PUBLIC MANAGEMENT REFORM IN THE UK AND ITS CONSEQUENCES FOR PROFESSIONAL ORGANIZATION: A COMPARATIVE ANALYSIS

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It is often assumed in the literature on public management reforms that radical changes in values, work and organization have occurred or are under way. In this paper our aim is to raise questions about this account. Focusing on three services in the UK, each dominated by organized professions – health care, housing, and social services – significant variations in the effectiveness of reforms are noted. The available research also suggests that these outcomes have been inversely proportional to the efforts expended on introducing new management practices. The most radical changes have been in housing, where, paradoxically, successive UK governments focused least attention. By contrast, in health and social services, management restructuring has been less effective, despite the greater resources devoted to it. This variation is attributed to professional values and institutions, against which reforms were directed, and the extent to which different groups became locked either into strategies of resistance or accommodation.

For 25 years, public services in the UK have been subjected to unprecedented demand for change. After 1979, the Conservative government sought to intensify control of costs, but soon shifted its attention to service re-organization. Reform efforts quickly came to focus on the introduction of management, drawing for support on public choice theory and private sector management doctrines. This general emphasis has continued. Even after 1997, with the New Labour government’s pragmatic emphasis on modernization, the development of management has remained central to reform. As Dawson and Dargie (2002, p. 43) suggest, current policy ‘is developing within a discourse which is familiar as new public management, rather than a radical departure from it’.

In the literature there are now many overviews of this process, but few systematically compare the effects of restructuring. With some exceptions (see Boyne et al. 2003) accounts tend either to analyse public services as separate cases or emphasize general trends in them all. Hence, what is often lacking is a ‘comparative analysis across different domains’ (Ferlie et al. 2003, S3). Added to this are general assumptions made about the transformative
power of management reforms and a tendency to treat ‘the claims of NPM advocates as though they describe new realities …’ (Clarke et al. 2000, p. 7). While the contested nature of restructuring is often acknowledged (Exworthy and Halford 1999), few dispute the claim that the long-term trajectory is towards ‘more corporate and managerial modes of operation…’ (Powell et al. 1999, p. 2). Management values and priorities, it is argued, have or soon will colonize professional work, leading progressively to new incentives, perceptions of significance and mentalities (Broadbent and Laughlin 2002).

In this paper our aim is to raise questions about this account and present an alternative. The focus is on comparing management reforms in three areas of provision: (1) social services – particularly social services departments (SSDs); (2) NHS hospitals; and (3) housing organizations – both local authority and voluntary. We argue here that the advent of the first Thatcher administration in 1979 represented an important watershed. Since then the thrust of policy in all three services was to induce a movement from the traditional pattern of administered services (in which professional ideas about services were dominant) to managed provision and an emphasis on efficiency (in which professional priorities may be overridden). However, our analysis of the research suggests important relative differences in the timing, methods and outcomes of reform. It also reveals, somewhat surprisingly, that the results of this process have been inversely proportional to the efforts expended. By far the greatest resources were poured into the restructuring of the health services where, as we shall see, change has been most problematic. By contrast, in housing, a sector to which governments devoted far less attention, new management practices and mentalities have become more firmly embedded. These variable outcomes are attributed in large part to the professional values and institutions against which reforms were directed and the extent to which different groups locked themselves into strategies either of resistance or accommodation.

The three services considered here vary systematically in scale and organization (informal and formal) of their professional cadres. Of the public services we examined, the UK Health Service is the most strongly professionalized. In 2002, approximately 603,077 professionally qualified staff worked in the NHS (DoH 2003), with clinical staff – doctors and nurses – in the majority. Personal social services, on the other hand, such as occupational therapy and so on, also exhibit high numbers, but a lower density of professional staff (Eborall 2003). In England, local authorities employ a total of 52,650 qualified social workers and 2244 occupational therapists (approximately 15 per cent of their workforce). Our third example, housing, is the least professionalized. In the late 1990s, there were approximately 15,000 members of the Chartered Institute of Housing (CIH), approximately 10 per cent of all local authority and voluntary sector housing staff (Walker 1998). In addition, these three services exhibit distinct patterns of formal organization. Heath care professionals, especially those in hospitals, work within single purpose organizations with strong informal networks. Social care and
housing, by contrast, have traditionally been located in more bureaucratic and ‘managed’ settings, with professionals less able (and in the case of housing less willing) to assert their autonomy.

