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Recipe for permanently failing organisations? Private provision in publicly funded healthcare¹

This article outlines the radical management changes introduced by *The Health and Social Care Act 2012* (HSCA) in the English National Health Service (NHS) in 2013 and discusses their possible effects on NHS as an organisation. This article argues that the HSCA reforms—designed to enhance market principles—represent a political solution to management problems, driven by financial and ideological priorities. Because of conflicting objectives, unclear distribution of authority, organisational complexity, and lack of sensitivity to the NHS’ historical culture and structure, the outcome may be a ‘permanently failing organisation’.

Healthcare is a major preoccupation for governments, as for individual citizens. In 2010, expenditures on healthcare represented 11.6 per cent of GDP in France, 11.6 per cent in Germany, 9.6 per cent in the UK, and 9.1 per cent in Austria. For the US, the figure was 17.6 per cent—for Hungary, 7.8 per cent (OECD 2012). For England (not the whole UK), the GBP 20 billion budget in the financial year 2012–13 dwarfed expenditure on education and defence combined—the National Health Service (NHS) employed over a million people. The rate of increase in healthcare expenditures is greater than the rate of increase in expenditures in other areas, due to ageing populations with greater healthcare needs and increasingly sophisticated and expensive medical technologies, and with inflation in pharmaceutical costs rising more rapidly than general inflation. In Europe, life expectancy is rising, but the experience of old age is increasingly characterised by ill health. Against this background, the management of healthcare has become a major issue. Drawing on the English experience, this article argues that the application of market principles to healthcare provision is unlikely to improve healthcare management performance—and may even damage it.²

With the extension of market principles to NHS, the British government has launched a massive experiment in managing healthcare. NHS is unusual in providing publicly funded healthcare, free at the point of need. The system—established in 1947 by the Labour government of the time—was not copied by

¹ This article stems from *The Future Organisation of the NHS*, a memorandum submitted to the Public Bill Committee on the Health and Social Care Bill (Martin 2011).

² NHS England, NHS Northern Ireland, NHS Scotland, and NHS Wales are managed differently—the analysis in this article refers to NHS England.

other advanced economies, which instituted various forms of insurance-based systems, with some public funding, as in France, Germany, and Scandinavia. The NHS model was similar to socialist healthcare systems. Historically, NHS has been the major means of providing healthcare, managed as a single public sector organisation through regional strategic health authorities (SHAs) and local primary care trusts (PCTs) (with different names at different times). In addition to public provision, private care has always been available, both for general medical services (medical examinations for life insurance, for example) and for specialised medical purposes (in vitro fertilisation, for example, for a time). Private patients were able to arrange medical appointments at their convenience, not at times specified by the doctor, and a small number of procedures were not available through NHS. Such private treatments were normally covered by insurance—through Bupa (the British United Provident Association (BUPA), originally), for example, sometimes funded by employers.

The NHS management structures and procedures were transformed by the implementation of *The Health and Social Care Act 2012* (hereafter, HSCA), which came into operation on 1 April 2013 (HM Government 2012). Although the basic principle governing healthcare—free of cost for the patient at the point of need—remained unchanged, the management means to implement this principle changed dramatically. The managed market became the mechanism underlying the new system for healthcare provision, with separation between purchasers and suppliers—and competition among suppliers on the basis of quality and price—replacing a national, largely bureaucratic structure. General practitioners (GPs)—acting for the patients registered on their general practice lists—remain the purchasers, using NHS funds and operating through purchasing consortia, but the suppliers are no longer necessarily NHS organisations. HSCA abolished the previous structure of regional and local offices. Instead, the new structure (see Figure 1, p. 36) comprises local GP commissioning consortia (GPCC), consisting primarily of GPs supported by professional financial managers. GP commissioning consortia are responsible for providing primary care and for purchasing clinical treatment from providers—often, but not invariably, from NHS hospitals, themselves reorganised into independent trusts (DH 2011b). Coordination is achieved through four NHS regional commissioning offices and 27 local area teams (LATs). A central NHS Commissioning Board (NHS CB) is responsible for managing the system, together with a central Monitor—responsible for overseeing quality, innovation, and competition—and a central Care Quality Commission (CQC).

The reorganisation seeks to achieve three stated objectives, according to HSCA. The first objective is to increase freedom of choice for patients, with GPs required to inform patients of the availability of different suppliers for the medical services they—on GP advice—require. This follows common practice under the pre-2013

system. The second objective is to improve the quality of patient care—and to accelerate innovation—through increasing competition, and through expanding the financial resources available to the industry from the private sector. The third objective is to improve cost effectiveness, within the context of a large, annually set, nominally protected budget—GBP 20 billion, approximately, in 2012–13. The objectives are to be achieved through increasing competition, both within NHS itself and between public and private sector suppliers—‘Any Qualified Provider’ (AQP) approved as meeting the performance criteria established by the NHS Commissioning Board. HSCA sought to provide the institutional means for effective, transparent market operations and contained detailed provisions concerning procurement arrangements—including bidding processes—and shortlisting procedures, and for monitoring transparency in the allocation of contracts.

