Reforming the National Health Service in England: The Problems of Delivering the Health and Social Care Act 2012

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Abstract

This thesis explores the implementation of the health policy reforms following the Health and Social Care Act 2012 in the National Health Service in England. The government introduced reforms in 2012 intending to marketise health services, but the reform largely fell short of achieving this aim. This thesis studies why it was so difficult to deliver the market-based reforms introduced by the 2012 Act. In order to address this question the study employs an institutionalist framework for understanding implementation, and the problems associated with this process. Case studies in three different CCG areas highlight that the dynamics between policy implementers and institutional factors influenced the delivery of the reforms. The conclusion that can be draw from the empirical findings is that: It was difficult to implement the market-based reforms introduced by the 2012 Act, because there were no supportive institutional settings for implementing the reforms on the ground. First of all, there were no clear policy goals for implementation, with the co-existed goals of improving competition and collaboration in health service commissioning. This allowed CCGs the space to make their own choices about how to deliver the market-based reforms. Second, the reforms failed to create appropriate and effective incentives for both CCGs and healthcare providers to support the reforms. Moreover, normative and cultural factors shaped commissioning decisions in ways that were significant at the point of delivering the reforms. Intensifying marketisation and competition was widely perceived as conflicting with the shared values, norms and cultural beliefs within the NHS organisations, which resulted in the resistance of commissioning bureaucrats against marketisation at the point of delivery.

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Author’s Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

Chapter 1 Introduction

Marketisation has been seen as potential mechanism to improve efficiency and cost-effectiveness of health services and there have been continuing attempts to marketise health services in the NHS in England since the 1980s. When the Conservative-Liberal Democratic Coalition Government came into power in 2010, a new round of market-based health policy reforms was introduced within the English health system. The Health and Social Care Act 2012 was implemented under the Coalition Government, with a clear intention to intensify competition in the provision of health services. Following the 2012 Act, new competition policies and rules were developed to shape commissioning decisions and behaviour, encouraging Clinical Commissioning Groups (CCGs) to use market mechanisms (such as competitive procurement, tendering and contracting out) and to diversify healthcare providers when commissioning health services. The reforms in 2012 intended to further marketising the English NHS, but they largely fell short of achieving this goal. The evidence suggests that CCGs had limited success in increasing the use of market mechanisms in health service commissioning from 2013-2017, and that there was a low level of provider diversity in practice (Allen et al., 2015; Calovski, 2018; Osipovic et al., 2017). The market-based reforms following the 2012 Act appeared not to be effectively translated into practices. Thus, it is important to investigate why there was a gap between policy changes and practice. From this point of departure, analysis of implementation processes of the

market-based reforms introduced by the 2012 Act become into the focus of this research.

The core aim of the Act was to marketise the English NHS and this thesis examines the difficulties faced by the government in achieving this goal. The main research question of this study is: Why was it so difficult to implement the market-based reforms following the 2012 Act? Case studies were conducted in three different local CCG areas to investigate the implementation process of the 2012 reforms, and the institutional perspectives are employed to explain the problems of implementation. The research finds that the goal of intensifying competition in the provision of health service were problematic within the English NHS, because of the difficulties of delivering the reforms on the ground. The thesis argues that it was difficult to implement the market-based reforms following the 2012 Act, because there were no supportive institutional settings for implementation. First of all, the commissioning policy goals of the 2012 Act were ambiguous, with the co-existed goals of improving competition and collaboration in health service commissioning. The central government failed to clarify which of these goals should be prioritised. This allowed greater discretion to CCGs to exercise and provided them the opportunity to limit the degree of competition on the ground. Second, the market-based reforms failed to create appropriate and effective incentives for both CCGs and providers to support the goal of intensifying competition. Moreover, greater marketisation and competition were not compatible with the normative and cultural framework of the NHS system, which resulted in the resistance of commissioning bureaucrats against the reforms. The central government failed to

produce sound policies for structuring the implementation of the market-based reforms and ensuring compliance by implementers, and this provided the opportunity for implementers to limit the degree of marketisation and competition, in order to meet the normative and cultural demands of their own organisations.

1.1 The Focus of the Research

When coming into power in 2010, the Coalition Government faced a challenging fiscal position, a major economic recession and the largest budget deficit since the Second World War. During the 13 years of Labour Governments before 2010, there was a clear commitment to high levels of public investment, abandoning the Conservative's retrenchment policies of 1979-1997. The previous Labour governments were committed to maintaining the welfare state, with a considerable focus on public infrastructure and public service provision (Smith, 2010, 821). Public spending increased dramatically during this period, and the UK had a significant sustained increase in spending on healthcare for the first time in its history. However, the massive increases in public service expenditure exacerbated the budget deficits in the context of economic downturns which erupted in 2008 starting with the American banking collapse. In the UK, tax receipts declined and spending on welfare rose, and this generated great financial burden on the government (Elliott, 2010). The newly-elected Coalition Government in 2010 inherited this challenging financial position, and cutting

public spending was regarded as necessary. Since 2010, a wide range of reforms in public services were conducted by the Coalition Government, including public spending cuts, austerity and public service restructuring (Vizard and Obolenskaya, 2015).

Health reforms following the Health and Social Care Act 2012 were introduced in this context. As a kind of universal health services, free of charge and tax-funded, the NHS inevitably needed a significant public expenditure to maintain the increasing healthcare demands from medical technology development, an increase in chronic diseases and demographic changes. Against a background of economic recession and a large public deficit, it was impossible to maintain the increased rate of funding, like the previous Labour administrations, to meet the rising demands of health services. Although the Coalition Government promised to increasing the NHS budget, it was actually not sufficient to meet the rising healthcare demands and public expectations (Roberts et al., 2012, 6). There was an increasing tension between the requirement to maintain universal health services and the imperatives to cut public spending in the presence of economic recession and great financial pressures. In this situation, how to balance the finance of the NHS and simultaneously meet the increasing healthcare demands became a significant challenge for the Coalition Government. It was believed by some in the government that increased efficiency through marketisation and competition, was the best solution to this dilemma (Taylor-Gooby and Stoker, 2011). The assumption was that competitive pressures would force healthcare providers to deliver services in an

efficient and cost-effective manner. According to this assumption, the Coalition Government introduced a range of inter-linked policy initiatives to intensify competition within the English NHS system under the Health and Social Care Act 2012.

The core aim of the 2012 Act was to increase the level of competition to a much greater degree than before in the English NHS. Following the Act, Clinical Commissioning Groups were established at local levels, taking over around 60 percent of the overall NHS budget for purchasing and commissioning healthcare in the needs of local population. They were formally given greater levels of autonomy to make commissioning decisions and selecting providers. In order to further marketising health services, the 2012 Act introduced a range of inter-linked policies and rules in relation to commissioning and procurement. In doing so, the Act made a direct correlation between competitive behaviour in the NHS and competition law (Sanderson et al., 2016). CCGs were required to create markets and competition through being exposed to legislative pressures (Davies, 2013). Market mechanisms such as competitive tendering and contracting out were encouraged as instruments for CCGs to shape the behaviour of healthcare providers in an efficient and cost-effective manner. Following the Act, a new commissioning policy framework has been introduced in order to marketise the English NHS, including two key policy elements:

- Competitive procurement rules (known as Section 75 regulations of the 2012 Act): CCGs should create markets and competition in the processes of

commissioning health services. They were required to use the market mechanism of competitive procurement and tendering in the practices of commissioning health services.

- Provider diversity policy: CCGs should produce a level playing field for any qualified providers (public, private and voluntary) to compete for the NHS contracts. CCGs were encourage to contract out health services for diversifying providers and enhancing competition in health service provision, and particularly the reform put weight on the use of private sectors to deliver healthcare.

The reforms in 2012 had an intention to marketise the NHS, but they largely fell short of achieving this aim. The evidence suggests that CCGs had limited success in enhancing provider competition in their commissioning activities. Moreover, provider diversity was never really developed, with the exception of a small amount of private sectors involvement in some particular services, which could be delivered profitably like elective care, community and mental health services (see for example, Allen et al., 2015; Buckingham and Dayan, 2019; Krachler and Greer, 2015; Karchler et al., 2021; Osipovic et al., 2017; The King's Fund, 2021). The reports from Policy Research Unit in Commissioning and the Healthcare System indicated that there was a decline in the use of competitive strategies by commissioners from 2013-2017, despite competition still having a place in the provision of health services at times (Allen et al., 2015;

Osipovic et al., 2017). These reports concluded that CCGs decreased the frequency of putting service out to tender, and the services which put out to tender did not amount to a major procurement.

One important indicator of the effective implementation of the market-based reforms could be the increase of private provider activity, as the 2012 reforms sought to marketise the NHS by diversifying healthcare providers and contracting out to private sectors in particular. The 'ideal health market' would cover multiple types of providers, such as the NHS, the private sector and the voluntary sector providers. To make market competition happen, it is necessary to have alternative providers for CCGs to select. At the beginning of this research, a statistical analysis was conducted in terms of the spending on different types of providers (including NHS organisations and non-NHS organisations) between different CCGs across the England. The data was based on the officially published CCG annual and financial account reports between 2013/14-2017/18 and from FOI (Freedom of Information) requests. This was helpful to gain an initial impression of the development of provider diversity in the English NHS, after the adoption of the 2012 Act. The statistical analysis found that the spending on healthcare providers highlighted similarities rather than differences in terms of the use of non-NHS providers. The vast majority of the CCGs' funding continued to be spent on NHS providers. In contrast, the share of all CCGs spending on non-NHS bodies was significantly lower, although it increased annually. This suggests a low level of provider diversity in the NHS England. Public providers still dominated NHS service provision

at a local level, and seemingly, provider diversity was not well-developed after the adoption of the 2012 Act.

The Department of Health's published annual accounts indicated that the share of spending by NHS commissioners on the private sector was 7.7 percent of the budget in 2016/17, which increased slightly from 7.3 percent in 2014/15 (Department of Health, 2017, 170). Simon Stevens, Chief Executive of NHS England suggested that ninety-four pence of every pound spending on care was delivered by NHS providers and that this position would continue to be the case for the foreseeable future (Campbell, 2014). More recently, David Hare, Chief Executive Officer of the Independent Healthcare Provider Network, which represents many private sector providers, revealed that spending on the independent sectors accounted for just 3 percent of annual NHS spending, in order to meet the patients' demands in healthcare (Campbell, 2019). In reality, public providers retained the monopoly position in the English NHS, and non-public provider's share of the NHS spending was relatively small and stable after 2009/10 (Buckingham and Dayan, 2019). Under the Coalition Government, the rate of growth as to CCGs' spending on private sector providers was actually very similar to that of Labour's last years in office (The King's Fund, 2021).

Moreover, many media reports and think-tank research have revealed that there was no significant increase in the share of spending on private sectors after the implementation of the 2012 Act. Private sector providers tended to hold much smaller-scale contracts

than NHS providers. Although there were some cases that CCGs attempted to put out high-valuable and large contracts for tender, these procurements was terminated eventually. For example, in 2015, a five-year £800 million outsourcing contract to deliver services for older people was planned by Cambridgeshire and Peterborough CCG (BBC, 2015), and a £1.2 billion plan to outsource cancer and end-of-life care over ten years was conducted across four Staffordshire CCGs (Godfrey, 2015). In both cases, private sectors were expected to deliver the NHS services (Lacobucci, 2016). But the procurement of both contracts was dropped, because of widespread criticism, lengthy delays and problems with designing the contracts (The King's Fund, 2021). A survey of BMA (2017) indicated that the NHS heavily depended on a small number of private sector providers, such as Virgin, Ramsey Health Care and Care UK. The evidence suggests that the government's intention of intensifying competition has not been translated into practice, and there continued to be a low participation rate of private sectors in the provision of health services.

Calovski's (2018) research on the effect of decision making by CCGs on the selection of private providers suggested that the balance between the public and private sectors had changed in the NHS, but on a very limited extent. Private sectors have managed to expand their role in some services, albeit ones where they have been successful in the past. However, they have not become a viable alternative to the large existing public providers, as the 2012 Act expected. They might only act as an alternative in some smaller and profitable areas of health care, such as elective surgery. In addition, the

private sectors have not expanded its role to the funding of any health services. This study suggests that CCGs contracted out health services when it could assist them in generating savings, but this was only limited to smaller contracts on a very limited scale. The NHS has not become into a competitive market with diverse providers, and there were few alternative ones to compete with public sector providers in the majority of health services.

The literature above suggests that there was a gap between what was happening in reality and what was expected by the market-based reforms following the 2012 Act. While the Coalition Government introduced policy changes to increase competition, there were seemingly no major moves in this direction in practice. CCGs were expected to increase the level of competitive procurement and the use of private sectors in the activities of health service commissioning. But the results of the implementation seemed disappointing that the reforms failed to produce the desired effects: market mechanisms were applied only in limited way by CCGs in their commissioning activities, and there was no large-scaled use of private sector providers in practice. The market-based reforms following the 2012 Act appeared not to be effectively translated into practices. The following questions thus arise: why there was a gap between policy and practice? Is it because the relevant policies were not effectively implemented? If they were not implemented, then what were the problems with the implementation? These questions are the main rationales to examine the implementation of the market-based reforms following the 2012 Act in this thesis. Therefore, analysis of

implementation processes of the market-based policies introduced by the 2012 Act becomes into the focus of this research.

1.2 The Key Concepts: 'Marketisation', 'Quasi-Market' and 'Privatisation' in the NHS Reforms

Since the 1980s, marketisation has become into an attractive solution for policy-makers to solve the perceived crisis of the public services such as overspending and inefficiency in the UK (Glennerster and Le Grand, 1995; Wilding, 1997). Market elements have been introduced to nearly all areas of the public sectors and policies, opening up public services to compete with private sectors and contracting out public services to private companies. There have been a wide range of public service reforms, focusing on changes to policies and rules aimed at creating or increasing competition. The rational for these changes was based on the perspectives of New Public Management (NPM) that the structure of welfare state generated massive inefficiency and overspending in public services (see, for example, Dunleavy and Hood, 1994; Glynn and Perkins, 1997; Gruening, 2001; Hood, 1991; 1995). The introduction of market elements into public services was justified on the basis of improving efficiency and effectiveness (Greener, 2005). This reflected the widely held belief that the best way of improving efficiency was to change the incentives within public sectors and that the introduction of market competition could achieve this aim (Saltman and van Otter, 1992).

Since the 1980s, there were widespread New Public Management (NPM) reforms in the UK public services and policies, which centred on 'a greater reliance on market forces for the provision of public services and an opening up to competition at all levels' (Simonet, 2015, p.806). The British governments began to seek ways of reducing the role of the state in the funding and provision of public services, encouraging greater use of the private sectors in public services. In health, these changes have also been observed (see, for example, Cousins, 1998; Dixon et al., 2011; Exworthy et al., 1999; Exworthy et al., 2016; Farrell and Morris, 1999; Lewis and Gillam, 2003; Lewis et al., 2009; Moran, 1998). Marketisation has been seen as potential mechanism to improve efficiency and effectiveness in health care. Over the subsequent decades, there have been continuing attempts to marketise health services, with considerable policy changes aimed at marketising the English NHS system.

It is necessary to outline the definition that this thesis utilises when discussing 'marketisation', before moving on to exploring the implementation of the market-based reforms following the 2012 Act. The NPM theory intends to introduce market elements into public services. What nature did that marketisation take in the NHS? Following the Thatcher Government's White Paper – *Working for Patients* in 1989, an 'internal market' was created to separate the functions of purchasing and providing health services on the basis of contracts, introducing competition in the provision of healthcare (Department of Health, 1989). This market was 'quasi' rather than 'pure', as the state

remained to be the primary funder of the NHS. The Le Grand and Bartlett's (1993) definition of 'quasi-market' has been employed to characterised the marketisation of the NHS in this thesis. Quasi-market is defined as a mechanism for breaking the monopoly of the state in public services, by introducing competition through new policies and rules that allow existing service providers to compete with each other; and therefore mimicking the incentives and forces that can be found in an ordinary market (Le Grand and Bartlett, 1993). Fundamentally, the concept of quasi-market refers to a separation between the state finance and the system of public service provision, whilst the state remains its role in public services at least in the level of funding (Glennerster and Le Grand, 1995). The development of quasi-market seek to introduce or intensify competition into public sectors, and thus improve efficiency and effectiveness of services.

The term 'quasi-market' emphasises the difference between a market for publicly funded services and a conventional market. Le Grand and Bartlett (1993) point out that they are 'markets' as they replace monopolistic state providers with competitive ones. But they are 'quasi' because they differ from conventional markets in several ways. Notably, the state remains the responsibility to fund services, and state agencies purchase services on behalf of consumers. In the NHS, the reason for the establishment of a quasi-market was the existence of political goals such as equal access to healthcare that would not be fulfilled in an normal market (Allen, 2013; Hsiao, 1995; Klein, 1998). The fundamental principles of the NHS (free, universal and comprehensive health

services) have always enjoyed high level of popularity in the UK. Since the 1980s, the market-based reforms were deliberately designed not to undermine these fundamental principles. As Greener (2008) suggests, the NHS 'is a national treasure, regarded by policy makers as a welfare service they must treat with extreme caution because of the disastrous electoral consequences that could result from being seen to be privatising healthcare' (p.1). Thus, health reforms were always committed to the taxed-funded approach and cautiously constrained the role of market in order to avoid unacceptable damage to the principles of universality and equity. By and large, the employment of the markets did not resulted in the rollback of the state in health services that the English NHS remained predominantly publicly funded after decades of marketisation reforms (Arora et al., 2013).

The policy of quasi-market exhibited a hybrid of private sector ideas and practices with public sector funding and regulation (Exworthy et al., 1999). The distinctive feature of the quasi-market policy is the dual role of government: it both creates 'markets' and takes responsibility for funding and regulating services (Saltman and von Otter, 1992). As Le Grand (1991) suggests, 'the intention is for the state to stop being both the funder and the provider of services. Instead, it is to become primarily a funder, purchasing services from a variety of private, voluntary and public providers, all operating in competition with one another' (p.1257). A necessary feature of a quasi-market is the split between 'purchasers' (they are formally called 'commissioners' following the 2012 Act) and 'providers' who are linked by contracts (Powell, 2003). In the NHS,

quasi-market reforms retained state funding and purchasing of services, but separated purchasers from providers and encouraged competition between these providers for service delivery (Le Grand, 1999).

Following the theory of 'quasi-market', marketising the NHS mainly refers to the introduction or intensification of competition amongst healthcare providers. Within the NHS, marketisation in healthcare can be charaterised as a quasi-market reform, referring to changes of policy and rules aimed at introducing or intensifying competitive pressures in the provision of health services whilst remaining the funding and financing of health services untouched. The introduction or expansion of competition is a key component of the NHS quasi-market reforms, creating the incentives for healthcare providers to behave in an efficient and cost-effective manner (Klein, 1998). The primary method to make competition occur for efficiency is the development of competition policies and rules that shape the behaviour of NHS commissioning and provider organisations. In particular, procurement and commissioning polices and rules have been formed as important elements of the marketisation reforms, encouraging commissioning organisations to use diverse sources of provision through competitive procurement, tendering and contracting out. As contracts can be shifted by commissioners to the efficient one, competition between providers has become possible due to the fear of losing contracts and incomes (Krachler et al., 2021). In effect, the development of marketisation within the English NHS is the introduction or intensification of competition through adopting a range of inter-linked policies and

rules.

Following the 2012 Act, marketising the NHS in England mainly focused on a range of inter-linked commissioning policies and rules to creating a more competitive market where health care could be bought from diverse providers by CCGs. It included two key policy elements. First of all, there was an introduction of new procurement rules in respect of competition in health service commissioning, with efforts to require CCGs to create markets through competitive procurement and tendering processes. Second, the 2012 reforms focused on the diversification of healthcare providers for enhancing competition, and especially, the increased use of private sector providers through contracting out was encouraged in service commissioning. Contracting out is a process whereby non-public sectors are contracted to deliver services for publicly funded patients on behalf of the government instead of providing these services in-house (Larbi, 1999). Competitive tendering and contracting out have formed as important policy mechanisms available for CCGs to provide a level playing field for diverse providers, and thus extend provider diversity and competition (Bach, 2016). Competition is more likely to happen in spaces where a number of potential providers exist (Greener, 2008). So in the 2012 reforms, CCGs were encouraged to enter a contract with one or more providers, either public or private actors (Greve, 2008). In particular, the private sectors were advocated as important alternative for healthcare providers, in order to marketise the NHS.

The enactment of the 2012 Act, introduced by the Coalition Government, has provoked considerable controversy that the NHS has been privatised, as it had a potential to significantly increase the involvement of private sectors in the publicly funded health services (see, for example, Coote and Penney, 2014; Davis and Tallis, 2013; Davis et al., 2015; Hunter, 2011; 2013a; 2013b; Lister, 2012; Pollock, 2004; Pollock and Price, 2011; Reynolds et al., 2012). Whether the English NHS was privatised by the 2012 Act is not the focus of this thesis. But it is worth outlining the definition of 'privatisation', as the 2012 Act led to widespread arguments that the reforms of greater marketisation following the 2012 Act would lead to the increased use of private sectors within the English NHS (Davies, 2013; Speed and Gabe, 2013). In the health reforms, the main reason for the use of private providers was to facilitate the competition between healthcare providers (as a strategy to marketise health services). This was based on the belief that public sectors had no incentives to adopt more efficient practices without external pressures, and thus the private sectors should be allowed to deliver public services to create external competitive pressures (Le Grand, 2006; Walker et al., 2011). Also, there was a widespread assumption within the government that the private sector could deliver services, more cheaply than the public sector, although the evidence for this was ambiguous (Field and Peck, 2003). Based on these assumptions, the 2012 market reforms encouraged the CCGs to increase the use of private sectors. However, the involvement of private sectors in the NHS was widely regarded as a kind of 'privatisation' strategy.

In the existing literature, there are a number of definitions and typologies of 'privatisation' in public services which are often unclear and conflicting. Different scholars and commentors have different explanations, ranging from a narrow definition that focuses on the transfer of assets to a broader definition that involves provision, finance and regulation (Powell and Miller, 2015). Narrowly considered, privatisation is defined as a process of turning public assets over to private ownership (Saltman, 2003). This definition highlights the ownership of the assets and utilities. According to this definition, privatisation occurs exclusively when assets are transferred from the public to the private sector. In this sense, there is a distinction between the notions of 'marketisation' and 'privatisation'. Marketisation refers to the introduction of market-style incentives within public sectors, which is typically used to describe the behaviour and consequences of quasi-market (Saltman, 2003). Building on a narrow definition of privatisation, marketisation and privatisation are two distinct concepts and separate processes that need to be approached differently. What makes the process of marketisation different from that of privatisation is the maintaining of the accountability of the government to public services.

In a broader definition, the term 'privatisation' can be used to describe the situation that more non-public providers involve in financing and delivering public services. As a critical part of public service marketisation, the private sectors are introduced into the financing and provision of public services, in order to make competition happen for ensuring better service outcomes. According to the broader definition, the development

of marketisation and competition is regarded as a model of privatisation. Dunleavy (1986) points out that privatisation refers to transferring the production activities of goods and services from the public service bureaucracies to the non-public sectors such as private firms or voluntary groups. Savas (1989) suggests that privatisation means to depend more on the private sectors of the society and less on government to provide public services for meeting the public needs. In his view, privatisation involves many forms: contracting, franchising, and vouchering; selling and leasing government-owned assets to the private sector; and shedding services and deregulating. The World Health Organisations (WHO) has defined the term 'privatisation' as a process in which the non-state actors are increasingly involved in the financing or provision of public services (Muschell, 1995). Young (1986) sets out seven different forms of privatisation including selling off public assets, relaxing state monopiles, contracting, private provision of services, investment projects, extending private sector practices into the public sector and reduced subsidies and increased charges. From a boarder view, privatisation is more than the transfer of asset from the public sector to private sector. It involves a comprehensive range of strategies to restructure public services and reduce the role of the state in the financing and provision of public services.

In health, there is often a lack of consensus as to what constitutes the 'privatisation' in practice, which illustrates the difficulty in establishing a universally accepted definition of 'privatisation'. The governments and politicians tend to use the narrow definition of asset transfer to deny the privatisation of the NHS, with the argument that NHS services

remain publicly funded and free at the point of delivery. In contrast, opponents of market and competition typically use the broad definition of greater private provision to demonstrate the fact that the NHS in England has contained some privatisation features. Looking through the literature review around the definitions of 'privatisation' in health care, 'marketisation' and 'privatisation' are different concepts that need to be treated separately. But there are some connections between these two conceptions. In this thesis, 'marketisation' and 'privatisation' are considered as separate but sometimes linked processes. Marketisation reforms mainly seek to introduce competitive pressures within the NHS, and privatisation eventually requires a transfer of assets.

But there is a close connection between these two processes in the NHS reforms, as the government seeks to use the involvement of private sector providers to intensify marketisation and competition. In the 2012 reforms, contracting out to private providers was an attractive policy for the government to marketise the NHS, exposing NHS providers to competitive pressures from the external providers for service improvements (Cousins, 1998). The government advocated the benefits of private provision, encouraging more private sectors involved in delivering the publicly funded health care (Bach, 2012; 2016). This has been seen as the most common form of privatisation strategy by opponents of the market-based reforms. This kind of definition views privatisation in a broader way. It is presumed that marketisation would lead to privatisation because of greater use of private sectors in health service provision. Marketisation of the NHS entails the diversification of healthcare providers to make

competition occur for efficiency and effectiveness, and this process has a tendency of increasing the use of private providers. From this point of view, we can understand that why the 2012 Act was hugely controversial and widely criticised for privatising the English NHS, as it focused on bringing in more private providers in efforts to marketise health services and intensify competition.

1.3 Existing Research on Implementation of the Market-Based Reforms following the Health and Social Care Act 2012

In the literature of the 2012 reforms, there is a widely held argument that the way in which CCGs commission health services and select providers has been changed by the 2012 Act and this will result in the increased use of private sector provision within the NHS in England (see, for example, Davies, 2013; Hunter, 2013a; 2013b; Speed and Gabe, 2013; Sturgeon, 2014). The Any Qualified Provider (AQP) policy of the 2012 Act attempted to address the lack of competition by breaking the public sector monopoly of health care provision, and allowing more private sector providers to compete for the NHS contracts. The encourage of private sector provision was a critical part of the Coalition Governments' attempts to marketise the NHS (Sturgeon, 2014). Under the new policy arrangements, some scholars suggest that CCGs were required to create markets and competition, which could make NHS providers exposed to a more competitive markets (Davies, 2013; Speed and Gabe, 2013). They may need to compete

not only amongst themselves, but also potentially with new private sector providers.

Speed and Gabe (2013) stress the significant changes introduced by the 2012 Act such as the creation of CCGs and the policy of any qualified provider. In their commentary, it has been argued that the Act has introduced policies to force CCGs to increase the use of private providers in the provisions of publicly funded health care. They suggest that 'what is now, post legislation, is that the changes have resulted in private companies becoming the principal providers of those services such that NHS employees are required to move from NHS contracts on to private sector company contracts'. What they have argued is that CCGs are given the power to tender contracts to the private sector within a broadly more competitive market context, and that NHS providers will operate in a very explicit market setting where they compete for contracts against a number of healthcare providers (both public and private ones). Speed and Gabe (2013) assume that the private sectors will become much more involved in the publicly funded health services as a result of the reforms.

Davies (2013) has a similar assumption as to the involvement of private sector provision within the NHS in England after the adoption of the 2012 Act. His study focuses on analysing the key features of the Act and its associated policy. He argues that the 2012 Act contains the creation of new policies and rules aiming at encouraging and compelling CCGs to act as autonomous 'market players' by threatening them with legal consequences. According to Davies's (2013) view, the Act contains various

elements that may encourage private sector involvement in the provision of the NHS services. For example, the Act might make it difficult for CCGs to reject the involvement of private sectors, because of CCGs' duties to prevent anti-competitive practices. A private sector is able to complain to Monitor if it is excluded from a NHS service tendering exercise by CCGs. Davies (2013) concludes that the 2012 Act has created highly favourable policy environment for greater private sector participation. It produces an equal opportunity for private sector providers to compete with public sectors for the NHS contracts. He calls this 'creeping privatisation'.

All of these studies reviewed above indicate that the policies and rules for health service commissioning have been shifted towards the direction of intensifying marketisation following the 2012 Act. Some scholars' (e.g. Speed and Gabe, 2013; Davies, 2013) analysis of the policy of the 2012 Act has further implications for understanding the degree to which the market-based reforms may have been implemented. Their analyses stress the potential impact of the 2012 legislation on shaping the behaviour of CCGs, forcing them to create competition and increase the use of private sector in health services. However, these studies mainly focus on explaining the path of changes and estimating their potential effects in the future, without considering the process of policy implementation. Some questions remain: what are the effects of these changes in practice? To what extent these policies and rules can be translated into practices?

Indeed, some scholars have mentioned the role of implementation of the 2012 Act in

determining the outcomes of the reforms. For example, Timmins (2012, p.188) argues that the effectiveness of the 2012 Act will depend on its implementation. From his view, passing the legislation is not the same as implementing it, and the Act does not guarantee what will happen in practice. He points out several uncertainties in the process of implementation. For example, how will Monitor behave within the new policy framework for enhancing competition? How will local authorities seek to use their influence? Timmins (2012) notes that the successful implementation of the Act requires the changes in the behaviour within the CCGs. But the question of how much the legislation can actually achieve that have not been answered in his research.

Similarly, Klein (2013a, p.866) explains the policy changes within the English NHS, from the Thatcher Government to the Cameron-led Coalition Government, arguing that 'the two previous waves of NHS changes showed that, in each case, both the hopes of the reform advocates and the fears of the reforms critics turned out to be exaggerated. On past experience, the shape edges of reform tend to be blunted in implementation. And while the organisational structure may change with disturbing rapidity, and new incentives designed to change behaviour may be introduced, the norms and rhythms of professional culture change only slowly, if at all'. Klein (2013a) realised that the importance of the legislation should not be over-stated, as the effectiveness of the market-based reforms under the 2012 Act might be diluted during the implementation process. Klein (2013a) suggests that evaluating the effectiveness of the 2012 Act should not neglect the impact of implementation.

As reviewed above, some scholars (e.g. Klein, 2013a; Timmins, 2012) have realised the importance of implementation. They suggest that the 2012 market-based reforms could be constrained when the reforms are translated into actions. Such studies have a role in contributing to implementation debate. However, there is no empirical research to support these conclusion, and they fall short of rigorous academic research. In reality, there is only a limited amount of academic studies, formally exploring the implementation of the 2012 market-based reforms. For example, Krachler and Greer (2015) provided an analysis of the impact of the 2012 Act on the involvement of private sectors in practice. They argue that private provision will not increase after the adoption of the 2012 Act, because the barriers to profit-making remain within the NHS in England.

Krachler and Greer (2015) assume that private sector is for-profit in nature, and thus they discuss a theoretical framework on the conditions of profitability. The study explains the profitability situation of the NHS after the adoption of the 2012 Act, suggesting that there are some barriers to profit-making such as uncertain rules, the top-down price squeeze, state dominance and failed depoliticisation. The study concludes that there is a limited extent of private provision following the market-based reforms because of the unprofitability condition of the NHS. This conclusion is in conflict with that of some previous studies (e.g. Speed and Gabe, 2013; Davies, 2013), which suggest that the 2012 Act will resulted in greater increase of private sectors in the English NHS.

Thus, it is important to conduct research around the policy implementation of the 2012 market-based reforms, and examine what exactly has happened in practice. It remains to be seen whether CCGs increased the use of private sectors through contracting out, and whether private sector became more involved in the delivery of the health services. These questions are answered in this thesis by the analysis of the implementation process of the 2012 reforms, seeing how CCGs implemented the market-based policies, and whether they increased the use of private providers on the ground.

In addition, this study only focused on analysing the involvement of private sectors in the NHS as well the factors that affected their actions (i.e. profitability). In effect, the Act created a new policy framework in respect of competition, including two key policy elements: the competition rules for commissioning and procurement and provider diversity. The reforms attempted to change the decisions and behaviour of CCGs, making them more involved in competitive procurement, tendering and contracting out health services. The encourage of private sector provision is only a part of the reforms. The level of private sector provision can be used to understand the outcomes of the implementation. But this does not tell the whole picture of the implementation. Importantly, we need to figure out the decisions and behaviour of CCGs and NHS providers in response to the competition framework introduced by the 2012 Act. This research concentrates on examining the commissioning activities of CCGs, and evaluating if the market-based changes have been implemented.

The study of the 2012 reform implementation has been further developed by Sanderson et al. (2016). They examined the impact of the 2012 Act on the regulation of competition in the NHS in England. This study had a particular focus on how regulators (such as Monitor) enforced competition law. This study explains the changes to NHS competition rules introduced by the Act. It has been argued that competition rules have been transferred from a system of sector-specific regulation to a national competition law (Sanderson, et al., 2016). As Sanderson et al. said, 'whilst the reforms of the 2012 Act in many ways continued the direction of travel for the incentivisation of competition in the English NHS, the legislation significantly altered the regulation of competition through the clear extension of competition law to apply to the planning and provision of NHS services'. They suggest that before the 2012 Act, competition rules were mainly sector-specific rules, internally negotiated within NHS organisations, but the 2012 Act had altered this situation. NHS competition has become a national legislation, enforced by Monitor and the national competition authorities. They indicates that the competitive behaviour within the NHS has been connected with the competition legislation.

Sanderson et al. (2016) sought to assess the impact of the new competition policy framework in practice. Their study did so by conducting an investigation of the interpretation of the NHS competition rules by the relevant regulatory bodies, such as Monitor. The study tried to identify how the decisions regarding the operation of competition were reached at the regulator level, how these regulators responded to

competition rules and how they enforced the competition rules in practice. It concludes that the effect of the competition law have been limited by the reality that the NHS need to manage and solve issues internally where possible. The regulation of competition still remains as an internal matter for the NHS despite the increasing emphasis on the role of national legislation and external regulators. The study indicates that the Act has not achieved its aim to protect competition by the creation of regulators in practice, and instead, the operation of competition were still internally regulated.

The study of Sanderson et al. (2016) provides some useful insights into the implementation of the 2012 reform, but a series of questions still remain. It argues that the role of the new competition framework and regulators has been constrained by the need to manage and solve NHS issues internally. What issues the NHS need to manage and solve internally? Why these issues need to be managed and solved internally? And how exactly this process constrained the effectiveness of the competition legislation in practice? In order to answer these questions, it is necessary to fully examine the decisions and behaviour of CCGs, because they are the policy actors in charge of operating competition in their day-to-day work, responsible for translating policy changes into changes in behaviour or hampering such changes. In reality, the implementation of the competition rules has not been entirely examined by the research of Sanderson and his colleagues. My thesis will fill this gap by examining how CCGs implemented the competition policy and rules introduced by the 2012 Act, and furthermore this study will explain the factors influencing the implementation. It differs

from the study of Sanderson et al. which mainly focuses upon the decisions and behaviour of regulators, while agreeing with many of their observations that the impact of the new competition framework was limited in practice.

Allen et al. (2017) conducted a research of detailed case studies around the implementation of competition policies in four local commissioning areas. They explored the understanding and experience of senior managers in both commissioning and providing organisations, regarding to the application of market and competition mechanisms in the activities of commissioning health services. Their study observed a co-existence of competition and collaboration rules for regulating service commissioning and procurement practices. They found some evidence that the policies and rules around procurement and commissioning were not clear to local actors and changed over time. There was a complex policy framework encouraging both competition and collaboration, which made commissioners and providers (including non-state providers) feel confusing, hard to follow. Moreover, they provided some evidence that markets and competition were created by CCGs, but they were not doing so at all times. A mixture of competition and collaboration in commissioning activities were evident in this research.

Allen et al. (2017) conduced an empirical research around how senior managers within commissioning and provider organisations understood the 2012 Act, and how they behaved in relation to competition and collaboration. This study points out the gap

between pro-competition policy and practices, but it fell short of theoretically and systematically explaining why there was a gap. Their work is more like a report rather than a rigorous academic research. Their arguments around why CCGs did not become more engaged in competitive procurement are unexplicit without further explanation and discussion. One of their conclusions is that 'the lack of clarity of the regulatory regime for local actors are important' (Allen et al., 2017, p.11). But it is not clear what does 'the lack of clarity of regulatory regime' mean? What role does this lack of clarity play in the implementation of the market-based policies? Without sufficient discussion and explanation, this work failed to connect the lack of clarity of the regulatory framework with the failure of delivering competition polices. In addition, Allen et al. mentioned that the influence of the institutional logics are also important to understand the behaviour of local actors. But they did not explicitly explain what institutional logics were and how they could affect the behaviour. This study is overly descriptive and under-theorised, which failed to fully address issues of theories, concepts and explanations.

In summary, a review of existing literature suggests that implementation of the market-based reforms following the 2012 Act is full of unanswered questions, although they can provide some useful insights into the reform implementation. The weaknesses of the existing literature on the 2012 reforms is identified as follow. First of all, much research focus on the changes to policy rather than policy implementation. These studies tend to evaluate the impact of policy changes without considering

implementation in practice, which may overstate their effects. Second, some studies point out the potential gap between the policy intentions and implementation, but fall short of providing strong empirical evidence to support this argument. The third problem relates to the existing research is that there are still no satisfactory explanations for implementation difficulties of the 2012 market-based reforms. There is a lacuna in the existing literature on the implementation of the 2012 market-based reforms in both theoretical and empirical terms. This thesis seeks to conduct an in-depth examination of the implementation process of the reforms, identifying the factors contributing to the problems of implementation.

1.4 Research Questions

The new competition policy framework introduced by the Act included two important policy elements: competitive procurement rules for commissioning health services; and provider diversity policy. The government expected that CCGs would become more involved in the application of competitive tendering and contracting out. Moreover, the government expected that CCGs would diversify healthcare providers through using these market mechanisms. But seemingly this has not really happened on the ground. As discussed in Section 1.1 above, CCGs had limited success in intensifying marketisation and competition. Moreover, there was no significant increase of private sector involvement for stimulating competition. The existing literature is relatively

sparse with regard to examining the implementation process of the market-based reforms introduced by the 2012 Act, without providing a definitive account of the difficulties in achieving the goal of marketising the English NHS. The purpose of this thesis is to examine the process of implementation of the market-based reforms following the 2012 Act, explaining the difficulty of implementation both theoretically informed and based on detailed empirical research. Based on this overall aim, the main research question of this thesis is created as:

> Why was it so difficult to implement the market-based policy reforms introduced by the Health and Social Care Act 2012?

There are two elements in the main research question. The first is to examine how the market-based policies introduced by the 2012 Act were implemented at local levels, evaluating the outcomes of implementation of the reforms. The second element is understanding and explaining the factors responsible for implementation of the reforms in practice. This thesis will provide an in-depth analysis of the implementation process of the market-based reforms following the 2012 Act, explaining why it was difficult to deliver the reforms on the ground.

Policy implementation is a process in which a collection of decisions and actions is conducted by various actors with the ability to control the delivery of public policy and affect the achievement of policy goals. The extent to which policy goals can be achieved

will be determined by the decisions and actions of these actors. In public policy process, governments have the power to initiate policy at the top, but often have problems in delivery, because they depend on subordinate actors to implement (Rhodes, 1996; 1997). Even in unitary and centralised forms of government such as the United Kingdom, governments have to rely on subordinate actors to deliver policies (Smith et al., 2011, 976). The decisions and actions of those actors involved in the implementation process could be critical to decide the effectiveness of a policy, i.e. the achievement of policy goals. That is to say, in order to understand the effectiveness of policy reforms, it is particularly important to examine the decision-making and behaviour of the relevant actors responsible for implementing these changes on the ground. The aim of this research is to analyse the nature of decisions and actions of implementers and their reasons for action.

In the case of the 2012 reforms, the implementing actors mainly refer to the key commissioners within local commissioning organisations (i.e. CCGs). They are government bureaucrats and officials at local levels, including a group of GPs, doctors, nurses and managers, responsible for purchasing and commissioning health services and allocating health funds on the behalf of the government. The empirical research will explore how these local commissioning bureaucrats both interpreted and implemented the policy reforms from the government by conducting cases studies in three different CCG areas (discussed in Chapter 4). An in-depth analysis of the commissioning decision-making and actions undertaken within CCGs will be provided

in this study, exploring the outcomes of implementation of the market-based reforms following the 2012 Act, and identifying the problems with the implementation. More specifically, this research will explain whether CCGs became more involved in the activities of competitive procurement, tendering and contracting out after the adoption of the 2012 Act, and why this was so.

For understanding the decisions and actions of implementers, an institutional analysis framework are employed by this research (fully discussed in Chapter 3). The institutional environment within which implementers make decisions and take actions is particularly important for analysing the process of implementation and the potential problems associated. In this study, the starting point for examining implementation is that decision-making and behaviour of implementing actors are shaped by the demands of a broader institutional environments, and implementers need to cope with different and sometimes contradictory demands from these environments. Scott's (2014) definitions of institutions is employed to conceptualise the institutional factors that may influence implementation, with a focus on the regulatory, normative and cultural factors. Based on theoretical discussion, formal rules and policies are identified as regulatory factors that may influence implementation. More specifically, the design of government policies such as the characteristics of policy goals and inventive structures are identified as the critical institutional factors that may affect implementation. Moreover, normative and cultural environments in which implementers are situated may affect implementation through shaping the decisions and behaviour of these actors. Problems

with implementation may occur, when government policy cannot find a fit with the requirements of the normative and cultural environments. The institutional analysis focus on the dynamics between implementers and institutional factors to understand implementation. Based on institutional perspectives, four specific sub-questions are presented to answer the main research questions:

1. Whether or not the policy goals of the 2012 Act were formulated ambiguously at the legislative level, and how this could affect the effectiveness of implementation?
2. Whether the market-based reforms under the 2012 Act consisted of appropriate and effective incentive structures for facilitating implementation, and result in effective implementation?
3. Whether commissioning bureaucrats were subjected to shared norms and values, and how this could affect the implementation of the market-based reforms?
4. Whether commissioning bureaucrats were subjected to prevailing cultural assumptions and beliefs embedded within the NHS system, and how this could affect the implementation of the market-based reforms introduced by the 2012 Act?

These sub-questions have also helped to develop he structure of the thesis, as presented next.

1.5 Structure of the Thesis

There are seven further chapters which is structured as follows:

Chapter 2 provides the policy history and background of the study, with a narrative literature review about the development of the market-based reforms in England. Based on the review from the creation of the NHS to the rise of the market-based policy reforms, the policy history and background of the market-based reforms following the 2012 Act are presented in this chapter. Three important contextual issues will be discussed in this chapter, including the fundamental principles of the NHS, the long-standing cost issues of the NHS, and the quasi-market policy direction that is emphasised by the 2012 Act. This chapter illustrates that the focus of this thesis concentrates on the new commissioning policy framework for enhancing marketisation and competition under the 2012 Act, with regard to commissioning, procurement and provider diversity.

Chapter 3 provides an overview of the theoretical and analytical framework that underpins this thesis. It reviews the broader literature on both policy implementation and institutionalism theories, and identifies the factors that may affect the implementation of the market-based reforms under the 2012 Act. These factors are characterised through the Scott's conceptual framework applicable to institutions. This

framework has been developed to identify the institutional factors which may influence how policy actors reach decisions and take actions at the point of delivering policies. The main argument here is that policy implementers are subjected to mixed institutional pressures from their regulatory, normative and cultural environments, which could affect their decisions and behaviour. In this thesis, the institutional factors are employed to explain the implementation difficulty of the market-based reforms following the 2012 Act.

Chapter 4 focuses on the methodology of the thesis, explaining how the research was undertaken in the field. It includes four main parts: research design, approaches of data collection, data analysis and ethical considerations. The research uses case studies in three different CCG areas, along with documentary analysis and interviews. This is helpful in illustrating how the market-based reforms were implemented on the ground, and what factors affected this process.

Chapter 5 considers the impact of regulatory factors on the implementation of the market-based reforms following the 2012 Act, in the light of the theoretical and analytical discussion in Chapter 3. This chapter answers the first sub-question in relation to the characteristics of policy goals and its impact on implementation. It examines whether the 2012 Act have actually created clear goals for CCGs to achieve, how commissioning bureaucrats interpreted the goals of the reforms, and how this affected the implementation of the market-based reforms.

Chapter 6 continues to explores the impact of regulatory factors on the implementation of the market-based reforms, in the light of the theoretical and analytical discussion in Chapter 3. This chapter answers the second sub-question, focusing on the examination of the incentive structures included in the market-based reforms. It considers whether the market-based reforms have actually created appropriate and effective incentives for both CCGs and healthcare providers, and furthermore, it explains how this affected the implementation process of the 2012 market-based reforms.

Chapter 7 examines the impact of normative and cultural factors on the implementation of the 2012 reforms, in the light of the theoretical and analytical framework provided by Chapter 3. It addresses the third and fourth questions, analysing the extent of normative and cultural influences on policy implementation. This chapter focuses on examining the shared norms, values and culture embedded within the NHS organisations, and how these institutional factors affected the way in which the market-based reforms was implemented through shaping the decision-making and actions of commissioning bureaucrats.

Chapter 8 presents a discussion of the conclusions that can be draw from the empirical evidence. There are three main tasks. First of all, it brings the empirical findings together and provides a systematic review of the main research questions created in Chapter 1. Secondly, it evaluates the contributions to knowledge which arise from this

study in both theoretical and empirical terms. Finally, this chapter considers suggestions for future research.

Chapter 2 The Development of the Market-Based Reforms Following the Health and Social Care Act 2012: Policy History and Background

In order to understand the implementation of the market-based policy reforms that followed the Health and Social Care Act 2012 – undertaken by the Coalition Government – it is necessary to explore the policy history and background of the 2012 Act. This chapter offers a narrative literature review which outlines how the market-based reforms have been developed within a publicly funded system since the 1980s. It is aimed to illustrate the policy history and background against which the Act were introduced by the Coalition Government. It focuses on a brief history of the NHS reforms from the creation of the NHS to the rise of the market-based transformations in the English NHS. Through this review, the policy history and background of the 2012 reforms are presented in this chapter. The chapter discusses three important contextual issues, including the fundamental principles of the NHS, the long-standing cost issues of the NHS, and the quasi-market policy direction that was emphasised by the 2012 Act. Based on the discussion of policy history and background, this chapter illustrates the nature of the market-based reforms following the 2012 Act, which were quasi-market reforms, aiming at intensifying competition in the provision of health services within the English NHS.

This chapter is divided into three sections. The first section provides an historical overview of the creation of the National Health Service in the UK, which assists in understanding the fundamental principles of the NHS. The second sections discusses the financial contexts, the cost problem of the NHS and the wider political austerity, in which the market-based reforms following the 2012 Act was introduced. The last section moves on to review the history and reforms of the NHS in relation to marketisation in the past four decades, which are illustrative of a 'quasi-market' policy direction followed by the 2012 Act.

2.1 The Creation of the National Health Service and its Fundamental Principles

This section discusses the fundamental principles of the NHS. To illustrate the nature of the fundamental principles of the NHS, a brief history of the creation of the NHS has been explored, including health services before the NHS, debates about health reforms during the wartime, and the creation of the NHS by Attlee-led Labour Government in 1948. Through reviewing this period of history, this section outlines the fundamental principles of the NHS that were adopted by the market-based reforms following the 2012 Act. These principles are based on collectivist solution (Addison, 1975), including three critical elements: free of charge, universality and comprehensiveness.

Health Services before the NHS

Before the establishment of the NHS, a mixture of private insurance, charities, and state insurance programmes provided a range of health services for the British people. The state played a limited role in health service improvement, and most of the British population obtained health care through private healthcare market, based on their ability to pay. The original state-led health service programmme was the National Health Insurance (NHI), which was proposed by David Lloyds George, the then Liberal Chancellor of the Exchequer in his budget speech of 1909. This scheme provided compulsory health insurance for all manual industrial workers and offered cash benefits and access to some basic medical treatments (Pringle, 1912). It was a general scheme of insurance against ill-health, which was financed through the contribution of employees, their employers and government.

However, there were many criticisms of this scheme in terms of the coverages, and limits on medical treatments (Klein, 2013b). The NHI just covered about half the British population. The NHI only covered workers, their families were excluded, and it was only available to workers aged over 16 years old. Workers below 16 years old were excluded from this scheme, even if they were in a work environment with a high accident rate. Women had limitedly coverage because the NHI scheme was just available to those employed, and many women did not work after getting married. In addition, cash benefits were the key to this scheme, and medical treatment benefits were

not sufficient under the NHI arrangement. Free medical treatments that were covered by the NHI were limited. Manual workers only gained free access to the basic services such as GPs and access to sanatoria for tuberculosis. Hospital treatments were not free, with financial compensation for ill-health provided instead.

The NHI could not meet the requirement of the British population's expectations in health care. A range of reforms in healthcare started to be developed before the Second World War during the 1920s-1930s, with an increasing recognition within the British politics that the state should take more responsibility for the provision of health care. The report of the Dawson Committee was published in 1919, providing a proposal for creating a comprehensive scheme of hospital and primary health care provision (Ministry of Health, 1920). Later in 1929, the Local Government Act was published, requiring local authorities to take over responsibilities to run health services, and to provide medical treatments to everyone (Hart, 1929; Snell, 1929). People who were able to pay for medical treatments would be charged, but those people who did not have the ability to pay could have treatments for free as ratepayers. There was a growing shift to collectivist solution in health services, which contributed to the emergence of the national health service in the UK and the ideas behind it in the subsequent years.

Wartime Debates about Health Reforms

During the Second World War, there was a political and ideological consensus that

government should play a greater role in protecting social security and social justice (Marwick, 2003; Sullivan, 1999; Titmuss, 2018). The formation of the Coalition Government during wartime paved the way for the rise of the Labour party in British politics and forced the Conservatives to integrate some essential elements of the Labour's ideology into their philosophy (Addison, 1975, 278). The Labour party believed that the state should have the responsibility for delivering welfares, in the forms of healthcare, education, housing, and pension (Marwick, 1967). This was increasingly influential in British politics and public policies during that period. Government intervention and collective provision in welfare were increasingly perceived as the best way to promote equity and security of society (Gamble, 1981, 181; Hindess, 1987, 18-19). Since the 1930s and with the outbreak of the Second World War, there was a recognition that there needed to be an increase in equity and social justice amongst the British society. This resulted in the requirements to reform the system of social security in the UK. The need for some sort of 'welfare state' was seen as a solution for maintaining national stability and rebuilding the normal order by post-war governments (Sullivan, 1999, 116-117). As an important part of the welfare state programmes, the political agenda of creating a universal health care had considerable political supports during the 1930s-1940s.

The 1942 Beveridge Report, *Social Insurance and Allied Services* was commissioned by the Conservative-Labour Coalition Government during the Second World War. The government accepted in principle the recommendations of the report that there was a

need to create a comprehensive system of social security after the war. It founded the theoretical basis for the post-war welfare-state reforms in the UK in general and the creation of the NHS in particular. In this report, it was suggested that a full range of social welfare programmes 'from cradle to grave' should be created in the post-war time (Beveridge, 1942). People should be free from the fear of illness, and thus a 'safety net' should be established against poverty and illness. 'Disease' was identified as one of the five 'giant evils' that would block the path to civilised post-war society (Beveridge, 1942). The report suggested that the government should create a tax-based national health service as a public good applicable to all citizens. This was a complete departure from the established practices of the 1911 health insurance scheme in terms of the scope and coverage. The goal of creating a universal health care proposed by the Beveridge report was largely supported by many political parties.

The inter-war debates of health reforms were summerised by the 1944 White Paper, *A National Health Service* (Ministry of Health, 1944*).* It detailed the wartime coalition government's vision for the creation of a comprehensive, free and universal health service system, prepared by the then Conservative Minister for Health, Henry Willink. It had an explicit aim to expand health care available to the whole British population through a tax-funded service. This proposal was based on the 'collective provision' approach, presenting an outline of what a national health service might look like. It had two basic principles: first, that the health service should be comprehensive, and second, that it should be free. Discussions over the principles of health care in the UK appeared

to reach a political consensus, with the state to increase the role in health services for creating a universal and free health care system. During the 1945 British General Election, both Conservative and Labour parties proposed free access to health care available to all citizens in their manifestos. The basic principles of the 1944 White Paper were reflected later in the National Health Service Act 1946.

