. Firms will seek to develop rapid and flexible responses and to generate a strong customer focus. Heydebrand's definition of the new post-bureaucratic organisational form stresses that such organisations will be small scale or located as subunits within larger organisations [28]. They will be service or information based, possibly using automated forms of production with advanced IT capacity. The division of labour will be informal or flexible and the managerial structure decentralised, eclectic and participative.

Starkey *et al.* [1] summarise the pressure for greater 'flexibility' within firms, often associated with unbundling of large vertically integrated organisations. This can lead internally to the adoption of an 'adhocracy', with greater levels of intrapreneurship, of temporary teams and of special project-based working. Externally, there may be more externalisation and contracting out, with the shedding of unrelated activities and a reduction in unrelated diversification. Firms remain organised around a set of core competencies and a relevant set of specific assets.

Bahrami reports empirical data on a set of high-tech firms sited within Silicon Valley, which illustrate some key features of the new 'flexible' organisational form that can provide a faster pace of innovation, learning and change. They have typically delayered and downsized, and report much flatter hierarchies, smaller corporate staffs, and increased use of ad hoc teams. There has been a growth in subcontracting and alliances and also increased labour-market flexibility. There is a growth in workforce diversity, with multiple cultures within the firm. Finally, the expert worker continues to play a strategic role in providing the basic knowledge upon which the firm trades.

Bartlett and Ghoshal [30] also report comparative case study data from 18 major global businesses attempting radical change processes. These suggest the emergence of a new organisational form as a successor to the old multidivisional-based corporation. This new organisational form is based on an aggregation of strategic business units where control over resources undergoes decentralisation. There is drastic delayering and reduction of corporate staffs, reflecting a new emphasis on value creation. There is stronger horizontal (rather than vertical) thinking across the whole process of production. Management is seen as an active renewal process rather than an

enactment of fixed administrative routines with the identification of specific management roles at each tier.

Yet Hoggett [6] argues that the rapid transition within the public sector to 'post-bureaucratic forms' heralded in his earlier analysis [31] has not been fulfilled. While strong elements of self control have been developed within public service organisations, they are combined with new and old forms of external control with increased coercion, labour-market insecurity and proceduralism associated with the NPM. There is a 'flawed hybrid' emerging, which does not mark a smooth transition from bureaucratic to post-bureaucratic modes of control but contains strong elements of innovation with a reassertion of a number of fundamentally important bureaucratic mechanisms. The degree of centralisation and formalisation apparent within the NPM remains far higher than predicted by proponents of the post-Fordist thesis, and hyper-regulation remains in the public sector, even though neo-liberalism increasingly characterises private sector organisations. The State then retains sufficient levers of control to prevent public sector organisations from imitating developments in much of the private sector.

Network-based organisations

Hierarchies, markets and networks are often seen as three alternative modes of organising. Some organisations may be moving from hierarchical to network-based forms, especially in high-tech sectors where there is a need to develop a stronger outwards-facing orientation. Market-based forms of organising may be too atomistic and fail to provide the rich contacts and tacit knowledge that are needed in order to effect rapid adaptation to changing customer tastes. A basic theoretical consideration of the rise of network-based organisations is contained within Nohria and Eccles [32].

Ghoshal and Bartlett argue from theory and also a review of the literature that, within multi-national corporations, there has been a shift from an old and hierarchically based headquarters (HQ)/subsidiary model to new co-ordination and more network-like tasks of managing a grouping of established subsidiaries [33]. These organisations can increasingly be seen more as an interorganisational set rather than as a unitary organisation. Eroding levels of hierarchical authority here coexist with increasing levels of local autonomy and elaborate interorganisational linkages.

Within the American health care sector, Goes and Park argue that organisations are increasingly blending competitive with more co-operative strategies, using denser interorganisational links to strengthen the organisational capacity to learn and to innovate [34]. They observed growth in various types of interorganisational linkages (multi-hospital systems, management contracts, lobbying and trade groups and informal but regular resource exchanges) within the Californian acute-care hospital industry.

