THE CRITICAL POTENTIAL OF INNOVATION STUDIES: THE CASE OF HEALTH POLICY

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Introduction

Contributors to this panel discussion were asked to reflect, in less than 3,000 words, ‘on how, specifically or generally, Innovation Studies (broadly defined) might have or already does have potential for yielding distinctive critical perspectives or data (broadly defined) on issues beyond Innovation (or Science & Technology Studies). The intention is to use the Panel to generate discussions which explore beyond the issues and positions outlined in the ‘Politics of Sociology of Scientific Knowledge’ (SSK) Special Issue of Social Studies of Science (May 1996, Vol. 26 No. 2)’. These ‘issues and positions’ explored whether the sociology of scientific knowledge could be, should or is inescapably political.

We work not in SSK but in health policy and management (HPM), so we are asking these questions not of the sociology of science but of HPM. The managerialisation of health since the early 1980s has resulted in a seeming struggle for dominance between the two male power blocs of medicine and management. Current developments in policy promise further increases in the managerial control over medicine. To explore whether IS can make a significant contribution to our understanding of these developments we will contrast mainstream/malestream analyses of these developments with our own analyses using feminist/gender, Foucauldian and post-structuralist perspectives. This short paper is therefore structured as follows. Firstly, we focus upon the recent work of one of health policy’s leading academics. We then explore policy developments from within IS, and show that where ‘main/malestream’ health policy analysis implicitly supports the managerialisation of health services, IS reveals the existence of four male power blocs: management, medicine as science, medicine as practice, and the academic discipline of political science. Returning to the task originally set for the panel we conclude that our arguments show that IS ‘already has potential for yielding distinctive critical perspectives or data (broadly defined) on issues beyond current analyses’ of health policy and management. So can or should the sociology of HPM be political, or is it inescapably so? In the nature of IS, we cannot agree on an answer to this question.

Health Policy from a Mainstream/Malestream Perspective

The academic sub-discipline of the politics of health has five founding fathers, four of them still leaders within a field that has been little influenced by IS. We should
emphasise, very strongly, that we are not seeking here to critique their work but merely to show the alternative readings of health policy made available by IS.

We will summarise, very briefly, developments in health policy since 1980 and will illustrate the important and influential analyses of these developments made recently by one of the field’s leading academics. Space does not allow us to do justice to the complexity of his arguments; all we can do is hint at them.

Current Developments in Health Policy – Towards a Control of Medicine

For 40 years, from the founding of the NHS in 1948, governments specifically upheld the principle of clinical autonomy, allowing doctors largely unfettered freedoms within the health service. Until the 1980s there was, ‘consensus’ management in which decisions were ostensibly taken by teams on which doctors were strongly represented and had the power of veto. Effectively then, rather than management, there was administration, whereby administrators were the butlers of the doctors, alongside the handmaiden nurses (Harrison, 1982).

Changes began in the 1980s with the introduction, by government diktat, of general management, followed in the 1990s with the internal market and the move to evidence based medicine (EBM), the last augmented most recently with New Labour’s clinical governance. There will be three new institutions of clinical governance: the National Institute for Clinical Excellence (NICE) the DoH’s programme of ‘National Service Frameworks’ (NSFs), and the Commission for Health Improvement (CHIMP) (DoH, 1998). The evidence-based appraisals to be carried out by or for NICE will include evidence of cost- as well as clinical-effectiveness. NSFs will specify pathways through which particular types of patients will be expected to pass, and compliance will be included in NHS performance management. CHI will review every Trust over a period of three/four years, and will explore local compliance with both the clinical guidelines issued by NICE and the NSFs. From 1999 all hospital doctors will be required to participate in national specialty-based audit programmes.

