Shifting the paradigm: Managerialism in the NHS

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Shifting the paradigm: Managerialism in the NHS

This paper explores the means through which managerialism was introduced into the NHS. The theoretical approach adopted is a synthesis of the social learning theory of Peter Hall, which attempts to view shifts in policy in a similar way to Kuhnian scientific paradigms, and critical discourse analysis, which examines how key words such as 'efficiency' have been re-defined within the service and helped to define management practices through their ideational properties.

Within this context, the present managerial paradigm of the NHS is seen as owing most to the Conservative reforms of the 1980s and 1990s through the introduction of what we have come to call the 'New Public Management'. The resulting conflict between medical and managerial professionals is analysed in terms of the structural constraints present within the ideological and organisational structures of the NHS, as well as the potential for actors to liberate themselves from these constraints. The underlying ideological and political assumptions of 'managers' and 'doctors' are examined to try and understand the nature of this conflict, and how the legitimacy of the previous 'administration' was questioned. New Labour's attempts to deal with the problems of the NHS are seen as being incremental in nature, offering little new, and serious questions are raised about the Blairite attempt to manage the health service.

A history of the introduction of managerialism shows how the roots of the present managerial paradigm can be traced back to the 1970s and beyond, and questions why the NHS remained relatively unscathed until the end of the 1980s, whereas other public services more quickly discovered the zeal with which the Conservatives were prepared to introduce radical reform. The paper also suggests that the need for radical reform of the NHS has been with us for considerably longer than traditional accounts of the service suggest, and questions what it is about the service which seems to cause organisational inertia, and the lack of political will to deal with long-standing problems. The move from 'administration' of the service to 'management' is examined for its significance, along with the change in language and philosophy in the service that this signified. The introduction of computerised information
**Introduction**

The paper examines claims that health policy has undergone a historically significant shift during the 1980s and 1990s, and attempts to contextualise the changes that have occurred within the social learning framework proposed by Peter Hall (1993) and Michael Oliver (1997). This allows us to explore the extent to which we might have seen the paradigm shift within health policy which some authors claim (Taylor-Gooby, 1993), and the role that the introduction that the new managerialism or New Public Management (NPM) has played within these changes. First we will look at social learning theory, and then how this inter-relates with the notion of ideology. We will then attempt to explore the ideologies present in the development of the NHS, and how the policy paradigm of 1948 represents those ideologies. The notion of policy consensus is then examined, and the reasons for the apparent continuity in health policy until the late 1970s questioned. Finally we will look at the significance of the changes in health policy in the 1980s and 1990s, and present a conclusion.

**Social learning theory**

Hall (1993) presents us with a model which can be used to assess the extent of change that a particular policy has undergone. First order change occurs where the settings of policy instruments in response to changes in the environment. Policymakers do not change the underlying assumptions behind policies, or the policies themselves, they are simply making everyday changes which they deem necessary to keep existing policies on course. Second order learning takes place where the existing tools of policy are questioned, and replaced. Again, the underlying goals behind policy do not change, we just find another way of fulfilling them. An example would be a government abandoning a fixed exchange rate system as a tool against inflation, and using interest rates instead. The policy goal of low inflation is kept, but
The third order of learning, or paradigmatic change, comes when we question our underlying policy ideas and goals. Not only do we need to find new policy instruments, and new settings for those instruments, we find a new framework within which to base policy. The move in the 1970s from a consensus Keynesian approach in British government toward a free market monetarist approach is the example used by Hall (1993) and Oliver (1997). The process of paradigm shift is sociological in nature, and essentially unpredictable in any detail because of the complexity of the policy arena. Hall discusses paradigms in relation to the dynamic of their change:

> paradigms are by definition never fully commensurable in scientific or technical terms. Because each paradigm contains its own account of how the world facing policymakers operates and each account is different, it is often impossible for the advocates of different paradigms to agree on a common body of data against which a technical judgement in favour of one paradigm over another might be made.