An innovation 'score' was compiled for each hospital using a bundle of 15 tracer innovations. They concluded that those hospitals that linked into multi-hospital systems, that regularly exchanged resources with related hospitals and

aggressively built institutional affiliations, were more likely to adopt innovative services and technologies.

Within NHS purchasing organisations, Ferlie and Pettigrew [35] explored the possibility that there was a move to a network-based form of organisation underway They concluded that network-based styles of management should be seen as of substantial and rising importance when assessed against both hierarchical and market-based forms of management. This represented, however, a shift of emphasis rather than a total displacement of one mode by another so that mixed modes of management may be emerging. It is as yet unclear whether centrally sponsored initiatives consistent with network-based approaches will be sustained or whether networking will be no more than a faddish phase.

With NHS provider organisations, Dent also presents an interesting case study of a 'soft' organisation that emerged in one post-1990 hospital [36]. Contrary to the usual interpretation of the NPM as a force for professional deskilling, here general management orchestrated the development of a flexible, informally networked and autonomous organisation. It in essence represented the legitimation of pre-existing professional networks. It should be remembered that the adoption of a network style is not a panacea and there can be causes of failure in network-based organisations, such as the retention of a mixed or confused logic of action [2].

The knowledge-based organisation

Knowledge production, rapid learning and effective innovation are emerging as key factors of production to a greater extent than traditional concerns with cost control or economies of scale. Within many service industries, groups of so-called knowledge workers (e.g. Microsoft) now produce the basic products upon which the firm competes for customers. A clear discussion of the transition to the knowledge-based organisation is contained in Stehr [36]. Given the emphasis on the central role of expertise (and hence experts) in contemporary societies, the key argument is that we are moving into a form of society significantly different from earlier industrial society. The mode of production is in transition to a knowledge society in which the major source of added value is expertise.

Lowendahl and Revang also detect a high-level shift to post-industrial forms of organisation that are based both on powerful and knowledgeable employees and on demanding customers [38]. These are flexible organisations offering a wider range of products than is historically evident, so that the ability to innovate and learn has become a core competence. In a knowledge-based economy, the processes of rationalisation and deskilling seen within Fordist modes of production are replaced by an increased emphasis on the creation of human capital and also the development of far more sophisticated information systems that enable the transfer of knowledge on a virtual basis. The trend is towards self-organising and empowered forms of knowledge work, where individuals take broad responsibility for their actions and contributions. Hedlund [39] not only describes the emergence of the new N-form corporation (which is based on a managed network rather than conventional divisional

structures) but also discusses implications for knowledge management processes. Kolodny *et al.* [40] argue that the rapid rise of computer-based technologies will in turn have strong implications for the redesign of social and organisational systems. In particular, there will be a shift from manual to professional work areas and the rapid increase in uncertainty and unpredictability contained within high-tech work processes may lead to a higher degree of local self-organisation in order to manage such complexity.

In an important theoretical piece, Teece [41] argues that in the new economics the pay off to intellectual capital has increased. There has also been a widening of scope of tradable forms of knowledge with the tightening of intellectual property rights (IPRs) and patenting regimes. Firms increasingly need cognitive entrepreneurs who can combine learning and management skills. Knowledge workers and their assets represent a major basis for competition and require high-powered incentive structures and a high degree of autonomy if they are to maximise responsiveness to changing market conditions. Teece argues that the competitive advantage of firms will increasingly stem not from their market position but from knowledge assets that are difficult to replicate (because leading-edge knowledge is tacit rather than codified).

The knowledge-worker stream of analysis clearly points in a very different direction from the deprofessionalisation and deskilling arguments often associated with the NPM. Indeed, it suggests that leading-edge professionals will if anything be more critical to the success of their employing organisations than previously, as they represent a key basis of competition. As such, they should be empowered to innovate and hence to add value to the goods and services produced by their organisations.

KEY ISSUES IN TRANSITION MANAGEMENT

Three possible new organisational forms have been outlined. However, the nature of any transitional period between archetypes has not so far been considered. But what might happen to populations of organisations within archetypal transition? It might well be thought to be a difficult and uncertain period, as old models decay but new ones are not yet clear.

