

Implementing market-based reforms in the English NHS: Bureaucratic coping strategies and social embeddedness

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Abstract

This paper reports findings from an ethnographic study that explored how market-based policies were implemented in one local health economy in England. We identified a number of coping strategies employed by local agents in response to multiple, rapidly changing and often contradictory central policies. These included prioritising the most pressing concern, relabeling existing initiatives as new policy and using new policies as a lever to realise local objectives. These coping strategies diluted the impact of market-based reforms. The impact of market-based policies was also tempered by the persistence of local social relationships in the form of ‘sticky’ referral patterns and agreements between organisations not to compete. Where national market-based policies disrupted local relationships they produced unintended consequences by creating an adversarial environment that prevented collaboration.

Key words: Health care policy, policy implementation, markets, England

Introduction

O'Toole [1] defines policy implementation as what happens ‘between the establishment of an apparent intention on the part of government to do something, or to stop doing something, and the ultimate impact in the world of action’ (p. 266). Studies of policy implementation can be classified according to whether they assume a ‘top-down’ or ‘bottom-up’ perspective. A study that assumes a ‘top-down’ perspective will start with a specific policy and examine the extent to which the formal objectives are achieved. These studies proceed from a rational, linear view of policy processes whereby policy is made at the national level and communicated to subordinate levels to put into practice. Top-down studies often have a normative dimension in their orientation to recommendations for how policy makers can close the ‘gap’ between policy intentions and results [2] [3].

Bottom-up studies begin with the decisions and strategies of local actors which are seen as crucial to how national policies are implemented [4]. This perspective, as Elmore notes, does not assume that a particular policy is the only, or even the major, influence on the decisions of individuals involved in the process of implementation [5]. One of the advantages of a bottom-up perspective is that by beginning with the perceived problems of local actors, and the strategies developed to deal with them, this perspective affords a consideration of the relative influence of different policies and initiatives on the actions of local implementers. Moreover, as these studies do not start with a focus on formal policy objectives they are able to capture a range of (unintended) consequences [6].

In an early example of the bottom-up approach, Weatherly and Lipsky showed how the coping strategies adopted by teachers and other school staff to manage the demands of their job distorted the implementation of special education reforms [7]. For instance, the policy required uniform treatment of children with special needs, but with no explicitly mandated system of prioritising children, and faced with an increase in workload, staff biased the scheduling of assessments in favour of children whose behaviour was disruptive, who were not likely to cost the system money, or who matched the specialty interests of individual members of staff. Weatherly and Lipsky showed how the patterns of responses developed by local staff to the multiple demands placed upon them effectively became the policy.

In this study we adopt a 'bottom-up' perspective to consider how the implementation of market-based policies in the NHS is influenced by the actions of local agents. We draw on interpretive sociology in presupposing that the actions of local agents can be understood as rational and reasonable when viewed in light of their priorities and the daily constraints that they face [8]. We found that local health service managers work in a context of multiple, rapidly changing and often contradictory central policies. The coping strategies employed by

these local implementers include prioritising the most pressing concern, relabeling existing initiatives as new central policies and using central policies as a ‘lever’ for local plans. These strategies dilute the impact of market-based reforms. The impact of the reforms is also tempered by the persistence of local collaborative arrangements and social networks. Nonetheless our study also revealed instances where market-based reforms were disrupting these networks, impeding potentially beneficial service developments.

Market-based reforms in the English NHS

The introduction of market-based reforms to publicly funded healthcare delivery systems has been a feature of health policy in countries across Europe over the past twenty years. The English National Health Service (NHS) is an example of this trend. Since 1991 successive governments have introduced market-based policies. The first ‘internal market’ was introduced by the conservative government in the 1990s. This created a split between local purchasers and providers of health care. On coming to office in 1997 the Labour government initially dismantled the market (although the basic split between purchasers and providers was retained) but then from 2002 it re-established it through a package of policies that emphasised choice for patients and competition between providers. The current coalition government has gone the furthest in extending the market in the NHS by introducing a right for patients to receive care from ‘any qualified provider’ and introducing competition in primary care.