(Hall, 1993: 280)

Paradigms are not true or false knowledge, they are prisms through which the world is viewed, defining the membership of their advocates, and the social beliefs and means they will use to achieve those beliefs. Given this, paradigms must be based on an ideology, or combination of ideologies. We will therefore turn to a recent development in the theory of ideology in order to try and examine how we might be able to characterise the structure of a paradigm.

**Ideology**

Van Dijk (1998) puts forward a multidisciplinary approach which uses the notion of ideology to explain how the social representations of groups are determined, and how these competing
Ideologies then, are not intrinsically coherent, or right or wrong, they are the shared representations through which groups make sense of the world. Ideologies, according to van Dijk, may be used to sustain relations of domination, and will give members of groups an idea of what they regard to be true or false, and the ability to act upon this. This means that the definition retains the critical edge which Thompson (1990) favours whilst at the same time offering the possibility that the concept might not be used to secure means of domination, otherwise it would make little sense to describe socialism as an ideology.

Van Dijk provides us with a schema for the analysis of ideologies, dividing them into Members, Activities, Goals, Values, Position and Resources (van Dijk, 1998: 69-70). Members is about who is part of the group, as well as who is excluded, and who opposed. This is a useful distinction because, to refer to the literature on autopoiesis, ‘People develop cognitive structures because they undergo similar experiences in developing within a culture or society and because of the structural coupling which occurs between them within the consensual domain of language’ (Jessop 1990). Activities is what they do, providing reasons for shared identity (most visible in the professions, where membership and function may be clearly defined). Goals is about what the group wants (most clear in the case of pressure groups, which may exist for one goal only). Values is what the group believes, the "common sense" that members share. Position is where the groups stand in relation to other groups, which could be in terms of social position, or income, or expertise, for example. Resources are what the group has (or doesn't have), what it is able to mobilise in its support, or what it is excluded from, in the case of the homeless, for example.
macro level. This, of course, reflects an area of concern in itself, but is not one which this paper will explore further.

a Socialism – This ideology is centred around the idea that the NHS should be a centrally controlled body with a salaried health profession, this was the view of the Socialist Health Council during World War 2, and was certainly prevalent in the founding of the NHS. Socialism in health is about centralised state control and uniform standards of excellence in the service, rather than devolvement and muddling through. There is a strong link between the approach of the founder of the Health service, Bevan, and this view. What differentiates the Socialist view from the Fabian view is that the Fabians are happy to use the power of the state as a means to achieve improvement for its citizens as a stepping stone to a Socialist society, whereas Socialists would dispute the possibilities of achieving equality within a capitalistic state. This is significant in terms of the critique of the NHS which each approach develops, and the solutions each offers.

In terms of the Socialist discourse, we would expect to see mention of equality, and, in the 1940s version of the ideology, central control, nationalisation and central control. Moving from the capitalist means of production is regarded as being crucial for Socialism to be introduced, and thus the state must involve itself extensively in all areas of business and industry, as well as taking control of public utilities.

b The middle way - This ideology is a broad church, but at the same represents a distinctive view of welfare policy as a collaborative effort embracing Keynes and Beveridge, as well as Conservatives such as Macmillan and Butler. There is a faith in the free market system as the
differentiates the view from Fabianism for much of the post-war period, alongside the latter's concern with equality and fairness, which those of the middle way would regard as being secondary to, and contrary to, the workings of the marketplace. Hard work should reap rewards, and the state's role is in alleviating the worse externalities of the market rather than trying to instigate some sort of Socialism. Benefits should be means-tested, and welfare expenditure targeted to go to only the worse off in society.

c Laissez-faire - The radical alternative to the Fabianism of the NHS is where health is provided on an insurance based, individualistic way, with markets present as a spur to efficiency. The 'invisible hand' of the market is the best guarantee of individual freedom and the best regulator of social affairs, and the values of 'self-help' and 'family' are especially important. This view is significant by its absence in the founding of the NHS, but resurfaces as a challenging discourse in the 1980s.

