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Scholarly Article

Reluctant public sector entrepreneurialism among clinical professional managers: corporate colonization in the English National Health Service

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In public service, the replacement of traditional professional and managerial cultures by a more entrepreneurial ethos has reemerged as a political goal in recent years, presented as a necessary response to acute fiscal challenges. In this paper, we consider the impact of increasing influence of enterprise and entrepreneurial discourses in the UK public sector, specifically in respect of healthcare in the UK. We examine the evolution of managerial and professional identities in healthcare in the UK, considering the evolution of health service management identities from administrator through leader to entrepreneur in the late twentieth and early twenty-first centuries. Drawing on an empirical study of a health care organization in the English National Health Service, we examine how engineered competition in this sector drives opportunistic entrepreneurial behaviour among staff, with direct implications for the identity and conduct of professional healthcare managers. Following Deetz on 'corporate colonization', we explore the perceived inevitability of this shift, even where it is felt that such changes occur to the detriment of professional and clinical concerns. We integrate these practical and theoretical issues together to critically evaluate how short-term entrepreneurial activity acts as a powerful organizing principle, at the risk of undermining the ethics of care.

KEYWORDS: public sector; entrepreneurialism; clinical; professional; managers; corporate colonization.

INTRODUCTION

The denigration of professional management as a concept and function has been observed across sectors for some years now (Khurana and Nohria 2008; Brocklehurst, Grey and Sturdy 2009) with increasing emphasis placed on more fashionable, more dynamic and purportedly less 'bureaucratic' alternatives, such as leadership (O'Reilly and Reed 2011) and consultancy (Sturdy, Wright and Wylie 2016). Public sector management has not been immune to these currents of changing managerial discourse, with various writers identifying the widespread stigmatization of professional management in favour of leadership, particularly in the healthcare context (e.g. Martin and Learmonth 2012; McDonald 2014). Concurrently, this sector has seen a trend towards increasing 'hybridization' of professional and management roles (Croft, Currie and Lockett 2015; McGivern et al., 2015; Noordegraaf 2015; Bishop and Waring 2016; Bresnen et al. 2018), while clinical professionals themselves are increasingly encouraged to assimilate responsibility for cost-effectiveness (Benton and George 2018; WHO 2024). This results in highly

varied roles and a greater degree of 'connectivity' in new hybrid professional identities (Noordegraaf et al., 2014; Kanon and Andersson 2023); a potential source of both creativity and anxiety (Swan, Scarbrough and Ziebro 2015). Building on the argument that denigration, hybridization and connectivity are all consequences of the shifts away from traditional bureaucratic forms of public organization in this and other public sectors internationally (Learmonth 2005; Noordegraaf 2007; Croft, Currie and Lockett 2015), we bring a renewed focus upon 'entrepreneurship' (du Gay and Salaman 1992) to this set of concerns. We argue that this renewal of the debate is necessary given the ongoing impact of enterprise and entrepreneurship in the contemporary English National Health Service (NHS), and the renewed appetite for Public Sector Entrepreneurship (PSE) (Torfing 2019; Vivona and Clausen, T.H, Gullmark, P., Cinar, E, Demicioglu, M.A 2024) in political discourse in response to fiscal and productivity challenges.

Discussions of enterprise and entrepreneurial behaviour in the public sector are not new (du Gay 1993; Hoggett 1996) and have been examined in detail in debates on 'enterprise culture', powerfully informed by the work of Paul du Gay and others in the 1990s and 2000s (du Gay and Salaman 1992; du Gay et al., 1996; du Gay 2000, 2004). The more ambitious claims made by both proponents and detractors of this shift—that enterprise would sweep away outdated bureaucratic modes of organizing—have proven to be exaggerated (Courpasson and Reed 2004). Nonetheless, at the same time there has been a normalization of enterprise in the last decade, built on a mythic faith in the transformative powers of the heroic entrepreneur (Ogbor 2000; Perren and Jennings 2005; Down 2006). Romantic and individualized notions of freedom, self-reliance, bravery, innovation, and creativity have served to legitimize the notion of entrepreneurship as a moral good in itself (Down 2010), as well as a vital ingredient in delivering economic growth or recovery (Weiskopf and Steyaert 2009; Torfing 2019). However, the linked assumptions according to which enterprise first displaces bureaucracy, as the *right way* to do organization, and secondly, translates unproblematically into economic and moral good, are topics of ongoing contestation (Tams and Marshall 2010; Goss 2016). In particular, the following contribution takes its lead from du Gay and Vikkelsø's (2016) reappraisal of enterprise culture, and its contribution to the 'disappearing' of the core concerns of 'task', 'purpose', and 'formal organization' itself, from the contemporary field of organization studies. In relating enterprise culture to Deetz's (1992) concept of 'corporate colonization', we draw out the professional, organizational and wider sociopolitical consequences of the resurgence of entrepreneurial public management that we describe.

We argue that reforms of the public sector in the UK over the past 10–15 years have facilitated the displacement of both professional and managerial 'ethos' with a more entrepreneurial orientation. Specifically, key aspects of the reorganization of the English NHS through the Health and Social Care Act (2012), such as the renewed emphasis on competition between providers and the greater freedom of hospitals to raise commercial income, enhance the reach and impact of entrepreneurialism in this sector (Department of Health 2010). Although the more recent Health and Social Care Act in 2022 adopts a language of collaboration over competition, this is impeded by entrepreneurial forms, relations, and mechanisms that have become embedded in the intervening period. These structural reforms drive new strategies in health providers, and this, alongside a revived discourse of enterprise, influences the identity and conduct of managers engaged in the organization and delivery of health and care (Saks 2013; Hodgson et al. 2021). Exploring recent changes in one health trust in England, we identify increased entrepreneurial opportunism among professionals and managers, often to preserve jobs and balance budgets, and the privileging of entrepreneurial acumen over professional (clinical) expertise. In line with Deetz's (1992) arguments on 'corporate colonization', we witness the normalization of this process even among the 'reluctant entrepreneurs' with deleterious effects on the ethos of care in such organizations.