Private sector involvement in British healthcare is not new—NHS has always been a mixed economy, not a fully state-planned economy. GPs are independent professionals, responsible for maintaining their own surgeries and support staff, operating in effect as small businesses, with funding primarily from fees from the state. Hospital consultants engage in private practice, treating both domestic and international patients, alongside NHS patients—consultant contracts are based upon undertaking an agreed number of NHS sessions, allowing mainly senior consultants to treat patients privately at other times, often using NHS facilities. Large numbers of dentists, pharmacists, and opticians provide both private and publicly funded services, the latter according to a table of fees and charges established by NHS. HSCA provides for a massive expansion in the private sector, with increase in existing privately financed services, as well as entrance of new private firms into service provision—Circle has operated Hinchingsbrooke Health Care NHS Trust in Huntingdonshire under franchise arrangements on behalf of NHS since early 2012 (the first to do so in England). Major international medical corporations—including HCA International (the international arm of Health Corporation of America (HCA)) and BMI Healthcare (owned by the South African company Netcare through the General Healthcare Group (GHG)) (NHS Support Federation 2012: 7–16)—undertake routine operations and specialised treatments. In future, hospitals will be permitted to use up to 49 per cent of their beds and operating theatre time for private patients, compared with fewer than 5 per cent under the former system. HSCA provisions regarding competition encourage the large-scale growth of private providers, purchasers being prohibited from excluding private Any Qualified Providers from lists of suppliers, except under a very limited number of specified circumstances. The expansion of private sector provision raises possible issues of competition policy and market regulation (see pp. 42–3). Opponents of the new management system perceive creeping privatisation.

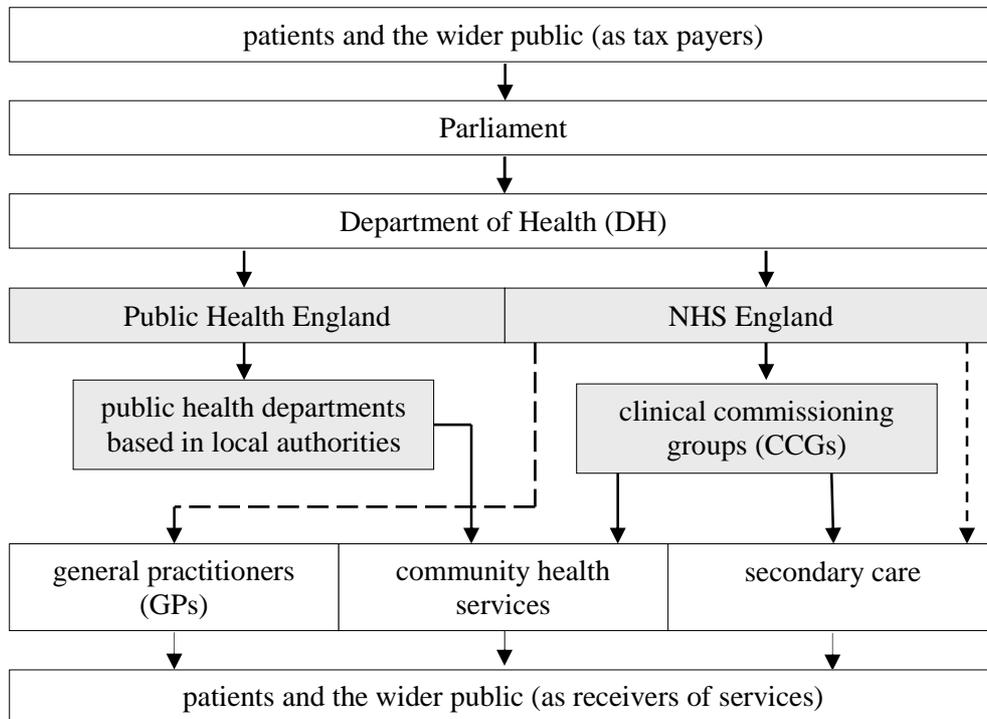


Figure 1: New funding arrangements

Source: Based on The Nuffield Trust (2013).

Legend:

- = new organisation
- \longrightarrow = funding
- \dashrightarrow = service provision
- \dashrightarrow = holds contracts directly
- \dashrightarrow = direct commissioning of specialised services

This article has two purposes. The first is to examine recent changes in healthcare management structures from the perspective of organisational analysis. The second—addressed in the concluding section—is to compare the organisational logic of the new structures with the historical organisational logic of NHS. As the new management system has only been operational since 1 April 2013, the conclusions are based on examination of the Department of Health (DH) proposals, analysed in the light of research into organisational transformations in other sectors—a procedure also used to develop the DH proposals. This article is

concerned with the NHS management structures and processes, not with its overall performance. Research on smaller scale transformations than the radical NHS restructuring showed the difficulty of achieving success, especially in the absence of coherent strategic leadership (Burnes 2000³). Substantively, this article argues that the HSCA provisions for the future organisation of NHS are likely to produce the structures and practices characteristic of ‘permanently failing organisations’—organisations which survive long-term, but never optimise performance—a concept introduced by the US sociologists Meyer and Zucker (1989), albeit in a different sense. The foremost feature of permanently failing organisations is the pursuit of contradictory objectives, where the achievement of one is necessarily at the cost of another—objectives oppose rather than reinforce one another. Another feature is the lack of fit between the organisation’s systems and its institutional ecology—permanently failing organisations seek to operate contrary to the culture and structures of existing organisations in the sector, and run counter to the expectations of the sector’s personnel and clients. There are four major grounds for suggesting that the current restructuring of the English healthcare management system will result in permanently failing organisations. First, the HSCA provisions and the structures it establishes seek to achieve incompatible objectives, with incompatibility reflected in the complex allocations of roles and responsibilities. Second, the roles and responsibilities are not clearly defined, resulting from the political compromises necessary to secure the passage of the legislation—organisational arrangements reflect political rather than management considerations. Third, the structures are highly complex, with multiple, overlapping responsibilities. Finally, fourth, the structures do not articulate clearly with professional alignments within NHS, in particular the role of clinical priorities in management.