The discourse of the laissez-faire approach is concerned with choice, freedom (from state intervention), the responsibilities of the individual and the primacy of the market. In the context of the 1980s we also see the primacy of the managerial discourse which is viewed as being crucial in order for markets to function, and the commodification of the patient as a consumer of healthcare, capable of making rational decisions concerning his or her wellbeing. Doctors, in this view, are professionals to be marshalled by managers in the provision of healthcare, but as such seem to merit no additional status. This means that healthcare is treated in the same way as any other commodity with a prominent professional body, and loses the mystique which is often granted it by the other ideologies.
Only fairly recently have Fabians recognised the converse side of this, the possibility that social services might also act as a means of social control.

Fabians believe in 'the machinery of progress guided by careful analysis of social problems and the construction of solutions through professional expertise' (Clarke, Cochrane and Smart, 1987). The pre-eminent role of the medical profession in the NHS is made clear by the important role of Fabians in the establishment of the NHS, with perhaps the converse being true in the 1990s. The discourse of Fabianism is concerned with fairness, equality, and the rational solving of problems. Benefits should be, for at least the most part, universal in order to de-stigmatise them, and there is a strong stand of paternalism in the societal resolution of social problems. Doctors, in this view of the world, are professionals who are to be granted considerable autonomy in exercising the state’s will to provide a comprehensive and free healthcare system. The implicit concordat between the state and the medical profession in the UK, whereby the state provides the finance for the NHS from general taxation, and the medical profession are then left, for the most part, to decide how the money should be spent. This has created a mutual interdependence between the politicians and the doctors which is now, we shall argue, under considerable tension.

**The 1948 policy paradigm in the National Health Service**

The NHS went through its formative process during the very time that the 'classic welfare state' (Lowe, 1993) or the Keynesian Welfare state was set up, with a view to slaying Beveridge's giant of disease (although sadly making little attempt at alleviating want or squalor). Beveridge’s plan of centrally planned welfare combined with the emergent economic
The initial NHS paradigm is shown below, along with its constituent parts and elements of ideologies.
<table>
<thead>
<tr>
<th>Ideology category</th>
<th>Description</th>
<th>Ideology</th>
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<tbody>
<tr>
<td><strong>Members</strong></td>
<td>Consultants as experts</td>
<td>Fabian</td>
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<tr>
<td></td>
<td>GP's as gatekeepers</td>
<td>Laissez-faire</td>
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<td></td>
<td>Administrators as planners</td>
<td>Socialist and Fabian</td>
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<td>Politicians centrally responsible</td>
<td>Socialist and Fabian</td>
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<td><strong>Goals</strong></td>
<td>Efficiency</td>
<td>Fabian</td>
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<td></td>
<td>Equity</td>
<td>Fabian and Socialist</td>
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<td></td>
<td>Comprehensiveness</td>
<td>Fabian and Socialist</td>
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<tr>
<td><strong>Activities</strong></td>
<td>Nationalised hospitals</td>
<td>Socialist</td>
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<td></td>
<td>Sickness-based. Curative</td>
<td>Fabian</td>
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<td></td>
<td>GPs as independent contractors</td>
<td>Laissez-faire</td>
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<tr>
<td><strong>Values</strong></td>
<td>Equality</td>
<td>Fabian and Socialist</td>
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<td></td>
<td>Planning and rationality</td>
<td>Fabian and Socialist</td>
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<td></td>
<td>Paternalism</td>
<td>Fabian and Socialist</td>
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<td></td>
<td>Collectivism</td>
<td>Fabian and Socialist</td>
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<tr>
<td><strong>Position</strong></td>
<td>Policymaking through consensus</td>
<td>Fabian</td>
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<td></td>
<td>Clinical freedom gives medical profession veto power</td>
<td>Fabian</td>
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<td></td>
<td>Administrator as facilitator</td>
<td>Fabian</td>
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<tr>
<td><strong>Resources</strong></td>
<td>Taxation funded</td>
<td>Fabian and Socialist</td>
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<tr>
<td></td>
<td>Poor quality information</td>
<td>Fabian and Socialist</td>
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What then follows, according to what Harrison et al (1990: 6-8) describe as being the 'shared version' of health policy, was a period of consensus in which the main elements of policy remained substantially in place until challenged as a result of welfare state ‘crisis’ in the 1970s, after which a new kind of health policy appeared under the Thatcher government of the 1980s. Under this view of policy we have seen, in the terms of this paper, the introduction of a new health policy paradigm. We therefore need to consider the significance of claims of crisis, and their relationship with the apparent continuity which preceded them.

