

Alternative paradigms of hospital work organisation and health provision

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Health and hospital services have been under pressure to cut costs and increase efficiency in most European countries. This article analyses how organisational change in health care now is moving in two ways: either towards “internal markets” on the implicit presumption of widening choice for both providers and patients, or towards “internal flexibility” and efficiency gains based on explicitly aiming at mutual advantage for both patients and health service providers. It relates these paradigms to those which they mirror in the production sphere, including “Fordist” models of lowering costs in volume provision, and “post-Fordist” models of flexible work practices focussed on more customised quality provision of services. It suggests on case study evidence from the UK that “internal markets” and more Fordist health provision have increased patient throughput, but have not reduced costs or widened patient choice, while in key cases reducing the quality of patient service. It draws on other case studies of alternative “post-Fordist” models of hospital organisation as an example of how cost reduction can be achieved by focussing directly on patient flow and thereby also increasing the

quality of patient care. It draws implications from these for alternative paradigms of flexibility-by-constraint and flexibility-by-consent in hospital and health provision, and relates these to proposals for innovation-by-agreement, life-long learning and a better work-life balance as recommended by the Lisbon European Council in June 2000. Allowing for cultural differences, it submits also that the efficiency gains in hospital provision justify assessing whether a transition to flexible post Fordism on the basis of mutual advantage for patients and providers is feasible in Portugal, and draws attention to the degree to which continuous improvement has been achieved in Portugal in the production sphere.

Keywords: fordism taylorism; implicit logic operational and organisational logic; innovation-by agreement; mutual advantage.

Throughout Western Europe ageing populations and new medical techniques and treatments are increasing demand for hospital services at the same time as governments are seeking to restrain the mounting costs of health provision. Several are trying to externalise direct costs either by more out-sourcing, or increasing health charges to patients, or public-private partnerships, or a combination of all three. Some are rethinking the “flexibility” issue in relation to “internal markets” in health provision. Many are trying to gain more patient throughput from a system whose organisational and operational design is still inflexible. Few are following through the recommen-

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dition of the Lisbon Agenda for a different flexibility based on:

“agreements between social partners on innovation and lifelong learning, by exploiting complementarity between lifelong learning and adaptability through flexible management of working time and job rotation,... reducing occupational segregation, and making it easier to reconcile working life and family life”. (European Council, Lisbon, 2000).

Implicit within these alternative approaches are different paradigms of health organisation, each of which mirrors paradigms of work organisation in the production sphere. This article seeks to make these more explicit and to identify different actual and potential outcomes both for patients and health care providers.

It does so first by briefly outlining paradigms of Fordist mass production and alternative post Fordist models of flexible work operation. Second, it considers the degree to which these are relevant to the provision of health services and especially hospital organisation. Third, it considers the scope and limits of Fordism in the case of reforms of the British National Health Service and hospital organisation since the 1980's. Fourth, it outlines alternative paths to flexibility in health provision and hospital organisation in the case of a leading Swedish hospital. Fifth, it relates the concepts of changes in organisational and operational logic to premises for consensual achievement of efficiency gains by health service providers and health workers. Sixth, it suggests the conditions for gaining a paradigm shift in hospital and health organisation in line with the recommendations of the Lisbon Agenda which can improve efficiency in service to patients while enhancing both job fulfilment and work-life balance for health employees. It also addresses the cultural factor in institutional and organisational learning and whether it need be a barrier to international transfer of best practice, before drawing summary conclusions.

1. Fordism and post Fordisms

“Fordism”, as it was identified before WW2 by Antonio Gramsci (1975), concerned not only Henry Ford's mass production on a moving assembly line, but also his realisation that “the American dream” of a mass consumption society depended on highly paid workers who could afford to buy what the new system could produce (Ford, 1923). He combined this with Frederick Taylor's (1911) reduction of assem-

bly work to simple unskilled tasks, monitored by time and motion studies against benchmarks of performance and with supervisory surveillance of assembly operations. Such Taylorist “scientific management” (Taylor, *ibid*), was consciously adopted by Ford himself in his first integrated mass production factory and became the standard paradigm for work organisation in most high volume western companies for most of the 20th century.

The outcome of Ford's production revolution was dramatic throughput gains combined with massive cost reduction. Within a few years the company had eliminated near three hundred individual craft producers of autos in the US, and was supplying nearly half the vehicles in the world (Lacey, 1987). But the highly pressured and strictly monitored Taylorist labour process also meant high levels of absenteeism and major labour turnover despite high pay. Henry Ford also was an authoritarian who refused to delegate, or vary his initial Model T, notoriously declaring that customers could have it colour they liked so long as it was black. He would not allow correction of faults in assembly since stopping the moving line for a few minutes could lose him a whole vehicle. He initially refused to recognise trades unions. His reluctance to modify or replace his early success, the Model T, led increasingly to a loss of market share from a peak of nearly two thirds to less than two fifths (Lacey, *ibid*).

When half a dozen of Ford's surviving competitors regrouped themselves in General Motors, they hired Charles Sloan as general manager. Sloan matched the operational logic of Ford's moving assembly line and Taylorist high task segmentation with a new organisational logic, structuring the company in divisions with their own units, services and assembly lines, specialised and delegated management roles, introduced annual model changes, and accommodated trades unions in a manner which stabilised labour relations and reduced labour turnover. As in many hospitals, there was no explicit agreement to “lifetime employment”, but the stability and market dominance of General Motors, Chrysler and Ford, commanding 95% of the US market for decades to come, itself assured the presumption that working for them was a “job for life”. Henry Ford II, replacing his father, promptly adopted the principles of Sloan's multi-divisional management variant of “Fordism”. But this, for all three of the auto majors, still stressed volume throughput rather than quality. Fault rates were high since only some vehicles were quality checked after being assembled. None were customised to individual specification. Buyers could choose from the colour combinations and other features producers offered. Consumer choice was presumed to

count for more than fuel efficiency or reliability, but also limited to what the major producers were prepared to offer (Lacey, 1987; Mintroff, 1988; Senge, 1990).

It was only from the 1980s's that management in Europe and the US became aware that leading Japanese companies were achieving both fault-free production and diversified output on the same assembly line by a new "post Fordist" operational logic. Unlike Taylorism and its top-down operational logic, or Ford's concern to maintain the speed of throughput despite faults, (Lacey, 1987), Japanese firms were emulating the Toyota production system which allowed workers to stop the assembly line to remedy faults at source, and which drew also on their tacit knowledge, latent abilities and implicit skills to gain suggestions for continuous improvement or *kaizen* in methods of work operation, including cutting out wasted time and materials. This was with combined with *kanban* or "just-in-time" delivery of components to the vehicle assembly point by suppliers both to meet the day's working needs and also "make-to-order" (Womack *et al.*, 1990; Colenso, 2000).

This "post Fordist" production logic more than doubled output per worker per decade in Toyota and Honda by the 1970's (Ohmae, 1982), reduced unit costs, increased competitiveness, and also achieved fault-free production (Colenso, 2000). Motivation for workers was a combination of profit sharing equivalent to a total of a quarter of income, and a commitment by employers to lifetime employment to the age of 55, with a then lump sum pension payment which employees could use either for retirement at that age, or invest in their own enterprise (Womack *et al.*, 1990). From producing 7,000 vehicles a year shortly after WW2, as much as GM then produced in a day, within 25 years Toyota became the world's second largest global producer and within 50, was set to overtake GM itself as world no. 1 (The Economist, 2005a). Meanwhile, GM and the two other US auto majors were competing between themselves not on quality, but who would file first for bankruptcy (The Economist, 2004).

