Health Policy 111 (2013) 52–59

Contents lists available at SciVerse ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

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

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ARTICLE INFO

Article history:
Received 28 March 2012
Received in revised form 13 March 2013
Accepted 18 March 2013

Keywords:
Health care policy
Policy implementation
Markets
England

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, relabelling 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.

1. 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, Whetherly 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

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0168-8510/$ – see front matter © 2013 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.healthpol.2013.03.010

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. Whetherly 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, relabelling 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.

2. 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 20 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 [11–13]. 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 [14–17]. 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 [16,20] 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