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TRIPLE-ACCREDITED, WORLD-RANKED



# **Implementing Marketization in Public Healthcare Systems: Performing Reform in the English National Health Service**

## **ABSTRACT**

To implement marketization in public healthcare systems, policymakers need to situate abstract models of prescriptive practice in complex settings. Using a performativity lens we show how policy processes bring about the changes they presume. Investigating the implementation of the Health and Social Care Act 2012, and the development of a policy instruments and Clinical Commissioning Groups, we explicate the performance of a marketization programme. This longitudinal perspective on the interactions amongst the Act's aims, the multiple constituencies the Act attempted to enrol and the existing socio-technical arrangements the Act aimed to change, generates three core contributions. We (1) characterise the performativity of policy instruments as a process of bricolage that incorporates the principled attitude of making do on both sides of the divide – those who design the policy and those who are charged to implement it; (2) identify the mechanisms through which the performativity of an envisioned model of marketization operates at multiple scales within a complex and highly distributed system of provision; and (3) document and explicate why specific performances result in misfires and unintended outcomes. Thus, we conceptualise policy performativity as a non-linear, dynamic process where theories and their effects are constantly being assessed and reconfigured.

## **KEY WORDS:**

Bricolage, Healthcare Systems, Marketization, Performativity, Policy Instruments

## INTRODUCTION

This paper investigates how public policy is used to promote the marketization of a public healthcare system. Policymakers confront the fact that transferring the provision of goods and services hitherto supplied by bureaucratic, political or professional means, to market-based arrangements is hardly straightforward (Crouch, 2009). While marketization ideas often prescribe a vision of the systemic change needed to put marketization into practice, the ways in which ideas and instruments are mobilised to effect change remain opaque (Henriksen 2013a).

We define marketization as the “...entirety of efforts aimed at describing, analysing and making intelligible the shape, constitution and dynamics of a market socio-technical arrangement.” (Çalışkan and Callon 2010, p.3). Marketization reforms have taken root in education (Molesworth, Scullion and Nixon 2010), development (Berndt 2015) and healthcare systems (Araujo, La Rocca and Hoholm 2018, Ashburner, Ferlie and FitzGerald 1996, Cribb 2008, Moreira 2012, Sjögren and Helgesson 2007, Zeiss and van Egmond 2014, Zuiderent-Jerak 2009, Zuiderent-Jerak, Grit and van der Grinten 2015), amongst others.

We propose that the concept of performativity (Callon 1998, MacKenzie, Muniesa and Siu 2007) provides a powerful way to understand how policy changes designed to reconstruct social and political relations according to market principles, are put into practice. We define performativity as a process by which the introduction of elements from one or more expert domains (e.g. a theory, a model) is used to induce changes within a practical domain so that the world envisaged by the theory or model becomes progressively actualized. This process, as Callon (2007, p.320) reminds us, “...is a long sequence of trial and error, reconfigurations and reformulations”.

To date, studies of performativity have focused on the economic realm and the work of market professionals with its applications to public policy area remaining limited (Henriksen 2013a). As Henriksen (2013a) suggests, performativity studies would benefit from examining normative struggles over who gets to claim authority over the nature and scope of markets, by giving a voice to the sceptics or critics of markets.

We heed this call by studying a marketization policy for a public sector domain whose socio-technical order is markedly different from a market. In doing so, we broaden the study of performativity by: 1) describing the range of instruments through which policy is carried to the different levels of a complex, hierarchical and distributed system; 2) explicating how the world envisaged by policymakers is rendered progressively more detailed through multiple reformulations; 3) showing how the performative struggles of the model envisaged by policymakers with the models embedded into the existing socio-material order produced a patchwork of multiple orders; and 4) illustrating how the under-determined nature of the world envisaged by policymakers facilitated the emergence of a variety of agencies and relations other than the ones contained in the original model.

Rather than looking at performativity as the actualization of a single model or a theory and its linear impact on a practical domain, we look at dynamic, non-linear processes, involving multiple stages and using a variety instruments, to effect changes in a complex domain populated by reflexive agents whose predisposition to comply with change is open to question. To broaden extant perspectives of performativity, we ask; *how does a marketization model promoted by public policy become actualized through multiple policy instruments over a period of time, and reconfigures (or fails to reconfigure) the practices of a diverse group of actors embedded in a complex, distributed and hierarchical system?*

Our empirical setting is the English National Health Care System (NHS) and the Health and Social Care Act 2012, the last major reform imposed on the system (Ferlie and McGivern 2013). Our focus is on three early implementation stages. By unpacking the work different actors accomplish to put the Act into practice, we generate three theoretical contributions. First, we characterise the performativity of policy instruments as a bricolage that incorporates the principled attitude of *making do*. Second, we identify the mechanisms through which the performativity of the Clinical Commissioning (CC) model of marketization prescribed by the Act operates at multiple scales. Third, we explicate why specific performances result in unintended outcomes. In so doing, we show the ability of policy instrument to perform marketization relies not just on the presence of felicitous conditions (Butler 2010), but on the concurrent development of the original policy aims *and* the conditions that support the policy's performativity.