2. Fordism and hospital work and organisation

It is clear that Taylor's (1911) single task segmentation is not relevant to key hospital workers, especially nurses and junior doctors, who both are multi-tasked and need multiple skills. Nonetheless, hospital work organisation shares some of the features of Fordism in the production sphere. Although diagno-

sis and treatment of patients is individual, the aim is the dedicated mass production of a health service. This is needed if a service is to be available to the public as a whole rather than only some individuals or social groups. It is integral to social inclusion. It also reflects increasing demand. For instance, in Portugal the number of patients treated in hospitals increased from 374,500 in 1970 to 823,000 in 1990, while the number of patient consultations over the same period increased from 1.5 million to 6.3 million and urgency cases from 774,000 to nearly 6 million (Barreto, 1996; Portugal. Departamento de Gestão Financeira, 2002).

But, while there has been such a dramatic increase in service provision, the organisational paradigm of many hospitals remains the same as when provision and patient turnover was at much lower levels. Cross referral of patients for diagnosis in different specialisations and services tends to lengthen waiting lists and slow patient flow, especially with appointments with different services on different dates, or simply "lost files" through no coordinated information system. Patients are people not products, but there is a strong case for considering their diagnosis and treatment as "work in progress" through "patient path planning", focussing on how wasted time in such assessment and treatment can be reduced, (Kaplinsky, 1995 and direct enquiry).

2.1. Under-utilisation of capacity

Further, the organisation of most hospitals reflects the vertical multi-divisional model adopted by General Motors in the 1920's, and typical of large private sector organisations before many of them more recently sought to gain more "horizontal" structures (Womack & Jones, 2005). Just as large companies are organised in production, finance, marketing and other divisions, so hospitals are organised in different departments, services and units. Each specialisation tends to have its own operating theatre, its own diagnostic unit, its own wards and its own nursing and surgical staff. This tends to replicate much of the inflexibility of a Fordist organisational paradigm. In particular, capacity utilisation between departments and their operating theatres and wards will tend to vary, and may vary widely. An early 1990's study of it in the Karolinska hospital in Stockholm found differences between departments and units ranging from 57% to 97%, with an average use of less than four-fifths (Kaplinsky, 1995). This was not simply a function of waiting lists, which were long in most cases, but under-utilisation of operating theatres, wards, equipment and of available staff time.

In Portugal, average capacity use in hospitals rose from 68.7% in 1970 to 75.5% in 1998. This was close to the European average (OECD, 2002, cit Simões, 2004), yet was an increase of less than 7% over 28 years in which demand vastly increased. It was 5% below the capacity use of Karolinska when it decided to go for major change in its organisational paradigm. Less than full capacity use is not “wrong-in-itself”. A department, operating theatre and ward which is not fully utilised should have shorter waiting lists than one which is so. But this may not be the case. Lack of integration in diagnosis and patient flow may be the cause.

2.2. Skill specialisation and career prospects

Higher levels of medical staff in hospitals tend to have higher degrees of specialisation. Many diagnostic and surgical skills are not general. Paediatrics and gerontology, neurology and cardiology are different. Their senior personnel need to be near the frontier of knowledge and best practice in their area. But Simões (2004) has reported a lack of both doctors and nurses in several specialisations in Portuguese hospitals and a difficulty in reconciling the demands of different services because of this. Anaesthetics, with special skills but general relevance for operations, can be a classic case of this (Kaplinsky, 1995). Lack of lateral mobility also may mean that the general skills of junior doctors and nurses are not available in highly pressured units or services because the “tacit rules and implicit norms” of custom and practice (Oliveira, 2002) mean that no one has considered that they might be redeployed there. Inversely, though for the same reasons, no consideration has been given to the feasibility of nursing staff in high pressured services or units being able to reduce stress and avoid “burn out” by moving for extended periods of time to those which are less pressured. Or, in Donald Schön’s (1991) terms, there has been no joint “reflective practice”.

Skill paths for junior doctors tend to be chosen by them on a range of explicit or implicit criteria. They cannot afford to neglect probable future demand and supply of such skills. Some may opt for geriatrics rather than paediatrics precisely because the work, although less readily rewarding, is relatively under-supplied. But if junior doctors start low they nonetheless know that whichever specialisation they choose will have an articulated career path. They are aware that after a certain number of years they will be candidates for promotion from junior to middle medics, and then consultants. The path is long, and the early steps may be highly demanding in terms of working

anti-social hours, such on night duty with consultants only on call, but ultimately rewarding in terms of personal fulfilment, status and pay.

2.3. Skills and tacit knowledge

Skill and career grades for other medical staff also may be clear, but with fewer promotion prospects and less vertical mobility. Nurses may move from probationary to assistant, to principal and then senior grades, depending on the hierarchy within the system. They may be able to specialise, as with the category of “specialised nurse” in Portugal, or become a “head nurse” or “nursing supervisor”. But the top two levels by definition are restricted to a few nurses only. Skill shortages either may be evident or concealed. Skills extension through systematic formal retraining may be rare, and there may be no recognition of general nursing skills acquired informally from years of experience. Ancillary staff, whether in maintenance, security, catering or cleaning, tend to have no path to skill enhancement or higher work fulfilment, nor any “voice” (Hirschman, 1970) on what may be going wrong in hygiene standards, especially if their work is contracted out. Failure to integrate what they tacitly know in learning-from-work may prove damaging to the integrity of hygiene for a hospital as a whole, as illustrated later.

An EU funded four country project to identify skill acquisition which was an outcome of the Lisbon Agenda commitment to lifelong learning (Oliveira & Holland, 2006) found that individual attribution of skills to non-formal learning-from-work averaged two thirds more than skills gained from formal education or training; i.e. people credited their own skill acquisition much more to experience of “learning on the job” and “learning from life” than to formal instruction. This is especially likely to be the case at lower levels of hospital employment where nursing staff need to gain multiple skills from experience to perform at minimally acceptable levels of efficiency, and when many such skills are closer to what normally would be deemed to be professional rather than only vocational standards. But such “on the job” skill acquisition is not formally credited and nurses’ informal skill trajectories acquired from tacit experience tend to be under-recognised when there is no articulated career structure for them. The lack of recognition of skills gained from experience and therefore of individual “implicit learning” (Reber, 1993), plus the lack of job variation or any horizontal mobility between departments, units or services tends both to decrease commitment and constrain actual skill deployment.

2.4. Lack of dialogue

Many hospital staff, especially nurses and junior doctors, work hours which exceed even formal limits to overtime with “blind eyes” turned to this because otherwise what needs to be done would not be done within the current tacit rules and implicit norms of work organisation. Such staff may do their best, but there are limits to how well they can do so for long hours without reducing the quality of service. The work they do is highly flexible, but when they “need a break”, either short term or longer term, inflexible organisation may inhibit it. Staff needing to balance work time and the responsibilities or personal needs of non-work time may not be able to “voice” (Hirschman, 1970) this need and, not being able to do so, quit when the two become irreconcilable. This will especially be the case if there is no structure for dialogue between lower and at top levels, such as the lack of trades union representation or nursing representatives on the management board of a hospital, or the management committee of a department (Simões, 2004). The outcome can reinforce what Morrison & Milliken (2003) have recognised as institutional “silence”. People may know at varying levels of consciousness what could be done, but see no point in proposing it. And this in turn understates efficiency gains since as Thompson, Warhurst, and Callaghan (2001) have found in other operational contexts, it is employees themselves who often know best how to make the connection between knowledge, skills and effective services from non-formal on-the-job learning.

A large organisation needs explicit rules and procedures to function. Procedural justice in health services also is vital. Patients need to know, and feel, that they have been fairly treated and not neglected. Most general practices and hospitals try hard to ensure this. But most hospital management would admit that gaining a balance between management procedures and both employee and patient needs is difficult to achieve. As Bolton (2004) stresses, resentment grows if health employees are judged only by performance indicators which neglect their professional dedication to their craft and fail to recognise the degree to which this is based on skills, experience and commitment. Benchmarking of performance can be vital for efficiency, but either may be top-down, Taylorist and implicitly authoritarian, or devolved, cooperative and self-directed (Riesman, 1954) at group, unit or service level within a context of commitment to continuous improvement (Wolfram Cox *et al.*, 1997).

