

## **Unpicking the managerial stitches: strengthening critical action in the public sector workplace**

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### **Abstract**

This paper draws on research and education with public sector managers in the UK health and social care sector to expose the intensity and rapid spread of private profit within public services. It conceptualises this spread as key to 'high managerialism' which enables the incursion of capital into public services with corrosive impact: perverse results of performance targets, distorted priorities and dehumanised practices which impact crucially on the public. We chart the shift from control through direct performance management techniques to the use of more nuanced, discursive resources for control such as market structures and assumptions and 'morphing' of public services into new forms akin to corporate models. Key contours from the international arena to the individual manager are interpenetrated by market discourse and 'stitch' managers into a 'common sense' of how to act within the structures of high managerialism: a business mindset held in place through fear and silence. The paper describes how through our role in management education we challenge this 'common sense' using three interlinked strategies to work with managers and help 'unpick the stitches'. These strategies challenge the normalisation of market assumptions; name and connect what is usually implicit and disconnected; and take a campaigning approach to action. Our work focuses on supporting the agency of individual managers who lead key public services both to act for progressive change and public service improvement and to take a critical perspective.

### **I Introduction**

This paper addresses the incursion of capital into the public sector, in the context of the increasing intense global polarisation between rich and poor and its tragic impacts. As the 'public sector' morphs into a range of 'independent' <sup>1</sup> forms, the critical public sector manager faces the corrosive impact of global corporate power. We argue that management education must have a critical global dimension to make visible the role that corporate profit plays in providing services for vulnerable people. We aim to apply to the public sector 'the long-delayed extension of critical management perspectives to the international arena' (Murphy 2006:142).

We begin by exploring the terrain of 'high managerialism' in which all the key contours, from the international arena to the individual manager are *interpenetrated* by market discourse. In the UK health and social care public sector, high managerialism is embodied in the recent split between

commissioning and service provision, so that the idea of *purchasing* health and social care like a product becomes 'common sense' even when publicly funded. High managerialism is internalised and individuals are 'stitched' (or appropriately for health workers, 'sutured') into subject positions (Hall et.al. 1992:276). We then turn to local experiences of this managerial terrain, drawing on our research and on experiences of managers we have worked with to illustrate both the internalisation of market assumptions and the fear and silence that hold the system in place. Finally we discuss three strategies we have used with managers to make a start on 'unpicking the stitches'.

## II The terrain of 'high managerialism'

Here we want to explain and map the terrain of what we term 'high managerialism', which builds on the concepts of 'managerialism' and 'New Public Management'. Managerialism has been summed up as 'an approach to management which increases both direct and indirect methods of control in order to enhance productivity, increase profit and/or reduce costs. Managerialism gives managers the right to manage. It incorporates .....both *control of the body* and *control of the mind*.' (Macalpine & Marsh 1999). New Public Management (Fairclough 2006:33; Hall 2003; Newman 2001, Turner and Hulme 1997), a term stemming from the context of aid and 'development', refers to public sector reform compared with traditional public administration. Clarke and Newman (1997) use this term to describe managerial responses to global competition, but their critique does not explicitly problematise the expansion of capital in its search for profit.

'High managerialism' is characterised by the *interpenetration* by capital of key contours stretching from international global trends, to the state, the organisation and the individual manager. We conceptualise these as concentric layers with the individual at the centre. The mutually shaping nature of these layers is powerful in creating complex processes that have resulted in a hegemonic impact on local managers and their identities<sup>ii</sup>. 'High managerialism' has an intense discursive grip across these contours which produces a sense of inevitability concerning the current organisation of health and social services.

So high managerialism is highly evolved both in its reach and its intensity. Our concept draws on Giddens' 'high' modernity, where he describes 'the regularised control of social relations across indefinite time-space distances' (Giddens 1991:16). It extends New Public Management to include an explicit recognition of capital's need to expand and to shape the public sector to fit its requirements for profit, both for shareholders and for top management. It does this through direct tools such as performance management, and increasingly through indirect processes that mimic the private sector. These include the commissioner/provider split, and a raft of other modes that facilitate privatisation. These indirect processes enable the decentralisation and shrinking of the state, allowing more space for capital to penetrate, while still allowing the state to attempt to regulate at a distance. These local practices cannot be understood adequately without placing them within the terrain of

the global economy and linking them to the neo-liberal discourse which Fairclough terms 'globalism' (Fairclough 2006 passim).