This article is divided into five sections. Following this initial introduction, the second section discusses the extent to which the objectives of the new system may be reconciled with one another. The third section discusses the clarity of the roles and responsibilities allocated by HSCA, and their overlap. The fourth section identifies the problems of complexity arising from the new structures. The fifth, concluding section returns to the broader question of organisational logic, and the respective roles of the state, markets, independent professionals, medical and state bureaucrats, and patients in the management of the new healthcare system.

³ The overview includes a small-scale NHS case study (Burnes 2000: 346–53).

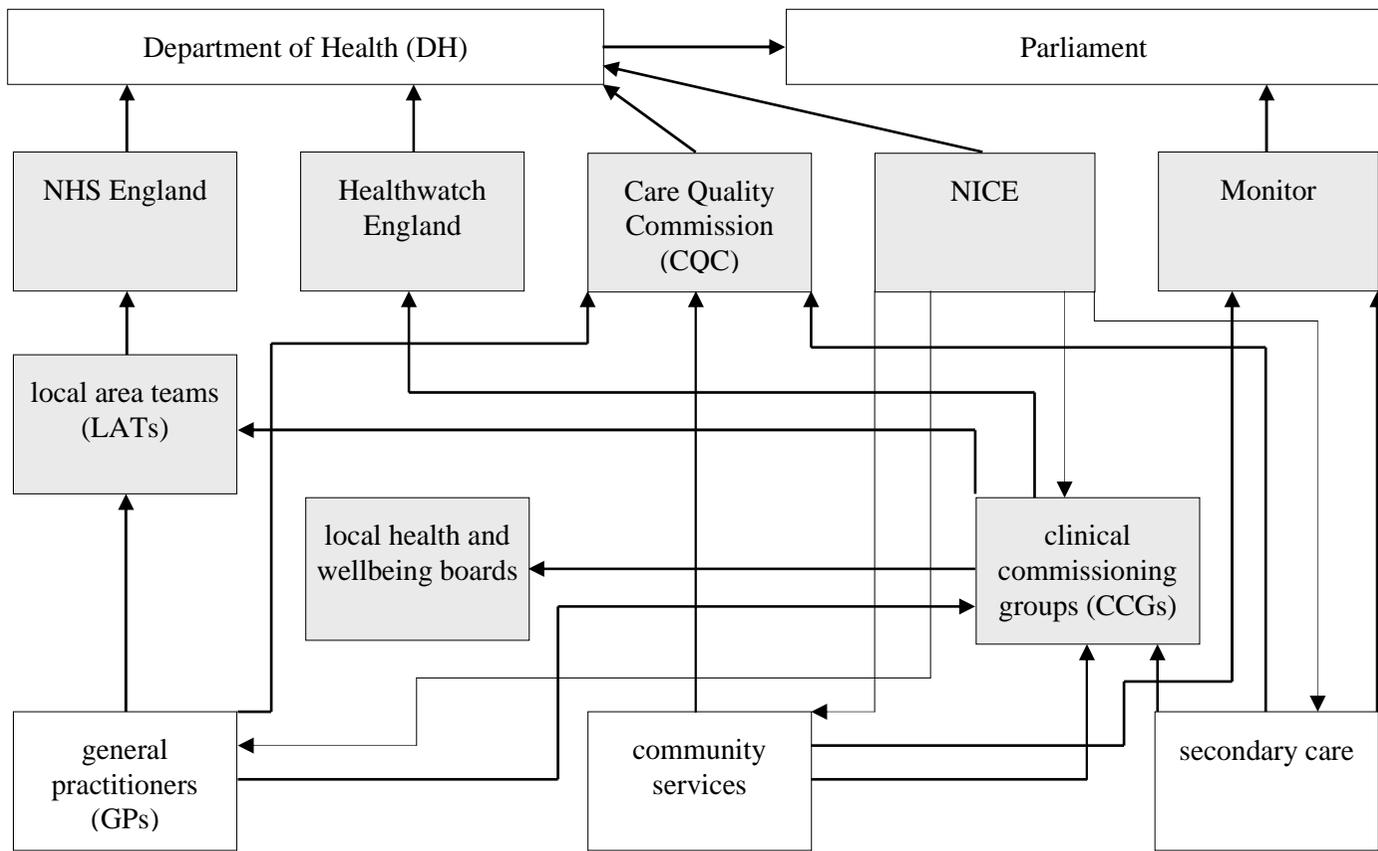


Figure 2: Regulating and monitoring the quality of services
 Source: Based on The Nuffield Trust (2013).
 Legend: = new or reconfigured organisation; → = accountability; → = advice

