

**INTERROGATING INSTITUTIONAL CHANGE: ACTORS' ATTITUDES TO
COMPETITION AND COOPERATION IN COMMISSIONING HEALTH SERVICES IN
ENGLAND**

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ABSTRACT

Since the beginning of the 1990s the public health care system in England has been subject to reforms. This has resulted in a structurally hybrid system of public service with elements of the market. Utilising a theory of new institutionalism this paper explores National Health Service (NHS) managers' views on competition and cooperation as mechanisms for commissioning health services. We interrogate the extent of institutional change in the NHS by examining managers' understanding of the formal rules, normative positions and frameworks for action under the regime of the Health and Social Care Act 2012. Interviews with managers showed an overall preference for cooperative approaches, but also evidence of marketisation in the normative outlook and actions. This suggests that hybridity in the NHS has already spread from structure and rules to other institutional pillars. The study showed that managers were adept at navigating the complex policy environment despite its inherent contradictions.

Keywords: new institutionalism, institutional change, competition, cooperation, NHS

INTRODUCTION

Studying the process of institutional change is one of the core preoccupations of scholars of public administration. Such processes are often elusive and their consequences are hard to predict. This paper explores the process of institutional change by analysing different actors' views of the regulatory structures which guide commissioning of health care in the quasi-market of the English National Health Service (NHS) under the regime of the Health and Social Care Act 2012 (HSCA 2012).

The efforts to instigate institutional change towards greater marketisation of the English NHS date back to the beginning of 1990s when the hitherto unified local health authorities were split into state-owned purchasing organisations (or commissioners) acting on behalf of patients and state-owned

providers of healthcare for local populations (DH 1989; Paton 2014). Since then successive UK governments have enhanced elements of competition by introducing policies designed to increase diversity of organisational types of providers, allowing patient choice and commercialising the terms of procurement and contracting within the English NHS (DH 2005). Most recent reforms to the English NHS contained in the HSCA 2012 reinforced this direction of change by introducing formal legislation encouraging competition between providers. Overall, the process of institutional change has resulted in hybridisation of the NHS and utilisation of the market alongside the pre-existing political hierarchy as modes of social control (Allen et al. 2011).

Health care is not the only public service sector that has experienced a shift towards marketisation in the UK since the 1980s. There has been a somewhat unreflective extension of the notion of consumer choice taken from private sector to social housing and education, despite big differences in the type of constraints characterising the quasi-markets in each field (Greener and Powell 2009). On the supply side, the provision of many public services has been supplemented by or outsourced outright to private and third sector organisations, for example in education (Goodman and Burton 2012) or ‘welfare to work’ support (Rees et al. 2014).

As a result of 25 years of market reforms, the NHS in England constitutes a structural hybrid featuring quasi-market structures, private and third sector providers, market regulators and some (albeit limited) consumer/patient choice (see e.g. Allen et al. 2011). However, the extent to which the encroaching marketisation has permeated mind sets and practices of NHS managers and clinical staff is debatable (Checkland et al. 2012; Mannion et al. 2009). This paper provides new empirical insights on this matter.

The study reported here examined how managers in commissioning and providing organisations related to and dealt with the marketisation of NHS structures. The purpose of this paper is to report and analyse NHS managers’ attitudes to competition and cooperation in the NHS under the regime of the HSCA 2012. By analysing managers’ understanding of the rules, normative views and actions in respect of the mechanisms of competition and cooperation in the NHS, we interrogate the process of

institutional change itself, together with the extent to which marketisation has become an internalised feature of commissioning practices. We find signs of marketisation in the norms and cognitive frameworks employed by some NHS managers. However rather than a wholesale market turn, they reflect creative incorporation of some market principles into everyday commissioning practices mostly favouring collaborative working.

We view the HSCA 2012 as one event among many along the continuum of institutional change put in motion by the introduction of quasi-market at the beginning of the 1990s. Whilst adhering analytically to the *longue durée* perspective, in this paper we assess the role of the HSCA 2012 in the process of marketisation of the NHS as the most recent and controversial event (see e.g. Reynolds et al. 2012).

We used a case study design selecting four local health economies in England. In each site we investigated the views on competition and cooperation of senior managers in both providing and commissioning organisations. Arguably, focusing on managers as ‘street level bureaucrats’ is key to detecting any ‘real’ institutional shifts in the NHS (Pettigrew et al. 1988). This is because they hold the power of either translating structural changes into practices or hampering such processes. We looked for signs of hybridity in their normative outlook and agentic dispositions, and explored how individual actors within organisations in different local contexts dealt with the structural hybridity of the NHS. By focusing attention on the level of individuals within the organisations the study contributes to the literature on diversity of normative and agentic responses to structural hybridity (e.g. Denis et al. 2015; Skelcher and Smith 2015; Waring 2015). The paper also addresses the currently under-researched empirical question concerning the extent to which hybridity occurs at different levels of analysis and in different institutional dimensions (Denis et al. 2015).