The corrosive effects of 'high managerialism' continue and intensify (McMaster 2002a). These effects encompass the notorious perverse results of performance targets, distorted priorities and dehumanised practices which impact crucially on the public. Not only are health inequalities widening but also public money is fuelling extreme growth in profits and top salaries for senior corporate personnel (Sklair 2002). Adam Curtis tracks this calculative managerialism: reflecting on the present as if from a future point he comments that people now believed in selfishness, and had

'a simplified idea of human beings - that at heart they were just self seeking individuals whose needs could be best met through the marketplace not politics. ...What had actually happened was the return of inequalities and social injustices not seen for 100 years.....' (Curtis programme 2).

In addition, 'high managerialism' supports continued criticism and undermining of public sector (management) capabilities offering only one solution, that of privatisation. Its theoretical base in public choice theory (Hall 2003; McLean 1987; Niskanen 1971) argues that the terrain for market forces must be increased through competition. Thus the terrain for the state is reduced in order to combat the supposed inevitable tendency for public sector 'bureaucrats' to continually expand their budgets.

'We will now explore how 'high managerialism' operates simultaneously throughout the layers from global to individual.

### ***The global contour***

In the international context, 'high managerialism' has produced the discursive resources for global corporations to push for international public policies that will benefit them i.e. to increase the terrain for market forces. Corporations have influenced the international economic institutions such as the International Monetary Fund (IMF), the World Bank and the World Trade Organisation (WTO) to enforce a reduction in the role of the state through notorious 'structural adjustment policies' as loan conditions. These include 'liberalisation' in trade and employment practices<sup>iii</sup>; deregulation; reduction in welfare spending and removal of local food subsidies; introduction of 'cost sharing' (i.e. charging fees) for health services and education; privatisation of state industries, such as rail, telephone, coffee, tea (see Lister 2005:54;). This corporate influence has led to the 're-formulation of state/capital relations' (Whitfield 2001:8), leading to a hugely increased role for the private sector in providing public services (see typology of privatisation in Whitfield 2001:76-77; Whitfield 2006). McMaster (2002a) notes the assumed neutrality of mainstream economic policy advice yet 'the general tendency in capitalist economies for benefits to be privatized while costs are socialized' (McMaster 2002b:324) As Keaney concludes: 'the globalization of health care privatization is a key constituent of a continuing process of global economic restructuring that is both profoundly anti-democratic and imperialist' (Keaney

2002:351). As Shiva (2005) points out privatisation is the latest in a long series of 'enclosures of the commons'.

Corporations have taken up a discourse which supports their penetration of the public sector, through notions such as 'the consumer', 'choice', 'efficiency' and 'partnership' and created a hegemonic acceptance through their constant iteration of these ideas, also used by international policy-makers (Murphy 2006). They drive this 'liberalisation' discourse through corporate lobbying and through 'revolving doors' whereby their senior executives circulate from their corporate job to an influential state post and back<sup>IV</sup>. This degree of influence is exacerbated by the growth of unaccountable private equity, driven by an acute need for short term profitability. This form of extreme capitalism actively lobbies international policy-makers; for example the European Private Equity and Venture Capital Association were invited to speak at a conference organised by Europe's Socialist Group of the European Parliament in March 2007.(EVCA 2007)