Our analysis of the impact of reform on the organization of these three services is presented in four parts. First, we consider the origins of management restructuring and the nature of change that was planned. Next we explore the nature of the professional service organizations that emerged in the UK, drawing on organization theory and the literature on the sociology of professions. In the third and main section of the paper we compare restructuring and its impact on our chosen services. Finally, we look at how the observed variations in the effectiveness of management reform can be explained.

TOWARDS MANAGED SERVICES

In the ideas that have motivated reform and the policies that have been followed, there are elements of both ideology and pragmatism. Academics in particular have raised questions about the status of new public management (NPM) and whether it represents a coherent approach towards reorganization of services (see debates in McLaughlin et al. 2002). However, as Pollitt et al. (1998, p. 34) suggest, while ‘the history of public management reforms…contains its fare share of twists, turns and ex-post rationalization’, there has been ‘a certain consistency and continuity in the objectives’.

Such conclusions remain valid. From the late 1970s, with deepening fiscal crisis worldwide, the first objective was to restrain costs. This led to demands to invest in systems of financial control and performance management. From this it was only a short step to the identification of the professions and their organizations as potential obstacles to change. Even by the late 1970s, political support for these institutions had begun to wane. The thinking of the New Right depicted the professions as self-interested, self-serving, inefficient and ineffective (Foster and Wilding 2000). In addition, public confidence was undermined by a series of high profile tragedies and scandals in education, housing, health and social services. A key aim of reform has therefore been to reduce (if not eliminate) the autonomy and independence of the professions. This meant closing off ‘…indeterminate and open-ended features of professional practice, in order to conform with broader corporate goals and resource constraints’ (Flynn 1999, p. 35).

As we have suggested, management reform represented the key strategic weapon used to drive through this desired change. Since the early 1980s, a consistent emphasis has been placed on replacing professional administration with ‘an active managerial function’ specializing in ‘the organisation and co-ordination of services and the consideration of efficiency in service delivery’ (Ackroyd, 1992, p. 342). Public services were to become ‘managed services’, efficient and performance oriented. The focus would no longer be on maintaining customary modes of provision as defined by practitioners,
but on responding to changing conditions (as defined by managers) in a strategic fashion (Clarke and Newman 1997). The objective has therefore been to achieve radical or transformational change. The question is, however, whether this reforming project has fully displaced not only key aspects of professional organization but also their associated values.

THE ORGANIZATION AND ADMINISTRATION OF WELFARE PROFESSIONS

To assess the likely success of management restructuring, it is helpful to consider the origins and character of the institutions against which it was directed. For this, a useful starting point is Johnson’s (1972) typology of professions based on their different types of clientele. So-called ‘corporate patronage’ professions (for example, accountancy) are groups dealing with clients (such as large firms) who articulate their own needs. By contrast, public service professions are in relationships with clients that are mediated by the state. Johnson (1972, p. 77) suggests this means that ‘the state intervenes in the relationship between practitioner and client to define needs and/or the manner in which such needs are catered for’. In developing these ideas others have focused on the concept of a ‘regulative bargain’ negotiated between different occupational groups and the state (MacDonald 1995). Here, organized professions are seen as exchanging a degree of autonomy in public service delivery in return for resources and policies that favour their growth. As well as the freedom to organize services, these occupations may also be granted ‘structurally determined privileges’ (Cousins 1987, p. 106) such as employment security and the right to regulate their own education (Flynn 1999). Considered in these terms, the adoption of the NPM involves this state sponsorship being, if not revoked, then at least fundamentally revised.

But while this suggestion is theoretically correct, it fails to take into account how deeply and thoroughly welfare state institutions have been colonized by professionals. In the UK, even relatively weak occupational groups were able to ‘influence the kind, pace and structure of provision’ (Perkin 1989, p. 344), adapting institutions to their orientations and practices. This was supported until the late 1970s by a degree of consensus about the inevitability and desirability of professional self-regulation (Clarke and Newman 1997). At local levels this process of professional and state formation led to and reinforced distinctive forms of organisation. Weakly developed administrative structures were combined with those of professional services providers, the latter constituting the ‘operating core’ (Mintzberg 1993) of the organization with autonomy from the direct line of administrative control. Within broad financial and legal constraints, professional groups were in fact able to exercise considerable control over the means and (sometimes) ends of service delivery.