NEW INSTITUTIONALIST PERSPECTIVE ON HYBRIDISATION OF THE NHS

We chose Scott’s (2008) approach to new institutionalism to ground our analysis. Scott (2008: 48) views institutions as relatively resistant to change and “comprised of regulative, normative and cultural-cognitive elements that, together with associated activities and resources, provide stability

and meaning to social life.” According to Scott the three institutional pillars both enable and constrain actors’ behaviour in distinctive ways. The regulative pillar refers to practices of rule-setting, monitoring, sanctioning and incentivising and encompasses a continuum from formal legislation to less formal rule making. The normative pillar includes both values – “conceptions of the preferred or the desirable” (Scott 2008: 54) and norms – the scripts outlining desirable goals and legitimate means of attaining them in the agentic pursuit of the elusive ‘what ought to be’. Finally, the cultural-cognitive institutional pillar refers to the intersubjective processes and frameworks which enable sense making at the junction where the individual meets “external world of stimuli” (Scott 2008: 57).

The robustness of an institution is strengthened when its three pillars – rules, norms and cognitive frameworks – work in harmony and reinforce each other. The institutional pillars may become misaligned when they “support and motivate differing choices and behaviours” of individuals and organisations (Scott 2008: 62). Each relationship between any two pillars can be characterised by alignment or misalignment creating a complex interplay between three pillars in a given case. Yet according to Scott (2008) even in cases of misalignment between pillars, the institutions have a natural tendency towards convergence, or internal consistency, over time. For instance, the weaknesses in regulative pillar such as ambiguous rules or ineffective sanctioning, instead of undermining the institution, may lead to interpretative searching for meaning to inform conduct, thus activating normative and cognitive elements which in turn maintain the stability of the institution (Scott 2008: 54). In short, “institutions supported by one pillar may, as time passes and circumstances change, be sustained by different pillars” (Scott 2008: 54).

Yet at the same time, Scott concedes that in some circumstances the misalignment between different institutional pillars (e.g. between normative and regulative or between regulative and cognitive) may result in institutional change or deinstitutionalisation, a process which may be sparked by weak laws, fragmentation of normative consensus, questioning of taken for granted assumptions or presence of competing institutional frameworks (Scott 2008). The process of deinstitutionalisation of existing forms is followed by a process of institutionalisation of new arrangements (Scott 2008). In this sense classic new institutional theory is sceptical about the ability of misaligned pillars to co-exist in the

long-term, treating them instead as catalysts for change or accommodation resulting in the domination of one logic.

The phenomenon of misalignment between institutional pillars is akin to what other scholars have termed hybridisation of institutions, and which we see as a process of being imbued with, and operating under, conflicting principles or institutional frameworks. However, it has been shown that the concept of hybridisation itself is elusive and suffers from low explanatory power (Skelcher 2012). In each instance of ‘hybridisation’, spelling out the underlying phenomena and levels of analysis is required. For instance, Denis et al. (2015: 274) advocate studying hybridity at “multiple levels” going beyond the traditional focus on structure and governance. Despite such conceptual caveats, the phenomena underpinning ‘hybridisation’, such as “existence of plural normative frames (logics)” and multiple actor identities, have become common in many modern institutions (Skelcher and Smith 2015: 12; Skelcher 2012).

The process of structural hybridisation of the NHS has been progressing gradually over the last 25 years through changes in the regulative pillar to enable operation of the quasi-market for clinical services. Policy makers saw value in market competition to drive up quality, efficiency and outcomes of clinical services. Using Scott’s (2008: 132-133) terms, the NHS has been on a receiving end of ‘diffusion’ of neoliberal market logic implemented by successive UK governments. What remains unclear is the extent to which NHS professionals share the normative conviction about the benefits of market mechanisms for the NHS, or whether their shared frameworks for everyday practices have changed as a result of structural hybridisation.

Checkland and colleagues (2012), utilising theories of new institutionalism, identified a lack of fit between the norms permeating the NHS, such as the focus on individual patients and seeing the NHS as a common enterprise, and the formal rules of commissioning pushing for greater marketisation of relationships between different actors within the health system. This suggests that hybridity instigated by marketisation of the NHS is present only at the level of structures whilst norms governing actors’ behaviour remain relatively unaffected. However, the authors point out that normative shifts may

occur in the future if market principles become more embedded in NHS culture. Other empirical studies find that hybridisation has already permeated the norms and culture of the NHS. For instance, Mannion and colleague (2009) found that the ‘clan’ culture bonded by loyalty and tradition, hitherto the most common type of managerial culture within the NHS organisations, has been overtaken by a ‘rational’ organisational culture bonded by competition and emphasis on winning market share.

In line with Scott’s (2008) theoretical framework, one can envisage two types of organisational responses to changes in the NHS regulative pillar. The actors may appropriate such misalignment cognitively, mostly relying on organisational inertia and diverging in their responses. Alternatively, the misalignment may set in motion full scale institutional change characterised by adjustments in cognitive and especially normative pillars.