Yet such devolved and self-direct commitment to continuous improvement will be unlikely unless hospital staff see it is to the mutual advantage of both

patients and themselves, rather than only an intensification of the work process. If over-worked, as commonly the case for much or most staff in many hospitals, the response of “it’s not my job”, or absenteeism, may not be small minded. It may be a defence mechanism against exhaustion. It also may reflect tacit knowing (Polanyi, 1958, 1962) that the tasks concerned should be redesigned to assure more effective availability of staff in relation to predictable pressures during a day or night working cycle. It may imply that pressure should be directly or indirectly addressed in other ways, such as that the hospital and its various units should be able to allow more flexibility in the incidence of working time in relation to personal life cycle needs, and allow more horizontal mobility for, especially, nursing staff, between more and less pressured departments or units. Because of role and task segmentation, under-recognition of informal skills, and cumulative pressures from inflexible organisation, the hospital may not be able to achieve otherwise feasible efficiency gains. It also thereby will not be a “learning organisation” (Argyris & Schön, 1974, 1996).

2.5. Work-life balance and career planning

Nursing staff therefore may be committed to nursing as a profession, but with lower prospects than doctors of promotion and professional recognition, less chance for skills extension, or job variation, and little to no chance to “voice” what they need or what in their view should be changed in their own or patients’ interest. The outcome may be that they therefore have a lower degree of psychological commitment to the hospital as an organisation than higher level medical staff. Most hospital managers, head nurses and nursing supervisors will recognise the need for nurses to gain time off when subject to family or other personal pressures. But despite a plethora of government commitments to the principle of work-life balance since the Lisbon Agenda (c.f. Hildebrandt & Littig, 2006) few hospitals appear to have followed through its recommendation that social partners should initiate procedures to ensure better work-life balance.

The principle of the right to such a balance recognises that commitment to work changes with different phases of people’s own life cycles, such as from being single and willing enough to work overtime to fund a particular life style, to becoming a parent and focussing on the needs of children, or needing to provide psychological support for an elderly or bereaved parent. “Mid-life crisis” is a cliché, but also a reality when a marriage or other relationship may be

under strain, or adolescent children “join the wrong crowd” because of lack of parental time for earlier care of them rather than patient care. For a combination of such reasons, absenteeism among lower level nursing staff not only may be higher than for medics, but may seriously compromise the operational efficiency of a hospital. High labour turnover also relates to the lack of the right to work-life planning, especially with women leaving full-time nursing when they have their own children and not returning, or only returning to part-time, and on a contract basis. UK evidence indicates that this tends to be related to the implicit down-grading of part-time work and a resulting gender imbalance in vertical mobility. Although nursing is overwhelmingly a profession dominated by women, they have the least chance of promotion within it, and take much longer to gain it. Thus Davies and Rosser (1986) found that promotion for women to Nurse Officer in the NHS on average took more than twice as long as for men (17.9 years compared with 8.4), while Wyatt and Langridge (1996) later found that although time until promotion had been lowered, women still had to wait much longer than men (11.4 years compared with 6.9). In a case study of three Welsh NHS hospitals, Lane (2000) found that promotion depended on full time working, no flexible working time, and continuous employment with no career breaks. As she says:

“Organizational policies and procedures did not actively or explicitly favour men, but they did reflect a male career model... women who choose to work part-time due to childcare constraints find that they cannot access the higher grades” (Lane, *ibid*, p. 708).

Commenting that: “In a ‘lean’ world, no organization can afford to neglect policies which will maximise the utilization of available human resources”, she identified “a clear need for diagnosing potential patterns of disadvantage which may be relatively covert” and “managers” need to evaluate the adequacy of not simply equal opportunities policies, but the broader issue of long-term career planning” (Lane, *ibid*, p. 705).

3. The British NHS reforms

Responses to increased demand for hospital services, and lower unit costs, recently have gone two ways. One is towards new methods of work organisation addressing some of the issues just raised. The other, in the United Kingdom, has moved towards a “new Taylorism” (Burchill & Casey, 1996) with more spe-

cialisation of health management, and increased time and motion studies and more intense benchmarking and surveillance of employees’ performance. In the UK this began with the incoming Thatcher government and its presumption that a flexible private sector always was more efficient than inflexible public sector “bureaucracies”, which then was echoed by New Labour (Pollock, 2004). Its explicit logic was the introduction of an “internal market” within the health service, measuring, pricing and, where feasible selling health services by out-contracting much of what hitherto had been internal to hospital or health centre provision. It also was claimed that this would raise the quality of health service by enlarging choice of private enterprise provision (UK. Department of Health and Social Security, 1983; UK. Department of Health, 2004). Its implicit logic was that by making first “trust” and then “foundation” hospitals responsible for their own finance would encourage efficiency, while in the later case of foundation hospitals, their being able to fund how and what they wished without approval from the Secretary of State for Health should attract more private capital and, according to Pollock, Professor of Health Policy at University College London, also showed the determination of New Labour to prove itself credentials as a “pro-business” party (Pollock, *op. cit*).

3.1. “Change Management”

In itself, the case for more “professional” new public management within the NHS was not without its own justification. In many of the former NHS “directly managed hospitals” there was limited financial control. In some cases, consultants and other staff could be hired without even reporting to the management board (Mueller *et al.*, 2003). The explicit justification of this was clinical needs. But these were within an implicit logic which assumed that methods of work organisation could not be re-thought or changed to improve either patient flow or enhance job fulfilment for different categories of medical staff. For instance, consultants were being hired not only to train junior doctors, but also nurses. While this could be justified in cases of introducing an entirely new medical technique such as non-invasive heart transplants (Edmonson, 2003), it was much less so for routine training. Also, NHS management boards in many cases had little to no information on the timing of increased demand for individual services in terms of referral, patient flow, average time spent in diagnosis, or other features of what actually was happening within different departments and services. Clinical standards could be high or excellent, but whether

there either was economic efficiency in terms of resource use, or social efficiency for patients in terms of reducing waiting times for treatment, was less evident (Mueller *et al.*, 2003).

On what initially appeared the constructive side of the “change management” reforms, general practitioners or GPs for the first time since the foundation of the NHS were given the right to influence the provision of hospital services. The Community Care Act of 1990 offered a new voluntary scheme of GP “fundholding” by which local doctors in larger group practices could gain more funds with more responsibility for their use, including the right to purchase hospital treatment or community care for patients, thereby introducing an internal market of “purchasers” and “providers”, rather than a capitation principle based on a flat rate for every patient. The hitherto powerful British Medical Association opposed this on the basis that it would tend to privilege bigger practices and also reinforce the imbalance of provision in favour of the South East of England, but was overruled. Over half the general practices in the UK signed up to the new “fundholding” scheme (Pollock, 2004). The implicit logic was Fordist on the basis that larger more efficient practices would provide models of greater efficiency which others then could emulate, rather than the “craft” provision of services by doctors working from one room surgeries or even from their own homes. But the surveillance of the new and quickly common fundholding was both external and internal. Since there was increased money, but within “no excess” limits, the implicit logic of the new principle was that doctors within general practices took to monitoring their own time and motion practice on a Taylorist basis, such as that the time for consulting patients should average not more than seven minutes (Pollock, 2004).

The Conservative government reforms devolving budgets to hospitals initially resulted in more effective management in many general hospitals. A new Clinical Governance principle resulted in Boards being set up including high level managers considering all the information that was routinely being collected about performance, such as readmission rates, deaths, non accidental injuries, drug errors, complaints, health and safety accident reports, etc. These boards now had enough authority to effect “change management” in systems and services. But for more than ten years the Conservative governments took money out of the NHS under the pretext of “cost-improvements”. Since the start of the Blair administration in 1997 more money was undoubtedly invested, but a rhetoric of “devolved power” in fact increased bureaucracy at what was the former NHS Health District level, while ensuring that control was

in reality more heavily exercised from the centre, on a divide and rule principle between those opting for “fundholding” and those who did not. Another related problem was that “change overload” created an environment of “change on change” which meant that there rarely was time for a policy to be completed and the effects evaluated before the government decided to try something else and while talking of “devolving power” imposed this top down and monitored it from the centre (Mueller *et al.*, 2003).