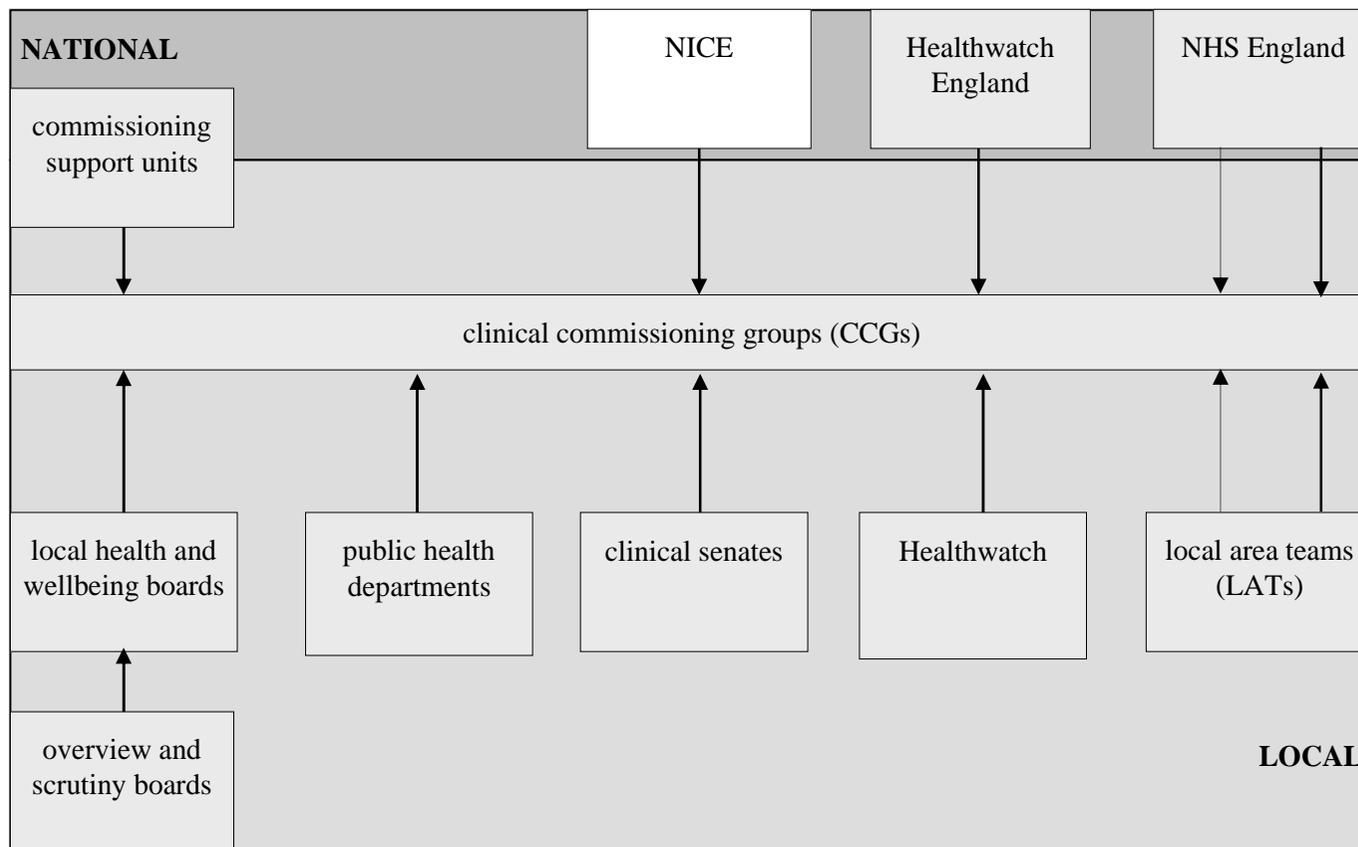


Figure 3: Advice and performance management

Source: Based on The Nuffield Trust (2013).

Legend: = new or reconfigured organisation; \blacktriangleright = advice; \blacktriangleleft = performance management

Incompatible objectives

The passage of HSCA was highly contentious politically. The Conservative / Liberal Democrat coalition government claimed that HSCA was a continuation and extension of the previous Labour government's policy, which had included contracting out some routine clinical procedures—hip replacement, for example—to the private sector. However, HSCA was strongly opposed by Labour, and by many Liberal Democrats, especially in the House of Lords, Parliament's second chamber. The professional medical associations (including the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), and the Royal College of Nursing (RCN)), the Patients Association, and campaigning organisations like 38 Degrees all lobbied actively against HSCA. Even the Institute of Healthcare Management (IHM) had reservations. Opposition in the House of Lords—spearheaded by Liberal Democrat peers—forced the coalition government to suspend the passage of HSCA through Parliament in 2012. Even after HSCA was passed, the HSCA regulations laid before Parliament in 2013 were challenged in the Lords, forcing further revision. In view of the political compromises that the government was forced to make, it is hardly surprising that HSCA contained conflicting provisions—and paid 'no or perhaps little regard to the administrative and financial burden arising from the [new] regime' (Chatterton 2011). HSCA reflected the parliamentary political context more than the practical difficulties of effectively managing a publicly funded NHS.

The HSCA's five objectives discussed below were (1) raising quality, (2) ensuring patient choice, (3) facilitating innovation, (4) increasing competition, and (5) securing value for money.

(1) Comparative assessments of quality of healthcare provision are difficult to make—and highly controversial, especially for non-professionals. Comparative assessment of hospital performance based on caseload-adjusted death rates—taking account of social, demographic, and economic conditions—provides useful overall measures of quality, but not the fine-grained information required for individual management decisions. National political controversy is easily generated—as over the quality of child heart surgery provided by Leeds General Infirmary and Newcastle General Hospital, for example, even when data on caseload-adjusted death rates became available (Jones 2013). Other widely used measures of quality—such as patient satisfaction surveys—involve subjective judgements reflecting environmental conditions as much as clinical competence. Overall, comparative data on death rates from specific diseases indicate that—pre-2013, and without being outstanding—NHS matched international levels of performance, at relatively low cost (OECD 2012). Decisions designed to raise quality—by raising ward nurse staffing levels and reducing reliance upon nursing assistants, for example—may increase costs, threatening 'value for money' performance.

