

## Point of view

### Doctors, economists and managers

The term “economic rationalism” was originally used to describe a view that commercial activity represents a sphere of activity in which moral considerations (beyond basic business integrity) have no role to play.<sup>1</sup> The potential for conflict with the traditional altruistic basis of medical practice is obvious, requiring only that health care be accepted as a form of commercial activity, which in many ways it undoubtedly is.

Somewhat ironically, the term was introduced to Australian politics by the Whitlam Labor government, but it was initially used in the positive sense of “economically rational” in relation to the abolition of protective tariffs and the support of free enterprise.

Gradually, the early focus on critical evaluation and scepticism, a kind of “evidence-based economics” movement, changed. The UK Thatcher government in the 1980s promoted almost a quasi-religious faith in market forces and the supreme importance of “efficiency” and “competition”. Privatisation, corporatisation and competitive tendering became widespread under the banner of “microeconomic reform”. Competition was seen as forcing individuals and institutions to “work harder and work smarter”, though a number of economists pointed out that working harder for the same pay is simply the economic equivalent of a wage cut, and working smarter often just amounts to a particular form of working harder.

In Australia, the Hilmer Inquiry’s report, released in 1993, embodied similar ideas, emphasising competition above all else in areas as diverse as electricity generation, legal services, ports and, of course, health care. While in some areas, such as waterfront reform, the net effect has been undoubtedly positive, these policies have also resulted in such excesses as the duplication of cable systems by Optus and Telstra, with no benefit, and considerable expense to the consumer.

In parallel with the development of economic rationalism, and to some extent an outgrowth of it, has been the ascendancy of the career manager and the ideology of managerialism. Essentially, this began early in the 20<sup>th</sup> century, as family capitalism (owner-entrepreneurs) gave way to corporate capitalism, and owners gave control of their enterprises to managerial lieutenants.

Managerialism is difficult to define, but has been described as a mindset which glorifies hierarchy, technology and the role of the manager in modern society.<sup>2</sup> The manager’s role is seen as balancing the needs of all the stakeholders in an enterprise – shareholders, suppliers, customers, employees, governments and so on. Not surprisingly, it has been suggested that by being nominally responsible to everyone, managers are in fact accountable to hardly anyone but themselves (as the current controversy about executive salaries illustrates.)

For the managerialist, economic considerations always predominate. A factory is a bank, is an airline, is a school, is a hospital – they are all simply organisations to which the same principles can be applied. Principles such as corporate planning, the industrial ideology of quality improvement, grouping of activities by outcome or output, a hierarchical, divisionalised organisational structure (with managers, naturally, at the top), results-oriented funding or remuneration, and performance monitoring.

In New South Wales all senior doctors employed in public hospitals are now required to develop performance agreements to which they will be bound. Every “worker” is expected to show they are “working harder and working smarter” and a line manager – the managerialist’s equivalent of a factory foreman, will regularly appraise performance.

Unfortunately, these industrial concepts don’t work very well when applied to specialist doctors in public hospitals. Hippocratic ideals like altruism, compassion, care and commitment have no place in such documents – the focus is on “deliverables”. The “efficiency” of our outputs is difficult to measure or standardise, as is the quality. Our principal economic target is cost rather than profit, but costs are often beyond our control. Our work properly includes such “inefficient” activities as teaching and research. And so on.

The position of department heads such as ICU directors, in their role as supervisors and appraisers, is even more difficult. They are not line managers in the managerialist sense. The working culture of doctors is collegiate rather than hierarchical. The ICU director, like the senior partner in a law firm, is not the boss, but a “first among equals”. The director does not supervise the work of colleagues, but is a coordinator of activities, the primary advocate for a group, the primary administrative link and, hopefully rarely, the settler of disputes. There is some authority to make some executive decisions on the fly, and the right to an occasional “casting vote”. It’s a difficult administrative, representative and diplomatic job, which can require great skill, but it’s not at all like being a factory foreman.

There are many signs that history will not treat the excesses of the economic rationalist era kindly. Managerialism may well suffer the same fate. In the meantime, as in previous eras, hospital doctors must cope somehow with the “dominant paradigm”. In the case of performance agreements, the obvious strategy is to develop generic “motherhood” documents and pay only lip service to the appraisal process. However, this is a risky approach, and we could lose an opportunity to enshrine at least some of our fundamental values and culture in a format acceptable to the managers. This would serve not only to remind them that we do not accept the managerialist view of the world, but also

could offer us some small protection from their future onslaughts.

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#### REFERENCES

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2. Edwards DJ. Managerial influences in public administration. <http://www.utc.edu/~mpa/managerialism.htm>