The Attlee-led Labour Government and the Creation of the National Health Service

After the Attlee-led Labour party won the general election and came into office, a full range of social and welfare programmes were implemented based on a collectivist approach (Page and Silburn, 1999; Pierson, 2001). In health, Aneurin Bevan, the Minister of Health in the post-war government, discarded the previous health reform White Paper 1944 proposed by the Coalition Government, and presented more radical reforms to Cabinet based on collective provision and the nationalisation of hospitals. The basic principles of the white paper were accepted by Bevan that a system of free and universal health care should be created. He argued that equity and universality in health care could only be achieved by sharing the risks and costs of care across the whole of society through a collectivist approach (Stewart, 2017). But more radically, Bevan favoured the nationalisation of all hospitals, whether municipal or voluntary. This was different from what the previous Coalition Government proposed. In the 1944 White Paper, the Coalition Government had no intention to replace the existing

institutional arrangement of health care provision that hospital treatments were operated by municipal and voluntary organisations. At that point, the government did not plan to nationalise hospitals. However, Bevan viewed nationalisation as the best way of dealing with the problems of local hospitals such as financial problems (Greener, 2008).

The National Health Service Act 1946 was published to establish a universal health care system financed by general taxation. Collective provision and nationalisation of hospitals were embedded into the original structural arrangements of the NHS. Health care was mostly provided by the public sectors, and the funding mainly came from general taxation through collectively sharing the risks and costs of services. The relationship between the state and health was transformed with the nationalisation of the hospitals. Previous municipal and voluntary hospitals were nationalised, with most of hospitals being owned and managed by the state as parts of the NHS system. With the establishment of the NHS, healthcare financing and provision were transferred into the hands of the government. A universal health service system was introduced in 1948 to provide universal, equal and free health care to all members of the British population.

Fundamental Principles of the NHS

The fundamental principles of the NHS are to provide free, universal and comprehensive health care to the whole British population, based on the clinical needs

rather than the ability to pay. These principles are significantly influential in shaping NHS policies and services, reflecting a collectivist solution – everyone contributes to total costs through taxation and people receive the amount of care they need, however expensive that is (Addison, 1975). The NHS was primarily financed and provided by the state, in order to ensure the fundamental principles of the NHS. Behind these arrangements were the legal responsibility of the Secretary of State to safeguard the fundamentals of the NHS as a health system to provide a free, universal and comprehensive health service to all citizens. Adopting these principles, health care in the UK has been regarded as a right of 'citizenship' (Marshall, 1950), with the promotion of risk sharing, risk pooling and collective provision (Tritter et al., 2012). The fundamental principles of the NHS are summarised in Table 1.

Table 1 NHS Fundamental Principles and Description

NHS Fundamental Principles	Description
Health care is free at the point of delivery	NHS services are free of charge. Access to NHS services is based on clinical needs, rather than the individuals' ability to pay.
Health care is universal	Care is provided to all the British population, irrespective of gender, race, disability, age, sexual orientation and

	religion.
Health care is comprehensive	The NHS should provide a comprehensive range of health care to meet the needs of patients.

Source: The NHS constitution (Department of Health, 2015)

First of all, one of the most important NHS fundamental principles is that the NHS provides health services, free of charge. The design of a free health service means that the ability to get treatment is based on the ability of needs rather than the ability of pay (Klein, 1995). The principle of free health care stresses the freedom from fear of cost, which is aimed to abolish any direct financial barrier between the patient and the service (Thunhurst, 1982, 30). Citizens do not first have to consider whether they can afford health care, but instead can expect to receive it regardless of their ability to pay (Greener, 2008). This reflects a collectivist approach that the whole of society pays for health care in a mutual, collective way. As Aneurin Bevan said, 'a free health service is a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst' (Bevan, 1978, 109). In the UK, society bears health costs, while enabling people to live fulfilled lives free form the effects of ill-health. Based on the principle of free health care, the NHS is mainly funded by general taxation.

Secondly, the NHS provides universal health care, which means the universal coverage

and the equal access to free health services. The NHS covers all the British population as a right of citizenship. All the citizens in the UK are entitled to free health care, financed by general taxation. As Bevan said, 'the essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged' (Bevan, 1978, 101). The universality principle highlights that 'there were to be no means-testing, insurance or any other eligibility checks' (Powell, 1966, 30). This is fundamentally different from the previous national health insurance system (i.e. NHI) in terms of scope and coverage. The health insurance scheme often only covered the particular individuals. The coverage of the NHS is universal that all British citizens irrespective of who they are, wherever they live, rich or poor, healthy or sick, receives equal opportunity to the treatment and free of charge (Pollock and Price, 2011).

The comprehensiveness of health care is a fundamental principle of the NHS as well. This means that the NHS should offer a comprehensive range of health care including prevention, diagnosis and treatment of illness. In the theoretical sense, the NHS is meant to provide all-inclusive health care 'from the cradle to the grave'. But demands for health care typically outstrip supply. Covering all health services within the publicly funded NHS is not economically possible and realistic. As a consequence, some types of health services are excluded from the NHS such as medicines and social care. The NHS has always been subject to limitations upon resources, and a comprehensive service is not in the sense of being all-inclusive (Syrett, 2010). The definition of comprehensiveness refers to 'comprising much; of large content or scope' rather than

covering all services (Howell, 1992, 297).

2.2 A Long-Standing Problem of the NHS: The Rising Healthcare Costs

In the UK, the market-based health reform at its origin comes from the rising health service costs which has generated great financial pressures on all the British Governments. Inter-war assumptions about the costs of health care would decrease over time by the creation of a universal health service system, which have never been the case (Greener, 2008). The reason behind this assumption was that, there was a fixed quantity of illness in the community which would gradually reduce when the whole population became healthier by the introduction of a universal and free health service. Politicians expected that costs on health care would decline over time as a result of the improvements in the health of the whole population. However, this failed to take into account that costs of health care would increase rapidly and consistently because of the rising demands from medical technological developments, increases in chronic diseases, the demographic changes and the increased expectations from the public and health professions (Burton, 2013). It was not surprising that healthcare costs had an irrepressible tendency to rise.

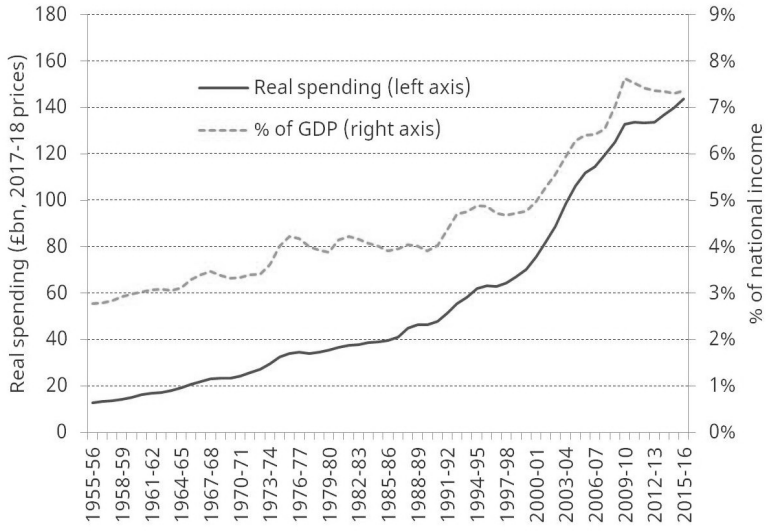
In the first year of NHS operation, the British government spent about £11.4 billion on

health care, accounting for about 3.5 percent of the gross domestic product (GDP) (Harker, 2012). But by 2015/16, the expenditure increased more than tenfold to around £147 billion, representing nearly 7.5 percent of the GDP (ONS, 2017). Growth in health expenditure has increasingly far outpaced the rise in both GDP and total public expenditure. As the Figure 1 reveals, there was a significant increase in the healthcare spending in the NHS from its creation. The delivery of universal health care free at the point of use has inevitably generated great financial burdens to the British governments since its creation, and the rising costs has emerged as a great concern. Increases of health costs were much greater than the governments' estimate, and supplementary funding was always necessary to meet the increased healthcare demands (Ham, 2009, 17). Even if the funding has been increased year after year, the money available for the NHS cannot keep pace with the increased healthcare demands and improvements in medical technology.

When the Conservative party won the general election in 1979, the reduction of healthcare expenditure immediately became a top priority during the economic recession. From the mid-1970s onwards, the financial situation of the NHS deteriorated as the UK economy faced continuing difficulties. Demands for new resources and funding continued to grow while the Conservative government was financially constrained by both the economic recession of the 1970s, and the overall expansion of public expenditure (Day and Klein, 1991). It was difficult for the NHS to balance its budget to meet the increasing demands. How to meet the public expectations of

maintaining and improving health services without largely increasing the financial burden became the key question for the newly-elected Conservative government. A tension occurred within health services between rising demands and limited budgets. As Moran (1995) suggested, the British governments managed to square a very difficult circle: maintaining universal access to comprehensive health care with restrained resources. The rising healthcare costs led to the NHS being regarded as a service that was unable to keep within its budgets and so it was criticised as inefficiency and overspending (Giaimo and Manow, 1999). Many efforts have been made by the Conservative governments since 1979 for addressing the perceived cost and inefficiency issues of the NHS. Since then, reforms for improving efficiency and cost containment have emerged as persistent themes within the NHS in England.

Figure 1 Annual UK Public Spending on Health in Real Terms (2016/17 Prices) and as a Percentage of National Income, 1955/56 to 2015/16



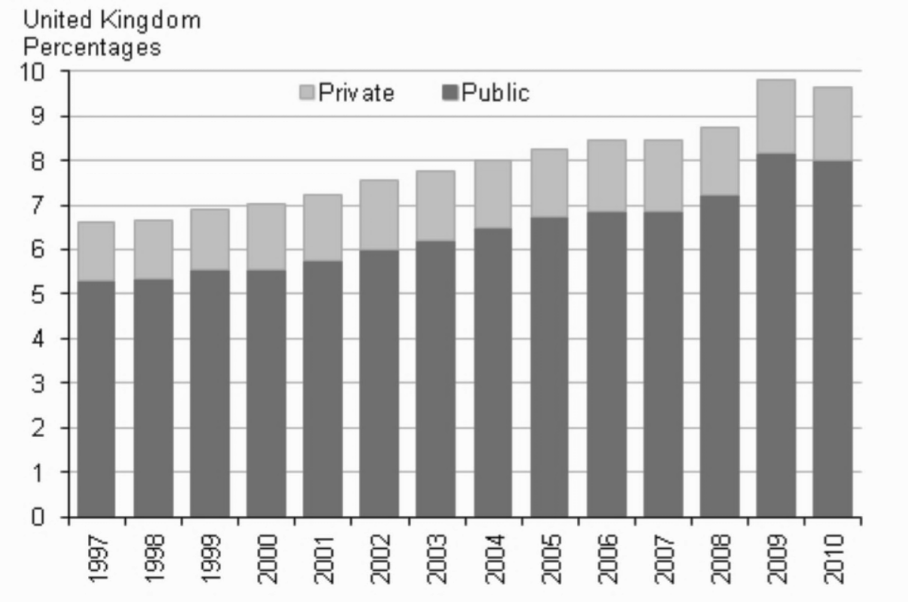
Source: IFS Briefing Note BN201 (Stoye, 2017, 3)

The funding of the NHS became different after the Labour party won the general election in 1997. Funding for the NHS increased at an unprecedented rate under the Labour Government between 1997-2010, in order to deliver the commitments to reduce waiting lists and improve health services. Prime Minister Tony Blair pledged to increase NHS spending up to the European average by 2006, on the television programme of BBC One – *Breakfast with Frost*. An extra £12 billion would be invested into the health care by 2006. This meant health care spending in Britain would increase from 6.7 percent to 8 percent of the GDP (Watt, 2000). As the Figure 2 reveals, the funding of the NHS increased from £55 billion in 1997 to £140.8 billion in 2010, accounting for around 8 percent of GDP. There was an annual increase of 5.7 percent on average, significantly larger than 3.2 percent under the previous Conservative Governments 1979-1997 (Chote et al., 2010, 9). During that time, the UK had a significant sustained increase in spending on health care for the first time in its history.

However, the world-wide financial crisis, which erupted in 2008 starting with the American banking collapse, challenged the arrangements of the Labour Government in terms of the increased public spending and the expansion of welfare state programmes (Smith, 2010, 821). The increase of public expenditure, especially in health service provision created a great financial burden on the Labour Governments. Since 2001, public spending exceeded available revenue, and as a result, the government gradually increased the extent of government borrowing to meet the expansion of the public

service provision (Clarke, 2005). The expenditure on public services increasingly exacerbated the structural budget deficit in the context of economic downturns, because tax receipts declined and spending on welfare programmes rose (Elliott, 2010; Taylor-Gooby and Stoker, 2011). This challenged financial pressures have been inherited by the new-established Coalition Government, with the large structural deficit and one of the greatest economic recessions in the British history.

Figure 2 Public and Private Healthcare Expenditure, Percentages of GDP 1997-2010



Source: Office for National Statistics (ONS), 2012, 6

When the Coalition Government came into office in 2010, it has been dominated by concerns with the budget deficit, and the cuts in public services were regarded as necessary (Lowndes and Pratchett, 2012; Taylor-Gooby, 2012). The national debt was

predicted to peak at around 70 percent of the GDP in 2013-2014 (Lowndes and Pratchett, 2012, 23). In response to this crisis, the government proposed to cut public spending and adopt a range of austerity policies (Vizard and Obolenskaya, 2015). The cuts in public expenditure were massive and rapid, intending to set the UK on a different spending trajectory. In the Spending Review 2010, a reduction of about £30bn in public spending over the next four-year period (HM Treasury, 2010). That meant by 2015, around 490,000 public sector jobs would be lost, with an average 19% cut in the departmental budgets and £7bn to the welfare budget (Lowndes and Pratchett, 2012, 23). Reducing public service costs was regarded as necessary in response to the economic recession and the budget deficit. As the Coalition Government Spending Review 2010 argued:

> "The Coalition Government inherited one of the most challenging fiscal positions in the world. Last year, Britain's deficit was the largest in its peacetime history – the state borrowed one pound for every four it spent. The UK currently spends £43 billion on debt interest, which is more than it spends on schools in England. As international bodies such as the IMF and OECD have noted, reducing the deficit is a necessary precondition for sustained economic growth. Failure to take action now would put the recovery at risk and place an unfair burden on future generations. The Spending Review makes choices. Particular focus has been given to reducing welfare costs and wasteful spending." (HM Treasury, 2010, p.5)

In health, the reforms following the Health and Social Care Act 2012 had its origins in financial concerns about the costs of public services and health care in particular as well as the cuts in public services. Prior to the change of government in 2009, a stringent financial pressure on the NHS was anticipated by David Nicholson, the then Chief Executive of the NHS, known as "Nicholson challenge". An "efficiency saving" programme of £15-£20 billion between 2011-2014 was suggested in order to fill the gap between increasing demands and limited budgets (House of Commons Health Committee, 2010a, 18-19). A report from the Nuffield Trust suggested that the NHS in England "must either achieve unprecedented and sustained increases in productivity or increase the funding in real terms after 2014/15, in order to avoid the falls in the levels or quality of service" (Roberts et al., 2012, p. 44-45). Although in health, the Coalition Government promised to increase the budget annually, with a rise by £10bn by 2014 to £114bn (HM Treasury, 2010), that did not mean a sufficient rate of increase in health budgets. When the inflation in health care was considered, the budget was only planned to increase by about 0.1% every year. Nevertheless, since its creation, healthcare spending has annually increased by an average of 4% in real terms (Roberts et al., 2012, 6). That is to say, although the government announced that the NHS would be excluded from the spending cuts, the NHS would still suffer a financial squeeze from 2010 because of the slowdown in the funding increase and growing demands. As the House of Commons Health Committee (2010a, p.3) revealed:

"The October 2010 Spending Review has imposed tough settlements on both health

and social care, and sets a highly challenging context for the delivery of health and social care services over the next four years. In both cases efficiency gains will need to be made on an unprecedented scale if care levels are to be maintained and the quality of services improved."

The introduction of the marketisation agenda following the 2012 Act was under this wider context where public services were operating with reduced budgets. The priority of eliminating the deficit from the economic recession and the expanding costs of public services resulted in policies of austerity being pursued by the Coalition Government and successive governments. Although the NHS has not been fully exposed to the wider austerity policies, these policies had an influence on health services, since the average annual growth rate of health spending would be far below both historical trends and the increases under the previous Labour governments (The King's Fund, 2015). This made it very difficult to meet the rising demands of health care in reality. The increasing demands for health care in the presence of the economic and financial constraints created a number of dilemmas for the Coalition Government. The most pressing problem was to meet the increasing public expectations on health services in a context of austerity and limited health budgets. It was not surprising that reforms around service improvements within limited health budgets in the NHS were necessary. Health reforms following the 2012 Act that centred on efficiency and cost-effectiveness were argued as inevitable by some in the government, in order to meet the challenges outlined above.

2.3 The 'Quasi-Market' Policy Direction: The Intensification of Competition and the Health and Social Care Act 2012

This section outlines the recurrence of familiar themes and the key characteristics which are illustrative of a 'quasi-market' (Le Grand and Bartlett, 1993) policy reforms adopted by the Coalition Government in response to cost issues in health. In the market-based reforms, the assumption has been that the introduction of market principles can provide more and better quality services at a reduced cost (i.e. producing cost-efficiency and value for money) (Curristine et al., 2007). Although market mechanisms were introduced to transform the NHS, the fundamental principles of the NHS have never been significantly challenged. This was because the fundamentals of the NHS underpinned by a tax-funded approach have always enjoyed overwhelming supports from the public. Therefore, marketisation of the NHS were always deliberately designed to reconcile market elements with the NHS fundamental principles, in order to make changes happen in such a popular institution (Klein, 1995). In reality, the market-based health reforms within the English NHS illustrated the nature of a 'quasi-market' policy direction. The 2012 Act followed this direction to transform the English NHS. The funding and financing of health service remained unchanged, and the reforms were aimed at intensifying competition in the provision of health services. A brief discussion of what constitutes the core policy elements of the 2012 market-based reforms is presented in this section, and this will be further expanded upon in the

Chapter 5.

Assumption: Efficiency Improvements and Cost Reduction through Marketisation

The economic and financial challenges generated pressures and opportunities for the Coalition Government to introduce their own health reform strategies that centred on efficiency and cost containment. The practical problems of the great economic recession and budget deficit limited the ability of the government to increase health care budget greatly, and ideologically, Conservatives were unwilling to support massive increases in the budget to meet healthcare expectations. As a result, increased efficiency through enhancing competitive provision was argued as the best way to meet the gap between the increased demands and limited health budgets. This market-based solution have a political and ideological basis – the New Public Management (NPM) ideas of the early 1980s. The NPM ideas highlight that many functions of the state should be returned to markets, because service provision would be more efficient in the market settings. During the 1980s, NPM reforms in the UK centred on marketisation of public services, including a greater reliance on competitive pressures for the provision of public services and an introduction of private sector provision for competitive reasons (Bevir and Rhodes, 2003; Hood, 1991; 1995; Ferlie et al., 2005). The aims of these reforms were to improve economic values such as efficiency and cost-effectiveness in public service delivery. The role of market was a critical part of the debates of the NPM

reforms that have attracted considerable attention of the successive governments and policy-makers. Under the brand of NPM, there have been a range of the market-based reforms in the UK public sectors, with the emphasis on the extension of market elements into the public services for improving efficiency and reducing costs. This has changed the way public services being delivered in the UK (including health services).

In health, there have been continuing attempts to marketise health services in the NHS in England since the 1980s. The market-based approach to transforming the NHS is based on the presumption that market incentives and competitive pressures will force public sectors to improve efficiency of services and reduce costs. According to this presumption, public sectors and bureaucrats responsible for providing health services have little or no incentive to ensure cost-efficiency and cost less, and thus market mechanisms (such as competitive tendering and contracting out) should be extended into health care provision to force public agencies and bureaucrats towards more cost-efficient behaviour in service delivery. In particular, the market-based approach emphasises the involvement of private sectors in the delivery of health services, as the external pressure for enhancing competition, and furthermore improving cost-efficiency of health services. In doing so, it is assumed that market competition occurs both internally (within the public sectors) and externally (across the public, private and voluntary sectors). Internally, public agencies need to compete within each other for resources and funding, and externally, the competitive pressures may come from the non-public sectors.

The market-based reforms are aimed at opening up the NHS markets and encouraging a wider variety of healthcare providers to deliver health services for competitive reasons. Under the forces of competition, healthcare providers are assumed to be more efficient and more responsive, because they could be rewarded for the delivery of service improvements (notably efficiency); if they failed, they would lose incomes as their contracts could be switched (Klein, 1998, 113). The competition occurs as funds are reallocated and contracts are renewed. For winning contracts for rewards, public sectors might improve their services, and in this sense, the forces of competition would maximise efficiency of health services and reduce costs. According to this presumption, health services have been changed to operate in a competitive environments for achieving efficiency and reducing costs since the 1980s, and the British governments have almost continuously attempted to make their environments become more competitive (Walker et al., 2011).

The claim that market elements would improve efficiency of services was a central justification of the market-based reforms following the 2012 Act. The Coalition Government sought to enhance market competition within the English NHS for improving efficiency and reducing health costs. The changes in the economic and financial environments (i.e. the economic recession began in 2008 and financial pressures created by a free and universal health services) strained the resources and funding available to the NHS. Many Conservatives (notably the then Health Secretary

Andrew Lansley) argued that these pressures had rendered healthcare provision unsustainable, and therefore, it was important to improve efficiency of healthcare provision and reduce healthcare costs. The political discourses within the Coalition Government 2010-2015 were that public services could overcome the challenges of the resource limitation and increased demands through delivering services in a more efficient and effective manner (Solar and Smith, 2020a). Health reforms under the Coalition Government were based on the NPM belief that market incentives and competitive pressures could produce more efficient and cost-effective service delivery. Following the 2012 Act, the Coalition Government introduced new competition policies and rules to shape commissioning decisions and behaviour of CCGs, intending to expand the level of market competition in health service provision.

The Popularity and Persistence of the Publicly Funded Health Services

Although the health reforms have introduced the market elements into the delivery of health services, it is important to note that the market reforms in the NHS were always deliberately designed to reconciling market elements with the fundamental principles of the NHS. The British public is strongly in support of the NHS as an institution to provide free, universal and comprehensive health care that is primarily tax funded (Gershlick et al., 2015). In the British politics, there was a general recognition that radical changes in the funding of health services were politically and electorally impossible, because universal and free health care had overwhelming electoral supports

in the UK (see, for example, Dixon et al., 2011; Enthoven, 2000; Giaimo and Manow, 1999; Greener, 2002; Le Grand, 1999; Paton, 2016; Tuohy, 1999; Klein, 1995; 2013a; 2013b).

When the Thatcher Government was established in 1979, in order to cope with the economic failure and the financial pressures from the expanded welfare state, it decided to restructure public sectors and citizen entitlements to welfare. The aim was to reduce the state role in the public services and to dismantle welfare entitlements (Moran, 1988, 22). In health reforms, the initial proposals were to place the funding of health services by an insurance-based scheme (Howe, 1994). There were some senior Conservatives, and some groups on the right that supported the NPM ideas of privatising health services, with an intention to radically transform the post-war consensus that health care should be tax-funded. Some Conservatives committed to the ideas of replacing the tax-funded system by private insurance, and in the 1979 election manifesto, the Conservative Party raised this issue (Klein, 1985). A compulsory private insurance scheme was suggested by Thatcher, her chancellor Geoffrey Howe, and other senior Conservatives (Travis, 2016). Thatcher had explicit ideas around the NHS reforms that supported the privatisation of health services in the UK. As she recorded in her memoirs:

> 'If one were to recreate the National Health Service, starting from fundamentals, one would have allowed for a bigger private sector – both at the level of general practitioners (GPs), and in the provision of hospitals; and one would have given

much closer consideration to additional sources of finance for health, apart from general taxation.' (Thatcher, 1993, p. 607)

However, the NHS was largely immune to funding reforms because of its popularity (Greener, 2008). Privatising the NHS by certain private insurance scheme was proved to be politically and electorally impossible. The health reform of the Thatcher-led government was in a position that the NHS was the most popular part of the welfare state, with the majority of population insisted that it deserved higher level of funding even at a cost of the higher taxation (Taylor-Gooby, 1995, 4). A strong public support for general taxation as the principal funding stream was realised by many Conservatives such as the then Secretary of State for Health, Norman Fowler. The Labour party perceived the issue of the NHS as a critical weapon for increasing their political credit in the general election, claiming to be in favour of the fundamentals of the NHS. Under the threat of political and electoral punishments, the Thatcher Government was committed to protecting the universality and equity of the health service provision. They decided not to turn health care over to the market, but focusing on policies designed to introduce market and competition into the publicly funded NHS.

Privatisation of funding was never taken seriously by the Conservative government (even though some Conservatives may have believed in it). They knew that any suggestion of privatisation was likely to be a major vote loser. The Conservative government withdrew privatisation of the NHS from political discourses and affirmed

their commitments to the fundamental principles of the NHS and the existing arrangements of financing (Walsh, 2000, 504). It was not politically feasible to change the institution of funding the service from general taxation that was employed to ensure universality and equity in health care. The most important constraints on the radical transformations (such as privatisation of health service funding) within the NHS was political. The NHS meets the shared needs of the vast majority of the British population, enjoying the overwhelming support of the public. Any reforms within the NHS might provoke a significant reaction. In effect, the NHS is an extremely political issue (Salter, 1998). As Giaimo and Manow (1999, p.974) commented:

> 'The NHS expresses this solidarity as the right of all to a comprehensive level of care, (nearly) free of charge, on the basis of clinical need rather than on ability to pay. And the public continued to expect the state to act as the guarantor of this right. Such considerations prevented Thatcher from moving towards outright privatisation of health care financing and also compelled her and Major to carefully craft and constrain the workings of the internal market to avert the most egregious inequities and chaos that unbridled competition would have unleashed'.

When introducing health reforms, all British governments claimed to protect the fundamental principles of the NHS and insisted that their reforms would not compromise these principles (even though the Conservatives ideologically dislike living with the welfare state and support the privatisation of public services). Under the

Coalition Government, health reforms following the 2012 Act had no intention to transform the way how health services were financed, although it was facing an extremely challenging financial problem and proposed to reduce public service spending to solve its budget deficits. In the 2010 general election, the Cameron-led Conservatives realised that the fundamental principles of the NHS had been entrenched under the previous Labour Governments, resulting in a commitment to the NHS embedded in the consciousness of the voters (Smith, 2010). Therefore the Conservatives promised to increase the funding the NHS, in order to avoid a loss of electoral confidence and support. The public support for the NHS's fundamentals was overwhelming so that politicians were unwilling 'to be held responsible for undermining popular programmes that benefit all' (Béland et al., 2014, p.753). The reforms following the 2012 Act have remained the funding of the NHS untouched, with a clear statement that 'the services provided as part of the health services in England must be free of charge' (Department of Health, 2012, p.2). The Prime Minister of the Coalition Government, David Cameron stressed that he was committed to the NHS fundamentals and pledged to increase its funding. Even as the Coalition Government attempted to restrain the growth of general public spending, health care experienced a continued growth in funding (Hills, 2011, 605).

In the 2012 reforms, the commitment to taxation-funded services was politically and electoral critical, reflecting that equity and universality principles were still strong priorities while market elements were employed to increase efficiency. The NHS was

too popular for direct attack, and thus the reforms were deliberately designed not to compromise the fundamental principles of the NHS. The reforms sought to achieve the economic values such as efficiency and cost reduction, but they were adopted on grounds of equity of access and universal coverage (Allen, 2013). So the state retained the responsibility of financing and providing universal health care, and preserved collective provision through a tax-funded national system. It represented an attempt to combine the advantage of a publicly funded service (social equity) and those of a market system (efficiency and cost-effectiveness) (Day and Klein, 1991). Marketisation co-existed with the fundamental principles of the NHS was used to legitimise the actions of reforming such a popular institution. The market-based reforms were argued to be a necessity to control costs and increase efficiency, which was great for the Conservative governments as they could argue for the use of market methods to improve health services. They were not privatising the NHS as the vast majority of health services were still publicly funded by taxation, but they were using market elements to improve the service.

The central parts of the market-based changes in the Act were around the way in which health care was provided rather than the funding of health care. The government highlighted to use the existing budgets in an efficient and cost-effective manner, and then the 2012 Act largely focused on the expansion of competition in service provision. The Coalition Government held a vision of marketising health service but within the confines of a publicly funded care system. The fundamentals of the NHS were accepted

by the Coalition Government, but substantial investment in health to achieve this aim was rejected (see, for example, Bochel, 2011; Corbett and Walker, 2013; Smith, 2010; Taylor-Gooby, 2013; Taylor-Gooby and Stoker, 2011). The reforms following the 2012 Act attempted to reconcile the extension of market competition with those NHS fundamental principles and goals (Millar et al., 2011). There was a wider argument within the government that maintaining universal health care could be achieved within limited budgets through increased efficiency in the use of public money, and this could be done by competition and greater private provision, rather than considerably increasing the budget. The Coalition Government had a clear intention to intensify competition in service provision for economic values of efficiency and cost reduction, but universality and equity in health care were never neglected.

'Quasi-Market' Policy Reforms: The Intensification of Competition under the 2012 Act

Marketisation of the NHS following the 2012 Act was around intensifying competition in health service provision, in an effort to solve the cost issues of the NHS, rather than directly changing the financing and funding methods. The Coalition Government sought to combine the advantages of market competition with the safety of retaining public funding to protect universality and equity in access to health care (Allen, 2013). The reforms following the 2012 Act illustrated the nature of a 'quasi-market' policy direction (the conceptions of 'marketisation' and 'quasi-market' used in this thesis has

been discussed in previous Chapter 1). Overall, the reforms had four key features. First of all, the reforms remained the funding and financing of the NHS largely untouched, although a range of policies and rules have been adopted to enhance competition in the provision of health services. Secondly, the changes were based on the split between the functions of purchasing and providing health care. Thirdly, the policy reforms were related to the commissioning and procurement of health care, with an emphasis on competition law to shaping commissioning decisions and behaviour. Additionally, the reforms entailed provider diversity (especially the increased use of private providers by CCGs) for enhancing competition. In this section, the market-based policy changes of the 2012 Act are briefly presented, with regard to a range of new competition policies and rules (these changes will be further discussed in Chapter 5).

Publicly Funded Health Services

As discussed in previous Chapter 1, the essence of 'NHS marketisation' is something of a hybrid: reconciling market principles with publicly funded services, which refers to 'internal market' or 'quasi-market' policy reforms (Klein, 1998). The collectivist solution through general taxation was a 'given' that all the British governments had accepted since the creation of the NHS in 1948, willingly or not. The popularity of the NHS ensured that the role of the state remained crucial and that the funding of health services did not change in any significant way (Hills, 2011). In the NHS quasi-markets, consumers (patients and service users) were not using their own resources to make

decisions about the use of health care (Allen, 2013). Instead, the state was the primary funder of health services, with the responsibility to fund healthcare through using general taxation. Patients and service users were not 'customers' in the usual sense. They did not pay for their own healthcare, and the state funded the health care they received. According to the report of the ONS (2017), health care in 2017 was mostly funded by the central government, with low private medical insurance coverage and scarce out-of-pocket expenditure from patients. Following the 2012 Act, reforms of enhancing marketisation and competition were conducted within the context of publicly funded services.

Funding health services through general taxation means that the overall budget of health services is effectively determined by the central government. Funding for health services in England comes from the Department of Health's budget (announced in the Department's expenditure plans and published as part of each Spending Review). Within the NHS system, the Department of Health and ministers have the overall responsibility for providing health service, accountable to Parliament for all healthcare expenditure. The Department is accountable to Parliament for ensuring that the overall spending on health care is contained within the overall budget authorised by Parliament. It is responsible for ensuring that all NHS agencies perform effectively and have controls in place to ensure value for money. Moreover, public funded service means that the NHS is always subject to resource limitations. Health care is budget-limited so that it has to be provided within a set amount of available financial resources and funds

(Greener, 2008). The central government can decide the level of funding for health services, and often it has the political authority and motivations to control its total costs (Bevan and Robinson, 2005). The government can directly underfund the NHS to limit the growth of health expenditure from the top. This can generate pressures on NHS organisations to balance their finances and control health costs at the point of delivering health services (Barber, 2008). Cost control is inevitably one of the most important priorities for NHS organisations in the context of publicly funded health services.

The Split of 'Purchasing' and 'Providing' Functions

The marketisation of the NHS are characterised by a split between state authorities' purchasing and providing roles, and the introduction of contracts (Bartlett, 1991). Instead of a provider of health services, the state attempted to become primarily only a purchaser of the services, with service provision being replaced by diverse providers (including NHS providers, private providers and voluntary providers). These provider compete with each other for contracts from purchasers in quasi-markets (Glennerster and Le Grand, 1995). Purchasers are responsible for planning and purchasing health services (GP services are excluded) for local populations within budgets devolved from the centre. They allocate budgets as they choose between competing healthcare providers. The providers are NHS hospitals and community service Trusts/Foundations Trusts (FTs) for delivering and producing a comprehensive range of health care to local populations. These providers are semi-independent, with degree of autonomy to

develop their own strategies of operation and service provision, in competition with each other for contracts from purchasers. In addition, non-NHS providers (especially private sector providers) are allowed to deliver health services in order to create external competitive pressures for those NHS providers. A split of 'purchasers' and 'providers' exists in the English NHS whereby the purchasers are responsible for contracting with healthcare providers to deliver services for patients. Health budgets could be reallocated and contracts could be switched if providers failed to improve their services. As a result, competition between providers was assumed to be possible due to the fear of losing contracts from purchasers. To win contracts, providers might be motivated to improve their services to meet the requirements of their purchasers. Market competition are thus introduced within the NHS system, acting as a way to force healthcare providers to improve their service in an efficient manner.

The separation of 'purchasing' and 'providing' functions was initially introduced by the White Paper *Working for Patients* under the Thatcher Government (Department of Health, 1989). A 'internal market' was established by the Conservatives, in which health authorities (i.e. District Health Authorities, DHAs) and GP-fundholders as 'purchasers' were able to manage their own budgets for the first time and could purchase health services from healthcare providers (Giaimo and Manow, 1999). By exposing providers to competitive pressures, it was assumed that resource allocation and service provision would become more efficient (Gilbert et al., 2014). Since then, the themes of markets and competition have become central for policy-makers. When

it took office in 1997, the Blair-led Labour Government inherited the legacy of the Conservatives' reforms, accepting the role of market and competition in health service provision (Hughes and Vincent-Jones, 2008). The split of 'purchasers' and 'providers' remained, even though the Labour party claimed to abolish the 'internal market'. In place of DHAs and GP-fundholders, smaller locality-based purchasers were created known as primary care trusts (PCTs) (Allen, 2002). A series of new policy initiatives was introduced to produce a more marketised system, with an emphasis on the introduction of private sector providers (Allen et al., 2015). On the basis of the split between 'purchasers' and 'providers', the Coalition Government, taking power in 2010, introduced its own health reforms following the 2012 Act. The reforms were intended to increase the level of marketisation and competition within the NHS in England. It did this by creating new competition rules for commissioning and procurement practices, and by allowing competition for the provision of health care between any qualified providers (especially including the private sector providers).

Health Service Commissioning and Procurement

Policy initiatives related to the procurement and commissioning of health services since the 'internal market' reforms have set the basis for the market-based reforms introduced by the 2012 Act. Commissioning organisations are responsible for planning and purchasing health services on behalf of patients who cannot do so themselves, and on the government's behalf. Commissioning health care is 'the activity of agencies and

agents who secure health services on behalf of a population, aiming to maximise benefit for that population by obtaining the best value in terms of cost and quality of services' (Lewis et al., 2009, p.44). Commissioning organisations need to ensure that services meet the needs of local population and that budgets are not overspent. Health care commissioning functions include a set of linked activities such as health needs assessment, procurement of services (selecting and contracting providers to meet the needs) and monitoring the outcomes (Lewis et al., 2009, 45).

Within the NHS in England, commissioning, procurement and contracting have been adopted as important market mechanisms to achieve important goals such as efficiency improvements and cost containment. At local levels, funding and resources are transferred between commissioning and healthcare provider organisations through procurement and contracting. Procurement and contracting policies are fundamental to strengthen competition in the NHS. In the process of commissioning, commissioning organisations can shape the structure of healthcare providers, as they can choose providers, reallocate health funds and swift their contracts. By threatening of reducing or losing contracts and income, commissioning organisations can exercise power over providers who are largely dependent on the them for their resources (Sheaff et al., 2015, 11). In this situation, providers are assumed to compete for NHS funds and to be rewarded for efficiency.

Following the 2012 Act, Clinical Commissioning Groups (CCGs) were established by

the 2012 Act. They took over the vast majority of the health budget for purchasing and commissioning health services from healthcare providers at local levels, including urgent and emergency care, elective hospital care, and community and mental health services. They were given more autonomy in the selection of and contracting with healthcare providers. In order to expand competition, a new policy framework was created by the Act that competition rules and regulations (notably the section 75 of the Act) were passed into legislation to shape commissioning decisions and behaviour. Monitor became into economic regulator, enforcing competition law to prevent anti-competitive behaviour by CCGs. Creating markets and competition were encouraged in the health service commissioning. Through competitive tendering exercises, CCGs can stimulate competition between public and private providers, with contracts shifted to the efficient one (Krachler et al., 2021). Market mechanisms such as competitive tendering and contracting-out were encouraged as important tools for CCGs to create competition to shape the behaviour of healthcare providers, forcing them to be more efficient and cost-effective. For the first time, competitive procurement and tendering were legally forced in service commissioning, rather than an internally-negotiated rules within NHS organisations (Sanderson et al., 2016, 2). This new competition policy framework for service commissioning created a new dynamic, which will be further explored in Chapter 5.

Provider Diversity

Another important element of the market-based reforms following the 2012 Act focused on greater provider diversity that CCGs were encouraged to use alternative providers of care for enhancing competition. Any qualified providers (AQPs) were allowed to tender for contracts from the CCGs (Speed and Gabe, 2013). These providers can be public, private or voluntary sector organisations. CCGs were required to produce a level playing field for any qualified providers to compete for NHS contracts (Department of Health, 2012). Traditionally, the provision of health care was publicly dominated when the NHS was founded in 1948. The NHS had been a monolithic provider that public sectors dominated the provision of health services. In order to make competition happen, there is a need to create a comprehensive range of healthcare providers for commissioners to choose (Farrell and Morris, 1999; Greener, 2005). Market can be competitive if commissioners have a choice between alternative providers who are competing for their business. Since 1979 reforms of the NHS had a provider-side component with regard to provider diversity policy under which a range of differently-owned organisations (especially private sector providers) were incorporated to create competition for the NHS contracts (Sheaff and Allen, 2016). One theme of the market-based reforms was to replace a single provider (i.e. the NHS provider) with a diversity of possible providers, and the policies of competitive tendering and contracting out were expected to have that effect (Cousins, 1988). Commissioning organisations were encouraged to diversify providers by using competitive tendering and contracting out. In theory, health services are put up for tender rather than being delivered in-house, with contracts being awarded to the provider able to deliver the most cost-effective

services (Greener, 2008).

The theme of provider diversity has been introduced by the Thatcher Government reforms, it was further developed under the Labour Governments and the Coalition Government, which was particularly reflected by a range of policy initiatives around private sector involvement. Since 2002 further reforms in England have begun to create a more competitive market with greater diversity of healthcare providers, and private sectors have become an integral part of the NHS (Brookes and Harvey, 2016; Lewis et al., 2009; Powell, 1999). Under the Labour Governments 1997-2010, more market entrants (especially private sectors) were encouraged to deliver services in the name of increasing choice for patients (i.e. choice of where they are treated and by whom) (Allen, 2009). The 'purchasers' of care in the NHS, Primary Care Trusts (PCTs) were required to promote competition and patient choice by larger-scale contracting out and outsourcing. They were given the freedom to select between alternative providers, including both public and private sectors (Lewis and Gillam, 2003). Under the Coalition Government, the 2012 Act sought to encourage CCGs to increase the use of non-NHS providers. The AQP policy was introduced to expand the range of providers that were allowed for health service provision within the NHS in England (Department of Health, 2010; 2012). Competition rules was applied to the NHS quasi-market, requiring CCGs to produce a level playing field which allowed neither public not private providers to tender for NHS contracts (Exworthy et al., 2016). This encourage of provider diversity was critical part of the attempts to intensify competition within the English NHS.

Greater provider diversity is underpinned by a contracting and payment policy, known as 'Payment by Results (PbR)'. It is a standard national tariff, with a list of fixed prices for a range of operations and procedures (Department of Health, 2007). This policy was introduced by the Labour Government in 2002 and inherited by the Coalition Government. Prior to 2002, hospitals were predominately funded by block contracts in which prices for delivering certain services were locally negotiated between purchasers and providers. From 2002, the Labour Government introduced the PbR policy – a prospective, nationally-fixed, case-mix adjusted payment for each episode of care (Marshall et al., 2014). Under this policy, the way CCGs pay for care provided by NHS hospitals is largely based on the activity-based contracts (Sheaff et al., 2015, 5). Starting from a small range of elective surgeries, PbR tariffs have been extended into nearly all acute hospital services and certain mental and community health services.

The policy of PbR is a kind of financial incentive to mobilise providers to become much more involved in the NHS markets for competition. Providers are paid a nationally fixed amount of money for every activity they have carried out, such as hip replacements. In this sense, a potential financial incentive is created for healthcare providers to participate in the NHS markets. In theory, for receiving more rewards, healthcare providers need to compete for more contracts and attract more patients to be treated at their hospitals, and at the same time, they have to improve their efficiency to keep the costs below the national prices. By winning more contracts and reducing their

costs below the levels of tariff price, providers have the opportunity to gain extra income (Mannion et al., 2008). Otherwise, they will lose rewards. In the theory of the PbR policy, providers could have strong financial incentives to become involved in market competition and improve their efficiency in exchange of more rewards from CCGs. That is to say, CCGs can use PbR contracts to incentivise local healthcare providers to participate in the NHS markets and compete for the NHS contracts.

2.4 Conclusion

This chapter focuses on the policy history and background of the market-based reforms following the 2012 Act in the NHS in England. By reviewing the history and reforms of the English NHS from its creation to the development of the marketisation reforms, this chapter provided the policy background and context against the market-based reforms introduced by the 2012 Act. The background discussion included three main issues, i.e. the fundamental principles of the NHS, the long-standing cost issue of the NHS, and the nature of the quasi-market policy reforms. First of all, this chapter outlined the fundamental principles of the NHS by reviewing the history of the creation of the NHS. These principles are based on the solution of 'collective provision', with three distinctive elements: free of charge, universality and comprehensiveness. As an important part of the welfare state, the NHS was created to provide free, universal and comprehensive health care to all the British citizens, free at the point of delivery in

1948. Everyone has been entitled to a range of comprehensive health care, free at the point of use. In order to guarantee these principles in health care in the UK, the NHS was designed to be a public service, primarily funded by general taxation and mainly provided by public organisations (i.e. nationalised hospitals) at the point of its creation.

Second, this chapter considered a long-standing problem of the NHS which had been emerged soon after its creation, i.e. the uncontrolled increase in healthcare costs. This contributed to the emergence of the market-based reforms in the NHS in England. Costs of health care have increased rapidly and consistently since its creation, because of the rising healthcare demands for a growing elderly population, the increases in chronic diseases and the development of medical technologies. Increase of health costs was inevitable to meet the increasing healthcare demands. This has created a number of dilemmas for the British governments. The economy went into recession from 2008, and public deficit rose sharply, and as a result, the cost issue has been exacerbated within the NHS. Reforms were perceived as necessary in the contexts of economic recession and rising health costs which generated financial pressures on the Coalition Government.

Thirdly, this chapter discussed the quasi-market policy direction that was followed by the 2012 Act. The rising costs of the NHS led to it being criticised as inefficiency and overspending, and increased efficiency through marketisation became an attractive solution since the 1980s. However, the fundamental principles associated with the tax-

funded approach always enjoyed the overwhelming supports from the public. The funding and financing of the NHS remained largely untouched, immune to trends of the market reforms. In health, the reforms tended to focus on the introduction or intensification of competition in the provision of health services rather than changing the way in which it was funded. This was the case in the Coalition Government reforms following the 2012 Act. The Act had no intention to transform the funding of the NHS. It was aimed at intensifying competition in the provision of health services for improving efficiency and reducing costs. The reforms following the 2012 Act were deliberately designed to reconcile market competition with the NHS fundamental principles, in order to make changes happen in such a popular institution.

The market-based health reforms following the 2012 Act reflected the nature and characteristics of a 'quasi-market' policy direction, with four key elements. First of all, the 2012 reforms accepted the publicly funded approach in health services, the main merit of which was to ensure the fundamental principles of the NHS. Secondly, the reforms were based on a split between the functions of purchasing and providing health services. Thirdly, the reforms included a range of policy initiatives in relation to health care commissioning and procurement. In order to intensify competition in health service delivery, CCGs were required to apply market mechanism of competitive procurement and tendering in health service commissioning activities. Moreover, the reforms highlighted grater provider diversity. CCGs were encouraged to diversify healthcare providers and to increase the use of private sector providers for enhancing

competition. Overall, the 2012 Act had a clear intention to enhance the level of competition in the provision of health services, through creating new competition framework for health service commissioning and procurement, and through greater provider diversity policy (especially the increased use of private sector providers).

Chapter 3 Identifying Factors that Influence Policy Implementation: From an Institutionalist Framework

The purpose of this chapter is to develop a theoretical and analytical framework for understanding the process of implementation of the market-based reforms following the 2012 Act and identifying the factors in existing studies that may influence the delivery of the reforms. As discussed in previous Chapter 2, the 2012 Act has changed the policy framework of health service commissioning and procurement, with regard to the intensification of competition. Following this new framework, CCGs should create markets and competition when they commission health services and select healthcare providers. Market mechanisms such as competitive procurement, tendering and contracting out were encouraged to be applied in the practices of health service commissioning, for intensifying marketisation and competition between healthcare providers. As key policy implementers, the decision-making and behaviour of local commissioning bureaucrats within CCGs is critical to influence the implementation process of the market-based reforms introduced by the Act. When examining the implementation of the reforms, we need to find out what factors can influence how commissioning bureaucrats reached decisions and behaved in the process of commissioning health services, and of which may hinder the implementation of the market-based transformations introduced by the 2012 Act.

This chapter reviews a broader literature on policy implementation and institutional theories, in order to answer a central question: what are the factors that may influence the process of implementation? The aim of this chapter is to identify factors that can help us to understand the nature of implementation of the market-based reforms under the 2012 Act. By reviewing theories from both implementation and institutionalism, this chapter seeks to provide a systematic approach to the study of policy implementation. In this study, the starting point for understanding implementation is that decisions and behaviour of policy actors involved in implementation are shaped by the demands of a broader institutional environments, and they need to cope with different and sometimes contradictory demands from these environments. The institutional environment within which implementers make decisions and take actions is particularly important for analysing the problems of implementation in this study. Scott's (2014) framework of dimensions of institutions are employed to conceptualise the institutional factors, with a focus on the regulatory, normative and cultural influences on implementation. Implementation literature on top-down, bottom-up and hybrid approaches is reviewed in order to specify these institutional factors. As a result, a theoretical and analytical framework has been developed to understand implementation and implementation problems. It is assumed that policy implementation will be affected by a range of institutional factors through structuring the decisions and behaviour of policy implementers.

There are a range of institutional factors identified to examine the process of implementation, including regulatory, normative and cultural factors. These factors consist of the institutional environments within which implementers reach decisions and take actions. On the basis of institutional perspectives and implementation theories, regulatory factors with regard to formal rules and policies are identified as critical to influence implementation. Implementation problem may be a consequence of ambiguous policy goals and/or the lack of appropriate incentive structures. Moreover, the literature review suggests that normative and cultural factors could have impact on implementation. Implementers are often social actors necessarily in response to the normative and cultural demands of their own organisations. There are some problems with implementation, when government policy decisions are perceived as conflicting with the shared norms and culture within organisations. In this study, the dynamics between policy implementers and institutional factors is particularly important for understanding implementation process.

This chapter is organised in the following way. It begins with reviewing the existing implementation literature around the 'top-down', 'bottom-up' and hybrid approaches, with a conclusion that a hybrid approach of both 'top-down' and 'bottom-up' is more suitable for studying implementation, rather than simply focusing one of them. The second section discusses an institutionalist framework for implementation as core analytical approach used in this study. The next three sections consider important institutional factors that may influence the process of policy implementation. Lastly, an

analytical framework used by this study is summarised for understanding implementation process and implementation problem.

3.1 Literature Review of Implementation Studies: 'Top-down', 'Bottom-up' and 'Hybrid' Approaches

In the analysis of implementation, approaches to understand implementation have been developed over the last fifty years. Researchers of implementation disagreed on the theory of implementation nor even on the variables crucial to the effectiveness of implementation (O'Toole and Montjoy, 1984). They explored implementation from diverse theoretical perspectives, identifying different variables to make sense of their empirical findings. There are three major approaches that can be identifies as the most effective methods for studying implementation, i.e. 'top-down', 'bottom-up' and 'hybrid' approaches of 'top-down' and 'bottom-up' (see, for example, Barrett, 2004; Barrett and Fudge, 1981; Brynard, 2005; deLeon and deLeon, 2002; Goggin et al., 1990; Hjern and Hull, 1982; Hjern and Porter, 1981; Hill and Hupe, 2014; Lester et al., 1987; Lester and Goggin, 1998; Lipsky, 2010; Matland, 1995; O'Toole, 2000; O'Toole and Montjoy, 1984; Pressman and Wildvasky, 1984; Sabatier, 1986; Sabatier and Mazmanian, 1980). In general, the implementation literature suggests that policy decisions are often difficult to translate from ideas into practices. But the factors influencing implementation are identified from different insights. Top-down

perspectives focus on the problems of the structure of the policy itself, seeking to provide advice for ensuring the centre can achieve its policy intentions. Bottom-up perspectives are concerned with what actually happens to policy in the hands of implementers, and the factors affecting this process. The hybrid approaches are trying to combining the strengths of both top-down and bottom-up perspectives. In this section, it begins with a broader literature review of the approaches to policy implementation study, and then it points out that a combination of both top-down and bottom-up perspectives on implementation will be employed in this thesis.

Top-down Approaches

Top-downers highlight the role of policy designers and concentrate their attention on factors that can be manipulated at the central level to understand policy implementation (see, for example, Bardach, 1977; Gunn, 1978; Hogwood and Gunn, 1984; Pressman and Wildavasky, 1984; Sabatier and Mazmanian, 1980; Van Meter and Van Horn, 1975). Sabatier and Mazmanian (1980) suggest that implementation is the carrying out of policy decisions that identify the problems to be addressed, and the goals needed to be achieved. These decisions structure the implementation process. Implementation analysis is concentrated on understanding the degree to which the stated goals of policy-makers at a national level have been achieved by the subordinates. This approach is dominated by the assumption that implementation starts with policy goals, and that the implementation process is an essentially top-down administrative and hierarchical

follow-on in a linear fashion (Barrett, 2004; Schofield, 2001). Such top-down assumption of policy delivery mechanism is reflected in the traditional structures of public administration and public sector organisational model, i.e. the 'Weberian ideal-type' model, 'emphasising the separation of politics and administration, and co-ordination and control through authority and hierarchy (Barrett, 2004, p.254). In Weber's description of bureaucracy, the decisions made at the centre would be delivered at local levels through a process of hierarchical, bureaucratic organisations with a clear lines of control measures and tight boundaries discretion (Smith et al., 2011, 977). Centrally located actors and policy itself are regarded as most relevant to producing the desired outcomes.

From the top-down perspectives, implementation studies identify the causes of implementation problems, with a focus on policy design flaws (Keiser and Meier, 1995). Implementation problems have been seen as a function of poorly-designed primary policy and legislation. There is some common advice about implementation provided by top-downers: make clear and consistent policy objectives (Van Meter and Van Horn, 1975; Mazmanian and Sabatier, 1980), minimise actors and agencies involved in implementation and ensure communication and co-ordination between them (Pressman and Wildavasky, 1984), limit the extent of policy changes (Sabatier and Mazmanian, 1980; Van Meter and Van Horn, 1975), provide sufficient resource (Pressman and Wildavsky, 1984; Van Meter and Van Horn, 1975) and effective administrative control (Sabatier, 1986; Van Meter and Van Horn, 1975). Top-downers have a strong desire to

provide generalised policy advice, which requires to find consistent, recognisable patterns in behaviour across different policy areas (Matland, 1995, 147). They believe that such patterns exist and focus on identifying factors that can be manipulated by the centre.