The paper is structured as follows. We first consider debates on enterprise culture and entrepreneurs within bureaucratic and public sector contexts, revisiting the seminal work of du Gay and others, and link this with the broader concept of corporate colonization. We then trace the evolution of managerial and professional identity in the historical context of health service management (in the context of the English NHS), considering how discourses of professional/managerial identity have shifted; from managers being considered as administrators through to the formal introduction of the general manager role with an accompanying growth in hybrid managers with clinical backgrounds, and from there, the rejection of both these positions in favour of an identity as leaders and, latterly, as entrepreneurs. Following that, we turn to the impact of entrepreneurialism in our empirical case. Drawing on empirical data from one of three organizations involved in a larger ethnographic study of healthcare managers, we examine the emergence of an organizational strategy of market growth and diversification in response to sectoral reforms around competitive tendering. In this context, we consider how this has embedded enterprise

and an entrepreneurial ethos among staff, and in particular how professionals and managers, reconstituted as entrepreneurs, are both the target and the vehicle for such changes. To maintain position and defend jobs for themselves and their teams, we find that professionals and managers are driven to an increased entrepreneurial focus on identifying and securing market opportunities, which many feel is at the expense of a professional focus on the delivery of care. Finally, we consider the perceived inevitability of this process as discursive closure is reinforced through the normalization of 'corporate colonization' of public services, despite articulated misgivings of clinicians, managers, and clinician-managers.

ENTERPRISE AND ENTREPRENEURIALISM IN THE PUBLIC SECTOR

It is not a coincidence that the recent resurgence of political and media interest in Public Sector Entrepreneurialism (Hayter, Link and Scott 2018; Vivona and Clausen, T.H, Gullmark, P., Cinar, E, Demicioglu, M.A 2024) is mirrored by a growth in nonstandard employment in the UK in recent years, underpinned by deregulation. While politicians of the Right often celebrate the growth in self-employment in the UK as evidence of a new wave of entrepreneurship, researchers have identified a wave of involuntary or 'forced' self-employment resulting from the erosion of conventional employment structures and the unavailability of standard employment contracts and conditions (Kansikas 2007; Kautonen et al., 2010). The notion of the 'reluctant entrepreneur' has gained traction as a consequence, typically used to describe those forced against their will from standard employment into self-employment (Boyle 1994; Galbraith and Latham 1996). As we will argue below, forced entrepreneurship and reluctant entrepreneurs are not concepts limited to deregulated industries and self-employment in the 'gig economy', but rather the transposition of this economy back onto the changing face of state-led bureaucracies. To make this case, we must first return to the critical work on enterprise and entrepreneurship, before exploring the relevance of this to the contemporary public sector.

The concept of enterprise discourse, and the extension and promotion of entrepreneurialism across private and public sectors, was firmly established through seminal work by du Gay and others in the 1990s. In this work, du Gay describes 'enterprise' discourse as underpinned by the conviction that 'economic, political, social and personal vitality is considered best achieved by the generalisation of a particular conception of the enterprise form to all forms of conduct' (du Gay 2004: 38), a conception based on the inherent superiority of private sector market relations as a principle of organizing. On one hand, the impact of enterprise discourse can be traced through the fundamental reconstruction of industries, sectors and organizations, through deregulation, privatization or through the institutional of internal (quasi-) markets (du Gay and Salaman 1992)—a theme that will be familiar to any student of politics and economics in the West from the 1980s onwards. On the other hand, du Gay maintains that this process also depended in the late 20th century upon 'radical attempts to reconstitute the nature and conduct of management' (du Gay et al., 1996: 263), with the manager her/himself becoming the vehicle for transformation (Bresnen et al. 2018). Through the formation of entrepreneurial managers, both in standard large corporations and throughout public sector organizations such as schools, hospitals and public utilities, enterprise discourse, and entrepreneurialism were extended across and embedded in organizations, typically promoted as a solution to the limitations and dysfunctions of bureaucracy (du Gay et al., 1996; du Gay 2000). Llewellyn, Lewis and Woods (2007: 254) collate a range of terms which point to the extension of entrepreneurialism to the public sphere and capitalize on the attractive yet indeterminate nature of enterprise as a 'free-floating signifier', including 'civic entrepreneurship', 'community entrepreneurship', 'social entrepreneurship', 'public entrepreneurship' and 'policy entrepreneurship', which can be collated under the theme of PSE (Ostrom 1965; Hayter, Link and Scott 2018; Vivona and Clausen, T.H, Gullmark, P., Cinar, E, Demicioglu, M.A 2024).

This movement parallels and echoes many of the debates and changes subsumed under the concept of New Public Management (NPM) since the 1980s (Hood 1991; Pollitt 1993; Kirkpatrick 1999). Such debates over NPM have typically centred on the way in which political ideas about the proper and efficient delivery of public services have been reshaped in the last 40 years, with greater faith in the value of extending private sector dynamism and assertive managerialism to noncommercial or public sector activities. Writers such as Osborne and Gaebler (1992) have celebrated this transformation as the reinvention of the public sector in a new, entrepreneurial form, and various attempts have been made to list the features of NPM (cf. Hood 1991; Pollitt 1993). It was, however, apparent by the mid 1990s that there are numerous varieties of NPM in policy and in practice (Ferlie et al., 1996; Kickert 1997), and given the inherent ambiguity which resulted from this, it was suggested by the early 2000s that 'the term is also too crude (to capture) the fine-grained distinctions between different sorts and themes of managerialism' (Hood 2002: 12555). Enterprise and

entrepreneurialism thus are not inherent to NPM, but certain NPM-inspired reforms are particularly focused on generating the conditions in which entrepreneurial orientations and behaviours can flourish in the public sector. These conditions include the delegation of strategic and operational independence to public sector organizations and leadership, the enforced hybridization of professional roles, and, pivotally, the engineering of market competition in public services. When describing this transformation, however, du Gay underlines John Law's (2002: 34) important distinction drawn between the behaviour of the paradigmatic, free-market entrepreneur and artificial efforts to recreate or 'mimic' this behaviour in the public sector through 'a relatively limited repertoire of formal administrative mechanisms' (du Gay 2004: 38).

In principle, this movement reflects the 'post-bureaucratic' turn in the private sector (Heckscher and Donnellon 1994; McSweeney 2006), and there are many parallels between the drive to place enterprise within public sector organizations and an older discourse which sought to do the same within private sector corporate bureaucracies (Kanter 1990). The creation of this 'corporate entrepreneurship' (Stopford and Baden-Fuller 1994), or 'intrapreneurship' (Pinchot 1984), required the formation of an environment within which employees act as if they were 'in business for themselves', in terms of their appetite for risk, their sensitivity to opportunities, and their willingness to accept the responsibility for making entrepreneurial decisions within the corporation. Pongratz and Voß (2003) extend such arguments by highlighting the pressure on individuals at all levels to reconsider their role in the workplace, described as the emergence of the 'entreployee' who takes on more individual responsibility and acts in a more entrepreneurial manner than the traditional worker. More recently, the concept of the 'street-level policy entrepreneur' (Oborn, Barrett and Exworthy 2011; Bailey et al. 2017) has emerged, in order to account for the new opportunities, which were unavailable to the former 'street-level bureaucrats' (Lipsky 2010), in marketized public institutions where the line between reforms and their implementation are increasingly blurred. Recently, this debate has been drawn together as a debate on PSE (Hayter, Link and Scott 2018; Vivona and Clausen, T.H, Gullmark, P., Cinar, E, Demicioglu, M.A 2024), which largely promotes and celebrates this as the pathway to more innovative and dynamic public services.