Moreover, medical judgements of quality might conflict with patient choice, when specialist treatment involves patients in extensive travelling, for example.

(2) Patient choice was given prominence by government spokesmen, although little evidence was provided for its significance for patients. GPs are obliged to provide patients with choice of alternative service providers—but prevented from making recommendations on grounds of ownership. However, patients are ill-placed to make informed judgements, at best relying upon Internet-derived evidence on comparative performance—which does not include the performance of individual consultants—or word of mouth. GPs are naturally reluctant to criticise the performance of their local hospitals—or to run the danger of incurring legal responsibility for advice which subsequently turns out to be wrong. In the absence of relevant knowledge and understanding, meaningful patient choice is impossible—self-diagnosis via the Internet is high risk. Patients consult medical professionals for the kind of professional knowledge and understanding they themselves do not have. Moreover, the objective of patient choice inevitably raises practical difficulties in planning, and is likely to result in increasing costs. The quality of clinical performance is heavily influenced by the level of experience, and the number of operations performed. Improving clinical performance by concentrating operations in a limited number of centres—and thus building up professional experience and skills—is difficult to reconcile with patient choice.

(3) Encouraging innovation was given less prominence than improving quality or enhancing patient choice. Innovation was sought both as a means of reducing costs, through process innovations, and as a means of improving healthcare performance, through developing new products and new services. Market mechanisms are unlikely to result in process innovation in clinical practice, since such innovation often involves cross-functional cooperation, both within and among teams. Such cooperation is easier to achieve with integrated teams in a common organisation than in combinations involving different types of service providers. The DH (2011a) *Impact Assessments for the Health and Social Care Bill 2011*—which accompanied the initial publication of the parliamentary bill—argued that competition would lead to innovation, and, thus, to quality improvement. This may be so in the production of physical products, especially where consumers are able to compare quality effectively, as in motor vehicles or consumer electronics. However, innovation depends upon collaboration as well as competition—and upon high levels of trust among both suppliers and consumers, especially when inputs are difficult to define and outputs difficult to measure. HSCA and the attendant procurement rules may assist in product and service innovation, for example in the introduction of new drugs or new methods of organising, especially to reduce costs.

(4) Increasing competition was a major objective of the management reforms. DH (2011a) stressed the role of competition in enhancing quality of services and

reducing costs, regulation being necessary only where competition failed. Competition was regarded as clearly superior to regulation—‘competition where appropriate, regulation where necessary’. The terminology reflected the government’s comparison between healthcare and a regulated industry such as telecommunications—where, indeed, competition between suppliers drove technological innovation (Vickers and Yarrow 1988). According to DH (2011a: 34), ‘[t]here is very clear evidence from across services and countries that competition produces superior outcomes to centralised management and monopoly provision. Competition is more effective where markets are highly contestable and contestability requires that organisations are able to expand / enter the market and contract / exit particular markets in response to consumer preferences.’ In support, DH referred to the positive impact of competition on economic performance in the Central and Eastern European post-socialist transitions. Purchasing bodies—such as the clinical commissioning groups (CCGs)—could select without competition when ‘satisfied’ that the services could be provided by one supplier only—a higher threshold than ‘the best provider’. Reflecting the political conflicts, *The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013* underlined that providers must be treated ‘equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership’ (HM Government 2013: 2). Discrimination in favour of NHS providers would open the clinical commissioning groups to legal challenge from unsuccessful private sector bidders, and expensive and time-consuming litigation. A specific service being integrated with other services—with other healthcare services, for example, or with social welfare services—was the major exception.

Legal opinion differed on the implications of the 2013 *Regulations* for the NHS subjection to EU competition law. Neither the British government nor NHS wished NHS to become subject to EU competition law. However, the 2013 *Regulations* were derived from *The Public Contracts Regulations 2006* (HM Government 2006), derived in turn from EU legislation. In particular, competitive tendering was required for any contract above GBP 156,442, with heavy penalties for breaches. Moreover, the EU competition law ‘brings under scrutiny any collaborative and collective arrangements and the exercise of dominant local purchasing or providing power’ (Cragg 2011: 2), precisely the form of arrangements which had existed within NHS pre-2013. The costs and confusion resulting from any challenge under the EU competition law would be deeply damaging.

For many NHS professionals, the introduction of market principles and competition conflicted with fundamental NHS principles (NHS Support Federation 2012). Differences of principle were reinforced by differences of interest. Controversy over the significance of competition in procurement was partially

driven by the NHS professionals' concerns over creeping privatisation, undermining the financial viability of the service and thus its basic foundations. Private providers could 'cherry-pick' services that were easy to provide, leaving NHS hospitals with only difficult and expensive services, such as acute or accident and emergency, inevitably leading to financial imbalance, or even bankruptcy. Moreover, suppliers competing on price were only able to secure contracts by reducing the costs of labour through lower wages, an obvious threat to the terms and conditions of existing, highly unionised NHS employees.