Spotting trigger points

Incremental or non-cumulative change can easily be absorbed by a strong preexisting template. At some point, however, radical or sustained change in the environment - such as the stance of government - may eventually trigger off a brief period of radical change in the population of organisations. For example, Ginsberg and Buchholtz tracked the effects on populations of American health maintenance organisations (HMOs) of the federal government's decision in 1983 to withdraw the loan programs available to non-profit HMOs [42]. Given that only the largest non-profits had sufficient debt capacity to cover their capital requirements, this decision triggered off a period of growth of with-profit HMOs. Furthermore, some non-profits converted into profits, although the response times varied. Over a short period of time, substantial change was evident over the whole population of organisations. The demutualisation wave of British building societies in the

1990s would be another good example of a rapid period of changes to historic organisational forms that had persisted for many years (indeed centuries in some cases). Have these key trigger points for radical change yet been reached in the UK health care system?

Increasing diversity

The old NHS template has been presented as highly homogenous, evident across populations of organisations [8]. In fact, there was always some variety by setting, with mental health services characterised by strong multi-disciplinary teamwork and primary care settings approximating more to small businesses. It is possible that, in the early stages of archetype transition, organisational variety will increase, at least until a new dominant template emerges. Dent's case study of a 'soft organisation' emerging in one NHS Trust (contrary to the perceptions that the NPM would lead to the universal application of neo-Taylorist principles) provides at least some evidence that organisational diversity still permeates the NHS [36].

Anderson and Tushman [43] discuss the nature of a radical organisational transition in relation to historical data drawn from diverse organisational settings over different time periods. Their empirical analysis suggested that a large number of competing designs could be introduced in the period of ferment but that in most cases a dominant design reemerged (although in a minority of cases this did not happen). In the transition between dominant designs, there could be a wide variety of alternative variants, with an increase in experimentation and innovation.

Experimental new settings

One 'institutionalise view is that organisations are characterised by strong pressures towards inertia, and radical organisational change is both infrequent and risky, dependent on the investment of intense energy. However, data on change in one organisational population (loans and savings banks) presented by Haveman suggests radical change may indeed be functional in the face of major environmental shocks [44]. They argue that there is also a need to look at the founding of new, non-traditional forms as well in order to provide clues to how populations of organisations may be reshaped in due course. This implies the need for research that can track and study experimental new settings or extreme cases where the forces of change reveal themselves with a greater level of clarity.

Time periods of organisational transformation

If an organisation is undergoing transformation, over which time period might this process take place? Romanelli and Tushman attempted to investigate empirically the punctuated equilibrium theory of organisational change, which suggests that organisations are characterised by long periods of organisational stability punctuated by short bursts of organisational transformation [45]. Their data confirmed the punctuated equilibrium model and further suggested that the organisations studied overwhelmingly accomplished organisational transformations within two-year periods. Such organisational transformation was associated with the succession of a chief executive officer (CEO) and

major environmental changes. Kitchener also suggests a relatively short time period for archetypal change in health care [8].

Ashburner *et al.* argue that an organisational transformation has been successfully initiated, if not yet completed, as a result of the 1990 health care reforms within the NHS [7]. However, they suggest a much longer time period for such a reorientation within health care organisations, particularly at the most basic level of organisational culture. This could be because health care remains a highly institutionalised sector, regulated by both the State and the professions. Greenwood and Hinings argue that such institutional forces act as sources to regulate and pattern behaviour within organisations and to slow down processes of radical change [46].

The management of change in health care

Fundamental to the whole discussion is the need to generate greater conceptual and empirical understanding of change processes within complex health care organisations. The management of change has emerged as an area of intense policy concern within health care over the last 10 years, but often assumes a top-down or planned approach ('implementing desired change'). We here present an overview of key themes within the management of change literature as applied to health care.