The welfare state ‘crisis’

The notion of crisis ‘pervades’ much of the literature of the welfare state (e.g. Mishra, 1984; Sullivan, 1996; Wilding, 1986; Deakin, 1987). Pierson unpackages this idea to give three possible meanings to the term:

1. crisis as turning point

2. crisis as external shock

3. crisis as long-standing contradiction

(Pierson, 1991: 144, italics in original)

The first of these views is referred to as coming from the 'classical' origin of the word, where crisis represents a situation where participants must 'succumb to the logic of fate or summon up the moral will or energy to defy it' (Rader, 1979: 187). Secondly we have crises being imposed externally onto the system where 'the crisis event or the defenceless against it is not
economic recession and slow economic growth undermined popular support for the welfare consensus in a number of states. The Thatcher governments’ policies of tax cuts, privatization, ‘prudent’ finance, squeezing state expenditure and cutting loss-making activities has had echoes in other western states (Kavanagh, 1987: 9)

Pierson concludes that the most significant form of crisis is not mentioned within the notion as we have so far explored it, and that ‘intellectual’ crisis may be the most salient explanation of the position of welfare after 1975. This is because the ‘core elements, the commitment to economic growth, the enabling capacity of the state bureaucracy and the attempt to exercise indirect control over capacity are increasingly under challenge’ (Pierson, 1991: 178). There seems to rather less evidence than we might expect of a financial crisis in the NHS (Klein and O’Higgins, 1985; Chalkey, 1991; Johnson, 1986; but see Ham, 1992), and it seems that the inability of Keynesian thought to explain the economic phenomena of the 1970s may well be a more significant factor. This is part of the accumulation of anomalies which is so significant as part of an economic paradigm shift (Oliver, 1997) – ‘real’ events within the economy (which themselves are open to discursive reinterpretation, see Hay, 1996) prompt an ideological crisis (or at least crisis of ideas) in which the ‘common sense’ can be questioned. This leads to the conclusion that it is not the particular economic position of policymakers that we should consider when reflecting on the link between the economy and the NHS, but the economic paradigm that is in place (Klein, 1984), as this will also include assumptions about the role of welfare. The Conservative government of the 1980s, driven at least initially by their new economic doctrine, held a very different set of beliefs concerning the role of the welfare state in an economy, and the importance of introducing market-based incentives into the public sector. Hence the government’s diagnosis of the problems facing it in the 1980s were fairly
the lack of information about the everyday activities of the NHS made it difficult to assess its performance; the institutionalisation of the medical profession at every level of policy implementation granted the body considerable veto power from the level of the individual GP up to the representation granted to the doctors at regional, area and district health boards. All of these reasons contributed to the continuity in policy, but we would prefer to use the term ‘constraint’ rather than continuity; as early as the 1950s policymakers were proposing radical alternatives to cure the perceived problems of the NHS (Webster, 1988; 1994), but they remained largely unimplemented because of the dangers of being seen as a political party attacking the NHS, or the unsavouryness of the battle over policy that would occur from a prolonged battle with the medical profession. The lack of a coherent, politically viable solution (which we might define as a policy framework which would not be perceived as exposing the party to accusations of trying to disassemble the NHS from the media, medical profession and general public) means that, even though claims of healthcare crisis are a recurrent feature of the NHS in the 1980s and 1990s, we still remain ostensibly within the same healthcare model as 1948, even if we have found an alternative means of delivering the policy. We will return to this discussion below.