FORMS OF COMPETITION AND COOPERATION IN THE NHS

In order to assess the extent of shift towards marketisation in the normative and cognitive dimensions of the NHS we explored managers’ views on competition and cooperation in commissioning practices. Competition and cooperation are the two fundamental mechanisms of service procurement in the NHS and represent the tools for ‘getting things done’. Cooperation is closely related to co-ordination through hierarchies, as opposed to markets, where competition is paramount. Thus, they are also associated with the two contrasting institutional logics of market and hierarchy. A mix of competitive and cooperative pressures is one of the core characteristics of the hybrid arrangements, which sit between market and hierarchy (Ménard 2004).

Competition in the NHS is realised through several models. Competition *for* the market is a result of tendering processes whereby different providers compete to deliver a particular service. Competition *within* the market exists when a number of providers are accredited to provide a particular service and they compete to attract as many patients as possible. Examples of the former include tendering out of community health services, and the latter include the Any Qualified Provider (AQP) model of contracting and patient choice of elective secondary care.

Cooperation in the NHS is harder to define. There is a number of closely related terms such as collaboration, coordination, integrated care, networking and partnership. Integrated care implies the coordination of separate but interconnected components which should function together to perform a shared task (Kodner and Spreeuwenberg 2002). Cooperation can take place at a service, organisational or clinical level (Fulop et al. 2005). It can occur horizontally between providers of similar services, or vertically between different sectors (e.g. primary and secondary care). It also may include the process of planning necessary for ensuring efficient and comprehensive delivery of health care services. Commissioners are engaged in planning and monitoring provision of health care services. They need cooperation from providers in order to fulfil these tasks successfully. Thus commissioners have the dual objective of promoting cooperation between different providers in terms of clinical service delivery and fostering cooperation between providers and commissioners themselves for the purposes of strategic planning and ongoing monitoring of service provision.

THE REGULATIVE PILLAR OF THE NHS - RULES, REGULATORS AND HIERARCHY

Formal rules guiding the implementation of the principles of competition and cooperation in commissioning health care services in the English NHS are complex and difficult to interpret. Although the rules about the use of competition in procurement and ensuring patient choice were in place prior to the HSCA 2012, the Act which came into force in April 2013 gave them statutory force (Sanderson et al. 2016).

The Statutory Regulations that accompanied the Act state that commissioners have a duty to follow transparent procurement processes and to promote patient choice (SI 2013). Commissioners and providers are also prohibited from reaching agreements which restrict patient choice. The benefits of any potential mergers between providers have to outweigh the loss of competition and patient choice. Cooperation and integration is also envisaged in the Act.

Under the HSCA 2012, Monitor (as the new economic regulator) has been given the most prominent role in interpreting the legal principles and advising the NHS on what behaviours are acceptable in terms of competition and cooperation (Monitor 2014; Monitor 2015a).

Monitor (2015b) maintains that delivering integrated care and complying with competition conditions are not mutually exclusive. It states that it is possible to design models of care that “give patients a choice of a provider, deliver care to individual patients in an integrated way, and enable competition between providers to provide services” (Monitor 2015b). However, it is the role of NHS commissioners, including local Clinical Commissioning Groups (CCGs) led by General Practitioners, to ensure that the appropriate levels of competition and cooperation exist in their local health economies (HSCA 2012).

When the HSCA 2012 came into force there was lack of clarity as to what these legislative changes mean for services on the ground. The rules were being interpreted on a case by case basis and regulators were vacillating between giving greater weight to competition and favouring cooperation.¹

Regulators are not the only actors influencing competition and cooperation in the NHS. The NHS is a hierarchical organisation with top down budget allocations and bottom up accountability flows.

Despite the recent restructuring of commissioning functions, the hierarchical structure remains. Local commissioners need to justify their decisions to NHS England, which has overall commissioning oversight, which in turn is accountable to the Department of Health (Checkland et al. 2013).

Similarly, policy guidance filters down the organisational hierarchy which can, depending on local circumstances, increase or decrease the urgency of certain messages before they reach local commissioners.

Arguably the complexity introduced by the HSCA 2012 and subsequent guidance lies in the fact that cooperation and competition in the NHS can be understood both as means to achieve other policy objectives and as policy objectives in themselves. To complicate matters further, competition may serve as a tool for attaining greater cooperation and vice versa. For instance, commissioners may decide to follow a competitive procurement process to increase service integration. On the other hand, a situation may arise when cooperation may facilitate increased diversity of provision, as in case when

¹ For more details on the impact of the regulatory regime following the HSCA 2012 see Sanderson et al. (2016).

NHS providers have to cooperate with new market entrants in order to maintain care pathways for patients.

STUDY DESIGN AND METHODS

In order to investigate how commissioners and providers dealt with the challenges of competition and cooperation in their local health care systems we selected four CCG areas across England. These constituted four case studies. The case study method enabled us to carry out an in-depth study of policy processes and their embeddedness in “real-life” contextual conditions (Yin 2009: 18). Case study sites comprised a mix of rural and urban health economies and were located in the North (CCG1, CCG3), Midlands (CCG2) and London (CCG4). Before commencing the field work we obtained university research ethics and NHS research governance approvals, as well as research permissions from each participating organisation. Between August 2013 and June 2014 we carried out thirty-three interviews with senior commissioners (13) and provider managers (20), including five with independent providers. All but one interviewed commissioner were senior level managers. Similarly, the majority of interviewed provider managers did not have a clinical background.