### ***The national contour***

In the UK the change in public/private relations was first formulated as compulsory competitive tendering in health and local government, later as the private finance initiative (PFI) and so-called 'public-private partnerships' (PPP). This shift was deliberate: the department in charge of local government specifically stated they wished to 'encourage the competitiveness of the supply base' (DETR 1999 cited by Whitfield 2001:8). Below in Table 1 we track a chronological view of the growing corporate presence in health and social care giving examples of how corporate/private provision has increased since the 1980s. This shows how corporate access to public health and social care has moved from contracting for more peripheral or support services to contracting for core professional services. It charts the gradual disinvestment in the public sector and the growth in outsourcing to private organisations<sup>V</sup>. In parallel to these changes in strategy, the table shows key structural shifts that enable a private sector mode of working, such as developing a market for particular services, establishing new bodies with boards of directors, introducing apparently autonomous financing of health organisations, bringing in legally binding contracts for provision. The tools to achieve this increasingly rely on the ubiquitous contract, alongside (self) monitoring and regulatory bodies.

Key to the expanding colonisation of the public by the private is the process of *isomorphism*, where public organisations mimic corporate structures (highlighted in this table). This has been encouraged by the Organisation for Economic Co-operation and Development (OECD): 'a new paradigm for public management has emerged, aimed at fostering a performance-oriented culture in a less centralised public sector.' (OECD Public Management Service 1995:8 quoted in Whitfield 2001:114) Whitfield comments:

'The internationalisation of public management provides a common operating system for transnationals... Service and finance capital want to

improve and consolidate government management systems in order to safeguard their infrastructure investments. ' (2001:62)  
 Thus the global influences the national, which in turn directs what is required at an organisational level. A whole range of shifts charted in Table 1 attest to the power of an isomorphic approach that uses structures and discourses to shape remaining public sector bodies so that they look like their private sector equivalents. One of the most potent is the marketised split of commissioner from provider of services.

**Table 1 Summary of public to private changes in UK health and social care 1980s<sup>vi</sup> - 2000s**

Decade	Mode	Managerial tool	Examples
1980s	Compulsory Competitive Tendering	Contracts; Contract monitoring	Non-clinical activities – e.g. laundry, cleaning, catering – in acute hospitals subject to Compulsory Competitive Tendering (CCT) and increasingly provided by corporate firms.
	Purchasing private services	Inspection of purchased services	Continued closure of long-term care beds in the NHS, and growth of private long-term care industry. Local authorities became responsible for long-term care funding largely spent within the newly developing private sector.
1990s	Internal market 'isomorphism'	Internal Service Level Agreements	Purchasers – health authorities and some GPs – buy services from providers – acute & community trusts i.e. the public sector re-modelled itself on private sector structures.
	Outsourcing	Contracts	Privatisation of 'white collar' areas including ICT, accounting and service planning. Domiciliary services in social care increasingly privatised.
	Disinvestment	Increasing regulation and inspection processes	Withdrawal of public sector from long-term care; residential properties sold.
	'Isomorphism'	Re-structuring	Trusts set up modelled on commercial companies, with chief executives, boards of directors including non-executives. Capital charging introduced, so trusts pay interest on capital assets. Trusts earn income through private beds and other contracts.
	Private financing	Long term financial contracts	Introduction of Private Finance Initiative (PFI) partly through pressure following recession in construction industry: premises, facilities management and in some cases clinical care funded by corporate sector and leased by trusts; ownership of buildings remains with private sector. Local Improvement Finance Trusts (LIFT) introduced whereby new or renovated GP practices owned by and leased from corporate bodies