The existing literature has been recently well summarised by Garside in a comprehensive overview of various established change models such as forcefield analysis, the diffusion model and the learning organisation [47]. The notion of differential 'receptivity' to change at local system level was developed by Pettigrew *et al.* [48] in their study of strategic service change processes within health care. Often the organisational development literature assumes that professional ownership of the change agenda is critical. A counter proposition is that sustained autocracy (provided that there is a consistent steer and a high degree of institutional centralisation over a long period of time) provides an alternative model of top-down transformation [49], at least at a strategic level.

There are a number of different approaches to this problem area. There has recently been a search for discrete 'levers' of change [50][51], with a growth of systematic reviews of particular change interventions. The Cochrane Review Group on Effective Practice and Organisation of Care has been set up. Multi-faceted interventions targeting different barriers to change are seen as more likely to be effective than single interventions. Interventions seemed to work well in some settings but not others, so that local context could exert a powerful mediating effect. It seems that the distinctive nature of professionalised organisations (as seen throughout health care) continues to make implementation processes even more complex than in other types of organisations. Implementation should be seen in negotiated and interactive terms rather than in linear or 'stage like' terms. There are many different professions within health care so that there may be interprofessional disputes for 'jurisdiction' as well as disputes between professionals and lay management. Recently, there has been a strengthening of the performance management function within the NHS, but many of the fundamental obstacles

to linear top-down implementation remain in place, such as the discretion over practice held by local professional groupings [51][53][54], which is difficult to challenge.

The question of changing professional practice is likely to remain of policy interest, with the stress on clinical governance systems and the arrival of NICE and the Commission for Health Improvement (CHI) in the near future.

POSSIBLE IMPLICATIONS FOR THE FUTURE

The view from the academic, organisational and managerial literature presented here has clearly brought to the surface perspectives and issues different from those evident in current health policy analysis. A potentially valuable role that a major charitable foundation could play is to help develop work in these longer-term and more speculative areas, which understandably might not be so fundable through governmental channels. Some important areas where more work might be usefully commissioned are discussed below.

Empirical and theoretical explorations of radical change

The literature review highlighted the possibility that radical or archetypical change may emerge within health care organisations. Such transformational change processes have already been apparent in other sectors and may occur in the health sector in due course. The review also provided a model for conceptualising these processes, suggesting that there are five key parameters along which archetypical change could be assessed.

This remains a controversial area in theory, given Hoggett's argument about possible contradictions between the deregulated private sector and the hyper-regulated public sector [6]. The possibility remains that we may not see a smooth transition to post-Fordist, network-based or knowledge-based forms, or that flawed hybrids may emerge. More theoretical work on modelling possible processes of archetypical change within health care organisations would be useful.

While we have pockets of data based on small-scale case studies, we lack substantial, cumulative or longitudinal empirical studies of the extent to which radical or hybrid change processes are already occurring within the health care sector. It is possible that the pace of such change may vary by locality (one proposition would be that London is likely to be an early mover) or by type of care (one proposition would be that the elective acute sector may be an early mover). There is a need to look at the emergence of new organisational and managerial settings. It would be helpful to track changes in populations of health care organisations over long periods of time, perhaps using historical techniques of archival analysis. A modest number of well-designed, large-scale studies may now provide more of a generalisable empirical base than a larger number of smaller-scale studies.

Changes to accountability and control systems

Another key issue relates to how accountability and control systems might be changing within health care. Many of the developments discussed could in principle be seen as likely to erode traditional politically based notions of

public accountability, as opaque forms of private/public hybrids emerge with a possible transfer of property rights and control into the private sector. Tracking the implications of the new generation of PFI hospitals represents an important area of work within this domain.

Some might welcome the retreat of highly politicised interventions at the level of individual cases, but also be concerned about the loss of public dialogue at the level of policy. Will effective democratic debate and scrutiny of health care policies erode? How do politicians with a special interest in health care construe their role in preserving public debate? Scrutiny-based bodies (such as the Select Committee on Health or the Public Accounts Committee), think tanks and non-executives at local level also represent in principle channels for the stimulation of public debate and it would be interesting to know more about how their roles are changing. One scenario would be the retreat of public or political forms of accountability as shareholder- or market-based models of accountability develop, should the private sector expand its role within health care.