There is also tension between competition and quality, and between competition and innovation. Assessment of contracts will inevitably focus substantially on price—value for money—a criterion easy to measure, and easy to justify publicly. This may often be at the expense of quality, especially quality of nursing provision, difficult to measure or monitor, as shown by the political controversy over nursing 'compassion' which followed the report into premature deaths at the Mid Staffordshire NHS Foundation Trust (Francis 2013). There is also potential conflict between competition and innovation, where innovation rests upon cross-functional integration and cooperation, difficult to achieve among different types of service providers. Competition also creates difficulties for ensuring continuity in service provision, where private providers have less incentive—and fewer resources—to provide long-term follow-up care. Ensuring continuity in healthcare is more difficult—and more important—than company car after-sale service, for example. Release from hospital raises practical difficulties (over arrangements with social services, for example), whilst postoperative relapses may raise issues of financial responsibility. HSCA proposed measures to facilitate entry into and exit from contracts, for firms facing financial difficulties, for example. However, it is difficult to see how exit could be eased without disrupting continuity of service provision, with serious medical as well as financial consequences. (The financial difficulties of private firms providing social care for the elderly had already resulted in serious financial problems, requiring major financial support from local authorities (Bingham 2013).)

(5) Underlying other objectives, HSCA was concerned to secure value for money, usually interpreted as reducing costs—an urgent objective, in view of the critical state of public finances. The introduction of market principles and the new commissioning arrangements were intended to facilitate control of costs in the medium and long term. Overall expenditure on healthcare increased from GBP 51 billion in 1999–2000 to GBP 102 billion in 2009–10, and GBP 104 billion in 2012–13, and was expected to rise further with a growing—and ageing—population (OECD 2012). Competition between private providers and NHS—and among private providers—would be an obvious means of reducing costs, at least in the short run.

One of the fundamental messages of corporate strategy is the importance of establishing priorities amongst competing strategic objectives, despite the usual difficulty in doing so. Neither HSCA (HM Government 2012) nor the supporting *Regulations* (HM Government 2013) indicated priority among the competing objectives. However, the explanatory note which accompanied the *Regulations*—but which was explicitly excluded from legislation, presumably for political reasons—stated that their purpose was to ensure ‘good practice’ in procurement, and to protect ‘patients’ rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners with regard to such services’ (HM Government 2013: 8–9). Choice and competition were the priorities—a view shared neither by political opponents, nor by the majority of NHS professionals. Both priorities were underpinned by concern with value for money—the *Impact Assessments* pointed to the overriding purpose of the new management system as aligning clinical and financial responsibility, ‘to [create] incentives to ensure commissioning decisions provide value for money and improved quality of care through efficient prescribing and referral patterns’ (DH 2011a: 7). The alignment was to be achieved through GPs combining clinical with financial responsibility. The means for linking patient quality of care with patient preference—and efficient prescribing and referral patterns—were not specified. Given the overall financial context—and the supervising role of Monitor—the incentives for GPs to prioritise value for money are difficult to resist.

Lack of clarity in roles and responsibilities

One source of uncertainty and lack of clarity is the relationship between the central government DH and the new NHS Commissioning Board, at the apex of the new management system. The relationship is critical—it reflects the fundamental balance between political and commercial considerations, and the extent to which the NHS Commissioning Board could be insulated from political influence. The initial bill envisaged the transfer of the majority of commissioning responsibilities from DH to the NHS Commissioning Board, funded by a (very large) annual budget allocation. The NHS Commissioning Board was expected to operate on business principles, insulated from political interference. However, this was very strongly opposed by the Labour Party—and by NHS professionals—who argued that it would practically remove commissioning responsibilities from public scrutiny. It is difficult to see how DH could have transferred such a large element of its overall responsibilities to an independent body. The bill envisaged the Secretary of State for Health being accountable for NHS, but not responsible for its day-to-day management. In effect, the bill imposed a self-denying ordinance on the Secretary of State for Health, despite the failure of previous attempts to avoid

political ‘interference’ in NHS matters. Ministers had not been very good at adhering to self-denying ordinances, especially in the face of constituency pressures, and with possible justifications for action provided by ‘accountability’, exceptional circumstances, and budgetary responsibilities. Under the original proposals, the Secretary of State for Health would have presented a mandate to Parliament for the forthcoming year, with authority to revise the mandate only in ‘exceptional circumstances’. There would have been little possibility for the opposition to question the minister on the performance of the commissioning process. The original proposals would have ‘muddied the waters’, resulting in marked lack of clarity in the respective roles of Secretary of State for Health and NHS Commissioning Board Chair, and the relationship between them. Following the government’s suspension of proceedings on the bill over the summer of 2012, to allow further consultation, the proposal for distancing the Secretary of State for Health from the commissioning process was dropped—the Secretary of State for Health was to remain responsible for the commissioning process and unable to disclaim knowledge. The attempt to reinforce market principles through legislation—by restricting the role of the Secretary of State for Health—was dropped. The issue remains to be resolved in practice.

The issue of institutional arrangements for monitoring quality is confused, with responsibility diffused over several entities (see Figure 2, p. 38, where NICE stands for National Institute for Health and Care Excellence). Overall responsibility for quality rests with the Care Quality Commission, while responsibility for stimulating competition—including the role of competition as a means for improving quality—rests with Monitor. The concerns of the Care Quality Commission differ from Monitor’s, and are highly likely to result in conflict. HSCA simply provides that the two should cooperate with each other—there is no mechanism suggested for resolving conflict.

Organisational complexity

The new organisational and funding arrangements are highly complex (see Figure 3, p. 39, where NICE stands for National Institute for Health and Care Excellence), involving both medical and managerial staff in substantial learning processes—the arrangements for public oversight are especially complex. The information technology (IT) systems required to support such structures are also complex—and currently untested.