Early 2000s	Long term contracts	Increasing self regulation	Agreement between Independent Healthcare Association and government to create long term contracts, including for provision of intermediate care.
	Market creation	Contracts	Care homes increasingly provided by large corporate owners. More specialist private sector providers for people with challenging behaviour/ complex needs both residential homes & medium term hospitals for assessment and rehabilitation.
	Outsourcing	Arms-length agencies	Increase in licenced private fostering agencies.
	Direct private investment	New specialist vehicles	Introduction and fast expansion of Independent Treatment Centres (ITCs) also called Diagnostic and Treatment Centre (DTCs) for routine operations, with guaranteed contracts for 5 years. (Pollock 2004:69)
	'Isomorphism'	Re-structuring	Foundation trusts introduced: public sector but structured as autonomous corporate bodies.
	Outsourcing	Contracts	Contracting out of hospital carparking, TV and phone services.
	Outsourcing & blurring of organisation boundaries	Contracts	New GP contract enables some services e.g. out of hours to be privatised or sub-contracted to agencies. Private primary care available through insurance companies. Walk in centres for primary care both within NHS and private providers, e.g. retail stores.
Later 2000s	Mergers and acquisitions		Foundation Trusts and private care providers expand their influence through mergers with other organisations.
	Market freedoms	Externalised management	Foundation Trust network pushing for cap on private patients to be lifted; Foundation Trusts provide income generation 'branded boutiques' in other hospitals Management of 'failing' hospitals franchised out to private sector (Pollock 2004, 123) Management of NHS fast track surgical centres privatised without knowledge of existing managers
	Outsourcing	Performance management	SHAs to be performance managed on number of PCTs working with the private sector
	Market re-structuring	Contracts	PCTs divest themselves commissioning and/or providing role e.g. Hillingdon. Vertical integration – hospitals as well as private sector to provide both primary and secondary care. (Sue Slipman, chair of Foundation Trust Network says: 'Foundation Trusts are all-terrain vehicles') Private sector expansion in chronic disease management
	'Choice'	Consumer purchasing	Expansion of individual budgets and payments for people with disabilities, adults receiving social

	policies		care. Choices for secondary care offered by GPs to patients must include one private sector source.
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### ***The organisational contour***

The modes and tools of managerialism highlighted in the table exemplify a range of processes on a continuum between wholly public and wholly private. These change over time and co-exist with some continuing direct public provision of services. The latter are subject to a high degree of direct control through performance management whereas the table above shows more indirect disciplinary technologies which control organisations as well as individuals. Methodologies for managerial ‘modernisation’ have shifted from a focus on internal plans and targets, league tables and star ratings to self-rating alongside external scrutiny, fewer (but just as stringently applied) national targets, and crucially, a huge increase in contracting, with the resulting artificial chasm/split between those commissioning services and those providing them.

The division between those planning and funding services, and those delivering hands-on care has become hegemonic: it is rarely questioned. In a recent national gathering of health professionals, people from England and Wales found it very hard to comprehend that in Scotland no such divide exists, and that Health Boards both plan, fund and deliver services. Such entrenched thinking clearly impacts strongly on individual managers.

The split between commissioner and provider has now been more fully developed through the ‘choice’ agenda, to allow for, indeed push for, an increased private sector role. Strategic Health Authorities are now required to report on the percentage of Primary Care Trusts (PCTs) commissioning from the private sector (Mooney 2007a). At Lymington New Forest Hospital in Hampshire, clinical services as well as buildings and facilities are now provided by a private company: Partnership Health Group, a partly owned subsidiary of Care UK. Doctors and nurses will be seconded from the NHS to work alongside staff employed directly by PHG. In Hillingdon, London, the interim PCT Chief Executive commented: ‘I want to get rid of everything, outsource it’ (Vaughan 2007), and is inviting private sector bodies to commission some areas of service (Mooney 2007b). Articles in influential sources such as the Health Service Journal continually propose competition as the answer to change and responsiveness (Stevens 2007, Dash and Garside 2007).

In addition, structural change of public organisations has continued at a destabilising rate, with the continued development of arms-length agencies and other (quasi-)corporate bodies such as NHS Foundation Trusts, and recent encouragement for ‘social enterprises’ as health and social care

providing bodies, which constitute a new aspect of isomorphism. (Davies 2007)

The points discussed here represent extreme and persisting examples of morphing of public to private, penetrating both people and structures. This applies to the community and voluntary sector as well. Treleaven and Sykes (2005) show how in a not-for-profit organisation, 'the linguistic and discursive practices of financial management are marginalizing and displacing practitioners' organizational knowledge' (Treleaven and Sykes 2005: abstract) and indeed producing clients as 'outcomes' (ibid :10).

### ***Individual contour***

Previously (Macalpine and Marsh 2002) we have focused on the impact of performance management and the perverse effects of inspection under a managerial regime, as this was the strongest theme emerging then from our work with managers. Currently as we have seen, the shift from direct performance management to more discursive disciplinary controls is sharp.