Control mechanisms are likely to remain multiple and mixed. The old NHS template was always characterised by the coexistence of three different modes of control: professional clan control, administrative control within a vertically organised chain of command and political control through chairs and non-executives. Some new forms of control are already evident. Kirkpatrick and Martinez Lucio argue that there has already been an upsurge in contract relations within the public sector, reflecting a process of commodification and a shift to a low-trust milieu [19]. This appears to be 'sticking' as a form of co-ordination, although it now takes the form of service level agreements rather than contracts. More explicit external regulation of the professions is likely to grow as a new instrument of control, and it would be interesting to assess its long-term impact on changing patterns of clinical behaviour.

Changes in professional, managerial and regulatory roles

A third area of long-term interest centres on the tracking of changing patterns of professional, managerial and regulatory roles within the health care system. Will there indeed be a process of reduced professional autonomy and an upsurge in forms of externally imposed regulation of the professions? Will traditionally tacit forms of professional knowledge really be codified and performance managed? Or will the premium placed on leading-edge knowledge in fact increase the labour market position and autonomy of cognitive elites such as the learned professions?

Of course, the health care sector is characterised by a system of different professions, with varying degrees of autonomy. Will these different professions respond in different ways, with an increasing divergence between the experience of the mass and the elite professions? Will we see the growth of health care general management as a new profession, joining the traditional range of professions? There are in fact various new professions emerging within health care (including some non-clinical professions such as accountancy, IT and perhaps management consultancy). What will be the changes to management roles, and will we see a shift from general

management to a new generation of clinico-managerial hybrid roles? We now see the emergence of new forms of regulatory roles (such as NICE and CHI) about which we know little.

Some key scenarios

Three key areas where radical change may be regarded as at least possible - and perhaps even likely - over the next 20 years can be summarised as follows:

Creeping privatisation

The gradual growth of private finance (e.g. PFI, and the more explicit rationing of new drugs available on the NHS that may then lead to more private prescriptions as in the case of Viagra) may be limited in the first instance to particular budgets, conditions and localities but eventually a point of self-sustaining growth would be reached. This creeping process of privatisation has already been evident in the cases of dentistry, in vitro fertilisation (IVF) and long-term nursing care for the elderly. We should not forget the growth of private expenditure on a range of complementary medicines. Any growth of the private sector would have implications for the distribution of property rights and control. It is a likely consequence of a constrained and explicitly rationed public sector system that is unable to satisfy the increased expectations of a large middle-class population. One key scenario is for creeping privatisation of health care, with a constrained and rationed public sector core, around which a growing privately funded periphery emerges.

Deprofessionalisation

There are likely to be attempts to deprofessionalise health care. We currently see the rise of external and explicit systems of regulation (such as NICE and CHI) that may constrain the traditional extent of clinical autonomy. The new systems of clinical governance may add further to these pressures. Will the impact of any such strategy vary by profession so that nursing may experience a different outcome from medicine? Will primary legislation be needed to achieve these goals? Any changes to the consultant contract and to the distribution of merit awards would be good indicators to follow. From theory, it would be predicted that these strategies would largely fail, if the fundamental preconditions of professional dominance are not removed. One scenario would be a mass/elite split, with mass professions (such as nursing, perhaps also the lower ranks of medicine) increasingly subject to external regulation, while elite professionals (e.g. in teaching hospitals and clinicians with a flourishing private practice) retain high autonomy levels.

Depoliticisation

Some depoliticisation of health care is also likely. We may see the rise of a private sector outside direct political control, of assertive consumers having recourse to markets (exit) rather than politics (voice), the growth of contracts enforceable in the courts and the emergence of a highly scientific and technical discourse around health policy - as well as clinical science - which excludes lay personnel (e.g. the rise of NICE, the expanded R&D function). This scenario would imply a reduction in the historic role of ministers,

politicians and also local non-executive members. Many would welcome the reduction of political control over micro managerial issues, but the pendulum could swing too far. The quality of the public discourse around strategic issues in health care could erode, despite the important issues that require active dialogue and debate (what does society think about the rise of the private sector in health care? What are the ethical issues thrown up by moves to explicit rationing? What are the arenas in which such informed debate can take place?).