Importantly, much of this work focuses less on the structural conditions for entrepreneurship and more on efforts to spread the entrepreneurial 'mindset' (Kets de Vries 1996; Torfing 2019) into public and private large organizations, by transposing entrepreneurial values from the archetypal self-employed business owner to the corporate manager, civil servant or shop-floor employee. As Scharff (2016: 109) notes, the enterprising self is 'bound by specific rules that emphasize ambition, calculation, accountability and personal responsibility'. This recalls the original focus on enterprise discourse working on and through the self as 'the self-actualizing capacities of individuals become aligned with the goals and objectives of the organisation' (du Gay 1996: 130). While for some writers (e.g. Sennett 1998), this reflects a social change in our conceptions of work and employment in developed countries, others have focused more directly on the reconstruction of managerial identities in public sector organizations post-NPM (Thomas and Davies 2005; Llewellyn, Lewis and Woods 2007). This has inspired a body of work which looks in more detail at how individuals 'do enterprise' (Cohen and Musson 2000; Tams and Marshall 2010; Goss 2016) in practice, and how particular subjectivities are promoted while alternatives to enterprise and entrepreneurship are simultaneously repressed (McCabe 2008; McNay 2009). It has also been argued that, while we should be wary of exaggerating the power of a monolithic discourse of enterprise (Fournier and Grey 1999), it may be that 'even if people do not take the enterprise culture seriously (…) they are inevitably reproducing it through their involvement with the daily practices which are imbued with the notion of enterprise' (Cohen and Musson 2000: 31).

More broadly, it can be argued that the normalization of entrepreneurial behaviour in the public sector is underpinned by Deetz's (1992) concept of 'corporate colonization', used to describe the process by which market relations and market ideology are naturalized, neutralized and legitimized across all areas of society. Deetz argues that 'the modern corporation has emerged as the central form of working relations and as the dominant institution in society (…) eclipsing the state, family, residential community, and moral community' (Deetz 1992: 2). Crucially, for our understanding of the public sector, this legitimizes the entry of an economic/commercial logic into the business of state so that 'the state becomes the most powerful promoter of commercial organizations as the means of fulfilling its public obligation' (Deetz 1992: 20). This process is supported by efforts to suppress alternative explanations and to 'preclude careful discussion of, and decision making regarding, the values implicit in experience, identity, and representation' (Deetz 1992: 188–89). In line with work on the 'enterprising self', corporate colonization works through the identity and conduct of those located in such settings, affecting not only the manager *as* entrepreneur, but invoking and embedding these 'entrepreneurial selves'

within a range of 'private sector-like' relations, including notions of free markets, private risk/private benefit and the beneficial consequences of competition, and enrolling citizens themselves also (Bovaird 2007). This shift is accompanied by changing behaviours as the organization and delivery of public services is imbued with alternative values, including flexibility, innovation, opportunism and willingness to take risks. Critically, by rendering such changes apparently normal or 'inevitable', corporate colonization creates discursive closure around the commercial values and undermines the perceived ability of those engaged in this process to challenge or defend alternative values.

There is a danger of attributing sweeping and rather deterministic powers to this process, a challenge often levelled at more abstract work on neoliberalism and, indeed, enterprise discourse (Fournier and Grey 1999). Key to Fournier and Grey's (1999) critique is the claimed overreliance of enterprise discourse on a hard distinction between bureaucratic and nonbureaucratic forms. In response, there is a need for more empirical research on the lived experience and implications of entrepreneurialism in the public sector (Llewellyn, Lewis and Woods 2007), where it might be expected that this process would face stronger challenges from complex bureaucratic governance frameworks and, here, effective resistance by the powerful clinical professions which dominate healthcare (Bolton 2005; O'Reilly and Reed 2011). Llewellyn et al note, 'it is important that we understand how individuals such as public sector managers involve themselves in "the practices of subjective self-constitution" (…) and how these involvements connect with the social activities of managing'. (Llewellyn, Lewis and Woods 2007: 264). In connecting enterprise to the concept of corporate colonization as we have sought to here, our intention is to draw out both the individual and social costs that enterprise and entrepreneurialism bring to a sector in which public goods and the professional ethos are at stake. In bringing these concepts together, we are alerted to a distinct set of dangers, associated with the idea of discursive closure and the increasing dependence of the State upon corporate forms. These dangers relate to the relegation of resistance and other agentic human responses, such that resistance to corporate ideology cannot be separated entirely from internalization (c.f. Waring 2007); consistent with the totalizing effects of *colonization* (e.g. Said 1978). This helps us to explain how the nominal change in direction from competition to collaboration in the more recent UK Health and Social Care Act (2022) will be unlikely to generate meaningful changes in organizational or individual behaviour. By focusing down upon the experience of acting entrepreneurially grounded in a particular setting, and in light of historical shifts towards enterprise and entrepreneurialism in a particular sector, we aim to situate these discursive forces securely in the site of their enaction. This historical context will be addressed in the next section.

'LIBERATING THE NHS': EVOLUTION OF THE HEALTHCARE MANAGER IDENTITY

Although frontline services may, for a time, remain relatively unchanged during health service reforms, they certainly affect professionals and managers who are cast in a variety of roles as they are required to perform distinct and competing functions. This section provides a brief overview of government policy, informed broadly by New Public Management, as it has prepared the NHS for commercialization (Hodgson et al. 2021; Sheaff et al., 2024) and how it has affected NHS managers (for a fuller account of NHS policy reforms, see Harrison and McDonald 2008). These changes can be broadly grouped into five stages of NHS reform that have cast managers into various roles: administrator, bureaucrat, business person, leader, and, most recently, entrepreneur.