In all these processes, managerialism is internalised and individuals are as Stuart Hall says 'stitched' (or appropriately for health workers, 'sutured') into subject positions (Hall et.al. 1992. 276). Hall develops his analysis in relation to managerialism pointing out the critical role of behaviour and practices in subjectification.

'[It] re-produce[s] all of us in the new position of practising 'entrepreneurial subjects', by fostering certain 'capacities' while down-grading others, shifting individual behaviour indirectly by altering the environment in which people work, and operationalising new values by 'modernising' old practices..... Slowly but surely, everybody - even if kicking and screaming to the end - becomes his/her own kind of 'manager'. The market and market criteria become entrenched as the modus operandi of 'governance' and institutional life' (Hall 2003:np).

Hall draws upon Foucault whose critique focuses on the detailed processes by which individuals in the heart of an organisation take on their identities, in this case as managers. Judith Butler examines the paradoxical process by which power both oppresses from the outside, as well as actually forming subjectivity:

'We are used to thinking of power as what presses on the subject from the outside, as what subordinates, sets underneath, and relegates to a lower order. .... But if following Foucault, we understand power as *forming* the subject as well as providing the very condition of its existence and the trajectory of its desire, then power is not simply what we oppose but also in a strong sense, what we depend on for our existence and what we harbor and preserve in the being that we are. ' (Butler 1997:2)

We may here be approaching some of the deeper forces that stitch managers into managerialism. The unrelenting nature of this process especially for senior and middle public sector managers requires the subject to take on the managerial identity. They therefore become immersed in the 'dominant logic'

(Battram 1999.92) and cannot see beyond it. The next section will illustrate from practice how high managerialism affects individuals.

### III Local experiences in the terrain of high managerialism

We draw here both on experiences managers report while on an academic leadership programme<sup>vii</sup> and on our extensive research into cross agency working 'on the ground' within UK health and social care ([www.swampyground.org](http://www.swampyground.org) 2000 and 2006; Macalpine and Marsh 2007 and 2008 ). Clearly the perverse effects of performance management and other tools of managerialism have not stopped (Macalpine and Marsh 2002). But we are struck now by the increasingly intense effects of disciplinary technologies working through discursive means to produce both hegemonic internalisation and fear.

Box 1 below contains comments from health and social care managers regarding how they experience their work in this managerialist setting.

#### Box 1 Comments from managers in health and social care: market discourses

- Manager A Social care commissioner: *'we have to keep a tight focus on new business, we can get up to 60 pieces of work a day. The perception is it is working – the numbers are looking good. But an old person doubly incontinent whose home had been flooded was assessed as having no health needs and we [i.e. Social Services] had to take them on.'*
- Manager B Mental health provider talking about relationship with commissioning body at a time of major funding cuts: *'We've done all the work, we've found a million, we're still positive but their stance hasn't changed. Our finance director says he's going to stand up to them but when it gets to the big room he doesn't stand his ground'*
- Manager C Social care commissioner: *'[the Department] are raising criteria for access for services to include only people with substantial needs, it's not thought through yet. there is a level of risk and a lot of challenge from the voluntary sector. Managers have to sign they agree their budgets now.'*

We see here the deep penetration of the high managerialist discourse. Manager A, who is progressive and reflexive, nevertheless refers to older people as 'pieces of work' and 'new business'. Manager B similarly in discussing people with mental illness assumes a competitive position and the need to 'stand your ground'. The separation of the two bodies on whom the mentally ill client depends – commissioner and provider - is stark. Manager C while despairing at the impact of ill thought through cuts in provision nevertheless expressed this in market terms: 'risk', 'challenge' and signing for the budget. In relation to the market model and the commissioner-provider split, we found evidence of a damaging barrier between those commissioning services, and both users and front line staff. Another manager, a District Nurse commissioning end of life care from a privately owned home for older people, did not feel she had a right to talk to users. She had internalised the

contractual boundary to the extent that she did not pursue her professional imperative, that of connecting to the patient.