This control by producers gave rise to a particular form of ‘custodial’ management at lower levels, focused on the ‘necessity of maintaining minimum
standards of provision...almost invariably wedded to the conceptions of practice held by service providers themselves' (Ackroyd et al. 1989, p. 613). Arguably, hands-off management of this kind was (and is) hard to avoid. The complexity of many public services made it necessary for front line practitioners to exercise some discretion (Lipsky 1980). Attempts to direct work were also countered by powerful discourses of service that emphasized the need for professional independence and judgement (Pratchett and Wingfield 1996). Finally, the fact that many managers themselves were drawn from the ranks of the professions made it likely that they would seek to preserve rather than fundamentally challenge practitioner control.

This form of custodial administration was most developed in NHS hospitals. Here, a system describe by Klein (1989) as a ‘producers’ cooperative’ emerged, with key decisions about resource allocation determined largely by professional judgements. By contrast, in social services and housing, we find a defined management hierarchy with professional autonomy more constrained by extensive rules and guidelines, often linked to legislation (Harris 1998; Franklin 2000). Hence, it is important to note variations not just in the ability of different groups to achieve professional closure, but also to extend their control over the domain of service delivery itself (Ackroyd 1996).

EVALUATING CHANGE

Overview of reform of the three sectors examined

We now turn to the question of how broad policy goals of reforming management were translated in housing, health and social care. The evidence on these changes is fragmentary and no longitudinal sources exist. Our approach therefore is to draw on the abundant range of secondary data sources from the academic and practitioner communities. Inevitably this means relying on ad hoc studies with varying baselines and research questions. However, while it is hard formally to test the impact of management reforms using these data, one can construct a rich picture of the kinds of changes that have occurred and their consequences.

The first point to note is differences in the timing and process of reform programmes. From the late 1970s, all three services experienced deepening financial pressure. This was especially true of housing with the introduction of ‘Right to Buy’ policies and cuts in local authority spending on new construction (Cole and Furbey 1994). However, in terms of management restructuring, health – the largest and most costly service – was targeted first. Within months of taking office, the first Thatcher administration repudiated the centrally planned and administered NHS in favour of managed localism (Klein 1995). After 1983 (and the recommendations of Griffiths (1983), this sector faced continued demands to implement general management within hospitals. These were later intensified with the introduction of the internal market in the 1990s and later proposals to develop a regime of clinical governance. By contrast, in social services and housing, sustained effort to
develop management practices began later. In the former, while there had
been guidance offered to SSDs (most notably from the Audit Commission)
it was not until the NHS and Community Care Act (1990) that pressure to
implement new management systems (such as purchaser-provider splits)
intensified (Harris 1998). Radical change in housing also began at this time
with legislation in 1988 and 1989 promoting housing associations as the
main providers of social housing and local authority stock transfers into this
sector.

Turning to the process of change and methods of implementation, there
are similarities and differences between our three sectors. In all three, change
has been coercive in nature. Use was made of both legislation and executive
powers to push through new policy agendas. Regulatory agencies such as the
Audit Commission, Social Services Inspectorate and Housing Corporation
also played a directive role (Henkel 1991). The Audit Commission in par-
ticular slowly established itself as an independent expert, actively ‘champi-
oning’ new forms of management in local government (Kelly 2003). At local
levels, public agencies faced mounting pressure to follow this advice in
a context of national performance targets and league tables (Cutler and
Waine 2000).

In contrast to earlier waves of administrative reform (for example, in the
1970s), professional associations were not involved in the design of policy
and in many instances were in fact hardly consulted at all (Laffin and
Entwistle 2000). Only in housing is there some evidence of the professions
actively shaping the reform process. In the late 1980s, the CIH played a
pivotal role in developing proposals for large-scale voluntary transfer of
housing stock from local authorities to the voluntary sector (Malpass 2000).
However, even in this case one might question how far professional involve-
ment was driven by a genuine enthusiasm for the new management. As
Pollitt et al. (1998) suggest, moves to promote restructuring by the profession
were also an attempt to pre-empt central government intervention and the
full privatization of services.