Participants were asked about their understanding of policy and regulations regarding the use of competition and cooperation in commissioning NHS services. Commissioners were also asked about their actual use of competition and cooperation in managing the local health care system. Providers were asked about their experiences of competition and cooperation in the NHS.

The interviews were audio recorded and transcribed. Three authors agreed a thematic coding framework derived from the research questions, the literature on competition and cooperation, and the data. The major themes covered the understanding of policy set up including incentives to cooperate and compete, views on sector regulators, impact of the HSCA 2012 and the amount of local discretion; personal views on the role of competition and cooperation in the NHS system; and specific examples of competition and cooperation in the local context including the different rationales that led managers to adopt a particular solution in a particular case. The interviews were uploaded to NVivo and coded using the agreed coding framework by two authors who each coded half of the interviews.

The coding authors met periodically to check whether the coding framework was working well and to agree any necessary modifications.

We obtained in-depth data on actors' understandings of formal rules, their personal normative views about the role of competition and cooperation in the NHS and the ways of dealing with day-to-day commissioning dilemmas that the co-existence of principles of competition and cooperation posed. This dovetailed with the Scott's (2008) tripartite analytical framework applicable to institutions. We used the framework to check whether our data showed any signs of hybridisation/marketisation in the normative and cultural-cognitive institutional pillars.

SOURCES OF VARIATION BETWEEN PARTICIPANTS

In the course of the fieldwork we observed some important variations between participating organisations. On the commissioning side, the case study sites varied in terms of the actual usage of competitive mechanisms in commissioning local services. No case study site utilised competition for major service reconfiguration, but all sites put out to tender at least one service as a result of a decision taken locally. In particular, commissioners in two sites (CCG2 and CCG4) had substantial experience of utilising competitive tendering, whilst CCG1 and CCG3 had very limited experience.

In turn, providers faced different external pressures depending on the type of services they provided (acute hospital, community, mental health) and the type of pricing mechanism to which they were subject (cost per case or fixed budget). In particular, acute providers were more affected by competition *within* the market than *for* the market. In contrast, community and mental health providers were facing a prospect of their core services being subject to the competition *for* the market instigated by the commissioners. Some providers worked across a number of different CCGs and contracted with a series of different commissioning bodies, such as local authorities. This led to the providers encountering different commissioning styles. Private providers represented a different institutional paradigm focused on profit and rewards for shareholders, and they faced different

challenges than NHS providers.² Overall, individual participants reflected on the role of competition and cooperation from their unique perspectives and spoke about issues that were especially important to them as actors in the system. Yet despite such differences many views on competition and cooperation were shared by both commissioners and providers.

UNDERSTANDING OF FORMAL RULES

The structural hybridity of the NHS, taken here as a starting point, is epitomised in its regulative pillar discussed above. Rules are important as they constrain and enable actors' behaviour. Yet as Scott (2008: 54) concedes, in reality formal laws are sometimes ambiguous and "do not provide clear prescriptions for conduct." Thus the rules have an impact on actors' behaviour only after passing through the cognitive filter of an individual's interpretation. In that sense, understanding of the rules crosscuts both regulative and cultural-cognitive institutional pillars.

Ideally, a shared understanding of the 'rules of the game' is necessary to ensure a level playing field and procedural fairness. In this study, conducted under the regime of HSCA 2012, we did not find a shared understanding of the rules. Instead, we uncovered a widespread confusion about the rules on competition in the NHS. Most participants understood that not every clinical service had to be tendered but there was a requirement to justify why competitive procurement was not used. It was much harder to pinpoint when tendering ought to be conducted and why. Some commissioners thought that the decision to use tendering or not depended on whether the service was "extremely specialised" and could be provided only by a certain provider (Commissioner 4, CCG1, April 2014). Another commissioner (Commissioner 6, CCG1, November 2013) made a distinction between the expansion of existing services with good outcomes which, in their opinion, could bypass the requirement to procure; and setting up new services with new specifications, which ought to go to full tender.

² In our conceptual framework private providers represent one of the signs of structural hybridity of the NHS. As such, the detailed analysis of their views falls outside of the scope of this paper. We report some private providers' views merely to contrast and compare with NHS managers.

We don't have to tender all services, there are exceptions. But I think the default position is that we are expected to tender services, as a generality. So we have to, I think, the expectation is that you will explain why you haven't (Commissioner 1, CCG2, November 2013)

Some providers admitted not being able to keep up with the “dynamic” nature of the rules, and the lack of “nice neat answers” (Provider 1, NHS, acute, CCG1, April 2014). Their approach was to make judgements on a case by case basis by consulting most up to date guidance and taking legal advice. Providers noted that different commissioners interpreted the rules in different ways. This heightened anxiety on the part of commissioners about potential formal challenges from providers.