However, the top-down approaches have substantial weaknesses in explaining implementation. Most notably, top-downers view implementation as a purely administrative and hierarchical follow-on process, exclusively focusing on the role of central policy-makers and thus neglecting local actors. Graham (2005) criticises that top-downers overemphasise the role of central control in implementation and the insufficient attention paid to how policy actually gets executed. The core argument of Barrett and Fudge (1981) in the book of *Policy and Action* has challenged the traditional 'top-down' view of the implementation process, and its assumptions about the existence of hierarchical relations between policy-making and implementation. They argue that implementation is an integral and continuing part of the political policy process rather than an administrative follow-on, which 'involving negotiation and bargaining between those seeking to put policy into effect and those upon whom action depends' (Barrett, 2004, p.253). Sabatier (1986, p.30) also criticises the top-down assumption that 'the designers of the policy decisions are the key actors and that others are basically impediments'. Top-downers tend to overemphasise the role of policy and the central government in controlling the decision-making and behaviour of local policy implementers such as street-level bureaucrats, local implementing officials, local

administrators, and private sectors. These actors often have some degree of discretion and autonomy to modify and revise policies according to their own interpretations and purposes. Because of these weaknesses, the top-down approaches cannot fully explaining the implementation process.

Bottom-up Approaches

In responses to the problems of top-downers, a range of 'bottom-up' approaches have been developed to analyse implementation during the late 1970s and early 1980s (see, for example, Elmore, 1978; 1980; Barrett and Fudge, 1981; Berman, 1978; Hiern and Hull, 1982; Hjern and Porter, 1971; Lipsky, 2010). Bottom-uppers believe that policy mediated, negotiated and modified during its formulation will continue to be shaped by the decisions and behaviour of those involved in its implementation seeking to pursue their own goals, values and interests. In contrast to the top-downers focusing on formal organisational hierarchies, communication and control mechanisms, bottom-uppers focus more on the actions and activities of implementing actors and agencies, and the nature of their interactions in shaping implementation processes. Berman (1978) argued that policy is implemented on two levels: the central government devise a government programme at the macro-implementation level; and local agencies react to the central programme and develop their own plans to implement it. He suggested that problems of implementation are often the result of the interaction between central policy and local institutional settings. McLaughlin (1987, p.172) argues that 'local capacity and will'

are critical to determine the outcomes of implementation: the former can be addressed by policy at the top through providing sufficient training, funding, and consultants; 'but will, or the attitudes, motivation, and beliefs that underlie an implementor's response to a policy's goals or strategies, is less amenable to policy intervention'. Elmore (1980) puts forward a term 'backward mapping' as an analytical approach for understanding implementation. In the study of implementation, it is necessary to understand how policy actors shape the way the policy is delivered at the local levels.

One of the most important features of the bottom-up approach is that it highlights the role of local actors and their ability in shaping implementation. This approach emphasises that local actors have significantly more autonomy and discretion than those at the top believed, thus their decisions and behaviour are critical to shape the implementation process. Bottom-uppers point out that top-downers fail to consider, or at least underestimate, the role of street-level bureaucrats and target groups to divert policy to their own purposes (Lipsky, 2010; Elmore, 1980; Berman, 1978). Street-level bureaucrats are seen as the key actors who implement public policies, and deliver public services on the ground. Lipsky (2010) suggests that these street level bureaucrats have considerable discretion in determining the nature, amount, and quality of benefits and sanctions provided by their agencies. More recently, Riccucci (2005, p.115) notes that 'professional norms, work customs and occupational culture' are better explaining the behaviour of street-level bureaucrats than management. Dubois (2010, p.150) also observed that street-level bureaucrats were not just sticking to 'merely implementing

the regulations', but 'using their discretion and apply[ing] the rule according to their interests'. Clearly, these are cases of bottom-up perspectives, which emphasise the ability of local bureaucrats in shaping public policy, probably frustrating the centre according to their own goals, strategies and activities (Sabatier, 1986). During the implementation process, the nature of the policy and its potential impact might be modified, elaborated or even negated by implementing actors (Hill and Hupe, 2014, 7). According to the bottom-up perspectives, public policy is likely to be modified in ways that match local specific conditions, institutional environments, the norms, values and beliefs of implementing actors as well as their perceived interests.

However, the bottom-up models also have some limitations in terms of their explanatory capacity for studying implementation, because they overemphasise the role of local actors and assumes that policy implementation occurs in a decentralised policy-making environment (Sabatier, 1986; Linder and Peters, 1987). The central issue is that the bottom-up methods exaggerate the level of local autonomy, and ignore the resources of central policy-makers and the policy itself which could shape implementing actions (Matland, 1995) – i.e. those critical factors significantly concerned by many top-down researchers. Sabatier (1986) points out that bottom-up perspectives overstate the ability of the periphery to frustrate the center. Simply focusing on the role of local actors could underestimate the centre's ability to influence the decisions and actions of local actors through shaping the policy and regulatory structures in which they operate. In effect, implementing behaviour is inevitably constrained by a range of policies, rules and

regulations set by the central government. In the study of policy implementation, we should not ignore the influence of the policy itself.

Despite the weaknesses, the bottom-up approaches have provided an important methodological contribution to analyse implementation. Instead of the role of the central government and policy itself, the decision-making and actions of subnational actors need more considerations from the insights of bottom-uppers. Top-downers start with the objectives of policy, and attempt to figure out 'what ought to happen', without insufficient attention on the complexity of relationship and interactions taking place in the implementation process. Bottom-up approaches tend to identify factors influencing decision-making and behaviour of implementing actors. But importantly, in the process of identifying these factors, we should include the role of governmental policy and rules playing in shaping implementing behaviour and outcomes.

Hybrid of the Top-down and Bottom-up Approaches

Conventional approaches of top-down and bottom-up have some limitations in the analysis of implementing behaviour and implementation processes as discussed above. Top-down models assume that implementation can be controlled by policy decisions, and therefore, implementing behaviour and outcomes are coherent and linear. These models believe that legislators and policy-makers would set a clearly defined role for each step or actor in the implementation process, and align it with an associate outcome

consistent with the original intentions of the policy (Elmore, 1980). These perspectives have been questioned and critiqued both by academics and practitioners. For example, the nature of political decision-making process in which policy is formulated makes it difficult for policy-makers to provide clear directions and goals for implementers to follow (Matland, 1995). It is unrealistic to see policy process as linear and coherent, and there is often some problems of translating policy into actions. Bottom-uppers do not see implementation as simply a managerial or administrative issue, but a political process involved in multiple local actors' decisions and actions. Implementation is a result of 'interactions among a plurality of separate actors with separate interests, goals and strategies' (Scharpf, 1978, p.337). Implementers are often somehow independent of central influence or control. Implementers are seen as important 'policy-makers' who can not only decide which laws, rules, or procedures are applied or enforced, but also have the ability to revise and redefine the nature of policy delivered. So it is important to get inside the decision-making and implementing practices of those actors who are in charge of delivering public policies and services on the ground, and explore the factors affecting this processes.

More recently, in the light of criticisms of both top-down and bottom-up perspectives of policy implementation, a number of researchers have attempted to combine these two approaches (see, for example, Elmore, 1980; Goggin et al., 1990; Linder and Peters, 1987; Matland, 1995; O'Toole, 1986; 2000; Sabatier, 1986). With the development of implementation studies, scholars have increasingly focused on both the ability of

central control and local autonomy. Solely applying either of each has been seen as unhelpful in explaining the complex implementation process. O'Toole (1986, p.204) suggested that 'it is worthwhile to seek synthesis on some of the empirical questions, and to build upon the strengths of and contextual questions implied by the separate perspectives'. This focuses on incorporating the strengths of both approaches, and to avoid the conceptual weakness of them. There are various attempts in terms of combining top-down and bottom-up approaches, which is still under development by implementation theorists. The synthesis of implementation analysis developed by Sabatier (1986; 2005) adopts the bottom-uppers' unit of analysis (i.e. a whole variety of public and private actors involved with a policy problem) and their emphases of understanding the perspectives and strategies of major actors, combining with top-downers' focus on the manner in which socio-economic conditions, legal instruments and the basic government structure constrain behaviour.

In recent decades, implementation has been characterised by complexity and the trend of implementation studies is towards a multi-theoretical approach. Implementation scholars are trying to combine insights of both the 'top-down' and 'bottom-up' approaches into an analysis model of policy implementation. Researchers of implementation have realised that it is not possible to come up with any single or simple model for meeting the challenges of the study of implementation in the context of the changing governance structures of the public sectors. As Gornitzka et al. (2005, p.48) suggest that 'the complexity of public policy and political sub-system poses serious

challenges to the study of implementation, when ideas of self-regulation mix with continued aspirations and practices of central control, and when structures of responsibility and governance are unclear'. Thus, it is important to develop partial theories to understand implementation, which combine the most convincing elements of different theories, depending on the policy area and context (Cerna, 2013, p.25).

By a broader review of implementation literature, this research uses both top-down and bottom-up perspectives to explore the implementation process of the market-based reforms following the 2012 Act. Starting from the bottom-up perspectives, the thesis focuses on the what actually happens to public policy in the hands of implementers, that is, the process of implementation. The study seeks to examine the way decisions and actions are constructed by implementers, and identifying factors affecting these processes (Hill and Hupe, 2014). But adopting a purely bottom-up approach to this research has some limitations. This may over-emphasise the power of local actors to challenge the central government. It is critical to realise that decisions and behaviour of local implementing actors can be affected by the centre, because the centre has the ability to influence implementation through structuring policy decisions (Matland, 1995; Sabatier, 2005). Underlying the quest for understanding implementation is the assumption that decisions of policy implementers are shaped by the very nature of a policy itself. It is necessary to examine how the design of the policy by central government structures the decisions and actions of implementing actors. Therefore, this study adopts the position that one of the important factors influencing implementation

is the design of policy. The research focuses on the decision-making and behaviour of implementers from a bottom-up perspective but does not exclude from some top-down insights. Generally, it advocates for a hybrid approach combining both perspectives when examining implementation.

3.2 Institutionalism and Public Policy Implementation

The section discusses how institutionalists' perspectives could provide a lens for analysing implementation. From the insights of institutionalist theories, the impact of institutions is particularly critical for the study of implementation, as human actions are often structurally determined. In the political organisations, policy implementation is a specific instance of collective actions, since it requires collective choice and responsibilities from various actors (Fowler, 2018). Institutions are particularly critical for understanding the organisational activities, and so are critical for the analysis of implementation (Hill and Hupe, 2014). Policy actors with the responsibilities for the implementation of public policy do not make their decisions and take actions in a vacuum defined by governmental policies and their statutory obligations. Instead, they are situated in a broader political and social environments in which they have to cope with different and sometimes contradictory demands of the government, society and service users (Smith et al., 2011). These environmental factors are particularly important for understanding the decisions and behaviour of the policy actors in charge

of delivering a given policy.

From an institutionalist perspectives, policy actors in charge of implementation are subjected to mixed institutional pressures that shape how they reach decisions and take actions. The central theme of analysis to implementation is how decisions and behaviour of implementers are shaped, mediated, and channeled by institutional arrangements (Hill and Hupe, 2014). It is important to place implementation processes in their institutional contexts, as implementing actors are often faced with a wide variety of policy decisions or environmental pressures from a range of resources. When conceptualising these institutional factors, Scott's (2014) framework of the dimensions of institutions is employed, with a focus on regulatory, normative and cultural factors. This section starts with presenting the definition of 'institutions' used in this thesis. It then moves to a discussion of the main institutionalists' perspectives, exploring how institutional factors may affect implementation through shaping decision-making and behaviour of implementers.

The Definition of 'Institutions'

There is a lack of a universally agreed definition of an institution, with many interpretations and perspectives within institutionalism from different disciplinary fields and from the traditional and more recent schools of thoughts (Currie and Finnegan, 2011). From the perspectives of old institutionalism, institutions have a

particular association with the rules, procedures and formal organisations of government. The old institutionalism is more focused on the study of constitutions and the organisational arrangements of representation and government, explaining constraints on both political behaviour and democratic effectiveness (Rhodes, 1997). Old institutionalists tend to compare executive and legislatures, or political parties and electoral systems across countries and over time, with an aim to assume about what constituted a 'good political system' (Lowndes and Roberts, 2013). Attention has mainly been given to the legal framework and the organised and evident arrangements of government such as constitutions, cabinets, parliaments, counts, and bureaucracies (Scott, 2014). This approach has been criticised for its limitations in terms of concentrating with the formal rules and institutions of government. The theory of old institutionalism cannot 'explain governance through networks and coalitions, the growing interpenetration of markets and bureaucracies, or the withering of political parties as mass organisations (Lowndes and Roberts, 2013, p.26). This limitation became increasingly clear in the context of public management and governance reforms, as the formal hierarchies of government came under pressure.

New institutionalism, which has been developed since the 1980s, reconsiders institutional theories and integrated some insights of old institutionalism. Based on the work of new institutionalism, the term of 'institutions' has a broader definition, not only focusing on formal rules and structures of the government. Institutions has been conceptualised as anything from marriage, family, markets, management, religion and

media. They all show resilience over time, providing stable, valued and recurring patterns of interactions and behaviour (Peters et al, 2005). Hall and Taylor (1996, p.947) regard institutions not just as 'the formal or informal procedures, routines, norms and conventions, embedded in the organisational structure of the polity or political economy', but also as institutions providing 'moral and cognitive templates for interpretation and action'. From the perspectives of new institutionalists, institutions such as informal socially-structured behaviours and practices, shared cognitions and belief as well as the formal rules and structures in relation to government have been seen as core elements for analysis in political science. This is different from the old institutionalism which largely concentrates on formal structures and rules of government. Scott (2014, p.56) has effectively integrates various institutional theories from economics, sociology and political science in a systematic way, offering his own interpretation about the definition of institution:

> Institutions comprise regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life.

The regulative, normative and cultural elements have been argued as the building blocks of institutions, which provide the concept of 'institutions'. This study is consistent with this definition, as it provides a systematic and comprehensive definition of institutions. In this conception, institutions are multifaceted, durable social structures,

made up of symbolic elements, social activities, and material resources (Scott, 2014, 57). From the definition of Scott (2014), informal social relationships and behaviour as well as shared cognitions and beliefs can become institutionalised to determine how decisions are made, what actions are possible and what has meaning (Meyer and Rowen, 1977). This definition highlights the social and cultural environments organisational actors are located. From this notion, there are a wide range of institutional factors that could affect decisions, choices and behaviour within organisations, such as the formal rules and policies made at the top of the government, as well as informal norms and values, and shared beliefs embedded within organisational behaviour. In this sense, actors are embedded within an institutional matrix, and their behaviour are therefore subject to pressures form their environments (Selznick, 1949).

The Scott's (2014) definition of institutions is suitable to identify the factors that affect implementation in this thesis, as it can combine the perspectives of both top-down and bottom-up approaches. From top-down perspectives, governmental policies and rules are the key factors that constrain the decision-making and behaviour of policy implementers, whilst the bottom-up perspectives typically focus on the discretionary power of implementers to modify a policy in accordance with their own purposes. Scott's definition of institutions refers to a wide range of institutions that may affect actors' decisions and behaviour within organisations, which can include the key factors influencing implementation that have highlighted by both top-down and bottom-up approaches. Implementing actors are subject to a mix and complex institutional

environments (including regulatory, normative and cultural environments) at the point of delivering a given policy. The institutional environments implementers exist is critical for understanding their activities and policy implementing process. The study adopts the position that the institutional environments of implementers comprise regulatory, normative and cultural aspects, which is based on the definition of Scott (2014).

Institutions and Implementation

After clarifying what institutions mean in this study, the next question is around how institutions can determine decisions and behaviour of implementers and implementation processes. Institutionalist approaches to analysing public policy implementation highlight a wide range of institutions that affect the decisions and behaviour of actors within organisations with responsibilities for implementing government policy decisions. Generally, institutional factors can enable or constrain behaviours of policy implementers. Institutionalism highlights that the actions of policy actors are driven, at least in part, by their institutional contexts (Hall and Taylor, 1996). Existing institutional settings could play a critical role in constraining and enabling how implementing actors decide and behave. According to institutional analysis, policy implementers' decisions and behaviour are often affected by a range of institutional factors, and therefore implementation are shaped by these institutions. As Smith et al. (2014, p.340) argue, existing institutional arrangements 'structure how actors think

about what they are doing, both individually and collectively, and this bounds the possible and conditions the probable'. These institutional factors constrain or incentivise the actions of implementers, and so affect which policy will or will not be undertaken by them. As Scott (2014, p.58) suggests:

> Most treatments of institutions emphasise their capacity to control and constrain behaviour. Institutions impose restrictions by defining legal, moral, and cultural boundaries, distinguishing between acceptable and unacceptable behaviour. But it is equally important to recognize that institutions also support and empower activities and actors. Institutions provide stimulus, guidelines, and resources for acting as well as prohibitions and constraints on action.

In terms of how institutions affect decisions and behaviour of actors, there are two main insights: rational choice institutionalism and sociological institutionalism. Rational choice institutionalism is based on the 'cost-benefit calculus approach' to understand actors' decisions and behaviour, and the 'culture approach' is highlighted by sociological institutionalism (Hall and Taylor, 1996). The calculus approach builds on insights from rational choice theory, based on the application of economic assumptions that actors are often self-interested, behaving rationally and strategically according to the calculation of benefits and costs (Ostrom, 1986). This approach emphasises instrumental behaviour in pursue of relatively stable and calculated goals. From these insights, institutions primarily refer to formal rules and policies. Institutions are

constructed as a way of regulating behaviour because they are backed by incentives and sanctions (Scott, 2014). Ostrom (2011) argues that rules affect the structure of a situation in which actions are selected, primarily through influencing the costs and benefits attached with particular combinations of actions and outcomes, and they serve as incentives for actions. From this view, institutions can provide the 'prescriptions' that define what actions and outcomes are required, prohibited or permitted, and the sanctions authorised if the rules are not followed (Ostrom, 2011). Actors' decisions and behaviour are in conformity to institutions under the incentive forces such as sanctions or rewards.

Perspectives of sociological institutionalism emphasises 'culture approach' to understand the relationship between institutions and behaviour, adopting that decisions and behaviour of actors is not fully rational – a calculus of costs and benefits – but bounded by the socially-structured institutions – a products of social interactions such as the shared social norms, values, and beliefs (Hall and Taylor, 1996; March and Olsen, 1984;1989; Scott, 2014). The general understanding of sociological institutionalism is that the behaviour of actors should be grounded not only in rational choice models, but social and cultural perspectives as well. From the insights of sociological institutionalism, actors tend to adjust their behaviour to socially-structured institutions for gaining legitimacy and supports for their activities (DiMaggio and Powell, 1983). Crucially, sociological institutionalism is more focused on informal socially-structured values and norms as well as shared conceptions and beliefs embedded within

organisations. These socially-structured institutions have constraining effects on the patterns of actor's decisions and behaviour through providing 'moral or cognitive templates for interpretation and action' (Hall and Taylor, 1996, p.939). These institutions define the appropriate behaviour in given circumstances (March and Olsen, 1984; 1989).

These two institutional insights imply that institutional factors can affect decisions and behaviour of policy actors at the point of delivering public policies. In the complicated processes of translating policy decisions into practices, the government depends on a range of organisations and bureaucrats to deliver policy and achieve a particular outcome, and these actors are crucial actors involved in implementation. From the perspectives of rational choice institutionalism, the decisions and behaviour of implementing actors are guided by self-interests or utility maximization, and hence, appropriate incentives mechanisms of public policy are essential to structure their decisions and actions and secure compliance. That is to say, it is critical for the government and policy-makers to design certain incentives attached with policy decisions to ensure compliance by implementers. This is because these mechanisms can control implementers' choices and actions for achieving the intentions of government and policy-makers. If a policy does not involve some appropriate incentives, then the process of implementation may be difficult.

Sociological institutionalism emphasises the social obligations of actors in charge of

delivering policy and the social world in which these actors are located (Smith et al., 2011). A range of socially-structured institutions such as values, norms, beliefs and culture are highlighted as explanatory factors for implementing actions. These kinds of institutions shape decisions and behaviour of actors mainly through defining the appropriate way to think and act. In this sense, it is critical for government and policy-makers to design a policy that is not incompatible with those socially-structured institutional factors. If government policy decisions cannot find a fit with the normative and/or cultural environments in which implementers are located, there could be a number of implementation problems. In sum, implementers are subjected to mixed institutional pressures that shape how they should behave. In robust institutional arrangements, regulatory, normative and cultural factors can work in combination to shape the decisions and behaviour of the actors in charge of delivering policy (Scott, 2014, 56).

These insights provide a general understanding that institutional factors could be used to explain the implementation process and implementation problems. But we need to further specify and elaborate the details of each institutional factors and examine how these factors are able to affect policy implementation. The theoretical and analytical framework for this thesis need further development. The following sections will do this through an in-depth literature review around both institutionalism theories and policy implementation. How different categories of institutional factors influence implementation are then amplified with three modes of institutional influences: the

regulatory, normative and cultural. In each case, the study review insights from both implementation and institutionalism theories to explain how institutional factors can be used to examine policy implementation and the problems with this process. Section 3.3 examines the impacts of the regulatory factors on shaping the process of implementation. Section 3.4 analyses the normative institutional factors that could be used to understand implementation. Section 3.5 considers how cultural factors could affect the process of implementation.

3.3 Regulatory Factors and Implementation

This section discusses two main regulatory factors that could influence public policy implementation, which are associated with the design of formal rules and policies by the government. The characteristics of policy goals and incentive structures are identified as critical regulatory factors that may affect implementation. The regulatory factors in this study refer to formal rules and policies that attempt to influence the decisions and actions of local commissioning actors, and ultimately how they should behave. These institutions are formally constructed and written down rules, including legislations and laws, regulations and policies. They provide regulatory processes within which policy implementers work to deliver policy in the interests of the government. The regulatory processes involve practices of rule-setting, monitoring, and sanctioning activities and incentivising in an attempt to influence behaviour of actors

(Scott, 2014). In this study, the regulatory institutions mainly consist of extant legislation and policy framework in the NHS in England that guided commissioning decisions and actions. The government introduced a range of formal policies and rules in relation to commissioning following the 2012 Act, which are important regulatory institutions. By the 2012 Act, there was a newly-established national executive body, i.e. NHS England, managing the NHS system and overseeing commissioning at the top, operating at arm's length to health ministers (the details of the newly-structured NHS system will discussed in Chapter 5). Formal rules and policies made by NHS England are also seen as part of the regulatory framework that may influence the decisions and behaviour of commissioners. In this study, formal policies and rules at the national level are seen as the regulatory factors, by which implementation of the 2012 market-based reforms might be affected.

Ambiguity of Policy Goals, Room for Discretion and Implementation

In order to examine how regulatory factors could affect implementation, it is helpful to start from an in-depth analysis of the design of formal rules and policies by the government. Institutional perspectives indicate that the general function of regulatory institutions is to provide stability and order of behaviour in political system which otherwise would not exist (Lowndes and Roberts, 2013; Peters et al., 2005; Scott, 2014). Institutions can reduce uncertainty and risks by providing clear guidelines and frameworks of what type of activities is considered legitimate (Scott, 2014). Visible,

transparent and precise rules are vital characteristics of regulatory institutions, allowing actors to know what they are agreeing to when they participant in a 'game' (Lowndes and Roberts, 2013). Ambiguous rules may lead to interpretative searching for meaning to inform decisions and actions (Scott, 2014). If formal rules are formulated ambiguously, it is difficult to constrain behaviour and secure compliance. As an important regulatory factor, public policy defines intentions of government and specific patterns of activities required from implementers. Effective implementation means the compliance with the requirements of the governmental policy about changing behaviour accordingly. From the institutional perspectives, public policy formulated ambiguously may hinder implementation, as the likelihood of different interpretations at the point of delivery can increase in the context of unclear and ambiguous policy framework.

These institutional insights are supported by many typical top-down studies for implementation, suggesting that the nature of policy goals will affect implementation processes (see, for example, Gunn, 1978; Hanf and Scharpf, 1978; Matland, 1995; Pressman and Wildavasky, 1973; Sabatier and Mazmanian, 1980; Van Meter and Van Horn, 1975). Public policy is the implicit or explicit intentions of government and the expression of those intensions entailing specific patterns of activity or inaction by governmental agencies (Barrett and Fudge, 1981). The extent to which a policy can clearly define its intentions, and the way implementing actors should behave to achieve these intentions will affect whether and how the policy is implemented. It can be argued

that clearly and precisely designed policy goals in the legislative level are critical for effective implementation, allowing policy implementers to know what actions are required from them, and then to adjust their behaviour. A sound policy is one that explicitly articulates the desired goals and objectives that the policy-makers seek to achieve through the implementation of the policy, and the means to make these goals a reality (Syvester and Ferrara, 2003, 9). Therefore, one of the important regulatory factors influencing implementation could be identified as the characteristics of policy goals, i.e. the level of clarity or ambiguity in terms of policy goals.

However, public policy literature suggests that it is difficult to design a clear and unambiguous policy goals, and that the ambiguity of policy goals is an inherent characteristic of a public policy (Lindblom, 1959; 1979; Matland, 1995; Taylor et al., 2021). Policy design is a problem faced by most policy reforms in the legislative process, and few reforms avoid problems with clarifying policy goals (Keiser and Meier, 1996). This is because there are multiple goals difficult to reconcile with each other in the policy-making processes. Policy are often the result of political negotiations and compromises. Policy-making process is often involved in political conflicts, in which policy-makers disagree about their most desired policies (Oosterwaal and Torenvlied, 2011). It is difficult to reach agreed-upon set of goals in policy-making. Most of public policies are not the result of decisions made by single policy-makers based on agreed-upon goals (Lindblom, 1959; 1979). Political parties are strategic to mask conflicting objectives in order to build a legislative majority, and policies tend to ‘be creatures of

compromises in which policy inconsistencies, ambiguities, and silences constitute a necessary price for passage' (Brodkin, 2008, p.320).

In effect, the legislative passage of a policy reform is subject to political negotiations and compromises, often requiring 'the ambiguous language and contradictory goals to hold together a passing coalition' (Matland, 1995, p.147). Such ambiguity provides policy-makers opportunities to skip over contentious issues and reach political agreements, which is a way to increase the chance of its adoption, although probably at the cost of implementation complications (Baier et al., 1986). To make policy agenda successfully passed through legislative processes for implementation is probably at the expense of policy clarity and unambiguity (Oosterwaal and Torenvlied, 2011). The political decision-making system tends to produce policies with degree of ambiguity and vagueness in terms of goals. Policies are often legislated with many key elements left ambiguous and indeterminate, because policy-makers are unable to agree with each other. The ambiguity of policy goals reflects the natural and inevitable result of the political decision-making process. It is reasonable to expect that policy goals have some degree of inherent ambiguity and vagueness.

In the legislative process, the ambiguity of policy goals as a consequence of compromises between various policy-makers will leave room for multiple interpretation and discretion in action (see, for example, Gunn, 1978; Matland, 1995; Pressman and Wildavasky, 1973; Sabatier and Mazmanian, 1980; Van Meter and Van

Horn, 1975; Zahariadis, 2008). The implementation process 'begins with a decision about what policy is to be implemented and is then followed by a course of smaller decisions made by implementers as they interpret said policy' (Fowler, 2018, p.406). When policy goals are ambiguous, there are unclear boundaries between formal policy and informal rules of the game as implementers can interpret them in multiple ways (Sharkansky and Friedberg, 1998). These blurred boundaries leave the flexibility for policy implementers to make decisions and choices themselves about the appropriate courses of actions in relation to policy delivery based on their own interpretations and understandings from and about the policy. The ambiguous policy goals directly influences implementation process, because it allows discretion for implementers to interpret how the policy is executed. The ambiguity can affect the ability of the central control over implementers' interpretations and the level of discretion granted to implementers. Policy implementers tend to be left to cope with policy reforms with ambiguous goals which may have limited guidance from the centre (Fowler, 2020). In the context of highly ambiguous goals, it is unavoidable for implementing actors to decide how policies work in practice.

Implementation studies have acknowledged that policy goal ambiguity in formulation and the discretion associated could be responsible for implementation problems, as it paves the way for uncontrolled decisions and actions of implementers (see, for example, Gunn, 1978; Hupe, 2011; Matland, 1995; Pressman and Wildavasky, 1973; Sabatier and Mazmanian, 1980; Van Meter and Van Horn, 1975). From the top-downers' insights,

effective implementation is dependent on setting clear and consistent policy goals and objectives. If the policy goals are unclear and ambiguous, then it is logical that implementing actors would have more discretion for implementation. Not surprisingly, policy is likely to be interpreted and implemented differently to the intention of the central government and policy designers. In the context of ambiguous policy goals, implementors will be confused about what needs to be implemented, and they will have discretion to impose their own views on the implementation of policies, views that may be different from policy-makers (Hupe, 2011). The modification, redefinition or even resistance of the government policy decisions may be seen as appropriate behaviour by implementers, because ambiguous goals allow multiple interpretations and the room for discretion. The ambiguity of policy goals could reinforce the likelihood of ineffective implementation, because it provides room for implementing actors to adjust policy according to their own interpretations (Matland, 1995).

Looking at the literature of the 2012 NHS reforms, there are several empirical-related studies suggesting that the goals of commissioning policy and rules were ambiguous and unclear (Allen et al., 2017; Osipovic et al., 2017). By examining the overall regulatory environments in which CCGs reached decisions and took actions, some studies observed the co-existence of competition and collaboration polices within the English NHS, which resulted in widespread confusion about commissioning policy and rules at local levels (Osipovic et al., 2016). Neither commissioners nor providers fully understood the regulatory framework in respect of competition and collaboration (Allen

et al., 2017). Especially, since 2014, policy development by NHSE has been significantly towards a more collaborative and integrative directions under the national policy – Five Year Forward View. There were two different commissioning policy goals, i.e. improving competition and collaboration (Osipovic et al., 2016). On the basis of theoretical discussion above, the ambiguous commissioning policy goals may influence the implementation of the market-based reforms on the ground. This study seeks to investigate the extent to which policy goal ambiguity can be used to explain the problems with implementation. More specifically, this research will examine whether or not the policy goals of the 2012 Act were formulated ambiguously at the legislative level, and how this affected the implementation of the market-based reforms. This will be discussed in the Chapter 5.

Policy Incentives and Implementation

Another important regulatory factor that may influence policy implementation is the incentives that the policy creates. From the perspectives of rational choice institutionalism, actors conform to formal rules as pursuing their self-interests, and they could comply with the formal rules that can bring about some incentives and benefits (Ostrom, 1986; 2011). Institutions can shape actor's behaviour through providing incentives. Formal rules often involve incentives (such as rewards and sanctions), in attempt to influence behaviour and secure compliance. Actors are in conformity to the requirements of formal rules, probably because those rules provide incentive

framework for behaviour within which actors could take advantage of. Whether formal rules are attached with incentive structures could influence behaviour of actors and secure compliance. The lack of incentives cannot effectively shape behaviour and secure compliance. This suggests that policies with appropriate and effective incentives that can bring about benefits to implementers are more likely to be implemented. The absence of incentives may contribute to the problems in delivering the policies.

These institutional insights are in line with many studies of policy implementation. Implementation literature highlights the role of policy incentive structures in implementation, suggesting that public policies have the ability to structure implementation process through offering incentives for compliance of implementers to engage in certain patterns of activities (see, for example, McDermott, 2016; Sabatier, 1986; Stoker, 1991; Van Meter and Van Horn, 1975; Weissert, 2001). This mainly concerns the structure of incentives faced by the key actors in charge of implementing policies. Some types of public policies seek to provide incentives for behaviour within which policy implementers could take advantages of. Appropriate incentives are critical for determining the effectiveness of implementation, as they can motivate implementers to behave in a desired way (McDermott, 2016). Especially, incentives are critical in situations where there are multiple relatively autonomous actors involved in the delivery of public policy (Stoker, 1991). A set of incentives could produce motives for these actors to comply with the requirements of governmental policy decisions. In some circumstances, even if implementing actors understand what the requirements of policy

are, they may fail to translate policy decisions into actions when there is a lack of incentives such as financial resources or funding (Brodkin, 1997; McDermott, 2016).

The incentives that a policy creates have been used as an explanatory factor for the delivery of the market-based reforms in the literature of the NHS reforms, with a focus on insufficient financial conditions for competition, marketisation, and greater private provision (see, for example, Krachler and Greer, 2015; Le Grand, 1999). The market-based reforms need to consider the incentive structures they attempt to create and through which competition might occur (Greener and Powell, 2008). Often the market reforms in health services lack incentives necessary to allow competition to happen (Le Grand, 1999). Krachler and Greer (2015) found that resource limitation and the unprofitability of delivering certain health services limited the involvement of private provider in competing for the NHS contracts. The literature on the NHS reforms suggests that the delivery of the market-based policies is often limited by the absence of economic and financial incentives for facilitating implementation. That is to say, the lack of incentive structures may result in the difficulty in implementing the market-based reforms on the ground. This study will examine how and the extent to which policy incentives could be used to explain the process of implementation. More specifically, this study will explore whether the market-based reforms under the 2012 Act consisted of appropriate and effective incentive structures for facilitating implementation, and result in successful implementation. The chapter 6 will answer these questions.

3.4 Normative Factors and Implementation

This section considers normative factors that could be used to examine the process of public policy implementation. Normative institutions are composed of values and norms about 'what ought to occur'. Scott (2014, p.64) suggests that normative institutions guide individuals' behaviour through values ('conceptions of the preferred or the desirable together with the construction of standards to which existing structures or behaviour can be compared and assessed') and norms (which 'specify how things should be done; they define legitimate means to pursue valued ends'). Normative institutions introduce a prescriptive, evaluative, and obligatory dimension into social behaviour, defining desirable objectives and designing appropriate ways of pursuing them. Organisations develop values and norms to make sense of their role and objectives, and of their institutional environment, which provides order to actions (see, for example, DiMaggio and Powell, 1983; Keiser and Soss, 1998; Lowndes and Roberts, 2013; March and Olsen, 1984; 1989; Selznick, 1949; Scott, 2014; Sikula, 1973). Organisations get infused with values through norms, and these norms and values are carried, shared and reinforced by the people working in the organisations.

The values and norms institutionalised within organisations create the internal institutional environment to structure the decisions and behaviour of organisations and

their members. Normative institutional analysis stresses the importance of 'a logic of appropriateness' to understand how institutions influence decisions and behaviour of actors (March and Olsen, 1984; 1989). Normative factors seek to shape behaviour by providing framework to actors about what is appropriated in their daily work, i.e. around what is the 'right' thing to do. This logic implies that the decisions and behaviour of actors are 'grounded in a social context and guided by a moral framework that takes into account one's relations and obligations to others in the situation' (Scott, 2014, p.82). Some values and norms are applicable to selected types of social actors or social positions, which give rise to the normative expectations regarding how specific actors are supposed to behave (Scott, 2014, 64). For example, public organisations such as schools, hospitals, social service agencies often conform to certain normative pressures as they dictate social values, ethics and role expectations which have been internalised by actors within these organisations (Edelman and Suchman, 1997). The compliance with these normative institutions is derived from social obligations and social necessity about what organisations and their members ought to do (Scott, 2014).

From these perspectives, some policy changes emanating from the regulatory environment may face the challenges of ensuring some degree of consistency when translating into actions. Decisions and behaviour of implementers may be constrained by certain normative institutions embedded within their organisations. When policies are seen to undermine the shared organisational norms and values that implementers desire to maintain, implementing these policies could be difficult. In contrast, policies

are expected to be effectively implemented when policy-makers make them fit with the shared norms and values within implementing organisations. When we review the literature on public policy implementation, there are many studies suggesting that the shared organisational values and norms by implementers have an influence on policy implementation (see, for example, Hupe and Hill, 2007; Lipsky, 2010; Maynard-Moody and Musheno, 2003; Sabatier and Mazmanian, 1980; Teodoro, 2014; Tummers, 2011; 2012; Tummers et al., 2012). Within public organisations, shared values and norms are powerful in shaping the judgement and assessment of bureaucrats around what ought to do. These actors often have a strong norm-based motives to service the public interests and society in a worthwhile way (Le Grand, 2003; 2010; Rainey and Steinbauer, 1999; Perry, 2000; Perry et al., 2010). Local bureaucrats are likely to implement policies that are perceived as compatible with the values and norms that are already institutionalised within their own organisations (Sabatier and Mazmanian, 1980). The decisions and actions of implementing bureaucrats could be constrained by normative institutional factors. Policy might not be implemented, where these policies are perceived to violate the shared norms and values within organisations. In other words, the mismatch between policies and normative factors could result in problems in delivering the policies.

Professional values and norms deeply embedded within many public organisations have been highlighted by implementation studies, which have been identified as a critical normative factor affecting implementation (see, for example, Brehm and Gates, 1997;

Dubois, 2010; Exworthy and Halford, 1999; Maynard-Moody and Musheno, 2003; Meier and O'Toole, 2006; Lipsky, 2010; Riccucci, 2005; Tummers, 2011; Tummers, Steijn and Bekkers, 2012). The implementation literature suggests that decisions and actions of public professional bureaucrats in the process of delivering services and policy are often shaped by their professional background and knowledge. Professional framework reflects a unique set of social obligations and roles that shape decision-making of bureaucrats and affect their assessment concerning appropriateness of actions (DiMaggio and Powell, 1983; Meyer and Rowan, 1997). For people working in an organisation such as school, hospital, health service agencies, professional knowledges and the interests of their 'clients' are important normative factors to shape their decisions and actions (Le Grand, 2010; 2018). Professional bureaucrats often have strong commitments to their professional values and norms such as the interests of people they serve.

Professional and normative framework can generate legitimacy for implementing actors to reject a particular policy (Brunsson, 1993). Street-level bureaucracy literature suggests that local service-delivery bureaucrats seek to meet the professional norms and the expectations of their service users, probably acting not in accordance with policy objectives and political will (see, for example, Hupe and Buffat, 2014; Hupe and Hill, 2007; Lipsky, 2010; Sager et al., 2014). Professional bureaucrats are not often the faithful executors of government policy decisions, because these actors' thinking and actions are situated in a particular normative environment that constrains and enables

their actions (DiMaggio and Powell, 1983). Maynard-Moody and Musheno (2003) found that when policies and beliefs conflict, citizen-client centred judgements are often employed by public bureaucrats to rationalise their behaviour. That is to say, professional bureaucrats are not just 'policy takers' to implement policies according to the intention of the higher levels, but also service deliverers with the aim to provide good services to their clients (Lipsky, 2010). Professional bureaucrats may reject a particular policy which is perceived as not 'fit' in the shared values and norms within their organisations, such as the dominant professional roles and the needs of service users.

Looking at the literature of the NHS reforms, few attention has been given to normative factors as an analytical clue for understanding the implementation of the market-based reforms. Professional and normative factors could be powerful in shaping the decision-making and behaviour of bureaucrats within the NHS organisations, as the NHS system is highly professionalised. Within the NHS, professional bureaucrats (such as GPs, doctors and nurses) are able to exercise considerable control over resource allocation and health service delivery. Despite decades of NPM reforms that management and managers have been introduced to operate the English NHS, professional bureaucrats have still remained significant influence on policy and service delivery (see, for example, Ackroyd et al., 2007; Curroe and Suhominova, 2006; Evans, 2010; Exworthy and Halford, 1999; Farrell and Morris, 2003; Gatenby et al., 2015; McNulty and Ferlie, 2004). A report of The King's Fund reveals that CCGs have secured better clinical

engagement than previous forms of commissioning, with more than 70 percent of GP members engaged with the commissioning work (Robertson et al., 2016). As some literature on 'neo-bureaucracy' suggests, there is seemingly an alignment between managerial and clinical principles in the NHS (Exworthy et al., 1999), but health care professionals still retain considerable power over service delivery and policy implementation (Ferrell and Morris, 2003). In the NHS, most of local bureaucrats involve complex mediation between professionals and managers (Llewellyn, 2001), with key decisions about resource allocation and service delivery determined largely by professional judgements (Ackroyd et al., 2007).

This suggests that normative (professional) influence could be powerful in shaping the decision-making and behaviour of commissioning bureaucrats within CCGs. These bureaucrats might value their social roles and obligations, being socially and normatively forced to improve health services in responsiveness to the patients' interests and needs in the process of commissioning health services. Professional values and norms embedded within the NHS organisations may condition on how service commissioning and provision should be done. This may explain why a particular government policy is rejected. The shared professional values and norms within the NHS organisations may have some influence on the implementation of the market-based reforms following the 2012 Act. The study seek to examine how and the extent to which the normative factors could influence implementation. More specifically, this research will explore whether commissioning bureaucrats were subjected to shared

norms and values, and how this affected the implementation of the market-based reforms. This will be discussed in Chapter 7.

3.5 Cultural Factors and Implementation

This section considers cultural factors affecting policy implementation. The cultural institutions are the most informal. They consist of shared conceptions that constitute social actors and actions as well as the nature of social reality and create the frames through which meaning is made (Scott, 2014, 67). Cultural factors have a wide range of forms, such as 'the shared definition of local situations', 'the common frames and patterns of belief that comprise an organisation's culture', 'the organisational logics that structure organisation fields' and 'the shared assumptions and ideologies that define preferred political and economic systems at national and transnational levels' (Scott, 2014, p.68). The central to the cultural analysis is that actors' interpretive processes are shaped by cultural frameworks. In other words, cultural elements provide patterns of thinking, feeling, and acting. For the cultural mode of influencing actions, compliance are secured as other types of behaviour are inconceivable and impossible; routines are followed as they are taken for granted as 'the way we do these things' (Scott, 2014, p.68). Cultures are powerful constraints through providing templates for actors and scripts for actions (DiMaggio and Powell, 1983; March and Olsen, 1984; 1989; Meyer and Rowan, 1977).

These cultural views provide many implications for understanding policy implementation processes. Implementers may be constrained by certain cultural factors that make certain forms of decisions and actions seem more natural, conceivable, and appropriate than others. Within organisations, cultural factors such as the shared assumptions and beliefs by organisational members may quickly 'decide' which actions are appropriate, and how policy should be delivered. That is to say, the shared belief systems and cultural frames can condition how implementers interpret and respond to a particular policy, which excludes other way of thinking and acting. Decisions and behaviour of implementers are regarded as taken-for-granted in a particular cultural context. Sociological institutionalism provide insights about how the decisions and actions of implementing actors could be shaped by the shared conceptions, assumptions and beliefs within their own organisations. Decisions and choices of implementers can be culturally structured models and schemas which result in taken-for-granted behaviour (Brunsson, 2002). The cultural frame can shape the way the policy is implemented on the ground. The mismatch between policy decisions and cultural beliefs of implementers may lead to the resistance against these policies at the point of delivery. In contrast, implementation is likely, if they are compatible. Thus, cultural factors can be employed to examine the effectiveness of policy implementation.

The literature on the NHS reforms suggests that cultural analysis could be useful to understand the implementation of the market-based reforms. The cultural factors can

arise from a variety of sources, primarily referring to widely shared beliefs as well as some take-for-granted assumptions within NHS organisations in relation to the way of health service provision. An earlier research on the previous Labour government's market-based reforms observed the notion of a shared 'NHS family' whose integrity must be protected, which was meaningful to commissioning bureaucrats (Checkland et al., 2012). This suggests a cultural belief shared within CCGs that the notion of 'we' includes all of those within the local NHS family rather than simply an individual NHS organisation. This kind of cultural belief was critical to understand how commissioning bureaucrats made decisions and behaved in the work of commissioning health services. Influenced by this cultural belief, competing to maximise the gain of one organisation at the expense of another was unthinkable for many people within the NHS (Checkland, et al., 2012). That is to say, a lack of fit between NHS cultures and market reforms could resulted in the problems of delivering the reforms. This study investigates how and the extent to which culture factors can affect the implementation of the 2012 market-based health reforms. More specifically, this research will examine whether commissioning bureaucrats were subjected to prevailing cultural assumptions and beliefs, and how this could affect the implementation of the market-based reforms introduced by the 2012 Act. This will be discussed in chapter 7.

3.6 Explaining Policy Implementation Problem from an Institutionalist Framework

This chapter develops a theoretical and analytical framework that explores implementation problems. In this study, it focuses on examining the decisions and actions of implementers in a complex institutional context which considers regulatory, normative and cultural factors. First of all, regulatory factors could have an impact on how policy actors in charge of implementation reach decisions and take actions. This is in line with the fundamental perspective of top-downers who highlight the importance of the design of policy and central governmental control in understanding implementation process. Public policies define intentions of government and specific patterns of behaviour required from implementers. The characteristics of policy goals and incentive structures can affect the process of implementation. Well-designed public policy can facilitate implementation. Implementation may be possible when policy goals are clearly-defined and attached with appropriate incentives. Ambiguous policy goals and/or the absence of incentives may result in difficulties in implementing the policies.

Moreover, normative and cultural factors could hinder implementation. Often there are some problems with implementing policies, as implementers are social actors with their own organisational imperatives, and their decisions and behaviour are subject to the

normative and cultural demands of their organisations. Policy implementation are likely to be constrained by a range of socially-structured normative and cultural factors. Pressures may arise from the demands of regulatory, normative and cultural environments simultaneously, and these demands may conflict with one another. The dilemma for implementers can be that they have to cope with different, and sometimes contradictory and often ambiguous demands from the wider institutional environments (Smith et al, 2011). When government policy decisions can find a fit with the requirements of normative and cultural environments in which implementers are situated, we can expect implementers to adopt to such governmental demands and implement policy. But where policy decisions conflict with the normative and cultural demands, there could be problems in delivering the policies. With the organisational imperatives to meet normative and cultural demands, we could expect that actors in charge of implementing policies do not always comply with the requirements of governmental policies and rules.

It is important to note that there is not straightforward relationship between policy and actions. Both implementation and institutionalism literature highlights the problems of policy implementation. Policy and action are not necessarily related to each other. It is difficult to ensure correspondence between policy changes and implementation. It is misleading and simplistic to assume that policy-makers could design clearly-defined policy goals and effective incentives to facilitate control and ensure compliance with the desired outcomes, and accordingly implementers will act instrumentally to translate

policy decisions into actions. First of all, the central government and policy-makers do not necessarily have the ability to formulate a policy with clearly defined goals and directions, and they may not create appropriate and effective incentives for facilitating implementation. Moreover, we need to realise that policy actors in charge of delivering policies somehow are in control of the public policy process. Their interpretation and actions are often conditioned by some particular normative and cultural settings, which can influence implementation. From an institutionalist analysis, implementation might be 'more complex fields of social action, embracing a range of agencies that may be more or less involved with the specific policy that is being implemented and who have their own organisational objectives' (Smith et al., 2011, p.978). Implementation could be seen as a decision-making process of refinement, adoption or even rejection at the point of delivery. This process involves complex fields of collective and social actions. Implementers have to cope with different and potentially inconsistent demands from the regulatory, normative and cultural environments in which they are located. The dilemma for implementers is the imperatives to reconcile with the demands of these institutional environments. This study seeks to explore the extent to which regulatory, normative and cultural factors could influence the process of policy implementation, and result in implementation problems.

3.7 Conclusion

This chapter reviewed the literature on policy implementation and institutional theories, with the aim of identifying the factors that may influence policy implementation. The chapter is based on the combination of top-down, bottom-up and institutionalist perspectives, in order to provide a systematic analytical framework for this study. There is a focus on the discussion of the influence of regulatory, normative and cultural factors on implementation process. Institutionalist perspectives can provide a robust theoretical explanation for implementation and the problems of implementation. It is assumed that implementation process will be affected by a combination of various institutional factors, as these factors can simultaneously shape decision-making and behaviour of actors involved in policy implementation. Implementation process will involve managing regulatory, normative and cultural influences, and implementers need to reconcile with these factors for making changes happen in practice. On the basis of theoretical discussions, factors that potentially influence the implementation of the 2012 market-based reforms have been identified in this chapter as a guideline for the empirical investigations to answer the main research questions. More information underpinned by empirical research is needed to demonstrate how and the extent to which these factors can affect the delivery of the market-based policies in the real world. The next chapter will discuss how we can understand implementation through conducting an empirical research.

Chapter 4 Methodology

This research is aimed at providing an explanation for the difficulties the Coalition Government faced in marketising the NHS in England following its 2012 reforms. It is a project to understand why it was so difficult to implement the market-based health policy reforms introduced by the Health and Social Care Act 2012. Based on the main research question, there are two tasks in the empirical research. The first is to examine the process of implementation of the 2012 market-based reforms, and the second is to explain the factors responsible for implementation of the reforms on the ground. To examine the process of implementing reforms, the study collected data concerning the application of competitive procurement and the selection of providers in the process of health service commissioning. These data provided information on how the 2012 market-based reforms were implemented on the ground, and the current outcomes of implementation of the market-based reforms. Then through comparing what was happening in reality with what goals the reforms were expected to achieve, the implementation processes were deeply explored and the outcomes of implementing reforms were evaluated in the empirical study.

To explain the factors responsible for reform implementation and the problems associated with this process, the study required the data on the factors that influenced the implementation process. The theoretical and analytical discussion in the previous

Chapter 3 identified three important institutional factors (that is the regulatory, normative and cultural) that may influence implementation through shaping the decisions and behaviour of implementers. The institutional framework could allow the policy actors, particularly with their normative and cultural frame, to make certain choices about how to implement the policy. A particular institutional settings are able to influence policy implementation through decisions and actions of implementers. Although factors influencing the implementation of the 2012 market-based reforms have been assumed from institutional theories and implementation literature, more information underpinned by empirical research was needed to demonstrate how and the extent to which these factors could shape implementation. It was necessary to collect the data and information around the dynamics between policy implementers and institutional factors, testing if institutional factors could affect the delivery of the market-based policies and how these factors affected the delivery in the real world.

As discussed in Chapter 3, policy implementation may be affected by the regulatory factor concerning the characteristics of policy goals and room for discretion (as discussed in Section 3.3 of Chapter 3). The lack of clear policy goals may prevent implementation. To test these theoretical assumptions, the study collected data and information on the current policy framework consisting of extant legislation and policies in the NHS in England that guided commissioning decisions and behaviour. Specifically, this included the commissioning and procurement polices introduced by the 2012 Act, as well as the relevant rules and policies made by NHS England. The

empirical research needed to examine whether or not the commissioning policy goals of the 2012 Act was formulated ambiguously at the legislative level, how commissioning bureaucrats interpreted commissioning policies, and how this could affect the effectiveness of implementation.

Secondly, policy implementation may be affected by another regulatory factor – the incentives that the policy creates (as discussed the Section 3.3 of Chapter 3). The lack of appropriate incentives may result in the problem of delivering the policies. To examine whether policy incentive structures had an impact on implementation, the study collected information around the dynamics between incentives and implementers, seeing whether incentives were factors that commissioning bureaucrats considered when delivering the market-based policies.

Thirdly, Chapter 3 suggested that policy implementation may be affected by normative and cultural factors (Section 3.4 and 3.5). Normative and cultural factors may result in the implementer's resistance to the delivery of reforms on the ground. To test these theories, the empirical work collected data concerning the dynamics between normative/cultural factors and implementers, in order to examine whether they were factors that commissioners considered at the point of delivering the market-based policies. More specifically, it collected information around the shared values and norms in health service commissioning process. The empirical research sought to figure out whether commissioners had shared norms and values, and how these normative factors

affected the implementation of the market-based reforms. Moreover, data and information was collected in the empirical study, concerning whether commissioners had prevailing cultural assumptions and beliefs, and how these cultural factors could affect implementation.

Theoretical discussions in Chapter 3 provided a guideline for the empirical investigations in this research, mapping out the data and information that had to be collected to examine theoretical assumptions and answer the main research question. This chapter describes the methodology employed in this research, including its four main parts: research design, approaches of data collection, data analysis and ethical considerations. First of all, it considers research design. The study's methods and selection of case studies are justified. Secondly, the data collection approaches of this research are discussed in detail, which are documentary analysis and elite interviews. The third part outlines how the data was collected from interviews, and how its reliability and credibility was ensured. Lastly, ethical considerations of this research are discussed.

4.1 Research Design

The case study approach was used in this research in order to collect data and information outlined above. This allowed for in-depth reviews of new or unclear

mechanisms, processes, and phenomena in the real-life or contemporary context (Yin, 2014). It is one technique consistent with 'realistic evaluation', helpful to explore which outcomes are produced from interventions, how they are produced, and in which contextual conditions (Pawson and Tilley, 1997). On the basis of theoretical discussions in Chapter 3, a range of institutional factors (i.e. the regulatory, normative and cultural) were identified as potential influences on the implementation of the market-based reforms following the 2012 Act. The empirical investigations were conducted to test if these institutional factors could affect implementation. In order to achieve this aim, it was necessary to figure out what were the key factors that influenced the decisions and behaviour of policy actors in charge of delivering the 2012 market-based reforms on the ground. Local conditions could have some impact, and it was necessary to involve the impact of the local conditions of CCGs in the process of understanding implementation. Thus, the study selected three different CCG areas with regard to populations and financial positions, trying to investigate how CCGs in different local contexts delivered the market-based reforms. The selected three CCGs were not entirely the same, and collecting data in these three different locations facilitated comparative analyses. This enabled me to compare whether the three CCGs have similarities or differences in terms of implementation of the market-based reforms.