3.2. New Taylorism in the NHS “Reforms”

The combination of more centralised control with a rhetoric of “devolving power” meant a single-loop return (Argyris & Schön, 1974, 1996) to one of the main principles of Fordism — reintroducing Taylorist time and motion studies and performance benchmarking (Burchill and Casey, 1996). Focus was on process and outcomes, with mission statements, target setting, practice protocols, performance appraisals, vacancy reviews, quality audits, and “clinical nurse managers” similar to the line supervisors in Fordist production. “Practice protocols” gave step-by-step details of how nursing should be performed as if nurses had not come to appreciate both this and the ethos of nursing in training. To be told by managers who might have no former experience of the health service how it should be delivered in Taylorist detail was an invitation to resent or ignore strict observance of such performance criteria (Bolton, 2004).

With investment also of more resources, the outcome of both the Conservative and New Labour changes was an increase in patient admissions and patient-staff ratios. In a longitudinal study of a gynaecology unit in a northern hospital, Bolton (*ibid.*) found that patient admissions rose by nearly half from 1993-4 to 1997-8 and that the patient to staff ratio rose from less than 3 to 1 to nearly 8 to 1 over the same period, although both admissions and patient-staff ratios fell after this dash for growth or what Cousins (1987) had earlier called the “factory-like logic” of the “new” National Health Service. The outcome by 2004 also had been a reduction in waiting lists. Therefore, the new Taylorism did achieve more patient throughput and thus higher productivity. But the ongoing pursuit by government of higher Fordist volume throughput on the presumption of economies of scale, rather than of scope, also posed “size” problems. As an outcome, some chief executives chose to take early retirement rather than manage trusts that the government decided should be vastly enlarged since in their view they then would have been too big to be able to know

what was going on, far less continue with “change management by consent”.

There also has been serious challenge to key figures published by the government. For instance, one of the highest profile Taylorist benchmarking projects of the New Labour NHS has been that no patient should spend more than four hours in a hospital Accident and Emergency or A&E departments. Government figures claim that by mid 2004 the target was being met for 96% of patients. But according to a survey of 55,000 patients by the independent Healthcare Commission, only 77% of patients said that they stayed no more than four hours in A&E. A survey by the British medical Association of A&E departments found that only 26% thought that the figures claimed by the government were a true reflection of performance. Within the same target area, a 2003 report by the Public Administration Committee of the House of Commons cited evidence where A&E maximum waiting times “were being circumvented by imaginative fixes”. As *The Economist* (2005b) commented: “The worry is that the official figures start to reflect a parallel world created by administrators striving to hit the target”.

3.3. New bureaucracy and surveillance

The outcome has not clearly been more “customising” care to patients’ needs than focus on timed throughput of patients, just as Taylor (1911) timed work operation to raise throughput in production. It also involved a new “surveillance” bureaucracy. In 2000, a Commission for Health Improvement was set up to undertake clinical governance reviews across all hospitals in the NHS which within two years had 300 full time central staff and 500 staff in part-time teams to carry out the reviews. A National Institute for Clinical Excellence (NICE) also was set up with the in itself worthwhile explicit aim of limiting the growth of the NHS drugs bill by submitting the sales-focussed clinical claims of drug companies to independent scrutiny. But the Fordist standardisation of lower cost drug provision to which NICE aspired could not take account of different specialities and scales of operation in different hospitals, while its review teams were not sufficiently qualified in pharmacology to carry weight either against the pharmaceutical lobby, which managed to reverse even its first recommendation (Pollock, 2004). Meanwhile surveillance added to rather than reduced bureaucracy. Frank Dobson, the Labour former Health secretary, who earlier had tried to avoid much of this (Pollock, *ibid*), claimed in the tenth year of New Labour government that: “The so-called NHS re-

forms are costing a fortune. The government is spending hundreds of millions of pounds on management consultants and franchising operations to the private sector. Money is being squandered on the new payment system. Paperwork used to cost 4% of the NHS budget, but now costs 15-16%” (Carvel & Woodward, 2006).

Much of the resistance to the new Taylorist surveillance in British hospitals has been vocal, through the Royal College of Nursing but, lacking agency for “voice” through dialogue (Hirschman, 1970), ineffective. Case studies confirming this at hospital level (e.g. Bolton, 2004) indicate that nursing staff resented the fact that while the new “consumers” of health service have been given a formal voice, through complaint procedures, they as health providers were not. Although a senior nursing officer under the New Labour reforms was a member of the new “management board”, this voice was too far removed from the “shop floor” of operating theatres and wards. Nurses in particular resented the implication that they were “doing a job” for two employers, the customer and the manager, rather than being able to demonstrate commitment to giving a service. As Bolton (*ibid.*, p. 330) comments:

“Nurses have patients’ welfare at heart and are generally supportive of management schemes that are seen to benefit patients. However, while welcoming moves towards empowering patients, the notion of aggressive consumerism remains an alien concept. Nurses have taken on the guise of entrepreneurs, but in order to further their own definition of quality care. Nurses feel that they do not need to become customer focussed as they are already patient focussed, and they remain attached to a public service ethos”.

3.4. External illogic

The new Taylorist focus on internal hospital efficiency in the NHS also has neglected the costs of resulting external diseconomies. Part of the gain in patient admissions was due to patients spending less time in hospital and thus an externalisation of post operative care from hospital staff to general practitioners or health workers, as well as families, whose members could have to take time off work to care for those concerned during recuperation. Faster throughput also has meant a higher rate of re-admissions of patients who formerly would have stayed longer in hospital. Perversely also, although suiting managers’ claims on admissions, the total admission figures include those who have had to be readmitted because

of complications or failure to recuperate, with a “revolving door” effect that sending patients home early raised “success” in later re-admission rates (Stern, 2006).

The introduction of new hospital managers and a change in the composition of governing bodies also meant a loss of “externalities” of interrelated local knowledge and experience of the causes of health problems. For instance, it is commonplace for local politicians to receive letters from a local doctor stressing that there was nothing that he or she could do to remedy a patient’s chest condition until the damp problem in his or her local authority housing had been remedied. With community representatives including local councillors on or chairing the governing bodies of hospitals and local and regional health authorities until the early 1980s, such problems could be addressed in an integrated manner. But this is less the case when the managers now are from the commercial sector rather than the local community. The readmission of the individuals with the chest complaint therefore will increase the performance benchmark of admission rates, while doing nothing to resolve the underlying problem causing their ill health.

3.5. Counter productive out-sourcing

The focus on Taylorist time, motion and cost reduction also has resulted in a deterioration of health in UK hospitals. Infections have always been acquired in hospitals, whatever the rigour with which nursing or other employees seek to avoid them. But in NHS hospitals they have increased significantly since out-contracting of cleaning and its subjection to Taylorist criteria. Many contractors concerned limited the disinfectant which ward cleaners could use, and increased the wards they had to clean in a given time, meaning that they could not change the water or add cleaning fluid over allotted cost, time and motion limits. Cleaners were swabbing different wards with the same bucket of increasingly dirty and infected water. The result was an infection crisis in hospitals from the summer of 2003 caused by lack of hygiene, including MRSA (Revill, 2005).

The new hospital management boards that could see the problem coming could do little about it since out-sourcing had been adopted as a national policy by the government. Further, in its initial response to the hygiene crisis, rather than rethinking the basis of its cost reduction and out-sourcing strategy, and restore control of both hygiene and health to nursing staff, the government mirrored the Sloan version of Fordism by appointing new national, regional and local hospital “hygiene managers”, quickly dubbed

“health commissars” by the national press. Several of these claimed that their inspectors could not find evidence for the attribution of increased infection to out-sourcing. The government also recognised an increase in MRSA related deaths only in those cases where they had been directly attributed by coroners. Yet, even on this basis, they have increased from less than 390 in 1997 to an ascribed near thousand in 2004. More generally, the government’s National Audit Office recognises that as many as 5.000 persons may have died of hospital acquired infections in 2004 alone (Revill, *ibid.*).