1. *1948–82: the manager as public administrator*

The NHS, founded in 1948, operated as a professional bureaucracy with clinicians exerting considerable influence and autonomy. This logic meant that management in the NHS operated on the principle of consensus, relying on agreement between members of the medical profession and hospital administrators—while accepting that medical professionals held the dominant position. The first major reorganization of the NHS took place in 1974, bringing together GPs, community and hospital services into single local NHS organizations. Decision-making continued to follow a triumvirate, consensus management arrangement. Throughout this period GPs and consultants shaped service development. The net result was that management plans, decisions and capital expenditure reflected their priorities. Managers, as *administrators*, had a relatively clear identity, being inward-looking and reactive, solving problems and gathering resources to satisfy their medical staff (Harrison and McDonald 2008). Future waves of reform led to increasingly complex interweaving of commercial/competitive, clinical professional, and statist/public service logics.

2. *1983–88: the manager as bureaucrat*

In 1983, in line with the new Thatcherite political philosophy dominant in the UK, an inquiry into NHS

Management led by Roy Griffiths, Chairman of Sainsbury's supermarkets PLC and the subsequent Griffiths Report (1983) institutionalized management in the NHS and reaffirmed the professional identity of managers, whose role was to control clinical activity, budgets and performance. Attempts to manage perceived declining NHS performance included two changes in 1983. The first saw the introduction of annual top-down reviews against a rudimentary set of performance indicators. These reviews allowed the performance of local health authorities to be compared. Although these reviews were said to have had little immediate effect (Harrison and McDonald 2008), they did institutionalize the idea of performance against quantitative targets. The Griffiths Report also attempted to abolish 'consensus management' in favour of 'general management' and provided the structural arrangement for a 'rational' management system. Griffiths' recommendations generated a long-standing rift between clinicians and managers, displacing the professional identity of clinicians in the process under consensus management. Management budgets were introduced alongside greater financial controls. Managers, as *bureaucrats*, became more responsive to government demands.

3. *1989–96: the manager as business person*

The period from 1989 to 96 saw the first attempts to prepare the NHS for market competition, advancing and extending the Thatcherite politics of markets and competition in public services. The 1989 White Paper 'Working for Patients', passed into law as the NHS and Community Care Act in 1990, introduced an (internal) quasi-market for health care by encouraging services to split along 'purchaser' (Health Authority and some GPs) and 'provider' (acute, mental health, ambulance and community) lines. Purchasers were given budgets to buy health care from providers, while providers became NHS trusts (independent organizations with their own management teams) and trusts would then compete with each other to provide services to the purchasers. Between 1991 and 1995, all providers became NHS trusts. GPs could also hold budgets (GP fund holding) to purchase care for their patients from the NHS or private providers. As well as attempting to extend managerial control of services, these changes were also designed to introduce competition and a business culture akin to the private sector. The management role was thus orientated towards *business* matters, but accompanying this shift was a growth in professional-manager hybrid roles with clinical backgrounds, with profound effects on the professional identity of clinicians adopting these roles (Croft, Currie and Lockett 2015; McGivern et al., 2015; AUTHOR 3, 2019)

4. *1997–2009: the manager as leader*

With the election of the New Labour government in 1997 came a centralization of NHS management and an emergent culture of 'leaderism', where the new NHS manager was someone capable of leading change and, counter-intuitively, of simultaneously being directed by the national agenda (Bresnen et al. 2015). This period saw the introduction of a star rating system for NHS organizations as trusts were rated by the newly established Commission for Health Improvement (CHI). Although national targets were later abandoned, along with the star rating system, priorities continued to be indicated through the annual Operating Framework for the NHS, published each year, and by the creation of the National Institute for Clinical Excellence (NICE), which had responsibility for making decisions on the adoption of treatments. These two institutions (CHI and NICE) took control of areas previously controlled by the medical profession, further constraining the professional identity of senior clinicians in the NHS. Decisions about suitable treatments were now being made by NICE, and clinical governance was being carried out by CHI, subsequently named the Health Care Commission, and then the Care Quality Commission.

Although targets and associated penalties were initially successful in reducing waiting times, the negative consequences of top-down micro-management and intense centralized control preceded a radical change in direction towards decentralization and the re-adoption of market-based reforms (Ham 2004). These reforms included the promotion of patient choice and competition between providers as well as encouraging healthcare organizations to adopt not-for-profit structures as 'NHS foundation trusts'. Through this process of 'corporatization', enhanced performance was expected through 'giving managers enhanced freedom to pursue service innovation and making public services more "business-like"' (Kirkpatrick, Altanlar and Veronesi 2017: 2). In practice, this layering of different logics was not without its challenges and contradictions, reflecting the tensions within the politics of the New Labour government.

The first wave of foundation trusts came into being in 2004. At the same time, the previous system of block contracts to service providers was replaced by a new funding system of Payment by Results, very much aligned with the New Public Management logic (Hood 2002). This system was aimed at reducing waiting times by targeting payments towards specific treatments and thus providing a powerful incentive for trusts to direct activity towards areas of greatest need. This period encapsulated ideas of

the manager as *leader*—leading change while complying with rapid-fire structural and policy changes—extending and transforming the professional identities of both general/functional managers and professional hybrid managers.

5. *2010–date: the manager as (reluctant) entrepreneur*

The first White Paper of the Conservative-Liberal Democratic coalition government in 2010, 'Liberating the NHS', brought health policy almost full circle by proposing the removal of management layers to improve efficiency (promising to reduce management costs by 45%), reflecting a key tenet of the policy of austerity enacted from 2010 which focused on removing management costs and perceived bureaucracy in public services. The Health and Social Care Act (Department of Health 2012) took the changes even further by making explicit provision for commissioning from the private and voluntary sectors. 'Liberation' came to refer to the liberation of commissioners to contract 'any qualified provider' in a competitive consumer market. At the same time, providers were 'liberated' from regulations on commercial income, and any foundation trust was now permitted to raise up to 49% of its total income by commercial means (Exworthy and Lafond 2021). Thus, managers of provider services had to become increasingly *entrepreneurial* in a multi-commissioning, competition-driven health service, and healthcare professionals increasingly driven to engage in a collaborative, inter-professional manner and aligned with newly 'liberated' management in a more connective, hybridized fashion (Saks 2013), with profound effects on the professional identity of managers, clinicians, and hybrid clinician-managers.

These changes were moderated somewhat by the 2022 Health and Care Act, removing the emphasis on competitive retendering in favour of more collaborative and integrated delivery of healthcare services through regional Integrated Care Systems (ICSs). This does not, however, remove competitive processes around tendering, but provides ICSs with a broader range of options for commissioning services from providers, and the cultural shifts within providers persist as the new model beds in.