The local conditions of CCGs such as populations and financial positions might have an impact on the delivery of the market-based reforms. It was possible that CCGs would commission health service and select healthcare providers differently according their

own local conditions and the needs of their local populations. For example, with different sizes and health conditions of populations, CCGs may use different strategies to commission health services and select healthcare providers. If CCGs have a larger population size, they may involve more in creating markets and competition for purchasing health services, because the demands for health care are larger than those CCGs with smaller size of population. Moreover, if a CCG has a healthier population, it may less involved in purchasing health services in the NHS markets for their population. Thus, this research selected three different CCGs with different populations in relation to population size and health conditions.

The financial position of an individual CCG might have an impact on the delivery of the market-based reforms, especially on the involvement of private sectors in service provision. As discussed in Chapter 2, in the market-based reforms, it was assumed that competitive pressures would force healthcare providers to deliver services in an efficient and cost-effective manner. On the basis of this assumption, CCGs may increase the use of market mechanisms in service commissioning for achieving efficiency. Private sectors might increase their involvement, as CCGs were given the ability to choose any service provider they saw as fit, and in face of challenged financial position, private sectors, promising to deliver more cost-effective services could be a particularly attractive option to commissioning bureaucrats. CCGs working in circumstances of difficult financial positions might favour private providers who were perceived as efficient and cost-effective. That is to say, CCGs with difficult financial

position might support the delivery of the market-based reforms and increase the level of competition and private provision in health services in their local areas. Thus, the three different CCGs selected in this thesis had relatively different financial positions, in order to see whether financial position of an individual CCG could affect the delivery of the market-based reforms.

Three different cases were chosen with different populations and financial positions, based on the idea that there might be differences in terms of how the 2012 market-based reforms were delivered on the ground. The impact of local conditions logically exist and might empirically occur. But on the basis of the assumptions being made in the theories set out in Chapter 3, I expected to see more similarities rather than differences. If empirical variety was evident in the way policy actors implemented the market-based reforms, this might mean the theoretical assumptions provided by the Chapter 3 were wrong. In this situation, institutional factors were probably not the primary determinant of implementation, and instead, the outcomes of implementation might largely depend on local conditions or other factors. If the results of the empirical investigations suggested that the three CCGs had a lot of similarities in the delivery of the market-based reforms, such as the similar patterns in terms of using competitive procurement, tendering, contracting out and private provision in the commissioning processes, this could demonstrate that the dynamics between policy implementers and institutional factors mattered more than local conditions in the case of the 2012 reforms. Empirically, three different case studies could facilitate demonstrating the theoretical assumptions

discussed in Chapter 3 that institutional factors would significantly affect implementation. In this sense, it was helpful to have an empirical investigation in different CCG areas, in order to examine the theoretical assumptions discussed in Chapter 3.

According to the documentary analysis of the CCG board meeting minutes and their annual reports, three CCG areas were selected with different populations and financial positions in this study. In order to guarantee anonymity of interviewees, the three CCGs remain anonymous as CCG 1, CCG 2 and CCG 3. More details can be seen below:

CCG 1 area

CCG 1 was located in the north of England, serving a number of towns and cities. Its footprint (the area for which it commissioned services) included urban, semi-urban and rural areas. It shared administrative boundaries with three local authorities, including one Council area and parts of two Council areas. People in the CCG 1 area had good health overall, with life expectancy which was above the national average. The population of CCG 1 had a higher proportion of people over the age of 50 compared to the national average. People in the CCG 1 were living longer and more of the population had complex and long-term conditions. There was a greater demand for health care due to the ageing population.

According to its annual and financial account reports, CCG 1 had operated in a challenging financial environment since its creation, and a recovery plan was implemented to try and manage its finances. In 2013/14 and 2014/15, CCG 1 reported a small surplus at the end of these financial years. However, the financial position of CCG 1 area deteriorated from 2015. It was under unprecedented financial strain and both providers and commissioners in CCG 1 area were struggling to balance the finances. They were also faced with a serious financial situation to address. They had worked together to resolve local problems as a health and care system. The return to a financial balance was a key priority in this locality.

CCG 2 area

CCG 2 was located in the north of England, covering a whole city council area. It had the largest population among the three selected CCGs. CCG 2 area had a relatively high level of deprivation and health inequality compared with the England average, and parts of it had the widest life expectancy gap. In CCG 2 area, there were significant numbers of minority ethnic groups within this population with higher health needs. One of its key priorities was to reduce the health inequalities and unwanted variations in quality of care that people face in this area.

Since its creation, there had been a relatively challenging financial environment. The ageing population, along with the growing numbers of treatments and growing public

expectations, increased the demand for services, at a time when funding for public services did not increase accordingly. This resulted in demand outstripping the capacity of the main providers of CCG 2 area, most notably was an increased use of hospital beds. For CCG 2, the challenges were to secure suitable out of hospital care so that patients could be discharged from those beds.

CCG 3 area

CCG 3 was located in the north of England, covering a population much smaller than the average for CCGs in England. It had the smallest population size among the three CCG sites. CCG 3 had one of the 20 percent most deprived local authorities in the country and there was a great inequality between the most and least affluent areas within the borough. In CCG 3 area, there was the mix of population by age, with an ageing population. It had a lower life expectancy than the national average, along with higher levels of poor mental health, alcohol consumption, smoking, obesity, cancer, respiratory and heart disease.

Between the financial years of 2013/14 – 2018/19, CCG 3 reported a small surplus every year, within their financial accounts.

4.2 Data Collection Methods

Case study sites were selected, and then the processes of data collection were initiated. Qualitative approaches such as documentary analysis and interviews were helpful in data collection, which could explain the questions about the 'why' and 'how' (Harrison, 2001, 79). These two kinds of methods complemented each other wherever possible to ensure the findings were reliable and credible. In line with the main research question and theoretical discussions, attitudes, perspectives, concerns and experiences of key policy actors in charge of implementing the 2012 market-based reforms, were explored in the research. As the processes used for implementing the 2012 reform were the focus of investigation, commissioners from CCGs were identified as the most relevant interviewees to the research. They were the primary policy implementers, referring to a group of GPs, doctors, nurses and managers responsible for purchasing and commissioning health services and allocating health funds at local levels. Moreover, senior managers from provider organisations including NHS hospitals and private hospitals were also identified as the focus for investigation. This was because they were the potential players in NHS quasi-markets as 'providers'.

Documentary Analysis

Documentary analysis was an important approach in this research to collect information

and data. A variety of documents were collected and analysed between 2016 and 2019 in order to understand the implementation of the market-based reforms following the 2012 Act, focusing on the reform background, goals, the major policy actors (and their policy preferences), the policy changes introduced by the reform and the process of its implementation on the ground. The process of documentary analysis was an initial but important part of my research, and the appropriate documents were helpful for the preliminary identification of the formulation and implementation of the 2012 health policy reforms. Through a large amount of documentary literature analysis, the wider background of my research was acquired, including the contents of the reforms, its goals and expectations, and the strategies applied to deliver the reform in practice. In addition, these documents were used to understand the responses of the public, politicians, campaign groups, and NHS managers towards the 2012 reform and their policy preferences and attitudes in the reform. All of these analyses were aimed at understanding the whole process of the 2012 market-based reforms from its legislation to the implementation, and initially understanding the extent of implementation and the factors that influenced this process.

In the process of documentary analysis, the data was from both primary and secondary sources, such as academic books and papers, governmental documents (e.g. white papers and reports), NHS England/CCG/Trust documents (board meeting minutes and published reports), news, specialised health policy journals, and think thank research papers. The primary sources were mainly from government documents around the 2012

Act, including conference records and reports from the House of Commons and the House of Lords, the government white papers from the Department of Health, Health Select Committee reports, HM Treasury reports, party manifestos and speeches. These documents were helpful in understanding the formulation of the 2012 Act, as well as the official assessments of its implementation. Beside this, official documents from NHSE in relation to health service commissioning were analysed to figure out the overall national policy framework for the operation of CCGs. Moreover, documents of local NHS organisations were analysed to understand local responses to the 2012 reform in depth. Main sources used were the published materials from NHS organisations, such as NHSE/CCG/Trust board meeting minutes and the annual reports and financial accounts between 2013/14 – 2018/19. These documents were valuable in selecting case study sites for research, figuring out the reform goals, and evaluating the effectiveness of the 2012 reforms on the ground.

Secondary sources were also helpful in this study, including academic books and papers, news, journal articles and researches from think tanks related to NHS reforms in England. The information collected from these sources was helpful in understanding the issues around NHS reforms as well as the wider political, economic and social environment of health reforms. However, there is a potential problem of reliability and credibility in relation to data that could occur when using the resources which have already been interpreted by other people (Gibson and Brown, 2009). It is a common issue in the use of the secondary sources. In order to ensure the reliability of the

information collected from the secondary sources, they were used in a critical way in this study: analysing and interpreting the data whilst taking into account the standpoint of the author. For example, journals and articles from the medical professional associations like British Medical Association (BMA) were collected in the research. They were mainly used to understand the attitude and standpoint of the medical professionals in the 2012 reforms.

Some secondary sources such as news and newspapers are critical to this project. Likewise, the study did not use their perspectives directly, instead it was just to explore the social and political landscape and the attitudes of the public, the government, politicians, and policy actors of NHS organisations in the delivery of the 2012 reforms. Moreover, it was useful to collect the data from reports of health policy think tanks, such as the King's Fund, Nuffield Trust, the Health Foundation and Centre for Health and the Public Interest. They highlighted previous achievements in the study of the market-based reforms, which provided a preliminary understanding of the potential issues that might occur during the implementation of the 2012 reforms. Other useful sources were from academic books and papers on the related topics of politics, public policy and the English NHS reforms. They provided a general academic literature to review the significant contributions and achievements of previous works, which were valuable in contextualising and theorising my research. Table 2 reveals details of the documentary data collection in this study.

Table 2 Documentary Data Collection

Documents	Sources	Purpose
Government white papers and reports	Department of Health and HM Treasury	Helpful to understand policy changes and governmental viewpoints on the 2012 reform
Conference records and reports of governmental institutions	House of Common and House of Lords Library	Helped understand the legislation of the 2012 reform as well as the issues of implementation; identify key actors and their standpoints
Party manifestos and speeches	The Conservatives, the Labour Party, and the Liberal Democrats	Helped understand the standpoints of political parties and politicians on the 2012 reform
Minutes of Board Meetings	NHS England, CCGs and Trusts	Helped explore local responses to the reform; identify key actors; case selection
Annual Reports and Financial Accounts	Department of Health, CCGs and Trusts	Statistical analysis specifically to understand local resource allocation and provider diversity; case selection
Association	BMA	Helped understand the standpoint and

articles		attitude of professionals on the reform
News and newspapers	BBC, The Guardian etc.	Helped identify the key actors involved in the reform and their standpoints; help understand the wider social and political environment
Reports of think tanks	The King's Fund, Nuffield Trust, the Health Foundation and Centre for Health and the Public Interest.	Literature review to primarily understand the issues of the market-based reform implementation within the NHS in England; helped identify key actors
Academic books and papers	Academic publishing outlets	Literature review to explain the background and build the theoretical framework for the research

Source: The author

Elite Interviewing

In the research, another important method of data collection was 'elite interviewing'. This approach is appropriate, because it could help explore 'the insider's perspective'

(Jensen, 1989), 'how research participants understand their world' (Secker et al., 1995), and the informant's 'frame of reference' (Britten, 1995). Interviews could provide insights into the activities that could not be gleaned from official published documents or contemporary literatures (Lilleker, 2003). It was a crucial supplement to the utilisation of documentary analysis. In the study, interview participants were the key policy actors involved in the 2012 reform from the process of legislation to the delivery, including policy makers at a national level who were involved in the legislative process of the 2012 Act, and local actors who had the responsibility to deliver the Act on the ground. The same level of interview participants was asked the same set of interview questions related to their perspectives, observations and experiences while participating in the 2012 reform. From September 2018 to May 2019, 36 people were interviewed in the research, including politicians, governmental officers, government policy advisors, senior managers and officials of the NHS organisations, and managers from private sector providers (see Table 3). Semi-structured interviews with these policy actors were helpful in gaining a more comprehensive and systematic understanding of the process of delivering the 2012 reform within the NHS in England.

Table 3 Categories of Interview Participants

Policy actors involved in the formulation process	Policy actors involved at the implementation level

Politicians and health officials at the central government level, MPs, representatives from think tanks, advisors, experts, and campaigners	Senior Managers and Officials from CCGs (number: 6) Senior Managers and Officials from Hospital FTs/Trusts (number: 7) Managers from private sector providers (number: 6)
Total number: 17	Total number: 19

Source: The author

Sampling and Recruiting

In the process of interviewing, the first question is related to whom should be interviewed, i.e. identifying and sampling key actors involved in the 2012 reform, especially the actors involved in the delivery process. The study is aimed at identifying factors that influenced the delivery of the market-based transformations introduced by the 2012 Act. So, it was critical to interview 'insiders' who were influential in the 2012 reform, and particularly, who had observations and experiences of delivering it on the ground. Purposeful sampling and snowball sampling strategies were employed in this project (Creswell and Poth, 2018, 159). All the participants were identified and categorised mainly via their official and positional status. This approach is a useful tool to identify the key actors in the policy domain, according to the occupancy of a position in a formally constituted organisation. In general, one kind of participants were

politicians at national level, including the relevant MPs, policy advisors/experts, think tank representatives, and campaigners. Another level of participants were senior managers and officials of local NHS organisations who were involved in delivering the market-transformations at local level, and managers from private companies who participated in the NHS service provision. Data and sources used for identifying these participants are mainly from conference records of Parliament, Minutes of Board and published reports from NHSE/CCGs/Trusts, news/newspapers, and think tank reports.

In terms of identifying key policy actors involved in the formulation and legislation of the 2012 reform, the list of participants was determined by information collected from the conference records of the Parliamentary processes and news/newspapers. It focuses especially on the actors that participated in the legislative process of the 2012 Act. Members of parliamentary who were involved in the Second and Third Reading of the Act are identified. Also, a number of witnesses to this legislative processes were identified, which were from bodies representing health professionals and managers, from think tanks and policy experts, from regulatory agencies, and representatives from patient groups, health charities and local government. These actors were critical to supplement the information collected from the key policy-makers, because they were the observers of the reform legislation. In addition, the key actors were identified through other relevant sources, such as news and newspapers like the Guardian and the BBC news, and think tank reports. These sources were particularly useful to identify some external policy actors, for example, individuals who were involved in the 2012

reform, advocating their own policy interests, and trying to influence the reform by ways such as lobbying.

As far as the implementation process is concerned, another important participant is senior manager or officials such as Chief Executive Officers (CEOs), Chief Financial Officers (CFOs) or other representative individuals of various NHS organisations (mainly including NHSE, CCGs and NHS Trusts/Foundation Trusts) and private sector providers. The research explored their attitudes, perspectives, concerns and experience in the processes of delivering market-based transformations in practice. These interviews are helpful in gaining an insider knowledge of the thinking of local implementers in response to the 2012 reform, which is of great importance to examine the process of the reform delivery and the problems associated. Documentary sources such as minutes of board meetings and annual reports of NHS organisations are used to identify the key local actors who participated in delivering the market-based transformations at local level.

With regard to the recruitment of these participants, it mainly depends on contact details which are available in the public domain. Participants were approached by email, letter and via the phone. Invitation emails or letters were sent along with the information sheet for participants helping them to understand this project. Those interested in participating in the project contacted me by email or by phone. Then, a date and a place were arranged for interviews. Interviews were face-to-face or by phone. Each

interviews lasted between 45 minutes and an hour. All interviews were recorded and then transcribed, with the permission of the participants gained before the interviews. One of the problems is that the key actors in the operation of the state authority and the NHS organisations are bureaucrats and executives with busy schedules, and therefore, difficult to access. In my experience, the 'network' is important. It is very helpful to start with approaching people in local NHS organisations, and then using the snowball sampling process to recruit other participants wherever possible.

Interview Question Design

The interview questions for this study are designed to be semi-structured in order to let participants feel more comfortable and be more willing to express their own opinions. At the same time, as the semi-structured interviews have the guided questions, these ensure interviewees focus on the specific issues that the study is interested in, which is more efficient and time-saving (Barbour, 2008, 119-120). The interviews questions were designed to understand the ways in which the market-based reforms were implemented at local level, how local actors responded to it, and what factors affected the local responses. For policy actors at a national level, interview questions were based around the objectives and goals of the 2012 reforms, but also allowed an assessment of the extent to which the NHS had been changed by the Act. Interviews with policy actors from CCGs and healthcare providers, the questions were around their perspectives, attitudes, concerns and experience in the process of health service commissioning and

procurement in their own locations. The lists of interview questions are enclosed as Appendix 1.

Challenges during the Interviews

During the data collection process, it was unavoidable that I would face some difficulties and challenges, mainly due to the form of the research method designed around the research questions of the project. A potential problem might occur in the process of 'elite' interviewing: some 'elites' might not speak frankly about their own weaknesses or on controversial issues (Harrison, 2001, 99). So, it is important to build trust and credibility during the interviews (Creswell and Poth, 2018, 172). In the research, interview questions included some controversial topics around marketisation, competition and private sector involvement in the NHS service delivery. As a public service with high popularity, the greater use of private provision was largely seen by the public as an attempt to privatise the NHS by the public. There were wider debates in the public and political discourses that the NHS was being privatised by the 2012 Act, and lobbying groups were powerful within the NHS against the involvement of private companies in NHS services. Within this environment, the topic around private sector involvement in the NHS services and local resource allocation might be sensitive to politicians, government officials, and NHS managers. This situation could make some NHS managers and officials cautious in expressing their views around private provision. In order to address this problem, the interview locations were agreed by the

participants, generally in the workplace of the participants. This could offer privacy and safety, helping make participants speak frankly. In addition, before the interviews I declared that ethical considerations were taken into account, and I would ensure the privacy and anonymity of the information I collected. This was helpful in building trust and increasing the participants' willingness to speak. In my interviews, most of my interviewees were quite critical, and open to talk. All of them had no objection to being recorded, and spoke with confidence.

4.3 Data Analysis

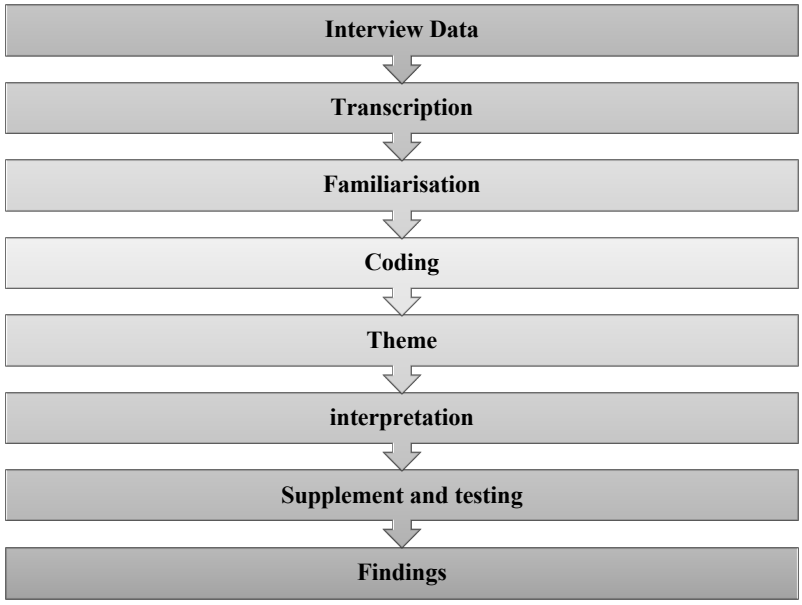
The process of data analysis started after data collection. The analysis was on information and data collected from documents and interviews. The variety of data sources helped ensure the reliability and validity of data in the final stage of analysis. In the study, data analysis was a process of data synthesised when all of the information collected from documents and interviews were summarised, coded, and conceptualised, before eventually findings were produced (Creswell, 2009). The analysis process had some specific issues to explore (the problems and difficulties of implementing the 2012 reform), but also allowed some room to discover other unexpected aspects of the participants' experiences that cannot be predicted by the research in advance (Gale et al., 2013). So the thematic analysis involved meant that the deductive-inductive approach was most suitable in the study. Themes for managing and organising data

were generated from the previous literature review, previous theory building along with the data collected from documents and interviews (Braun and Clarke, 2006; Gale et al., 2013).

The data analysis process of this study included around six steps inspired by Creswell (2009), i.e. transcription, familiarisation with the interview data, coding, creating themes/categories, and interpretation (see Figure 3). The first step was to organise and prepare the data for analysis, mainly the transcription of the interview data. The second step was the familiarisation with the data. The transcripts of data were carefully read one by one and line by line, in order to gain a general sense of the content and identify the general ideas, tones, impressions and credibility. Third, the open (unrestricted) coding process was initially conducted to place the segregated data into categories. In this step, the framework of coding was iteratively refined throughout the whole coding process as new concepts became apparent, until no additional codes emerged. Fourth, it was a process of conceptualising and categorising data that followed by the initial coding processes. In this step, the key themes were identified around the research question, dividing into two main groups: the process of implementation and the factors affecting implementation. The former group of themes included ‘competitive procurement and tendering’, ‘contracting out’ and ‘private sector provision’. The latter group of themes included ‘policy goals’, ‘incentive structures’, ‘values’, ‘norms’ and ‘culture’. During this process, each individual case was analysed separately, and then a cross-case analysis was conducted. The fifth step was to decide which themes were the

most relevant and more importantly, how they were connected with each other. In this step, the themes were described and interpreted as a narrative. During the interpretation stage, the first group of themes (i.e. the process of policy implementation) identified in the interview data analysis process were compared with the statement of the 2012 Act. This was to evaluate the extent to which the market-based reforms were implemented. With regard to the second group of themes (i.e. the factors influencing policy implementation), the aim of analysis and interpretation was to figure out whether these themes had any impact on implementation.

Figure 3 Interview Data Analysis Process



Source: Creswell, 2009, 185

The final step focused on supplementing interview data and testing the accuracy of the results from interviews by the information from the documentary analysis, previous

literature reviews and theory building. Eventually, the main findings of this project emerged. In particular, the last step of analysis (i.e. supplement and testing) was critical to ensure the validity and reliability of the data and information collected from the elite interviews. Issue of data validity and reliability is pronounced in the political studies (Davies, 2001). In many cases, individuals can have very different perspectives of an event and have a unique perspective of what the facts are. This issue cannot be reasonably avoided in elite interviewing. In order to ensure the validity and reliability of the information collected from interviews, this study employed multiple data collection methods and data sources to develop a comprehensive understanding of the policy reform phenomena. Analysis of various documents took place to understand some of the issues around the 2012 reform for example, drivers to reform, government' efforts to push the reform, the consequent institutional changes and the effectiveness of implementation. Additionally, the qualitative 'elite interviewing' was conducted to explore the attitudes, actions and experiences of policy actors involved in the 2012 reform, which was valuable in understanding the issues around the reform in depth. These different ways of data collection were mutually complementary in making the collected data more reliable and credible.

4.4 Ethical Consideration

Ethical approval for the study was granted by the Economics, Law, Management,

Politics and Sociology Ethics Committee in the University of York. In addition, this project received the approval of the Health Research Authority (HRA) of the NHS. The approval of the HRA was required for this project, primarily because the project needed to interview people who were working within the NHS organisations. Applying for the approval from the NHS was a time-consuming process, and required collaboration with the thesis' supervisors and the University. A number of forms and documents had to be well-prepared before applying for the approval online, including an application form, research proposal, curriculum vitae of investigator and supervisor, interview schedules, participant consent form, participant information sheet, letters of invitation to participant and other supporting documents. In my experience, people who conduct research in relation to the NHS should consider if the HRA approval is required as early as possible, in order to better manage your time and reduce the stress from the complicated procedures of applying for the HRA approval.

Informed consent (see Appendix 2) was obtained before participants engaged in the interviews. Participants need to read the consent form and sign it to agree to participant to interviews. Before the interviews, participants were clearly informed of the research aim, information about the ethical approval for the project, why they were chosen to participate in this research, what activities were expected of them with regard to the interviews and the measures that would be taken to protect their confidentiality and anonymity (see Appendix 3). This research was based on 'elite interviewing' participants who were policy-makers, politicians, academic professionals, and senior

managers. It had minimal ethical risks to interview participants. This project strictly maintained the principles of anonymity, and any information collected from the participants was retained confidentially. During the study, only the researcher (the author of the thesis) had access to the data and information collected from the participants. In the process of writing up my PhD thesis, care was taken to ensure that individuals could not be identified. All information that may reveal the identities of individual participants was deleted while discussing the findings and using quotes, in order to protect the privacy of the participants.

4.5 Conclusion

This chapter discusses the methodology of this thesis. The research design and methods used for data collection were guided by the main research question and the institutional analytical framework established in the previous Chapter 3. Perspectives, attitudes, concerns and experiences of the key policy actors involved in the formulation and implementation processes of the 2012 reforms were identified as the critical focus of the investigation in the fieldwork. Case studies in three different CCG areas were adopted in order to explore the implementation process of the market-based reforms, and eventually to ascertain the factors influencing this process in practice. Multiple sources of data such as documents and interviews were employed in order to ensure reliable and credible data and information for producing the findings. Ethical issues

were carefully considered before interviews took place. Throughout the fieldwork, the main research questions were pursued and theoretical assumptions were tested in depth by consulting the wealth of data and information obtained from documents and interviews. This all contributed to the originality of the thesis. The next three chapters will discuss the primary empirical findings of this thesis.

Chapter 5 Regulatory Factors: Commissioning Policy Goals, Ambiguity and Room for Discretion

In the health reforms following the Health and Social Care Act 2012, the Coalition Government had an clear intention to marketise the English NHS by introducing a new commissioning policy framework. This chapter examines whether the 2012 Act has created clear commissioning policy goals, and how this affected the implementation of the market-based reforms. On the basis of theoretical discussion in Chapter 3, regulatory factors could affect policy implementation, and the design of formal policies and rules structures implementation. One of regulatory factors is the characteristics of policy goals. Clearly-defined policy goals will provide a stable and explicit framework for implementation actions and activities. Failing to set clear goals for implementation will leave discretion for implementers to interpret policy and leave open the potential for implementation failure. Following the 2012 Act, a range of new commissioning policies and rules were introduced to govern commissioning decisions and behaviour, which included competitive procurement rules, provider diversity policy and collaboration policy. The goals of the new commissioning framework were formulated ambiguously in order to achieve a successful passage through Parliament. Political negotiations and compromises in the legislative processes resulted in a high level of goal ambiguity in the new commissioning framework of the 2012 Act: CCGs were required to intensify competition in the health service commissioning practices, and at

the same time, ensuring provider collaboration for delivering integrated care. This allowed for the goals of health service commissioning to be interpreted in different ways.

From 2014, there was an important policy development initiated by NHS England (NHSE), which did not emphasise the use of markets and competition in the English NHS (Allen et al., 2015). NHSE reinterpreted and modified the commissioning policies and rules of the 2012 Act, with a shift of policy emphasis towards the part of collaboration and integrated care. The Five Year Forward View was published by NHSE in 2014, without mentioning competition and instead focused on how NHS organisations need to improve collaboration. At national levels, the policy goals of commissioning were set up in a way that were unclear and ambiguous, so CCGs had option to improve either competition or collaboration. This provided the opportunity for CCGs to limit the degree of marketisation and competition on the ground.

This chapter presents a systematic review of the goals of commissioning policies at the national level, seeing whether the goals were clearly and precisely designed to indicate actions on the ground, and discussing how this could affect the implementation processes of the market-based reforms introduced by the 2012 Act. It is organised by four main sections. The first section considers the ambiguity in terms of the commissioning policy goals under the 2012 Act. It examines the processes of the legislation, commissioning policy changes introduced by the Act as well as the inherent

ambiguity of policy goals a consequence of political negotiations and compromises in the legislative processes. The second section focuses on the reinterpretation and modification of NHSE to the commissioning policies of the Act, examining the role of NHSE in reinforcing the ambiguity of policy goals at a national level. The third section then moves to explore the understandings of commissioning policy goals in respect of improving competition and collaboration at local levels. The last section of this chapter focuses on discussing the ambiguous goals of commissioning policy following the 2012 Act and its implications on implementation of the market-based reforms.

5.1 The Creation of the Health and Social Care Act 2012: Legislative Processes, Policy Changes and the Ambiguity of Policy Goals

This section focuses on ambiguity of the goals of the commissioning policies in the 2012 Act, which referred to the improvements of both competition and collaboration in health service commissioning practices. First of all, this section outlined the difficult legislative passage of the 2012 Act and the discourses around the reforms. It considers the political negotiations and compromises at a legislative level of the 2012 Act. This section then moves to present the commissioning policy changes introduced by the 2012 Act. These changes included the creation of NHS England and Commissioning Clinical Groups, competitive procurement rules (known as section 75 regulations of the

2012 Act), provider diversity policy and collaboration policy. Lastly, this section discusses the ambiguity of commissioning goals embedded within these policy changes. As a consequence of political compromises, the health reforms following the Act introduced a new commissioning framework which embodied a set of ambiguous goals. There had been twin and possibly contradictory objectives of improving both competition and collaboration in the practices of health service commissioning. The 2012 Act had an intention to intensify market competition for enhancing efficiency and reducing costs, and at the same time the reforms encouraged to improve provider collaboration for delivering integrated care.

The Legislative Processes of the Health and Social Care Act 2012*:* Difficulties, Negotiations and Compromises

In July 2010, the reform White Paper – *Equity and excellence: Liberating the NHS* was introduced by the Health Secretary Andrew Lansley, with an intention to marketise health services for the improvements of service efficiency and cost containment. Lansley emphasised the challenging financial position of the NHS for the next few years, with the statement that "our health service is facing huge challenges that, if not dealt with today, will almost certainly mean a crisis tomorrow" (Lansley, 2011). Before he became Secretary of State, Lansley has held the shadow post for over six years. During this time, he has developed his own ideas about health reforms and outlined them in his speeches and party documents (see, for example, Lansley, 2004a; 2004b;

2005a; 2005b; 2009; 2010). Lansley believed that reforms were necessary within the NHS system for service improvements, articulating his health policy preferences for market and competition (Lansley, 2009; 2010). In his series of earlier speeches between 2004-2005, Lansley suggested the importance of market, competition and choice in promoting efficient health services (Lansley, 2004a; 2004b; 2005a; 2005b). When he became the Health Secretary of the Coalition Government, health reforms were suggested as pressing in order to solve the problems of inefficiency and low-productivity in health services against the backdrop of a great financial challenge and the priority of reducing the public deficit (Department of Health, 2010, 10-11). The reform white paper was published with a clear aim to further marketising the English NHS by adopting a new commissioning policy framework, mainly through:

- Conducting a reorganisation of commissioning system. The White Paper 2010 proposed abolishing the existing management tiers of the NHS – Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). Instead, creating an independent NHS Board (now known as NHS England) to allocate resources and provide commissioning guidance at a national level, and new local commissioning organisations – Clinical Commissioning Groups (CCGs). In this new system, ministers and the Department of Health would issue strategic direction and mandates for running health services rather than direct control.

- Extending the level of competition and choice of provider in health services,

and opening the NHS for ‘any willing providers’ (including the private and voluntary sectors). The White Paper 2010 argued that ‘within the NHS social market, there is scope for purchasers to act anti-competitively, for example by failing to tender services or discriminating in favour of incumbent providers’ (Department of Health, 2010, p.39). Thus, Monitor was suggested to be developed into an economic regulator to oversee aspects of competition in the NHS.

- Both Monitor and the NHS Commissioning Board would ensure commissioning/purchasing decisions were fair and transparent, and would promote competition. Local commissioning organisations would be required to comply with competition rules, with the responsibility to increase provider competition in their procurement activities. In this sense, regulations and rules of competition would become a nationally legal framework to regulate the decisions and behaviour of local commissioning organisations.

Based on the proposals of the White Paper 2010, the Health and Social Care Bill was introduced by the Department of Health into Parliament on 19 January 2011, subject to the primary legislation. Its emphasis on marketisation and competition led to considerable debate within the House of Commons, and the role of market and competition was required to be limited in health reforms. One of the key debates in the primary legislation concerned many issues of competition in the NHS, such as ‘the

functions of Monitor as the economic regulator for the health service, and the extent to which competition and the private sector would be involved in commissioning and delivering services' (Powell and Gheera, 2011, p.1). There were wider concerns over the negative impacts of the expansion of markets and competition within the NHS, such as low cost-efficiency and poor quality of care. Many Labour Members raised their concerns about cost-efficiency and 'cherry-picking' activities of private providers in health markets (Powell and Gheera, 2011, 11). They argued that in health markets, non-NHS provider could take on easy cases and leave more complex, and expensive procedures to be carried by the NHS hospitals. The reform bill failed to address concerns about the cherry-picking of NHS services by private sector companies. From many MPs' view, this would pose a threat to the financial stability of NHS hospitals. In addition, a number of Labour MPs acknowledged 'trade-offs' between demands for quality and efficiency that had always existed in markets, arguing that the expansion of market competition in health could be at the cost of quality of care (Boseley, 2011). They required the Government to ensure the reforms would not compromise the quality and integration of health care received by patients.

Outside the government, the reform plans were faced with increasing opposition from the medical profession (Timmins, 2012). Many critics suggested that the reform agenda of 'any willing provider' would force commissioners to increase the use of private sector providers (Campbell, 2010). There were a wide range of concerns amongst health professionals about the negative impacts of the extensive role of markets and private

provision on health care, in terms of destabilising local health economies, fragmenting patient care, and facilitating private providers to make profits. For example, the British Medical Association (BMA), one of the biggest health unions and professional bodies for doctors in the UK, criticised that the policy of 'any willing provider' would force commissioners to contract out to private sector providers, and further privatisation was an inevitable consequence of many of policies contained in the reform bill (Peedell, 2011). A no-confidence motion in Lansley and his reform plans was conducted in the annual conference of the BMA, which reflected the resistance of medical professionals to the reform proposals (Campbell, 2012). Likewise, the chair of the Royal College of General Practitioners (RCGP), Clare Gerada voiced concerns that the expansion of competition in commissioning would cause fragmentation and long-term harm to patients' outcomes, insisting that "good commissioning was best achieved through cooperation, collaboration, and competition, but only where it adds value" (Wise, 2011). The Royal College of Surgeons (RCS) worried about the potential impact of the 'any willing provider', which could lead to simpler cases being contracted to new providers, and thereby harm the new surgeon training and destabilise acute services in the NHS (The BMJ, 2011).

The increasing opposition within and outside of the government eventually led to political criticisms of 'privatising the NHS'. Various pressure groups for social justice and protecting the NHS opposed the reform proposals in relation to the expansion of marketisation and private provision. Health campaigning groups were generally

regarded as anti-privatisation and active in the campaign against the 2012 reform. Some campaigning organisations, such as Keep Our NHS Public, 38 Degrees and Socialist Health Association mobilised their resources to oppose the Lansley reform (Timmins, 2012). For example, 38 Degrees conducted a petition against the reforms via Twitter and Facebook to get electronic signatures, in order to influence the debates of MPs on the Bill (Boseley, 2011). Increasing opposition activities attracted the attention of the mass media. Media reports exacerbated the political disagreements and the public's fear of the market-based proposals within the Bill. A threat of privatising the NHS caused by the reform proposals was widespread in the British society, which meant that policy-makers had to take the opposition seriously.

The pressures from these criticisims forced Liberal Democrat ministers to overwhelmingly reject the radical marketisation agenda proposed by the Bill, arguing for major changes to limit the role of competition and private provision in health services. In March 2011, a motion was passed at the Liberal Democrat spring conference in Sheffield, against supporting the Lansley reform. Nick Clegg, the leader of the Liberal Democrats, Deputy Prime Minister responded with a promise that reform would not lead to privatisation of the NHS (Helm, 2011). The level of political controversy increased, and Liberal Democrat ministers said they would withdraw the support for the Bill unless significant changes were made.

The pressure for amending the reform proposals was so strong that it was difficult for

the government and ministers to ignore (Watt, 2011). As a consequence, the legislative process of the Bill was paused in April 2011 to allow for the conducting of a 'listening exercise'. The government promised to listen and consider the concerns over the contents of the reform proposals and make amendments (Triggle, 2011). A group of experts (known as the NHS Future Forum) were appointed to take consultative exercise and then to propose a report back to government about recommendations for changing the Bill. During a period of eight weeks from 31 May 2011 – 13 June 2011, discussions were opened with the NHS staff, patients, citizens and all those organisations that cared about health services. Issues of market and competition were the most controversial area of the Forum's discussions. The reform bill was criticised that they would increase fragmentation and undermine integration of services around the needs of patients by the expansion of market and competition. The Forum responded to these concerns, with a view that both competition and collaboration had a place in improving health services, but competition would not be appropriate everywhere. It was suggested that the reform should strengthen collaboration and integration in health services.

On the basis of the NHS Future Forum, the government introduced significant changes to its reform proposals. In September 2011, the revised bill passed through the House of Commons, and reached the House of Lords. In this process, arguments and concerns focused on the lack of clarity in the statutory duty of the Secretary of State for Health and ministers under the newly reorganised system. Outside the Government, an increasing range of medical professionals built a union to entirely reject the reform. In

particular, some medical royal colleges working with ministers, turned to join the BMA to call for the withdrawal of the Bill (Triggle, 2012). Against such strong opposition, the House of Lords Select Committee produced further amendments to satisfy the concerns of medical professionals and the public. The Committee required that the Bill further clarified the responsibility of the Secretary of State in service provision (House of Lords Select Committee on the Constitution, 2011, 4). Eventually, the Bill was considerably amended and deliberately designed to limit the role of market and competition in health services:

- Firstly, the Bill was amended to make clear that the Secretary of State remains ultimately accountable for the NHS. Political accountability for health provision was still maintained, although a NHS Commissioning Board would be established with certain degree of independence to allocate resources and guideline service commissioning at a national level. The 2012 Act clearly stated that the Secretary of State would retain ministerial responsibility to Parliament for health service provision; health service provided in England must be comprehensive, universal, and free at the point of delivery (Department of Health, 2012).

- Secondly, the commissioning and procurement policy of the Bill was amended to limit the role of market and competition in health services. Originally, the reform proposals had the radical intention to marketise health services, clearly

stating to promote competition and choice in health service commissioning. The rule of competitive procurement was proposed as a nationally legislation to regulate the behaviour of CCGs, overseen by Monitor. However, following modifications, the role of Monitor was redefined as the one of 'preventing anti-competitive behaviour' for ensuring the interests of patients rather than 'promoting competition'.

- As a critical part of changes to limit the role of competition, the Bill was revised to highlight the goal of improving collaboration and integrated care in health service commissioning. The Act stated that NHS commissioners should increase the level of competition in services without damaging the integration of the health care (Department of Health, 2012). The national commissioning board (now known as NHS England), Monitor, CCGs should excise their functions with a view to secure integrated health services and quality of care. The revised duty of Monitor and commissioners to improve collaboration and integration of care was an important compromise on the market-based reforms in the legislative process of the 2012 Act.

In the policy-making process of the 2012 Act, the reform proposals experienced a difficult passage through Parliament, resulting in considerable political negotiations and compromises. A high level of pressure was put on the Coalition Government and the Department of Health to delay the passage of the Act through Parliament so that the

Government embarked in a 'listening exercise' for revising the reform proposals. Why did the legislative process of the 2012 Act encounter such significant difficulties with considerable negotiations and compromises? One reason was that market-based policies were highly controversial in health services, which were perceived as negative to the efficiency and quality of health care (Timmins, 2012). There were wider debates in the primary legislation of the Act concerning the role of market and competition in the provision of health services. A number of ministers set out their concerns about the proposals for competition to become the national law for NHS commissioning, and about the role of Monitor to become the economic regulator for promoting competition. These concerns focused on the negative effects competition law might have on efficiency and quality of care. The professionals, NHS staff and many ministers argued that marketising health services may fail to increase cost-efficiency in health services, because of the increased spending on the cherry-picking activities of private sectors. In addition, there were concerns with the negative effects of market competition on healthcare outcomes, because markets by their nature may produce damaging outcomes such as low-quality of care (e.g. fragmented care).

Second, the 2012 Act was confronted with opposition across the British society and the public, and thus negotiations and compromises were made out of political and electoral considerations (see, for example, Béland et al., 2014; Klein, 2013a; Timmins, 2012). In the UK politics, the NHS was a revered institution and was highly salient politically, and there was a sensitivity that radical reforms in health could evoke an electoral

reaction (Pierson, 1994). As a universal, publicly-funded health services, the NHS has a significantly close relationship with the interests of most of the population, thus receiving considerable support from the public. The NHS has been widely perceived as a kind of 'national treasure' in British society, and the health reforms were generally unpopular (Laws, 2017). Any changes to the NHS could become electoral and political issues, so the British governments always attempted to avoid doing anything that might considerably upset the voters when they conducted health reforms. In the UK, health reforms always required political struggle, as these reform programmes would easily revoke the public concerns of undermining the NHS fundamentals (Bambra et al., 2005). People were genuinely worried that the market-based policies such as 'competitive procurement' and 'any willing provider' would allow the private sector to get involved in large parts of the NHS. Given that health care has been understood as public goods and a citizen's right, privatisation is extremely unpopular and politically impossible in the NHS context.

The reform proposals of the 2012 Act were perceived as too radical in terms of the degree of marketisation, which led to an increasing level of opposition from the professionals, the public, campaigning groups and many politicians. The reform raised a political concern around the Conservatives' creeping 'privatisation' of the NHS (Timmins, 2012), which was widely suspected to satisfy Conservative business interests in the private healthcare providers (Greener, 2016, 121). Although the Conservatives stressed their commitments to protect the fundamental principles of the

NHS without the intention of cutting down healthcare funding, there had been considerable opposition to the reform. Klein (2013a, p.857) suggests that the reform proposals have threatened the Conservative party's 'long strategy of detoxifying the Conservative image as a party of hard-faced subverters of the welfare state'. The 'privatisation' of the NHS became central in the public and political debates in the UK, and the NHS became a political issue for the Conservatives, which cannot be ignored. Moreover, there were strong political opposition occurred from the coalition partners – the Liberal Democrats. Many Liberal Democrat ministers did not agree with most of reform proposals under the external pressure from interest groups and the public. The original reform proposals were not unreservedly supported by the coalition partners – Liberal Democrats (Cameron, 2019, 253). The coalition government context increased opportunities for veto points than would be the case of a government established by a party with an outright majority. A coalition in political systems limited the opportunities for major transformations towards marketisation, because there decision-making was more fragmented, and there was substantial opposition towards the reform within the Government. In order to reduce their political costs, both Conservatives and Liberal Democrats agreed to introduce major amendments to limit the role of competition in the provision of health care.

Thirdly, the reform proposals were introduced into Parliament without close scrutiny, which made the legislation significantly difficult (see, for example, Klein, 2013a; Laws, 2017; Seldon and Snowdon, 2016). The reform proposals were not discussed during the

general election campaign in 2010. Only the commitment to an increased health funding was mentioned in the Conservative Party's manifesto. In the general election campaign, Conservatives stressed their commitments to protect the fundamental principles of the NHS without the intention of cutting down healthcare funding. But the reforms to health services were not mentioned at all. In addition, the reform proposals of the Bill were not contained in the Conservative-Liberal Democrat coalition agreement for government, which even claimed to 'stop the top-down reorganisations of the NHS that have got in the way of patient care' (HM Government, 2010, p.24). Ahead of the introduction of the White Paper 2010, the top priority of the new government was to eliminate the financial deficit by the biggest spending cuts in public services. Health reform plans were far away from the top of its priorities (Timmins, 2012). All of these meant that NHS reforms were not one of the key negotiations areas for the Coalition. There was no discussion about the NHS reforms in details at the beginning of the new government.

Before the reform proposals were introduced into Parliament, the health reform proposals were not subject to adequate scrutiny. The new, inexperienced Cabinet ministers failed to scrutinise the details of the Lansley's proposals, and underestimated the extent of the changes brought about by these proposals (particularly the competition aspects). There was a lack of detailed discussion and close scrutiny about how the reform might to be and how it might be implemented across both the Conservative party and the Coalition Government ministers. The Cabinet ministers failed to realise the

degree of changes these reform proposals would bring about before the primary legislation. They might not even realise that the reform proposals were against the commitments of the coalition government in relation to keeping the health policy stability and avoiding more top-down reorganisation. Cameron (2019) admitted in his memoirs that the reform proposals were too complicated to be entirely understood in a short time, because they were uniquely designed by Lansley, based on his experiences and preparations in the shadow position of health secretary for over six years. The Cabinet members failed to properly understand the Lansley's proposals and scrutinise them before allowing them to proceed (Laws, 2017). They were either distracted by other matters or they simply did not understand what Lansley were proposing until the Act was already going through Parliament (Seldon and Snowdon, 2016).

The difficult passage of the 2012 Act could be partly understood as a consequence of new, inexperienced Cabinet of the government making mistakes of not adequately scrutinising governmental proposals and underestimating the extent of the changes (Klein, 2013a). Without the sufficient discussion and strict scrutiny from the government ministers, the reform with substantial changes was introduced in Parliament for legislation. Not until the Act was passed into Parliament and the details of the reform were publicly and widely debated did many ministers realise the significance of the proposed changes and how politically contentious they were (Laws, 2017; Seldon and Snowdon, 2016). Under the greater pressures of the public, professionals, campaigners and the media, the government had to delay the reform and

make significant amendments to limit the degree of changes towards marketisation, one of the most controversial aspects of the reform. Considerable compromises were made in order to reduce the criticisms and depoliticise the debates around the 'privatisation' of the NHS, a difficult and politically toxic issue that all political parties attempt to avoid. The government reacted to delay the reform when they realised that they had embarked on a course of risking the loss of electoral support (i.e. a pause to the legislation and a highly unusual decision – a 'listening exercise'). This contributed to the difficulty in making the reform proposals passed through legislative process.

The legislative processes of the 2012 Act was difficult and prolonged, with considerable political negotiations and compromises made in order to reach a successful passage in Parliament. The policy changes introduced by the 2012 Act were based on a number of compromises that were made on the policy areas of market and competition in commissioning where had the greatest disagreements between policy-making actors. Compromises were significantly made to silence the criticism and get the reform through legislation. As a consequence of these negotiations and compromises, the reform proposals were deliberately revised to reflect multiple and ambiguous goals of commissioning policy, i.e. the co-existence of improving competition and collaboration in health services. More specifically, the 2012 Act clearly highlighted the critical role of market mechanisms (such as competitive procurement, tendering and contracting out) applied to service commissioning, but also contained policies to deliver collaboration and integrated services (Timmins, 2018, 36). The government reform goals were

created ambiguously following the 2012 Act as a result of the need for political compromise and successful legislative passage. CCGs had an option to improve market competition or collaboration in health service commissioning practices. Political negotiations and compromises in the policy-making processes of the Act produced not only policy changes, but also resulted in the ambiguity of the reform goals and objectives.

Policy Changes: A New Commissioning Policy Framework under the Health and Social Care Act 2012

The central aim of the 2012 Act was to increase the level of marketisation and competition in health services to a much greater degree than before. There were a range of new policy changes in health service commissioning for intensifying competition, including the creation of NHS England and Clinical Commissioning Groups, competitive procurement rules (known as Section 75 regulations of the Act) and provider diversity policy (Frith, 2015). Following the Act, competition rules and regulations became into a legal framework to regulate the activities of health service commissioning and procurement. CCGs were encouraged to increase the use of market mechanisms such as competitive procurement, tendering and contracting out, in order to diversify healthcare providers and to enhance competition. But at the same time, improving collaboration and integrated care in health services was another important policy goal of the 2012 Act. It co-existed with the goal of marketising health services.

A brief of policy changes in relation to commissioning introduced by the 2012 Act is provided in Table 4.

Table 4 A Brief of Commissioning Policy Changes in the NHS in England under the Health and Social Care Act 2012

The Creation of National Commissioning Board (now known as NHS England) • Functions: To directly commission primary care services and specialised services; to allocate resources and budgets to local commissioning organisations, including CCGs and local authorities; to manage the NHS system and oversee all the CCGs • Operate according to the general mandate set by the Secretary of State, and accounting to it in terms of finance, service outcomes and performances • General duties to improve efficiency, improve quality of services, promote autonomy, reduce inequalities, improve patient choice and promote integration
The Creation of Clinical Commissioning Groups • Abolition of tiers of administration: the PCTs and SHAs were abolished, transforming their responsibilities to NHS England and 211 CCGs • CCGs' function is mainly to purchase health care on behalf of the patients, including urgent and emergency care, elective hospital care, and community and mental health services, taking over around two-third of the

overall NHS budget • Operate according to the guidelines of NHS England, accountable to it for performances • General duties to improve effectiveness and efficiency, improve quality of services, reduce inequalities in access, improve patient choice and promote integrated health care
Competition Rules for Procurement • Competitive procurement rules (see the Section 75 of the Act): CCGs should protect patient choice and to prevent anti-competitive behaviour which is against the interests of service users; CCGs should use competitive tendering for the provision of services. • Monitor (economic regulator for the whole NHS marketplace): general duties are to protect and promote patient interests by improving efficiency and quality of health services; to prevent anti-competitive behaviour
Provider Diversity Policy • Any qualified providers (AQPs) can deliver the NHS services, and these providers includes the public sectors, the private sectors and the voluntary sectors etc. • CCGs should produce a level playing field for any qualified providers to tender for the NHS contracts, in order to diversify healthcare providers and enhance competition.

(NB: the original White Paper and the initial Bill referred to 'Any Willing Provider' but this was amended into 'Any Qualified Provider' following the report of the NHS Future Forum)
Collaboration Policy • NHS organisations have a duty to deliver integrated services for the interests of service users through collaboration and cooperation mechanisms • CCGs and Monitor should ensure collaboration and integration of healthcare in health service commissioning practices.

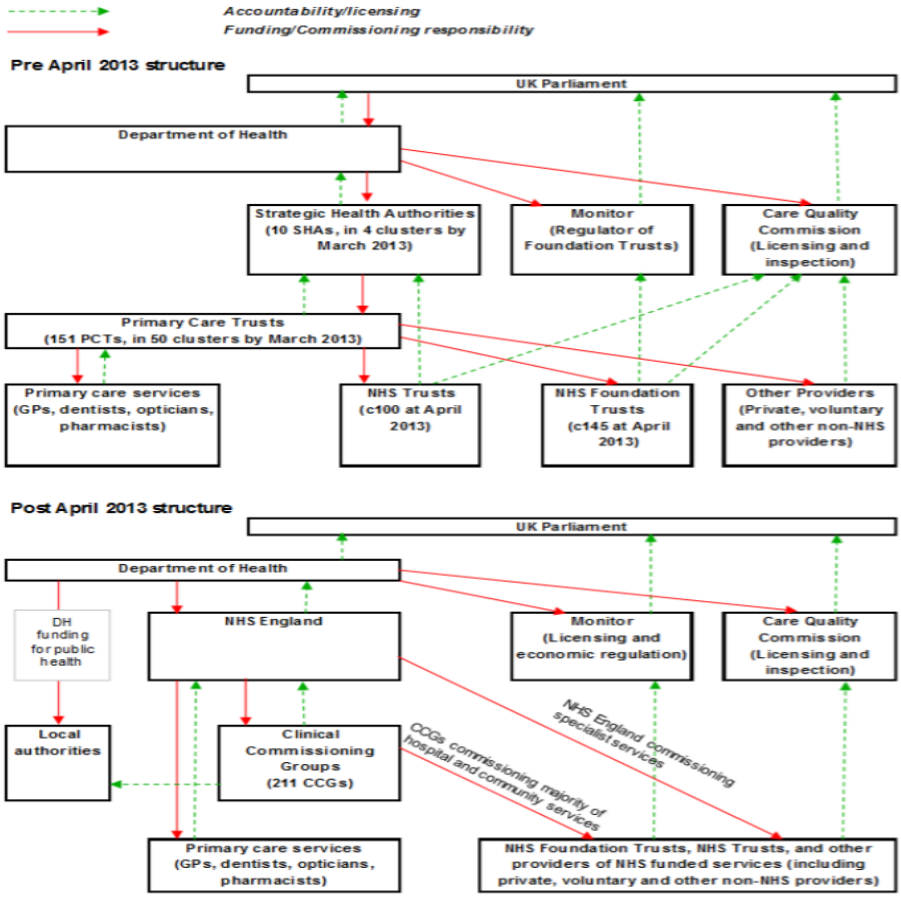
Source: Health and Social Care Act 2012

The Creation of Clinical Commissioning Groups and NHE England

The Act changed how health care was commissioned and purchased by creating new commissioning organisations – Clinical Commissioning Groups (CCGs) at a local level and NHS Commissioning Board (now known as NHS England) at a national level (see Figure 4). This kind of reorganisation was largely based on the quasi-market structure of separating 'purchasers' and 'providers', but allowed more autonomy to local commissioning agencies be more sensitive to market mechanisms. Before the 2012 reform, Primary Care Trusts (PCTs) were responsible for local health service commissioning, and at a regional level, Strategic Health Authorities (SHAs) had the responsibility for the coordination and supervision of interactions between commissioners and providers. The 2012 reform abolished the PCTs and SHAs,

transforming their responsibilities to the NHSE at a national level and CCGs at a local level. Members of a CCG would be made of general practices within given areas, and every CCG would create its own governing body including at least 6 members. The statutory duties of CCGs were mainly to purchase health services from providers on behalf of the patients, including urgent and emergency care, elective hospital care, and community and mental health services. They would take over around two-third of the overall NHS budget. All of these new arrangements attempted to increase CCGs' influence over the NHS budget and their autonomy as well as accountability in deciding local healthcare provision in the needs of local population.