Attention became focused in 1983 when Roy Griffiths was asked to look at the service. The result was his famous 'letter' to the Prime Minister which hi-lighted the need for someone to take charge of the ailing service. Florence Nightingale had become lost in the bureaucratic maze. The service needed direction, energy and above all, general managers. Once again, the challenge to medical profession was being thrown down, and this time by a government with little time for pressure groups which did not share their philosophy, no matter how powerful.
al, 1991). Even if the reforms did not manage to instil a new culture into the NHS overnight, they did at least succeed in putting in place a managerial class, a new player in the policy arena. The public popularity of the service, despite the constant concern over crisis in the service, remained largely unchanged, but the challenge to the medical profession had begun in earnest, and the technology was coming into place to allow greater control over the service. This appeared through the introduction of managerial technologies such as performance indicators into the service, and the rise of the desktop PC and its ability to be networked to create the management information systems that the internal market would rely upon. The appearance of computers in the NHS, while at one level being inefficient and disappointing (Buxton and Packwood, 1992) also marks a significant cultural shift in the history of the service (Bloomfield, 1992).

The concept of money following the patient became the bedrock on which the new NHS was to be founded. Gone were the days when the expert planner could be relied upon to efficiently distribute the scarce resources available to the service. The NHS was created in a spirit of scientific rationalism, where science held out the possibility of a cure to all illness, and planning showed the way that these benefits could be expanded to reach the whole population. Services were free at the point of delivery because of faith in the expert to deliver treatment not according to ability to pay, but according to medical need. By the 1980s there was increasing resistance to the dominant medical discourse. The growth of consumerism (as well as feminism) raised questions about the nature of medical treatment. Planning was now a term of abuse, if the market could not provide it, it simply was not needed. From this logic, it made perfect sense that the NHS was now going to rely on the invisible hand.
collectivism and planning is regarded with scorn, demonstrating a serious challenge to the welfare consensus from the 'laissez-faire' ideology (Clarke, Cochrane and Smart, 1989)

A scan of Chapter 1 of ‘Working for Patients’ brings forward most of the key words which we would expect to find: we are told that patients should be given greater ‘choice’ of services available wherever they live. We also find mention of making it easier for patients to choose and change their GP if they wish, and there is concern that people have ‘little or no choice over the time or place at which treatment is given.’ Finally, the proposition that buying care outside the health service is seen as ‘taking pressure off the Service and add to the diversity of provision and choice.’ We do not have to look far for the other key words identified earlier as being part of the Thatcherite discourse: we find mentions of the importance of ‘quality of service and value for money’, ‘wide-ranging value for money studies’, and ‘The quest for value for money must be an essential element in its work’. Alongside this there are a number of euphemisms concerning ‘resource usage’ and ‘cost effectiveness’. We also see passages explaining exactly what is meant by ‘quality service’, so imbuing this term with a particular context; any hospital which fails to provide what is on the list will clearly not be providing an acceptable level of service in the reformed service. In terms of commodification in the text, examples are, once again, rife. Hospitals will have to make to that ‘the service they offer is what their patients want’, GPs will be encouraged to ‘compete for patients’, and provide a ‘better service for patients’, and ‘provide a service which considers patients as people’. There is also the eye-opening opportunity to provide ‘a wider range of optional extras and amenities for patients who want to pay for them’. We can see complimentary referrals to the obviously superior private sector; there is talk of district health authorities considering purchasing care
At the time of ‘Working for Patients’ we can the New Public Management making its presence felt right across the health policy paradigm. The internal market created a system in which competition could exist, and economy and efficiency would be improved as a result. We see the largest employer in Europe being split up into purchasers and providers of healthcare, some of which we to be granted increased entrepreneurial ability. Finally, the importance of information is finally being both realised, and acted upon through the widespread use of performance indicators (Pollitt, 1985), league tables, and as a result of the implementation of management budgeting and the resource management initiative (Bloomfield, 1992). The early 1990s model of the NHS, then, seems to represent the very embodiment of the New Public Management, a dynamic, responsive, flexible service, which is decentralised, customer oriented, and committed to change.
Table 2: NHS paradigm in 1990