The underlying logic of market-based reforms is drawn from microeconomic theory. This posits that competition between firms creates incentives to improve quality and (micro) efficiency. The policies introduced by New Labour gave patients a choice of where they can receive treatment. With ‘money following the patient’ those health care providers that attract the most patients receive the most funds whereas less attractive providers may be subject to

closure [9]. In the NHS the introduction of market-based reforms has been controversial. Much of the academic debate concerns the *effectiveness* and *appropriateness* of market-based policies in the real-world context of the NHS.

It has been argued that market-based reforms are *ineffective* because the local NHS market is socially embedded [10] and this attenuates the effect of central policies aimed at stimulating competition between organisations [11][12][13]. This argument is supported by empirical studies of the 1990s internal market which found that at the local level the NHS was characterised by interdependencies and long-term relationships; norms of collaboration and loyalty; and the use of trust to obtain reliable information and manage the inherent uncertainty of healthcare [11] [12]. Similar findings have come from studies of the market-based policies introduced by New Labour [14][15][16][17]. For example, Frosini et al [15] found that patients and General Practitioners were loyal to the local provider and that rather than competing, providers ‘divided things up’ (p. 4). In another study Farrar et al interviewed CEOs of NHS providers. They reported that:

...issues of NHS culture and behavioural norms were raised by the interviewees, as affecting their responses to the incentives of the new system. For instance, a number of interviewees would not pursue greater revenues through increased supply if this was an action considered detrimental to the financial status of the commissioner and the local health economy as a whole. (p.15)

It has been argued that market-based reforms are *inappropriate* because they create an adversarial environment that disrupts the collaborative relationships between professionals and organisations thought to be essential to providing health services [18] [19]. According to Flynn et al [18] the complex, multidisciplinary and multiagency nature of some services, such as those for long-term conditions, mean that ‘relational contracting and collaboration

were not only desirable in themselves but the only practical approach'(p. 146) . The authors acknowledge that the NHS is known as much for inter-professional rivalry as it is for collaboration, but they suggest that in the case of the former market-based reforms would only make things worse (p. 146).

Research supports the contention that market-based policies foster adversarial relationships and erode trust [20][16] although evidence that this has translated into (other) negative effects is more diffuse. In one case study of the market-based reforms introduced by New Labour, Greener and Mannion [14] found what appeared to be a lack of planning across the local health economy, shown by a high number of admissions through the accident and emergency department, rather than through standard GP referrals. This was attributed to a lack of partnership working in dealing with the health problems of the local area. The authors concluded that market-based reforms had led to an aggressive and short-term management style and that this had 'reduced the potential for healthcare organisations to co-operate' (p. 99). Elsewhere there is ample evidence that the quality of working relationships between professionals and organisations is a key determinant of the quality of care, especially in relation to long-term conditions and the care of older people [21][22][23], and improving collaboration remains an objective of national policy [24].

There is clearly a tension between the above arguments that suggests a nuanced picture of local health care markets where the persistence and disruption of social relationships co-exist. We contribute to an understanding of these dynamics by exploring how national market-based policies were implemented in one local health economy in England. Our focus was on how implementation was shaped by features of the local context, specifically, how market-based policies interact with other policy streams; the perspectives of local actors; and social networks.

The local health economy

We build on a conceptual framework developed by Exworthy and Frosini [25] that sees the decisions of local agents as simultaneously influenced by vertical (central-local) and horizontal (local-local) relationships and dependencies. To capture these dynamics our primary unit of analysis is the local health economy. In our model the local health economy has geographical and organisational characteristics but we also use this term to refer to the relationships in which local NHS organisations are embedded.