Figure 4 Changes of the Structure of the NHS in England



Source: House of Commons Library, 2016

A national commissioning board (i.e. NHS England) was created as an independent national executive body following the implementation of the 2012 Act, managing the NHS system and overseeing commissioning at the top, operating at arm's length to health ministers. NHSE was designed as 'a lean and expert organisation, free from day-to-day political interference' (Department of Health, 2010, p. 30), with a degree of autonomy. In the reform, the department and ministers were expected to only act as

policy-makers, setting the strategic direction for the NHS in England through a mandate to NHS (Department of Health, 2012). NHSE would operate according to the general mandates set by health ministers rather than their direct management, in order to be less affected by political pressures. This was aimed to create a 'statutory division between ministers and the Department of Health on the one hand, and the commissioning and provision side of the NHS on the other' (Timmins, 2013, p. 3).

Under this arrangement, NHSE had the responsibility for providing national leadership and allocating resources to local commissioning organisations, supporting them to carry out their functions effectively. Local health services would be delivered by interactions between commissioners and providers without any formal management and functions of regional coordination, directly regulated by the mandates and guidelines issued by NHSE. NHSE published national guidelines for CCGs, assessing their performance annually (Checkland et al., 2013). CCGs must have regard for these mandates and guidance, ultimately accountable to NHSE for their performance. In the light of the 2012 Act, where it is considered that a CCG has failed to discharge any of its function, NHSE has powers to intervene and direct a CCG to discharge its functions (Department of Health, 2012). The intention of these structural changes were to create a context in which the government could control health service from a distance, and devolved managerial autonomy was used to deliver health services based on local needs.

Competition Policy and Rules

Apart from reorganisations, the new commissioning policy framework for enhancing competition under the 2012 Act included competitive procurement rules and provider diversity Policy. First of all, competition rules and regulations have been introduced under section 75 of the 2012 Act. Following these rules, CCGs were required to improve the level of competitive procurement and tendering of health care in the commissioning activities. The reform attempted to force CCGs to create markets and competition by threatening them with legal consequences if they do not (Davies, 2013, 566). The Act states that competitive procurement by CCGs is to be preferred, although not in all circumstances (Department of Health, 2012, 100). That is to say, when CCGs decide to purchase health services from the market, they have the obligation to treat any qualified providers equally and non-discriminatorily, and run the procurement process in a transparent and competitive way. CCGs were required to open up some health services to competition when they saw it as fit. Some health services might have to be put out to tender to ensure best value for money or quality of care. Competition became into the rule of law for changing the behaviour of CCGs, requiring them to act more as 'market actors' in health service delivery.

The Act made a direct relationship between competitive behaviour in the NHS and competition law (Allen et al., 2015, 3). Before the Act, the connection between NHS competition and competition law was largely theoretical that competitive procurement and tendering were not legally enforced, and was subjected to an internally-negotiated

mechanism within NHS sectors (Sanderson et al., 2016). The competition was regulated internally by the sector-specific rules in relation to commissioning and procurement practices, regardless of the relevant existing national or European legislations, hierarchically monitored by the Department of Health within the NHS (Sanderson et al., 2016). But the 2012 Act altered these arrangements. A nationally legislative framework for pro-competition was enacted to govern commissioning decisions and actions. Legislative pressures of using market competition mechanisms increased to affect the behaviour of commissioning organisations within the English NHS system (Davies, 2013, 581). Notably, CCGs were legally required to comply with competition rules when purchasing health services from the market. The Act in many ways continued the market reforms of the previous governments for applying competitive procurement in the NHS service provision in England (Sanderson et al., 2016). But the most different changes made by the Coalition Government in contrast with the previous reforms were that: Competition became into the rule of law to regulate commissioning decisions and actions.

Secondly, the reforms entailed the diversification of providers in the provision of health services (especially the reforms encouraged the increased use of private sector providers through the market mechanism of contracting out). The 'Any Qualified Provider' (AQP) policy was set up to enhance competition and choice (BMA, 2013). CCGs were required to produce a level playing field for any qualified providers (public, private and voluntary) to compete for the NHS contracts. The Act allowed non-NHS

providers (especially private sectors) to bid for services previously offered by the NHS providers. It had a clear statement that providers of NHS funded services should include non-NHS organisations, including private companies, charities and voluntary sector bodies (Department of Health, 2012). For a wide range of elective and community services, patients had the right to choose providers, and CCGs should ensure patient choice. In this sense, commissioners were encouraged to diversify healthcare providers through contracting out health services. They needed to consider any qualified sectors when purchasing health services. Within the NHS, the potential market entry for the private sector was enlarged by the logic of competition and patient choice. The NHS markets were further opened up to diverse providers for delivering health services.

Thirdly, Monitor was developed as an economic regulator to enforce competition law and prevent anti-competitive behaviour by CCGs. Monitor would work with a national competition regulator – the Market and Competition Authority (MCA), to prevent anti-competitive activities of commissioners, such as discriminating in favour of incumbent providers (Department of Health, 2012). Healthcare providers were allowed the right to complain to Monitor about any anti-competitive practices of CCGs (Department of Health, 2012). Monitor had the responsibility to investigate received complaints of anti-competitive commissioning and procurement activities. Once procurement exercises of CCGs breached competition principles, Monitor could mandate them to address their anti-competitive activities. These new regulatory arrangements were aimed at putting all healthcare providers on a level playing field, offering a fair opportunity for non-

NHS providers to equally compete with NHS providers in the provision of health services (Davies, 2013, 569).

The 2012 Act introduced a new commissioning policy framework to further marketising health service in the NHS in England. This framework emphasised the role of competition rules to govern commissioning decisions and behaviour, trying to force CCGs to intensify competition and realise provider diversity in health services under the threat of legal challenge. It attempted to generate certain legislative pressures for CCGs in response to the national requirements in terms of marketisation and competition (Sanderson et al., 2017). CCGs were legally obliged to apply market mechanisms to their commissioning and procurement activities. All these competition rules attempted to prohibit CCGs from pursuing a policy to favour one type of providers over another (Arora et al., 2013, 31). The Act attempted to create a more favourable environment for non-NHS providers involved in the NHS service provision through the legislative pressure of competition law (Davies, 2013, 585-587). Under the competition rules, it was expected that competitive procurement, tendering and contracting out health care would increase, and that a market with a range of comprehensive providers would be realised. CCGs were put in a position where they had to respond to legislative requirements for creating competition, overseen by Monitor.

Collaboration Policy

Apart from the commissioning policies in relation to marketisation and competition, the 2012 Act included collaboration policy for improving integrated care. The Act stated that there were many aspects of care quality which required collaboration between different providers, and thus the level of competition should be increased in health services without damaging the integration of the healthcare and the needs of patients (Department of Health, 2012). In the light of the collaboration policy, CCGs should excise their functions of securing collaboration and integrated care, and at the same time, increasing the level of competition in service commissioning and procurement. Although it was not clear in the Act about how CCGs could reconcile these two potentially contradictory goals, there was a clear position of collaboration and integration in the NHS, rather than simply focusing on the increase of marketisation and competition.

The Ambiguous Policy Goals of Health Service Commissioning in the 2012 Act

Looking through the policy changes of the 2012 Act, there was a lack of clarity in terms of the goals of commissioning policy. Out of political negotiations and compromises in the legislative processes of the 2012 Act, the government sought to improve marketisation and competition by the force of legal pressures, and at the same time, improving collaboration was required between local NHS organisations. More specifically, CCGs were expected to increase the level of competitive procurement, tendering and contracting out in service commissioning, but at the same time, they need

to consider how to improve collaboration between providers for delivering integrated care. There was no clear and explicit guidance for CCGs concerning what the goal of the 2012 Act they should prioritise in their commissioning practices. In the wording of the Act, the delivery of competition or collaboration rules in certain services should be based on the interests of people who use such services (Department of Health, 2012). Monitor would assess whether the 'interests of people' were being served, but there was no clear definition in the Act as to what constitutes 'patient interest'. In fact, 'patient interest' is a very general conception which could refer to many aspects of health services such as quality of care, safety, efficiency, and experience etc. Monitor would assess if collaborative behaviour was anti-competitive, but there was no guidance in the Act on what basis they would make such a judgement. Generally, the government believed that NHS commissioners would determine whether and how to implement competition and collaboration policies in service commissioning. In this sense, the actions of CCGs have not been precisely prescribed, and they were allowed greater discretion to interpret the goals of the Act and act accordingly.

It should be noted here that different policy goals of health service commissioning were not given equal attention by the 2012 Act. Looking through the wording of the Act, CCGs were required to improve both competition and collaboration, but overall, the Act emphasised the role of competition over collaboration. Competition and provider diversity were repeated in the Act, while collaboration and cooperation were only mentioned briefly. Notably, the Section 75 regulations of the 2012 Act indicated that

competitive procurement was to be preferred by commissioners, although not in all circumstances (Department of Health, 2012). This suggests that the policy emphasis of the Act was to use the competition rules in governing the decisions and behaviour of CCGs for enhancing marketisation and competition. The language of the Act has sent a strong signal that competition is beneficial to patients' interests, and increasing competition is in line with the interests of patients (Hudson, 2013, 4). Activities of restricting competition may be perceived as against the benefits of patients. One of the safe options for CCGs would probably conduct the competitive procurement through markets. The impact of collaboration policies was seemingly watered down by the section 75 regulations, and it was not clear as to when commissioners would be able to legitimately restrict competition, and prioritise the quality standard of services (e.g. integrated care) over competition without being punished legally (Frith, 2015). This means that CCGs may put competition as a priority and potentially ignore collaboration and the quality of health care.

In order to clarify the commissioning and procurement rules of the 2012 Act, the *National Health Service (procurement, patient choice and competition) regulations 2013* was published to provide guidelines for CCGs (Department of Health, 2013). The regulations indicated that it was not mandatory for the competition rules to be applied for commissioning all health services, because it would not be appropriate everywhere. NHS commissioners would decide how competition was introduced in their areas, including what services to procure and how best to do this. Commissioners would make

their own decisions about whether services could be improved by providing them in a more integrated way, by giving patients a choice of provider to go to, and/or by enabling providers to compete to provide services. In addition, the regulation 2013 explained the role of Monitor, with the statements that Monitor would not have the power to force competitive tendering, and commissioners should be free to use competition or collaboration where it was in the interest of patients. Monitor would only act when they have received a complaint about an alleged breach of competition rules.

In reality, the regulations 2013 did not resolve the ambiguity of commissioning policy goals under the 2012 Act. The guidelines were still not clear enough for CCGs to follow which allowed wide scope for interpretations. The basic guideline set out by the regulations indicated that competitive procurement was not mandatory, and not all of health services must be put out to tender. CCGs were given substantial discretion to make their own decisions about whether and how to implement the competition polices as well as what goals they should prioritise in their work. Goals of improving competition and collaboration in health service commissioning have been paradoxically adopted by the 2012 Act. In a large size, the Act left uncovered much of details on rules of which commissioning policies should be applied in which circumstances.

5.2 The Ambiguity of Policy Goals Reinforced by NHS England at a National Level

This section examines the reinforcement of policy ambiguity at a national level, which was as a consequence of the interpretations and modifications of NHS England to commissioning policies and rules. In the light of the 2012 Act, NHS England was created as an arm's length body to operate and manage the NHS at top of the system. NHSE was given degree of autonomy to make its own decisions on health service and policy delivery, guiding the decisions and actions of CCGs (as discussed in the previous Section 5.1). The Secretary of State for Health and ministers would only issue strategic directions and mandates for NHSE as well as its budgets, and NHSE sets details about how to deliver them within the English NHS system (Department of Health, 2012, 2-4). Because of the reorganisation of the NHS following the 2012 legislation, NHSE was allowed the flexibility to decide how to deliver health services and policies as it saw fit.

NHSE had a suspicious attitude towards the role of markets and competition in health service provision. It highlighted the limitations of market and competition approaches, and instead encouraged collaboration approaches to shape the relationships of local health organisations and service provision models. This was significantly different to what the Act had advocated. Since 2014, NHSE has managed to transform the NHS with an objective of improving a more integrated and collaborative model for health

service delivery (Vize, 2014; 2016). More collaborative forms of health care provision were perceived as essential for the NHS, instead of a complex and fragmented system driven by competition (House of Commons Health and Social Care Committee, 2019). Collaboration rather than competition were encouraged by NHSE as the most appropriate way to improve services and solve the problems caused by financial pressure and an ageing population (NHS England, 2014a; 2014b; 2015; 2019). It significantly shifted health policy towards a more collaborative approaches, which required local NHS organisations to follow.

Just 18 months after the implementation of the 2012 Act, the NHS Five Year Forward View was published by NHSE (NHS England, 2014). The View sets out the key plans for service improvements over the next five years. It did not mention competition between NHS organisations, and instead, focused on how organisations needed to collaborate with each other in order to deliver a more integrated care. The View stated that local primary care, hospitals and community health care services should be an integrated provider, jointly contracting with commissioners for service delivery. In order to deliver the objectives of the View, local health organisations were encouraged to work together to create Sustainability and Transformation Plans (STPs) for new models of integrated health care across England (NHS England, 2015). 44 STP 'footprint' areas emerged in total, each including multiple CCGs and NHS trusts with one local leader. Within the STP areas, NHS agencies were required to develop their own local blueprint for implementing the View. A "Sustainability and Transformation

Fund" of £2.1 billion has been provided to support the work of STPs. Simon Steven, the Chief Executive of NHSE explicitly stated their reforms on health services in the meeting of the Public Accounts Committee:

> "What we are going to be doing at the end of March is setting out quite clearly the NHS delivery plan for the next couple of years. That will be very explicit about what the integration will look like in each of the 44 STPs and about the move towards accountable health systems in key parts of the country…We are going to formally appoint leads to the 44 STPs. We are going to give them a range of governance rights over the organisations that are within their geographical areas, including the ability to marshal the forces of the CCGs and the local NHS England staff. We will get probably between six and 10 of them going as accountable care organisations or systems, which will for the first time since 1990 effectively end the purchaser-provider split, bringing about integrated funding and delivery for a given geographical population" (House of Commons Public Account Committee, 2017).

This statement suggests that commissioning policy goals formulated at a national level were in conflict to some degree within the English NHS. NHSE issued a range of policy and rules that emphasised the role of collaboration in health services, which was potentially in contradiction to the existing framework of government policy and legislation that had highlighted the role of markets and competition (Hammond, et al., 2019, 1159). Although there were no any changes in the pro-competition framework of

the 2012 Act at the legislative level, the impact of market and competition had been diluted by a range of policies introduced by NHSE. As a private company manager commented:

> "Simon Steven [and] NHS England decided they don't want choice and competition, they want to manage everything much more through integration care, and the American model of regional health system. The Secretary of State cannot stop what Simon Steven does, they can only give the Mondays' [meetings]. As soon as we broke the links between the Secretary of State and Simon Steven, the Chief Executive of the NHS, the Act was undermined, because it gave the NHS England the freedom to change the system from within."

Whilst NHSE set out a clear direction of policy shifts towards collaboration and greater integration in health services, these changes were perceived to be not mandatory at local levels. The View 2014 was just presented as recommendations for local NHS organisations to follow. The View explicitly encouraged to use locally-defined approaches to implement collaboration programmes, arguing that 'one size will not fit all' across diverse care model in England (NHS England, 2014a, p.4). The collaboration policy had substantial ambiguity on the details of process, with a lack of clear guidance about how local NHS organisations would collaborate with each other to deliver integrated care. It was intended that local NHS organisations would drive the process of collaboration and integrated care, and design appropriate local solutions to meet the

requirements set out by NHSE. As *The Forward View into Action: Planning ahead for 2015/16* stated:

> Over the next year we will co-design a programme of support with a small number of selected areas and organisations that have already made good progress and which are on the cusp of being able to introduce the new care models set out in the Forward view. Our goal is to make rapid progress in developing new models of promoting health and wellbeing and providing care that can then be replicated much more easily in future years. Achieving this goas involves structured partnership rather than a top-down, compliance-based approach (NHS England, 2014b, p.4).

More importantly, it should be noted here that there were no relevant legislative changes, so the competition law remained in force (Allen et al., 2015, 3). There was no official abandonment of the policy of marketisation and competition in the English NHS, although collaboration and integration strategies have been encouraged to exercise at local levels. The requirement to put health services out to tender was still not removed, so CCGs still needed to use the competitive tendering processes for commissioning services if applicable. The government did not accept decisively to end competition rules in the NHS in England, and thus the English NHS retained the possibility of using competition strategies to shape the behaviour of healthcare providers (Timmins, 2018). CCGs cannot entirely ignore the competition rules and regulations, because of the potential legal risks.

Following the Act, NHSE was created with the authority and power to decide how to manage and deliver health services as it saw fit. The fieldwork found that NHSE exercised considerable influence over health services, and that it played a curial role in reinterpreting the role of market competition in health services. At a national level, health policies have been modified and revised by NHSE towards a more collaborative approaches rather than market and competition. The commissioning policy goals of the 2012 Act was created ambiguously, with a lack of clarity in terms of the goals of improving competition and collaboration. Such ambiguity was institutionally reinforced by a range of NHSE's policies that highlighted the collaboration and integration parts of the Act. There were ambiguous policy goals and directions in service commissioning and procurement that CCGs were required to achieve. Actually, no clear framework for commissioning actions was provided at a national level.

5.3 Interpretations and Understandings of Competition and Collaboration Policies at a Local Level

In the fieldwork, commissioning bureaucrats recognised that the 2012 Act had a goal of opening up the NHS markets and increasing the level of competitive tendering and outsourcing of health services, in order to achieve efficiency and reduce health costs. All commissioners in the three case studies understood that the Act generated certain

legislative pressures for CCGs in response to the requirements in terms of extending marketisation and competition. CCGs had to apply competitive procurement and tendering in service commissioning, overseen by Monitor. Not doing so might expose the CCG to the risks of legal challenges from potential providers. Because of the fear of legal challenges, CCGs might use competition approaches to procure services, especially if there were some interested potential providers. As the Director of Operational Delivery of CCG 2 pointed out:

> [If there] is the legal challenge – that is the first we consider if we decide to stay with the current provider, and we award them with contract for another 2-3 years –what is the risk that another NHS provider and private provider would come to XXX and say you broke the rules, and we could not provide for that. So that is part of the consideration – what is the market, and which providers are there. For example, maybe Virgin care say hold on a minute, we could do that faster, cheaper, and better. So, the legal challenge is a big consideration.

That was confirmed by the Chief Financial Officer (CFO) of CCG 3:

> Look through the lens of the patients, certainly we have worried about the requirement for putting out the contracts into the marketplace, if providers come forward. We could be challenged legally by the potential bidders. We have actually gone to the market to award the contracts.

But bureaucrats of CCGs tended to believe that it was not mandatory for competition rules to be applied for commissioning all health services. They had the flexibility in deciding to use or not use the market mechanisms such as competitive procurement and tendering for service commissioning. When deciding not to apply competitive procurement and tendering for health services, commissioners needed to justify why these rules were not applied. In doing so, they would be not exposed to the risk of legal challenges from potential providers in the health market. As commissioners from different CCGs indicated:

> "We do have the discretion to do. The Act allowed us to talk more locally to look at what were the needs of the local patients. It probably allowed us to transform the system as the way we would like…There are some rules you have to go through. There might be that you have to look at the market and investigate any better ways of procuring services. However, it does not mean you have to do something. But I think there will be an area you have to look at it, maybe doing the risky impact assessment on other any providers would give specific things. I think as long as the process had gone through, then you will be all right." (Chair, CCG 1, December 2018).

> "Even with the Act in place, we have to consider and think carefully around what we take to market and what we don't take to market…It is still being the local

determination around what to take to market and when we take to market." (Director of Operational Delivery, CCG 2, March 2019)

Some commissioners suggested that the application of competition approaches was considered and evaluated on a case-by-case basis, and sometimes they would take legal advice. That means there would be multiple ways of interpreting competition rules, and different CCGs could interpret the competition rules in different ways according to different situations. As Director of Operational Delivery of CCG 2 said:

Is there any provider locally [that] can come to deliver this, is there a market, what are the benefits and disadvantages, what is the financial (situation) at the local [level]…and what the local political views for that, because sometimes local third sector groups or politicians or stakeholders will have particular views on services? …It is quite a mountain of consideration at the beginning. If we have the commendation from the managers and commissioners of not going to the market, we take the same legal procurement advices, and apply the same rules. We do get legal advice on some occasions. Some are quite small, then we just take a pragmatic approach. Some are big in value, then we will take legal advice. And then through the governing body, then they approved the decision not go to the procurement for something.

In relation to the policy changes towards collaboration introduced by NHSE, all

commissioning bureaucrats realised the shift in health policy goals and directions at a national level, which was seen as different from what the Act had advocated. In the light of these new policy turns, CCGs were encouraged and supported by NHSE to work around collaboration at local levels. Some commissioners believed that there was a reduced role of competitive procurement and tendering in service provision, because NHSE clearly emphasised collaboration mechanism as a national guideline. As commissioners from CCG 1 said:

> "The NHS England policies seem to encourage more cooperation. That was not what Act says. We are regulated by the NHS England, and we do what they suggest. Nobody says you must do what the Act says –the use of the competition and market." (CP-commissioner, CCG 1, December 2018)

> "*Five Years Forward View* is Simon Steven's sort of plan. We have the national policy, and legislative framework, but the *Five Years Forward View* says: we have not really got any new policies, but we quite like you to ignore what the Act says over there and work together." (Chief Executive Officer, CCG 1, November, 2018)

Likewise, directors from NHS provider sectors confirmed the changes of the national policy and a move away from competition to collaboration in health service delivery. Local health organisations were required by NHSE to conduct more collaborative approaches in health services. As directors from NHS hospitals suggested:

> "I feel the mode is different, and the expectation of national regulators is – commissioners and providers come together to find a solution. Competition is not popular, and it is not really being proven to solve the problem." (Finance Director, NHS Acute Trust, CCG 1, November, 2018)

> "We are moving away from the competition clearly. That view has been encouraged formally by NHS leaders, and by politicians. This competition in health services is not producing the right results. Increasingly, we are looking more to integrating systems...The shift towards long-term integrated care contracts and collaboration is a very good thing." (Director of Finance, NHS Mental Health Trust, CCG 3 area, February 2019)

Commissioners were allowed substantial discretion in the interpretations of the commissioning policies and determining the role of competition and collaboration in their commissioning activities. The ambiguity of commissioning policy goals has been reinforced by NHSE since it strongly supported the policies in relation to collaboration and integration. Such ambiguity allowed room for multiple interpretations and modifications at the point of delivery, and thus commissioners had degree of flexibility to make their own decisions in the implementation of the 2012 Act. In a context of highly ambiguous goals, how to implement competition and collaboration policies depended on local decisions and actions to a large degree. As the Director of Strategy,

Performance and Planning of CCG 2 commented:

> In terms of market, here is the law of procurement for competition, you must follow that, at the same time, you need to be creative as possible, and trying to encourage greater collaboration and integration provision…Positive thing around that, which is different from not having competition at all, is that we concept the rules, and we can describe how they should operate…I don't think there is much centralised [guidelines] to tell you about decision around competition. The national legislation and a guidance that we all need to collaborate, you take those two factors, what you then do is – it tends to be left to you.

Furthermore, many commissioners believed that the role of private providers within NHS services was not explicitly defined under the current policy framework. They indicated that the shift towards collaboration might provide an opportunity to disadvantage private sector providers. Private suppliers may either be excluded if they do not participate in local collaboration programmes, or they may enlarge the entry to NHS services through collaborating with NHS organisations. That is to say, private providers could be excluded from the local service provision on the justification of promoting collaboration. Commissioners could reject the involvement of private suppliers when they failed to collaborate. In this respect, commissioners could basically subvert the Act because they had the get-out clause of cooperation. As commissioners suggested:

"I think going forward now, it will be – the market is a different place for the private providers to be in, because they will have to change the way they interact with the commissioners, so we won't give them a certain amount of money per health care transaction. I think it will be more on patient outcomes and quality and fixed amount of results. So actually, we might get less and better private influence." (Chair, CCG 1, December 2018)

"I think it could disadvantage the private sector. For examples, we know we need to work collaboratively with the private sector. If they are willing to work collaboratively on the pathway approach. They would not be excluded. I think there is still a role for them – private providers in a new way of commissioning. But they have to expect to work collaboratively." (Director of Operational Delivery, CCG 2, March 2019)

Commissioners believed that a statutory obligation had been exerted over CCGs, which intended to improve the level of market competition. Market mechanisms (such as competitive procurement, tendering and contracting out health care) were required to be used in service commissioning, especially during the initial implementation of the 2012 Act. There were legal pressures experienced by commissioners to create markets and competition in service commissioning, particularly when there were potential providers available in the health markets. However, commissioners believed that they

were required by NHSE to improve collaboration and integrated care at the same time. Only a basic framework for commissioning was provide by the government and NHSE with wider possibilities of modifications at the point of delivery. In this policy context, both competition and collaboration rules were perceived as not mandatory and less decisive. Whilst the existing legislation highlighted the intention of intensifying marketisation and competition, the policy changes introduced by NHSE provided an opportunity for CCGs to employ the get-out clause of collaboration policy to resist the market-based reforms on the ground. In many respects, CCGs had large degree of discretion to choose whether and how to implement the market-based reforms, which was allowed by ambiguous goals of commissioning policy.

5.4 Discussion: Ambiguous Policy Goals and Implications for Implementation

The successful passage of the 2012 Act was at the costs of goal clarity. Despite advocacy of markets and competition by some in the Coalition Government, policy-makers had a range of goals for the NHS, not all of which can be delivered by using market mechanisms. These goals included promoting collaboration and integrated care for patients. Considerable political negotiations and compromises occurred between various policy-makers in the legislative processes of the 2012 Act, in order to ensure that important goals of the NHS (including both competition and collaboration) were

taken into account (Allen, 2013). As a result, the Act was created with ambiguous goals in respect of health service commissioning. Notably, there were twin and potentially conflicting goals for CCGs to achieve: the Act required CCGs to create markets and competition in service commissioning, and at the same time, the legislation required them to respond to demands of improving collaboration and integrated care. The co-existing goals of improving competition and collaboration created a sense of confusion and ambiguity, in terms of where and when competitive procurement and tendering ought to be applied. The goals of the 2012 Act was created ambiguously as a result of the need for political compromises and successful legislative passage, but eventually failed to provide clear prescriptions for actions at the point of implementation. A lack of clarity in terms of reform goals allowed for multiple ways of interpretation and room for modification in implementation (Osipovic et al., 2016, 9).

At a national level, NHSE played a critical role in reshaping commissioning and procurement policies based on its own perspectives. It attempted to respond to a range of practical problems such as the rising healthcare demands, increasingly elderly population, the fragmentation of care, budget deficits and an overarching political austerity agenda. The role of market competition has been reinterpreted and redefined by NHSE, in order to respond to these practical problems of the English NHS. NHSE believed that collaborative approaches rather than market competition were the most appropriate way to solve these problems. From 2014, there was an important policy development initiated by NHSE, which did not emphasise the use of markets and

competition in the English NHS, and instead, NHS organisations were required to develop collaborative programmes. This was different to the requirements of competition rules in the 2012 Act. As Timmins (2018, p. 101) commented: 'the 2012 Act proved, ironically, to be the high-water mark of faith in competition and choice as the key drivers of NHS reform; the language now is all about integration'. Commissioning policy emphasis was changed by NHSE towards a more collaborative approaches, although there were no any policy changes at the legislative level.

NHSE was not helpful in clarifying the goals and objectives in relation to health service commissioning. Its policy development influenced commissioners' understandings of the role of competition and private provision in health services. Some commissioners believed that they were expected to effectively deliver the collaboration programmes and to limit the impact of market competition within their local areas. Seemingly, the goal of collaboration improvements emphasised by NHSE provided a justification for CCGs to limit the degree of competition on the ground. However, the goal of improving competition has not been significantly challenged by the collaboration policies initiated by NHSE. There was no relevant legislative changes, and competition law was still in force. Collaboration improvements were encouraged by NHSE without denying the potential role of market and competition in health services. Commissioners needed to follow the guidelines from NHSE to improve collaboration, but at the same time, within the framework of competition rules. The goals of intensifying competition and collaboration still co-existed in the process of health service commissioning, and

furthermore, the ambiguity of policy goals was reinforced institutionally by NHSE through highlighting a range of policies towards collaboration.

In face of ambiguous policy goals, local commissioners tended to believe that, competition rules were framed in a less decisive and mandatory way so that their application would largely depend on commissioning decisions and actions on the ground. There were no clear and precise policy goals provided by the national policy-makers for CCGs to achieve in health service commissioning and procurement. Substantial discretion was allowed for interpretations and actions around the way in which the market-based policies should be implemented. The most important implication of the collaboration policy introduced by NHSE was that it had further opened local discretion for the delivery of competition and collaboration on the ground. Commissioners were allowed the space to determine how to commission health services in respect of competition and collaboration. They would not necessarily implement the 2012 Act as a way of intensifying marketisation and competition, basically because the ambiguity of commissioning policy goals allowed for divergent interpretations. In the face of such ambiguity, the implementation of the market-based reforms was largely depended on how CCGs made decisions and took actions in health service commissioning.

5.5 Conclusion

This chapter discussed the ambiguity of the policy goals designed by the national policy-makers and the implications of such ambiguity on implementation of the market-based reforms. At the legislative processes of the Act, considerable political negotiations and compromises resulted in the successful passage of the Act through Parliament, but left ambiguous policy goals of health service commissioning. One goal concerned the intensification of marketisation and competition. CCGs were supposed to increase the level of competitive tendering and contracting out health services for enhancing efficiency and reducing health costs. The other goal was related to improvements of collaboration and integrated care in health services. CCGs were required to deliver collaboration improvement in order to improve integration of care. The central government failed to clarify which of these goals should be prioritised, which was crucial in terms of implementation. In this policy context, NHSE modified and redefined the role of market competition and collaboration in health services, with a shift of policy emphasis towards collaborative approaches. CCGs had the option to improve competition in commissioning or they could choose to deliver collaboration and integration in health service commissioning, when they saw as fit. They had large degree of discretion to decide whether and how to implement the market-based changes introduced by the Act.

This chapter reveals that the commissioning policy goals of the 2012 Act was not well-designed and the ambiguity of policy goals allowed commissioners the space to decide how to interpret and deliver the competition policies on the ground. Such ambiguity was a result of political compromises in order to win support in Government and Westminster but ironically it resulted in the local levels having greater discretion in terms of how policy was implemented. Under the Coalition Government, the overall commissioning policy framework was ever-increasingly complicated with ambiguous goals and objectives. There were no clear directions for CCGs to follow, but a general framework of improving competition and collaboration was provided. On the basis of ambiguous policy goals, the implementation of the 2012 market-based reforms was then dependent on how commissioners made decisions and took actions. Such policy contexts may bring about unpredictable implementing actions and the difficulties in delivering the competition policies on the ground. This chapter was based on policy reviews and interviews around local commissioners' understandings of the national policies and rules. The implications of policy goals ambiguity on implementation has been analysed in this chapter. More specifically, this chapter indicated that the goals of service commissioning in the 2012 Act were designed too ambiguously in the legislative process and redefined by NHSE at national level. This allowed for implementers' discretion and increased the likelihood of ineffective implementation of the market-based reforms. As for the detailed processes of implementing the market reform on the ground, the following two chapters will discuss.

Chapter 6 Regulatory Factors: The Influence of Policy Incentive Structures on the Implementation of the 2012 Market-Based Reforms

Chapter 5 suggests that the ambiguity of commissioning policy goals created at national levels have allowed a relatively high level of discretion for CCGs to decide whether and how to implement the market-based reforms introduced by the 2012 Act. How CCGs reached decisions and took actions at the point of delivery were thus critical to implementation. This chapter is aimed at examining the implementation processes of the 2012 market-based reforms, as well as the factors that influenced this process. On the basis of theoretical discussions in Chapter 3, both institutional analysis and implementation literature have emphasised the role of policy incentive structures for affecting the implementation through the decisions and actions of implementers (see, for example, Hogwood and Gunn, 1984; Ostrom, 1986; 2011; Pressman and Wildavsky, 1984; Sabatier, 1986; Scott, 2014; Van Meter and Van Horn, 1975). Efforts of the central government to design appropriate incentives are critical to ensure local compliance and effective implementation. There is a need for designing certain degree of incentivisation that could bring about rewards and benefits to motivate implementers to act in a desired way. The absence of effective incentives and clear benefits may result in the problems of implementing the policies. In the light of this theoretical view, this chapter focuses on the examination of incentive structures included in the market-based

reforms following the 2012 Act, and the assessments of their influence over implementation.

In order to make competition happen, there is a need to motivate both 'commissioners' and 'providers' to change their behaviour towards 'market actors' (Le Grand, 1999). The reforms following the 2012 Act depended heavily on a complicated system of financial incentives that motivated 'commissioners' and 'providers' to support the intensification of competition in the provision of health services. The reforms in 2012 mainly included two kinds of potential incentives: the provision of cost-efficiency to CCGs and financial rewards to healthcare providers. However, the fieldwork found that these financial incentives did not work effectively to motivate local health organisations to support the intensification of marketisation and competition in the provisions of health services. First of all, the benefits of cost-efficiency from the use of competitive procurement and tendering could not act as a true incentive for CCGs to support the reforms, simply because creating markets was not necessarily efficient and value for money. Secondly, CCGs were seriously underfunded as a consequence of austerity and limited health budgets, and they cannot afford to increase competitive procurement and provider diversity. Moreover, the necessary incentives did not exist for healthcare providers to participate in the NHS markets, as financial rewards and profits for providing certain NHS-funded services continued to decline as a consequence of austerity. The 2012 reform intended to marketise health services but failed to provide appropriate incentives for facilitating implementation. Thus, this chapter reveals that

the lack of appropriate incentives contributed to the implementation difficulty of the market-based reforms following the 2012 Act.

This chapter is divided into four sections. The first section describes two kinds of potential incentive structures included in the 2012 market-based reforms in order to facilitate implementation: cost-efficiency for CCGs and financial rewards for healthcare providers. The second section moves to an examination of the role of cost-efficiency in affecting implementation and whether CCGs received appropriate incentives to support the market-based reforms. The third section then considers the role of the financial incentive (i.e. the PbR policy) for healthcare providers (including both NHS providers and private sector providers) in affecting implementation. The last section of this chapter discusses how the lack of appropriate incentives constrained the implementation of the 2012 market-based reforms on the ground.

6.1 Potential Incentives for Implementing the 2012 Market-Based Reforms: Cost-Efficiency and Financial Rewards

The market-based reforms following the 2012 Act depended heavily on financial incentives to affect the decisions and behaviour of CCGs and healthcare providers. An effective market system needed appropriate incentive structures to effectively persuade ‘commissioners’ and ‘providers’ to participate in the NHS markets (Le Grand, 1999).

Those participants need incentivisation to support and implement the marketisation agenda at local levels. There are two kinds of potential incentives included in the 2012 reform for motivating CCGs and healthcare providers to support the intensification of markets and competition. These incentives included cost-efficiency and financial rewards.

Cost-Efficiency as a Financial Incentive for CCGs

The market-based reforms were based on the ideas of the NPM that markets and competitive pressures would improve efficiency and effectiveness of services and reduce public spending (Hood, 1991; 1995; Saltman and van Otter, 1992). Market mechanisms (such as competitive procurement, tendering and contracting out) were introduced to force healthcare providers to act rationally and use resources efficiently within the NHS. CCGs could use these market mechanisms and diversify the delivery process to affect the behaviour of local healthcare providers, in order to achieve efficiency and effectiveness of healthcare provision. For market competition to work effectively, more sectors (public, private and voluntary sectors) were encouraged to participate in the delivery of health services following the 2012 Act. The relationships between these service provider sectors were based on contracts through which relevant sectors competed for rewards and resources (Le Grand and Bartlett, 1993). When purchasing health care, CCGs were encouraged to diversify providers and contract out health services for creating competitive pressures (Speed and Gabe, 2013). The

intention of the government was to create an NHS where competition between diversified providers would maximise efficiency in resource allocation and service provision.

The potential benefits of the use of market mechanisms were the improvement of efficiency and the reduction of health costs. These benefits were assumed as an financial incentive for CCGs to support the market-based reforms on the ground. The primary idea of the reforms was that markets were the best ways for resource allocation, because healthcare providers would be motivated to improve efficiency and effectiveness under the forces of competition (Hood, 1991). CCGs were assumed to be rationally motivated by these financial benefits to increase the use of market mechanisms in service commissioning. The Coalition Government made the role of CCGs as central to delivering the marketisation policies at local level by allowing them to freely choose any qualified providers for service provision (Calovski, 2018). They had the freedom to buy selectively and refuse to purchase services from the inefficient local healthcare providers with poor services. The government believed that rationally motivated with the aim to pursue utility maximisation in resource allocation, CCGs would support the market-based reforms that could enhance efficiency and reduce costs. The benefits of efficiency and value for money were assumed as potential financial incentives for CCGs to support the implementation of the market-based reforms on the ground.

Payment by Results Policy: Financial Rewards as Incentives for Healthcare Providers

Following the 2012 Act, CCGs were encouraged to diversify healthcare providers in the provision of health care through competitive procurement and contracting out. Provider diversity within the NHS is a necessary precondition for making market competition happen. The market-based reforms are based on the premise that a range of healthcare providers will compete for the NHS contracts, and that purchasers will be able to choose between diverse providers (Farrell and Morris, 1999, 35). There is a need to realise a comprehensive range of providers for CCGs to choose when they purchasing health care. It is important to provide certain degree of incentivisation for healthcare providers to participate in the NHS markets and tender for contracts from CCGs. Providers should be incentivised by money or they will not respond to market signals (Le Grand, 1999; Mulholland and McAlister, 1997).

In the case of the 2012 reforms, the incentives for providers were based on the deliberately designed payment and contracting system between CCGs and healthcare providers which could provide financial rewards or profit margins. Contracts between CCGs and providers are the essential medium for the NHS markets to operate through setting up the level of payment and prices for providing certain services (Mulholland and McAlister, 1997). CCGs often used either block contracts (pricing that is fixed and set locally), or Payment by Results (PbR) contracts (nationally fixed prices for case-

mix adjusted episodes of care) to pay for health services provided by NHS or non-NHS hospitals (Sheaff et al., 2015). In theory, providers who participated in the NHS markets and successfully gaining contracts from CCGs would be financially rewarded (Mannion et al., 2008). Healthcare provider agencies would respond to market competition as a direct function of its financial and economic values. Healthcare providers rely for funds on service contracts, and thus CCGs could use certain contracts for attracting the participation of healthcare providers in the NHS markets.

One of the most important financial incentives for healthcare providers is the PbR policy which was designed to provide the financial rewards for healthcare providers to participate in the NHS markets. This policy is a sort of contracting and payment mechanism which sets up a national 'tariff' prices based on national average costs for each type of treatment (Appleby et al., 2012). There is a list of nationally fixed prices for thousands of operations and procedures, determining how much CCGs should pay for health services provided by healthcare providers. Under this policy, hospital providers are paid a fixed amount of money by every activity they have done, such as hip replacements. This policy was first introduced by the then Labour Health Secretary Alan Milburn in 2002, and the Coalition Government continued to embark on the PbR policy to support its health reform of diversifying healthcare providers (Marshall et al., 2014). Under the PbR policy, financial funding and rewards for hospital providers are mainly based on the amount of activities or cases they provide. If hospitals attract more patients and do more activities, they will earn more money. Otherwise, they may be

subject to the loss of financial resources and funds.

This policy is a kind of market mechanism available for CCGs to attract healthcare providers to tender for the NHS contracts by the promise of financial rewards and profits. It was expected that provider diversity and competition would be improved within this kind of contracting and payment system: hospitals might compete with each other to win more contracts from CCGs in order to increase their incomes and rewards (Marshall et al., 2014). The PbR contract was a policy tool for CCGs to marketise health services, and also it was a type of financial incentive for making providers more responsive to the NHS markets. It can be used by CCGs to create competition between providers, and to attract more diverse providers (especially private sectors) involved in NHS service delivery. The government intended to provide direct financial incentives to diversify providers and enhance competition under the PbR policy. The market-based reforms expected that CCGs would use the PbR contracts to increase the participation of healthcare providers in the NHS markets. Marketisation of health services was expected to be enhanced by using this incentive, since healthcare providers could benefit from participating in the NHS markets and competing for the NHS contracts.

6.2 The Lack of Incentives for CCGs

This section examines the role of financial incentives in affecting decisions and

behaviour of CCGs in the process of delivering the market-based reforms. It focuses on exploring whether CCGs received appropriate incentives to increase the use of competitive procurement, tendering and contracting out in health service commissioning. This section starts by considering the role of cost-efficiency as financial incentive for implementing competitive procurement rules and provider diversity policy. It then moves to examines how austerity and financial pressures faced by CCGs influenced the delivery of the reforms. The empirical evidence observed that CCGs would not necessarily have benefited from the use of market mechanisms, as the operation of markets was highly costly and inefficient within the NHS. In reality, cost-efficiency did not constitute a true reform incentive for CCGs. Especially, in a context of austerity, insufficient funding and resources meant that CCGs could not be financially incentivised to support the implementation of the market-based reforms which were proved to be costly and inefficient.

Inefficiency of the NHS Quasi-Markets

Within the CCGs, the empirical work found that there was a general understanding that applying market elements to the delivery of health services was costly and inefficient, because of the high transaction costs. The whole processes of competitive procurement and tendering were criticised as over-complex, time-consuming, resource-intensive, and technically difficult, which required a large amount of investment in terms of time, resources and the workforces. Some commissioners indicated that there were

substantial transaction costs associated with the operation of markets, e.g. searching for and negotiating with providers and tendering contracts. As Director of Operational Delivery of CCG 2 pointed out:

> The learning, training and capacity impact, because running a big procurement is very time-consuming. So, we need to learn new skills…So it took a long time for the preparation to competition and procurement route. And even now, every contract ends, we have the internal discussion – what are the risks and challenges? what are the benefits of going out to procurement and the open market? When we do go to the open market, sometimes it is very time-consuming.

The CEO of CCG 1 confirmed that:

> Going to procurement is a big thing – very costly in terms of the resources and staff. It does take a lot of time to work through the market engaged services specification, the tendering process and mobilisation. All of this is quite resources-intensive for the need to go to the market.

The high costs of developing NHS markets has been well-documented in the literature. Many previous studies about the NHS market suggested that there were considerable transaction costs of operating a market, notably administration and management costs, as well as a high opportunity costs of money spent on the market that might have been

directly spent on patient care (see, for example, Bloor et al., 2005; House of Commons Health Committee, 2010b; Paton, 2014). In particular, Hood and Dixon (2015) found that market reforms such as competition, contracting and outsourcing increased the costs of public services in Britain over the past three decades. It was an irony of these reforms that were supposed to be more cost-efficient and better value for money, but in reality, were not. This was mainly because of the additional costs of managing markets, contracting and outsourcing.

The cost-efficiency from the application of competitive procurement was likely to be offset by the substantial transactions costs associated with the operation of healthcare markets characterised by uncertainty and imperfect information (Bartlett, 1991). The empirical work found that in the processes of competitive procurement, there was degree of uncertainty about outcomes because the nature of health care was such that the need for services could change rapidly. If the processes of competitive procurement failed, it was a huge waste of time and money. The consequences of competitive procurement and tendering were often uncertain and unpredictable, which might increase the time, resources and money spending on these processes. When uncertainty of health markets was taken into account, the possible benefits from competition were likely to be reduced (Paton, 2016). As a GP-Commissioner in CCG 1 revealed:

> Not all of them have being successful procurements. We put two out – pain services and dermatology services. Those procurements failed…We decided the service is too

> small to offer to the market – why we looked at it initially? because the service is bad and there is a long waiting list. But in the end, we found that the company awarded the service was not telling the truth in their application...When we find that some bidders are not telling the truth, we will stop the procurement process.

The Director of Operational Delivery of CCG 2 indicated that competition would not necessarily ensure improvements and changes in health service delivery, which might be a waste of time and resources:

> The disadvantages are sometimes that you could go through a long expensive process, very time-consuming, and the end of the road is quite similar to what you have before. So, the timing and the capacity, and the cost in time, money and resources to run the procurement process can be significant. It takes a long time and a lot of expertise.

Apart from the high costs associated with the operation of markets, many commissioners pointed out that contracting out to private providers was highly costly. This was mainly because the private sector providers might make the most expensive and unprofitable services left to NHS hospitals, which was called ‘cherry-picking’. In the context of healthcare, the cherry-picking refers to instances where private hospitals choose patients which are at the lowest risk to them, typically those that are generally healthy, while leaving the risky and costly cases for NHS hospitals to deal with. Private sectors are likely to make profits by cherry-picking easy cases. There is much evidence

that private sectors tend to not treat emergencies or people who have the complicated conditions, because they cannot make profits from these services (Lister, 2012; Mason et al., 2010).

In the empirical work, many commissioners pointed out that private providers often took the more profitable services from the NHS, but left the more expensive and complicated cases like urgent and emergency services to NHS hospitals that were obliged to provide universal and comprehensive care. Hence, the increased use of private sector providers had a potential risks to result in financial problems of the NHS hospitals. It appeared not to be an efficient strategy for CCGs. As the Chair of CCG 1 commented:

> If you completely open up to the competition, you would have to pay the [NHS] hospitals more for doing certain bit of works. This is because they would be left with the harder work, you need to remember that if people take the good and easy bids out to the market, then somebody would be left with the harder ones. Those would be the [NHS] hospital.

The ideas of the NPM assumed that markets and competitive pressures would improve efficiency and effectiveness of services and reduce public spending. However, the operation of markets within the NHS did not seem to be more efficient and better value for money as the government and policy-makers expected. This was mainly because

the substantial transaction costs of managing healthcare markets. The government saw market competition as a way of improving efficiency and reducing costs but the commissioners said that it may raise their costs. The real costs of setting up a properly competitive market in healthcare were significant, and the cost in using market mechanisms was higher than the cost of not using it. In many cases, it was not an economically and financially beneficial option for CCGs to increase the level of competitive procurement and private provision. That is to say, the incentivisation of cost-efficiency gains from the market-based reforms was more rhetorical and hypothetical than real.

Austerity, Insufficient Financial Resources and The Absence of Incentives

CCGs commission and purchase healthcare within available budgets which are determined by the central government. As the NHS is a universal health care system funded by general taxation, a 'market' in the NHS will need significant public expenditure to make it work. The increased level of competitive procurement, tendering, and outsourcing requires the support of significant resources and funding from the central government. However, the NHS has experienced years of underinvestment under the Coalition Government, even if the government committed to increasing the level of NHS funding. Faced with an unprecedented economic recession and financial crisis, the government proposed a wide range of austerity policies across the public sectors since 2010 (as discussed in previous Chapter 2). This political austerity resulted

in a prolonged period of budget cuts and resource limitation within the NHS. The average annual growth rate of health spending was far below both historical trends and the increases under the previous Labour administration. This cannot meet the increasing demands of health care in reality. A report from The King's Fund (2015) indicated that under the Coalition Government 2010-2015, the health care funding increased annually by an average of 0.8 percent in real terms, which was less than the estimated average growth of around 4 percent per year for meeting increasing demands since its creation in 1948.

At the level of funding provided, the English NHS was faced with great funding pressures and financial problems. Since 2010, CCGs have been under the growing financial deficits because of the austerity of a budgetary squeeze, which have been well-documented (see, for example, Dunn et al., 2016; Gainsbury, 2016; Lafond et al., 2016; NAO, 2016). There is much evidence to suggest that, under the Coalition Government, the overall financial position of CCGs has deteriorated shapely. A research of NAO (2016, 14) reported that NHS providers and CCGs ended up with a deficit of £1.85 billion by 2015/16, which was one of the largest aggregate deficits in the NHS history. A more recent NAO (2018, 25) report found that an increasing number of CCGs were overspending against their planned expenditure: 75 of 207 CCGs (36 percent) overspent against their expenditure budget in 2017/18, compared with 57 CCGs (27 percent) in 2016/17 and 56 CCGs (27 percent) in 2015/16.

Against the background of the stringent financial conditions, there was a wider discussion of national and local health leaders about how to operate the NHS at a local level in a way that was less costly and not in deficit (Ham, et al., 2016). Through assessing the likely cost of future health needs and comparing this to the future funds available to purchase that care, NHSE recognised that the NHS would face a significant funding gap of around £30 billion to meet rising demands and cost pressures between 2013/14 and 2020/21 (NHS England, 2014a). In response to meet this gap, a cost-saving programme was set up by NHSE in the *NHS Five Forward Review,* which required local NHS organisations to deliver a efficiency-saving of £22 billion by 2020/21 (NHS England, 2014a). CCGs and NHS providers had a great pressure generated by this requirement. A number of NHS organisations considered that the required scale of efficiency savings was unprecedented to be made, particularly when considering the fact that this expectation was balanced against the NHS priority for improving performance (House of Commons Health Committee, 2016). In this sense, local health organisations had to control their costs and improve health service within tightly squeezed budgets.

Due to the austerity of a budgetary squeeze, financial resources available for CCGs were highly restrained. The necessary financial resources for creating markets and competition were insufficient, which made the use of market mechanisms extremely unattractive to commissioners. The fieldwork found that the financial pressures faced by CCGs significantly reduced the willingness of commissioners to use competitive

procurement and private provision in their health service commissioning activities. As the CEO of CCG 3 confirmed that:

> For the last several years we have had a period of slowed NHS funding growth. So the NHS has never seen lots of growth in terms of budget. In real terms, the NHS budget has been cut. This is not seen as particularly a good time to be outsourcing to the private sector or allowing the private sector to compete with the core NHS business. So I think it was a difficult time to ask the private sector to come into the NHS market.

This was confirmed by a senior manager of IHPN (an organisation representing the independent sector providers):

> I think the incentives for commissioners not to look for alternatives to the NHS providers became much stronger, because you know the arguments that are always made by the NHS providers – you [CCGs] cannot tender this service, because we will be left with the expensive stuff, and the service could collapse, if you attempt to change any of part of it. I think that argument became stronger, as the NHS's finances got worse…There is only a little money in the health service. It is very difficult to do anything, maybe just sustain the NHS providers. Maybe you could have an effective competition, when you have a more generous level of funding.

In particular, the necessary financial resources for competition were absent, which made the use of the PbR contracts problematic. The PbR contracts were a kind of incentive mechanism focused on providing financial rewards to attract healthcare providers (especially private sector providers) to participate in the NHS markets and to compete for funding. CCGs could use the PbR contracts to attract diverse providers to tender for the NHS contracts. However, the empirical work found that CCGs cannot afford to operate the PbR contracts at a time of austerity. By the promise of financial rewards and profits, the operation of the PbR contracts needs the support of significant funding and financial resources. Under the PbR contracts, the more healthcare providers offer to NHS patients, the more money CCGs would pay. Following this logic, a significant amount of money would be required to make the PbR contracts effectively work. Financial control would be difficult, since the PbR contracts generated financial incentives for multiple providers to compete for more patients and thus increasing activities, which can encourage supply induced demand (Wright et al., 2017, 8).

Underinvested by the government from 2010, CCGs were faced with a significant financial pressures, which forced them to reject the use of the PbR contracts for diversifying healthcare providers in service commissioning. In the three case studies, commissioners pointed out that the PbR system was costly to run, which created issues in terms of achieving financial balances in their areas. Commissioners struggled to control the rising cost of the services with multiple qualified providers competing for rewards in the area of hospital services. Against the challenging financial background,

the PbR was seen as problematic. As Finance Director of NHS acute Trust in CCG 3 area revealed:

> Competition was less than before. But that happened naturally, because the money was different in the system. Before the 2012 Act, we had ten years' good investment in the NHS. And so people were incentivised to do more work to increase the business, because you could draw that in. You could make a profit to invest back into facilities. So people took up opportunities from that. But after the 2012, finances in the NHS started to reduce and the NHS went into deficit in 2013. That connected with the Act, so the money started to decline. That is what happened then. There was not any spare money to chase after. So if you did, the commissioners could not pay for it.