While the above indicate some broad similarities in the nature of reforms,
there were also marked differences between the three sectors in how change
was implemented. It is useful here to make comparisons along two key
dimensions. First is the extent to which major re-organizations occurred,
leading to the development of single purpose authorities and separate man-
gement boards with executive powers to control services. The intention
was to establish self-regulating, provider organizations, sometimes with
legal identity, to which responsibility for resources might be delegated. The
second dimension relates to change agents at the local level. A problem fac-
ing governments seeking to induce the new management has been that of
finding a group within each service willing and able to develop the executive
powers required. One option was to recruit trained managers from outside
the sector (possibly from the private sector) or to re-educate an existing ad-
ministrative group. Implied here is the establishment of an entirely new,
self-conscious, cadre of executive managers. The failure of this policy has meant that successive governments have been forced to work through existing professional hierarchies. This meant inducing senior personnel to act managerially and, for those in charge of institutions, to devote all their time to these activities. It was anticipated that professionals at all levels would undergo training and take on management responsibilities, such as staff supervision and the administration of budgets.

For the services under consideration here, there have been important differences in the use of these change methods. In health, a substantial investment was made in order both to recruit a new management cadre and to educate clinicians and induce them to take on management tasks. The principal recommendation of the NHS Management Enquiry under Griffiths (in 1983) was that ‘general management’ should be introduced to control resources. By this development, a dual hierarchy was established in hospitals, with managers on the one hand and clinicians, with strong professional loyalties, on the other. The establishment of a clear ‘chain of accountability’ in the management structure, from the centre to the local institutions, did little to shift this central divide. After 1990, the NHS also underwent major re-structuring, with the creation of an internal market whereby health trusts became relatively independent bodies with their own management boards and some degree of freedom. Such freedom extended to being able to settle pay for non-professional groups, to own assets, to borrow, and to take control of their affairs (Carr 1999).

All this is in contrast to social services where the focus was on developing managerialism through an existing professional hierarchy. Social workers retained their monopoly over senior posts in SSDs. One survey, for example, found that 89 per cent of senior managers had been involved in ‘social services work’ over the previous ten years (Lawler and Hearn 1997, p. 209), a trend confirmed by later research (see for example, Whipp et al. (2004)). In addition, no attempt was made either to restructure this service or develop new single purpose organizations. While some management functions such as finance and personnel where devolved, overall responsibility for planning and funding remained firmly within the ambit of local government.

In housing, a mixed picture emerges. Unlike health, there was no substantial investment in a new management cadre. A weakly organized profession increasingly viewed change as an opportunity to advance its interests and actively tried to colonize new management roles and functions (Walker 2000). This sector did however undergo major re-organization. From the early 1990s, while a rump of housing activity remained under local government control, much of it was transferred to the voluntary sector. Housing associations took on the shape of private firms with separate management boards and autonomy to deploy resources. Even in the local authority sector there has been a shift towards devolved structures with the creation of arms-length management organizations (Walker 2001).
Now that some broad patterns of change have been outlined we turn to the question of how far new management practices and orientations were installed within these services. Three main dimensions of change are considered. First is the development of general management roles, functions and capabilities. Second is whether management control over the nature of service delivery has been extended. Finally, we consider changes in culture and values.

**Strengthening the management function**

Our review suggests that an outcome of reform in all three services is that more time and resources are now devoted to management decision making. Case study research points to growing investment in management support functions and the importance of financial expertise: for example, in NHS trusts (Fitzgerald and Ferlie 2000a) and SSDs (Jones 2001). This is also reflected in the changing ratio of front-line professionals to administrative staff. In health the growth of support staff has been most extensive. Recent labour force statistics for the NHS as a whole indicate that the number of senior managers employed in England has risen from 21,400 in 1997 to 30,900 in 2002. A similar upward trend applies to central functions staff, with numbers rising from 60,900 to 72,700 over the same period (Department of Health/National Statistics 2003). In housing, figures on the number of managers are harder to come by. But here too all the indicators are that the trend is towards non-operational staff, especially in housing associations. As these organizations establish professional boards and grow in size (in 2004 it was estimated that a housing association with 4,000 homes would have a turnover in the region of £20 million), the demand for management skills and personnel increased steadily (CIH 2005). Only in SSDs has the trend towards a dedicated management workforce been less clear-cut. In the 1990s, as many local authorities engaged in downsizing and re-organization, it appears that the number of senior managers in England fell by 9.7 per cent (LGMB/CCETSW 1997). However, more recently, the number of ‘central/strategic and HQ’ increased slowly from 17,000 in 1998 to 18,000 in 2002 (Department of Health/National Statistics 2003).