Polly Toynbee, a deputy editor of *The Guardian* newspaper, recognises that: “It is phenomenally faster to get into hospital under Labour — but one in 11 will catch something nasty when they get there” (Toynbee, 2005). Countering Tony Blair’s comment that the problem was that “there are good cleaners and bad cleaners”, Toynbee responded that the problem in fact was: “squeezed cleaning budgets with contracted-out minimum wage cleaners using watered-down detergents, aged mops, no training, no equipment, one cleaner to five wards and 30% vacancies in London” (Toynbee, *ibid.*). She also found that one reason the government claimed that its inspectors could not agree with the diagnosis of the problem is that they give notice of inspections in advance to hospitals, “with managers bringing in all the night and weekend cleaners to thoroughly clean the areas to be inspected”. Overall, Toynbee commented: “This is a New Labour parable... the excellent new NHS pay system that rewards acquiring skills with extra pay, doesn’t apply to contracted-out cleaners, porters and security guards (who) should “now be brought into the mainstream NHS team” (Toynbee, *ibid.*).

3.6. Financial and clinical costs of sub-contracting

A further New NHS parable comes from the contracting out of cataract operations. In 2003, the New Labour government listed new “diagnosis and treatment centres” or DTCs. These were mobile clinics which the health minister John Reid claimed at the time would provide cheaper services than the NHS, cut waiting lists and offer patients a choice of where and when they have their operations. The Oxford Eye hospital was at first bemused and then affronted by this, and wrote in protest to its member of parliament. In May 2002, the health department had explained that the clinics would ensure that “no cataract patient is waiting more than three months by December 2004”. But this was precisely the target the Oxford Eye hospital already was meeting. Almost all

the cataract patients then handled by the hospital were to be referred to the DTC. The exceptions were to be complex rather than routine cases. The routine cases were to be treated in a mobile DTC clinic which would visit their area, according to an internal departmental memo, on only one day in every 10 or 11 weeks. To “save money”, the memo indicated that the clinics might operate “on both eyes at once”. NHS surgeons operate on only one eye at a time, in case an infection leaves a patient completely blind (Monbiot, 2003).

Most of the cataract operations at the time conducted by the Oxford Eye Hospital therefore were transferred to the foreign company running the new diagnostic and treatment centre. But while it cost the eye hospital £685 to perform each cataract operation, the internal departmental memo revealed that the private company was being offered £799.6 One of the reasons why the private surgery was more expensive is that surgeons needed to be flown in to perform it, and would be paid between £450,000 and £500,000 a year. Consultants employed by the NHS were paid £60,000 a year. There also were negative implications for hospital training. The Oxford Eye hospital had used routine cases to introduce apprentice surgeons to cataract techniques before bringing them onto cases which were more complex. But the routine cases now were to be out-sourced (Monbiot, *ibid*).

Such sub-contracting, therefore, did not fulfil the government objective of reducing unit costs by devolving responsibility for budget limits. By the spring of 2006, the National Health Service hospital trusts were faced with a financial crisis. Within two weeks in March 4,000 jobs were cut nation wide, with estimates of a further 10,000 further job losses, or more, being voiced in parliament (Carvel & Woodward, 2006). The Royal College of Nursing said a preliminary analysis suggested nurses on the basic grades were bearing the brunt of cuts, with work transferred to lower-paid healthcare assistants. Trusts were trying to recruit senior nurses to take on some tasks previously performed by doctors (Carvel & Woodward, *ibid*.) but in a tactical reactive context of trying to reduce costs rather than a proactive strategy to enhance senior nurses to career planning.

4. Alternative paradigms in practice

There are alternatives to the New Taylorism in health provision which could achieve efficiency gains without such direct or indirect costs. For example, in the early 1990’s, rising healthcare costs prompted a Conservative government in Sweden to reduce central

government support for local healthcare. In Stockholm, the city council cut funding for hospitals across the board and allowed residents greater choice in selecting a hospital. But, rather than implementing a downsizing programme, Jan Lindsten, Executive Director of the Karolinska teaching hospital, with 4,000 employees, commissioned a study of patient flow both into and through the hospital. The results showed that average waiting time for surgery was eight months. Surgeons spent as much as two thirds of their time between operations, much of it waiting rather than in pre or post operative evaluation. Operating theatres and wards for several specialisations were under-utilised. Others were over pressured.

4.1. Quality of service, morale and efficiency

Lindsten’s initiative had three objectives: to improve the quality of service to patients; to improve employee morale, and enhance operational efficiency. The diagnostic phase of the programme started with surgery. This showed that 59 per cent of potential operating time was not being utilised. One reason was a relative shortage of anaesthetists and anaesthetic nurses. Anaesthetists were spending 85 per cent of their time with patients, but surgeons only 25 per cent in surgery. Another was slow changeover procedures between operations. In one operating theatre, nearly a fifth of operations were cancelled. Less than a third of these were because the patient did not show up; the others were due to inadequate organisation. Hitherto there had been no distinction of routine from non routine surgery (Kaplinsky, 1995).

An analysis of 1,000 operations at Karolinska showed that more than two thirds of operations took less than an hour. Further analysis made it possible to identify that flexible capacity use of operating theatres should not be in terms of the medical specialisation, but on the likely duration of the operation rather than the type of operation. As a result all theatres were segmented in four groups – “fast”, “medium” “slow” and emergency. Flexible theatre use was matched by flexible use of wards. Underlying this was the principle of clustering “families of service” both within the organisational logic of the hospital and the operational logic of departments (Kaplinsky, 1995). In addition:

1. A new post of “nursing coordinator” was created and adopted by most departments, whose responsibilities included minimising the number of visits a patient must make for appointments and scheduling pre operative preparation and post operative care by doctors.

2. Two operating theatres were closed but a new pre-operation anaesthetic clinic opened.
3. More anaesthetists were hired, allowing senior staff to focus on surgery and junior staff to manage all pre-operative patients.

The new position of “nursing coordinator” created a career path for nurses, who in practice became responsible for the administration of the various departments. Not all the doctors at Karolinska were comfortable reporting to nurses, even on purely administrative matters. But the new structure freed doctors from administration to be able to spend more time on their clinical work and research.

The results were impressive. The health service offered by Karolinska had become “lean” (Womack *et al.*, 1990) by cutting wasted time and under-utilisation of staff and fixed resources. The time between operations was cut by up to half. Average waiting time for surgery was reduced from six to eight months to six to three weeks. Overall unit costs were cut by 15%. As an outcome, patient throughput also increased 25%. Since the hospital was paid on the basis of the number of patients treated, revenues increased. Unlike “downsizing”, no one was made redundant (Fortune, 1995).

4.2. An alternative paradigm

The Karolinska case has claims to paradigm status in terms of a new model of hospital organisation. The transition to a post Fordist model was conscious, since Lindsten was aware of it in production. Yet it also was externally driven by consultants. Many of the medical staff felt that they knew what the problems were before the reorganisation exercise was undertaken, and that it should have been “driven internally”. The implementation process also was more once off and “big leap” rather than ongoing, with less concern than within leading Japanese firms to ensure mechanisms for voice in proposing many ongoing “small steps” of “continuous improvement” (Kaplinsky, 1995).

As within the production sphere, this suggests that if a paradigm shift in health organisation is to be long term, consent for it should be integral, based on mutual dialogue between health managers, patients and staff, rather than simply led top-down. It implies that a hospital, or health clinic, or general practice, should be able to gain key features of what has become known as a “learning organisation”. It should enable people to develop the skills they have gained in their learning-from-work and recognise the value of the stock and flow of those skills. Internal proce-

dures for “voice” will be needed for feedback on new problems emerging from reorganisation, by drawing on and recognising tacit knowledge and experience. Especially, if “lean” health services are not to be “mean” for employees (Wilkinson *et al.*, 2001) their rights need to be enhanced in a manner which can ensure that change is to the mutual advantage of patients, the hospital or health organisation, and themselves.