Driven by financial pressures, CCGs began to change the contracting and payment policies, and they sought to collaborate with NHS providers to achieve their financial balances. During the period of the empirical work, CCGs and NHS providers began to negotiate a locally shared budget for service delivery in order to solve their financial issues. For example, CCG 1 worked with their NHS acute service providers to change the contractual and payment approach, moving from the PbR contract towards a kind of block contract – Aligned Incentive Contract (AIC) (it is a kind of contract with a fixed amount of money that is negotiated locally). In doing so, NHS acute providers contracting with the CCG 1 were not paid on the basis of the amount of activities they

had done. Instead, in a more collaborative manner, commissioners and NHS providers negotiated a fixed amount of money for certain health services. CCGs and NHS providers were bound together as an alliance to share the risks and responsibilities of delivering health care within the available budget (Addicott, 2014, 26-27). As a GP-commissioner of CCG 1 observed:

> The Aligned Incentive Contract is a more block contract with the hospital. That stimulated more cooperation than competition… That is the way the NHS is going at the moment, much more towards cooperation. In fact, it is a world the NHS was already in 20-30 years ago with the providers. Now we discuss the service details the providers can give us in more detailed than they used to – we understand how long the patient waits, and what is the reasonable expectations of the family doctor are. We don't pay [NHS hospital] providers through the PbR now.

A private company manager in the CCG 1 area confirmed that:

> We started to have a conversation around – if we were given a fixed amount of money, what can we do for that? So, we pitch some business on that basis, a fixed contract. It is different from the free market.

Since 2010, financial resources available for CCGs were highly constrained by the central government because of austerity and a budgetary squeeze. Setting up a properly

competitive market needed a significant amount of financial resources for CCGs to manage competitive procurement and pay for health services provided by multiple providers. Sufficient financial resources were not guaranteed by the central government to support the use of market mechanisms on the ground. Moreover, the limited health budget created great financial pressures for CCGs to pursue efficiency and reduce costs. The use of market mechanisms was unattractive to commissioners, as it was costly and expensive. In the absence of appropriate financial incentives, it was difficult to persuade CCGs to use competitive procurement and the PbR contracts in commissioning practices.

6.3 The Problems of Payment by Results and Insufficient Financial Rewards for Healthcare Providers

This section moves to examine whether the PbR incentive could mobilise healthcare providers to participate in the NHS markets. Following the 2012 Act, the most important incentive employed by the government to facilitate the reform was the PbR policy that provided financial rewards or profits for mobilising healthcare providers to participate in the NHS markets and tender for the contracts from CCGs. However, the fieldwork found that this financial incentive failed to have its intended effect, since the financial arrangement of austerity introduced by the Coalition Government prevented the PbR from functioning properly. As discussed in Section 6.2 above, one of the

problems of the PbR policy was that CCGs did not have sufficient funding to use this incentive for diversifying healthcare providers at a time of austerity. The fieldwork found that healthcare providers also perceived the PbR as a big financial issue as the money they got from CCGs based on the PbR contracts might not cover their costs. In certain service areas, healthcare providers found it difficult to benefit from participating in the market, as the financial rewards for delivering these services continued to decline in the condition of austerity, and sometimes these rewards even cannot cover their costs. In the absence of necessary incentives, it was difficult to mobilise healthcare providers (especially private sector providers) to participate in the NHS markets, which inevitably made competition unrealistic in many health services.

The main financial rewards and incomes of hospital providers was based on the PbR tariff, which included the prices of procedures and treatments, nationally-fixed by the central government. Most of NHS providers' total income was received via PbR tariff payments, which was around 60 percent (Lafon et al., 2016, 34). However, there were repeated cuts in the prices of the national tariff, falling to keep pace with the real costs of providers (Appleby et al., 2014; Dunn et al., 2016). This austerity policy resulted in the declining rewards available to providers, with large numbers of NHS Trusts facing deficits. As a report from the Nuffield Trust revealed:

> Cash cuts to the tariff continued unabated every year up until 2015/16, with providers' own cuts to their operating costs falling systematically short. That meant that by

> 2015/16, provider expenditure was running at around 5.5 percent higher than their recurrent income as determined by the tariff. In recognition of this structural driver behind the annual provider overspend or deficit, tariff prices were increased in cash terms for the first time this decade in 2016/17. However, this increase was still significantly below the level of inflation. As such, the increase in tariff prices merely stopped the size of the deficit growing larger still. It did nothing to actually close the expenditure-over-income gap behind it. (Gainsbury, 2017, p.6)

With a dependence on the PbR tariff for income, most of NHS hospitals failed to achieve financial balances and developed large deficits. A hospital trust was more likely to have a worse financial position if it received a higher share of its income from PbR (Lafon et al., 2016, 42). In this situation, the PbR policy was impossible to persuade NHS providers to respond quickly to compete for more contracts from CCGs, as they cannot get enough financial rewards to cover their costs in treatments. As the GP-commissioner of CCG 1 noted:

> Local NHS hospitals also have a negative bank balance from last year, even though they are still doing as much work as they could, under the PbR they still cannot earn enough money to pay all their costs. The only way out of that is to treat more and more, but they cannot treat more and more, because we don't have the resources to give them. And they already have very high levels of treatments, that is where we are – CCG is in debt. So they would like to run even harder to get a bit more money out

of us…They need to cut their costs and we need to reduce activity and we also need to cut the cost of the treatments.

As for private sector involvement, evidence from my case studies suggested that financial incentives were not strong to encourage the participation of private companies, because there were insufficient profit margins. Profit-making was a strong driver for private sectors to decide whether or not to participate in the NHS service provision. They would bid for services where profits were guaranteed, and they tended to withdraw from bidding for unprofitable NHS contracts. It was impossible for the government to compel private sector provider to bid for work that they perceived as unprofitable. For the most of acute and urgent care, A&E, intensive care and complicated procedures, the entry costs to compete with the existing NHS trusts were huge but the profits and rewards were low. As the CFO of CCG 1 suggested, 'the wider problem for the NHS was – there was not a competitive market. Looking at our CCG area, there were huge entry costs to try to compete with the Foundation Trust, the main acute provider'. For the most of the acute services, there was little or no economic incentives for private providers to engage in. As a result, there were often no alternative providers available in the markets for the majority of health services.

Rationally driven by profit-making, private sectors preferred to participate in some services, such as elective surgeries and diagnostic tests. Private sectors were interested in responding to the competitive tenders of these types of health services, because they

were low-risky, and relatively highly-profitable. So market mechanisms could be effectively used for some elective and routine surgeries, because it was profitable to deliver these services and there were available providers for commissioners to choose. As the Director of Operational Delivery in CCG 2 pointed out:

> The big private hospitals want to do what they want to do, and they don't want really complex patients. They don't want hundreds of patients they cannot cope with. They don't want too much low-paying NHS patients. They want their business model to grow their private business model, and get paid top price for a few patients, less complex patients. So it is limited on both sides.

In terms of services out of hospital, like some community care services and mental health services, there was a relatively active market. The research observed the differences in the practices of procurement and tendering between acute health services and community health services. For community and mental health services, there were alternative providers willing to enter the market, because delivering these services was profitable. But it was often the case that some small and local third sector and voluntary sector providers were involved in delivering community health services. Commissioners saw them as the best providers in these areas, because they were locally-based and close to the patients' homes. Purchasing health services from these providers was not for promoting competition to enhance efficiency and reduce costs, but for the convenience of patients. As the Director of Operational Delivery of CCG 2

pointed out:

> Local services for local people. The third sector/voluntary community sector are the best providers. Some services are very localised for local people. We have social prescribing for local services and local support for people. The third sector providers are absolutely the right provider for that, because they are so local and know the local community. Some services for old people in their own homes, taking them home from hospital services – we use Age UK and local providers, so it is worth something have to be very local, and service from local people to local people.

Making a profit was the ultimate reason that many private companies wanted to be involved in the NHS market, and the potential for profit existed if they delivered qualified and quantifiable services to patients based on contracts. However, the national austerity of squeezed health budgets made it difficult for private sectors to make profit margins from delivering the NHS services (Krachler and Greer, 2014). At a time of austerity, profit margins for private sectors by providing some health services continued to decline, as the government directly reduced the prices of the PbR contracts. The government directly reduced tariff prices for reasons of cost containment, which meant insufficient financial rewards and profits for private providers. The reduced tariff prices resulted in the lack of adequate financial rewards driving alternative providers to participate in the NHS marketplace. In the current financial environment, private provision was unsurprisingly limited, because of the lack of financial incentives.

Private companies had little or no interest in participating in the NHS markets out of profitability concerns. Making profits became more difficult and complex in the face of austerity, which reduced the enthusiasm of private providers involved to compete for contracts. As the CFO of CCG 1 observed:

> Most of the acute provider are in deficit and the commissioning sectors are in deficit…That is not an appetizing market for people to think about getting into. So that means people are very selective about where they choose to compete and introduce different ideas…But not having money, it is difficult to get them into the market. There are not enough incentives to take a risk.

The empirical work found that the PbR policy cannot act as an appropriate financial incentive for diversifying healthcare providers. At a time of austerity, the most important financial incentive – the PbR policy failed to function properly. The repeated cuts in the prices of the PbR contracts resulted in the decline of financial rewards for delivering certain health services within the NHS. Under this situation, there were insufficient financial rewards for healthcare providers to participate in the NHS markets and to compete for more contracts. This policy might even lead to counterproductive results in some situations where the PbR prices cannot cover the real costs. Providers were not willing to tender for those contracts that would bring about financial losses. The PbR contract that was designed as a policy tool for CCGs to attract providers in local NHS markets, but the challenging financial environment prevented this policy to

have this intended effect.

6.4 Discussion: Austerity, the Lack of Financial Incentives and The Problem of Implementation

There were two kinds of potential incentive structures in the 2012 market-based reforms for facilitating implementation: cost-efficiency gains for CCGs and financial rewards for healthcare providers. The reforms intended to incentivise commissioners by the potential benefits (i.e. cost-efficiency and cost reduction) from the use of competitive procurement. Moreover, the reform was dependent on the financial incentive of the PbR policy to create a market with diverse providers. CCGs could use the PbR contracts to attract more healthcare providers to tender for the NHS contracts, and then they could select the most efficient one. However, the fieldwork observed that these incentives of the market-based reforms were ineffective in producing significant changes towards marketisation on the ground. CCGs did not increase the use of competitive procurement and tendering in health service commissioning. Moreover, they had limited success in diversifying healthcare providers. There were a lack of alternative providers in the most of health services, such as acute and urgent services, A&E, intensive care and complicated procedures. Only for some services which can be delivered profitably like elective care, community and mental health care, there were certain potential alternative providers. The empirical work reveals that the financial incentives included in the

reforms failed to act as true reform incentives for facilitating implementation. The necessary incentives did not exist for CCGs and healthcare providers to change their behaviour and to become more involved in the NHS markets, which hindered the implementation of the market-based reforms on the ground.

The necessary incentives for CCGs to increase the use of market mechanisms did not exist. The benefits of using market mechanisms (i.e. cost-efficiency improvement and cost reduction) were more hypothetical than real, which cannot act as true incentives for CCGs to increase the use of competitive procurement and contracting out on the ground. The 2012 reforms highlighted the incentive of the cost-efficiency from the increased level of market competition to persuade CCGs to deliver the reforms on the ground. It was assumed that market competition would increase the efficiency in resource allocation by nature, and the use of market mechanisms in service commissioning would reduce healthcare costs. This assumption about the efficiency from market competition turned out to be inaccurate within the NHS system. This was because there were substantial transaction costs associated with the operation of markets. Additionally, market competition required a condition of diverse providers available for choosing, and therefore significant financial resources were needed for attracting alternative providers (especially private sectors who were largely driven by profits) in tendering for the NHS contracts. The use of market mechanisms was for enhancing efficiency and reducing costs, but the reality was not.

In order to make competition happen in the NHS, CCGs needed significant amount of money to create markets and competition, and to attract a comprehensive range of providers to tender for the NHS contracts. However, there were insufficient financial resources within the NHS as a consequence of austerity. Within a publicly funded health system by general taxation, CCGs depended greatly on central supports in terms of resources and budgets for purchasing health services. Since 2010, the Coalition Government conducted a range of austerity policies for cost containment in health services, leading to a tightly squeezed health budget. As a consequence, financial resources available for CCGs to purchase health services were significantly constrained, which was insufficient to support the intensification of marketisation and competition on the ground. The financial pressures of limited health budgets forced CCGs to concern cost-efficiency and financial balances. They had to conserve the available resources, reduce costs and balance their budgets in commissioning activities. Financial pressures made efficiency improvements significantly critical to the commissioning practices. Given that the use of market mechanisms was not necessarily value for money in health services, it was difficult to persuade CCGs to intensify marketisation and competition on the ground. Appropriate incentives did not exist in the 2012 reforms to mobilise CCGs to support the implementation on the ground.

On the other hand, there were no sufficient rewards and profits to attract alternative providers involving in the delivery of certain NHS-funded care, which could partly account for the difficulty in diversifying healthcare providers. The CCGs could use the

incentive of the PbR contracts (in the forms of the financial incentives and rewards) to persuade local healthcare providers to participate in the NHS markets and tender for the NHS contracts. Nevertheless, these incentives failed to function well at a time of austerity and squeezed health budgets. Within the NHS system, most of NHS hospital providers need compete for contracts from CCGs for financial funding and rewards in order to maintain the provision of health services for their local populations. Private sector providers might be motivated by profits to compete for NHS contracts. In theory, this situation could have made financial incentive (i.e. the PbR contracts) for facilitating reforms especially effective, since the providers might have become more involved in the NHS markets that would bring about financial benefits for them.

However, there was much evidence that the reform incentive of the PbR contracts cannot function effectively to diversify healthcare providers. Delivering health services under the PbR contracts might be not profitable, and sometimes, it would lead to financial losses. This was because financial rewards under the PbR contracts were often insufficient which could not attract healthcare providers to participate in the NHS markets. The delivery of the market reforms was accompanied by the austerity of health funding squeeze. The prices of the PbR contracts continued to be reduced for cost containment. As a result of that, the financial rewards for providing certain healthcare covered by the PbR contracts continued to decline, and sometime it was even below the real costs of delivering these services. Providers would not necessarily have benefited from the PbR incentives, and they might not be rewarded if they participated in the

NHS markets. In this situation, the PbR incentive cannot function effectively to mobilise healthcare providers to increase their participant rates in the NHS markets. The NHS had been a monopoly provider and so provider diversity have never really developed, expect a small private sectors which was anyway partly dependent on the NHS anyway. Although the 2012 reform included an explicit financial incentive – a bargain of financial rewards and profits in exchange for competition, the overall financial arrangement of the Coalition Government did not support the effective operation of this incentive. Actually, the PbR policy cannot act as true incentive to produce the desired results.

6.5 Conclusion

This chapter discussed the impact of reform incentive structures on the implementation, demonstrating that the lack of appropriate incentives constrained the implementation of the 2012 market-based reforms on the ground. In the case of the 2012 reforms, the incentives included in the market-based health reforms could not function properly as the government intended. One the one hand, the reforms failed to create appropriate incentives for CCGs to increase the level of market and competition in the health service commissioning activities. The benefits of efficiency gains and cost reduction were difficult to achieve through the creation of markets and competition. This was because the operation of the NHS markets was associated with high transaction costs.

In reality, it required significant public expenditure to make it work. The reality of the inefficient NHS markets associated with the financial pressures forced commissioners to reject the use of market mechanisms in commissioning. On the other hand, there was no sufficient rewards and profits to attract healthcare providers to participate in the NHS markets. The overall financial arrangement of austerity and limited health budgets could not guarantee sufficient financial rewards and profits for delivering certain health services within the NHS. Providers thus could not be effectively incentivised to become more involved in the NHS markets. Both CCGs and healthcare providers did not receive the necessary incentives to support the market reforms, which made it difficult to deliver the reforms on the ground.

This chapter thus demonstrates the fact that the absence of appropriate incentives results in the problem of implementation. The effectiveness of the market-based reforms were limited by the fact that the government did not create necessary economic and financial incentives to facilitate implementation. The Coalition Government attempted to create competition when incentive structures were inadequate. There was a lack of appropriate incentives for persuading CCGs and healthcare providers to intensify marketisation and competition. This chapter provides an explanation as to why it was difficult to deliver the market-based reforms on the ground, with a particular focus on the impact of the incentive structures included in the market-based reforms. The next chapter will examines the impact of the normative and cultural factors on policy implementation. It will examine how these institutional factors affected the way in which the 2012 market-

based reforms were implemented on the ground through shaping the decisions and behaviour of policy implementers.

Chapter 7 Normative and Cultural Factors: The Influence of the Organisational Norms and Culture on the Implementation of the 2012 Market-Based Reforms

This chapter continues to examine the factors that influenced the implementation processes of the 2012 market-based reforms. The previous Chapter 6 considered the influence of incentive structures on the implementation of the reforms. It found that the lack of appropriate incentives prevented the implementation of the reforms on the ground. On the basis of theoretical discussions in Chapter 3, this chapter explores the impact of normative and cultural factors on policy implementation. The views of sociological institutionalists suggest that the decisions and behaviour of implementers are not simply in response to the demands of government policy decisions, but often subject to the normative and cultural demands (see, for example, DiMaggio and Powell, 1983; March and Olsen, 1984; 1989; Selznick, 1949; Scott, 2014). The values, norms and culture of organisations help make sense of organisational objectives and imperatives, and of their internal organisational settings, which structures appropriate behaviour and provides order to actions (see, for example, DiMaggio and Powell, 1991; March and Olsen, 1984; 1989; Selznick, 1949). This means that policy implementers may not respond to the government policy decisions which are inconsistent with the entrenched values, norms and/or culture of their own organisations (see, for example,

Brunsson, 2002; Lipsky, 2010; Tummers, 2011; Tummers et al., 2012; Van Meter and Van Horn, 1975). The mismatch between the demands of the market-based reforms and the embedded normative and cultural institutions of the NHS system may enable resistance by implementers and result in the problem of implementation.

In the light of this theoretical view, this chapter presents the results of the case studies carried out to understand how normative and cultural factors embedded within the NHS system influenced the implementation of the 2012 market-based reforms. It is aimed at investigating the influence of local commissioning bureaucrats, organisational norms and culture over the implementation of the reforms. The empirical work found that the absence of appropriate incentives was not the only factor contributing to the implementation difficulties of the 2012 market-based reforms (this factor has been discussed in the previous Chapter 6). Normative and cultural factors were associated with the implementation problem as well. This chapter suggests that the deeply entrenched institutions such as professional norms and the collectivist culture had significant impact on shaping the decisions and behaviour of commissioners. The increased use of competitive procurement and private provision was widely perceived as conflicting with those embedded institutions of the NHS. This enabled the resistance of commissioning bureaucrats against marketisation, and as a result of that, the effectiveness of the market-based reforms was constrained at the point of delivery.

There are three main sections in this chapter. The first section examines the influence

of normative factor on implementation. It starts by considering what were the shared organisational values and norms that commissioners desired to maintain in their daily routine of commissioning health services. Then this section moves to examine how these normative factors could affect the delivery of the market-based reforms introduced by the 2012 Act. The second section of this chapter considers the role of the entrenched culture within the NHS organisations. It starts by illustrating the nature of NHS culture in relation to the notion of collectivism, and then examines how this culture could affect the delivery of the 2012 market-based reforms. The last section discusses normative and cultural reasons for the problem of delivering the 2012 market-based reforms on the ground.

7.1 Normative Factors and Implementation of the 2012 Market-Based Reforms: The Role of Professional Values and Norms

This section considers the influence of normative factors on the implementation of the market-based reforms introduced by the 2012 Act. Shared values and norms within organisations structure 'how things should be done' (i.e. 'what is the appropriate and right thing to do'), which could influence the decisions and behaviour of policy implementers, as well as their commitment to a particular policy (March and Olsen, 1984; 1989). When implementers perceive a particular policy as incompatible with their

shared values and norms, they are likely to resist it (Van Meter and Van Horn, 1975). When researching the problem of implementation, shared values and norms of implementers are important aspects that need to be examined. In this section, it examines the role of shared values and norms within NHS organisations in affecting the implementation of the 2012 reforms. There were two main sub-sections: the first sub-section discusses the shared values and norms embedded within NHS organisations (i.e. professional values and norms in relation to health care); the second one considers how professional values and norms contributed to the problems of delivering the reforms by structuring commissioning bureaucrats' decisions and behaviour.

Professional Bureaucracy and NHS Organisations

In the UK, NHS organisations reflect the nature of professional bureaucracy where health care professionals (such as GPs, doctors and nurses) are able to exercise considerable control over the delivery of health services and policies. Since the creation of the NHS, the British governments have accepted the role of professional dominance in health services. Health care professionals constitute the core operation of the NHS with clinical autonomy to decide how to deliver health services and policies. Health care professionals are persons with specialised formal education, applying their knowledge and expertise to provide health care in a rigorous and routine way (Tummers, 2011). Ideally, these professionals are supposed to control clinical decisions and work activities, as well as to freely deal with their patients, because they are directly in touch

with patients and knows what the patients really need (Baker and Denis, 2011, 355). They are subject to strict codes of conduct enshrining rigorous ethical and moral obligations in order to maintain professional standards of practices that are socially agreed upon and maintained by widely recognised professional associations. Value of professionalism has been embedded within the operation of the NHS and the delivery of health services, which is defined as a commitment to professional norms and standards of performance and behaviour and to do the work right and well.

Influenced by the NPM reforms, there has been long-standing policy changes towards managed provision and an emphasis on the role of managers in controlling resource allocation (Flynn, 2002). Prior to the Thatcher administration's reform, there was little management function in the NHS which was managed by consensus-style management teams of doctors and nurses (Oliver, 2005). Health care professionals had considerable autonomy over the NHS operation with little or no managerial oversight of their activities. As such, professional bureaucracy was criticised as self-interested, inefficient and spending-wastefully with little interest in the performance of the NHS (Enthoven, 2000; Ham, 1996). In 1983, the Griffiths Reports recognised the need to introduce general managers and management in the operation of the NHS, recommending the role of management be strengthened to control the behaviour of clinicians, and for efficient resource allocation. Elements of management were thus introduced to improve efficiency in resource allocation within the NHS, with an attempt to shift power from health care professionals to managers within the NHS.

Since then, health policy has emphasised the creation of management and managerial positions in service operation (Harrison and Ahmad, 2000; Harrison and Lim, 2003). It required traditional bureaucrats (turning into 'managers') to embrace the business-like values such as efficiency and value for money (Hood, 1991). By this development, many new managers were recruited in the NHS, and moreover, health care professionals were educated to take on the tasks of management. These changes led to a lot of debate that managerialism and management had increasingly guided the daily routines, procedures and practices of health service delivery in the NHS. As a result, it was widely assumed that the role of professionals and their autonomy had been significantly constrained by the pressures of managers and management practices (see, for example, Curroe and Suhominova, 2006; Farrell and Morris, 2003; Meyer et al., 2014; Riccucci, 2005; Veronesi et al., 2019). The NPM reforms have been seen as a threat to traditional bureaucratic structures (i.e. professional dominance) and the value of professionalism.

However, it is important to note that there has not been a case in the English NHS that NPM reforms have fundamentally challenged the traditional professional bureaucracy. Since the creation of the NHS, health care professionals were supported by the governments and service users to use their own professional knowledges and skills for making decisions about health service provision in response to patients' needs (Harrison, 2009; Le Grand, 2010). Although a proliferation of management methods

and ‘managers’ have been introduced at various levels of the NHS system starting from the Griffiths report in 1983, professional bureaucracy has never been replaced by a managerial model. Both Conservatives and Labour governments claimed to respect and maintain the professional values and norms in health services. In the 2012 reforms, the Coalition Government sought to give more power to clinicians to control commissioning processes and health care budgets (Department of Health, 2010; 2012). The 2012 Act highlighted the role of clinicians at the heart of the service commissioning decisions, with a commitment to clinical involvement and clinical leadership in health (Department of Health, 2012). GPs, doctors and nurses were encouraged to be involved in the operation of CCGs, attempting to align clinical and financial responsibilities within commissioning decision-making (NAO, 2018, 6). The Act explicitly highlighted the role of health care professionals and the values and norms of professionalism in health service provision.

In reality, the relationship between managers and clinicians is more complex than some earlier literature suggests as conflicts within the NHS. NHS bureaucrats may perform a hybrid role of professional and manager (Gatenby et al., 2015, 1127). As Meyer et al. (2014) suggest, the pattern of managerial changes within public sector organisations is not a replacement of the prevailing logic by a new managerial one but a ‘layering’ process (Mahoney and Thelen, 2010). At local levels, many managers of the NHS organisations are often professional themselves, and furthermore, considerable numbers of doctors have been engaged in the management process as clinical directors

(Exworthy et al., 1999; Farrell and Morris, 1999; McNulty and Ferlie, 2004). NHS bureaucrats often have the hybrid role of both professionals and managers, thinking and acting according with both managerial and professional tasks. The NPM reforms in the NHS are not a case of 'winners' or 'losers' between professionals and managers (Curroe and Suhominova, 2006). The bureaucratic model of the NHS compels managers and health care professionals to negotiate new forms of mutual accommodation with each other, rather than a shift of power towards managers (Harrision and Lim, 2003). Health professionals still retain their control over health services to a large degree, taking on more managerial tasks, while at the same time maintaining their professional autonomy (Exworthy and Halford, 1999).

The NHS remains a highly professionalised organisation in which health care professionals are socially and normatively expected to improve health services in response to the patients' interests and needs, exercising considerable control over the delivery of health services and policies. NHS bureaucrats have been socialised as advocates for their patients in ensuring effective, safety and high-quality care. They are exposed to normative pressures to comply with a range of professional norms and standards, subject to their professional roles and responsibilities such as working on service quality standard and responding to the needs of patients. They need to take professional norms into account when making decisions in relation to service provision and resource allocation. Based on their own professional judgments, health care professionals may not subject to the outside control of government policy decisions,

with a wide range of discretionary and interpretative power in respect of how policy should be delivered on the ground (Brunsson, 1993; Le Grand, 2010). The embedded professional bureaucracy govern the operation of the NHS with a strong normative frameworks infused with professional values and norms (Currier and Guah, 2007, 238). These normative (professional) factors embedded within NHS organisations may influence how policies were implemented through shaping the decisions and behaviour of NHS bureaucrats.

Implementation and the Influence of Professional Values and Norms

Despite decades of market reforms, the role of health professional bureaucracy continued to be critical in controlling health services within the NHS in England. NHS bureaucrats (both professionals and managers) were socially and politically expected to behave in accordance with their own professional knowledges and skills for protecting the patients' interests. Professional values and norms were deeply entrenched in the NHS organisations that shaped the decision-making of NHS bureaucrats. To protect the interests of patients was always one of the most important values of the NHS organisations. The research observed that professional norms (such as patients' needs and quality of care) were strong drivers that influenced the decisions and actions of commissioning bureaucrats. These norms framed 'a logic of appropriateness' regarding how they were supposed to behave at the point of commissioning health services and delivering health policies.

When commissioning health services, many commissioners highlighted their role and responsibilities as clinicians, committed to the norm of guaranteeing the quality of health care offered to patients. Professional norms provided important guidelines about what was the appropriate behaviour for them to conduct in the service commissioning. Whether or not creating markets and competition was heavily dependent on the normative considerations of patient interests. Many commissioners admitted that professional norms of maintaining quality of care and patients' safety were above the economic values of efficiency and value for money in their competitive procurement processes. Commissioners were willing to ensure that the needs of patients were met. As the Chair of CCG 1 revealed:

> The main thing is that – competition is by quality and patients' outcomes, not about the price. When we look at procuring services, we will go to a number of bidders. For me, as a doctor, the focus is always on the patients' safety and quality [of service]. Finance and value for money will come further down the list. (Chair, CCG 1, December 2018)

In the views of many commissioners, the inappropriate use of private sectors in the NHS-funded services was problematic when considering the quality and safety of care. The A&E services could only be provided by NHS hospitals, because they were well equipped with advanced staff and facilities, like ICU infrastructures (they are essential

conditions to maintain the safety of patients when they need complicated treatments). There was a general recognition amongst commissioning bureaucrats that most of private sector providers did not have the capacity to do complicated or urgent care, because of the lack of high-technology facilities and experienced staff. They criticised the fact that many private sector providers had insufficient capacity in delivering health care in a way that was safe and high-quality. Many commissioners believed that the majority of health services were supposed to be provided by the NHS providers, and private providers just could provide some easier, and lower-risky services. Professional considerations constrained the wider scale of private provision in NHS services. As a commissioner from CCG 3 indicated:

> I can use the private sectors when I don't need facilities for critical care, intensive care and specialist nurses. Private sectors just can do something simple, easy and low-risky, because they don't have the emergency services. If you get into the NHS hospital and you get something wrong, you will be surrounded by all care you need. That keep you safe in the NHS hospital. But you cannot get the sufficient access to facilities in the private hospital.

Moreover, commissioners found it difficult to treat health care as a 'commodity' to purchase in the markets on the basis of professional norms. In the process of commissioning health care, commissioners need to specify what services they require, and then conduct competitive procurement and tendering activities on one hand.

Providers bid to provide them on the other hand. Service commissioning requires an explicit definition and classification of units of activities that can be purchased as a 'commodity', in order to measure and control the providers' activities for efficiency and effectiveness (Harrison, 2009, 190-191). But for the nature of health care that largely depends on the knowledges and expertise of health care professionals, it often has blurred boundaries, interconnected with each other (Checkland et al., 2012, 542). For example, for patients with the long-term conditions, they need the integrated care provided by primary care, hospital care and community health care (this is called 'clinical pathway'). In this situation, it is difficult to separate health care into appropriate categories for competitive procurement and tendering. Commissioning and competition may be only appropriate for a single health service with a single provider, like mental health counselling services which can easily be classified and defined. The application of market mechanisms appears to be different according to the nature of different health care. The inappropriate use of market competition would have some negative effects on patients' outcomes. As Gilbert et al. (2014) revealed:

> The application of market competition may be very different depending on the nature of the healthcare service being provided. The negative impact may be small in acute healthcare settings where patient groups are relatively homogeneous and outcome measures are easily defined (i.e. accurate) and consistent (i.e. reliable). In this scenario, well-managed competition may confer benefits. However, it is difficult to envisage these positive effects in the treatment of heterogeneous patient groups with

chronic conditions in which there are few accurate or reliable measures of outcome.

This means that the use of competitive procurement and contracting out had no sufficient fit with the professional values and norms that many commissioners desired to maintain in service commissioning. The empirical work found that many commissioners had substantial professional concerns when asked to implement the market-based policies that focused on competition in health services. Considering the needs of patients, they argued that it was inappropriate to use competitive procurement to commission a single part of the 'clinical pathway' separately. Before contracting out some services via competitive procurement, commissioners would ensure that their decisions would not cause disruption to 'clinical pathways' and dismantle the integrated service provision of hospitals. For example, in the emergency department, it was necessary to have a comprehensive range of health services such as the emergency surgery, trauma surgeons, and critical care. Hospitals needed the whole infrastructure to support the full functions of the emergency department. Breaking up the 'clinical pathway' for competition had potential effects of damaging the quality of care and ignoring patient's needs. In this situation, the use of market mechanisms was perceived as inappropriate by commissioners, as this was in conflict with their professional norms. As the Director of Operational Delivery of CCG 2 indicated:

Some services – single services, single providers, competition may always be appropriate. But in healthcare, there are not many services which are not linked to

other services and patients are on a pathway journey. So single diagnostic care and endoscopy – it does not matter to the patient where or who will provide that, as long as it is quick, local and safe. Some single-touch services may always be suitable for the market. However, we would not often go out to the market for things that we need collaboration [of services] for best patient's outcome. In the mental health – counselling services is a single episode care – you get referred to it, get therapy, get better and finish it. For things like that, it is appropriate to look to the market. But the majority of what we do is now for long-term conditions…most of them is in the middle of the patient journey and the patient pathway crosses multiple providers. It is really difficult to go to the market, and we don't want to go to the market – the single part of the pathway. We want the collaboration between providers.

Another important finding in the fieldwork was that professional norms forced commissioners to embark on collaboration agenda. Commissioners admitted that they preferred to promote collaboration between NHS providers in order to establish the 'clinical pathway' and respond to patients' needs. Especially for the treatments of older people with chronic and long-term conditions, provider competition could result in fragment care, threating continuity and integration around patient pathway that are highly reliant on interactions and collaboration between a range of healthcare providers (Gilbert et al., 2014). Putting some of services out to tender may damage the existing relationships between different providers who work collaboratively on the 'clinical pathway'. This would possibly destroy the flow of patients across the whole system,

and result in poor outcomes of patients. As Hunter (2013b, p.6) argued:

> A further disadvantage of competitive markets is that they do not serve the need for joined-up policy and delivery when it comes to noncommunicable and/or chronic diseases. The key pressures on health systems, and drivers for change, now come from such diseases, and the complex care needs to which they give rise transcend professional and organisational boundaries. It is difficult to envisage circumstances in which a truly competitive market can be created for many chronic conditions for which there are few, if any, clear measures of outcome, and where the need is for a heavy reliance on joined-up working between a range of agencies. Competitive markets could actually work against the development of effective partnerships and result in greater fragmentation of care.

In the case of CCG 2, commissioners innovatively applied procurement rules to promote collaboration and deliver integrated care. They worked with their local providers to change the commissioning and contracting approaches for improving patient pathway. A hybrid of competitive and collaborative approaches was employed for health service commissioning: a pathway of various health services was procured through the markets, and different types of providers jointly bid for providing this pathway, led by a prime provider. In the CCG 2 areas, commissioners procured the whole pathway involving a range of inter-connected health services through the market rather than separating them in pieces for competition. In doing so, they sought to

encourage different providers in their area to work together for delivering integrated services, rather than competing for work. This suggests that professional values and norms were widely shared within the NHS organisations, which motivated the shift from competition towards collaboration by commissioners. As the Director of Strategy, Performance and Planning from CCG 2 noted:

> We recently ran the process of procuring for the IAPT to improve the access to the psychotherapy services. Traditionally, we just have a market approach, but now we set up the procurement really like that – multi-providers with one named provider coordinate for provision. What we are in fact doing is, we are procuring for collaboration. We use our procurement mechanism to drive cooperation. So, that isn't how it was envisaged originally, but it is within the laws, it does not stop somebody else coming into the market. But, if our local providers, community providers, third sector providers and mental health trust collaborate, jointly to respond to that bid, it probably gets a stronger bidder. It would be very difficult to compete with that, because we setting it up in a way to drive collaboration.

It is worth mentioning here that professional considerations did not always lead to the rejection of using market mechanisms. In some circumstances, professional considerations could force commissioners to contract out to private providers. When the patient waiting lists were long, the NHS had to depend on private sector providers to deliver a range of health services for relieving this pressures. Private provision would

be employed when there was a necessity to increase the extra capacity for reducing patient waiting lists. This was often the case in the elective care. However, in this situation, even if market mechanisms were used, private providers were not perceived by NHS providers as much as a competition threat. They were widely seen as partners able to increase the capacity of the NHS for meeting the demands of patients, rather than competitors focusing on winning contracts to earn money. As an interviewee who previously worked at NHS England and the Department of Health argued:

> The penetration of the private sector into hospital services remained very marginal, although it has gone up in recent years, it has gone up for very traditional reasons which is that the NHS has run out of capacity – which was always the old reason why they used the private sector. So not some radical world where private hospitals were competing with NHS hospitals, but a lot of sub-contracting where NHS providers would run out of capacity and then buy some capacity from the private sector which they were doing decades ago. So I think privatisation is… more than reality.

That was confirmed by a manager from an NHS acute hospital in CCG 1 area:

> I don't think the private sector is bad. Over the last 20 years, it had a really big role to play in helping to keep the waiting lists down and treat patients as quickly as they can. We couldn't live without them, adding capacity in the NHS.

As discussed above, this section reveals that the entrenched professional values and norms of the NHS organisations constrained the implemention of the market-based reforms on the ground. Professional values and norms were deeply entrenched within the NHS organisations which provided a critical framework for commissioners' decisions and actions, deciding how to implement the marketisation polices in practice. The empirical work found that the commissioning decisions were significantly shaped by a range of professional values and the associated norms such as quality of care, patients' safety and patients' needs. Commissioners had professional concerns over the damaging outcomes (such as low-quality and fragmented care) when competitive procurement and contracting out were used inappropriately. The large-scaled use of competition and private provision were widely perceived as inappropriate behaviour in service commissioning, as this could lead to damaging effects on patients. The market-based reforms potentially run counter to the established logics of health care professionalism, which made it difficult to gain the supports of commissioning bureaucrats. The intensification of marketisation and competition was resisted by commissioners, which was supported by the professional values and norms embedded within the NHS organisations.

7.2 Cultural Factors and Implementation of the 2012 Market-Based Reforms: The Role of the Collectivist Culture of the NHS

Apart from normative factors, cultural factors can also influence policy implementation, since they set the limits of what can be considered as possible to think or do in any given situation, providing framework for implementers' decisions and actions (DiMaggio and Powell, 1983; Hall and Taylor, 1996; Scott, 2014). If policies cannot find a fit in the cultural assumptions or beliefs of implementers, it will be difficult to deliver the policies. It is critical to take culture into account in the analysis of policy implementation. This can help explain implementers' decisions and actions, and furthermore, understand why some policies face much resistance on the ground. This section examines the role of culture embedded within the NHS organisations in influencing the implementation of the market-based reforms on the ground. There are two main parts. One is related to an examination of the prevailing culture of the NHS, and the other considers how the NHS culture contributed to the difficulty of delivering the market-based reforms by conditioning the decisions and behaviour of commissioners on the ground.

The Notion of 'Collectivism' and NHS Culture

In the UK, health services have been rooted in the values of 'collectivism' such as 'universality', 'equity', and 'public interests' since the creation of the NHS in 1948. The fundamental principles underlying the NHS are based on collectivist solution (Addison, 1975), including three critical elements: free of charge, universality and comprehensiveness (as discussed in previous Chapter 2). These fundamental principles reflect the value of securing access to health services irrespective of the socioeconomic or demographic circumstances of the individual (Oliver and Evans, 2005). In the UK, universal health care has been socially and politically advocated as a matter of 'citizenship' (Marshall, 1950) or shared commitments that all citizens are legally entitled to the right of universal, equal and free health services financed by the state (Titmuss, 2018). As Aneurin Bevan (1978), the architect of the NHS claimed, the NHS is 'a triumphant example of the superiority of collective action and public initiative applied to a segment of society where commercial principles are seen at their worst'. Those social values such as universality and equity have been initially implemented within the context of a wide political agreement about the need for collective provision – what some see as the post-war consensus. The NHS is a sort of public service to protect social values of equity and universality, representing the wider interests of the public.

The culture of the NHS is closely associated with the notion of the 'collectivism', emphasising cohesion, commitment and obligation in a society. It has been closely linked to the notion of 'NHS family' that refers to the NHS organisations as an

integrated entity with shared public health functions. 'NHS family' assumes an expectation of collaborative relationships among NHS organisations to deliver health services for the interests of the public (Checkland et al., 2012). All NHS organisations within the NHS system have shared common purposes and experiences, subject to the fundamental principles of the NHS in their decisions and actions. NHS organisations tend to see themselves as part of integrated system rather than in isolation, with a shared goal to provide universal and free health care to all British people. Although the split of purchasers and providers and market competition have been introduced since the 1980s, collaborative relationships amongst NHS organisations are still essential for local service delivery in the context of a publicly funded health care system. As Checkland et al. (2012, p.538) emphasised, 'in everyday speech, both NHS employees and commentators casually refer to 'the NHS' as a meaningful entity, even when many NHS services are delivered by private sector organisations'. The NHS has been widely recognised as an integrated entity rather than individual organisations, with a high level of the coordination and collaboration amongst the NHS organisations.

With regard to the culture of the NHS, 'collectivism' conception also assumes an explicit attitude of 'anti-privatisation' in the provision of health care, reflecting a way of delivering health care. There is a cultural belief within the NHS organisations that the state should play a primary role in funding and providing health care (Maarse, 2006). When the NHS was created in 1948, the NHS were financed by the government through general taxation, and health services were controlled and provided by the public sectors.

Public sector provision combined with the publicly funded approach is the best way of guaranteeing the fundamental principles of the NHS, which is a wider assumption across the British politics and society (Hunter, 2013a). Instead, private sector provision is often regarded as a challenge to the original conception of the NHS that the state has a responsibility to fund and provide health services. In the views of the public, some politicians and NHS bureaucrats, public sectors are the preferred providers to deliver health services, as their priority is to meet the interests of the public. But for the private sectors run by shareholders, profit margins tend to take priority over the public interests. The notion of private provision is inconsistent with the collectivist ethos of the NHS. In many respects, NHS culture displays a strong bias against private provision.

Negative aspects of private provision such as service failures and negative patient experiences are highlighted by the media, which accelerates public concerns about the quality standards of healthcare provided by private sectors (Krachler and Greer, 2014). Private provision is often attacked by the criticism of making profits at the costs of quality of care. Although there is no evidence demonstrating that the quality of care depends on whether a provider makes a profit from providing NHS services, the public distastes for private provision of the NHS-funded care is widespread in the UK (Chard et al., 2011; the King's Fund, 2015). This reflects the general feeling of the public with regard to private sector involvement in the NHS: that this approach is a kind of 'privatisation'. Ideologically, there was suspicions that the private sectors could not provide the same high quality healthcare as the public sectors. In contrast, public sector

provision is often perceived as the most appropriated way for health services, with widespread support from the public and healthcare professionals (BMA, 2016).

Implementation and The Impact of the NHS Collectivist Culture

The empirical work suggested a cultural level of belief existing amongst commissioners that was related to the ethos of collectivism. Competition are based on the advancement of self-interest and work counter to collaboration (Gore et al., 2019). The conception of competition suggests a relatively clear boundaries between commissioners and providers as they are encouraged to behave like 'market actors' (Davies, 2013): the former act as 'purchasers' and the latter act as 'providers' in the NHS quasi-market. However, my research found that the NHS was commonly regarded as a 'family' by local bureaucrats, and there were close relationships among different NHS organisations. There was a tendency of negotiations between CCGs and NHS providers for service commissioning. At local levels, the reality of commissioning practices was that CCGs tended to work collaboratively with existing providers for improving service provision, rather than using competition threats to force service providers to improve their services. As the CFO of CCG 1 pointed out:

> We would see if we are satisfied with the service. If not, we can look for competition But it is not quite often, just sometimes. Normally, we are trying to work with people. So we would meet with providers regularly via monthly meetings. We look a range

> of metrics as how they are doing. If we think they are not delivering what the contract asked them to deliver, we would ask them to produce the improvement plan, and then meet regularly to see what they are doing it.

Commissioners considered that the large scale of contracting out and private provision would make the NHS providers lose contracts and funding, thereby destabilising them, particularly under a challenging financial environment. For a NHS hospital in financial balance, losing contracts has a potential to cause a deficit because funds available for that hospital in the past are now going to other providers instead (Greener, 2008). Many commissioners believed that limiting the private sector entrants into local healthcare delivery could help NHS providers to earn more money and reduce their deficits. CCGs thus tended to limit the involvement of private sector providers, in order to protect the financial stability of the NHS providers. As a manager of private companies revealed:

> A fear from the commissioners – the independent sectors are allowed to come into the work, and take the money away from the acute hospitals, then the acute hospitals do not have enough money to run effectively. Repeatedly, we were told by the commissioners – we would like to use the independent sector, but we cannot, because, [if] we spent £10 million pounds with you, the NHS trusts cannot get [that money]. They think we would destabilise the acute trusts.

This suggests that there was a close relationship between CCGs and NHS provider

organisations. The notion of 'NHS family' was meaningful to local commissioning bureaucrats. In health service commissioning, there was a strong desire to maintain the financial sustainability of local NHS providers. It was difficult to make this situation compatible with the notions of 'market' and 'competition'. To maximise efficiency through competitive procurement and contracting out at the expense of destabilising local NHS providers was unthinkable and inconceivable for many commissioning bureaucrats. As a senior manager from IHPN NHS Confederation commented, 'the values of the people working in the NHS are very much like – you are working in a public system, we do things not because they are profitable, but because it is the right to do'. There was a high level of negotiations took place between commissioners and healthcare providers in order to ensure that budgets were balanced and local health services was sustained.

Commissioners preferred to embark on collaboration rather than competition in health service commissioning and provision. Behind the rejection of marketisation policies and the adoption of collaboration approaches, there was a deeper cultural reason. Based on the shared belief of 'NHS family', commissioners had a strong awareness of mutual dependence rather than mutual competition for the survival of the NHS as a whole. Collaborating to share the local funding for health services was considered as taken for granted against the challenging financial environment. Culturally, the notion of 'NHS family' has been embedded in the decisions and actions of local commissioning bureaucrats, which make it difficult to increase the level of competitive procurement

and contracting out health services.

In addition, the fieldwork found that some commissioners considered the use of private provision as inconsistent with the NHS way of doing things. In some commissioners' beliefs, outsourcing to private companies was not compatible with the NHS way as a publicly funded service, because the use of private provision would take money away from the patients to the shareholders of private companies. This was perceived as a waste of public money and damaging to public interests. As a survey from the BMA revealed, many doctors were concerned that private companies involved in the NHS service provision were primarily motivated by profits rather than high-quality services for patients (BMA, 2016). Some commissioners believed that public sectors were the preferred providers to deliver health services, because they were non-profit organisations with the priority to protect the public interests. This belief highlighted a preference for the public sector providers delivering health service provision, which constrained the diversification of healthcare providers, especially the involvement of private sector providers. As a managers from a private company argued:

> The commissioners can be very ideological buyers [working] against the independent sector. There is a lot of misleading information about the independent sector – quality is poor, etc. Also, a fear from the commissioners – the independent sectors is allowed to come in to do the work, this will take money away from the acute hospitals, then the acute hospitals do not have enough money to run effectively.

Moreover, the involvement of private provision was constrained by the political pressures generated by the public concerns over the privatisation of the NHS. Issues in relation to private provision are always contested and argued over in the NHS context, which has resulted in significant attention from the powerful campaigning groups. Health campaigning groups are quite strong in the UK. The delivery of the market-based policies was under the spotlight of various campaigning groups. Such as Keep our NHS public, it has a heavy focus on 'privatisation in the NHS in England', opposing the use of private companies in the NHS services (Buckingham and Dayan, 2019). Campaigning groups strongly criticised that contracting out would damage the interests of patients, making it more difficult for patients to get a high quality of health care. Reforms of marketisation and competition were often interpreted as 'the privatisation of the NHS', which were challenging NHS fundamental principles, engendering wider opposition towards their implementation. As a senior manager of IHPN commented:

> It is political. The Act has been seen as the privatisation of the NHS. These sort of concerns were raised from the public and from campaigner groups. Every time that the local CCGs have chosen to award a contract to the private sector, they received a lot of criticism, mostly from campaigner groups. It could cause huge political noise, all about privatisation. Politics has nothing to do with the quality of care. So, every time a private company gets awarded the contract, all of the local political noises grow…Now it feels like the rules underpinning the 2012 Act have been ignored,

because of the political difficulty in supporting the private sector in the NHS. Now any private sector involved in the NHS has been seen as privatisation. That is awful.

Following the 2012 Act, the policies around competitive procurement and provider diversity were perceived by the public as a way of privatising the NHS across the British society. The Act's attempt to expand the role of market competition led to the general feeling within the British society that the NHS system was being privatised, as the government was open to the charge of intending to privatise, and competition became contentious when it would not necessarily have been. As another senior manager from IHPN suggested:

That's the perception of the politics. People think that competition is about the privatisation and private sector involvement, but it is not…I think that lack of understanding and the mixing of the two different issues between competition and privatisation is a real barrier to getting competition right.

That was confirmed by a director of the National Institute for Health and Care Excellence (NICE):

There is a big concern of the British public about private sector involvement, because they see the private sector's way of working – for example, the private sector for social care, if they cannot make profit, then they would close down. That is the way

people tend to think. And, that is why they feel much more secure with the services provided by the state.

The attitude of 'anti-privatisation' in health service provision was important to justify the enduring actions of local commissioning bureaucrats in terms of constraining private providers. The emphasis of the 2012 Act on greater competition provoked wider public concerns about the privatisation of the NHS. Debates around the privatisation and the 2012 reform may be over, but they accelerated political pressures on commissioners, forcing them to limit the use of private providers. The fieldwork found that commissioners were cautious about expanding the role of private providers, as the wider cultural and political environments were not supportive of the involvement of private providers. In fact, it was politically and culturally unthinkable and impossible to massively involve private providers in the NHS. As a commissioner from the CCG 2 pointed out:

We use them [private sector providers] in a limited capacity for the areas where the NHS cannot cope, because of the waiting lists. It is just about acceptable to them. But if I started to stop commissioning things for [the NHS] hospital and move all of the surgeries out of the hospitals by going to the market and putting them all with the private hospitals, that would be so complex. As the NHS hospital is a capable provider, we would get questions from the politicians and local councils I hear you all using private providers, and you have to explain that – we are doing the sort of

> contracts that will increase capacity to help our local hospital, but I would never consider moving surgery completely to the private sector. That would never happen.

The public opposition to the expansion of private provision served to limit the involvement of private provider in the delivery of the NHS services. A manager from a private company provider criticised the situation that commissioners could easily ignore the competition law because of the massive public support:

> It is very easy when the NHS commissioner says they are going to ignore the Lansley Act, and just award the contract [to NHS providers]. It is very easy to judge – that is right, or that has to be done. [Private providers can] go to the court and to say here is the evidence they haven't followed the guideline set down in the Law… Every time, you sue the NHS for breaking the law, there are a lot of people in this country who think the NHS is a national religion, and it is wrong to sue the NHS – you are taking money away from the patients. It is not worth doing it, as far as we are concerned, it is about our reputation.

This section reveals that NHS collectivist culture was powerful in constraining the implementation of the market-based policies introduced by the 2012 Act. The culture of the NHS reflects the nature of collectivism, associated with features of collaborative relationships and a negative attitude towards private provision. This culture prevented commissioners from considering themselves as a real 'market players' and 'purchasers'

in pursuit of efficiency through using market mechanisms. CCGs and NHS providers tended to negotiate with each other to deliver health services within the limited budgets, taking a more collaborative approach. This was clearly compatible with the notions of 'NHS family'. Moreover, the NHS culture displays a strong opposition against greater private provision. Within such cultural context, increasing the use of private provision was a conceivable and impossible goal to aim at, difficult to be accepted by commissioners. It was highlighted that there was the existence of a recognisable 'NHS way of doing things', largely based on the collectivist perspectives. The entrenched culture of the NHS enabled the resistance to the delivery of marketisation by local commissioning bureaucrats. The insufficient fit between the marketisation and key elements of NHS culture inevitably constrained the implementation of the 2012 market-based reforms on the ground.

7.3 Discussion: Normative and Cultural Factors and The Problems of Implementation

The shared, institutionalised values, norms and culture within the NHS organisations were critical in accounting for the problem of delivering the market-based reforms introduced by the 2012 Act. The problems of implementation derived partly from the professional view that gave the priority to patient care, and partly from the pressures of the entrenched NHS culture which was closely connected with collaborative

relationships and anti-privatisation. Following the 2012 Act, CCGs were encouraged to increase the level of competitive procurement and provider diversity, with a core aim of marketising health services. However, the fieldwork found that local commissioning bureaucrats resisted the implementation of the reforms, which were supported by the entrenched organisational norms and culture of the NHS. Looking through the implementation process of the market-based reforms, commissioners had a strong commitment to the professional values and norms as well as the collectivist culture in their daily routine of service commissioning. The reforms were widely perceived as violating the shared values, norms and culture of the NHS organisations, which resulted in the resistance of commissioning bureaucrats.

On the one hand, the professional values and norms that commissioners desired to maintain constrained the implementation of the market reform on the ground. Within the NHS, professional bureaucracy played an important role in controlling health service provision and affecting the progress of reforms. NHS bureaucrats were subjected to a range of professional norms and standards in relation to quality of care and patients' needs underpinned by the professional value of protecting patients' interests. Despite decades of NPM and market reforms, professional values and norms remained deeply entrenched within the NHS organisations, which significantly affected the decision-making and actions of local commissioning bureaucrats. In the case of the 2012 reform, commissioners displayed a desire to improve the quality of care and meet the needs of patients, and decisions on which policies to engage with were often made

according to their professional knowledge and norms. The 2012 reforms were delivered within a particular normative context that professional values of protecting patient interests were high-profile, associated with a strong loyalty to professional norms (such as quality of care and patients' needs). The reforms to some degree conflicted with the shared, institutionalised professional values and norms within the NHS organisations. As a result, local commissioning bureaucrats paid careful attention to how these policies were translated into actions to ensure that key professional aspects of health services were not compromised.