Mainstream/Malestream Analyses

The major academicians working in health policy, such as Harrison (1999a and 1999b) see in these developments nothing more nor less than an underlying agenda of cost containment. The medical profession’s power is seen to be such that it is a major impediment to financial savings, and the medical profession has been regarded as out of control. The tool to be used for achieving this control is management. The phenomenally difficult task of managing medicine is to be achieved not solely by the imposition of a managerial cadre, but through ‘incorporation’, i.e. ‘the inculcation in professionals of managerial values and cognitive structures’ (Harrison, 1999a, p.56), to be reflected in the development of a de facto managerial hierarchy within medicine. Support for this policy of the managerialisation of the NHS is more or less explicit amongst analysts in this sub-discipline. For example, Harrison defines ‘successful reform of the medical profession’ as meaning ‘a significant reduction in …… the “professional monopoly” of doctors’ (1999b, p.2, emphasis added). The success of these policies should thus be measured, Harrison (1999b) argues, by the rise to dominance of the ‘corporate rationalisers’ who will use managerial and scientific
models to run the NHS. He is somewhat pessimistic about the possibility of this happening.

**Analysing Health Policy Using Feminist/Gender, Foucauldian and Poststructuralist Theories**

**Feminist/Gender Studies**

Health services are provided and used predominantly by women but the sub-discipline of health policy is one where, predominantly, male theorists explore the male worlds of politicians, civil servants and the medical profession. Feminist/gender studies occupy a strange and distant land. Let us here flash our feminist/gender passports at the border, and go on a quick excursion into this male world. We will take with us just one argument from within feminist/gender studies to test whether it provides further explanation of developments in HPM, that of the binary divide between ‘male’ and ‘female’.

The binary divide between the public and private, between the male and female, forms the core of many analyses within feminist/gender studies. The public is seen as the male space, the place of the rational, the cultural, the scientific and the objective. The private space is that of the female which is the opposite of the foregoing signifiers, for it is the place of the emotions, of subjectivity and intuition, and of nature (Seidler, 1994). The public space is that of a striving, competitive masculinity, the private of nurturing, domestic femininity (Felski, 1995, p. 18). This distinction, between a maleness defined as rational and self-controlled and a femaleness that is emotional and close to nature, has its roots in the Enlightenment (Seidler, 1994). Within modernity this denigration of the female and the particular identity of masculinity with reason gives men a particular authority to make the world according to their image. The female is relegated to the private world of the home, leaving the public world of health work as the domain dominated by the male and thus with politics, reason, justice, philosophy, power and freedom (Pateman, 1983). As patriarchy privileges men even to perspectives of the organic body (Annandale and Clark, 1996) the domain of the man (the public) is privileged against the domain of the woman (the private).

This patriarchal perspective informs the analyses of health policies discussed above. Government policies, and their mainstream/malestream analysts, are governing and exploring a public world where males are expected to exhibit male-associated characteristics of toughness, competitiveness, aggressiveness and control, definitions of masculinity that are built into the way certain jobs and occupations are understood (Mills and Murgatroyd, 1991; Hearn, 1992; Hearn and Morgan, 1990). Women and the female professions are rarely to be seen in policy documents and are sighted even more rarely in the work of academicians, a world of male ‘rationality’.

However, a gendered study of HPM takes us beyond this somewhat simplistic perspective, for it takes us beyond the simple dichotomy between male and female. In HPM we have managers or ‘corporate rationalisers’ seeking to impose their own version of ‘rationality’ upon medical ‘rationality’. We thus have two ‘rationalities’ or ‘ways of knowing’, but these can be further disaggregated, for scientific and evidence-based medicine is resisted by physicians who reject the possibilities of a scientific
medicine (Berg, 1992), suggesting that ‘medicine’ is not a unitary field but has two domains – medicine as science and medicine as practice.

Within the former, medicine as science, EBM is based upon a ‘gold standard’ of randomised controlled trials, with all other forms of evidence being seen as inferior. It is not necessary to rehearse with this audience critiques of science from within the sociology of science, but merely to note that scientific knowledge has, of course, long been revealed by feminist analyses of science to be a gendered construct (e.g. Donna Haraway’s work on the great apes, Emily Martin’s on biology). Further, the feminist critique of science argues that science is based within and reinforces a dominant, positivist, and overwhelmingly male rationality (Sandra Harding, 1986). The increasing influence of EBM therefore emphasises a dominant male rationality.