Vertical dimension

The vertical dimension of the local health economy corresponds to the hierarchical relationships and dependencies between central government and local managers and clinicians. In terms of organisations it includes the Department of Health and the relevant Strategic Health Authority, a regional body responsible for managing the performance of health services and ensuring that national priorities are integrated into local plans. In this study, rather than consider a single policy in isolation we are concerned with how national policies interact with each other in the local context. Therefore the relevant national policies at the time of our fieldwork are outlined below:

Health policy under New Labour has been described as consisting of three sequential periods of policy emphasising, in turn, ‘Cooperation’, ‘Command and Control’, and ‘Competition’ [26]. However, rather than the policies of each period replacing their predecessors, they accumulated, producing a complex mix [27][28]. According to Stevens [26] the mix of approaches was intentional with the task being to ‘ensure that this mixed model is internally coherent and the individual policy instruments appropriately balanced’ (p. 43). Others have been more critical, describing it as the ‘garbage can’ model

of policy making [27] [28].

Thus at the time we were doing fieldwork (2006-2009) market-based policies sat alongside a regime of national targets (e.g. for reducing waiting times for treatment) which were backed up by a top-down system of inspection and sanctions (in the form of removal of the management team) for failing organisations. Policies from an earlier 'cooperation' phase, such as National Service Frameworks, also remained in place. Indeed Powell [29] found that in some specialties, such as Diabetes, National Service Frameworks were considered by local actors to be the most relevant central policy with correspondingly little or no uptake of market-based incentives.

During fieldwork there was a change in Prime Minister and a new health minister, Lord Darzi, was appointed. Lord Darzi advocated a form of regional planning of health services based on the rationalisation of acute care and the expansion of services provided in primary care settings [30] [31].

In addition to policies from the Department of Health, local NHS organisations are also subject to guidance from other national bodies, such as the Royal Colleges (national bodies representing the medical specialties). The Royal Colleges specify how services are to be provided and set requirements for training doctors. These cover the size of catchment populations for particular service areas; the required throughput of patients; staffing patterns; and inter-professional linkages. As a result, Royal College guidance has a significant influence on the geographical configuration of hospitals [32][33] [34][35] Indeed West [33] has argued that the influence of Royal College standards on hospital planning is key to understanding why the internal market of the 1990s did not have its intended effect. Towards the end of our fieldwork Royal College guidance was given additional impetus by its

incorporation into the recommendations for regional planning set out in the reports published by Lord Darzi [30][31].

Horizontal dimension

The horizontal dimension of the local health economy corresponds to the relationships and dependencies between local organisations. In the NHS these inter-dependencies vary in nature and intensity and include institutional linkages, financial flows, patient flows and collaborative initiatives.

We defined the geographical boundaries of the local health economy in terms of the financial flows of the Primary Care Trust (PCT) with health care providers. PCTs were at this time the local bodies responsible for purchasing care on behalf of the population. Therefore the organisations included in our study were the PCT, four NHS Trusts (organisations providing hospital services) and an NHS Foundation Trust. Two of the providers were single-site hospitals. The other three had hospitals on different sites as a result of earlier mergers. Some of these providers also contracted with PCTs from neighbouring localities. Nonetheless, as is the case in England more generally [36] commissioning patterns in the local health economy were highly localised.

As well as implementing national policies, NHS organisations also pursue local objectives. The most significant of these in our study was a long-standing and seemingly intractable agenda concerned with planning hospital services across the region. During our fieldwork plans were in a constant state of flux but typically involved centralising some specialties in fewer, larger units and, as a consequence, ‘downgrading’ or closing some hospitals.

Methods

We used an ethnographic approach which involved fieldwork in a local health economy in England over a period of twenty eight months (November 2006 – March 2009).

Ethnography is well-suited to studying the complex interplay of policy processes with features of the local context [18] [37] [38].

Data was collected from a range of sources including documents, formal interviews (n=52) and informal conversations with national policy makers, local NHS managers and senior hospital doctors (known in the NHS as ‘consultants’) and observations of meetings (n=12). Data collection and analysis was an iterative process with initial analysis informing subsequent phases of data collection.