Regulators were not helpful in clarifying the rules. They were not prepared “to put a line in the sand for something and say, this is our stance” (Commissioner 5, CCG1, April 2014). Whilst NHS commissioners were concerned about being challenged by Monitor for not following the competitive tendering route, one private provider also complained about a perceived lack of readiness on the part of the regulator to support competition. Overall, a sense of confusion and loss of direction prevailed amongst commissioners and providers.

There's no clear framework, so people have got misconceptions (...) there's a huge misinterpretation, misconception, and I think what would really help would be some very clear guidance on what this is really all about, rather than it all being a bit cloak and dagger.
(Provider 2, NHS, community and mental health, CCG3, November 2013)

At the same time, some commissioners observed that the lack of clear top down guidance with regards to competitive tendering may be beneficial, as it allowed for local discretion. This can be contrasted with other policies on competition, such as AQP, over which they had little or no discretion. AQP policy mandated commissioners to open a number of community services to non NHS providers to stimulate competition *within* the market (Jones and Mays 2013). Although seen as a prescriptive policy, at the time of the fieldwork the pressure on commissioners to use AQP had eased. This shows

the fast changing stream of policy messages in the NHS whereby even those aspects of policy seen as coercive for a period of time can wane in national importance.

Similarly, during the fieldwork some participants began to note a ‘watering down’ of the imperative to increase the levels of tendering and competition. Arguably, a change in the tone of policy discourse could be noted in the aftermath of the rejection of the proposed merger of two hospitals in Dorset in October 2013, which forced Monitor to reassess the way the merger review process was being handled by the competition authorities (Competition Commission 2013; see also Sanderson et al. 2016). This merger rejection raised concerns among many that the competition regulations were detrimental to attempts to produce desirable reconfiguration of services.

My understanding is that it's now less of a requirement than it used to be ... you have to show ... value, which doesn't necessarily mean that you have to put everything out to competition.

(Provider 1, NHS, community and/or mental health CCG4, January 2014)

According to participants, the HSCA 2012 did not have much impact on how they thought about procuring services, as the rules requiring them to consider competitive procurement were in place prior to the Act. As one commissioner put it “*it was happening anyway, (...) the thought processes we go through have not changed for the last two or three years*” (Commissioner 1, CCG3, August 2013). The provisions of the HSCA 2012 legitimised further the use of competition to procure clinical services. In that sense the HSCA 2012 was seen as another step in a long process of marketisation of the NHS which commenced over twenty five years ago. The main impact of the Act was observed in changing commissioning structures and fragmenting commissioning functions (between CCGs, NHS England and local authorities), making the system more complex. As a result of such fragmentation the HSCA 2012 was perceived as unhelpful in enabling cooperation across local health systems by some interviewees.

The process of marketisation of the NHS, reinforced by the HSCA 2012, resulted in competitive procurement being promoted as a legitimate tool of commissioning on a par with collaborative approaches. Yet the co-existence of commensurate but contrasting principles of competition and

cooperation created a sense of confusion amongst interviewees as to the overall policy direction and the general premise of the NHS commissioning system. One participant noted a “lack of clarity about the role of the market” in the NHS (Provider 2, NHS, acute, CCG2, March 2014). In their opinion it was difficult to pinpoint a consistent policy direction in this respect.

It's almost like half the system wants there to be competition and half the system doesn't want it to be, and we're stuck in the middle, working out what we do and don't want.

(Commissioner 3, CCG1, April 2014)

Overall, commissioners and providers (including independent providers) found the rules confusing, hard to follow and potentially contradictory. Instead of a shared understanding of the rules, there was a shared sense of confusion, leading to divergent interpretations and organisational responses. The sense of a lack of clear policy direction and changing policy emphasis were also noted during the period of the fieldwork.

NORMATIVE VIEWS

Similar to rules, norms and values have an impact on actors' behaviour. Whereas rules may undergo quick changes, norms tend to be internalised in the socialisation process and are more resistant to change (Scott 2008). In the functionalist tradition, shared norms and common values ensure stability of social order by legitimising behaviour which is consistent with normative expectations ascribed to social roles (Parsons 1951). The NHS normative platform rests on the principles of universal care, free at the point of delivery, as well as on viewing different providers of care as a community of organisations sharing the belief in these fundamental principles and putting them above any other interests (Checkland et al. 2012). As shifts in a normative pillar are crucial indicators of embedded institutional change (see e.g. Caronna 2004), it is important to examine the normative element of the NHS health care system to ascertain to what extent the logic of marketisation permeated the system. We uncovered a whole spectrum of normative opinions about the place of competition and cooperation in the NHS. These ranged from great criticism of competition to approval of competition,

if treated as one of the tools at commissioners' disposal to achieve certain desirable aims, rather than as a policy mandate.

Some providers claimed that competition was unsuitable in the NHS as it inevitably led to fragmentation of services and adversely affected interdependent services.