Whereas medical scientists identify labels to be applied to disease states and search for cures for those diseases, in the domain of medicine as practice medical practitioners undertake diagnosis and prescription. Diagnosis is regarded as the art of medicine, i.e. a “fundamentally non-logical, qualitative activity which is emotionally concerned with the unique individual” (Dowie and Elstein, 1993, p. 5). Although the dominant discourse in medicine is now one in which medicine is seen as a science which is seriously flawed by its practitioners’ shortcomings (Berg, 1995), diagnosis has been seen as a scientific activity only since the late 1960s (Feinstein, 1967). What Malterud (1994) has termed the ‘clinical epistemology’ of medicine in practice, is based within a sociopsychological process that emphasise intuition and empathy, and which uses knowledge which cannot be put into words for it is gained through the senses (see Harding and Palfrey, 1997, for a full development of this argument).

Medicine in practice is therefore not the rational, logical application of science but an intuitive, empathetic and visceral process, i.e. one characterised by archetypal ‘female’ traits. The ‘art’ of medicine is thus practised largely by men who call upon and use a method of knowing that has been gendered as female and thus inferior. This suggests that rather than current developments being seen as a straightforward battle for dominance between medicine and management, what we have is a battle whereby two dominant forms of ‘male’ rationality (science and management) are seeking to dominate and perhaps eradicate a method of practice based upon a ‘female’ method of knowing. ¹

Further, and importantly, in supporting the managerialisation of the NHS, the mainstream/malestream academicians represent another form of male rationality, one which, along with contributions from malestream management/business studies, is contributing to and buttressing the policy of managerialisation of the NHS.

Deconstruction

Here we will demonstrate how seminal documents in HPM, in this case the Griffiths Report (1983) that led to the introduction of general management in the NHS, can be re-interpreted through deconstructive techniques.

¹ Dominance by ‘male’ management of the ‘female’ professions such as nursing was achieved not long after the introduction of management into the NHS.
Griffiths was the Managing Director of Sainsbury’s Supermarkets when in 1983 he was asked by the Thatcher Government to lead the NHS Management Inquiry. The inquiry team were asked, according to the introduction to the Report, “to give advice on the effective use and management of manpower and related resources in the National Health Service” (p.1). In response to this brief, the Report claimed to set out “an enormous programme of management action” (p.1) involving:

“the introduction of a clearly defined general management function throughout the NHS. By general management we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance” (DHSS, 1983, p.11).

The Report notes that some people within the NHS argued that such fundamental differences exist between industry and an NHS that is ‘not concerned with the profit motive’ that it ‘must be judged by wider social standards which cannot be measured’. Griffiths utterly rejected this perspective and in so doing eliminated the possibility of using within the NHS exemplary feminine methods of ‘caring, … interdependence, uncertainty and vulnerability’ (Davies, 1995, p.171). Griffiths, using what can be read as highly sexualised language, characterises these traits as ‘slowness’ (p.2/12); inability to ‘prove’ effectiveness (p.10) or to ‘achieve change’ (p.12); as ‘lack’ (p.11); ‘absence (p.12) or as necessitating ‘long delays’ (p.17).

From a psychoanalytical perspective (Roper, 1994) the NHS Management Inquiry team was staffed by idealised masculine “businessmen” (p.10). NHS administrators, in contrast, are portrayed as weak and emasculated, and as failures who have not risen to the management task of controlling doctors. This can be seen in the imagery used in the Report to portray the business environment, suggestive of an exemplary masculine world, redolent with phallic images and hints of successful male sexual performance. Management deals with measurement and proof, having therefore ‘a keen sense’ of what is good for the customer (p.10); is ‘clearly-defined’ (p.11) and ‘clearly performed … [by] … people in charge … [who through] driving force seeking and accepting direct and personal responsibility … [have] powerful … tool[s] … [to deal with the] demanding and continuous … [task of] sustained … change’ (p.12).