The study here seeks to contribute to a theoretically informed analysis of these ongoing changes. In particular, the research seeks to understand how, driven by structural and policy changes, notions of entrepreneurship are absorbed, interpreted and affect both the identity and actions of healthcare managers, as corporate notions of 'business' are explicitly and implicitly imported into parts of the English NHS.

METHODOLOGICAL APPROACH AND ANALYSIS

This paper draws on a qualitative study of a diverse sample of managers in the English NHS funded by the National Institute of Health Research (NIHR) Health Services and Delivery Research programme (DETAILS REMOVED). The research examined approaches to learning and sharing knowledge, networking practices and identity among healthcare managers in three NHS trusts. The healthcare organizations that participated in the study included one general hospital, one mental health and community care organization, and one hospital providing specialist, tertiary care. This paper focuses on the mental health and community trust, referred to here as Care Trust, where a dominant theme in the accounts of managers and hybrid managers was the extent to which their identities and activities were shaped by commercialism and competition. This reflected the fact that Care Trust was most exposed to commercial contracting and competitive tendering at an early period of the most intense era of competitive tendering (2010-2022), and had developed an explicit strategy to confront and take advantage of the conditions faced. In Care Trust, the case can therefore be taken to be an 'extreme case' (Miles and Huberman 1994) although not a 'deviant case', as similar accounts were found in the other organizations studied, particularly in the specialist trust, less so in the general hospital. The specific nature of commercialization in the specialist trust in this study has been explored in a separate paper by the authors (CITATION REMOVED).

The research was structured around formal, semistructured interviews with middle to senior-level managers in each trust, augmented by observations of meetings and other events. Within each organization, managers were selected on the basis of a framework that differentiated across a broad continuum between three broad clusters of managers—general/operational, functional, and professional hybrids. Within each cluster, the managers selected for interview and observation had mid- to senior-level responsibilities (with the exception of clinical staff, who were employed on clinical grades, this corresponded mainly to people working at Grade 8 or 9 of the Agenda for Change in the UK). Semistructured interviews were conducted by two members of the research team. A total of 68 formal interviews were conducted and transcribed (see Table 1, below). The study reported here draws upon the 25 interviews conducted within Care Trust. Within this trust, the majority of managers had a clinical background and thus could be described as hybrid managers (McGivern et al., 2015; Noordegraaf 2015; Bishop and Waring 2016; AUTHOR 3, 2019).

Table 1. Interviewees: Position and Demographic Information

Name	Role	Division	Gender	Group	Grade	Management training	Age	Years in post	Years in org	Years in NHS
Robert	Clinical Director	Rehab	Male	Clinical	Con	Some	30–40	6	9	17
Jenny	Clinical Director	Drug & Alcohol	Female	Clinical	Con	Minimal	40-50	5.5	5.5	23
Alice	Clinical Director	Psychology	Female	Clinical	8d	Minimal	50-60	5	24	30
Glen	Integrated Governance Manager	Governance	Male	Clinical	8d	Substantial	40-50	3	3	25
Thea	Modern Matron	Specialist Services	Female	Clinical	8a	Substantial	40-50	3	19	26
Leo	Lead Occupational Therapist	Rehab	Female	Clinical	7	Minimal	40-50	10	10	12
Harriet	Operations Manager	Learning Disabilities	Female	General	8c	Substantial	40-50	1	1	29
Gabrielle	Service Manager	CAMHS	Female	General	8b	Some	40-50	6	19	19
Hasin	Operations Manager	Rehab	Male	General	8b	Some	40-50	1.5	19	22
Heather	Operations Manager	CAMHS	Female	General	8b	Minimal	40-50	1	4	25
Jocelyn	Service Manager	Psychology	Female	General	8b	Some	50-60	4.5	20	30
Kerry	Operations Manager	Drug & Alcohol	Female	General	8b	Substantial	40-50	4.5	7.5	11
Laura	Service Manager	Psychology	Female	General	8b	Minimal	50-60	5	31	37
Luke	Service Manager	Rehab	Male	General	8b	Some	30-40	4	9	12
Beth	Service Manager	Rehab	Female	General	8a	Minimal	50-60	2	17	32
Elena	Service Manager	Rehab	Female	General	8a	Minimal	40-50	1.5	24	29
Justine	Service Manager	Drug & Alcohol	Female	General	8a	Minimal	40-50	9	12	23
Ross	Service Manager	Drug & Alcohol	Male	General	8a	Substantial	50-60	5	8	12
Kate	Service Manager	CAMHS	Female	General	8a	Some	40-50	4	4	25
Carl	Head of Performance & Information	Governance	Male	Functional	8c	Substantial	30-40	3.5	6	11
Ruth	Head of HR	HR	Female	Functional	8c	Substantial	50-60	0.3	1.5	34
Emma	Head of Business Planning	Business Planning	Female	Functional	8c	Substantial	40-50	1	1.5	25
Graham	Head of Financial Reporting	Finance	Male	Functional	8b	Minimal	40-50	4	10.3	18.5
Roger	Head of Facilities	Estates	Male	Functional	8b	Substantial	50-60	3	24	24
Theresa	HR Business Partner	HR	Female	Functional	8a	Substantial	30–40	3.5	3.5	7

Data from the interviews were coded and analyzed using NVivo software. Interview transcripts were initially coded independently by two members of the research team using open coding techniques (Strauss and Corbin 1990). Codes were then compared and discussed with a third member of the team to establish a common lexicon for interpretation and analysis, which evolved inductively throughout analysis in line with the exploratory nature of the research. For this paper, analysis focused on a set of nodes related to 'commercial orientation' and 'public versus private sector' issues in Care Trust. These were then framed by re-analysis of descriptive contextual nodes addressing 'change', 'growth', 'competition', 'reform' and 'reorganization' in Care Trust.

STRATEGIC CHANGE AT CARE TRUST

Care Trust was created as a mental health trust in the early 2000s as the amalgamation of several smaller locality-based mental health providers. After gaining Foundation Trust status, a central corporate function was created, in separate premises, with the original provider services reorganized into divisions and service managers at each locality level reporting to a divisional manager. During this time, the organization also expanded beyond providing 'traditional' mental health services by incorporating services for learning disabilities, drug addiction, and veteran and forensic psychology.