I think [competition] is inappropriate in the Health Service and I think there are too many interdependencies in the Health Service. So the minute you start leasing a bit out somewhere else then you don't think about the impact that has on all the other bits, or the whole and that increases costs. (Provider 3, NHS, acute, CCG4, March 2014)

Yet some commissioners were more open to the idea of competition, provided competitive procurement was not imposed.

As a commissioner you've got to have a variety of tools in the toolbox, competitive procurement is one of them ... you certainly don't want to rule out whole areas and say: "Well you can't collaborate" or "You have to competitively procure" or "You must use AQP". All you're doing ... is shooting yourself in the foot. So I think you keep as many options as you can. (Commissioner 1, CCG2, November 2013)

Some providers and commissioners saw potential benefits of transplanting some private sector principles to the NHS in order to increase efficiency, reduce costs and foster innovation, provided it was done in a carefully managed way. Another provider also called for a rebalancing of the negative attitudes towards competition as organisations were required by law to be mindful of both competition and cooperation, signalling a conformist stance. Not surprisingly, independent providers were enthusiastic about the place of competition in the NHS, emphasising the benefits of competition and private sector culture in terms of increasing efficiency, flexibility, innovation and streamlining services.

Despite such views, there was an overall preference for a collaborative service development approach between commissioners and providers. Furthermore, participants noted that cooperation between

different actors in the system was essential for long term service reconfiguration projects such as shifting care out of acute settings into the community. Providers also reflected on the long history of cooperation in the NHS especially with regards to clinical pathways. All in all, tendering was often portrayed as a last resort option and not (yet) part of NHS culture. One commissioner noted it would take time and a cultural change for NHS commissioners to embrace tendering as “customary practice” (Commissioner 1, CCG4, November 2013).

It was difficult to pinpoint any clear differences between the four case study sites in terms of their respondents’ normative outlook towards competition and cooperation. As we noted, commissioners located in the North (CCG1, CCG3) had less experience in utilising competition for commissioning services than those based in London (CCG4) and the Midlands (CCG2). The latter also spoke more favourably about the competition as a useful principle, which indicated a shift in their normative outlook.

However, this finding did not extend to providers. In contrast to local commissioners, providers faced a more varied landscape having to deal with different commissioning bodies at the same time. The fact that two sites (CCG4 and CCG2) had greater experience of competition did not seem to warm their local providers to it. For instance, despite having to compete in the local market, community and some acute providers interviewed in London held distinctly anti-competition views. This alerts us to the fact that what people think does not necessarily correspond to what people do. The origins of normative views held at individual level are complex and cannot be explained fully by the variations in characteristics of local health economies such as provider configuration, geographical remoteness or past experience of competition.

Although the study found that most interviewees preferred collaboration as a main method of solving local service delivery problems, especially in cases of complex service transformations, it was not the only normative position encountered. Some participants pointed out the benefits of competition when used in a non-prescriptive, creative way. This suggests that there is a greater variety of views in NHS managerial culture than one based on the domination of a common NHS identity (Checkland et al.

2012). In fact we found that, given the contradictory and ambiguous rules which exposed actors to various risks, participants were preoccupied first of all with preserving their own organisation's interests and identities. Overall, the findings suggest that the solidity of the normative framework underpinning actors' practices within the NHS, although still distinctly pro-cooperative, has been somewhat eroded by pockets of pro-competitive thinking.

CULTURAL-COGNITIVE FRAMES OF REFERENCE

Participants also expressed a range of views which exposed the interplay between the three pillars of rules, norms and practices. In Scott's (2008) analysis such elements represent the cultural-cognitive assumptions constraining and enabling action. These may include routine scripts for action, orthodoxies and common definitions of situation and represent cultural mores which have been internalised and filtered through individual cognition (Scott 2008: 56-59). Although analytically useful, we found Scott's third pillar too narrow and too focused on preconscious elements adequately to describe what our participants told us. Our participants showed heightened awareness of various paradoxes and inconsistencies inherent in the system. Merely by talking about 'taken for granted' assumptions they exposed them and showed a high level of reflexivity. Participants elaborated on systemic barriers such as ambiguous rules and resource limitations which constrained the feasibility of certain actions. Therefore participants' views are better described as representing various frames of reference and attempts at sense making.

In order to deal with the dissonance introduced by the changes in the regulative pillar, organisations interpreted the rules in line with their local path dependencies. Commissioners on the whole were continuing to develop local commissioning plans in a 'traditional' service development mode, avoiding elements of competition. At the same time some worried that such an approach might be considered a "heresy" (Commissioner 1, CCG2, November 2013) by regulators and authorities higher up the hierarchy. This shows that the NHS is a hierarchical organisation inasmuch as local managers defer to higher levels of authority in attempts to decipher policy messages and obtain approval of their plans.

In the light of the 2012 legislation, many participants pointed out the need for robust justifications for not tendering. Some were actively looking for such justifications for their current commissioning plans. In this sense commissioning was being carried out in defiance of regulatory policy rather than policy supporting commissioning choices.