The relationship between general practices and GP commissioning consortia will be critical to the success of the management reform. General practices will continue to receive direct funding for their patient lists, and for specific services—in connection with public health campaigns, for example, via a special funding

stream. For the purchase of clinical services, general practices will be tied to GP commissioning consortium decisions. GP commissioning consortium performance will be monitored by the Care Quality Commission, for quality, and by Monitor, for competition and value for money. The relationship between general practices and clinical commissioning groups—the extent to which general practices will be bound to follow the clinical commissioning group decisions if patients request an off-list service provider, for example—is unclear. Moreover, not all general practices are represented on their clinical commissioning group. Clinical commissioning groups contain professional managers and accountants, as well as clinically trained personnel. What is the relationship between the two groups? In particular, what influence—formal or informal—do professional managers and accountants exert? Post-2013 clinical commissioning groups may reflect traditional, pre-2013 tensions between clinical and managerial approaches. Finally, where GPs have financial interests in organisations bidding for contracts from their GP commissioning consortia, the new structures may give rise to acute conflicts of interest. Traditional methods of resolving conflicts of interest—by declaring interests and withdrawing from discussions, for example—may be difficult where clinical commissioning groups require inputs from specialised professionals. How effective are the means to control potential conflicts of interest, where medical professionals are involved in organisations competing for contracts?

The number and variety of clinical commissioning group *modi operandi* raise questions regarding the survival of a national health service. NHS is a national system designed—in principle—to ensure equal quality of healthcare for all citizens. There were already major disparities in healthcare outcomes among regions, before 2013, reflecting regional differences in the lifestyles, economic circumstances, and cultures of patients, as well as differences in quality of provision (ONS 2013). The new structure of 217 clinical commissioning groups—a larger number than initially envisaged—is designed to allow variations according to differences in local need, with budgetary allocations continuing to reflect DH assessments of such local needs. However, attempting to reflect differences in local need—within budgetary constraints—will inevitably lead to what critics have termed ‘postcode lotteries’, with treatments and services available in some—but not all—localities. Operating quality control procedures centrally via the Care Quality Commission (see Figure 4, p. 40, where ICAS stands for Independent Complaints Advocacy Service and PALS for Patient Advice and Liaison Service) will inevitably cut across the localism agenda linked to the clinical commissioning group structures.

The variety of opportunities for patients and the wider public to exercise influence within the new structure suggests that NHS will be subject to extensive oversight. The Healthwatch England committees include healthcare professionals as well as representatives of local authorities, social service organisations, and

patients. However, the extensive array of channels through which influence may be exerted may result in confusion and contradictory pressures—it is unlikely that assessments of quality, made at different levels of the structure, will agree. What pressure the Healthwatch England committees will be able to exert—beyond publicity—is unclear. Moreover, increasing private sector involvement will inevitably result in increasing claims for commercial confidentiality, restricting public access to meaningful data on funding arrangements, the allocation of contracts, and the quality of the services provided. The difficulties in oversight will naturally be greatest over patient complaints.

Monitor is the main mechanism through which DH seeks to implement its commitment to increasing competition. Initially, DH proposed that Monitor should have the responsibility for increasing competition as an end in itself. As a result of very strong opposition, including from healthcare professionals, Monitor's responsibility was reformulated, to expanding competition as a means of improving quality, enhancing innovation, and reducing costs, not as an end in itself. However, the relation between Monitor and other parts of the management system will prove contentious, in view of the continuing strong NHS opposition to Monitor's role in stimulating competition.

The mechanisms for assessing the quality of care are thus complex. Responsibility for quality rests ultimately with the Secretary of State for Health—The Right Honourable Jeremy Hunt, since 4 September 2012. His responsibility is discharged via the independent NHS Commissioning Board, Healthwatch England, regional bodies, and local committees that contain professional representatives, local government representatives, as well as patient representatives. Medical professionals—both hospital consultants and GPs—as well as non-medical staff are thus subject to a broad range of institutional monitoring and assessment procedures, as well as direct patient satisfaction surveys.

Conclusion: management in a permanently failing organisation

Managing healthcare raises in an acute form the relation between politics and public sector management. In the UK, NHS is a central feature of national consciousness, reflected in its prominent role in the London 2012 Olympic Games Opening Ceremony. Policies on NHS were central to the election manifestoes of all political parties in the 2010 General Election, with the Conservative Party promising to protect the NHS budget in real terms—exceptionally, alongside overseas aid and schools—and also to avoid top-down reorganisation. However, the public sector funding crisis that followed the 2008 banking crisis created a funding gap that made reducing public expenditure a priority. The financial crisis provided an opportunity for the Conservative Party to extend marketisation in the

public sector (especially NHS), expand the role of private sector finance, introduce private sector market disciplines, and reduce the entrenched power of professional interest groups. The model was the successful transformation of telecommunications in the early 1980s, which resulted in massively enhanced technological innovation and performance, funded by private investment. Transforming NHS along similar lines would complete the Thatcherite revolution.

Such radical government policies for restructuring the English healthcare management system were strongly opposed by opposition parties, public opinion, and medical and non-medical groups within NHS. HSCA reduces the basic NHS structure to a system of market relations, where patient care is bought by GP commissioning consortia—acting on behalf of general practices—and sold by Any Qualified Providers, within a competitive market. Government policy is designed to create a level playing field for market operations, with improvements in quality, innovation, patient choice, and financial discipline secured through market competition and—ultimately—fear of bankruptcy. Such competition would also drive costs down. In this model, there are strong pressures against inter-organisational collaboration and integration of services, and no role for cross-subsidisation—historically, two prominent features of NHS management. Where private sector providers win contracts, issues of commercial confidentiality arise, inhibiting transparency and accountability. Surprisingly, for a market-driven model, government statements make little mention of profit.