Thus, Griffiths might be seen as having legitimised a masculine approach to management. Rather than managers being the butlers of medicine as before they could now engage in a phallic challenge (what Hearn, 1992, has characterised as the ‘phallusy’ of management) with doctors.

This is one reading of the Griffiths Report. Foucault offers an additional or alternative reading of the current government’s health policies (EBM, NICE, CHIMP). Here we can only hint at the possibilities offered by his analyses for providing a further reading of governmental policies designed to achieve control of an out-of-control medical profession.

There is no space here to explore how this sentence contradicts some of Foucault’s arguments concerning the State. We are arguing elsewhere (Harding, forthcoming) that the individuals who comprise the government are themselves subject to the dominance of managerial discourse. See also Learmonth (1999, forthcoming).
A Foucauldian Analysis

Foucauldian scholars within Critical Management Studies, such as Burrell (1998), use Foucault’s argument that all of us belong to organisations and all organisations are alike and take the prison and the metaphor of the Panopticon as their model, so we are all imprisoned within a field of power, with all our thoughts and actions available to the professions for judgement. Society is seen as a homogeneous social body percolated through and through with mechanisms of power which emanate not from a central source but throughout the body politic. Both the professions and the large organisations of modern life allow even the most minute features of life to become subject to detailed analysis and control. Indeed, individuals’ sense of themselves as distinct subjectivities, their ontological security, is achieved through discursive practices where power features prominently. Individuals construct themselves within discourses of power that dictate how they shall see themselves. Power, from a Foucauldian perspective, constitutes the subjectivity of the agents of power relations. Power subjects and subjectifies (Clegg, 1998). Governmentality is thus built upon a ‘colonisation of the psyche’ where both ‘acts of obedience’ and ‘acts of truth’ seem normal and beyond contestation. What is sought is a population of docile bodies, committed to obedience, where people voluntarily and willingly delegate their moral autonomy and moral responsibility to obedience to the rules (Jackson and Carter, 1998). Obedience comes as a result of external observation and the internalisation of rules.

From this perspective, health policies are seeking to control those controllers who have evaded the power of the gaze, and managerial discourse is the process for achieving this control.

Conclusion

We can now, in a somewhat theoretically brusque drawing of the above strands of argument together, ignoring the subtleties of combining readings that are sometimes seen as incompatible, conclude that we have a markedly different reading from that which dominates within HPM. Where the managerialisation of the NHS is regarded within mainstream/malestream health policy analyses as a laudable attempt to control costs, we have demonstrated that current health policies can be read as attempts to further the Enlightenment project. Any discourses which can be understood as ‘female’ are being subjected to control by the ‘male’ logical discourses of management and science. Mainstream/malestream academicians are buttressing this elevation of managerial and scientific discourses and the subjugation of other, previous dominant discourses.

Returning to the task originally set for the panel we conclude that our arguments show that IS ‘already has potential for yielding distinctive critical perspectives’. But can or should the sociology of HPM be political, or is it inescapably so? We have shown that academia is inherently political. However, we, as joint authors, disagree about what this means. For one of us, in drawing attention to the possibility that HPM is open to a gendered reading we are (emphatically) not claiming that this representation is empirically ‘true’ or that others have been ‘false’, but rather we are suggesting that an
understanding of meaning that privileges an iterative approach to an essentially undecidable text opens new possibilities for understanding texts that conventional approaches tend to close. For the other, the possibility for bringing about meaningful change is enhanced through using IS to break through the veil of discrimination brought about by the power/knowledge positions that elevate some forms of knowledge (malestream, rational) and subjugate others. The possibility for real, meaningful change in health policies and practices can be made possible only by lifting this veil.

References


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