> *Our board, and particularly our chief exec, are ambitious and driven and, I think, if there's opportunities for us to grow, we will do, we've always sought to meet our financial targets in two ways: one is to make savings; but the second is to grow and we've always bid for new services. One thing we've been very successful on is providing services that other organisations have provided at a greater cost to us, particularly private sector organisations with very specialist services.* (Roger, Facilities Manager)

Following the dissolution of Primary Care Trusts in England, the organization won short-term contracts to provide community services in three out of the four areas in which it operated, in addition to two new areas where it had no history of provision. As we began the study, the organization had just completed the transfer of community services, which doubled the size of the organization and replaced its function as a 'mental health trust' with a new broader function as an 'integrated care trust'. The strategy was to grow in size and then reduce the number of managers.

> *We've had three PCTs join us, each with a HR team; a smattering of people generally, rather than a sort of full complementary team. Because obviously, some work had to happen with the PCTs to make sure that they were… you know, efficiencies were made before that date. So as a result, for corporate services, every single service has had to go through a reorganisation… For example, we've got* (PCT HR director)*, there was no other directors that came across. We had a head of HR here. We had another head of HR come across. In terms of HR managers, HR business partners, there's now ten of us rather than four. So there's a lot of restructuring that's currently going ahead. We've had a new structure proposed, we've consulted, and now we've got a final structure. So that will all be rationalised out, and we're losing some posts as a result of that.* (Theresa, HR Business Partner)

A strategic model emerged through this period, based on growth through success at competitive tendering and diversification, accompanied by ongoing restructuring to increase efficiency. This strategy, to find new business and cut costs, drove managerial activity at the Trust. Entrepreneurial behaviour involved two strategies. Firstly, to build on specialist capabilities within Care Trust, and secondly, to win any contract to protect the core business. This phenomenon was described as a 'private sector' way of doing things;

> *So whereas some of the more district services are trying to rationalise and cut down on nurses on wards, et cetera, we're getting new business in, from, say, drug and alcohol services, winning business there. We're getting growth opportunities from the private sector into rehab services… it's great to be sat round the table on, you know, negotiations with local businesses around well, what can we offer and how much that's going to cost, and what the return on investment will be for you. And being much more business focused about things, which is, again, sort of returning almost to the private sector and the way that they do things.* (Theresa, HR Business Partner)

The managers at the trust were acutely aware of the threat to jobs if they could not make savings or find new business;

> *Lots of people have been downgraded. Lots of people have been made redundant. And although part of our other job has been to make big efficiency savings, I've not made anybody redundant yet. I'm sure that will come if we don't manage things well… there is an encouragement of new business ideas. Whether they actually get further is another thing but you don't have to make as many efficiencies if you bring in some more money as well.* (Alice, Clinical Director)

The strategic response of Care Trust to the reforms implemented through the Health and Social Care Act of 2012 was therefore to pursue growth through competitive success, marked in terms of the acquisition of new contracts. This strategy typically involved diversification and a broadened portfolio of commitments, and depended upon regular restructuring to integrate these operations while at the same time making ongoing efficiency savings to ensure they could tender competitively for these contracts. As described by one clinical director, the only way to avoid redundancies was to bring in 'some more money'.

THE RELUCTANT ENTREPRENEURS

The recent history of Care Trust, its acquisition of new services and extension of its 'core business', meant that the organization now needed to operate with significant fluidity. However, managers came to experience this fluidity as precarity, as a tension inherent in the attempt to reconcile the twin strategies of expansion and protection of core business. By examining the tension between these strategies we present an empirical picture of the consequences of the reinvigorated competition in the NHS; between the political conditions which were perceived by managers to be driving the changes to their work, and their *reluctant* participation, which reinforced those perceived conditions—as one of the service managers explained;

> *My level of manager tends, in the NHS, to come from a clinical background. And I think it's very challenging for them because we're asking people to work in a different way, we're asking people to look at things from a business perspective. And it's not something that people are familiar with and it causes lots of cognitive dissonance for them in terms of how they put those two things together.* (Beth, Service Manager)

These managers recognized their disadvantage when competing against independent health providers and were fearful of losing their short-term contracts to more 'business savvy' contractors. Constant competitive threat made it more difficult to maintain a clear strategic focus;

> *I do see the independent sector as taking on more of this… Because I think where the independent sector is at the moment, they've got a better head on the way, because they're more focused. Our Trust has, you know, ten different types of services it provides. … I think NHS services, if it carries on the way it is, have to start to take on a bit of everything* (Robert, Clinical Director)

The discomfort in this regard reflects a perception that independent sector providers already benefited from the flexibility and financial support necessary to select and take advantage of opportunities with little notice. To cope with this competitive threat, a move away from 'amateur' status was seen as essential;

> *I do sometimes think we're the amateurs though, because we're only just getting into it. And, you know, if you've got a big organisation, an independent sector organisation with a lot of money behind it, you know, they can act quickly, develop things much quicker than we can. We've been fairly lucky recently, but, you know, they've got a good idea to fill a niche market, they can move in quickly, whereas we haven't been able to. I see that changing. I see that perhaps if we do become more competitive, or at least financially independent, then there's going to be a lot more work around, you know, identifying niche services* (Robert, Clinical Director)

In contrast to involuntary entrepreneurs whose position arises from an absence of other employment opportunities, we conceived of these managers as a group of reluctant entrepreneurs whose institutional embeddedness (Garud, Hardy and Maguire 2007) encouraged them to maintain organizational financial viability through entrepreneurial activities such as bidding for any available health contract, as well as trying to develop niche, high value, specialisms. This was described by one manager as follows;

> *And then another big part of the role which has absolutely taken off in the last 12 to 18 months is new business… this huge up-rise in competitive tendering that's taken place over the year actually is significantly different... And they're a bit like buses, unfortunately, tenders. They seem to come along in threes.* (Emma, Head of Business Planning)

The pressure was to go for any contract that would allow the organization to grow, and then retrospectively build a narrative which gives the appearance of coherence and strategic focus. Practical concerns about organization and delivery appeared to be second-order concerns;

> *So for me, you start to build a story around that. And that's how I would want to make sense of the world and say right, those areas where we can tell that story, we understand what our strengths are, we understand what we've got to offer; let's focus our efforts on winning new business in those areas. (…) And then we'd go down the list and then we'll say, right, well, this tender's come out,*

> *yeah, we'll go for it; this tender's come out, yeah, we'll go for it.* (I: So it's all about going for new business regardless?) *Just growth regardless. And, you know, I've introduced the scoring mechanism and I'll say well, you know, it's 50 miles away, how would the management structure work. They don't want to talk about it, quite frankly, they just want to win the new business.* (Emma, Head of Business Planning)