DH's consideration of the HSCA impact focused on a limited range of economic analyses, with little consideration of organisational and operational consequences, except as transitional inconveniences. Operational issues—such as IT system integration—received little consideration. Even in economic terms, there was no consideration of Leibenstein's (1966) 'x-efficiency'. The costs of organisational upheaval associated with the introduction of the new system were recognised as substantial, but regarded as transitional. However, evidence from research on private sector mergers and acquisitions showed that such costs are long term, especially where reconfiguration of IT systems is involved (Burnes 2000)—in the banking sector, for example, where the problems faced by the Co-operative Bank in absorbing the Britannia Building Society delayed the merger. Moreover, the costs of personnel recruitment and training for new management systems are substantial. The redeployment or redundancy of existing staff—and the recruitment and training of new staff—involve heavy costs, whilst the organisational restructuring renders the intellectual capital acquired through previous organisational learning often irrelevant. The supporters of the new healthcare system recognised that market failures occurred—due to externalities, natural monopolies, and imperfect information and uncertainty—but their significance for competition in healthcare provision was neglected, for example in the *Impact Assessments for the Health and Social Care Bill* (DH 2011a).

Permanently failing organisations are characterised by conflicting objectives, where high performance on one criterion generates low performance on another. This is exacerbated where there is no explicit prioritisation amongst objectives. In Meyer and Zucher's study (1989), the emphasis was on the conflicts among countervailing interests which develop within such organisations, which succeed in perpetuating themselves despite low performance. Such pressures exist within NHS, with strong, well-organised interest groups at all levels—amongst medical and nursing staff, as well as manual workers. However, the source of continuing failure is more fundamental, and lies in the conflict between professional commitment—reflected in the priority of clinical considerations, personal qualities such as nursing compassion, and quality of care—and market principles. Professional socialisation for medical staff—with strong orientation towards science and service—is very different from professional socialisation for corporate employees. For example, clinical leaders' reluctance to involve themselves in management concerns was experienced by the author in discussions with NHS staff about developing MBA-type programmes for NHS employees. Moreover, the relation between healthcare employees and patients differs from that between sellers and buyers—under the Hippocratic Oath, doctors ('sellers') are supposed to prioritise the interests of patients ('buyers'), not those of the organisation. Finally, the patient as consumer is not the purchaser, which remains the state—the links between service provision and the patient's financial contribution are indirect.

Governments and commercial organisations have historically had overlapping but distinct roles in healthcare provision in the UK. Governments have historically assumed responsibility for the provision of healthcare, with private sector provision as a peripheral contributor. The continuing role of healthcare as an aspect of social welfare is reflected in the HSCA title—and in the overall attempt to link healthcare with social welfare provision, especially needful for the elderly. However, HSCA shifted the boundaries between the roles of the state and those of private providers in practice, whilst seeking to maintain an element of continuity in rhetoric. The impetus for the shift derived partly from the increased cost of the state-provided service and partly from an ideological view that the role of the state—including its role in welfare provision—should be reduced, with individuals assuming greater responsibility for their own welfare. The Conservative-led coalition government introduced market principles into the provision of healthcare in the belief that markets were the most efficient means of allocating resources. The parallel between providing healthcare and providing consumer goods was explicit—the business practices of the private sector were a means of increasing efficiencies and controlling costs, in the provision of healthcare as in the provision of other services, such as telecommunications and transport. However, consumer attitudes towards healthcare differ from consumer attitudes towards other goods—and even transport—healthcare is more important. Moreover, patients as consumers are

heavily dependent upon the professional judgement and advice of those whom they consult, since they have difficulties in assessing the quality of the service they receive. Since 1948, patient trust has rested upon the absence of a direct financial relationship between patients and GPs, directly threatened by the new system which allocates both medical and financial responsibility to GPs.

Organisations providing healthcare have historically had different cultures and structures from conventional commercial organisations. In particular, healthcare is characterised by the central role of professionalism—amongst medical, nursing, and ancillary staff—institutionalised in the division of labour and reinforced by strong professional and occupational groupings, with associated status differences. Clinical considerations outweigh financial considerations, and clinical status managerial status. The characteristic form of organisation is not the entrepreneurial firm, but Mintzberg's (1979) professional bureaucracy, combining professional commitment with a strong emphasis on rules.

Providing healthcare involves a wide range of stakeholders—the state, commercial enterprises, qualified professionals (both salaried and independent), medical and non-medical managers and bureaucrats, as well as the patients themselves. Managing such a complex system requires recognising the interests of all stakeholders, within an overarching framework of patient needs. The interests of a national health service facing acute financial pressures are not best served by the model of aggressive market competitiveness that characterised financialised capitalism before the financial crisis of 2008. Even major private sector manufacturing organisations—especially in Europe—have rejected the forms of competitive market thinking enshrined in HSCA, as an inadequate basis for long-term competitive advantage (Streeck 2009). Such thinking is even less relevant to publicly funded service organisations, such as NHS. Market competition may stimulate innovation and controlling costs. But it may also lead to lack of investment, lack of long-term perspective, institutional instability, and inadequate learning. It is tragic that such a limited model should be reflected in the new NHS management system, even in a pale form. The HSCA organisational arrangements are a rehash of a market model popular in business schools in the 1990s, applied in a wholly inappropriate context.

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