Across all three services there has also been a trend to delegate management responsibilities to middle and junior ranking professionals. In hospitals, this is evident in the role of Clinical Director, giving senior consultants ‘substantial management responsibilities’ in the areas of finance, service planning and human resources (Fitzgerald and Ferlie 2000a, p. 727). In SSDs, there have been similar moves to devolve budgets to lower level team leaders and care managers. One survey found that 82 per cent of SSDs in England had devolved some budgetary authority to purchase community-based care packages to ‘first tier management or below’ (Challis et al. 2001, p. 679). While decentralization has been uneven – both within and between the three services – the available evidence suggests that the once rigid divide between professional and managerial domains of work has been eroded.
The extent to which new management roles and functions have transformed practice, resulting in more cost effective and strategic patterns of service delivery, is harder to gauge. In some areas changes have been marked. For example, in housing, organizations have developed their own strategic awareness and practices (Greer and Hoggett 1999) and strategy has developed into a tool for internal management and the co-ordination of partnerships, alliances and resources (Walker 2000). Furthermore, linkages to service delivery can be seen in both housing associations and local authorities as plans form a central tool in the assessment of organizational performance (Audit Commission (AC) 2003). By contrast, in SSDs, there is less evidence of the new management being effective in reshaping services (AC/SSI 1999). One survey concluded that: ‘most councils do not fully understand costs and struggle to forecast future activity and expenditure’ (SSI 1998). It is also noted how in most cases the approach to strategic planning remains ‘ad hoc or opportunistic’ (SSI 1999, p. 77), with Community Care Plans often representing little more than ‘public relations exercises’.

**Controlling the front line**

A further indicator of change is how far managers have been able to establish control over service delivery and, in doing so, move away from the custodial pattern described above. Across all three services there is evidence of increasing bureaucracy and managerial supervision. In health there has been clinical audit, focused on directing professional decisions on resource utilization. There have been agreements about regimes of care, designed to increase the number of patients treated per consultant. Day wards, where patients are admitted to hospital on the day of their treatment and discharged on the same day, have been introduced. For senior doctors, these regimes have reduced discretion with regard to patient throughput and the organization of care. Where nurses are concerned, the impact has been even more significant, leading to shifts in the nature and quantity of work (Bolton 2004; Attree 2005). The most recent NHS National Staff Survey reported that 63 per cent of 217,968 respondents (approximately 40 per cent of whom were nurses) felt they were ‘working extra hours due to pressures and demands of [the] job’ (Healthcare Commission 2005, p. 35). With shorter stays nurses have to familiarize themselves with more case notes and more conditions. In addition, management now expects manifest ‘customer care’ standards, obliging nurses to spend more time reassuring patients and heading off and dealing with their queries and complaints (Bolton 2002).

In housing, similar attempts have been made to extend control over front-line decision-making. Over the last decade, guidance on work, in the form of government prescriptions or best practice promoted by professions, regulators or trade bodies, has increased (see, for instance, Audit Commission/Housing Corporation 1997). Notable examples include the 1996 legislation on homelessness which sought to restrict the discretion of housing officers in the assessment of a homeless determination (DoE/Welsh Office 1995) and
the development of common housing registers and standard methods of needs assessment. Enhanced management control may also have resulted from changes in the inspection and audit regimes. The Housing Inspectorate, like the Best Value Inspectorate, works to a model of corporate management (Andrews et al. 2003) and promotes integration, common mission and standardized practices. Finally, we see a trend towards performance appraisal systems, adopted by approximately half of all housing authorities and a majority of housing associations (MORI/IRIS consulting/Aldbourne Associates 2003). All this marks a shift from locally determined housing practice and has had notable effects on service delivery and the day-to-day focus of housing officers.

In social care the drive to strengthen management oversight and supervision has, if anything, been even more intense. The past decade saw a marked increase in the volume of rules, procedures and tick box pro forma used to standardize decisions about care planning and needs assessment (Lymbery 2001). Added to this are procedures for the ‘scrupulous gate-keeping and strict rationing of scarce resources’ (Harris 1998). One survey of English local authorities found that 52 per cent had established policies aimed at ‘targeting’ resources (Challis et al. 2001). As in health, these developments appear to have led to marked changes in the nature of professional work. Not only is decision making more constrained by ‘ever increasing procedural instructions’ (Postle 2002, p. 343), but there is also evidence of work intensification (Jones 2001; Carey 2003). Drawing on a survey of 60 care managers in seven community based social services teams, Weinberg et al. (2003, p. 914) note how a growing amount of ‘direct time’ (currently, over 50 per cent) with clients is now taken up with administrative tasks such as completion of assessment forms. This they attribute to the ‘increasing focus on assessment turnover’ within SSDs.