### **PERFORMING THE MARKETIZATION OF THE NHS**

The notion of performativity has a variegated history (see for example, Austin 1962, Barad 2003, Butler 1990). We draw on the use of performativity in economics and management studies is associated with the seminal works of Callon (1998), MacKenzie (2006) and Mitchell (2005). For Callon (1998, 2009), performativity is concerned with how forms of expertise help configure their own subject matter. Thus, the economy does not exist outside the knowledge, statements, representations and expertise that make it up as an object of representation and intervention (Callon 2009, Mitchell 2005).

MacKenzie (2007) distinguishes between generic and effective performativity. Whereas generic performativity refers to situations when an aspect of economics is used in but does not have a discernible effect on practice. In the case of effective performativity, an aspect of economics must be shown to make a difference to practice. Borrowing from Austin (1962),

Butler (2010) distinguishes between illocutionary and perlocutionary performativity. Whereas illocutionary performativity conjures up a reality through discourse (e.g. “I declare this meeting open”), for a perlocution to succeed, “...*there has to be a sequence of events and a felicitous set of circumstances. Perlocution implies risk, wager, and the possibility of having an effect, but without any strong notion of probability or any possible version of necessity*” (Butler 2010, p.151). Thus, as (Callon 2010, p.165) notes: “*Perlocutionary performativity implies that misfires are the rules of the game. The constitution of economic markets is no exception to the rule: it is an on-going process, constantly restarted*”.

Christophers (2014) outlines three challenges for the study of performativity. First, there is no suggestion that models configure the world in splendid isolation. Plenty of influencing factors compete to influence political-economic worlds and the performativity of economics has to be judged alongside these factors (Callon 2007, Mirowski and Nik-Khah 2007).

Second, while all models have the potential to be performative not all manage to be so. As Mason et al. (2015, p.6) argue, to understand how models become performative, “...*it is necessary to go beyond the models and examine who they are used by, who connects with them, how ideas are translated and represented or reassembled for other audiences and importantly how related actions change the conditions of the model’s performance*”. Thus, for a theory to become performative, felicitous conditions in the form a socio-technical *agencement*, including the theory and its assumptions, have to be present (Callon 2007, D’adderio and Pollock 2014).

Third, the performative force of a model depends on its origin and epistemic status. Christophers (2014, p.4) asks: “*Is it an academic economic model, born in academia and confined forever to debates within scholarly journals and among those who read them — an artefact, that is to say, of Mitchell’s ‘caged economics’? Or is it a more ‘worldly’ model from the very start, one designed, say, by consultants, with a particular policy application in mind*

— *an artefact of Callon's 'wild' economics?*” The scope of what counts as a theory or models should not be confined to academia but extended to a variety of settings, from government departments to corporate boardrooms (Mitchell 2005), and include ‘folk theories’, models and instruments developed from and widely used in practice such as those originating from management consultancies (D’Adderio, Glaser and Pollock 2019).

Even in cases where economists portray themselves as market engineers or designers (Roth 2012), translating economic models into solutions that address societal challenges, we should regard them as *bricoleurs*, working in alliance with others and cobbling together a variety of materials to suit the task at hand (Mackenzie, 2003; Nik-Kha and Mirowski 2019). Mackenzie and Guerra (2014, p.157) suggest that “...*successful innovation is nearly always bricolage: the creative, ad hoc re-use of existing resources (ideas and other cultural resources as well as artefacts), not the mechanical implementation of a grand plan nor simply logical deduction from existing scientific theory*”.

So far, performativity studies have mainly studied how academic theories and models are translated and embedded into calculative technologies, managerial and market devices, metrologies, incentive systems and so on. Henriksen (2013b) asks whether performativity applies just as well to a policy rather than a market setting, as the purpose of a model in both cases is to induce change in line with a model’s representations and predictions. In the same vein, (Hirschman and Berman 2014) note that whereas market devices have been studied extensively, there has been little interest in the devices that help policymakers represent and intervene in the world in economic ways.

The sparse literature on the policy performativity suggests similarities and differences between the two settings. Henriksen (2013b) suggests bureaucracies face different accountability criteria than markets and new devices will often need to acquire legitimacy in a wider

professional–scientific community before they migrate to policy settings. As is the case of economists involved in finance (Mackenzie, 2003) or market design (Nik-Kha and Mirowski, 2007, 2019), policy makers are often portrayed as pragmatists, combining ideas culled from a variety of sources rather being than wedded to specific models or theories, a process described as epistemological or policy bricolage (Freeman, 2007; Cartensen 2011; Stone, 2017). Campbell (2005, p.56) defines bricolage as a “... *a blending of bits and pieces from a repertoire of elements. This may entail the rearrangement of elements that are already at hand, but it may also entail the blending in of new elements that have diffused from elsewhere*”.