The inappropriate use of market mechanisms would lead to the challenges to professional values and norms. These challenges may stem from the unwanted damaging outcomes produced by the use of competitive procurement and private providers, such as poor quality of care and the fragmentation of services. The fieldwork found that market mechanisms were not suitable for providing every kind of health care, and their application were significantly constrained by professional values and norms. In the cases of commissioning health care for patients with chronic conditions, many commissioners criticised that the use of competitive procurement would threaten continuity and integration of healthcare. In this situation, they rejected the use of market competition for avoiding the negative effects on patients. Instead, commissioners chose to improve collaboration and deliver a more integrated care for the patients' needs. The decisions and actions of commissioners were significantly driven by their professional norms and standards. Market mechanisms were rejected when they were perceived as

incompatible with these norms. Professional values and norms structured how commissioners should behave in the healthcare sectors, which resulted in the resistance against the use of market mechanisms in health service commissioning.

On the other hand, NHS culture constrained the implementation of the 2012 market reforms by structuring how commissioning bureaucrats thought and acted. Associated with notion of 'collectivism', the organisational culture of NHS displayed two main features. The first was a cultural belief of the collaborative relations between local NHS organisations. Despite reforms of marketisation, the fundamental principles of the NHS remained in place that the NHS was still based on collectivist values. There was never an attempt to challenge the finances of the NHS, and the reforms of the NHS were around how market competition could co-exist with the fundamentals of the NHS. All NHS organisations had a shared purpose of providing universal, equal and free health care to all the British population. On the basis of the NHS fundamental principles, there was a deeply entrenched cultural belief, symbolically interpreted as 'NHS family'. Collaboratively working together to deliver health services was considered as natural and conceivable. Commissioners tended to negotiate with healthcare providers to decide how to deliver health services that would best serve the public interests. Additionally, the second feature of the NHS collectivist culture was a distaste for the expansion of private provision. The private sectors were largely perceived as profit-pursuing for the benefits of shareholders, while the public sectors were seen as the 'defender' of the NHS. With regard to NHS culture, a strong bias against private

provision was obvious.

The collectivist culture of the NHS significantly shaped the commissioning decisions and behaviour, as well as the responses of commissioners to the market-based reforms introduced by the 2012 Act. Local commissioning bureaucrats valued the ethos of collectivism associated with wider political pressures of anti-privatisation in health services. The reforms were largely perceived as incompatible with the NHS culture based on the notion of 'collectivism'. Commissioners resisted the increased use of competitive procurement and private provision, believing that doing so was not the NHS way. The resistance to changes was considered as taken for granted, demonstrating care and respect for NHS culture. This could be justified as cultural, which highlighted the existence of a recognisable 'NHS way of doing things'. Implementation of the market-based reform was constrained by the cultural framework as to what action was assumed as conceivable, possible and natural within the NHS. The collectivist culture of the NHS required to promote collaboration of local NHS organisations and to limit the use of private provision in health services, which ultimately enabled the refusal of commissioners to comply with the goal of marketising the English NHS. The mismatch between marketisation and NHS culture constrained the implementation of the 2012 market-based reforms on the ground.

7.4 Conclusion

This chapter demonstrated that normative and cultural factors prevented the implementation of the 2012 market-based reforms. The research found that the reforms faced much resistance at the point of delivery. One reason for resistance was the professional values and norms that local commissioning bureaucrats desired to maintain. The use of market mechanisms was considered as incompatible with the professional values and norms of maintaining quality of care and patients' needs. Another important reason for local resistance revealed by the research was the collectivist culture of the NHS. The use of market competition were perceived as conflicting with the key aspects of the cultural context that the NHS was believed as an integrated entity and that NHS bureaucrats distasted the expansion of private provision. Driven by normative and cultural factors, commissioners tended to resist the creation of market competition and the increased use of private sectors in service commissioning. Resistance to changes was built on the normative and cultural considerations that the intensification of marketisation and competition was not the appropriate behaviour in the NHS system.

This chapter provided normative and cultural accounts of the implementation problems of the market-based reforms following the 2012 Act. The process of the implementation was understood by focusing on the shared, institutionalised values, norms and culture

that informed commissioning decisions and actions. The shared professional values and norms as well as the NHS collectivist culture represented constraints on how it was appropriate to act in a particular situation, and how it was conceivable to think about a particular issue within the NHS. These normative and cultural factors shaped the way in which the market-based policies were implemented on the ground. They provided multiple justifications for commissioners to reject the use of market mechanisms in health service commissioning. The expansion of marketisation and competition was perceived as incompatible with the organisational values, norms and culture of the NHS, which resulted in resistance by commissioners. Government policies that were aimed at fostering competition but disregard the existing normative and cultural settings of the NHS system, which resulted in little chance of effective implementation on the ground.

Chapter 8 Conclusion

This thesis examined the implementation process of the market-based health policy reforms in the NHS in England following the Health and Social Care Act 2012, demonstrating the difficulties and problems the government faced in implementing the reforms. The main research question of the thesis is that: Why it was so difficult to implement the market-based reforms introduced by the 2012 Act? The previous three empirical chapters (Chapter 5, 6 and 7) presented findings from the case studies in three different CCG areas, with an aim to answer this main research question. This chapter provides a discussion of the conclusions that can be draw from the empirical findings: It was difficult to implement the 2012 market-based reforms on the ground, because there were no supportive institutional settings for implementing the reforms. The ambiguous commissioning policy goals of the 2012 Act provided the opportunity for CCGs to shape the implementation in a way that limited the degree of marketisation and competition on the ground. Second, the market-based reforms failed to create appropriate and effective incentives for both CCGs and providers to support the reforms. Moreover, normative and cultural factors shaped commissioning decisions in ways that were significant at the point of delivering the reforms. This enabled the resistance of commissioning bureaucrats against market-based changes on the ground.

This chapter is organised into four sections. It begins by summarising research findings

presented in the previous three empirical chapters and addressing the main research question of this thesis. The following section presents the theoretical contributions of this thesis to the existing literature and knowledge. The chapter then considers the empirical contributions of this thesis. Lastly, opportunities for future studies are suggested.

8.1 Summary of Research Findings

This section summarises the empirical findings and addresses the main research question of the thesis. It first evaluates the outcomes of implementing the market-based reforms following the 2012 Act, suggesting that the reforms were not effectively implemented on the ground. Then it moves to explain why this was so, identifying the factors responsible for the difficulty in delivering the 2012 market-based reforms.

Evaluating the Implementation Outcomes of the Market-Based Reforms under the 2012 Act

In this research, the empirical findings suggest that the market-based reforms following the 2012 Act was not effectively implemented on the ground. Put differently, the goal of further marketising the English NHS has not been achieved. Following the 2012 Act, CCGs were required to improve the level of competitive procurement in the practices

of commissioning health services. Moreover, CCGs were encouraged to contract out health service for diversifying healthcare providers and stimulating competition, particularly through the increased use of private sector providers. The behavioural changes of CCGs and the level of provider diversity are two important criterions for evaluating the implementation outcomes of the 2012 market-based reforms. Chapter 5, 6, 7 of this study have shown that the reform implementation failed in attaining the goal of enhancing marketisation and competition in the NHS in England. CCGs did not increase the use of competitive procurement and contracting out in health service commissioning after the enforcement of the 2012 Act. Moreover, provider diversity was never really developed, with the exception of a small amount of private sectors involvement in delivering some particular services within the English NHS. Following the Act, it was clear that there was a potentially larger market available for private provision in the NHS. But the level of private sector involvement remained relatively limited, and the NHS providers still had the monopoly position in the provision of health services within the English NHS. The private sectors were mainly involved in delivering some particular services that were simple, low-risky and profitable.

As presented in Chapter 6, the empirical evidence indicates that CCGs undertook competitive procurement and tendering processes when commissioning services, but this was not used very often. What CCGs preferred to do was to work with the NHS hospitals, trying to improve the services those hospitals were delivering rather than embarking on competitive procurement to change existing healthcare providers. CCGs

decreased the frequency of putting service out to tender and the use of private providers as a consequence of austerity and limited health budgets. The health services which put out to tender did not amount to a major procurement. There was a lack of provider diversity in most of the health service areas. Most health services were provided by NHS hospitals, because there was no alternative provider. For example, in A&E services and some complicated care, nearly all of these services were provided by NHS hospitals. The health services being put out to tender were mainly in community health service and elective surgery, but this accounted for a very small amount of health services within the English NHS.

The market entry for private providers was quite limited in the English NHS, and there continued to be a low involvement of private sectors in the provision of health services. Chapter 7 has indicated that CCGs tended to use private sectors, when they needed the extra capacity to meet the waiting list target and reduce patients' waiting time. Mostly, this situation happened in the areas of elective care and routine surgeries. But the involvement of private sectors in these services did not create strong competitive pressures for NHS providers. Some managers from NHS hospitals indicated that the acute hospitals did not feel much competitive pressure from other providers in their local areas. The acute NHS hospitals often perceived private providers as partners rather than competitors, because the private sector could help them to release the pressures of increasing healthcare demands and long waiting lists. In recent years, private providers slightly increased their share of community health care and mental healthcare, possibly

because the national encouragement on the development of the out-hospital services.

Despite that there were a range of policy and rules for intensifying competition, Chapter 5, 6 and 7 have shown that commissioners and providers were actively engaged in collaborating within each other in order to deliver integrated care and solve financial problems at local levels. Some commissioners noted that they preferred to embark on collaboration strategies when commissioning health services, because there were more advantages in respect of financial balances and improve integrated care. CCGs had different reasons for supporting collaboration rather than competition. For example, in CCG 1 area, commissioners and providers collaborated with each other to deliver services with a shared budgets in order to solve the financial problems (Chapter 6). Commissioners had no any intention to improve provider competition in their local areas. In CCG 2 area, commissioners used collaboration approaches for improving integrated health care (Chapter 7). Local commissioners considered more around how to improve collaboration within local areas to deliver healthcare rather than improving provider competition.

Analysing the Implementation Process of the 2012 Market-based Reforms: The Factors Responsible for the Problems of Implementation

After evaluating the outcomes of the reform implementation, the study seeks to explain why it was difficult to deliver the reforms on the ground. Through exploring the

delivery process of the 2012 market-based reforms, this thesis demonstrated that there were a range of institutional factors preventing the implementation of the reforms on the ground. These institutional factors can be divided into three categories: regulatory, normative and cultural factors. First of all, the absence of clear commissioning policy goals allowed room for commissioners' discretion and left open the potential for implementation difficulties. The implementation problem was also attributed to the lack of appropriate incentive structures for facilitating implementation. In addition, normative and cultural factors shaped decisions in ways that were significant at the point of delivering the reforms. The mismatch between government policy decisions and the normative and cultural settings of the NHS enabled resistance by the commissioners against the delivery of the market-based reforms. In the case of the market-based reforms by the 2012 Act, there were no supportive institutional settings for implementation. This has turned implementation as an issue, and resulting in the failure to achieve the goal of marketising the NHS in England.

Regulatory Factors: Policy Goals, Ambiguity and Room for Discretion

As discussed in previous Chapter 5, the problem of delivering the 2012 market-based reforms was attributed to the lack of clarified policy goals in service commissioning. The 2012 Act was not well-designed by policy-makers and so the commissioning policy goals were ambiguous and inexplicit. The 2012 Act was highly controversial with a difficult passage through Parliament. This resulted in considerable political

negotiations and compromises during the formulation stage of the Act. These negotiations and compromises contributed to the successful passage of the Act through Parliament, but left multiple and ambiguous goals embedded within the Act. With regard to health service commissioning, there were two ambiguous and potentially contradictory goals for CCGs to achieve. One goal concerned the intensification of marketisation and competition in health service provision, and the other one was related to the development of collaboration and integrated care. Put differently, CCGs were supposed to increase the level of using competitive procurement, tendering and contracting out in the practices of health services. At the same time, they were required to deliver collaboration in order to improve integrated care. The central government failed to clarify the goals of commissioning in the 2012 Act.

The ambiguity of goals in relation to commissioning and procurement policies and rules was institutionally reinforced at a national level as a consequence of the interpretations and responses of NHSE to the 2012 Act. NHSE modified and redefined the role of competition and collaboration in health service commissioning, with a shift of policy emphasis towards collaboration improvement. In the current commissioning policy framework, there was no official abandonment of the competition rules introduced by the 2012 Act, although collaboration and integration strategies were encouraged by NHSE to exercise at local levels. In this sense, the government and NHSE did not take any decisive actions to end competition rules in the NHS in England, and thus CCGs still need to undertake the application of competition strategies in their commissioning

work. In this policy context, both competition and collaboration rules were actually not mandatory and less decisive. There were no any clear guidelines about what CCGs should do in service commissioning. This allowed large degree of discretion for commissioners to exercise.

The empirical evidence presented in Chapter 5 of this study suggests that the policy goals for health service commissioning were not well-designed by policy-makers (mainly the Department of Health and NHSE), which was partly responsible for the difficulties in delivering the 2012 market-based reforms on the ground. The commissioning policy goals of the 2012 Act were formulated ambiguously by the central government, and such ambiguity were reinforced by NHSE. With regard to commissioning health services, there were unclear and ambiguous goals for directing the decisions and actions of commissioners within CCGs. Goals of improving competition and collaboration co-existed for CCGs to achieve in health service commissioning and procurement. There were no clear national directions concerning which of these goals should be prioritised and how commissioners should behave in terms of applying competition and collaboration approaches. CCGs had the option to use competition approaches in commissioning or they could choose to deliver collaboration and integration, when they saw as fit. That is to say, commissioners would not necessarily concentrate on the goal of marketising the English NHS. This resulted in a series of problems with the implementation, because there was an opportunity for CCGs to limit the degree of marketisation and competition on the ground.

Regulatory Factors: A Lack of Appropriate and Effective Incentive Structures

Beside the ambiguity of commissioning policy goals, the difficulty in delivering the 2012 market-based reforms was attributed to the absence of appropriate incentives attached with the market-based policies. To facilitate the implementation of policy decisions, incentive structures were needed. Commissioners and healthcare providers were key market participants, and both of them needed necessary incentives to participate in the NHS markets. In order to deliver the goal of marketising health services, there was a system of incentive structures included in the 2012 reforms for intensifying marketisation. They were two kinds of potential incentives, mainly in the forms of provision of financial rewards and benefits. However, these financial incentives did not work properly in the context of publicly funded health service and austerity. The empirical evidence presented in Chapter 6 of this study suggests that appropriate incentives for implementation did not exist, which was responsible for ineffective implementation.

In the case of the market-based reforms in 2012, the lack of incentives for facilitating implementation was twofold: There were no appropriate incentives for CCGs to create markets and competition. The potential benefits of cost-efficiency generated by the use of market mechanisms in service commissioning were assumed as critical incentives for CCGs to support the market-based reforms. But the empirical evidence suggests

that efficiency improvement cannot act as an true incentive for CCGs to deliver the market-based reforms. The application of market mechanisms did not seem to be more efficient and better value for money as the government and some policy-makers expected. Ironically, the cost of setting up a properly competitive market in healthcare was significant, and the benefits in terms of efficiency and cost reductions were more hypothetical than real. The assumption about increased cost-efficiency though marketisation turned out to be inaccurate within the English NHS, since there were substantial transaction costs associated with the operation of healthcare markets. Moreover, competition required a condition of diverse providers available for choosing, and therefore significant financial resources were necessary for attracting alternative providers (especially private sectors who were largely driven by profits). CCGs need significant amount of funding to deliver the reforms, but this was impossible in the context of austerity and limited health budgets. It was clear that there was a lack of appropriate incentives for CCGs to support the delivery of the market-based reforms introduced by the 2012 Act, and thus the implementation was unsurprisingly difficult.

Moreover, the necessary incentives did not exist for healthcare providers to participate in the NHS markets. The market-based reforms were mainly dependent on the PbR contacts which provided financial rewards and profits to persuade healthcare providers to increase their participation in the NHS markets. Nevertheless, at a time of austerity, this incentive failed to function properly, partly because CCGs cannot afford to use the PbR contracts, and partly because there were no sufficient rewards under the PbR

contracts to attract more providers. Financial rewards for providing certain NHS-funded services covered by the PbR contracts continued to decline, and sometimes, it was even below the real costs of delivering these services. Providers would not necessarily have benefited from participating in the NHS markets. Especially for private sectors, their involvement was largely limited by the squeezed financial arrangements of the NHS, since it was too difficult to make profits. Although the 2012 reforms included financial incentive for diversifying healthcare providers and enhancing competition, the overall financial arrangement of austerity did not support the effective operation of this incentive. Actually healthcare providers did not receive appropriate incentives to become more involved in the NHS markets. The implementation of the market-based reforms were significantly limited by the fact that the government did not create necessary incentives to realise a comprehensive range of healthcare providers.

Normative and Cultural Factors: The Impacts of the Organisational Norms and Culture

The implementation of the 2012 reforms was not only constrained by regulatory factors, but also constrained by some normative and cultural factors. The empirical evidence presented in previous Chapter 7 suggests that the effects of normative and cultural factors were significant in constraining implementation of the market-based reforms following the 2012 Act. The shared, institutionalised norms and culture within the NHS organisations had impact on the decisions and actions of commissioners, enabling

resistance against the market-based changes on the ground. In the case of the 2012 reforms, the normative constraint mainly derived from the professional values and norms that structuring how commissioners were supposed to behave in the healthcare commissioning. The cultural constraint mainly referred to the collectivist culture of the NHS. Local commissioning bureaucrats were subject to the demands of the normative and cultural environments of the NHS, and they showed strong commitments to these institutional demands in their daily routine of commissioning health services. The market-based policies were often perceived by commissioners as undermining the professional norms and the collectivist culture of the NHS, which resulted in resistance against the delivery of the reforms on the ground.

More specifically, the professional values and norms embedded within the NHS organisations were associated with the implementation difficulty of the market-based reforms. Since its creation, the operation of the NHS has been dominated by professional bureaucracy. To guarantee patients interests was an important objective of NHS organisations and the people working within the NHS, associated with a range of professional norms and standards such as quality of care and patient's needs. Commissioners had the social responsibility to maintain the interests of health service users, and they managed to implement government policy decisions without undermining key professional aspects of health services such as the quality standard of healthcare and responsiveness to patients' needs. The decisions and behaviour of commissioners were largely driven by the professional norms and the views of how

best to serve patients' interests. From the professional perspectives, competition were not suitable for providing every kind of health care, and its application should be dependent on professional knowledge and skills. The use of competitive procurement and contracting out might lead to the challenges to professional values and norms, such as poor quality of care, the fragmentation of services and the damages to the delivery of integrated care. Commissioners rejected the application of the market and competition mechanisms, when it was perceived as incompatible with the professional values and norms embedded within NHS organisations.

Moreover, the evidence presented in Chapter 7 indicates that the collectivist culture of the NHS was responsible for the problem of delivering the market-based reforms on the ground. The actions of commissioners were culturally structured, and the collectivist culture of the NHS influenced how commissioners on the ground made decisions. Collectivist values such as universality and equity have been deeply entrenched in the culture of the NHS system, which was reflected by a cultural belief of 'NHS family' and the collaborative relationships between NHS organisations on one hand, and a distaste for private sector provision on the other hand. These two cultural elements had impact on the decisions and actions of commissioners, as well as their responses to the market-based reforms. The cultural contexts defined a widely shared belief system around 'the NHS way of doing things', which highlighted the collaborative relationships amongst NHS organisations and the limited use of competition and private provision. Clearly, there was a lack of fit between NHS culture

and market reforms, which enabled the resistance against the market-based reforms on the ground.

The Combined Influence of Regulatory, Normative and Cultural Factors on the Implementation of the 2012 Market-Based Reforms

The study of the 2012 market-based reforms showed how a range of institutional factors combined to influence the decisions and actions of implementing actors, and as a consequence, prevented the delivery of the reforms on the ground. The empirical evidence suggests that regulatory factor with regard to poorly-designed policy was one of the important factors explaining the ineffective implementation of the market-based reforms following the 2012 Act. Defects in the government policy decisions can be attributed to the design of commissioning policies and rules in the 2012 Act. The commissioning policy goals were ambiguous, which allowed greater discretion to implementers to interpret and left the possibility of implementation failure wide open. Moreover, the market-based reforms did not create appropriate and effective incentive structures for facilitating implementation. Poorly-designed policy reforms provided the opportunity for CCGs to shape the implementation in a way that limited the degree of marketisation and competition. In this situation, normative and cultural factors enabled resistance against the market-based reforms on the ground. This eventually resulted in the problems of delivering the market-based reforms. Implementation turned into an issue, leading to the difficulty in achieving policy goal of marketising the English NHS.

The dilemma of marketising the English NHS following the 2012 Act was that there were no proper institutional settings to support the delivery of the market-based reforms on the ground. The government failed to produce sound policies to structure implementation and enhance compliance by implementers. In this situation, implementers found a room to limit the degree of marketisation for meeting the normative and cultural demands of their own organisations. Put differently, on the basis of poorly-designed policy structures (i.e. substantial policy ambiguity and the lack of incentive structures), the entrenched norms and culture of the NHS were able to shape the delivery of the 2012 reform. The implementation problems of the 2012 market-based reforms were a result of institutional constraints. It was difficult to deliver the market-based reforms in the institutional contexts of poorly-designed reform policies and rules, the entrenched professional norms, and the prevailing collectivist culture. Although the role of market and competition has intensified within government policies and legislation, the related changes have been significantly watered down in the implementation process.

8.2 Theoretical Contributions to the Knowledge

This section discusses the theoretical contributions of this study to existing literature. This section starts by discussing the contributions to the studies of policy

implementation. It then considers the theoretical contributions of this thesis to the existing literature on marketisation reforms within the English NHS.

Institutional Perspectives and Policy Implementation: A Theoretical and Analytical Framework

The empirical findings demonstrated that institutional perspectives hold some explanatory power for policy implementation. Implementation analysis has been enhanced by analysing it through an institutional perspective. In particular, the normative and cultural perspectives can help explaining why some policies face much resistance at the point of delivery. In this thesis, the approach taken to understanding implementation adopts an institutionalist approach. Institutional theories imply that there are a range of institutional factors simultaneously influence implementation processes through shaping implementers' decisions and behaviour, which include regulatory, normative and cultural factors. These factors consist of the institutional environments within which implementers reach decisions and take actions. Policy actors in charge of implementing policy operate in a mixed institutional framework and act in a way structured by this framework. The dilemma for implementation is that implementers have to reconcile with the demands of different institutional requirements and make policy changes happen in practice. Institutional perspectives stress the importance of the institutional environment within which implementers are located for analysing implementation. Overall, supportive institutional settings are critical to

effective implementation.

Institutional perspectives argue that the regulatory factors (notably the design of government policies themselves) have impact on the process of implementation (Lowndes and Roberts, 2013; Ostrom, 1986; 2011; Scott, 2014). One is related to the extent of the clarity of government policy decisions. Visible, transparent and precise policies and rules are vital characteristics of regulatory institutions, providing clear framework for directing actions and securing compliance (Lowndes and Roberts, 2013; Scott, 2014). From an institutionalist perspective, ambiguous policy goals will hinder implementation, as such ambiguity allows room for discretion and increase the possibility of implementation failure.

Another important regulatory factor concerns the incentive structures that the policy creates. Institutional perspectives suggest that incentive structures of policy affect implementation, as policy actors conform to government policy decisions as pursuing their self-interests, and they tend to implement policy that can bring about some rewards and benefits (Ostrom, 1986; 2011). The lack of appropriate incentives cannot effectively shape actions of policy implementers and secure compliance. This suggests that having policy instruments may not be sufficient to ensure implementation, incentive structures are also needed. Especially, incentives are critical in situations where there are multiple relatively autonomous actors involved in the delivery of public policy (Stoker, 1991). The government often lacks the ability to control the process of

delivery, because it is difficult to control how implementers interpret policies and how they act in practice. This means a set of appropriate incentives is necessary to change behaviour when the government cannot directly control the delivery process. If these incentives are not there then the process of implementation will be difficult.

Moreover, apart from regulatory factors, institutional perspectives argue that normative and cultural factors can enable resistance against a particular policy (Brunsson, 2002; DiMaggio and Powell, 1991; March and Olsen, 1984; 1989; Meyer and Rowan, 1977; Selznick, 1949; Scott, 2014). From the sociological institutionalist perspective, implementers are often social actors with their own social responsibilities and organisational imperatives, necessarily in response to the demands of the normative and cultural environments in which they are located. While implementers respond to the demands of implementing government policies, they are preoccupied with meeting the normative and cultural demands of their own organisations. Their decisions and actions are often shaped by certain values, norms and cultural beliefs embedded within their organisations. These normative and cultural factors structure appropriate behaviour, shaping the way in which the policies are implemented on the ground (March and Olsen, 1984; 1989). If policies are seen to undermine the shared, institutionalised norms and culture that implementers desire to maintain, there will be problems in delivering the policies.

These arguments of the institutional perspectives have been confirmed by the empirical

findings of this thesis (as discussed in previous Section 8.1). In the empirical research, three case studies were employed as a way to explore the implementation of the 2012 reform in context, in order to investigate the process of the implementation and ascertain factors influencing this process. On the basis of theoretical discussion, institutional settings were assumed as important factors to shape implementation through the decisions and behaviour of policy implementers. Three different case study sites (CCG 1, CCG 2 and CCG 3) were thus selected as the sample to be examined in depth with regard to the variations on population and financial position, in order to ensure that the impact of the local conditions of individual CCG area was considered. These three different CCG areas were chosen to test whether there were differences in terms of delivering the 2012 market-based reforms, and the study suggests there were not. The delivery of the 2012 reform on the ground had many similarities in the pattern of implementing behaviour such as the use of competitive procurement and private provision among these three different CCG areas (as the empirical findings presented in Section 8.1 above). The result of my case studies reflected that the differences between these three CCGs did not matter to the delivery of the reforms in this case. The behaviour of CCGs in different areas of the country were very similar in terms of how they implemented the 2012 reform, because they were subject to the same set of institutional factors. These institutional factors conditioned their decisions and behaviour at the point of delivering the market-based reforms. This gives me confidence to say that what matters to the delivery of the 2012 reform was that the institutional contexts in which implementation occurred. Just as institutionalist theories

suggest, the empirical work of this thesis provided further evidence that the dynamics between policy implementers and institutional factors was the key to understanding the way in which the 2012 market-based reforms were implemented on the ground.

The employment of institutional perspectives for understanding implementation is the main theoretical contribution that this thesis can make to existing studies on policy implementation. The role of institutional factors in implementation has been explored in a detailed and systematic way. The decisions and actions of implementers are an intermediary between the institutional factors and implementation results. Institutional factors shape the way the policy is implemented through structuring the decisions and behaviour of implementers. In this sense, the result of policy implementation is institutionally structured. Whether the government policy decisions can be translated into practice is determined by a combination of regulatory, normative, and cultural factors. In a broader way, the thesis attempts to pave the way for the study of public policy implementation from an institutionalist perspective. Analysis of implementation should understand the extent to which mixed institutional arrangements might constrain or facilitate policy delivery through decisions and actions of policy implementers. Put differently, to understand the process of implementation, it is essential to understand the institutional environment in which implementation occurs.

The implementation study based on institutional theories is different to the conventional top-down and bottom-up perspectives. It rejects the top-down models that perceive

implementation as a linear manner, and that implementation can be controlled by policy decisions and central government. Also, it rejects the purely bottom-up perspectives, which have a risk of overstating the role of implementing actors and ignoring the influence of policy decisions themselves and the central government on implementation processes. In contrast, the institutionalist analysis can provide a more comprehensive approach for understanding implementation, which combines the strengths of both top-down and bottom-up perspectives. It focuses on the decision-making and behaviour of implementers from a bottom-up perspective but does not exclude from some top-down insights that highlight the impact of government policies themselves on implementation. The institutionalist framework seeks to figure out how various institutional factors combine to produce the actions for or against implementation. The problems of implementation can be seen as a result of institutionally-structured behaviour that resists government policy decisions.

Contributions to the Existing Literature on NHS Marketisation Reforms

Equally as important, this study can add some contributions to the body of knowledge of NHS marketisation reform literature, as it has investigated the 'why' of the ineffective implementation of the market-based reforms following the 2012 Act. Hitherto, in the extant literature on NHS marketisation, there are still no satisfactory explanations for the implementation problems of the 2012 market-based reforms. Most of studies are overly descriptive and under-theorised, which failed to fully address

issues of theories, concepts and explanations (as discussed in Chapter 1). This thesis filled this gap by employing institutional perspectives for understanding the implementation problems of the market-based reforms. Theoretically and analytically, the implementation process of the market-based reforms has been well-understood by allowing for the role of institutional settings in explanation, alongside the decisions and actions of implementers. It is demonstrated that no supportive institutional settings prevented the reform implementation on the ground. This goes beyond the previous studies on the NHS market-based reforms.

In the existing literature on NHS marketisation, the ideas of NPM assumed that efficiency and effectiveness of health services would improve through enhancing marketisation and competitive pressures in the provision of health care (Harvey, 2005; Hood, 1991; 1995; Saltman and van Otter, 1992). There was a widely held belief within the government that the best way of improving efficiency was to intensify market competition. But on the basis of empirical findings of this study, there was little evidence about the benefits of the market reforms within the NHS system in terms of economic efficiency and cost-effectiveness. The idea that market and competition can drive up efficiency improvements seemed problematic within the NHS system. The empirical findings suggest that there were substantial transaction costs associated with the operation of healthcare markets characterised by uncertainty and imperfect information (Bartlett, 1991). In order to make competition happen in a publicly funded health system, a significant amount of public expenditure are needed. Thus, it can be

argued that the market-based reforms in the NHS were difficult to deliver efficiency improvement and cost reduction in practice.

Moreover, in the extant literature, whether the NHS was being privatised was debated widely after the implementation of the 2012 Act (see, for example, Coote and Penney, 2014; Davies, 2013; Hunter, 2011; Lister, 2012; Pollock and Price, 2011; Reynolds et al., 2012). There was a widely held argument that the 2012 Act would result in the increased role of private sectors in the provision of health care in the English NHS (Davies, 2013; Speed and Gabe, 2013). However, this thesis did not find any evidence to support this argument. Instead, the empirical research observed that a market with diverse healthcare providers was never really developed, and only a small amount of private sectors involved in some particular services like elective care, community and mental health services. For solving waiting lists problems, there was private sector involvement in providing some health services, but it was still limited overall. The Coalition Government tried to marketise the English NHS through increasing the involvement of private sectors, but this was proved to be impossible. This was partly because CCGs cannot afford to increase the use of private providers at a time of austerity, and partly because the financial rewards were insufficient to attract the involvement of private providers (as discussed in the section 8.1 above). Fundamentally, the NHS is primarily funded by the government from general taxation, and the vast majority of health services are delivered by NHS providers. ‘Privatisation’ appears to be a simplistic and loaded word to describe the market-based reforms following the

2012 Act.

8.3 Empirical Contributions of the Thesis

Apart from theoretical contributions, this study can make some empirical contributions to the knowledge. Empirically, the case studies of this thesis, mainly through documentary analysis and interviews provide a clear story of how the institutional factors within the NHS system constrained the delivery of the 2012 reforms. This thesis highlights the importance of taking account of various sources of institutions into examining the issues and problems the government faced in implementing policy reforms. The findings have a number of empirical contributions to supporting efforts to improve policy implementation and health policy implementation within the NHS system in particular.

First of all, policy goals should be formulated by the central government as clearly as possible. The experience of the 2012 market-based reforms suggests that the ambiguity of policy goals in formulation could be a barrier to effective implementation, as it paves the way for uncontrolled actions of implementers. If the policy goals are unclear and ambiguous, then it is logical that implementing actors will have more discretion and space for interpretation and modification at the point of delivery. The precondition for effective implementation is a set of clear and consistent objectives which explicitly state

what implementers should do and what goals are going to achieve. This will decrease the variation in interpretation and limit the space for modifications at the point of delivery.

Secondly, the central government should provide appropriate and effective incentives for facilitating implementation. Especially when implementers had discretion and autonomy to control the delivery process of public services and policies, appropriate and strong incentives are necessary to mobilise implementers to support government policy decisions. By using some incentives such as financial rewards and benefits, this will make implementation become beneficial to implementers, and probably facilitate implementation.

Moreover, the decisions and actions of policy implementers are likely to be constrained by the normative and cultural requirements of their own organisations. Implementers are likely to shape policy in a way more suitable to the particular normative and cultural environments they find themselves in. The prevailing norms, values and cultural beliefs of a given public sector are critical to structure implementation. These normative and cultural factors could enable the resistance of policy implementers against some policies. From this perspective, it recommends that in the design of policy decisions, the central government should always consider the normative and cultural environments within which implementation occurs. The government policy decisions should avoid significantly violating the organisational values, norms and culture shared

by implementers.

8.4 Suggestions for Further Studies

The process of marketising the NHS is ongoing. This thesis only reflects a picture at a particular point which probably cannot represent how commissioners will respond to market-based policies in the future. During the period of this study, the English NHS system was experiencing a range of changes and transformations, notably the rise of collaboration policy in health service commissioning and provision. Operation of the NHS system was still under the legal framework of the 2012 Act which emphasised the importance of competition, while the policy changes towards greater collaboration have been introduced by NHSE since 2014. This thesis observed some impact of the collaboration policy framework on the implementation of the market-based policies in practice (as outlined in the Chapter 5). The pressure of implementing collaborative strategies increased by the newly-published NHS Long Term Plan 2019 (NHS England, 2019). Against this backdrop, it is necessary to conduct more empirical investigation on how CCGs deliver the market-based reforms introduced by the 2012 Act. This thesis is only a starting point for understanding the delivery of the market-based reforms within the English NHS system. More studies are necessary in order to explore the future of the marketisation within the English NHS system.

This thesis was written up in an unusual time as the whole world was suffering from the coronavirus (COVID-19) pandemic. The pandemic is an unprecedented challenge and pressure to the British healthcare system. The NHS responded to the crisis at rapid speed, creating emergency capacity to deal with the extraordinary increase of patients. But it seemed far away from success in many respects. After 10 years of austerity following the 2008 economic recession and financial crisis, the NHS is underfunded and vulnerable to the immense challenges brought by COVID-19. At the beginning of crisis, there were significant issues with access to personal protective equipment (PPE) and testing as well as the problem of track-and-trace (Booth, 2020; Proctor, 2020). During the COVID-19 pandemic, the state struggled to ensure public health and maintain sufficient health services provided to the British people. More private firms were used to deal with the pandemic crisis, because of the lack of capacity within the NHS. Many services were outsourced to private sectors such as testing, track and trace, and the supply of PPE (BMA, 2020). Seemingly, the pandemic provided an opportunity for marketising health services and increasing the involvement of private provision within the NHS system. For the future studies, it would be interesting to see if the pandemic could provide windows of opportunity for major changes in the role of market, competition and private sector providers in the provision of health services.

List of Abbreviations

A&E	Accident and emergency department
AIC	Aligned Incentive Contract
AQP	Any Qualified Provider
BMA	British Medical Association
BMJ	British Medical Journal
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CFO	Chief Financial Officer
COVID-19	Coronavirus disease 2019
DHAs	District Health Authorities
NHSE	NHS England
FOI	Freedom of Information
FT	Foundation Trust
GDP	Gross Domestic Product
GPs	General Practitioners
HRA	Health Research Authority
IAPT	Improving access to psychological therapies
ICU	Intensive care unit
IFS	Institute for Fiscal Studies

IHPN	Independent Healthcare Providers Network
IMF	International Monetary Fund
MCA	Market and Competition Authority
MPs	Members of Parliament
NAO	National Audit Office
NHI	National Health Insurance
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPM	New Public Management
OECD	Organisation for Economic Co-operation and Development
ONS	Office for National Statistics
PbR	Payment by Results
PCTs	Primary Care Trusts
PPE	Personal protective equipment
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCS	Royal College of Surgeons
SHAs	Strategic Health Authorities

Appendix 1. Interview Questions

The project is focused on understanding the health reforms of the Coalition Government following the 2012 Act. It aims to find out how the 2012 Act attempted to change the way that NHS operates and how service is delivered, and the extent to which these changes have been adopted in practice. The research has a particular interest in the use of market and competition mechanisms alongside the use of the private sector in the healthcare delivery after the implementation of the 2012 reform, trying to understand how they work in the context of publicly funded healthcare system and how local agencies make decisions about them. Interview questions are around the motivations and goals of the 2012 reform, but also allowing an assessment of the extent to which the NHS had been changed by the Act.

For Policy Actors at the National Level

First part is about your understanding of the rules and policy changes introduced by the 2012 reform:

- In your understanding, what are the objectives/goals of the 2012 reform?
- In your understanding, what is the biggest/most important change on the delivery of healthcare services following the 2012 Act?
- Do you think it is a radical change? Why or why not?

- What you can see as the changes in the national direction and policy about the commissioning activities/process after the 2012 Act, i.e. do you see some policy changes at the national level as to the rules of purchasing healthcare from providers?
- Do you think there are some changes to the policy with regards to the use of a competition mechanism in commissioning process? If yes, what kind of changes?
- What' s your understanding of policies encouraging private sector involvement in healthcare delivery (like Any Qualified Providers), which came into effect following the Coalition Government reforms?
- In your understanding, what are the objectives/goals of private sector involvement in the NHS healthcare delivery as stated in the 2012 Act?
- How do you think that private sector involvement is affecting the delivery of healthcare services in practice following the 2012 Act?
- In your opinion, what are the advantages and disadvantages of the use of market mechanisms (such as competition and private providers) when purchasing health care?
- Have you seen any policy changes in recent years related to commissioning at the national level after the 2012 Act?

Second part is about the assessment of the 2012 reform implementation in practice:

- What do you think the impact of the 2012 Act has been on CCGs and Trusts/Foundation Trusts?
- In your understanding, have the market-based changes introduced by the 2012 reform been effectively implemented by local agencies? Why or why not?

Third part is particularly around the role of the private sector in healthcare provision:

- What impacts has the 2012 Act had on using private sectors in healthcare delivery in your CCG?
- In your understanding, what are the objectives/goals of private sector involvement in the NHS healthcare delivery as stated in 2012 Act?
- Do you think the NHS has been opened-up more to the private sectors following the framework created by the 2012 Act? If yes, why? If not, why not?
- What do you see as the impacts of the cooperation policy on the use of private sectors in your CCG?
- In your understanding, why or why not do local organisations use the private sector?
- What do you see as the main effects (benefits and problems) of the use of the private sector?

Last questions are about your perspectives around some general debates:

- What do you can see as the consequences and impacts of the 2012 reform on NHS operation and service delivery?
- What you think about the debates that the NHS is being privatised?

For Senior Managers (Commissioners) in the CCGs

Frist it is about your understanding of policy changes around the market and competition introduced by the 2012 reform:

- In your understanding, what ate the objectives/goals of the 2012 reform?
- In your understanding, what is the biggest/most important change in the delivery of health services following the 2012 Act?
- Do you think it is a radical change? Why or why not?
- What do you see as the changes in the national direction and policy about the commissioning activities/process after the 2012 Act, i.e. do you see some policy changes at the national level as to the rules of purchasing health care from the providers?
- Do you think there are some changes in policy with regards to the use of competition mechanisms in commissioning process? If yes, what kind of changes?
- In your opinion, what are the advantages and disadvantages of the use of the

market mechanism (such as competition and private providers) when purchasing health care?

- What is your understanding about competition and marketisation, as stated in the 2012 Act?

Second part is about the implementation of the 2012 reform on the ground:

- How does that affect your CCG/your commissioning work in practice?
- How do you use competition strategies when purchasing health care?
- In your CCG area, what factors facilitate and encourage you to use the market and competition?
- In your opinion, what are the advantages and disadvantages of the use of competition when purchasing health care?
    - In your CCG area, what barriers impede you from using market and competition?
    - In your opinion, what are the benefits and problems of competition and marketisation?
- Do you see any policy changes in recent years about commissioning at a national level after the 2012 Act?
- Do you know how these types of changes affected your CCG and your commissioning work?

Third part is particularly around the role of the private sector in healthcare provision under the Coalition Government:

- What is your understanding of policies encouraging private sector involvement in the healthcare delivery (like Any Qualified Providers), which came into effect following the Coalition Government reforms?
- In your understanding, what are the objectives/goals of private sector involvement in the NHS healthcare delivery as stated in the 2012 Act?
- Do you think that private sector involvement is affecting the delivery of healthcare services in practice following the 2012 Act?
- In your opinion, how does that affect your CCG and your commissioning work?
    - Do you think there is more private sector involvement in the healthcare delivery after the 2012 Act in your CCG?
    - In your CCG, do you use the private sector? (If, yes) When and where do you use private providers? / (If no, why not use private providers?)
    - Why do you use the private sector to provide certain kinds of healthcare, as you said above?
- What are the advantages and factors that encourage the use of private sectors in your CCG area?
- What barriers are there that limit the use of private sectors in your CCG area?

- What are the benefits and problems of the use of the private sector?
- What do you see as the impacts of the cooperation policy on the use of private sectors in your CCG?

Last questions are about your perspectives around some debates in general:

- What do you see as the consequence and impacts of the 2012 reform on NHS operations and service delivery?
- What do you think about the debates that the NHS is being privatised?

For Senior Managers in the Trusts/Foundation Trusts/Private Providers

Firstly, the questions are about the policy changes introduced by the 2012 reform:

- In your understanding, what are the objectives/goals of the Lansley reform (i.e. the 2012 Act)?
- In your understanding, what is the biggest/most important change to the delivery of health services following the 2012 Act?
- Do you think it was a radical change? Why or why not?
- What is your understanding of policies encouraging private sector involvement in the healthcare delivery (like Any Qualified Providers), which came into effect following the Coalition Government reform?

- In your understanding, what are the objectives/goals of private sector involvement in the NHS healthcare delivery, as stated in the 2012 Act?
- How do you think private sector involvement is affecting the delivery of health services in practice following the 2012 Act?

Secondly, the questions are based around the implementation of the reform in practice:

- How has the 2012 Act affected your organisation?
- Could you please tell me what kind of services CCG purchase from your organisation?
- Do you know what kind of health services are usually provided by private sectors in the NHS?
- Why do you think CCGs choose private providers for certain healthcare services rather than NHS providers in some treatments/services?
- What are the advantages and disadvantages of using the private sector for service delivery in the NHS?

Last questions are about your perspectives around some debates in general:

- What do you see as the consequences and impacts of the 2012 reform on NHS operations and service delivery?
- What do you think about the debates that the NHS is being privatised?

Appendix 2. Participant Consent Form

This form is for you to state whether or not you agree to take part in the study. Please read and answer every question. If there is anything you do not understand, or if you want more information, please ask the researcher.

IRAS reference: 247722. Policy reform in the NHS in England.
Title of Project: the impact of Health and Social Care Act 2012 on the health policy in the NHS in England.
Name of Researcher: Xizi Wan

Please initial box

1. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without legal rights being affected. ☐
3. I understand that my data and information collected during the study will be anonymous, held by researcher in confidence, and be looked at by the researcher. I give permission for the researcher to have access to my records. ☐
4. I understand that the information collected about me will be mainly used for the PhD thesis, and may be published anonymously in some form at a later stage. ☐
5. I agree to take part in the above study. ☐
6. I agree to my interviews being recorded (You can take part in the study without agreeing to this). ☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

Appendix 3. Participant Information Sheet (PIS)

IRAS reference: 247722. Policy reform in the NHS in England.

Tittle of Project: the impact of Health and Social Care Act 2012 on the health policy in the NHS in England.

Name of Researcher: Xizi Wan

I would like to invite you to take part in a research project to discuss about how the health policy in the National Health Service (NHS) in England has been changed following the implementation of the Health and Social Care Act 2012. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the research about?

The health policy in England has been significantly shaped by the latest round of the NHS reforms in 2012, which has affected the local decision-making and health care delivery at hospital level. In this project, I want to find out the impact of the reforms following the 2012 Act and the way it is changing the way that the NHS is working. For this aims, it would be very useful to talk with the senior managers of the CCGs and Trusts around how the reform at the national level are affecting local decision making,

especially in relation to decisions about the allocation of resources.

Who is carrying it out?

Xizi Wan, a PhD student in the Department of Politics in the University of York. Xizi Wan is being supervised by Martin Smith and Eva Heims at the University of York.

Has the research been the subject of ethical review?

YES. This research has been approved by the ELMPS Ethics Committee. If you need more information about the ethical approval, you can contact the Chair of ELMPS, Tony Royle (Email address: tony.royle@york.ac.uk).

Why have I been chosen and do I have to take part?

You have been approached because you have connection with the national policy implementation and decision making practices at the local level involved in the study. As a senior manager in the CCG/Trust, you have an experience of local decision making process regarding the commissioning/purchasing of healthcare services. I will collect information through semi-structured interviews to gain a better understanding of your thoughts and perspectives. About 10 such interviews will be conducted as part of the study. It is up to you to decide whether or not to take part. If you decide to take part,

you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part – when, for how long, where, and with whom?

If you want to take part, please contact me through my email (xw1096@york.ac.uk). Then, you will take part through a semi-structured interview with me (Xizi Wan, the researcher). We can arrange a date and a place for interview. You will be asked to sign a consent form, and you also will be asked for the audio record the interview to ensure a more accurate account. If you agree, our conversation will be recorded and transcribed for the later analysis. But you do not have to agree to the audio recording. You can still involve in the study without agreeing the audio according. The interview should last around 45 minutes and no longer than 1 hour.

Will the data the researcher collect be kept anonymous and confidential and what will happen to the data collected from the participants?

The University of York is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in

order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally-identifiable information possible. All information collected from you will be treated in accordance with the Data Protection Act 2018.

This project will strictly maintain your anonymity and any information collected from you with be retained confidentially. During the study, only the researcher (Xizi Wan) will have an access to the data and information collected from the participants. Data recorded on paper (e.g. consent forms) will be stored in a locked cabinet and electronic data (e.g. interview recordings, transcripts and coded/analyzed data) in password protected file space on the University of York server. In addition, all identifying information will be removed from interview data. The data containing personal details that would lead to the identification of participants (e.g. participants email address but not consent forms) will be deleted as soon as possible.

After the study has been completed, the personal data (e.g. consent forms) and research data (e.g. interview recordings, transcripts, coded/analysed data) will be stored in electronic form. The consent forms will be scanned and saved in a password-protected file space on the university server and the paper consent form will be destroyed. The anonymous interview recordings and transcripts and any coded data produced during analysis will be save in a password-protected file space on the university server. According to the Research Data Management Policy of the University of York, the personal data could be stored for up to 6-12 months, with the research data being stored

for up to 10 years in the password protected university computers after the study ends.

The data and information collected during the study is mainly for a PhD thesis, but it may be subsequently published as academic journal articles. Under these circumstances, care will be taken to ensure that individuals cannot be identified form the details presented. This study has received the approval form the Health Research Authority and ELMPS Ethics Committee in the University of York.

Who can I talk to for more information or advice for taking part in the research?

If you would like more information about the research, please do not hesitate to contact the researcher, Xizi Wan, Email: xw1096@york.ac.uk. Or her supervisors: Martin Smith through martin.smith@york.ac.uk or Eva Heims through eva.heims@york.ac.uk.

What do I do now?

If you would like to hear more about the study or think you might like to take part, just approach the researcher or her supervisors.

Thank you for your time.

Bibliography

Ackroyd, S., Kirkpatrick, I. and Walker, R. M. (2007) 'Public management reform in the UK and its consequences for professional organisation: A comparative analysis', *Public Administration*, 85(1), 9-26.

Addicott, R. (2014) *Commissioning and Contracting for Integrated Care*. London: The King's Fund.

Addison, P. (1975) *The Road to 1945: British Politics and the Second World War, Previous ed.* London: Janathan Cape, Pimlico edition.

Allen, P. (2002) 'Plus ca change, plus c'est la meme chose: to the internal market and back in the British National Health Service', *Applied Health Economics and Health Policy*, 1(4), 171-178.

Allen, P. (2009) 'Restructuring the NHS again: Supply side reform in recent English health care policy', *Financial Accountability & Management*, 25(4), 373-389.

Allen, P. (2013) 'An economic analysis of the limits of market based reforms in the English NHS', *BMC Health Services Research*, 13(51), 1-10.

Allen, P., Osipovic, D., Shepherd, E., Coleman, A., Perkins, N. and Garnett, E. (2015) *Commissioning through Competition and Cooperation. Final Report.* PRUComm.

Allen, P., Osipovic, D., Shepherd, E., Coleman, A., Perkins, N., Garnett, E. and Williams, L. (2017) 'Commissioning through competition and cooperation in the English NHS under the Health and Social Care Act 2012: Evidence form a qualitative study of four clinical commissioning groups'. *BMJ Open* 2017, 7(2).

Appleby, J., Galea, A., and Murray, R. (2014) *The NHS Productivity Challenge. Experience from the Front Line*. London: The King's Fund.

Appleby J., Harrison, T., Hawkins, L. and Dixon, A. (2012) *Payment by Results: How can Payment Systems Help to Deliver Better Care?* London: The King's Fund.

Arora, S., Charlesworth, A., Kelly, E. and Stoye, G. (2013) *Public Payment and Private Provision: The Changing Landscape of Health Care in the 2000s*. London: The Nuffield Trust and Institute for Fiscal Studies.

Bach, S. (2012) 'Shrinking the state or the big society? Public service employment relation in an era of austerity', *Industrial Relation Journal*, 43(5), 399-415.

Bach, S. (2016) 'Deprivileging the public sector workforce: Austerity, fragmentation and service withdrawal in Britain', *The Economic and Labour Relations Review*, 27(1), 11-28.

Baggott, R. (1997) 'Evaluating health care reform: the case of the NHS internal market', *Public Administration*, 75(2), 283-306.

Baier, V. E., March, J. G. and Saetren, H. (1986) 'Implementation and ambiguity', *Journal of Management Studies*, 2(3-4), 197-212.

Baker G. R. and Denis, J. (2011) 'Medical leadership in health care systems: from professional authority to organisational leadership', *Public Money & Management*, 31(5), 355-362.

Bambra, C., Fox, D. and Scott-Samuel, A. (2005) 'Towards a politics of health', *Health Promotion International*, 20(2), 187-193.

Barber, M. (2008) *Introduction to Deliver: Fighting to Transform Britain's Public*

Services. London: Methuen.

Barbour, R. (2008) *Introducing Qualitative Research: A Student Guide to the Craft of Doing Qualitative Research*. London: SAGE.

Bardach, E. (1977) *The Implementation Game: What Happens after a Bill Becomes a Law.* Cambridges, MA: MIT Press.

Barrett, S. M. (2004) 'Implementation studies: Time for a revival? Personal reflections on 20 years of implementation studies', *Public Administration*, 82(2), 249-262.

Barrett, S. M. and Fudge, C. (1981) *Policy and Action: Essays on the Implementation of Public Policy*. London: Methuen.

Bartlett, W. (1991) 'Quasi-markets and contracts: A markets and hierarchies perspective on NHS reform', *Public Money & Management*, 11(3), 53-61.

BBC. (2015) 'Cambridgeshire's £800m NHS out-sourcing contract ends', *BBC News*. [Online]. Available at: https://www.bbc.co.uk/news/uk-england-cambridgeshire-35000421. [Accessed 3 December 2015].

Béland, D., Blomqvist, P., Andersen, J. G., Palme, J., and Waddan, A. (2014) 'The universal decline of universality? Social policy change in Canada, Demark, Sweden and the UK', *Social Policy & Administration*, 48(7), 739-756.

Berman, P. (1978) 'The study of macro- and micro-implementation', *Public Policy*, 26(2), 157-184.

Bevan, A (1978) *In Place of Fear*. London: Quartet.

Bevan, G. and Robinson, R. (2005) 'The interplay between economic and political logics: Path dependency in health care in England', *Journal of Health Politics,*

Policy and Law, 30(1-2), 53-78.

Beveridge, W. (1942) *Social Insurance and Allied Services*. The National Archives.

Bevir, M. and Rhodes, R. A. W. (2003) *Interpreting British Governance*. London: Routledge.

Bloor, K., et al. (2005) *NHS Management and Administration Staffing and Expenditure in a National and International Context, Report for the Department of Health*, University of York, unpublished.

BMA. (2013) *Understanding the Reforms…Choice and Any Qualified Provider*. London: British Medical Association.

BMA. (2016) *Privatisation and Independent Sector Provision of NHS Healthcare*. British Medical Association.

BMA. (2017) *Hidden Figures: Private Care in the NHS.* British Medical Association.