## **Box 2 Comments from managers in health and social care: fear and stress**

- Manager D Healthcare provider: *'they (commissioners) are using a weed-killer approach to change, not pruning. The stress we absorb because we are in the end professionals and want to make it work.'*
- Business (sic) manager E from mental health provider: *'I have so much to do, some days I sit in front of the computer screen paralysed. I could scream.'*
- Manager F Mental health provider: *'it is a volatile and aggressive environment. Being a Foundation Trust has made it worse..'*

These comments illustrate baldly what Bauman suggests, that 'overall is insecurity and fear: manufactured uncertainty is the 'paramount instrument of domination' (Bauman discussed by Lawson 2006:90). Sennett too believes that only the elite flourish in times of instability (Leighton 2006).

Further, our 'swampy ground' research included a study of the different perspectives of those involved in the outsourcing of services for people with learning difficulties. All parties including managers, commissioners, users and carers were opposed to outsourcing; in particular, users feared a lack of continuity. What was striking was the silence from everyone about their opposition. The decision had been taken by councillors and all, including the highly critical senior manager, did not want to '*let the cat out of the bag*' by voicing any opposition. Each manager felt silenced through a fear of the consequences of even talking to each other about their views, let alone voicing their concerns more publicly ([http://www.swampyground.org/catout\\_bag.htm](http://www.swampyground.org/catout_bag.htm)). A similar silence ensued in a senior social services management team concerning the negative impacts of performance related pay on staff. This silence was pervasive despite the presence of several senior managers who had participated in a research inquiry into the pay system, and who were convinced it was perverse and inequitable (Macalpine and Marsh 2007b).

We see then the discursive grip of high managerialism, as well as how silence is produced by fear: together these enable the contours of high managerialism to stay intact and unquestioned, held in equilibrium. Thus the corrosive results identified earlier and illustrated here - the perversities of performance targets, the distortion of priorities, dehumanised practices - are not challenged. The broader results of widening health inequalities and the pursuit of profits and high salaries persist.

How can we then disrupt this equilibrium ? How can public sector managers become aware of the discourses which shape them; once aware, how can they move from silence and fear to find a distinctive voice to resist high

managerialism, and express public service values that led them into their work. Our research shows that they have a choice: they either comply, leave, or find small spaces to enact their values (Macalpine Marsh 2007 and 2008). As Fairclough comments 'the dominance of a discourse ....is always contingent and precarious and constantly has to be maintained or re-established' (Fairclough 2006;36). There is an opportunity then to unpick the managerial stitches and find small spaces to act. In the next section we explore these ideas further.

#### **IV Unpicking the stitches?**

In section, we present three strategies developed through our educational work with public sector managers to 'unpick the stitches': we aim for awareness of the discursive forces and for them to feel a sense of more confident agency within their workplace.

The fear-induced silence we noted exists in the context of a managerial 'din' (Harlow et al 1995) about 'what matters is what works', 'choice', the ubiquitous 'partnership' or 'preferred providers'. Both dins and silences stitch managers into a hegemonic common sense of market structures and assumptions. The deeper forces of power forming professional identities (Butler 1997) also compound the difficulty of unpicking the stitches. Our three strategies are presented below:

##### **Challenging the normalisation of high managerialism**

The constant references to market models at all levels produce normalisation: it is 'common sense' for public services to be bought like products and that the purchaser and provider are therefore separate. So this split becomes the unquestioned way of organising and talking about public services for managers. This is reinforced by the targets system and a consequent narrow frame of reference within a professional group and/or workplace.

We have enabled a reflexive awareness of individual managers' identity through locating them at the centre of the concentric layers from global to individual. This has helped them visualise how the intersecting layers of managerialism interact to produce their own acceptance of the market model. We critically examine the notion of the market and public choice theory within high managerialism. Callon maintains that markets, rather than being rational and decontextualised, are always 'entangled' in a 'web of relations' (Callon 1998:19). We ask managers to explore the multiple impacts of high managerialism in each layer, how it is enacted and its impacts on them. This is new information for them; they come from professional cultures which assume the neutrality of (managerial) practice.