To study marketization as the process of taking market ideas and devices to policy settings, we focus on legislative texts and policy instruments. Legislative texts represent both outcomes of “...*sociopolitical and technoscientific debates and negotiations*” (Faulkner 2012, p.754), and once ratified, acquire performative power – i.e. they have the capacity to generate socio-material effects on the world they target. Legislative texts are regulatory performatives, by prescribing what actors can or cannot do backed up by sanctions for non-compliance but can also accomplish other functions. For example, they can introduce new actors, reconfigure how actors relate to each other, or define constraints and opportunities for action (Faulkner 2012). As Davies (2013, 2017) reminds us, market principles can become ‘state-endorsed norms’ through hard (e.g. legislation) as well as softer means (e.g. audits, rankings).

We see policy instruments as going beyond legislative texts by: (i) organising the relations between a polity (via its administrative structures) and civil society (via the administered subjects); and (ii) combining technical (e.g. legal rules, performance metrics) and social (e.g. representations, values, ideals) in support of policy aims (Lascoumes and Le Galès 2007, Le Galès, Scott and Jacobs 2010). As Lascoumes and Le Galès (2007, p.9) note: “...*the more public policy is defined through its instruments, the more the issues of instrumentation risk raising conflicts between different actors, interests, and organizations.*” Instruments embody

their own logic and create “...*original and sometimes unexpected effects*” (Lascoumes and Le Galès 2007, p.10). Voß (2016) suggests that instruments play a critical role in expanding spaces where envisioned realities are cultivated. These envisioned realities are constantly being made, contested and remade, often over long periods. As Hasselbladh and Bejerot (2017, p.297) note: “*It is not the case that great ideas crash when faced with a silent, material ‘reality.’ A pre-existing reality does not speak for itself, inevitably short-circuiting policy initiatives in advance.*”

Frankel, Ossandón and Pallesen (2019) suggest that selective features of markets such as competition or prices have become policy instruments in their own right as marketization reforms spread. One example of selective marketization is provided by the quasi-market interventions carried out by successive UK governments (Le Grand 1991, Le Grand 2006). Quasi-markets introduced market-like features in the public sector through: (i) not-for-profit organisations competing for contracts, sometimes with for-profit organisations; (ii) end-user purchasing power being expressed through administered rather than market prices; and, (iii) end-users’ choices being expressed through experts (e.g. doctors standing in for patients).

Whilst we support Frankel et al.’s (2019) call to study how markets for collective concerns, we do not regard market features as policy instrument in their own right. We suggest that policy instruments carry selected and adapted elements of markets to novel domains to “...programme the doing of a particular reality” (Voß 2016, p.7) as illustrated by Krafve (2014), Dix (2014, 2016) and Neyland, Ehrenstein and Milyaeva (2019). Krafve’s (2014) shows how instruments, involving rules, financial reimbursement schemes and incentives, helped introduce a quasi-market in the Swedish healthcare sector. Dix (2014, 2016) shows how economic models were brought into an experiment carried out in the Netherlands to introduce performance-related pay for teachers. Neyland, Ehrenstein and Milyaeva (2019) studied a range of devices used to

introduce selective features of markets into the treatment of electronic waste and social investment bonds for the protection of children at risk.

In short, studying the performativity of policy suggests we pay close attention to: (i) how marketization interventions are conceived and the mix of models, ideas and theories they carry; (ii) the multiplicity of instruments deployed to achieve their aims; (iii) the accommodation and resistances they encounter, and; (iv) the consequences that follow from these interventions including overflows and unintended effects.

## **METHOD**

Our aim is *theory elaboration*; extending ideas from performativity research without the need for inductive analysis (Maitlis 2005). In a five-year, longitudinal analysis of the creation, implementation and performance of the Health and Social Care Act 2012, we studied the performativity of an instrument, devised to marketize health and social care services. We paid attention to how particular market features from the Health and Social Care Act 2012 became embedded in policy instruments and how ‘Clinical Commissioning Groups’ became the key marketization instrument. We mapped out the production and use of key arguments in this process. Our approach treated documents “...as actors that can be recruited into schemes of organized activity and regarded by others as allies, enemies, or perhaps simply instigators of further actions” (Prior 2008, p.828).