Interview transcripts and observational field-notes were analysed with the aim of identifying emergent themes and developing theoretical categories. Analysis involved a process similar to the constant comparative method used in 'grounded theory' [39]. Data were assigned to a category and then further analysed to refine themes into subcategories. Data were also compared and contrasted within and between categories to clarify categories and re-assign data if necessary. The process of analysis involved the entire data set. The quotes included in the text are used to illustrate the findings. Square brackets indicate where we have edited a quote to preserve anonymity or to provide additional information for readers who are unfamiliar with the NHS. Pseudonyms have been used throughout.

There are a number of ways that findings from individual qualitative studies can have a broader applicability. One is through ‘conceptual generalisability’. Ethnographic research aims to find the ‘general in the particular’[40] and our analysis aimed to move beyond description to the application and development of explanatory concepts that might be applicable in other situations. Another route is through ‘scaling up’ individual studies by

comparing the findings with other studies with similar methods [41]. Thus in this paper we consider our findings alongside those of a number of other case studies of the implementation of market-based reforms.

In the next section we present our findings. In relation to the vertical dimension of the local health economy we consider how implementation of national policy was influenced by the coping strategies of local actors, specifically NHS managers and doctors. In relation to the horizontal dimension we consider the intersection of national policies with local social networks. For clarity we consider these processes in turn although in reality they interacted.

Bureaucratic coping strategies

The local NHS managers in our study worked in a context of multiple, rapidly changing and at times contradictory central policies:

One of the difficulties is the constant change of direction and the constant pace of change. The constant targets, although I'm very signed-up to targets, and if we take A&E as an example, I don't think the quality of care for patients would have improved unless a target was attached to it, so I think a lot of the targets have been patient-driven but it's the pace of change, it's the tone of 'if you don't achieve them what happens?'.
(Senior manager, South County Hospital)

Even within the package of market-based policies local actors felt that individual policies were contradictory. For example, in national policy documents patient choice (of where to receive treatment) and PCT commissioning (strategic purchasing) is presented as complementary [43], yet as one PCT manager put it, 'Commissioning is about getting the best for our patients, but then we ask them what they want'.

As well as conflicting with other national policies, market-based policies also conflicted with local plans. The PCT had a strategy aimed at encouraging organisations across the local health economy to collaborate to provide services, as outlined in the following quote:

If they work together and their consultants work across the organisations, they can become compliant [with Royal College guidance]. Now for me as a commissioner, what that means is I get a much broader range of services more locally because the consultants can go to the patients as well as the patients in some cases going to the consultants, than I could do otherwise. So we tick the quality standard and we get better care actually closer to where people live which is really important.... by working together they can provide a broader range of services which means they can provide those that up until now have been provided in London, they can provide them more locally and with that, also comes the money, so it ticks all sorts of you know, it ticks access for the patients, it's great for the clinicians, it's good for their ability to recruit, because it means they provide more interesting jobs, and it ticks the financial box because I think part of my strategy has to be to make sure I do business with organisations who are going to be clinically and financially sustainable in the future.
(CEO, PCT)

This quote also illustrates the way in which local health service managers sought to understand and reconcile multiple demands and objectives. Weatherly and Lipsky [7] consider the way that the coping strategies employed by local actors influence policy implementation.

Although Weatherly and Lipsky are concerned with the behaviour of public employees who interact directly with citizens (so-called 'street level bureaucrats'), we found that notion of coping strategies, and the way these influence policy implementation, could be applied to local NHS managers. We identify three such strategies employed by local managers in our

study: Prioritisation, relabeling, and the use of national policies as a lever to realise local objectives.

Prioritisation

In the context of multiple central policies, the priority, for all the organisations in our study, was meeting national targets. The most important were those for financial balance, waiting times and infection control:

Interviewer: How do you decide what to implement and what not to implement or what to prioritise?