Many of the above changes herald a step change in the ability of managers to direct front-line professionals. Decision making is more closely monitored and subject to centrally defined rules and performance metrics. Yet it is questionable how far this amounts to a process of radical de-skilling as some observers claim (see Broadbent and Laughlin 2002). While these tendencies are apparent, a closer inspection of the evidence leads one to doubt whether older patterns of custodial administration have been entirely displaced. In health, for example, it is clear that management has achieved only limited control over the deployment of medical expertise in hospitals (see Fitzgerald and Ferlie 2000a). The continuing existence of hospital waiting lists, the inequities in availability of medical procedures and varying standards of care between hospitals are testimony to this. Even where nurses (in relative terms a much weaker professional group) are concerned, the available research suggests that work routines have not been ‘Taylorised’ (See Pollitt (1993) for a full discussion of this concept). Ackroyd and Bolton (1999), for example, show how the intensification of nursing work has been achieved without the application of work-study methods such as the use of the stop-watch to
calculate bed making speeds or of Gantt (bar) charts to redesign ward medication rounds. Instead, the focus has been on indirect control and a continued reliance on nurse discretion to increase patient throughput.

In social services, one might also question the nature and effectiveness of attempts to standardize and control professional work. One report by the SSI concluded that in many departments eligibility criteria for allocating resources are ‘easily fudged’ as staff ‘applied their own judgments’ (SSI 1999, p. 46). Management information systems are often inadequate. According to a joint study of the Audit Commission and SSI (AC/SSI 1999, p. 28), managers were ‘not using the information that is available to assist them in monitoring activity or performance’. Other research confirms this picture and suggests that in many SSDs professionals now receive less formal supervision than before (Jones 2001; Postle 2002). One study, of residential care management in 12 SSDs, found that increasing work pressures on line managers had resulted in ‘marked variations’ in the ‘regularity of supervision’ (Whipp et al. 2004). Hence, in social services as in health, the available evidence suggests a mixed picture of change. While there has been work intensification and some extension of formal management controls, these have yet to fully displace older patterns of service organization that rely on the judgement and tacit skill of front-line practitioners.

Changing professional values and commitments
Turning to changes in values, our review suggests that the impact of management reform has been even more variable. Only in housing is there strong evidence of shifting commitments at all levels and the establishment of a business oriented culture (Walker 2001). This was apparent at an early stage. For example, in a study of four housing agencies in the mid 1990s, Pollitt et al. (1998, pp. 160–1) note how managers were ‘not bashful about using business jargon’ regarding the new language of customer care, a ‘healthy move away from the old paternalism’. More recently, Walker and Enticott (2004), in a survey of over 400 officers, find that professionals in housing departments are increasingly comfortable with the priorities of new management. Across a range of measures that include customer focus, continuous improvement, competition and performance measurement, 72 per cent of housing staff rated these management values as central to their day-to-day work.

In health and social care reaction to managerialism from senior professionals and rank and file staff has been more mixed. As in housing, one can note changes in nomenclature, with the language of management, budgets and quality control (to some extent) colonizing professional practice. There is also evidence that many senior professionals identify with the changes and have sought to benefit from them. In social services Lewis et al. (1997, p. 23) talk of how some managers ‘relish the changed environment in which they may exercise their entrepreneurial skills’. Similarly, in the NHS, Llewellyn (2001, pp. 618–19) notes how some clinical directors have actively sought to engage
with and capture the management discourse. This process, she argues, helped to ‘enable cost consciousness, performance review, standardisation and evidence based practice’ in UK hospitals.