4.3. Premises for consensual change

In the context of “continuous improvement” any member of a learning organisation should be able to lead, or propose a change to which, through dialogue, others could consent. In the “ideal type” case, it should be possible for ongoing improvement to be self-directed (Riesman, 1954) rather than only other-directed. Such self-directed operational learning is directly consistent with the mainstream tradition of the Tavistock Human Relations School, and especially the thinking on management and leadership of Barnard (1938). Barnard’s philosophy was that the prime role of management should be to promote the consent and commitment of its workforce to common work values and operational culture by involving them in what is done, why and by whom (Barnard, *ibid.*). Or, as Walton (1985) puts it: “Workers respond best — and most creatively — not when they are tightly controlled by management... but, instead, when they are given broader responsibilities, encouraged to contribute, and helped to take satisfaction in their work” (Walton, 1985, p. 77). But this means a shift from Taylorist top down “scientific management” according to a single design to fostering a multitude of designs by individual employees or groups of employees.

Notably Frank Heller (2003), himself of the Tavistock Institute, stresses that while motivation and commitment may be vital, the evidence suggests that they do not of themselves lead to changes or continuous improvement in operational efficiency. Any hospital manager will be well familiar with this. The motivation and commitment of the staff may be outstanding, but the organisation may suffer inertial logic at this attained level of commitment. It may be near, on or advancing a technical innovation frontier. But in organisational terms it has reached an efficiency “plateau” and neither is learning nor improving. It therefore is not achieving the “continuous improvement” potential evident in the production sphere from successful “*kaizen*” (Colenso, 2000).

Time and motion studies for efficiency of the kind recommended by Taylor (1911) measure actual per-

formance, not the potential to gain continuous improvement under changed conditions which can recognise both the needs of patients and also the needs of the health workers. *Kaizen* type suggestions for continual incremental improvements are not compatible with the top-down internal and external logic of the NHS health and hospital reforms. Nor are they feasible if there is no scope for internal “voice” (Hirschman, 1970), since such voice implies dissent from how things currently are being done. Major change in organisational design will tend to encounter explicit or implicit dissent (Pascale, 1990), some of which may be defensive, but for reasons grounded in learning from front line work experience of a kind unknown to top management or government and much of which, in terms of tacit learning-from-work may be creative. The relevance to organisational change is significant. While managers seeking change and finding opposition to it tend to react instinctively, in terms of considering such resistance “illogical”, they may in fact be encountering something more significant and deeper rooted — the fact that the new organisational design may be inconsistent with the “implicit logic” of their own employees’ operational work experience.

6. Changing operational and organisational logic

The logic or rationality of what individuals or organisations do or wish to do, may therefore be explicit or implicit (Oliveira, 2000, 2001). Bolton draws attention to the degree to which, at the heart of two decades of attempting reform in the National Health Service, there is “a logic that emphasizes contradictory elements: the hospital must cut costs but also deliver a quality service”. She adds that: “As nurses account for the largest part of the hospital budget, and also are accountable for how the quality of bedside care is perceived, these contradictions deeply affect their work” (Bolton, 2004, p. 320)

6.1. Organisational logic

Organisational logic amounts to what makes an organisation function well, less well or dysfunction. It has various forms, some explicit which can be written down such as its “mission statement”; or codified, as in specific contracts, or procedures in an actual “management code” or “code of financial practice” or “codes of procedure”. But the logic of

most organisations also is implicit in the management style of the organisation – how it actually behaves, and what is expected of it by its clients, and its employees. And, without reconciliation of a new organisational logic with employees’ own operational logic, proposed organisational change may fail.

In this context there is a difference between what Argyris and Schön (1974, 1996) call “espoused” theory, or what people think they do or should so, and “theory-in-use”, or what they actually do. Not least, there may be an implicit rationality in Argyris and Schön’s (1974, 1996) “theory-in-use”. In contrast with formal codes of practice, “tacit rules” and “implicit norms” may underlie and tend to govern both management style and organisational behaviour (Oliveira, 2002). The rationale of explicitly espoused theory may be widely ignored throughout the organisation: “you can forget that” or “ignore that” on the ward or even in the operating theatre is common. This is not necessarily derogatory or a lowering of standards. Someone’s Taylorist code of practice designed yesterday may be irrelevant to best practice today. Yet such learning in the sense of not doing something which already is redundant because the explicit logic of a code of practice has been outstripped by better actual practice remains implicitly negative. It is “not going by the book” rather than re-writing the book. Also, it does not of itself imply that an organisation rather than a work group can learn (Oliveira, 2004b).

6.2. Rethinking operational logic and job re-design

The involvement of employees in change, and encouraging them to give “voice” (Hirschman, 1970) therefore is vital, whether the context is radical, such as transition from a Fordist to a post Fordist organisational structure, or evolutionary in the sense of achieving continuous improvement and operational learning. What emerges is that the essence of a learning organisation is not only a style of leadership which encourages and recognises such learning, but proactive participation in proposals at and from operational level, or changes in operational logic from which the organisation can learn. This does not mean that change can be achieved without an initial concept or design for it. Someone has to start the process, whether in management or part of management, as in an operational unit, or employees, through a trade association of trades union. The implications of operational change for change in organisational logic also need to be

thought through, discussed, and able to modify an initial proposal for change. However:

- Proposals for change in *organisational* logic are less likely to succeed if they are only top down and if they make no allowance for “creative dissent” (Pascale, 1990) which can feed back from the operational level into an initial design concept and may modify it in either a primary or secondary manner.
- Proposals for change in *operational* logic are more likely to succeed if they can be made by employees at all levels. To be effective these should be “middle-up” (middle management or staff) and “base-up” (any employee or group of employees) rather than only “top-down”. The organisation therefore becomes more self-directed (Riesman, 1954) in its learning from the tacit knowledge, latent abilities and implicit skills of its workforce than “other-directed” by only top-down design for change.

6.3. Psychological contracts

Much of the above is consistent with increased attention in human resource management to the concept of “psychological contract” (Guest, 2003, 2004; Conway & Briner, 2005). This includes key issues concerning mutual trust, shared values and rewards, competence recognition and skill enhancement, and the degree to which these may improve not only performance but individual job satisfaction. As Guest (2003, 2004) puts the case, such a contract concerns the perceptions of both parties to the employment relationship, and of the reciprocal promises and obligations implied in that relationship. The state of the psychological contract is concerned with whether undertakings and obligations have been met, whether they are fair, and their implications for trust. Perception of it may not be explicit. It tends to be implicit in work attitudes and whether the organisation is committed to employee as well as customer or client welfare.

Implicit psychological contract therefore is two way. For employers, it may offer implicit sanctions for not respecting operational and organisational priorities. Inversely, employees may frustrate such priorities if they appear to them to breach an implicit contract. Especially, as evident in reaction from nurses in Bolton’s (2004) case study, Taylorist performance appraisal may reduce trust by indicating that employers are more concerned with operational performance criteria than with individual employee skills, rights or wellbeing or their own devolved decisions on the

best means of delivering quality in service to patients at operational level.

One of the main implications of Guest’s analysis is that while psychological contract is tacit, it needs explicating — or bringing into the open — to be effective. Notable among these are deliberate design of jobs to make full use of skills and abilities; devolution to units and services for decisions on how to best organise their own work operation within given criteria for quality of service; staff informed about overall performance and prospects; consultation on any changes in methods of work organisation; harmonised terms and conditions of work; explicit commitment to employment security, and a formal system of communicating current problems and potential solutions to higher levels of management.