Respondent: The absolute priorities are the Healthcare Commission standards and the targets within those standards... (Senior manager, PCT)

November last year we received a David Nicholson [then chief executive of the NHS] letter saying 'these are the top three things that you've got to hit: finance, improve quality of service and your A&E target and if you don't do it within 12 weeks then ...' potentially, well, unsaid but potentially we're moved out and a new system moved in. (Senior manager, South County Hospital)

The prioritisation of national targets diverted attention away from the implementation of other policies and in some cases directly impeded it. For example, concern for meeting the target for waiting times for treatment meant that the 'menu' of providers that were offered to patients under patient choice policy was restricted to those that met the target. One hospital consultant revealed that in these circumstances the referring GP simply reverted to the

previous system of referrals:

We will offer a patient five places to go and appointment times at those five places. That's what it says. It doesn't mean it's going to be within your county, or within your district, it's anywhere within the country. So all the GP does is she logs out of the Choose & Book screen and writes me a letter and sends it in, so that's all that's happening. There is no choice. Patients don't want choice, patients want to be treated in their local hospital. (Consultant, County General Hospital)

Our study did not include patient perspectives, but the belief, expressed above, that patients wanted to attend local facilities, was widespread among managers and clinicians. The above sequence of events illustrates the complex interplay at local level of different policies with the social context. In this case implementation of the policy to offer patients a choice of provider was impeded by the prioritisation by local managers of national targets; the historical relationship between the referring GP and the local consultant; and shared beliefs among local actors about 'what patients want'.

Relabeling

One way in which local managers managed the rapid pace of change in central policies was by relabeling existing initiatives as the new policy. So, for example, long-standing plans to close hospitals or hospital departments were simply relabelled as implementation of the Darzi report:

we sort of levered it into there really, into that process and then looked at the Darzi stuff and said, 'OK, they're broadly similar, we don't need to - you know, in exactly the Darzi headings' and decided we'd carry on in that way. (Senior manager, PCT)

Relabeling enabled local actors to demonstrate that their plans were consistent with national policy direction while meeting local objectives and ensuring the continuation of existing initiatives. Relabeling was evident where local plans dovetailed with national policy but it also occurred when the existing initiative might be considered to conflict with the new policy. For example, one trust had long-standing plans to reconfigure acute services across its two sites. This involved a controversial decision to close a maternity unit on one site. Following the introduction of patient choice policy, the rationale for closing the unit was amended to include 'increasing patient choice' (by offering women the choice of giving birth at home) even though the plans could be viewed as reducing patient choice by reducing the number of providers in the area and the range of possible locations of care.

National policy as a 'lever'

Local NHS managers were not simply doing what was required of them, in terms of implementing national policy, they were making national initiatives 'work for them' by adapting them to local interests. A sense of this is given in the following:

You can't get away from central directives, we're a Foundation Trust but all [the regulator] does is take central directives and add a few more to them so you don't have freedom so you've got to live with those, you've got to persuade yourself that actually there is some sense in them but when you don't understand some of the sense yourself it's a little bit difficult but to be a "successful Trust" you have to meet the stuff that is thrown at you so the trick is to try and get some joined-up thinking about it so that you can get what you want out of it...(Senior manager, Forest Hospital)

National policies were used as a 'lever' for local plans that were proving difficult to realise. For example, the PCT used the guidance from the Royal Colleges as part of its contracts with providers in order to force the providers to reconfigure services. This strategic use of Royal

College guidance was recognised by the other actors in the local health economy, as can be seen in the following quote from a Trust meeting. In this excerpt the CEO of the Trust is referring to a Royal College recommendation that emergency surgery have a catchment population of 500,000:

The PCT will want to hunker down behind college standards. That's the only lever.

That's why the 500,000 was so important to Greg [first name of the PCT CEO].

Thus while other studies have recognised Royal College standards for service and training as a significant 'driver' for local service configuration, we observed how they were also a 'lever', used by the PCT to give impetus to existing plans. This illustrates the non-linear, non-rational nature of policy processes.