I've commissioned [a community service] from Trust X as a pilot and I'm thinking about how I'm going to do it and I've done that on a clinical governance issue, but really I should procure it and I'm dreading it. (Commissioner 6, CCG1, November 2013)

On the other hand, some participants were sceptical about the role of formal rules in governing relationships within the NHS. They cited examples of tendering processes being abandoned without any consequences for the commissioners. Furthermore, providers were often reluctant to challenge commissioning decisions, even if they had clear basis for a challenge, in order to preserve relationships and avoid costly litigation.

We made an argument to say that [community] services should be put out to tender. The CCG decided that the process would be too disruptive for the community services and so decided not to do that, to leave them where they were. (...) Actually we could make a very good strong argument to Monitor to challenge it, (...) with a high likelihood that Monitor would overturn their decision. Now we decided not to do that for a whole host of reasons (Provider 5, NHS, acute, CCG3, December 2013)

This signals once again that the NHS commissioners and providers were not willing (or able) to adopt purely commercial principles due to the constraints of NHS quasi-market. Various supply-side constraints and political sensitivity surrounding provision prevent true competition from taking hold (Allen 2013). A number of areas of provision – such as acute and primary care – seem to be excluded from attempts to instigate competition *for* the market on the basis of ‘unwritten’ rules. Private providers saw the limits of their involvement in the NHS due to the resource intensity of certain areas of health care provision (such as specialist acute care), existing barriers to market entry and concerns about profitability (see also Krachler and Greer (2015)). On the demand side, some interviewees

assumed that patients want to use their local hospital rather than exercise choice. Yet others noted an increasing role of patient choice creating a “pull” for certain hospitals at expense of others (Provider 4, NHS, acute, CCG1, June 2014). In practice, competition was seen as affecting only the margins of health service provision. However even limited competition raised some concerns about the potential to destabilise existing service providers.

Aside from the inadequacy of the rules, participants were also concerned about resource limitations. The tight financial situation of many NHS trusts meant that providers were looking for different ways to collaborate with each other in order to cut costs. In turn, CCGs did not have sufficient resources and organisational capacity to carry out numerous competitive procurement processes, even if they wanted to. Maintaining competition was accompanied by high transaction and upfront investment costs and was not viable within limited fixed budgets.

Actually it is a massive resource [implication]. So I think we have to be very careful about which services we decide to procure and how many procurement processes we go through in any one year, because they are a massive drain on resources and in time and people.

(Commissioner 3, CCG4, May 2014)

Differing pricing and payment mechanisms drew a dividing line between community and mental health providers operating on fixed budgets, on the one hand; and acute service providers paid in accordance with the amount of care they provided, on the other. In addition to being more exposed to the competition *for* the market, some community and mental health providers felt frustrated about their inability to realise the benefits of competition *within* the market by increasing activity in respect of well-performing services.

Dual incentives in the commissioning system meant that providers had to ensure the viability of their organisation in a competitive environment and at the same time had to cooperate with commissioners and other providers. Contrary to policy makers and regulators, participants on the whole were not convinced that the principles of competition and cooperation could coexist harmoniously. For instance, some providers became more cautious about cooperating with commissioners after the

services which they helped to redesign were put out to competitive tender. In another instance, commissioners used a threat of opening services up to competition in order to encourage greater cooperation between providers, which was the ultimate aim. Yet using competition as a ‘stick’ was seen as ‘aggressive’ by providers and had the potential to increase the level of distrust in the system. Overall, many noted that “two drivers [of cooperation and competition] can compete against each other” (Commissioner 3, CCG4, May 2014).

Providers operating in different local contexts noted large differences between how different CCGs chose to interpret and implement policy on competition. Some commissioners chose not to use competitive procurement where services were working well, whilst others were tempted to make savings by putting services out to tender. Large amount of local discretion alongside duality of incentives and unclear rules of the game meant that providers were navigating a highly complex environment. Overall, one can argue that the existence of competition as a potential commissioning tool has decreased the amount of generalised trust between actors and made different NHS organisations more self-interested. This may have an adverse effect on collaborative working as various studies on partnerships in health and social care found that trust is one of the key components for successful collaboration (Cameron and Lart 2003; Dowling et al. 2004; Hunter and Perkins 2014).

DISCUSSION AND CONCLUSION

In terms of formal rules, the HSCA 2012 legitimised further the market principles within the NHS in a top down manner. However the new rules were not presented in a clear way and were overlaying rather than superseding the requirements for cooperation and integrated care. The policy messages regarding competition and cooperation in the NHS were characterised by certain fluidity. This created room for commissioners to use local discretion and to continue with the traditional ways of commissioning through partnerships and planning, whilst using or threatening to use competition.

In terms of norms, we found a mix of opinions, from outright opposition to competition in the NHS to some acceptance of the role of competition as a commissioning tool. There was no united front against competition or identification with the NHS as a “common enterprise” (Checkland et al. 2012:

544). Instead participants were maintaining separate organisational identities and were focused on preserving their organisation's viability. These findings suggest that some market principles had already slipped into NHS managerial culture resulting in an ambiguous normative framework.