After such a discussion, a manager commented on new awareness of 'circles, flow of management, where it all comes from, history, language'. Another asserted, '[it's] how to retain values and security in degenerate environments .....I am not a number!' A social services manager focused his dissertation research on the performance-related pay system in his organisation; this

enabled his colleagues to surface their negative experiences and review how they approached the process; it reinforced his action in supporting appeals against pay decisions made.

### **A strategy of naming and connecting up**

Within high managerialism connected issues are falsely separated and the material impact of policy and actions is discursively concealed. Performance management typically considers inputs, process, outputs and review without considering outcomes such as profit to shareholders or expanded opportunities for private business. Outcomes for the public sector are framed in terms of results for the public but not in terms of money flows to shareholders or top managers. 'Naming' profit, privatisation and their impact explicitly as a negative social result for the public sector is a powerful intervention that we have incorporated into teaching and materials. We have also explored how to surface the white dominance of the managerial agenda through explicitly naming whiteness (Macalpine and Marsh 2005).

We demonstrated the impact over time of high managerialism in building the table presented earlier. From their different professional and work experiences they each had a part of the picture but had not put it all together. They were astonished to see how pervasive privatisation has become over the last three decades. Following this discussion, two managers together left a budget meeting refusing to participate in implementing cuts.

We linked this table with broader impacts such as the widening gap between rich and poor and the resulting health inequalities. We also explored how qualified health workers are recruited into the UK at huge costs to developing countries, themselves subject to high managerial pressures from structural adjustment policies requiring them to reduce their public sector.

### **Taking a campaigning approach**

We have been curious about how embedded views in other fields have undergone radical shifts and how changes are achieved. Examples are the ban on public smoking, awareness of fair trade, debt, corporate power and climate change, and how grass roots global movements have developed on these topics. What we can learn about unpicking managerial stitches from these campaigns? We are struck by their use of discursive power and new alliances. Campaigns have enabled space for new stark voices from the south, and have produced simple disruptive statements such as 'Drop the Debt' ([www.jubileedebtcampaign.org](http://www.jubileedebtcampaign.org)) or 'Make Poverty History', 'End Poverty - Make Promises Happen' ([www.live8live.com](http://www.live8live.com)) aimed at corporations and governments. They have built extensive global alliances in the 'war of position' (Gramsci 1971 cited Levy and Newell 2002) linking diverse interests into single issue social movements through the internet.

What could managers learn from these campaigns? Can managers harness the clear voices of users and local movements to challenge global managerialism? As a step towards this, we have brought in to the education setting people from marginalised groups who use health and social care

services, such as a young man with learning disabilities, a stroke survivor, a group using mental health services. We have also invited in as speakers a low-paid care worker, a senior figure from London's Black Police Association, and a lesbian worker from a local forum representing LGBT communities forum. Another Black speaker offered an analysis of the reverberations today from the transatlantic slave trade which affect work relationships across ethnicities.

All of these had significant impact. We aim to explore in future how such alliances can impact further in the work place and in creating further discursive space there.

These three strategies – of challenging the normalisation of high managerialism, naming and connecting, and of taking a campaigning approach - are clearly interlinked. In practice we are aware that any explicit references to profit or capitalism are labelled 'political' and viewed as transgressive, which reinforces the silencing process. Like 'race', the subject of capitalism 'is considered a rude and transgressive one... a matter whose observation is sometimes inevitable but about which, once seen, little should be heard none the less' (Williams, 1997: 6). So using these strategies runs the risk of alienating some managers, while enhancing the awareness and agency of others.

## V Conclusions

We have charted the construction of high managerialism within the liberalised global economy. We have laid out the shifting contours of high managerialism as layers from the global, through the state and the organisation to the individual. We have explored how the inter-connectedness of these layers produces a hegemonic set of forces which makes the expansion of capital into the public sector a common sense. This is the common sense into which individual managers are stitched and within which their identities are constructed: 'An historical bloc ... exercises hegemony through the coercive and bureaucratic authority of the state, dominance in the economic realm and the consensual legitimacy of civil society.' (Levy and Newell 2002 p86-87).