Social embeddedness

There was a shared concern for the stability of other organisations, and the local health economy as a whole, which led organisations to agree amongst themselves 'who would provide what'. NHS providers had collaborative staffing arrangements that allowed them to provide services that would otherwise not meet Royal College standards. All providers in the local health economy were involved in these partnerships to some extent. Such partnerships were seen as beneficial, both in terms of providing a high quality service and in enabling patients to be treated locally:

you contribute your clinicians to the rota so each hospital doesn't have to build-in the overheads to do a whole service themselves, that makes absolute sense if you need 12 cardiologists to run a rota and you've got 4 Trusts with 3 each or 3 with 4 each, then for them to agree that they work together for County patients and set-up something in

the County is very much more sensible and it helps with that repatriation bit which helps their sustainability going forward, everyone wins. (Manager, PCT)

Well in terms of the [neighbouring NHS Trust] we've always had a good relationship, although they're quite close, we don't really ever tread on each other's toes particularly ... we have some of their clinicians do a few sessions here, some of our people do a few sessions there, so for the moment, I mean it may change, but for the moment we don't necessarily see them as a direct threat (Manager, Forest Hospital)

Professional networks were reinforced by the fact that many of the clinical staff that we interviewed had been in their current post for ten years or more. Long-standing social relationships between clinicians, and to a lesser extent between managers of different organisations, played an important role in keeping the day to day business of the NHS going in a turbulent policy environment. For example, social relationships between clinicians enabled the continued coordination of patient care between competing organisations. This is illustrated in the following quote which relates to the establishment of a 'walk-in centre' near to an Accident and Emergency department of one of the NHS trusts:

So the walk-in centre nurses were heavily reliant from support from the A&E team to manage individual patients and that's obviously not something we're going to decline as there's a patient on the end of this, you can't say 'well', you know, 'you work for a competitive service, I'm not going to help you' because the patient is the one who suffers from that but it's a bizarre system and very uncomfortable the marriage was, if you like, between the two services at management level, in fact the relationship at shop floor level was always pretty good... (Consultant, County General Hospital)

This is not to say that all pre-existing relationships in the local health economy were good. In

one instance an historical dispute between two providers had resulted in an ongoing antagonism which had prevented collaboration between the organisations at times when this would have otherwise been a rational decision. As one hospital manager observed 'it's a shame because I'm sure we could work much more closely together but it seems to be this sense of mistrust between us now'.

Social relationships were, at other times, disrupted by national market-based policies. This is illustrated in the following quote from a Trust board meeting. The CEO has just been told that a group of GP commissioners had decided to move referrals to another NHS provider. He responded by saying: 'The GPs can't have it both ways. They ask to collaborate with us then work to take our business away.'

The sentiment was repeated during interviews:

if you lose a load of business to someone down the road you don't necessarily go along and shake them by the hand and say, 'Well yes, we've lost you know, half a million quid's worth of work but you know, we want to collaborate with you on other things. (CEO, Forest Hospital)

In another instance relationships between one of the providers and local GPs had deteriorated following the introduction of a new activity-based system of payment that was introduced as part of the package of market-based reforms. This had generated a significant amount of bitterness which had prevented the coordination of care across the primary and secondary sector.

Because if you're the PCT and you can't pay the bill, you then imply to the GPs that the hospital's ripping them off so you are then setting GP against hospital doctor ...so that

doesn't help for relationships and if you don't have relationships you don't have joined-up clinical care. (Medical Director, Forest Hospital)

Discussion

Although writers such as Weatherly and Lipsky [7] are concerned with the behaviour of public employees who interact directly with citizens, we found that notion of coping strategies, and the way these influence policy implementation, could be fruitfully applied to local (operational level) NHS managers as well as doctors. We also exploited the ability of a 'bottom-up' perspective to consider the relative influence of competing national policies. In doing this we have addressed a paucity of research on how national policies interact in the local context.

We found that in the context of multiple, rapidly changing and often contradictory national policies the priorities for local organisations were meeting the nationally-set targets for financial balance, waiting times and infection control. Similar findings have been reported elsewhere [29] [43]. The prioritisation of targets is understandable given the severity of the associated sanctions but as a consequence attention was diverted from the implementation of market-based policies.