In practice, reluctance reflected the time committed to the process of identifying opportunities and developing bids, affecting their ability to commit to delivering services;

> *I do think about tendering issues, which are essentially about relationships with commissioners really a lot of the time. And my colleagues do, and we spend an inordinate amount of time actually involved in the practice of tendering. You know, as I say, there's a tender all the time going, and it is time consuming as it is. You know, because we've got the day job to do at the same time as well* (Ross, Service Manager)

These managerial entrepreneurs perceived this as a forced undertaking in the sense that they felt that they had no option but to tender for contracts and commit to growth in order to sustain the 'day job': win the contract or lose jobs;

> *Essentially they see it as their jobs are on the line always, you know. And I have to strike a balance between stick and carrot, well stick and stroke in the sense that it is true, unless we perform to the best of our ability in terms of our outcomes - you know, which are all up there, I've got sheets of them what we've got to do - unless we keep doing that pretty well, and we are pretty good, we are not going to get re-tendered; which means that, you know, they will actually move into the third sector or private sector. They might find their terms and conditions retained for some time, but you only have to do a reorganisation, technological, economical, whatever it is, you know. Or you might even be made redundant, which has been the experience of [another service in the region], you know… wholesale redundancies… You know, so they are fearful* (Ross, Service Manager)

Managers as reluctant entrepreneurs were therefore working increasingly hard to sustain existing business. This was achieved by bidding for short-term contracts and, where successful, stripping out management layers from the new business thus increasing the workloads of remaining staff.

CONSEQUENCES OF ENTREPRENEURIALISM AT CARE TRUST

The move towards regularly retendering services meant that managers were trying to gain skills in selling services they had provided for many years. Their attention was diverted away from the specific care provider focus of the trust with constant pressure to be winning the next contract;

> *What's happened in the drugs field has pre-figured some of what is to be in the NHS, in the sense of, if you like, a dismantlement and, you know, a privatisation of the NHS. Because for the last ten years the drug action teams, 149 of them up and down the country, have been de-tendering and re-tendering, and it's been an inexorable decline of the NHS in that. Most tenders that now go out to tender - and there's a tender out every month virtually across the different country, you know, if there's an incumbent NHS provider, they'll be lucky to retain it.* (Ross, Service Manager)

After Deetz (1992), the imperative to adopt business perspectives was widely recognized, even as interviewees raised concerns about the relative importance of clinical expertise. Clinical managers found that their clinical concerns were relegated in favour of 'good business' skills and capabilities;

> *… when I talk about clinical skills, and they say 'oh well, that's not necessarily important, it's about the transferrable things'. I think people will in the future think it is less about the clinical side of things, I really do think it'll be more the business things, being able to present things, being able to speak, being able to be a chair of a meeting and lead that in a way. And hopefully make sure you've got some good clinical people that are working beneath you that are feeding up the information that you need to know…* (Elena, Service Manager)

Bidding to retain existing services involved not only managers, but also doctors and other clinicians, which could divert activity and effort away from developing professional expertise;

> *I was involved in a tendering process, and the first time I've ever been exposed to anything like that. As a doctor you don't, you kind of don't expect anything like that… The amount of work and effort that went into that just trying to convince somebody that we could provide the best care, even though you've been doing that for years, you know, then having to demonstrate that against the*

> *new kids on the block coming in, just to say well we can do it at half the price and so much better. That was a whole new experience. I see that happening more and more* (Robert, Clinical Director)

Regular tendering for services at competitive prices created a dual process of good business processes driving down costs and attempts to sustain levels of care quality, with increasing work intensification in prospect as a consequence;

> *Unfortunately, I do think patient care will suffer because of* [competition]. *And I still try, you know, whatever we do, we always try to ensure that patients get the best care. But I suppose it's going to be, how can you ensure that in, with all of those other pressures going on? So I think, it's almost two parallel processes isn't it? You've almost got to convince, you've got the management side convincing people that this is what's absolutely needed, but then still trying to do your best with the actual care giving side of things. I think in my position it will become much more, not much more but relatively more strategic. Looking at how can we, with the resources that we have, how can we possibly come up with a service that's competitive? And it's going to take some, you know, trying to convince for example my consultant colleagues that, you know, you're going to have to take on an extra 10 patients each or something like that. That's going to be a difficult one to sell.* (Robert, Clinical Director)

Despite these concerns, there was little evidence in the accounts of alternative values or approaches being presented, or of a serious contestation of the strategy embraced by Care Trust. As the strategy was legitimized with reference to higher-order explanatory devices such as 'the market', or competition, such forms of conduct, while regretted, were nonetheless normalized in this trust as being part and parcel of providing care in the new NHS.

DISCUSSION: DOING BUSINESS IN A COMPETITIVE NHS

Our presentation of data was concerned initially with establishing the meaning and purpose of entrepreneurial behaviour, which can be read from general, functional and clinical managers' accounts of their work in Care Trust. We theorize the development of health services managerial identities as both the product of, and site for, a form of reluctant corporate entrepreneurialism. On the basis of this research, it is argued that NHS organizations represent sites of organizing where corporate colonization (Deetz 1992) intensified post-2010 beyond what was experienced in previous phases of NPM reforms. Here we see the extended role of competition in the English NHS, driven by the legislation that has opened the door to 'any qualified provider', driving changes in organizational strategies in this sector. These changes feed through and rely upon a transformation in the identity and conduct of healthcare managers and professionals.

Organizationally, the corporatization effects of a fairly consistent market-oriented trajectory in policy making in the English NHS since 2001 have been to create the potential for 'two-tier' healthcare organizations, characterized by a split between operational units focused on service delivery; and corporate centres, focused on developing and implementing corporate strategies, business plans and policies. These centres have gained security and legitimacy through the policy changes of Labour, Coalition and Conservative governments since the introduction of the internal market—manifested in the purchaser/provider split, payment by results, the spread of performance indicators and the openness to competition and commercialization provided by the Health and Social Care Act of 2012. Taking Care Trust as an exemplar, we can see that the service delivery end of the organization then becomes, to some extent, caught in the flow of shifting patterns of supply and demand. Decisions about what services to retain and what new services to bid for were effectively disconnected from the people delivering and managing those services day-to-day.