7. Gaining a paradigm shift

In effect, to transcend conflict in transition to new paradigms in health and hospital organisation, dialogue within management and with other employees should not be on how they should conform to change, especially in terms of the operational logic of what is done, how and by whom, but how they can contribute to it. It is in this sense that any initial design for change should be provisional. It also must be clear that the change as realised as an outcome thereby can be to mutual advantage for employees, the hospital and patients. Hospital staff are likely be aware of how this could be done, but never expressed it because the procedures enabling them to do so were missing. No one asked them how what they or their group did could be improved; what in their view would be needed to gain change, or how they thought such change would need to be approached to gain consent. Reversing this was very much the outcome of the “big leap” to post Fordist organisation at Karolinska, where medical staff had not previously been given the chance to voice or comment on proposals for change (Kaplinsky, 1995).

7.1. Mutual advantage

A health paradigm focussed on mutual advantage for patients, management and employees, unlike the British National Health Service reforms, offers at least three key gains, none of which concern “instrumental motivation” such as pay although none exclude it. The first is the right to negotiate the incidence of work time and personal time, or better work-life balance. The second is recognition of tacit knowledge, latent abilities and implicit skills, and the

right to formal skills extension in the context of Skills Path Planning. The third is the recognition of implicit skills and experience and explicit skills extension in the form of job redesign and re-designation.

Most management is prepared within certain explicit or implicit norms to negotiate the incidence of work time and personal time. X has worked so many hours last week and therefore is entitled to an additional half day off this week. Y has worked so many nights last month and therefore need not do so next week or next month. But time planning rather than time-off is rare. Rather than X or Y simply being entitled to time *in lieu* this could include the right of the individual to negotiate the specific incidence of working time in relation to his or her needs and aspirations: i.e. flexible work organisation which enables staff to “personalise” their working time in a manner which an organisation should in turn be able to integrate into its own forward personnel planning.

7.2. Time credits and work-life balance

Credit in the financial sphere is what keeps banks in business. Lifetime financial planning is what insurance and pensions are about. Time credits for employees in relation to gaining a better balance between work time and life time are overdue. They would mean the right to credit for overtime which in turn can be drawn on as later “undertime” in a manner which fits personal or family needs and improves work-life balance. This could include both annual and multi-annual planning time credits. Health workers could be invited to submit their own “forward plans” for overtime and undertime, such as “this year I need X weeks to study this or that short course” or “my mother has cancer and has only six to eight months before she goes. I cannot do any overtime in this period, or for however long she is with us”.

Time credits and work-life balance also could extend to life time planning. Such as a young health worker without family responsibilities being ready to work extensive overtime for several years in return for a paid sabbatical year to “see the world”, or study. Or a middle aged employee being prepared to see overtime pay invested in an increased pension, or increased early retirement bonus. The time credit principle does not mean all overtime being paid, on the one hand, or credited on the other. Individual staff may opt for a combination of both. Also, since health workers have been accustomed to paid overtime to maintain their standard of living, time credits would need to be able to take account of total personal income streams over time. But this feeds back to efficiency

gains from new methods of work operation. Inasmuch as these should make it possible to deliver either the same or a better service to patients in less time, employees should be able to gain the same overall pay and rate of pay increase to which they would be entitled with current overtime.

Time planning does not necessarily mean lifetime commitment, nor need it imply a formal right to this. But many large organisations such as hospitals either expect or aim to retain staff long term to avoid losing their skills and experience, while absenteeism because of unrelieved work stress is common to hospitals. Time planning therefore should suit rather than frustrate hospital organisation to the degree to which it reduces absenteeism or loss of skills with undue levels of early retirement, or nursing staff who stop working to have a family, or for other family reasons, and not returning.

7.3. Skills recognition

One of the principles for agreements on innovation between management and employees which was recommended by the June 2000 Lisbon Council was skill extension and lifelong learning (Oliveira & Holland, 2007). This needs organisational context. Not everyone can be promoted. But any implicit skill can be (1) recognised; (2), in principle, extended. Skills recognition happens in a hospital every day. Surgeon X asks for operating theatre assistant Y for what clearly is going to be a difficult operation. The recognition is tacit and implicit in the sense that X may say no more than “I’ll need him/her for this one” or “Make sure Y can be on the shift”. But it could be explicit. In the Karolinska case, the new position of “nursing coordinator” created a career path for nurses, who in practice became the administrative heads of various departments.

Such a career path for senior and experienced operating theatre nursing staff could include routine surgery. Rather than out-sourcing this as in the case of routine eye surgery in the NHS “diagnosis and treatment centres”, it could be delegated within the hospital. A senior nurse or operating theatre assistant may have 7, 10 or more years’ experience of a particular operation such as appendectomy. Such nurses not only can assist experienced surgeons but also by example indicate to those who are less experienced what might be “better” practice or, in some cases, simply what not to do. The offering of an alternative surgical instrument, with a gesture implying that it might be more appropriate; drawing attention to raised blood pressure, or heart rate which the junior doctor has not noticed because of preoccupation with

getting the surgical task done properly, and so on. In effect, an experienced senior surgical nurse may be better qualified informally for an operation than a novice surgeon despite his or her skills not being formally credited (Oliveira, 2004a). After appropriate assessment and accreditation by senior medical staff in the hospital, on criteria reflecting its own best practice, such senior surgical nurses could introduce junior doctors to basic surgical techniques rather than consultants needing to do so.

There is extensive corroboration of this in a study of 16 operating teams in different US hospitals by Amy Edmonson of Harvard Business School (Edmonson, 2003) with especial interest in that what she studied was how units in cardiac units reacted to, and then acted on, the feasibility of then new non-invasive techniques for heart transplants. She found a marked difference in the effectiveness of doing this between those teams which were led top-down by a lead surgeon who implicitly assumed to appropriate and claim leadership concerning the new specialised knowledge, and others who shared with the rest of the unit the degree to which gaining skill and experience in the techniques would be difficult and depend on a high degree of mutual cooperation and “speaking up”. Evidencing the above claims that a senior nurse might indicate to or suggest to a junior surgeon that “x” or “y” might be needed or better, she cites how in “mutual learning teams” a staff nurse could and did suggest to a consultant “maybe you should try this”, and of anaesthetists having the right to “speak out” and stop surgeons until they had secured the stability of the patient. Unsurprisingly, mutual learning teams had a faster and steeper learning curve, and a higher success rate (Edmonson, *ibid*).

7.4. Skills extension

Formally recognising the surgical skills of nominally unqualified nurses would nominally challenge hierarchy, overt rules and explicit norms. Yet, as with the new post of “nursing coordinators” at Karolinksa, it also could liberate surgeons from many routine operations, enable them to use their own cumulative skills on more complex cases, and give more time for research, or their own personal time. Recognising senior nurses’ surgical skills would need would need both evaluation and assessment by agreed procedures, and also patient consent. But if skilled nurses were able to perform routine operations, undue, stressful and painful waiting time for patients could be reduced. Hierarchy could be maintained, in a more flexible context, to the degree that a consultant

or senior doctor would need to decide what is or is not a routine operation. Some of them also could be “on call” in the vicinity in the event of the surgery proving more complex, or the patient’s condition hazardous not least if they were researching or training rather than also engaged in routine surgery.

Prime facie, there is a strong case for explicitly extending the skills and experience of such nursing and other technical staff in job redesign and re-designation. The job redesign could be recognised in job re-designation: “Nursing Surgeon” or “Assistant Surgeon” rather than only “Surgical Assistant” or “Senior Nurse”. The screening and approval procedure would be internal in order to gain consent within the unit concerned, and involve “customised training” and evaluation of the skills of the senior nurses involved. Consent from patients would be vital, but would tend to be gained to the degree that competence became evident. Trading off the presumption of needing a “surgeon” rather than a “nursing surgeon” against a waiting time of weeks rather than months, or over a year, for routine surgery could have its own supply and demand outcome.