After meeting targets, local organisations were preoccupied with pre-existing plans to reconfigure hospital services across the local health economy. Regional planning of hospital services in the form of centralisation of some services (implying a reduction in the number of providers) is occurring in most areas of England [44] but is in direct conflict with market-based reforms aimed at increasing competition between hospitals (requiring a plentiful supply of providers). Royal College specifications for clinical services and medical training are an important driver for regional planning and were identified as a key factor limiting the

development of a market in the NHS in the 1990s. Despite this, medical staffing and training issues appear not to have been taken into account in the formation of recent market-based policies.

We found that social relationships played an important role in the day to day running of local services and had a ‘smoothing’ effect in a turbulent policy environment. Consistent with other studies [15][43], we found that a shared concern for the stability of local organisations led providers to agree among themselves who would provide what, dampening the impact of policies aimed at encouraging competition between providers. Other studies have reported ‘relational contracting’ between purchasers and providers [15] [16] and ‘sticky’ referral patterns, as patients and GPs remain loyal to the local provider [14] [15].

However, we also found instances where market-based reforms had disrupted social relationships. As with other research [14][16][20], we found that market-based policies fostered an adversarial environment. In our case study this prevented collaboration between the primary and secondary sector that may have met other policy objectives, such as moving services out of hospitals [45].

‘Creative destruction’ of the existing system is one of the aims of market-based reforms [67]. It has been argued that, in many cases, the existing way of doing things is not responsive to patients and that market-based policies, such as those encouraging the entry of new providers, will introduce innovation[46]. In this sense the disruption of social relationships could be seen as intended. However it was not the intention of the government to impede other policies, such as those aimed at moving services out of hospital, or improving coordination of care between the primary and secondary sector [26]. In this respect our finding highlights the enduring tension between market-based reforms and the need to provide services for frail older people or people with long-term conditions that require

collaboration between organisations. This is important because the main challenge facing the NHS is an ageing population, many of whom have multiple chronic conditions and complex health and social care needs and an increasing proportion of whom have dementia [48].

Adversarial relationships can also lead to inefficiencies by diminishing trust[16] [20].

Fostering antagonism is also a concern because, as illustrated by two providers in our case study, once relationships deteriorate these can be difficult to remedy [49].

It may be that as the market matures individuals will become more adept at handling relationships that involve both competition and collaboration. In the future market-based policies may also become more sophisticated. For example, they may allow commissioners to use their judgement as to when to use market-based incentives so as to harness benefits whilst minimising harm. Similarly, commissioners may be afforded more discretion as to when to use ‘competition in the market’ and when to use ‘competition for the market’. The latter could involve, for example, commissioning a single organisation responsible for integrating care.

Limitations of the study

We have intentionally adopted a broad focus so as to capture the dynamics of how policies interact with each other and with features of the local context. This focus has also enabled a consideration of broader consequences. A weakness of the study is that this breadth is at the expense of depth of analysis.

Fieldwork was undertaken between 2006 and 2009. The study retains relevance due to the continuation of market-based policies under the current coalition government in England and in other countries. We have also sought to contribute to a more general understanding of

how the implementation of national policies is shaped by real-world constraints.

Conclusion

We identified a number of mechanisms that influence how national policies are implemented in the local context. Coping strategies employed by local NHS managers in response to multiple, rapidly changing and often contradictory central policies include prioritising, relabeling of existing initiatives as the new policy and using new central policies as a lever for realising local objectives. These coping strategies have the effect of diluting the impact of market-based reforms and diverting attention to other initiatives, in this case meeting central targets and regional planning of hospital services.

Cooperation between professionals and organisations continues to play an important role in the day to day running of the NHS. The persistence of social relationships, in the form of ‘sticky’ referral patterns, and agreements between providers not to compete in certain areas, mean that national market-based policies may not have their intended impact. Conversely the disruption of social relationships can produce unintended consequences, such as a preventing collaboration between organisations.

Conflicts of interest

None

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