BMA. (2020) *Outsourced and Undermined: The COVID-19 Windfall for Private Providers.* British Medical Association. [Online]. Available at: https://www.bma.org.uk/news-and-opinion/outsourced-and-undermined-the-covid-19-windfall-for-private-providers. [Accessed 8 September 2020].

Bochel, H. (2011) *The Conservative Party and Social Policy*. Bristol: The Policy Press.

Booth, R. (2020) 'What has gone wrong with England's Covid test-and-trace system?', *The Guardian*. [Online]. Available at: https://www.theguardian.com/world/2020/oct/13/what-has-gone-wrong-with-englands-covid-test-and-trace-system. [Accessed 13 October 2020].

Boseley, S. (2011) 'NHS bill will let Andrew Lansley wash his hands of health service',

The Guardian. [Online]. Available at: https://www.theguardian.com/society/2011/aug/29/nhs-bill-lansley-wash-hands. [Accessed 30 Aug 2011].

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), 77-101.

Brehm, J. and Gates, S. (1997) *Working, Shirking, and Sabotage: Bureaucratic Response to a Democratic Public*. Ann Arbor: University of Michigan Press.

Britten, N. (1995) 'Qualitative Research: Qualitative interviews in medical research', *British Medical Journal*, 311, 251-254.

Brodkin, E. Z. (2008) 'Accountability in street-level organisations', *Intl Journal of Public Administration*, 31(3), 317-336.

Brookes, G. and Harvey, K. (2016) 'Opening up the NHS to market: using multimodal critical discourse analysis to examine the ongoing corporatisation of health care', *Journal of Language and Politics*, 15(3), 288-302.

Brunsson, N. (1993) 'Ideas and actions: Justification and hypocrisy as alternatives to control', *Accounting, Organisations and Society*, 18(6), 489-506.

Brunsson, N. (2002) *The Organization of hypocrisy: Talk, Decision and Actions in Organizations, 2nd edn*. Chichester: John Wiley.

Brynard, P. (2005) 'Policy implementation: Lessons for service delivery', *Journal of Public Administration*, 40(4.1), 649-664.

Buckingham, H. and Dayan, M. (2019) *Privatisation in the English NHS: Fact or Fiction?*. London: Nuffield Trust.

Burton, M. (2013) *The Politics of Public Sector Reform: from Thatcher to the Coalition*. New York: Palgrave Macmillan.

Calovski, V. (2018) *The New NHS in England: Exploring the Implications of Decision Making by Clinical Commissioning Groups and their Effect on the Selection of Private Providers*. Doctor of Philosophy (PhD) thesis, University of Kent.

Cameron, D. (2019) *For the Record*. London: William Collins.

Campbell, D. (2010) 'Opponent of NHS reform driven by grim memories of 60s', *The Guardian.* [Online]. Available at: https://www.theguardian.com/society/2010/nov/19/nhs-gp-leader-clare-gerada. [Accessed 19 November 2010].

Campbell, D. (2012) 'Andrew Lansley called on to resign at doctors' conference', *The Guardian.* [Online]. Available at: https://www.theguardian.com/politics/2012/jun/28/andrew-lansley-resign-doctors-conference. [Accessed 28 June 2012].

Campbell, D. (2014) 'NHS boss Simon Stevens defends privatisation', *The Guardian*. [Online]. Available at: https://www.theguardian.com/society/2014/oct/23/nhs-boss-simon-stevens-defends-privatisation. [Accessed 23 October 2014].

Campbell, D. (2019) 'Private firms handed £15bn in NHS contracts over past five years', *The Guardian*. [Online]. Available at: https://www.theguardian.com/society/2019/nov/29/private-firms-handed-15bn-in-nhs-contracts-over-past-five-years. [Accessed 29 November 2019].

Cerna, L. (2013) *The Nature of Policy Change and Implementation: A Review of*

Different Theoretical Approaches. Organisation for Economic Co-operation and Development.

Chard, J., Kuczawski, M., Black, N., and van der Meulen, J. (2011) Outomces of elective surgery undertaken in independent sector treatment centres and NHS providers in England: audit of patient outcomes in surgery. *The BMJ*. [Online]. Available at: https://www.bmj.com/content/343/bmj.d6404. [Accessed 19 October 2011].

Checkland, K., Harrison, S., Snow, S., Mcdermott, I, and Coleman, A. (2012) 'Commissioing in the English National Health Service: What's the problem?', *Journal of Social Policy*, 41(3), 533-550.

Checkland, K., Allen, P., Coleman, A. et al. (2013) 'Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS', *BMJ Open*, 3(12), 1-11.

Chote, R., Crawford, R., Emmerson, C. and Tetlow, G. (2010) *Public Spending under Labour: 2010 Election Briefing Note No. 5. IFS BN92.* London: Institute for Fiscal Studies.

CHPI. (2015) *The Contracting NHS – can the NHS Handle the Outsourcing of Clinical Services?.* Centre for Health and the Public Interest.

Clarke, K. (2005) 'I left Gordon Brown a strong economy. He squandered it', *The Guardian.* [Online]. Available at: https://www.theguardian.com/politics/2005/apr/25/election2005.economy. [Accessed 25 April 2005].

Coote, A. and Penny, J. (2014) *The Wrong Medicine: A Review of the Impacts of NHS Reforms in England*. New Economics Foundation.

Corbett, S. and Walker A. (2013) 'The big society: Rediscovery of 'the social' or rhetorical fig-leaf for neo-liberalism?', *Critical Social Policy*, 33(3), 451-472.

Cousins, C. (1998) 'The restructuring of welfare work: The introduction of general management and the contracting out of ancillary services in the NHS', *Work, Employment & Society*, 2 (2), 210-228.

Creswell, J. W. (2009) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* Los Angeles: SAGE.

Creswell, J. W. and Poth, C. N. (2018) *Qualitative Inquiry and Research Design: Choosing among Five Approaches*. Fourth Edition. London: SAGE.

Currie, W. L. and Finnegan, D. J. (2011) 'The policy-practice nexus of electronic health records adoption in the UK NHS: an institutional analysis', *Journal of Enterprise Information Management*, 24(2), 146-171.

Currie, W. L. and Guah, M. W. (2007) 'Conflicting institutional logics: a national programme for IT in the organisational field of healthcare', *Journal of Information Technology*, 22, 235-247.

Currie, G. and Suhomlinova, O. (2006) 'The impact of institutional forces upon knowledge sharing in the UK NHS: The triumph of professional power and the inconsistency of policy', *Public Administration*, 84, (1), 1-30.

Curristine, T., Lonti, Z. and Joumard, I. (2007) 'Improving public sector efficiency: Challenges and opportunities', *OECD Journal on Budgeting*, 7(1), 1-41.

Davies, A.C.L. (2013) ‘This time, it’s for real: The Health and Social Care Act 2012’, *The Modern Law Review*, 76(3), 564-588.

Davies, P. H. J. (2001) ‘Spies as informants: Triangulation and the interpretation of elite interview data in the study of the intelligence and security services’, *Politics*, 21(1), 73-80.

Davis, J. and Tallis, R. (2013). *NHS SOS*. London: Oneworld.

Davis, J., Lister, J. and Wrigley, D. (2015) *NHS for Sale*. London: Merlin Press.

Day, P. and Klein, R. (1991) ‘Britain’s health care experiment’, *Health Affairs*, 10(3), 39-59.

deLeon, P. and deLeon, L. (2002) ‘What ever happened to policy implementation? An alternative approach’, *Journal of Public Administration Research and Theory*, 12(4), 467-492.

Department of Health. (1989) *Working for Patients. Cm 555*. London: The Stationery Office.

Department of Health. (2007) *Options for the Future of Payment by Results 2008/9 to 2010/11*. London: The Stationery Office.

Department of Health. (2010) *Equity and Excellence: Liberating the NHS. Cm 7881.* London: The Stationery Office.

Department of Health. (2012) *Health and Social Care Act 2012*. London: The Stationery Office.

Department of Health. (2013) *National Health Service (Procurement, Patient Choice and Competition) Regulations 2013*. London: The Stationary Office.

Department of Health. (2015) *The NHS Constitution: The NHS Belongs to us all*. London: The Stationery Office.

Department of Health (2017) *Annual Report and Accounts 2016-17*. London: The Stationery Office.

DiMaggio, P. J. and Powell, W. W. (1983) 'The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields', *American Sociological Review*, 48(2), 147-160.

Dixon, A. Mays, N and Jones, L. (2011) *Understanding New Labour's Market Reforms of the English NHS*. London: The King's Fund.

Dubois, V. (2010) *The Bureaucrat and the Poor: Encounters in French Welfare Offices*. Farnham: Ashgate.

Dunleavy, P. (1986) 'Explaining the privatization boom: Public choice versus radical approaches', *Public Administration*, 64(1), 13-34.

Dunleavy, P and Hood, C (1994) 'From old public administration to new public management', *Public Money & Management*, 14(3), 9-16.

Dunn, P., McKenna, H. and Murray, R. (2016) *Deficits in the NHS 2016*. London: The King's Fund.

Edelman, L. B. and Suchman, M. C. (1997) 'The legal environments of organisations', *Annual Review of Sociology*, 23, 479-515.

Elliott, L. (2010) 'What caused the deficit?', *The Guardian*. [Online]. Available at: https://www.theguardian.com/politics/2010/jun/07/what-caused-budget-deficit. [Accessed 7 June 2010].

Elmore, R. F. (1978) Organisational models of social program implementation, *Public Policy*, 26(2), 185-228.

Elmore, R. F. (1980) 'Backward mapping: implementation research and policy decisions', *Political Science Quarterly*, 94(4), 601-616.

Enthoven, A. C. (2000) 'In pursuit of an improving National Health Service', *Health Affairs*, 19(3), 102-119.

Evans, T. (2010) *Professional Discretion in Welfare Services: Beyond Street-Level Bureaucracy*. Surrey: Ashgate.

Exworthy, M. and Halford, S. (1999) *Professionals and the New Managerialism in the Public Sector*. Buckingham: Open University Press.

Exworthy, M., Mannion, R. and Powell, M. (2016) *Dismantling the NHS?: Evaluating the Impact of Health Reforms*. Bristol: Policy Press.

Exworthy, M., Powell, M. and Mohan, J. (1999) 'Market, bureaucracy and public management: The NHS: Quasi-market, quasi-hierarchy and quasi-network?', *Public Money and Management*, 19(4), 15-22.

Farrell, C. F. and Morris, J. (1999) 'Markets, bureaucracy and public management: Professional perceptions of bureaucratic change in the public sector: GPs, headteachers and social workers', *Public Money and Management*, 19(4), 31-36.

Ferlie, E, Lynn, L. E. and Pollitt, C. (Eds). (2005) *Oxford Handbook of Public Management*. Oxford: Oxford University Press.

Field, J. E. and Peck, E. (2003) 'Public-private partnerships in healthcare: the managers' perspective', *Health and Social Care in the Community*, 11(6), 494-501.

Flynn, R. (2002) 'Clinical governance and governmentality', *Health, Risk & Society*, 4(2), 155-173.

Fowler, L. (2018) 'Problems, politics, and policy streams in policy implementation', *Governance*, 32, 403-420.

Fowler, L. (2020) 'How to implement policy: Coping with ambiguity and uncertainty', *Public Administration*, 99(3), 1-17.

Frith, L. (2015) 'The changing National Health Service: Market-based reform and morality', *Intonational Journal of Health Policy and Management*, 4(4), 253-255.

Gainsbury, S. (2016) *Feeling the Crunch: NHS Finances to 2020*. London: Nuffield Trust.

Gainsbury, S. (2017) *The Bottom Line: Understanding the NHS Deficit and Why It won't Go Away.* London: Nuffield Trust.

Gale, N. K., Heath G., Cameron, E., Rashid, S. and Redwood, S. (2013) 'Using the framework method for the analysis of qualitative data in multi-disciplinary health', *BMC Medical Research Methodology*, 13(117), 1-8.

Gamble, A. (1981) *An Introduction to Modern Social and Political Thought*. Basingstoke: Macmillan.

Gatenby, M., Rees, C., Truss, C., Alfes, K. and Soane, E. (2015) 'Managing change, or changing managers? The role of middle managers in UK public service reform', *Public Management Review*, 17(8), 1124-1145.

Gershlick, B., Charlesworth, A. and Taylor, E. (2015) *Public Attitudes to the NHS: An Analysis of Responses to Questions in the British Social Attitudes Survey*. London:

The Health Foundation.

Giaimo, S. and Manow, P. (1999) 'Adapting the welfare state: The case of health care reform in Britain, Germany, and the United States', *Comparative Political Studies*, 32(8), 967-1000.

Gibson, W. J. and Brown, A. (2009) *Working with Qualitative Data*. London: SAGE.

Gilbert, B., Clarke, E. and Leaver, L. (2014) 'Morality and markets in the NHS', *International Journal Health Policy Management*, 3(7), 371-376.

Glynn, J. J. and Perkins, D. (1997) 'Control and accountability in the NHS market: a practical proposition or logical impossibility', *International Journal of Public Sector Management*, 10(12), 62-75.

Glennerster, H. and Le Grand, J. (1995) 'The development of quasi-markets in welfare provision in the United Kingdom', *International Journal of Health Services*, 25(2), 203-218.

Godfrey, K. (2015) 'The biggest privatisationin in NHS history: why we had to blow the whistle', *The Guardian*. [Online]. Available at: https://www.theguardian.com/commentisfree/2015/mar/16/nhs-privatisation-biggest-history-staffordshire-cancer. [Accessed 16 March 2015].

Goggin, M. L., Bowman, A. O'M., Lester, J. P. and O'Toole, L. J. (1990) *Implementation Theory and Practice: Towards a Third Generation*. Upper Saddle River, NJ: Scott Foresman.

Gore, O., Hammond, J., Bailey, S., Checkland, K. and Hodgson, D. (2019) 'Not every public sector is a field: evidence from the recent overhaul of the English NHS',

Public Management Review, 21(4), 559-580.

Gornitzka, A., Kyvik, S. and Stensaker, B. (2005) 'Implementation analysis in higher education', in A. Gornitzka, M. Kogan and A. Amaral (eds), *Reform and Change in Higher Education: Analyzing Policy Implementation*. Dordrecht: Springer, pp. 35-56.

Graham, A. (2005) 'Pressman/Wildavsky and Bardach: Implementation in the public sector, past, present and future', *Canadian Public Administration*, 48(2), 268-273.

Greener, I. (2002) 'Understanding NHS reform: The policy-transfer, social learning, and path-dependency', *Governance: An international Journal of Policy, Administration, and Institutions*, 15(2), 161-183.

Greener, I. (2005) 'The role of the patient in healthcare reform: customer, consumer or creator?', in S. Dawson and C. Sausmann (eds), *Future Health Organisations and Systems*. Basingstoke: Palgrave, pp. 227-245.

Greener, I. (2008) *Healthcare in the UK: Understanding Continuity and Change*. Bristol: The Policy Press.

Greener, I. (2016) 'An argument lost by both sides? The parliamentary debate over the 2010 NHS White Paper', in M. Exworthy, R. Mannion, and M. Powell (eds), *Dismantling the NHS? Evaluating the Impact of the Health Reforms*. Bristol: Policy Press, pp. 105-123.

Greener, I. and Powell, M. (2008) 'The changing governance of the NHS: Reform in a post-Keynesian health', *Human Relations*, 61(5), 617-636.

Greve, C. (2008) *Contracting for Public Services*. London: Routledge.

Gruening, G. (2001) 'Origin and theoretical basis of New Public Management', *International Public Management Journal*, 4(2001), 1-25.

Gunn, L. A. (1978) 'Why is implementation so difficult?', *Management Services in Government,* 33(4), 169–176.

Hall, P. A. and Taylor, R. C. R. (1996) 'Political science and the three new institutionalism', *Political Studies*, XLIV, 936-957.

Ham, C. (1996) *Public, Private or Community: What Next for the NHS?* London: Demos.

Ham, C. (2009) *Health Policy in Britain*. Basingstoke: Palgrave Macmillan.

Ham, C., Buckley, T. and Baylis, A. (2016) *Policy Changes to Implement the NHS Five Year Forward View: A Progress Report. Part of the NHS Five Year Forward View*. London: The King's Fund.

Hammond, J., Speed, E., Allen, P., McDermott, I., Coleman, A. and Checkland, K. (2019). Autonomy, accountability, and ambiguity in arm's-length meta-governance: The case of NHS England. *Public Management Review*, 21(8), 1148-1169.

Hanf, K. and Scharpf, F. W. (1978) *Interorganisational Policy Making: Limits to Co-ordination and Central Control*. London: Sage.

Harker, R. (2012) *NHS Funding and Expenditure*. House of Commons Library: Sources of Statistics. [Online]. Available at: http://www.nhshistory.net/parlymoney.pdf [Accessed 03 April 2012].

Harrison, L. (2001) *Political Research: An Introduction*. New York: Routledge.

Harrison, S. (2009) 'Co-optation, commodification and the medical model: Governing UK medicine since 1991', *Public Administration*, 87(2), 184-197.

Harrison, S. and Ahmad, W. (2000) 'Medial autonomy and the UK state 1975-2025', *Sociology*, 34(1), 129-146.

Harrison, S. and Lim, J. (2003) 'The frontier of control: Doctors and managers in the NHS 1966 to 1997', *Clinical Governance*, 8(1), 13-18.

Hart, W. E. (1929) *Hospitals as Affected by the Local Government Act, 1929*, by Sir Willian E Hart, O.B.E., LL.D. Clerk to the Sheffield Insurance Committee.

Harvey, D. (2005) *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Helm, T. (2011) 'Nick Clegg suffers defeat as Liberal Democrats reject health reforms', *The Guardian*. [Online]. Available at: https://www.theguardian.com/politics/2011/mar/12/nick-clegg-defeat-liberal-democrats. [Accessed 12 March 2011].

Hill, M. and Hupe, P. (2014) *Implementing Public Policy: An Introduction of the Study of Operational Governance, 3rd Edition*. London: SAGE.

Hills, J. (2011) 'The changing architecture of the UK welfare state', *Oxford Review of Economic Policy*, 27(4), 589-607.

Hindess, B. (1987) *Freedom, Equality, and the Market*. London: Tavistock.

Hjern, B. and Hull, C. (1982) 'Implementation research as Empirical constitutionalism', *European Journal of Political Research*, 10(1982), 105-115.

Hjern, B and Porter, D. O. (1981) 'Implementation structures: A new unit of administrative analysis', *Organization Studies*, 2(3), 211-227.

HM Government. (2010) *The Coalition: Our Programme for Government*. London: Cabinet Office.

HM Treasury. (2010) *Spending Review 2010. Cmnd-7942.* London: The Stationery Office.

Hogwood, B. W. and Gunn, L. A. (1984) *Policy Analysis for the Real World*. Oxford: Oxford University Press.

Hood, C. (1991) 'A public management for all seasons?', *Public Administration*, 69(1), 3-19.

Hood, C. (1995) 'The 'New Public Management' in the 1980's: Variations on a theme', *Accounting, Organisations and Society*, 20(2-3), 93-109.

Hood, C. and Dixon, R. (2015) *A Government that Worked Better and Cost Less? Evaluating Three Decades of Reform and Change in UK Central Government*. Oxford: Oxford University Press.

House of Commons Health Committee. (2010a) *Public Expenditure: Second Report of Session 2010-11. HC 512*. London: The Stationary office.

House of Commons Health Committee. (2010b) *Commissioning: Fourth Report of Session 2009-10. Volume I. HC 268-I.* London: The Stationary Office.

House of Commons Health Committee. (2016) *Impact of the Spending Review on Health and Social Care.* [Online]. Available at: https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/139/13902.htm. [Accessed 15 July 2016].

House of Commons Health and Social Care Committee. (2019) *NHS Long-term Plan:*

Legislative Proposals, Fifteenth Report of Session 2017-19. HC 2000. London: The Stationary Office.

House of Commons Public Account Committee. (2017) *Oral Evidence: Integrated Health and Social Care, HC 959.* [Online]. Available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/integrated-health-and-social-care/oral/48009.html. [Accessed 27 February 2017].

House of Lords Select Committee on the Constitution. (2011) *Health and Social Care Bill Report, 18th Report of Session 2010-12.* London: The Stationery Office Limited.

Howe, G. (1994) *Conflict of Loyalty*. London: Macmillan.

Howell, J. (1992) 'Re-examining the fundamental principles of the NHS', *British Medical Journal*, 304, 297-299.

Hsiao, W. C. (1995) 'Abnormal economics in the health sector', *Health Policy*, 32(1995), 125-139.

Hudson, B. (2013) *Competition and Collaboration in the New NHS*. Centre for Health and the Public Interests.

Hughes, D. and Vincent-Jones, P. (2008) 'Schisms in the church: National Health Service systems and institutional divergence in England and Wales', *Journal of Health and Social Behavior*, 49 (4), 400–416.

Hunter, D. (2011) 'Change of government: One more big bang health care reform in England's National Health Service', *International Journal of Health Services*,

41(1), 159-174.

Hunter, D. (2013a) ‘A response to Rudolf Klein: A battle may have been won but perhaps not the war’, *Journal of Health Politics, Policy and Law*, 38(4), 871-877.

Hunter, D. (2013b) *To Market! to Market.* Centre for Health and the Public Interest.

Hupe, P. L. (2011) ‘The thesis of incongruent implementation: Revisiting Pressman and Wildavsky’, *Public Policy and Administration*, 26(1), 63-80.

Hupe, P. and Buffat, A. (2014) ‘A public service gap: Capturing contexts in a comparative approach of street-level bureaucracy’, *Public Management Review*, 16(4), 548-569.

Hupe, P. and Hill, M. (2007) ‘Street-Level bureaucracy and public accountability’, *Public Administration*, 85(2), 279-300.

Jensen, G. M. (1989) ‘Qualitative methods in physical therapy research: A form of disciplined inquiry’, *Physical Therapy*, 69(6), 492-500.

Jordahl, H. (2019) ‘Perspectives on public sector outsourcing: quasi-markets and prices’, *CESifo Economic Studies*, 65(4), 343-348.

Keiser, L. R. and Soss, J. (1998) ‘With good cause: Bureaucratic discretion and the politics of child support’, *American Journal of Political Science*. 42(4), 1133-1156.

Klein, R. (1985) ‘Why Britain’s Conservatives support a socialist health care system’, *Health Affairs*, 4(1), 41-58.

Klein, R. (1995) ‘Big bang health care reform – Does it work? The case of Britain’s 1991 National Health Service Reforms’, *The Milbank Quarterly*, 73(3), 299-337.

Klein, R. (1998) ‘Why Britain is reorganising its National Health Service – yet again’,

Health Affairs, 17(4), 111-125.

Klein, R. (2013a) 'The twenty-year war over England's National Health Service: a report from the battlefield', *Journal of Health Politics, Policy and Law*, 38(4), 849-869.

Klein, R. (2013b) *The New Politics of the NHS: From Creation to Reinvention*. London: Radcliffe.

Krachler, N. and Greer, I. (2015) 'When does marketisation lead to privatisation ? Profit – Making in English health services after the 2012 Health and Social Care Act', *Social Science & Medicine*, 124, 215-233.

Krachler, N., Greer, I. and Umney, C. (2021) 'Can public healthcare afford marketisation? Market principles, mechanisms, and effects in five health systems', *Public Administration Review*, 1-11.

Lacobucci, G. (2016) 'CCGs told to delay signing £1.2bn deal or cancer and end of life services', *British Medical Journal*. [Online]. Available at: https://www.bmj.com/content/352/bmj.i745. [Accessed 05 February 2016].

Lafond, S., Charlesworth, A. and Roberts, A. (2016) *A Perfect Storm: An Impossible Climate for NHS Providers' Finances? An Analysis of NHS Finances and Factors Associated with Financial Performance.* London: The Health Foundation.

Lansley, A. (2004a*) Setting out the Framework of Conservative Health Policy. Speech to the Somerset Local Medical Committee Conference*. [Online]. Available at: https://conservative-speeches.sayit.mysociety.org/speech/600708. [Accessed 20 February 2004].

Lansley, A. (2004b) *Action on Health. Speech to Conservative Party Conference 2004*. [Online]. Available at: https://conservative-speeches.sayit.mysociety.org/speech/600566. [Accessed 05 October 2004].

Lansley, A. (2005a) *The Future of Health and Public Service Regulation. Speech to the NHS Confederation*. [Online]. Available at: https://conservative-speeches.sayit.mysociety.org/speech/600287. [Accessed 07 September 2005].

Lansley, A.(2005b) *A Vision for the National Health Service. Speech to Conservative Party Conference 2005*. [Online]. Available at: https://conservative-speeches.sayit.mysociety.org/speech/600248. [Accessed 04 October 2005].

Lansley, A. (2009) *Our Chance to Make the NHS the Finest in the World*. [Online]. Available at: https://conservative-speeches.sayit.mysociety.org/speech/601298. [Accessed 05 October 2009].

Lansley, A. (2010) *Our NHS – Our Number One Priority*. [Online]. Available at: https://conservative-speeches.sayit.mysociety.org/speech/601523. [Accessed 27 February 2010].

Lansley, A. (2011) 'Why the health service needs surgery', *The Telegraph*. [Online]. Available at: https://www.telegraph.co.uk/comment/personal-view/8551239/Why-the-health-service-needs-surgery.html. [Accessed 01 June 2011].

Larbi, G. A. (1999) *The New Public Management Approach and Crisis State*, UNRISD Discussion Paper No. 112, September 1999.

Laws, D. (2017) *Coalition: the Inside Story of the Conservative-Liberal Democrat*

Coalition Government. London: Biteback Publishing.

Le Grand, J. (1991) 'Quasi-markets and social policy', *The Economic Journal*, 101(408), 1256-1267.

Le Grand, J. (1999) 'Competition, cooperation, or control? Tales from the British National Health Service', *Health Affairs*, 18(3), 27-39.

Le Grand, J. (2003) *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens*. Oxford: Oxford University Press.

Le Grand, J. (2006) *The Blair Legacy? Choice and Competition in Public Services*. LSE Public Lecture. [Online]. Available at: http://www.lse.ac.uk/website-archive/publicEvents/events/2006/20051206t1246z001.aspx. [Accessed 21 February 2006].

Le Grand, J. (2010) 'Knights and knaves return: Public service motivation and the delivery of public services', *International Public Management Journal*, 13(1), 56-71.

Le Grand, J. (2018) 'The public service mutual: Theories of motivational advantage', *Public Administration Review*, 78(1), 82-91.

Le Grand, J. and Bartlett, W. (1993) *Quasi-Markets and Social Policy*. London: Macmillan.

Lester, J. P., Bowman, A. O. M., Goggin, M. L. and O'Toole, L. J. (1987) 'Public policy implementation: Evolution of the field and agenda for future research', *Policy Studies Review*, 7(1), 200-216.

Lester, J. P. and Goggin, M. L. (1998) 'Back to the future: The rediscovery of

implementation studies', *Policy Currents*, 8(3), 1-9.

Lewis, R. and Gillam, S. (2003) 'Back to the market: yet more reform of the National Health Service', *International Journal of Health Service*, 33(1), 77-84.

Lewis, R., Smith, J. and Harrison, A. (2009) 'From quasi-market to market in the National Health Service in England: what does this mean for the purchasing of health services?', *Journal of Health Services Research & Policy*, 14(1), 44-51.

Light, D. W. (1992) 'Equity and efficiency in health care', *Social Science & Medicine,* 35(4), 465-469.

Lilleker, D. G. (2003) 'Interviewing the political elite: Navigating a potential minefield', *Politics*, 23(3), 207-214.

Lindblom, C .E. (1959) 'The science of muddling through', *Public Administration Review*, 19(2), 78-88.

Lindblom, C. E. (1979) 'Still muddling, not yet through', *Public Administration Review*, 39(6), 517-526.

Linder, S. H. and Peters, B. G. (1987) 'A design perspective on policy implementation: the fallacies of misplaced prescription', *Policy Studies Review*, 6(3), 459-475.

Lipsky, M. (2010) *Street-level Bureaucracy: the Dilemmas of Individuals in Public Service, 2nd Edition*. New York: Russell Sage Foundation.

Lister, J. (2012) 'In defiance of the evidence: conservatives threaten to "reform" away England's National Health Service', *International Journal of Health Services*, 42(1), 137-155.

Lowndes, V. and Pratchett, L. (2012) 'Local governance under the Coalition

Government: Austerity, localism and the Big Society', *Local Government Studies*, 38(1), 21-40.

Lowndes, V. and Roberts, M. (2013) *Why Institutions Matter: The New Institutionalism in Political Science*. Basingstoke: Palgrave Macmillan.

Llewellyn, S. (2001) 'Two-way windows: clinicians and medical managers', *Organization Studies*, 22(4), 593-623.

Maarse, H. (2006) 'The privatisation of health care in Europe: an eight-country analysis', *Journal of Health Politics, Policy and Law*, 31(5), 981-1014.

Mahoney, J. and Thelen, K. (2010) *Explaining Institutional Change: Ambiguity, Agency and Power*. Cambridge: Cambridge University Press.

Mannion, R., Marini, G. and Street, A. (2008) 'Implementing payment by results in the English NHS: changing incentives and the role of information', *Journal of Health Organisation and Management,* 22(1), 79-88.

Marshall, T. H. (1950). *Citizenship and Social Class*. London: Pluto Press.

Marshall, L., Charlesworth, A. and Hurst, J. (2014) *The NHS Payment System: Evolving Policy and Emerging Evidence*. London: Nuffield Trusts.

March, J. G. and Olsen, J. P. (1984) 'The new institutionalism: Organisational factors in political life', *The American Political Science Review*, 78(3), 734-749.

March, J. G and Olsen, J. P. (1989) *Rediscovering Institutions: The Organizational Basis of Politics*. New York: The Free Press.

Marini, G. and Street, A. (2007) 'A transaction costs analysis of changing contractual relations in the English NHS', *Health Policy*, 83(1), 17-26.

Marwick, A. (1967) 'The Labour party and the welfare state in Britain, 1900-1948', *The American Historical Review*, 73(2), 380-403.

Marwick, A. (2003) *British Society since 1945*. London: Penguin Books.

Mason, A., Street, A. and Verzulli, R. (2010) 'Private sector treatment centres are treating less complex patients than the NHS', *Journal of the Royal Society of Medicine,* 103(8), 322-331.

Matland, R. E. (1995) 'Synthesizing the implementation literature: the ambiguity-conflict model of policy implementation', *Journal of Public Administration Research and Theory*, 5(2), 145-174.

Maynard-Moody, S. and Musheno, M. (2003) *Cops, Teachers, Counselors: Stories from the Front-lines of Public Service*. Ann Arbor, MI: The University OF Michigan Press.

McDermott, K. A. (2016) 'Incentives, capacity, and implementation: Evidence from Massachusetts education reform', *Journal of Public Administration Research and Theory*, 16, 45-65.

McLaughlin, M. W. (1987) 'Learning from experience: Lessons from policy implementation', *Educational Evaluation and Policy Analysis*, 9(2), 171-178.

McNulty, T. and Ferlie, E. (2004) 'Process transformation: Limitations to radical organisational change within public service organisations', *Organization Studies*, 25(8), 1389-1412.

Meyer, R., Egger-Peitler, I., Hollerer, M. A., and Hammerschmid, G. (2014) 'Of bureaucrats and passionate public managers: Institutional logics, executive

identities, and public service motivation', *Public Administration*, 92(4), 861-885.

Meyer, J. W. and Rowan, B. (1977) 'Institutionalized organizations: Formal structure as myth and ceremony', *American Journal of Sociology*, 83(2), 340-363.

Millar, R., Snelling, I. and Brown, H. (2011) *Liberating the NHS: Orders of Changes?* Health Services Management Centre, University of Birmingham.

Ministry of Health. (1920) *Interim Report on the Future Provision of Medical and Allied Service 1920 (Lord Dawson of Penn)*. London: The Stationery Office. [Online]. Available at: https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/interim-report-on-the-future-provision-of-medical-and-allied-services-1920-lord-dawson-of-penn/.

Ministry of Health: Department of Health for Scotland (1944) *A National Health Service.* London: The Stationery Office. [Online]. Available at: https://www.sochealth.co.uk/national-health-service/the-sma-and-the-foundation-of-the-national-health-service-dr-leslie-hilliard-1980/a-national-health-service/.

Moran, M. (1995) 'Explaining change in the National Health Service: corporatism, closure and democratic capitalism', *Public Policy and Administration*, 10(2), 21-34.

Moran, M. (1998) 'Explaining the rise of the market in health care', in W. Ranade, (ed.), *Market and Health Care: A Comparative Analysis*. New York: Longman, pp. 17-33.

Mulholland, G. and McAlister, D. (1997) 'The quasi market in health care: Pre-requisites, problems and prospects', *Public Policy and Administration*, 12(1), 21-

33.

Muschell, J. (1995) 'Health economics series: Technical briefing note: Privatization in health', *WHO Task Force on Health Economics Series*. Geneva: WHO, 1995.

NAO. (2016) *Financial Substantiality of the NHS. HC 785, Session 2016-17*. London: National Audit Office.

NAO. (2018) *A Review of the Role and Costs of Clinical Commissioning Groups. HC 1783, Session 2017-2019*. London: National Audit Office.

NHS England. (2014a) *NHS Five Year Forward View*. [Online]. Available at: https://www.england.nhs.uk/publication/nhs-five-year-forward-view/. [Accessed 22 October 2014]

NHS England. (2014b) *The Forward View into Action: Planning for 2015/16*. [Online]. Available at: https://www.england.nhs.uk/publication/the-forward-view-into-action-planning-for-201516/. [Accessed 19 December 2014].

NHS England. (2015) *Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21*. [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf. [Accessed 22 December 2015].

NHS England. (2019) *The NHS Long Term Plan*. [Online]. Available at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/. [Accessed 7 January 2019].

NHS Future Forum. (2011) *Summary Report on Proposed Changes to the NHS*. London: Department of Health and Social Care.

Nichols, L. M., Ginsburg, P. B., Berenson, R. A., Christianson, J. and Hurley, R. E. (2004) 'Are market forces strong enough to deliver efficient health care systems? Confidence is waning', *Health Affairs*, 23(2), 8-21.

Oliver, A. (2005) 'The English National Health Service: 1979-2005', *Health Economics*, 14(Suppl 1), S75-S99.

Oliver, A. and Evans, J, G. (2005) 'The paradox of promoting choice in a collectivist system', *Journal of Medical Ethics*, 31, 187.

ONS. (2012) *Expenditure on Healthcare in the UK, 1997-2010*.

ONS. (2017) *UK Health Accounts: 2015*.

Oosterwaal, A. and Torenvlied, R. (2011) 'Policy divergence in implementation: How conflict among decisive legislators reinforces the effect of agency preferences', *Journal of Public Administration Research and Theory*, 22, 195-217.

Osipovic, D. et al. (2016) 'Interrogating institutional change: Actors' attitudes to competition and cooperation in commissioning health services in England', *Public Administration*, 94(3), 823-838.

Osipovic, D., Allen, P., Petsoulas, C. and Moran, V. (2017) *Next Steps in Commissioning through Competition and Cooperation (2016-2017): Additional Report December 2017*. Policy Research Unit in Commissioning and the Health System.

Ostrom, E. (1986) 'An agenda for the study of institutions', *Public Choice*, 48(1), 3-25.

Ostrom, E. (2011) 'Background on the institutional analysis and development framework', *The Policy Study Journal*, 39(1), 7-27.

O'Toole, L. J. (1986) 'Policy recommendations for multi-actor implementation: An assessment of the field', *Journal of Public Policy*, 6(2), 181-210.

O'Toole, L. J. (2000) 'Research on policy implementation: Assessment and prospects', *Journal of Public Administration Research and Theory*, 10(2), 263-288.

O'Toole, L. J. and Montjoy, R. S. (1984) 'Interorganisational policy implementation: A theoretical perspective', *Public Administration Review*, 44(6), 491-503.

Page, R. M. and Silburn, R. (1999) *British Social Welfare in the Twentieth Century*. Basingstoke: Macmillan.

Paton, C (2014) *At What Cost? Paying the Price for the Market in the English NHS.* Centre for Health and the Public Interest.

Paton, C. (2016) *The Politics of Health Policy Reform in the UK: England's Permanent Revolution*. London: Palgrave Macmillan.

Pawson, R and Tilley, N. (1997) *Realistic Evaluation*. London: SAGE Publications Ltd.

Peedell, C. (2011) 'Further privatisation is inevitable under the proposed NHS reforms', *The BMJ* 2011, 342. [Online]. Available at: https://www.bmj.com/content/342/bmj.d2996.full. [Accessed 17 May 2011].

Perry, J. L. (2000) 'Bring society in: Toward a theory of public-service motivation', *Journal of Public Administration Research and Theory*, 10(2), 471-488.

Perry, J. L., Hondeghem, A. and Wise, L. R. (2010) 'Revisiting the motivational bases of public service: Twenty years of research and an agenda for the future', *Public Administration Review*, 70(5), 681-690.

Peters, B. G., Pierre, J. and King, D. S. (2005) 'The politics of path dependency:

Political conflict in historical institutionalism', *The Journal of Politics*, 67(4), 1275-1300.

Pierson, P. (1994) *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment.* New York: Cambridge University Press.

Pierson, P. (2001) *The New Politics of the Welfare State*. Oxford: Oxford University Press.

Pollock, A. and Price, D. (2011) 'The final frontier: The UK's new coalition government turns the English National Health Service over to the global health care market', *Health Sociology Review*, 20(3), 294-305.

Pollock, A. (2004) *NHS Plc: The Privatisation of Our Health Care*. London: Verso.

Powell, J. E. (1966) *Medicine and Politics*. London: Pitman Medical.

Powell, M. (1999) 'The Third Way in the health care sector: New Labour and the Third Way in the British National Health Service', *International Journal of Health Services*, 29(2), 353-370.

Powell, M. (2003) 'Quasi-markets in British health policy: a longue Durée Perspective', *Social Policy & Administration*, 37(7), 725-741.

Powell, M. (2015) 'Making markets in the English National Health Service', *Social Policy & Administration*, 49(1), 109-127.

Powell, M and Miller, R. (2015) 'Seventy years of privatizing the British National Health Service?', *Social Policy & Administration*, 50(1), 99-118.

Powell, T. and Heath, S. (2013) *The Reformed Health Service, and Commissioning Arrangements in England. SN06749.* London: House of Commons Library.

Powell, T. and Gheera, M. (2011) *Health and Social Care Bill: Committee Stage Report. Research Paper 11/31.* London: House of Commons Library.

Powell, T. (2020) *The Structure of the NHS in England, Number CBP 07206*. London: House of Commons Library.

Pressman, J. and Wildavsky, I. (1984) *Implementation, 3rd Edition*. Berkeley, CA: University of California Press.

Pringle, A. (1912) *The National Insurance Act, 1911. Explained, annotated and indexed*. Edinburgh: W. Green.

Proctor, K. (2020) 'Lack of testing and PPE among key England COVID-19 mistakes, MPs told', *The Guardian*. [Online]. Available at: https://www.theguardian.com/world/2020/jul/24/lack-of-coronavirus-testing-and-ppe-among-uks-key-mistakes-mps-told. [Accessed 24 July 2020].

Rainey, H. G. and Steinbauer, P. (1999) 'Galloping elephants: Developing elements of a theory of effective government organizations', *Journal of Public Administration Research and Theory*, 9(1), 1-32.

Reynolds, L., Attaran, A. Hervey, T. and McKee, M. (2012) 'Competition-based reform of the National Health Service in England: A one-way street?', *International Journal of health Services*, 42(2), 213-217.

Rhodes, R. A. W. (1996) 'The new governance: Governing without government', *Political Studies*, XLIV, 652-667.

Rhodes, R. A. W. (1997) *Understanding Governance: Policy Network, Governance, Reflexivity, and Accountability*. Buckingham: Open University Press.

Riccucci, N. M. (2005) *How Management Matters: Street-Level Bureaucrats and Welfare Reform*. Washington, DC: Georgetown University Press.

Roberts A, Marshall, L., and Charlesworth, A. (2012) *A Decade of Austerity? The Funding Pressures Facing the NHS from 2010/11 to 2021/22*. London: Nuffield Trust.

Robertson, R., Holder, H., Ross, S., Naylor, C.and Machaqueiro, S. (2016) *Clinical Commissioning: GPs in Charge?.* London: The King's Fund and Nuffield Trust.

Sabatier, P. A. (1986) 'Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis', *Journal of public Policy*, 6(1), 21-48.

Sabatier, P. and Mazmanian, D. (1980) 'The implementation of public policy: A framework of analysis', *Policy Studies Journal*, 8(special issue), 538-560.

Sager, F., Thomann, E., Zollinger, C., van der Heiden, N. and Mavrot, C. (2014) 'Street-level bureaucrats and new modes of governance: How conflicting roles affect the implementation of the Swiss Ordinance on Veterinary Medicinal Products', *Public Management review,* 16(4), 481-502.

Salter, B. (1998) *The Politics of Change in the Health Service*. Basingstoke: Palgrave Macmillan.

Saltman, R. (2003) 'Melting public-private boundaries in European health systems', *European Journal of Public Health*, 13(1), 24-29.

Saltman, R. B. and van Otter, C. (1992) *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems*. Buckingham: Open University Press.

Sanderson, M., Allen, P. and Osipovic, D. (2016) 'The regulation of competition in the National Health Service (NHS): What difference has the Health and Social Care Act 2012 made?', *Health Economics, Policy and Law*, 12(1), 1-19.

Savas, E. S. (1989) 'A taxonomy of privatization strategies', *Policy Studies Journal*, 18(2), 343-355.

Scharpf, F. W. (1978) 'Interorganisational policy studies: issues, concepts and perspectives', in K. I. Hanf and F. W. Scharpf (eds), *Interorganisational Policy Making: Limits to Coordination and Central Control*. London: Sage, 345-370.

Schofield, J. (2001) 'Time for a revival? Public policy implementation: a review of the literature and an agenda for future research', *International Journal of Management Reviews*, 3(3), 245-263.

Scott, W. R. (2014) *Institutions and Organisations: Ideas, Interests and Identities*, 4th ed. Los Angeles, California: SAGE.

Secker, J., Wimbush, E., Watson, J. and Milburn, K. (1995) 'Qualitative methods in health promotion research: Some criteria for quality', *Health Education Journal*, 54, 74-87.

Seldon, A. and Snowdon, P. (2016) *Cameron at 10: the Verdict*. London: Willian Collins.

Selznick, P. (1949) *TVA and the Grass Roots*. Berkeley: University of California Press.

Sharkansky, I and Friedberg, A. (1998) 'Ambiguities in policymaking and administration: A typology', *International Journal of Organization Theory & Behavior*, 1(1), 1-16.

Sheaff, R. and Allen, P. (2016) 'Provider plurality and supply-side reform', in M.

Exworthy, R. Mannion, and M. Powell (eds.). *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol: Policy Press.

Sheaff, R., Charles, N., Mahon, A., Chambers, N., Morando, V., Exworthy, M., Byng, R., Mannion, R., and Llewellyn, S. (2015) 'NHS commissioning practice and health system governance: a mixed-methods realistic evaluation', *Health Service Delivery Research*, 3(10).

Simonet, D. (2015) 'The New Public Management theory in the British health care system: A critical review', *Administration & Society*, 47(7), 802-826.

Sikula, A. F. (1973) 'The values and value system of governmental executives', *Public Personnel Management*, 16-28.

Smith, M. J. (2010) 'From big government to big society: Changing the state-society balance', *Parliamentary Affairs*, 63(4), 818-833.

Smith, M. J., Richards, D., Geddes, A. and Mathers, H. (2011) 'Analysing policy delivery in the United Kingdom: the case of street crime and anti-social behaviours', *Public Administration*, 89(3), 975-1000.

Smith, N., Mitton, C., Davidson, A. and Williams, I. (2014) 'A politics of priority setting: Ideas, interests and institutions in healthcare resource allocation', *Public Policy and Administration*, 29(4), 331-347.

Snell, E. H. (1929) 'The Local Government Act, 1929, from a medical point of view', *The BMJ*, 16(2), 221-223.

Solar, C. and Smith, M. (2020) 'Austerity and governance: coordination policing and mental health policy in the UK', *Policy Studies*.

Speed, E. and Gabe, J. (2013) 'The Health and Social Care Act for England 2012: The extension of new professionalism', *Critical Social Policy*, 33(3), 564-574.

Springer, S., Birch, K. and MacLeavy, J. (2016) *The Handbook of Neoliberalism*. New York; London: Routledge.

Stewart, J. (2017) 'The birth of the NHS: Why wasn't it local government?', in H. Quilter-Pinner and M. Gorsky (eds.), *Devo-then, Devo-now: What can the History of the NHS Tell us about Localism and Devolution in Health and Care*. London: Institute for Public Policy Research, pp. 7-9.

Stewart, J. and Walsh K. (1992) 'Change in the management of public services', *Public Administration*, 70(4), 499-518.

Stoker, R. P. (1991) *Reluctant Partners: Implementing Federal Policy*. Pittsburgh, PA: University of Pittsburgh Press.

Stoye, G. (2017) *UK Health Spending. IFS Briefing Note BN201*. London: The Institute for Fiscal Studies.

Sturgeon, D. (2014) 'The business of the NHS: the rise and rise of consumer culture and commodification in the provision of healthcare services', *Critical Social Policy*, 34(3), 405-416.

Sullivan, M. (1999) 'Democratic socialism and social policy', in R. M. Page and R. Silburn (eds), *British Social Welfare in the Twentieth Century*. Basingstoke: Macmillan, pp. 105-130.

Sylvester, R. K. and Ferrara, J. A. (2003) 'Conflict and ambiguity: Implementing evolutionary acquisition', *Acquisition Review Quarterly*, Winter(2003), 1-27.

Syrett, K. (2010) 'Mixing private and public treatment in the UK's National Health Service: A challenge to core constitutional principles?', *European Journal of Health Law*, 17(3), 235-255.

Taylor-Gooby, P. (1995) 'Comfortable, marginal and excluded: Who should pay higher taxes for a better welfare state?', in R. Jowell, J. Curtice, A. Park, L. Brook and D. Ahrendt (eds), *British Social Attitudes, The 12th Report.* Aldershot: Dartmouth, pp.1-17.

Taylor-Gooby, P. and Stoker, G. (2011) 'The coalition programme: A new vision for Britain or politics as usual?', *The Political Quarterly*, 82(1), 4-15.

Taylor-Gooby, P. (2012) 'Root and branch restructuring to achieve major cuts: The social policy programme of the 2010 UK Coalition Government', *Social Policy & Administration*, 46(1), 61-82.

Taylor-Goodby, P. (2013) *The Double Crisis of the Welfare State and What We can Do about It*. Basingstoke: Palgrave Macmillan.

Taylor, K., Zarb, S. and Jeschke, N. (2021) 'Ambiguity, uncertainty and implementation', *International Review of Public Policy*, 3(1), 1-26.

Teodoro, M. P. (2014) 'When professionals lead: Executive management, normative isomorphism, and policy implementation', *Journal of Public Administration Research and Theory*, 24, 983-1004.

Tuohy, C. H. (1999) *Accidental Logics: The Dynamics of Change in the Health Care Area in the United States, Britain, and Canada*. New York and Oxford: Oxford University Press.

Thatcher, M. (1993) *The Downing Street Years*. London: HarperCollins.

The BMJ. (2011) *Reaction: What They Say about the Health Bill.* [Online]. Available at: https://www.bmj.com/content/342/bmj.d413.full. [Accessed 20 January 2011].

The Health Foundation. (2011) *Evidence Scan: Competition in Healthcare*. London: The Health Foundation.

The King's Fund. (2015) *Is the NHS Heading for Financial Crisis? Part of the King's Fund Verdict.* [Online]. Available at: https://www.kingsfund.org.uk/projects/verdict/nhs-heading-financial-crisis.

The King's Fund. (2021). *Is the NHS being privatised?* [Online]. Available at: https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised. [Accessed 1 March 2021].

Timmins, N. (2012) *Never again? The Story of the Health and Social Care Act 2012: A Study in Coalition Government and Policy Making*. London: The Institution for Government and the King's Fund.

Timmins, N. (2013) *The Four UK Health Systems: Learning from Each Other*. London: The King's Fund.

Timmins, N. (2018) *'The World's Biggest Quango': The First Five Years of NHS England*. London: The Institute for Government and The King's Fund.

Titmuss, R. M. (2018) *Essays on the Welfare State*. Bristol: Policy Press.

Tummers, L. (2011) 'Explaining the willingness of public professionals to implement new policies: A policy alienation framework', *International Review of*

Administrative Science, 77(3), 555-581.

Tummers, L. (2012) *Policy Alienation: Analyzing the Experiences of Public Professionals with New Policies*. Rotterdam: Optima Grafische Communicatie.

Tummers, L., Steijn, B. and Bekkers, V. (2012) 'Explaining the willingness of public professionals to implement public policies: Content, context, and personality characteristics', *Public Administration*, 90(3), 716-736.

Travis, A. (2016) 'Thatcher pushed for breakup of welfare state despite NHS pledge', *The Guardian*. [Online]. Available at: https://www.theguardian.com/politics/2016/nov/25/margaret-thatcher-pushed-for-breakup-of-welfare-state-despite-nhs-pledge. [Accessed 25 November 2016].

Triggle, N. (2011) 'PM seeks to allay fears, but insists change is needed', *BBC News*. [Online] Available at: https://www.bbc.co.uk/news/health-12981370. [Accessed 6 April 2011].

Triggle, N. (2012) 'NHS plans: Unions move to 'outright opposition', *BBC News*. [Online]. Available at: https://www.bbc.co.uk/news/health-16618207. [Accessed 19 January 2012].

Tritter, J., Koivusalo, M., Ollila, E., and Dorfman, P. (2012) *Globalisation, Markets and Healthcare Policy: Redrawing the Patients as Consumer*. New York: Routledge.

Van Meter, D. and Van Horn, C. E. (1975) 'The policy implementation process: A conceptual framework', *Administration and Society*, 6(4), 445-488.

Veronesi, G., Kirkpatrick, I., and Altanlar, A. (2019) 'Are public sector managers a "bureaucratic burden"? The case of English public hospitals', *Journal of Public*

Administration Research and Theory, 2019, 29(2), 193-209.

Vizard, P. and Obolenskaya, P. (2015) 'The coalition's records on health: Policy, spending and outcomes 2010-2015', *Social Policy in a Cold Climate Working Paper 16*. London: LSE.

Vize, R. (2014) 'Simon Stevens sets out vision for radical NHS change and innovation', *The Guardian*. [Online]. Available at: https://www.theguardian.com/healthcare-network/2014/apr/03/simon-stevens-vision-nhs-change. [Accessed 3 April 2014].

Vize, R. (2016) 'Patients with long-term conditions need a jointed-up NHS', *The Guardian*. [Online]. Available at: https://www.theguardian.com/healthcare-network/2016/feb/05/patients-long-term-conditions-need-joined-up-nhs. [Accessed 5 February 2016].

Walker, R. M., Brewer, G. A., Boyne, G. A. and Avellaneda, C. N. (2011) 'Market orientation and public service performance: New public management gone mad?', *Public Administration Review*, 71(5), 707-717.

Walsh, J. I. (2000) 'When do ideas matter? Explaining the successes and failures of Thatcherite ideas', *Comparative Political Studies*, 33(4), 483-516.

Watt, N. (2000) 'Blair's £12bn pledge to NHS', *The Guardian*. [Online]. Available at: https://www.theguardian.com/society/2000/jan/17/futureofthenhs.health1. [Accessed 17 January 2000].

Watt, N. (2011) 'Andrew Lansley and Norman Lamb in fight to the death over NHS reforms', *The Guardian*. [Online]. Available at: https://www.theguardian.com/politics/wintour-and-

watt/2011/apr/11/andrewlansley-nhs. [Accessed 11 April 2011].

Weissert, C. S. (2001) 'Reluctant partners: The role of preferences, incentives, and monitoring in program compliance', *Journal of Public Administration Research and Theory*, 11, 435-453.

Wilding, P. (1997) 'The welfare state and the Conservatives', *Political studies*, XLV, 716-726.

Wise, J. (2011) 'Commissioning will cost £1.3bn less every year under GP consortiums, says Lansley', *The BMJ*. [Online]. Available at: https://www.bmj.com/content/342/bmj.d418. [Accessed 20 January 2011].

Wright, A., Cornick, E., Jones, H., Marshall, L. and Roberts, A. (2017) *Towards an Effective NHS Payment System: Eight Principles.* London: The Health Foundation.

Yin, R. K. (2014) *Case Study Research: Design and Methods*. Los Angeles: SAGE.

Young, S. (1986) 'The nature of privatisation in Britain, 1979-85', *Western European Politics*, 9(2), 235-252.

Zahariadis, N. (2008) 'Ambiguity and choice in European public policy', *Journal of European Public Policy*, 15(4), 514-530.