However, in both health and social services one is hard pressed to argue that this engagement with the new management has been anything more than expedient. One study by Syrett and colleagues of culture change in social services found ‘little evidence of any existing or developing congruence between the “new” managerial culture and the “old” culture of social work’. More likely, according to this study, was ‘overt antagonism’ to the use of management labels and titles and a ‘deep rooted hostility to the central tenants of managerialism’ (Syrett et al. 1997, p. 160). Research by Jones (2001, p. 559), based on interviews with 40 social workers in England, also points to rising cynicism and ‘divisions between front line practitioners and their managers’. According to Carey (2003, p. 133): ‘New idioms such as those of efficiency and economy, which have now possessed social care…appear insensitive, inappropriate and vulgar – especially when they nearly always imply an encouraged drive for cost cutting and a quest for “cheap” and often poor, services’.

A similar picture emerges from studies of NHS hospitals. Fitzgerald and Ferlie (2000b, p. 9), after reviewing the structural changes that have been introduced, conclude ‘there was still uncertainty about the extent of underlying change in the cultural and ideological sphere…’. A more recent survey, of 1,092 chief executives and lower level managers in 192 trusts, also questions the strength of support for change (Davies et al. 2003). While senior managers were generally positive, a larger number of clinical directors (445) included in the survey expressed considerable dissatisfaction with limited resources, declining autonomy and the growing emphasis on financial (over clinical) goals.

Where other health professions are concerned, support for management restructuring seems to be even more muted. For example, a study conducted by Bolton (2005, p. 6), of 170 nurse line manages, found that while some senior staff did embrace aspects of their new role (such as the perceived freedom to introduce change) most were ‘keen to dissociate themselves from the title of manager’ and saw their role as ‘mediating the excesses of NPM’. Only 21 per cent said they would consider a career in management while 65 per cent claimed to feel ‘uncomfortable’ with new management values associated with cost control and customer care.

The available evidence therefore suggests that in many areas (most notably in health and social care) professional values have remained ‘surprisingly robust’ (Morgan et al. 2000). While there has been some accommodation of management concerns, especially amongst more senior professionals, this does not amount to a wholesale change in culture. Added to this are indications that management practice itself may have been shaped or partially captured by professional ways of thinking. An example in health is how the attempt to use clinical audit as a mechanism for control was ‘blunted’ by
clinicians imposing their own definitions of quality and ensuring that data were aggregated (Exworthy 1998, p. 50). Fitzgerald and Ferlie (2000a, p. 731) also note how ‘active clinical audit represents a return to the basic professional values of self-regulation and performance review by peers’. Even in SSDs, despite the weaker position of social work, one finds examples of how management policies have been interpreted to suit professional concerns. In the early 1990s, all SSDs were obliged to implement care management, dividing up the assessing and commissioning of services from their actual provision. Survey evidence reveals, however, that in practice many did not fully comply (Challis et al. 2001; Whipp et al. 2004). As Cambridge (1999, p. 397) suggests, a large number of departments ‘simply redefined the role of social workers...to approximate to care management roles or have simply relabelled existing posts’.

DISCUSSION AND CONCLUSIONS

This review reveals a picture of change and continuity. In all three services management reforms have had considerable impact, most notably in terms of restructuring provision and shifting priorities. Public organizations now strive to be more financially driven, accountable and transparent. However, these changes have been far less radical than many assume. The available evidence suggests that in many areas older patterns of custodial administration continue to be important in shaping service provision. Added to this is the variable nature of the effects of policy across the three sectors examined. Our analysis suggests that the most marked effects have been in housing. Here, new structures and decision-making systems have been implemented with some success, especially in housing associations, and professionals at all levels have engaged positively with change. By contrast, in health and social services, the shift to managed provision has been far more uneven as well as contested.

This being so, a key conclusion to draw from our analysis is that, paradoxically, the effectiveness of management restructuring has been inversely proportional to the resources expended on it. The most sustained efforts to introduce change were in NHS hospitals. Here, as we have seen, major reorganizations went hand in hand with a significant investment in management recruitment, training and support functions. This in turn led to a marked increase in administrative costs, according to one estimate, from 5 per cent of total expenditure in 1981 to 12 per cent in 1996 (Rowland et al. 2001). And yet, as our review suggests, the development of new management practices, and (above all) mentalities in this area, has been painfully slow. By contrast, in housing, a sector where successive governments devoted far less attention, the policy of installing new forms of management has been much more successful and (especially where housing associations are concerned) may even have exceeded expectations. Interestingly, therefore, the sheer weight of demands for reform alone have not been sufficient to induce desired new patterns of action. In some areas, notably health, older
professional modes of working remain entrenched despite years of reform and untold disruption to staff and users.

