

Against excellence

According to Bill Readings (1996), the function of the university is shifting from education to administration. Thus 'teaching is the administration of students by professors; research is the administration of professors by their peers; administration is the name given to the stratum of bureaucrats who administer the whole'. We can see this, for example, in the way that teaching quality is assessed. When the Quality Assurance Agency for Higher Education (Motto: Promoting higher quality) last visited, they had little interest in the quality of my teaching. Indeed, they did not even bother to observe it. Instead, they wanted to know about curriculum design, student progression, learning resources, student support and quality management. In fact, in their 10 page report (QAA 2000), only a single paragraph was given over to an assessment of observed teaching sessions, and the evaluation was limited to noting that it 'confirmed that the University's objectives related to teaching and learning are being achieved'. Clearly, high scores in the QAA assessment are to be gained not through high quality teaching, but high quality administration and management.

I am not claiming that individual lecturers are no longer concerned with the quality of their teaching, nor that they, as individuals, no longer see themselves primarily as educationalists. However, we work in a culture where every mission statement is driven by a striving towards excellence ('The mission of the University of Portsmouth is to be a centre of excellence and innovation in education, etc, etc'). And since excellence is measured primarily by QAA scores, it is fairly clear where the university is going to focus its priorities. Indeed, lecturers need look no further than the encroachment of paper work and other office tasks into their day-to-day workloads to realise that the aim of the university has become administration; that is, the smooth progression of the student through the system from admission to graduation with the least fuss and discomfort to either party (despite the fact that

many educationalists would argue that education is *supposed* to be uncomfortable).

Readings (1996) argues that this state of affairs has come about because universities are being forced to regard themselves as businesses, as sites for the delivery of public services rather than as sites for education. Thus, the university sees the student as a paying customer, and as a customer who is paying for a qualification rather than for an education. This rather cynical view has recently been born out in the statement from the government minister for education that students should regard their time at university as a financial investment for the future rather than as an educational experience. What the customer is looking for is therefore not primarily a high quality educational experience but a high quality of customer service, and ultimately a qualification that they can literally 'cash in' in the workplace.

In nurse education, the situation is slightly different. For one thing, many of our paying customers are not individual students but consortia of healthcare managers and practitioners. But just as with individual students, they are primarily concerned with educational *product* rather than with educational *process*. What they wish to purchase is, by and large, a trained and (more importantly) qualified workforce. Again, this is not to say that individual managers in healthcare trusts are unconcerned with the educational experience of their workers, but that what the organisation *as a whole* values in a course is high and rapid throughput and low dropout rates.

However, my real concern is that what has been happening in higher education over the past 10 years is now being replicated in the health sector. We might argue, then, that the function of the National Health Service is shifting from health care to administration. Health service workers might like to think of themselves as working solely for the health needs of their patients, just as I might like to think of myself as working solely for the

educational needs of my students, but that is not how they are judged by the government. When the quality inspectors came to award merit stars for performance to my local hospital (Mission statement: to provide excellence of care and quality of treatment), they were not interested in health care per se, but were judging nurses and other health care professionals on their skills as administrators; on how patients and services are *managed*. We can see from the NHS Performance Ratings web site (NHS 2002) that stars are awarded for issues such as waiting times, discharge times and record keeping rather than directly for quality of care. Of course, quality of care is a factor, but only to the extent that it leads to a faster throughput of patients and shorter waiting lists. As far as the star rating system is concerned, it is largely irrelevant whether short waiting lists and high throughput are the result of successful treatment leading to discharge, or of unsuccessful treatment leading to death. And when data on success rates are collected, they are interpreted so naively that crucial factors such as socio-economic background and demographics are largely overlooked. Hospitals, and indeed, individual practitioners, are judged on how many successful operations they perform, regardless of whether their patients are predominantly young, well-fed, middle-class professionals or elderly, poorly nourished manual workers. Of course, one of the worrying effects of this attitude towards quality assessment is the fear that high-risk patients might be refused treatment in order to maintain high success statistics. In other words, management objectives begin to take precedence over health care objectives and patients become the means to the end of government targets rather than the end itself.

The problem, I suggest, lies in our obsession with excellence. It is perhaps no coincidence that the missions of my university and my local hospital both express a commitment to excellence (in education and health care, respectively), since most universities and healthcare trusts in the country see their missions in similar terms. The worry is not with excellence per se; after all, who could argue against it? The problem is rather with what it has replaced. Mission statements should explicitly state the *mission* of the

organization. To state that the mission is to achieve excellence says nothing about the mission itself, only the standard to which it should be achieved. As Readings (1996) observes, 'excellence' is non-ideological; it is value neutral. Or rather, it makes a value-statement without specifying what is to be valued. In stating that its mission is to provide excellence of care, my local hospital is leaving itself wide open for the government to define excellence (and hence, the mission of the hospital) according to its own agenda. And as we know, the government's agenda is with health *services* rather than with health *care*.

There is nothing wrong with the government's agenda of having 50% of all school leavers in higher education, nor with its agenda to reduce waiting times for hospital treatment to 6 months. But these targets are concerned with the management and administration of students and patients through the system rather than with the quality of education or care that they receive whilst they are in it. The problem is rather that, in defining their missions simply in terms of excellence, universities and hospitals are allowing the government not only to set their missions for them, but to specify how the success of those missions will be measured. Thus, my university (like most others) defines its success predominantly in terms of QAA and RAE ratings, and the new chief executive of my local health care trust sees his primary aim as to 'build on the recent hitting of waiting list targets, to improve our all round performance, *so we can significantly improve our star rating*' (Portsmouth Hospitals 2002, my italics).

In our scramble for political correctness, we have forgotten an important lesson. Education and health care are ideologically driven, and neither can be adequately defined by value-empty terms such as 'excellence'. If we decline to state our mission clearly and unambiguously, then we can hardly complain when someone else does so on our behalf.

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