**Research Context:** Our research questions required a context where a marketization initiative required practice changes for significant groups of actors with multiple forms of expertise. The research context needed to be typical (Yin 2009) of wider policy driven marketization initiatives (cf. Larsson, Letell and Thörn 2012, Lundahl et al. 2013, Petersen and Hjelmar 2013). The development and implementation of an Act of Parliament envisioning the marketization of a highly visible and critical public service is a particularly suitable context.

Acts of Parliament constitute Statute Law in the UK<sup>i</sup> and often identify specific groups and areas for change, particularly for the provision of public services. An Act's aim is to bring new worlds into being by setting out, reconfiguring or terminating rights, obligations and setting behavioural expectations for individuals and collectives. We adopted a qualitative approach suited to the study of dynamic processes and the coordinated practices of multiple groups of actors (Denis, Langley and Rouleau 2007, Mason, Friesl and Ford 2018).

**Case Selection:** The Health and Social Care Act 2012 was selected to meet the study's aim: to explain how an Act embodying a marketization process, has been made performative across a distributed group of actors. The Act followed decades of efforts to open the provision of public services to the 'benefits of market behaviour' (Freeman III 1979). In July 2010, a White Paper<sup>ii</sup> entitled *Equity and excellence: Liberating the NHS* was published. It set out a template for transformation of health and social care through the introduction of 'Clinical Commissioning'. As envisaged by the Act, local Clinical Commissioning Groups (CCGs) would be able to *commission* the services they needed from markets. Following the debates surrounding the White Paper, its transformation into a Bill, its passing as an Act and its enactment, presented a tightly framed opportunity to observe the performativity of a policy-led marketization process. It enabled us to trace how the provision of health and social care through clinical commissioning generated new practices at the junctures where the scenario envisioned in the Act collided with existing socio-technical arrangements.

**Data Collection and Analysis:** Through our study of the Act, we soon discovered that policy instruments generated a number of tensions and misfires. This quickly became the focus of our study. From June 2010 to July 2015 we moved abductively between data collection and analysis (Charmaz 2006, Dubois and Gadde 2002), developing our understanding of the case and related literatures concurrently, progressing our theoretical framework as we went. The data collected are summarised in Table 1.

Table 1: Summary of Data Collection between June 2010 and July 2015

Policy Instruments and Debates and evidence presented at Select Committees	Interviews & Workshops	Reviews & Evaluations: Health & Social Care System Research	Other Documentary evidence illustrating concerns and controversies
<p>White paper <i>Equity and excellence: Liberating the NHS</i>, (July 2010)</p> <p>Health and Social Care Act (2012)</p> <p>Debates where the White Paper and the Bill are presented and discussed in the House of Commons and House of Lords March 2011 to March 2012 (see Appendix 4 for process, dates and links to transcripts) including:</p> <ul style="list-style-type: none"> <li>▪ 3x Readings of the Bill in House of Commons</li> <li>▪ 3x Readings in House of Lords</li> <li>▪ 40x Debates in House of Commons</li> <li>▪ 15 Sittings in House of Lords</li> </ul> <p>Much of this work is filmed and/or audio recorded, and is available on the Parliamentary website: <a href="http://Parliamentlive.tv">Parliamentlive.tv</a></p> <p>Health Select Committee Evidence includes:</p> <ul style="list-style-type: none"> <li>▪ 3<sup>rd</sup> Report Commissioning oral and written evidence <a href="#">HC 513-I</a> <a href="#">HC 513-II</a> (Jan 2011)</li> <li>▪ 5th Report Commissioning: further issues <a href="#">HC 769-II</a> (April 2011)</li> <li>▪ 11<sup>th</sup> Report Appointment of the Chair of NHS Commissioning Board <a href="#">HC 1562-I</a> (October 2011)</li> <li>▪ 14<sup>th</sup> Report Social Care Report (Feb 2012 – 3 Volumes)</li> <li>▪ Social Care Oral Evidence <a href="#">HC317</a> (Feb 2013)</li> </ul>	<p>17x GPs on Commissioning Groups (Jan 2012- July 2015)</p> <p>3x Directors NHS Trust ( Jan-August 2013)</p> <p>4x workshops on NHS reforms (Sept 2012; Jan 2013) and selling to the NHS (July 2013; January 2014)</p>	<p>Smith and Mays (2012)</p> <p>Sheaff <i>et al.</i> (2015)</p> <p>Chambers <i>et al.</i> (2013)</p> <p>Imison <i>et al.</i> (2011b)</p> <p>Ham (2008)</p> <p>1x <a href="#">King's Fund time line</a> of the history of the Health and Social Care Act incorporating x35 data points including media reports, video footage of the Bill being discussed in the media and by politicians. (April 2013)</p>	<p>5x Fact Sheets: published by Department of Health:</p> <ul style="list-style-type: none"> <li>▪ <a href="#">Overview of the health and Social Care Act factsheet</a></li> <li>▪ <a href="#">Health and Care Structures factsheet</a></li> <li>▪ <a href="#">Scrutiny and improvement factsheet</a></li> <li>▪ <a href="#">Clinically-led commissioning</a></li> <li>▪ <a href="#">Provider regulation to support innovative and efficient services</a></li> </ul> <p>7x Slide Decks: published by Department of Health describing new structures and organisations</p> <p>Kings Fund Blogs including:</p> <ul style="list-style-type: none"> <li>▪ August 2012: <a href="#">How do the Commissioning Outcomes Framework indicators measure up?</a> Veena Raleigh</li> <li>▪ October 2012 <a href="#">How can we deal with the financial pressures in health and social care?</a> Professor Sir Chris Ham</li> <li>▪ November 2012: <a href="#">Is the NHS entering treacherous waters?</a> Professor Sir Chris Ham</li> <li>▪ Dec. 2012: <a href="#">Clinical Commissioning Groups</a>: what do we know so far? Chris Naylor</li> <li>▪ December 2012: <a href="#">Measuring Accountability for outcomes</a>: is transparency enough Veena Raleigh</li> <li>▪ The Health Foundation Policy Navigator: Blogs and timeline <a href="https://navigator.health.org.uk/">https://navigator.health.org.uk/</a></li> </ul> <ul style="list-style-type: none"> <li>▪ The Nuffield Trust Blogs</li> </ul>