We noted the assumption that public services can only be envisaged through the lens of a commissioner/provider, i.e. market, discipline. Previously managerial focus was on performance management – a direct tool. This has been much criticised and currently the commissioner/provider split can be seen as a more nuanced approach drawing on disciplinary technologies that persuade people there is no alternative. Thus the construction of older people or people with disabilities as '*heavy care packages*' is not challenged. This is a hegemonic process: but there is no clear evidence that splitting commissioning from service provision brings better social results.

To unpick these stitches is to restore autonomy and agency to managers so they can challenge the concept of the self-seeking individual at the core of the

market view of the world. We attempt this within our field of management education through three linked strategies:

- *challenging the normalisation* of the local/global market through locating the individual manager (and their identities) at the centre of contours of high managerialism
- a strategy of *naming* that links public sector management to global capital
- *taking a campaigning approach* through learning from others who have been successful in using their discursive power and new alliances

These efforts break a silence about the conversion of public funds into private profit and the global drivers that create this imperative. They constitute a transgressive act that is labelled 'political' within the alleged neutrality of the management academy. Similarly within organisations, this neutrality has been reinforced by Weberian concepts of the workplace as a neutral field, a hierarchy without bodies (Acker 1990). 'Neutral' post-holders are assumed to have no political views of their own. It is acceptable for managers to talk about national politics and policies, and their local equivalents. There is a 'din' about these continuously changing policies and targets, but a conspicuous silence about capital and its global reach that corrodes public managers' capacity to act.

In the context of public sector health and social care, our task is to legitimise the breaking of this silence. Our work involves both action for progressive change and public service improvement as well as a critical perspective. The danger is that critique becomes cynical commentary, while uninformed action can uncritically 'swallow whole' the managerial discourse (Macalpine and Marsh 1999). Education provides a space for enabling hard-pressed public sectors managers to avoid these dangers and pursue their values for public benefit.

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## Notes

<sup>i</sup> The term 'independent' is used by the UK government to include both private and voluntary sector providers, eliding the differences.

<sup>ii</sup> Murphy (2006) similarly has connected the global managerial order with organisational managerialism: 'the nascent global managerial order is built upon the intertwined material and discursive hegemony of a globalised power elite' (Murphy 2006:142). His overriding concern however is with this emerging elite across public and private sectors and civil society, rather than our focus on the construction of local managerial identities

<sup>iii</sup> An interesting comparative international study of the impact of public sector reforms on employment by Lethbridge (2006) shows that while there are broad trends towards more outsourcing and other forms of privatisation in the countries surveyed, the impact on workers including women workers is nuanced. In some countries such as Kenya, Tanzania and Uganda, there have been increases in jobs and in permanent contracts, contrary to the requirements of international finance institutions.

<sup>iv</sup> See Revolving Door ; a directory of people passing between government and the private sector. This website is run by the Center for Responsive Politics in US and enables anyone to track the movement of individual between corporate and public sector. ([www.Opensecrets.org/revolving/index.asp](http://www.Opensecrets.org/revolving/index.asp) accessed on 8.5.07. Examples are: Channing Wheeler, formerly with the US United Health Group as Vice President, recently appointed to head UK Dept. of Health Commercial Directorate, in spite of public sector union legal action still in process against him in the US for financial irregularities (Mooney 2007);

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Alan Milburn former UK Health Secretary of State, now adviser to Pepsi-Cola (Guardian 30.5.07 p.3

<sup>v</sup> This paper focuses on public to private shifts; we recognise that the community and voluntary sector play an increasing role and also represent a blurring of boundaries with the public sector, which for reasons of space we are not covering..

<sup>vi</sup> This table was constructed through our experience and reading, and in discussion with an inter-professional group of managers in health and social care. It is a snapshot as this terrain is constantly being re-landscaped

<sup>vii</sup> MA in Leading, Managing and Partnership Working at Thames Valley University