Finally, in terms of cognitive sense making, we found continuing preference for a cooperative service development mode of commissioning. However at the same time many commissioners acknowledged that competition was a useful 'tool' to have at their disposal. Although NHS providers were less enthusiastic about competition as a method to improve services than some commissioners, they were mindful that competition could be deployed and were prepared to act strategically. This undermined somewhat the trust between actors in the system. Commissioners and providers were grappling with resource limitations, service interdependencies, payment structure inequalities and presence of many 'unwritten rules' about commissioning health services.

According to Scott (2008) the robustness of an institution is ensured if all three pillars are aligned, whereas a mismatch requires some work to bring it back to fit the current institutional framework or may set in motion a process of deinstitutionalisation. Our analysis suggests that the confusion about the relative importance of cooperation and competition in the NHS was present in all three institutional levels. In other words, hybridity introduced by market logic was discernible not only in the structural aspect of the rules governing the system, but also in norms and cognitive sense making. Yet in our view, the signs of hybridisation in normative and cognitive pillars do not amount to a full scale deinstitutionalisation process but rather, as Scott suggested, the process of appropriation of market elements is under way as actors interpret the ambiguous rules and incorporate them into their practices in search for locally optimised solutions.

More recent studies acknowledge that hybrid structures and logics may be more permanent than new institutional theory suggests, representing "enduring but unstable" features of modern institutions (Denis et al. 2015). We can speculate that the ambiguous rules may actually mitigate some of the misalignment between pillars. The hybridity in the NHS spread from structure and rules to other institutional pillars such as norms and cognitive dispositions. If hybridity is present within each pillar

(as this study showed) then the misalignment between pillars may be more fuzzy, and less pronounced than if inherent contradictions persisted between internally consistent pillars. In that sense the internal hybridity of institutional pillars may provide certain stability to a hybrid institution.

This study has some limitations. The process of marketisation of the NHS is ongoing and the study represents a snapshot of views at a particular point in time and may not represent how actors will understand the system in the future. Furthermore, due to the fact that only four case studies were used, we were not able to quantify the prevalence of two co-existing logics of competition and collaboration in the NHS, focusing instead on the extent these logics had an impact on commissioning practices in particular locations.

Scott's (2008) framework was useful but had also some limitations. It appears that the cognitive-cultural pillar does not capture well the thought processes and actions in institutions undergoing change. We found few taken for granted assumptions. Instead managers were highly reflective about their environment and often contesting it rather than routinely replicating it. It seems that Scott's third pillar does not recognise sufficiently the role of actors' reflexivity in navigating complex and sometimes contradictory environments leaving little room for agency (Denis et al. 2015; Lowndes 1996).

Notwithstanding this, we found the institutional framework on the whole helpful in explaining changes affecting the NHS. Arguably, the institutional framework has advantages over the notion of hybridity because it offers insight into how organisations deal with hybridity by exposing the interplay between and within different institutional pillars.

It has also advantages over using a metaphor of "public sector diaspora" as an analytical device for studying reforms of the NHS in England (Waring 2015: 345). A metaphor of diaspora implies a one-way migration from a public sector culture to a private sector culture with subsequent 'resettlement'. Contrary to this, our findings suggest that the public sector is already permeated by the overarching principles of neoliberalism. If one ascribes to a non-essentialist view of culture and agrees that no 'pure' culture types exist, then no movement between such 'pure' types is possible and the so called

in-between space occupied by the 'diaspora' does not exist. We found evidence of market mechanisms at the levels of rules, norms and actions characterising NHS commissioning.

Although in this cross-sectional study we uncovered the signs of hybridisation in norms and cognitive frameworks adopted by the NHS managers, they do not amount to a full scale marketisation of the NHS. This is due to limitations imposed by the quasi-market and the fact that the rules remain ambiguous leaving different avenues for interpretation. This ambiguity allows managers in some instances to disregard the rules on competition. Yet some participants ascribed some normative value to competition and adopted it into their cognitive frameworks as a tool for instigating change in provider behaviour. Overall we discerned some infiltration of market principles in all three pillars, but not a full scale paradigm shift. The fundamental change in the normative pillar seems less likely (at least for the time being) given the diminished urgency of national policy messages about the use of competition since the publication of the 'Five Year Forward View' policy document in October 2014 (NHSE 2014).

Our study has some implications for policy makers. Local commissioners should be allowed to make their own decisions about which modes of commissioning are most appropriate in their particular circumstances. Setting up nationally imposed rules about what mechanisms must be used is unhelpful (and probably will not be adhered to). It appears that in most circumstances, the use of cooperative modes of coordination is likely to be more appropriate. At the same time for the sake of efficiency and transparency, it is important to clarify the rules of the game for local actors. As the NHS continues to be a predominantly hierarchical institution, the clarity of the rules under which local commissioners operate is crucial for the effectiveness of the local health economies.

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RESEARCH ETHICS

The study received ethical approval from the LSHTM Research Ethics Committee.

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