Our abductive approach followed three overlapping stages:

*Stage One: the marketization context.* First, we spent time tracing the history of the Act to map out the concerns it was attempting to address. We made use of and followed public discourses using the resources detailed above and drew on the work of healthcare scholars (including, Chambers et al. 2013, Ham 2008, Imison et al. 2011b, Sheaff et al. 2015, Smith and Raven 2012). We used these observations to sensitise ourselves to how a variety of policy instruments had been used through successive waves of marketization and the effects they produced (Le Grand and Cooper 2013).

*Stage Two: following the Act.* Next, we observed how the Act progressed through parliament. A key observation was that a version of a market was “...*fitted into something that might be called ‘theory-based’ policy making*” (Timmins 2013, p.266), with concepts being plucked from the private sector and economics textbooks without supporting evidence that they might actually work in a public service system: “[T]he policy was, in a sense, a leap of faith founded in theory, rather than hard evidence from existing health policy” (*ibid*).

*Stage Three: following the Act’s implementation across multiple sites of practice.* We wanted to understand the performative effects of the Act at the scale of both programmatic actions and situated practices. Although the targets of policy interventions often have no option other than comply with what is prescribed, reactions to those interventions are neither passive nor bound by existing rules – they fall under what (De Certeau 2004) described as the ‘tactics of consumption’.

The economist Alain Enthoven, often credited as the inspiration for marketization reforms (Timmins 2013), observed that the NHS structure relied “...*on dedication and idealism. It is propelled by the clash of interests of the different provider groups. But it offers few positive incentives to do a better job for the patients, and it has some perverse ones*” (Enthoven 1985,

p.18). This observation sensitised us to the notion of *bricolage* as a way to heighten our awareness of the tensions between the world envisaged by the Act and the work performed to overcome its limitations, misfires and unintended consequences. A significant part of this work was carried out by healthcare practitioners who had to improvise, make do and use what was at hand in order to work *with* as well as *around* what the Act asked of them.

## THE HEALTH & SOCIAL CARE ACT IN PRACTICE

In this section, we outline the Health and Social Care Act 2012 and describe the roles and relations it set out to organise. We explore the contested aspects of the Act through an analysis of public commentaries as well as through observations and interviews with actors involved in putting the Act into practice.