The threat of private sector activity was important in shaping the perceptions and conducting the behaviour of managers and professionals in Care Trust, and naturalizing economic and commercial logics throughout the sector. Corporately colonized identities of managers which internalize concepts of choice, efficiency, performance management and competition are central to entrepreneurial activities aimed at '*getting the contract*' regardless of sector expertise, strategic relevance or ability to integrate this with other activities, and it is upon this activity that the survival of Care Trust depended. This created entrepreneurial behaviour on the part of managers and hybrid manager/professionals—horizon scanning, tendering, winning new business. However, the consequences of this behaviour demonstrate a 'constitutive circularity' (Ashmore 1989) between the political conditions which were perceived by managers and professionals to be driving the changes to their work, and their *reluctant* participation, which then reinforced those perceived conditions (Deetz 1992).

The extent to which 'closure' has been achieved despite the reluctance of managers and clinicians to engage with this process stems in part from the distinction between this activity and the kind of values espoused by those

interviewed. Given the complexity of management in the NHS and the tensions that have long existed within healthcare management between managers' professional and managerial identities (Bolton 2005; Croft, Currie and Lockett 2015), it is not surprising to find that attempting to reconcile these strategies should be situated in managers' struggles to adapt to different, more entrepreneurial expectations associated with their evolving managerial identity. While reluctance on the part of clinicians to engage in management has been documented in previous research (Kitchener 2000; Bolton 2005; Croft, Currie and Lockett 2015; Bishop and Waring 2016), the extension of market relations and competitive tendering since 2012 has changed the dynamic of this process. This conduct did not occur in a vacuum, of course, and the accounts of interviewees point up the tension between this commercial logic and other, powerful logics in play in the organization and in the sector as a whole (c.f. Reay and Hinings 2009; Harris and Holt 2013; McDonald et al., 2013). Hence, reluctance stems in part from an unfamiliarity with entrepreneurial behaviour and a perceived inadequacy when compared to independent, typically private competitors in this regard. It also reflects the difficulty experienced in managing the tension between winning contracts and delivering on those contracts, and also misgivings about the wider impact of this pressure on their work more generally—both in terms of the time which can be devoted to the organization and delivery of care, and in terms of the kinds of skills, and arguably the kind of healthcare professional and manager who will be needed by the trust in future as entrepreneurial acumen replaces clinical expertise.

As we demonstrated through our findings, there are several linked consequences of this process. First, it creates more fragmented organizations, constantly moving into new areas of business in order to survive, at the possible expense of local services, and resulting in constant 're-organization' (in the form of redundancies). Second, it disrupts the work of managers and healthcare professionals with the unpredictable and short-term demands of tendering, resulting in work intensification, stress, and reinforcing a sense of 'risk consciousness' (Beck 1992: 23). This, in turn, reinforces further the perceived need to grow and restructure. Third, it produces discord in the perceived purpose of the organization, effecting a shift away from professional concern with the principal actors and sites of a health care organization (patients and clinical service), towards 'the "moral fictions" of excellence, expertise and effectiveness' (Deetz 1992: 312). This demonstrates the relation between the fragmentation of care that results from the 'business logic' and the resulting constrained ability to continue to enact a logic of care (Mol 2008). While we illustrate how the confluence of corporate colonization and entrepreneurship was realized locally, the study also illuminates a broader social phenomenon. Ultimately, we see how short-term entrepreneurism driven by corporate ideology acts as a powerful organizing principle that operates in conjunction with social, political and economic relations in society. So, for example, economic necessity may trump values relating to care and ethics of care.

At the same time, the perceived inevitability of this kind of behaviour, despite what some perceive as negative consequences for the quality and nature of care delivered, appeared to produce reluctant but also resigned entrepreneurs. The recent history of Care Trust—and, in particular, its relentless acquisition of new services and extension of its 'core business'—showed how, strategically, there was a sense in which the organization was obliged to operate with an opportunistic, entrepreneurial fluidity in order to secure its own future. Symptomatic of corporate colonization (Deetz 1992), both healthcare professionals and managers lacked legitimate alternatives to their business-focused, entrepreneurial activity. For Deetz, this represents an extension of managerialism in public services—as he observes, 'institutionalised entrepreneurship as a source of innovation and progress is a key element of the discourse of managerialism' (Deetz 1992: 228)—but what is more striking is the displacement of clinical/professional expertise with entrepreneurial competence in management here.

As noted above, the organization analyzed here may be more extreme than others in its pursuit of entrepreneurial activity, observed at a period of most intensive competitive pressures, but given the shared institutional context, we would argue that it is far from unique. The resonance with other work on the evolution of health management (Learmonth 2005; O'Reilly and Reed 2011) also suggests the findings would have a wider relevance in the sector. The extent to which legislative changes under the Health and Care Act (2022), and the creation of ICSs to moderate competition in favour of integration and collaboration, limit or reverse this shift is yet to be observed, although broader pressures towards commercialization and public sector entrepreneurialism persist (Exworthy and Lafond 2021; Exworthy et al., 2024; Sheaff et al., 2024). Further research is necessary to explore the extent to which similar tendencies are evident in other parts of the public sector. While a specific reform affecting the NHS in England accelerated this process, increased reliance on competition in other healthcare contexts internationally (Hacker 2004; Schmid et al., 2010) points to wider relevance in other regions in which NPM has been implemented.

CONCLUSION

Drawing on critical studies of entrepreneurship, enterprise and corporate colonization, we have examined the experiences of 'reluctant' entrepreneurs in the English NHS and considered the implication of this for managerial identity and the delivery of healthcare. Building on the seminal work on enterprise discourse by du Gay and others (du Gay and Salaman 1992; du Gay 2000, 2004), and informed by more recent work on the normal and mythologization of entrepreneurship (MCabe 2008; Scharff 2016), we argue that the recent extension of healthcare in England is supported by a wider process of corporate colonization (Deetz 1992). We have traced how the extension of a private sector discourse of enterprise, accelerated by recent public sector reforms, influences identity and conduct of managers, professionals and hybrid professional managers who are both the target of and the vehicle for corporate colonization.

In practice, the impacts of this process are several; as organizational strategy mimics the private sector in the pursuit of growth and diversification in a competitive market, the focus of managerial activity shifts to an entrepreneurial opportunism. As a consequence, there is a shifting emphasis upon entrepreneurial acumen at the expense of professional/clinical expertise and the delivery of care. Despite reluctance and concerns over the impact of this on the service delivered, little evidence of meaningful resistance can be identified among the managers interviewed due to the perceived inevitability of a market logic within the sector, resulting in the production of not only reluctant but also resigned entrepreneurs. In the process, we see the colonization of the organization through the domination of a corporate logic over alternate commitments, with the manager as both vehicle and target of these changes.

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