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<th>Ideology category</th>
<th>Description</th>
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<tr>
<td>Members</td>
<td>Consultants as experts</td>
<td>Fabian</td>
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<tr>
<td></td>
<td>GP's as purchasers</td>
<td>Laissez faire and Middle Way</td>
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<td></td>
<td>Managers as directors</td>
<td>Middle Way and Laissez faire</td>
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<td></td>
<td>Politicians centrally responsible</td>
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<tr>
<td>Goals</td>
<td>Efficiency</td>
<td>Laissez-faire, Middle way and Fabian</td>
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<td></td>
<td>Equity</td>
<td>Fabian</td>
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<td></td>
<td>Comprehensiveness</td>
<td>Fabian</td>
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<td></td>
<td>Economy</td>
<td>Fabian</td>
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<tr>
<td></td>
<td></td>
<td>Laissez-faire and Middle way</td>
</tr>
<tr>
<td>Activities</td>
<td>Nationalised hospitals</td>
<td>Socialist</td>
</tr>
<tr>
<td></td>
<td>Sickness-based but challenge with public health initiatives</td>
<td>Fabian</td>
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<td></td>
<td>GPs as independent purchasers</td>
<td>Middle way</td>
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<td>Values</td>
<td>Equality</td>
<td>Fabian</td>
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<td></td>
<td>Markets and choice</td>
<td>Laissez-faire, Fabian and Middle way</td>
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<tr>
<td>Position</td>
<td>Policymaking through conflict</td>
<td>Laissez-faire</td>
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<td></td>
<td>Clinical freedom gives medical profession limited veto power</td>
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<td></td>
<td>Manager as director</td>
<td>Fabian</td>
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models of the constituents confront their utopian ideals with the harsh realities of post revolutionary existence. Formal rules may change overnight, but informal constraints do not. Inconsistency between the formal rules and the informal constraints (which may be the result of deep-seated cultural inheritance because they have traditionally resolved basic exchange problems) results in tensions which typically get resolved by some restructuring of the overall constraints - in both directions - to produce a new equilibrium that is far less revolutionary than the rhetoric

(North, undated: 8-9)

Even before the ink had dried on Working for Patients, it seems that the ideological purity with which the reforms had been pursued was being diluted. We can see this in the evolution of the language of the service – even by 1990 we had seen that

What were once ‘self governing hospitals’ in chapter three of *Working for patients* are now ‘NHS trusts’. GP ‘practice budgets’ are now ‘fundholding practices’, ‘indicative drug budgets’ are ‘indicative drug amounts’, ‘purchasing authorities’ are ‘commissioning authorities’ and ‘core services’ briefly became ‘designated services’ before disappearing altogether

(Sheldon, 1990)

The same article gives us the reason for this, it is that ‘commercial language switches every member of staff off’ (Sheldon, 1990). Perhaps the most important linguistic movement of all has not been mentioned, the move from ‘competition’ to ‘contestability’ which marks the NHS of the 1990s. This has occurred because of the inequalities which even managed competition can lead to, the disruption of competition (Light, 1997) and the high transaction costs of the internal market (Black, 1992; Klein, 1998), the fact that the centrally funded and centrally accountable NHS tends to lead towards central control, and the scarcity of resources blocking the market mechanism (Klein, 1998: 117). The change is from purchaser-provider split to
have an ideological shift in the means of achieving these goals, without the goals shifting themselves. From our social learning perspective, the internal market represents an example of second order change, and is a policy instrument, albeit a substantial one, to achieve the same policy goals. We should not, however, underestimate the significance of the 1989-1991 Reforms – they represent the biggest change made to the national healthcare system in the UK since its inception in 1948. But they are not as radical as the rhetoric of the time suggested. What they did do what to substantially affect the culture within the service. If we consider Handy’s typology, we are moving from a role based culture towards a form of power-based culture in which there appear to be two spiders in the web, doctors and managers. Through the increased status afforded to managers within the internal market, the raft of performance indicators, the use of league tables, the availability of comparative cost information, and the beginnings of a shift to preventative medicine, away from the curative model dominating the past (the National Illness Service) we are seeing an NHS which to many ‘feels’ significantly different from the service of the 1970s (Lee-Potter, 1997), especially within the medical profession. The extent to which many of the reforms have actually improved the quality of healthcare, however, is open to question (Le Grand and Robinson, 1994; Klein, 1998).
What of New Labour?