### *A Programme of Action: developing market representations as guidelines*

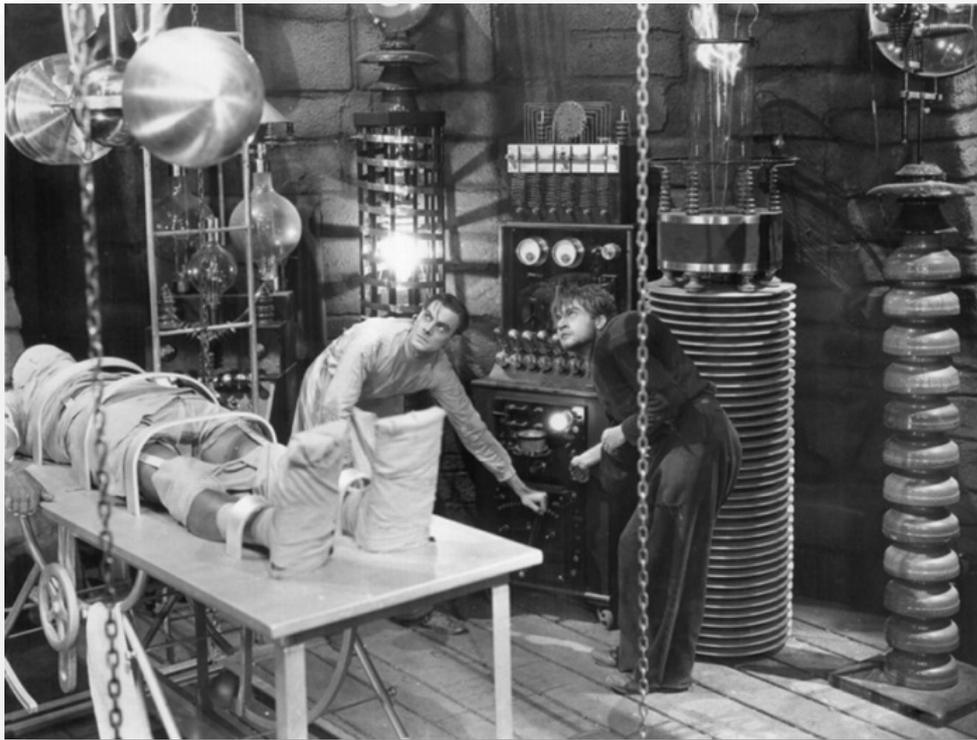
The first stage of implementation of the Act was to introduce it to key constituents and to set expectations about what the Act aimed to achieve. The Act was the largest piece of health legislation since the creation of the NHS and was subject to 50 days of debate<sup>iii</sup>. Over 2,000 amendments were agreed (Cambell 2012).

Introduced by Andrew Lansley, the then Secretary of State for Health, the Act was seen by key commentators as controversial, as it promised the delivery of excellent health and social care at a reduced cost (see House of Commons Health Committee 2014). Senior clinical practitioners regarded the Act as being impossible to implement. In a blog titled *Dr. Lansley's Monster* in the *British Medical Journal*, using an image from the film, *Frankenstein* (figure 1), Delamothe and Godlee (2011) wrote:

*“The scale of ambition [of the Act] should ring alarm bells. Sir David Nicholson, the NHS chief executive, has described the proposals as the biggest change*

*management programme in the world—the only one so large “that you can actually see it from space.” (More ominously, he added that one of the lessons of change management is that “most big change management systems fail.”<sup>iv</sup>)*

Figure 1. An image taken from the 1931 *Frankenstein* film (Universal Pictures)<sup>1</sup>, used in the *British Medical Journal* 2011 to represent feeling about the Health and Social Care Act 2012.



The Act decreed a significant re-organisation of the health and social care system, relocating the responsibilities of the Secretary of State to society and the healthcare system. This generated a major point of entry for private service providers by modelling new market engagement structures, the Clinical Commissioning Groups (CCGs) (Krachler and Greer,

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<sup>1</sup> Colin Clive (left) and Dwight Frye (right) in *Frankenstein* (1931), directed by James Whale. © 1931 Universal Pictures Company, Inc.; photograph from a private collection.

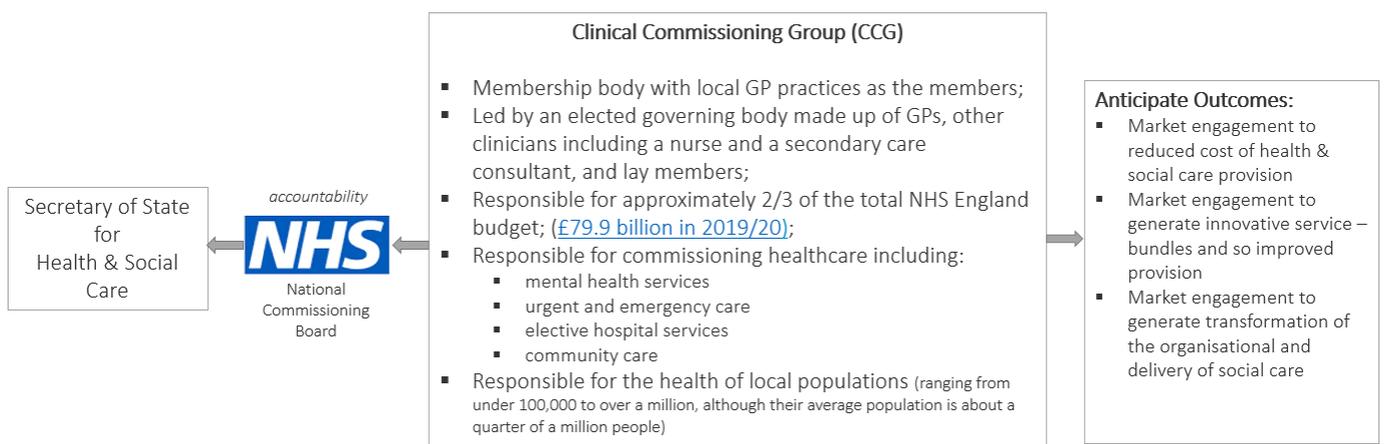
2014). CCGs were to access competitive markets to provide alternative, innovative and affordable healthcare provision.