To some extent this variable pattern of change can be explained by the way reforms were introduced. As we saw, with the exception of housing, there was limited consultation with key professional groups over the nature and objectives of change. In addition, in both health and social services, the expectation was that new management practices would be implemented quickly and, in the case of SSDs, with few extra resources. This resulted in confusion and ‘initiative fatigue’ as lower-level managers and professionals tried to respond to competing demands. Even bodies such as the Audit Commission now recognize this fact. One joint review of social services (AC/SSI 2001, p. 2), for example, noted how ‘councils can be excused for feeling bombarded by policy initiatives’ and that ‘some councils get submerged and overwhelmed’.

However, while it is important to focus on the reform process, our review suggests that a more plausible explanation for uneven change is the dispositions of the professions against which reform was directed. Crucial here is the extent to which different professions have been able to mediate top-down demands. As we noted earlier, public service professions achieved varying degrees of external occupational closure and autonomy. In some areas, notably health, this meant that professional groups had considerable scope to control provision and oppose or slow down the progress of reforms. By contrast, housing officers represent a weaker ‘techno-bureaucratic’ or organizational profession (Larson 1977) – with less control to start with – and have accommodated themselves more fully. In this area, senior administrators and politicians faced much less well-organized and entrenched opposition than has been the case either in health or SSDs.

The perceived implications of restructuring for the wider professionalization projects of key groups have also been important in mediating change. In all three sectors the reforms constituted both a threat and an opportunity. But it is clear that the level of opportunity and incentive to change was greater for some groups than for others. In health and social care, rank-and-file professions retained an interest in defending the status quo. Maintaining weak or ineffective management continued to serve as the basis for customary or de facto control over service provision. By contrast, in housing, the new managerialism seemed to offer much greater opportunity for collective advancement. As we saw earlier, there had been support amongst the practitioner community for transferring housing administration to the voluntary sector. While this was pragmatic, it served to advance collective professional interests (Flynn 1999). By means of restructuring, ‘housing managers were able to some extent retrieve former freedoms and to build upon them further’ (Pollitt et al. 1998, p. 179). Management reforms, leading to the acquisition of new skills, also served to strengthen the position and independence of housing officers vis-à-vis other more powerful professional groups such as surveyors, architects and civil engineers.
Finally, different responses can be understood by focusing on general values that inform professional action. The literature notes how professional groups operate with different definitions of their cultural resources or ‘cultural capital’ (Hanlon 1998, pp. 48–50). At one extreme are professional claims based on a ‘commercialized’ version of professionalism emphasizing technical ability, managerial skill and economic rewards. This can be contrasted with an image of professionalism based on a ‘social service ethos’, and the associated principle of ‘providing a service on the basis of need rather than ability to pay’. In all the services considered here, one finds historical evidence of strong attachments to a public service ethos (Pratchett and Wingfield, 1996), although this has arguably been less the case in housing. By comparison with social work and health, housing officers have always been exposed to the commercial sector and associated values. This may partly explain their greater readiness to accommodate management objectives of efficiency and quality control, as well as customer involvement. In social services and health, on the other hand, notions of public service still retain potency and relevance to practice. It is the difficulty of breaking down such values that helps to explain the slow, contested and piecemeal nature of change.

To conclude, the pressure of reforms must be weighed against the organization of key professional groups and the extent to which this has acted to mediate change. Where professional values and work practices remained entrenched, they have continued to operate and affect behaviour, despite the force of new policy brought to bear on them. Added to this are questions about the willingness of professions to engage with the new management. For some groups, reform represented an opportunity; for others, it has been perceived more in terms of a threat. Finally, we should not forget that the reform process itself influenced these responses. In many areas the likelihood of opposition was increased by the imposed and often coercive nature of change. In the UK, little attempt was made by governments to evaluate whether management reforms would actually work. Nor was there much effort to ‘cherish and build on the potentially positive elements in traditional professionalism’ (Foster and Wilding 2000, p. 157). Many of the strengths of this model were brushed aside in the clamour for change. So too was the idea that change is most effective when it ‘seeps in by the slow process of changing the professionals’ (Mintzberg 1993, p. 213). Hence one might argue that, in the UK, management reform was introduced in a way that was almost guaranteed to maximize disruption and opposition. It is both as a result of this and the strength of professional institutions that even after 20 years of almost uninterrupted policy change the gap between the rhetoric and reality of the new public management remains so significant.

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