So, if the Conservatives, despite their rhetoric, didn’t manage to introduce a new policy paradigm into healthcare, or to substantially implement the New Public Management in the NHS, what is the position today?

There is considerable continuity between Conservative and Labour health policy, both at the level of actual policy, and also at the level of discourse (Crismon, 1998). The notion of the patient as consumer has remained (Wilding, 1997), and at least some of the language of the previous Conservative government appropriated. Examples of this are the constructs of ‘patient participation’, ‘choice’ (a key Thatcherite word), ‘rights’, ‘wasteful bureaucracy’, ‘efficiency and effectiveness’ (both of which may actually signify economy in practice), and ‘an end to top-down management’ (Crismon, 1998: 238) which have been used extensively by both Conservative and New Labour governments. At the same time as this, the extension of the Patients’ Charter by New Labour may well represent an attempt, once again, to exert more central control over the service, despite the rhetoric of locality. Instead of providing a radical alternative, an outright abolition of the internal market and an alternative solution, Labour are ‘building on a legacy of the Conservatives’ (Klein, 1998: 124) because of the final lack of ideological radicalness of the Conservative programme; ‘quietly in the night, competition in British health care has slipped away, its passing unremarked and little noticed by those who brought it into being’ (Ham, 1996: 70-71). So, if the internal market has been given a mortal blow, does this mean the end of the New Public Management? This paper would contend not.

The need for efficiency remains a continuing theme in NHS policy, and this has been taken a step further with the inclusion clinical performance indicators in the Patient’s Charter and
impetus of cultural change as a result. We can see this in the mirror images of responses to the 1989 and 1997 White Papers in healthcare, perhaps indicating that the medical profession now understands that it does not have the right to automatic veto on health policy (Klein, 1998: 124), and is now prepared to engage with attempts to manage the service meaningfully. In effect, the shock medicine of the 1989 White Paper, might have worked, at least in one sense. As for the last two items on our list of characteristics, the stress for economy remains as great as ever with the new model NHS being expected to cut £1 billion from its managerial costs as a result of the increased dilution of the internal market (which seems extremely optimistic as it is coupled with the need to set up the new primary care groups (PCGs)). This leaves us with the style of management, which seems to be again, a continuity with what has gone before, with measurement and central control of health policy as acute as ever.

**Conclusion**

We have challenged existing periodisations of the NHS by claiming that health policy from 1948 to the late 1970s was not a time of policy consensus, but of policy constraint because of a number of factors that made the implementation of an alternative policy paradigm all but impossible. The 1974 NHS Reforms, for all the concern expressed at the time about managerialism coming from the report presented by McKinsey’s to the Conservative government, did not mark the introduction of a new style of management into the NHS. After this the perception of economic crisis created the discursive space in which a welfare crisis appeared which was probably more at the level of ideology than of finance. We see the introduction of the new General Managers with the Griffiths Reforms of the 1980s, and their increased status and importance with the emergence of the internal market in the 1990s.
We have seen the dominant ideology of the NHS shift from one of Fabianism and Socialism, with a discourse of planning, nationalisation and central control, to a coupling of the Middle way, Fabianism in the form of market socialism, and laissez-faire thinking. The role of the market, at least in the form of contestability, remains central to health policy, and the role of Managers, as opposed to the administrators of the 1950s, is also key to understanding the dynamic of the modern NHS. At the same time as these changes we have seen a move away from a role-based culture toward an uneasy power-based culture in which the web is being pulled in two directions, toward both doctors and managers. The person-based culture of GP's had been impinged upon by new rules concerning prescribing, and the probability of routine checks of effectiveness. All of these elements are crucially inter-related, and, in order to understand the changes in healthcare policy, culture, discourse and ideology, we must examine each of the elements. The most remarkable thing of all is the lack of change in the overarching paradigm of healthcare in the UK - the NHS remains for the most part a system based on comprehensive healthcare delivered free at the point of delivery. Whereas the goals of health policy remain intact, we have moved considerably in the means by which we achieve those goals.
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