The Act redefines the roles and responsibilities of the different organisations that constitute the NHS and the broader health provision system which, through CCGs, aims to engage the NHS with markets. The political desire to develop this approach had been evident for a while, motivated by the need to alleviate pressures and contain costs of secondary care<sup>v</sup> (c.f. Sheaff et al. 2015). GPs, given their gatekeeping roles in access to secondary care as well as their knowledge of patient lists, were seen as being in a pivotal position to commission the right type of healthcare on behalf of their patients (Smith and Mays 2012). The assumption was that if GPs were made accountable for large referral and treatment budgets, they would become more cautious in accessing secondary care and would be incentivised to alternative routes such as patient self-management and prevention (Imison et al. 2011b). This model is captured in section 6E (presented as amendments to section 6D of the National Health Service Act 2006 ‘insert’; figure 2) and is summarised by our visualisation (figure 3).

Figure 2. Extract from the Health and Social Care Act 2012 (Chapter 7)

- 20 Regulations as to the exercise of functions by the Board or clinical commissioning groups**
- (1) After section 6D of the National Health Service Act 2006 insert—
- “6E Regulations as to the exercise of functions by the Board or clinical commissioning groups**
- (1) Regulations may impose requirements (to be known as “standing rules”) in accordance with this section on the Board or on clinical commissioning groups.
- (2) The regulations may, in relation to the commissioning functions of the Board or clinical commissioning groups, make provision—
- (a) requiring the Board or clinical commissioning groups to arrange for specified treatments or other specified services to be provided or to be provided in a specified manner or within a specified period;
  - (b) as to the arrangements that the Board or clinical commissioning groups must make for the purpose of making decisions as to—
    - (i) the treatments or other services that are to be provided;
    - (ii) the manner in which or period within which specified treatments or other specified services are to be provided;
    - (iii) the persons to whom specified treatments or other specified services are to be provided;
  - (c) as to the arrangements that the Board or clinical commissioning groups must make for enabling persons to whom specified treatments or other specified services are to be provided to make choices with respect to specified aspects of them.

Figure 3. Our Visualisation of the Clinical Commissioning Model Described in the Health and Social Care Act 2012.



As public sector actors prepared to put the Act into practice, the King's Fund, in a submission to the House of Commons Health and Social Care Select Committee, wrote;

*“Commissioning has often been described as the weak link in the NHS since the purchaser-provider split was introduced in 1991. This Committee and its predecessors have highlighted its shortcomings .... Commissioning health services is a complex and difficult task and no other health system in the world that we are aware of places as much emphasis on it as a means of driving improvement.” (The Kings Fund 2013: 1)*

There was considerable ambiguity as to what commissioning meant within the NHS (Sheaff et al. 2015). To stabilise the meaning of the term, the newly formed NHS Commissioning Board produced a report, *“Developing Commissioning Support: Towards Service Excellence”* (2012: 7). The report represented commissioning as a complex set of functions, processes and tasks involving *“transactional”* and *“transformative”* functions. The transactional function was associated with routine purchasing and contracting issues whilst the transformative function was represented as innovative, involving clinicians leading change through service redesign and engaging with local stakeholder to define health priorities. The report left open how this support might be obtained apart from mentioning the independent, voluntary and charitable sector as a potential source of support (cf. Chew and Osborne 2009).