APPENDIX 1

METHODS

Search and inclusion criteria

The paper is based on a literature review of all relevant articles recently published in a set of leading rank organisational and management journals. These are tightly peer-reviewed journals and publication in these journals was taken as a key indicator of quality. These journals included: *The Administrative Science Quarterly; Academy of Management Journal; Academy of Management Review; Strategic Management Journal; Californian Management Review; Journal of Management Studies; Human Relations; Accounting, Organisation and Society; Work, Employment and Society; Public Administration; Organisational Studies; British Journal of Management.*

Inclusion criteria were specified as follows. A literature search was carried out manually on these management journals for the 1990-8 time period. All articles that examined large-scale changes to organisational and managerial patterns - whether in the private or public sector - were read and notes taken. These notes formed the source for later classification and interpretation. This definition excludes material published in other journals, in book or research monograph form or in the mass of 'grey literature' where quality indicators would have been more difficult to apply.

The nature of this managerial literature and the dominant research style are very different from those found in much other health services research. There are very few meta-analyses, randomised control trials or quasi-experimental evaluations in this corpus of work. Much of the literature is speculative in tone, based on theoretical analysis (some of considerable sophistication) or personal literature reviews. Distinct schools of theory that offer alternative and indeed competing interpretations are apparent (for example, the emergence of postmodernist approaches to organisational analysis over the last five years). Empirical work is often based on single or comparative case studies or is founded on descriptive statistics derived from large-scale surveys. Econometric techniques (such as multiple regression) are also evident and may be fruitfully used to analyse organisational data sets that have been coded up in numeric form.

Issues in comparative analysis

Much of the material accessed examines large-scale trends within private sector firms rather than public service organisations such as hospitals. Much of it is also based on work on American organisations, reflecting the centre of gravity of the managerial literature. This raises the question as to whether lessons can be easily read off from the American private sector and applied to British public sector organisations.

Harrow and Wilcocks analysis suggests that many public services organisations (PSOs) are at the 'far end' of many organisational dimensions (there are important social goals and high ambiguity in policy) and that very

important dissimilarities remain [55]. The view of the author is that this argument is somewhat overstated. While there are still differences, there are also some deep similarities apparent between the Fordist private corporation and its public sector analogue, the welfare state bureaucracy. Both are the products of the same society and culture and contain some common organising principles, when compared against the patterns found in Far Eastern organisations (more clannish in form) or Mediterranean organisations (often more family based). In addition, a key part of the NPM has been increasing inter-sectoral blurring between the public and private sectors, led by a one-way channel of personnel, models and management tools moving from the private sector to the public. As a result of this transfer process, public sector organisations have been becoming less distinctive or are moving 'down group' as a class of organisations, converging on a private sector template as the dominant model [56].

So it is potentially valuable to explore broadly based literature and to consider whether it illuminates similar trends increasingly apparent within a health care context. While parallels cannot be assumed, neither can they be dismissed at the level of principle. It would be curious if the NHS should remain entirely insulated from these broad trends that are evident in so many other organisations.

TABLES

Table 1 Summary of the five key dimensions

Five key dimensions	Possible direction of change	Early indicators
Professional dominance	Loss of professional control and autonomy	• Growth of performance management • move to external regulation • imposed protocols and guidelines • new contractual arrangements
Public sector base	Creeping privatisation	• Changing financial times • private finance incentive • retreat of NHS providers (long-term nursing)
High politicisation	Reduction in the scope of politics	• Creation of 'operational' agencies with delegated powers • growth of independent providers • rise of a technical apparatus
Large-scale bureaucratic forms	Shift to smaller-scale production	• 'Downsizing'of large hospitals • shift to primary and social care • move from mass to flexible production • less concern with activity targets
Distinct public service culture and values	Convergence into private sector culture and norms	• Influx of private sector personnel • changes in recruitment and employment practices

Source: Author's own compilations

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