Nor should it be presumed that reaction from professional associations representing doctors and consultants would be uniformly negative. As Bolton (2004) has stressed, within their own “professionalisation” project, UK nurses are taking on tasks normally associated with the role of junior doctors, albeit without an increase in either pay or status, and therefore considerable resentment concerning this. Higher pay, rather than skill recognition by job redesign and redesignation, nonetheless, need not be the only motivator, as we have found in case studies in other services. The potential of this for increasing internal efficiency and service to patients without loss of quality of service is considerable. It not only could reduce waiting lists, but do so without having to speed up the turnover time of ward and bed use and externalise the internally unaccounted costs of continued care to family members, general practitioners or health visitors, with the related gain of also reducing readmissions.

7.5. Five conditions for consensual change

On such grounds, it therefore is arguable that gaining both an organisational and operational change based on consent rather than constraint needs:

- 1) *Organisational Re-Design*. Someone should have a clear concept of a change in organisational design, whether in a department, unit or service of the hospital or for the hospital as a whole (as with

- the general manager of Karolinska), or a Head of HRM, or a professional association, such as that for nursing in the UK, or a trades union.
- 2) *Operational Re-Design*. Employees at all levels should be able to propose changes in procedures and methods of work operation, and modifications to the initial organisational re-design. This is vital if explicit design changes are not to be frustrated by failure to involve employees, and tacit resistance to them (Argyris and Schön, 1974, 1996).
 - 3) *Feedback and Voice*. Effective feedback and voice — both ways — is vital for management and employees on the varying options and their implications (Hirschman, 1970). Such voice should be able to articulate and improve what otherwise is implicitly assumed in “psychological contract”. And it should be ongoing rather than once-off.
 - 4) *Integration of Operational and Organisational Logic*. The implications of employee proposals for operational change should relate to and be able to modify the proposed change in organisational design and in this sense integrate changes in both operational and organisational logic. This also should be done in an incremental, iterative step-by-step manner rather than a “take it or leave it” basis.
 - 5) *Mutual Advantage*. All employees should be able to see potential mutual gains from the proposals for new organisational design because, at operational level, they themselves have proposed many of them. This need not take the form of written or legal contracts, but could be recorded on a mutually agreed basis which itself can be a benchmark for later assessment of the degree to which such mutual gains have or have not been sustained. This also could include the general principle through the right to customise working time by time credits balancing overtime with “undertime” as part of a mutual advantage strategy for better work-life balance.

8. The cultural factor

One of the key questions relevant to the proposals made in this article is whether Scandinavian or Japanese models can be translated to other institutional, organisational or national cultures. South Korean firms have been especially successful in adopting and adapting of the main principles of the Toyota production system. By contrast, some US companies since the 1980's have tried to adopt flexible or lean production as an operational logic, but have not been

able to translate the concept of *kaizen* style continuous improvement to organisational thinking and practice. Their consequent loss of market share both globally and within the States to Japanese and South Korean firms has been pronounced. Also, rather than seeking to address the need for organisational logic on continuous improvement principles, General Motors hived its internal components division, which now has filed for bankruptcy, while there is widespread speculation that one or more of the “big three” also may need to file (Simon, 2005, 2006; Simon & Mackintosh, 2006; Beales, Simon, & Mackintosh, 2006).

The Karolinska case indicates that a transfer of the flexible production and organisation paradigm from Japan to Scandinavia can be effected with marked success both across countries and from the auto sector to hospital organisation. We also have found by direct enquiry that the Volkswagen Autoeuropa auto assembly plant in Portugal which, like the rest of the parent group, has consciously adopted Japanese lean or flexible production, *kaizen* style continuous improvement and operational learning, has managed to do so with remarkable success and a high degree of management and employee consent and commitment. Overall, it has achieved high levels of efficiency on a range of group indicators and on this basis in 2006 was allocated a further new model which would diversify its range and increase its employment by three thousand persons (Prado, 2006).

9. Concluding recommendations

Specific recommendations have already been made, and the concluding recommendations therefore can be quite brief. Working with the people you employ is better than working against them when changes can be to mutual advantage. Cutting staff to cut costs without changing operational practice and organisational paradigms is a negative sum game which increases pressure on remaining employees and may further raise labour turnover without increasing the quality or efficiency of patient care. Inversely, a major increase in resources but within a Taylorist paradigm of flexibility-by-constraint, as in the British NHS reforms since the 1980's, will not allow sufficient voice for lower level employees either to express what is not going right, or is going wrong, or should and could be improved. It also, as in the UK case, may prove unsustainable financially. Externalising costs either by out-sourcing, or the cost of post operative care by more rapid turnover, may raise patient throughput but also decrease the quality of health care.

By contrast, dialogue on new methods of work operation can indicate better ways of using fixed costs by more variable work practices. This is consistent with the case for flexibility-by-consent on the basis of mutual advantage which in turn is consistent with the recommendation of innovation agreements between management and employees within the Lisbon Agenda (Oliveira & Holland, 2007). Where enlargement of lower level employee skills, and a shift of administering patient flow from doctors to nursing care coordinators could mean a net increase in the time for doctors to pursue research or other private practice in a sector under increasing demand, the consequence for them could be a positive outcome.

The underlying challenge is to change the paradigm of hospital organisation in a manner which can increase both patient throughput and the quality of service in terms of reduced waiting time with reduced costs through different methods of work organisation. In turn, such different methods should be able to focus on the needs of overstrained staff and enhance both their work-life balance and professional self-fulfilment. Since the Portuguese Presidency of the European Council in the spring of 2000, many EU governments have recommended or introduced legislation to enhance work-life balance (Hildebrandt & Littig, 2006). Whether legislation would be needed in Portugal to implement either this or the principle of innovation-by-agreement is a matter which the government itself could address if it is concerned to demonstrate to the rest of the EU that it is committed to the re-launch of the Lisbon Agenda by the European Union in 2005.

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□ Resumo

MODELOS ALTERNATIVOS DE ORGANIZAÇÃO E PRESTAÇÃO DE SERVIÇOS DE SAÚDE

Na grande maioria dos países europeus, os serviços hospitalares e de saúde têm vindo a ser pressionados a reduzir custos e aumentar eficiência. Este artigo analisa o modo como as organizações de cuidados de saúde têm vindo a adoptar uma das duas vias: «mercados internos» no pressuposto implícito de uma maior margem de escolha quer para quem presta o serviço quer para quem o utiliza, ou «flexibilidade interna» e benefícios na eficiência na base da vantagem mútua para ambos os utilizadores e prestadores de serviços de saúde. Estes paradigmas são analisados por referência aos que reflectem o que se passa no sector da produção, em particular os modelos «Fordistas» para redução de custos na base do volume dos serviços prestados, e os modelos «pós-fordistas» para a flexibilização das práticas de trabalho com ênfase numa prestação de serviços com qualidade e personalizada. Evidências de estu-

dos de caso na área da saúde no Reino Unido sugerem que «mercados internos» e o fordismo contribuem para o aumento do número de pacientes atendidos sem no entanto reduzir custos ou alargar a margem de escolha dos pacientes, tendo mesmo em alguns casos consequências na diminuição da qualidade do serviço prestado. As implicações destes paradigmas alternativos de flexibilidade-por-constrangimento e flexibilidade-por-consentimento são relacionadas com a proposta de acordos-de-inovação, aprendizagem ao longo da vida e melhor equilíbrio vida-trabalho tal como recomendado no Conselho Europeu de Lisboa em Junho de 2000. Partindo do princípio de que existem diferenças culturais, é argumentado que é possível em Portugal a transição para um modelo flexível pós-fordista com ganhos de eficiência nos serviços prestados na saúde na base de uma vantagem mútua quer para pacientes quer prestadores de serviços. Uma nota especial de atenção é dada ao facto de tal modelo de melhoria contínua ter sido bem sucedido no sector da produção em Portugal.

Palavras-chave: fordismo; pós-fordismo; taylorismo; lógica organizacional e operacional; acordos-de-inovação; vantagem mútua.



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