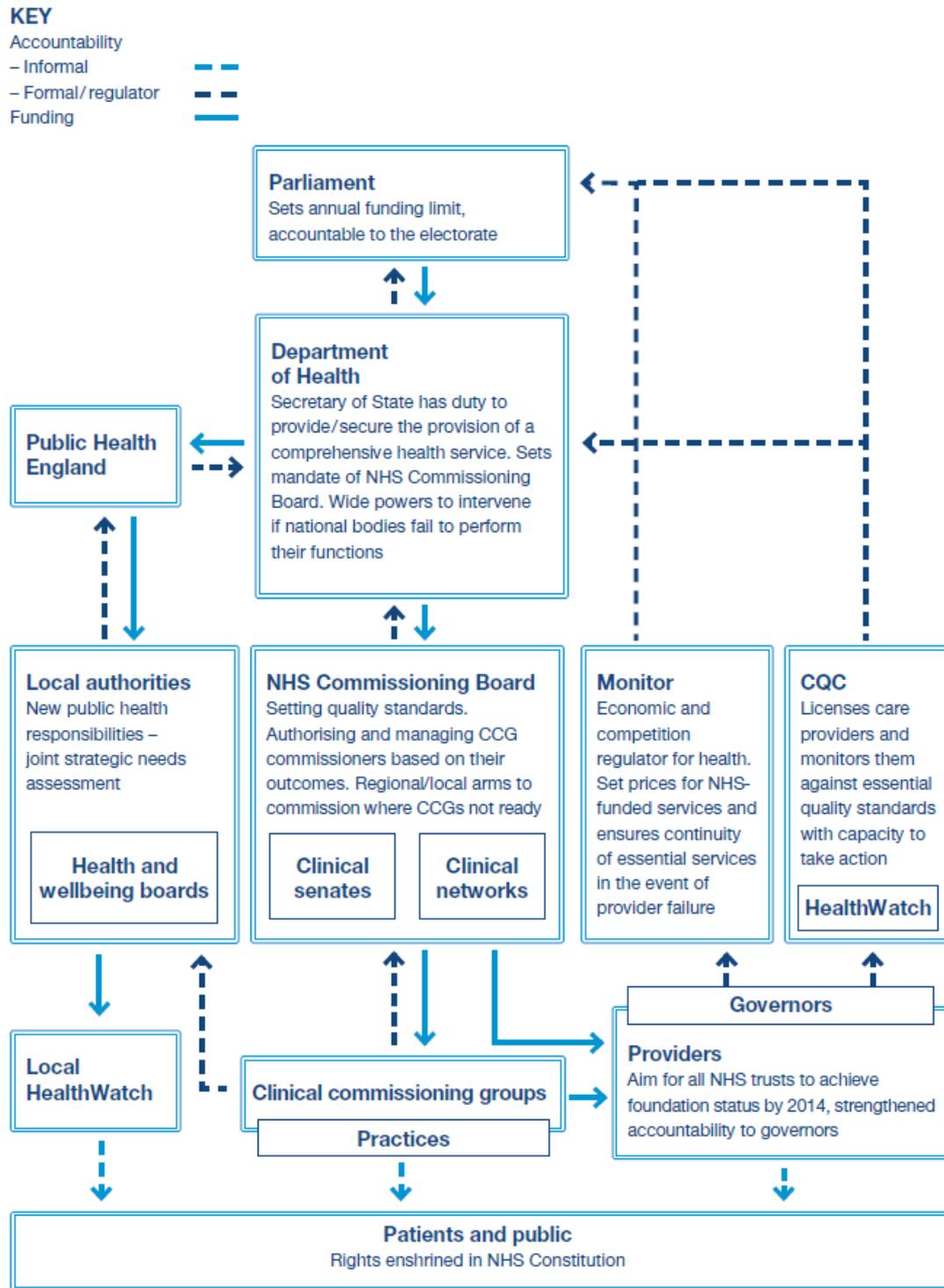
Unsurprisingly, given the well-documented past failures in commissioning<sup>vi</sup>, management consultancies looked at the NHS reforms as heralding opportunities to provide commissioning support. The National Association of Primary Care (NAPC)/ KPMG guide on Good Governance for CCGs (Imison et al. 2011a), suggested a hybrid partnership between different types of organisations, identified a host of issues with tips concerning governance and management, and referred to the *‘model constitution for Pathfinder CCGs’* (ibid, p.8):

*“Clinical commissioning groups (CCGs) will need to combine the nature of a statutory body with that of a membership organisation if they are to achieve their full potential in improving the health of their population. This is genuinely an opportunity to break new ground internationally in the pursuit of greater value health care. This guide provides a solid foundation on which emergent CCGs can build and as such should be regarded as an invitation to innovate.”* Dr Jonathan Marshall, Chairman, NAPC in the NAPC/KPMG guide on Good Governance for CCGs (p.3)

These observations show different worlds engaged with the performance of the Act. They reveal how the CC model gets re-presented for various purposes: as *‘impossible’* by clinicians contesting the programme of action and as *‘an opportunity’* by clinical bodies and management consultancies. These expectations shaped new relations as actors attempt to mobilise others to perform a particular version of the model, where *“Clinical commissioning groups (CCGs) ...combine the nature of a statutory body with that of a membership organisation...”* (Good Governance for CCGs, p.3). These novel combinations included actors from worlds external to the model and assembled experience from clinical and non-clinical settings to guide the operation of CCGs. A number of devices were introduced, comparability, accountability, transparency, and openness to market engagement activities was encouraged. The flow of funding to CCGs was modelled, along with the CCGs relations with multiple agencies including the “public and patients” (Figure 4).

Figure 4. The New Structure of the NHS following the Introduction of the 2012 Act: lines of funding and formal and informal accountability

Source: Good Governance for Clinical Commissioning Groups. Introductory Guide, 2011)

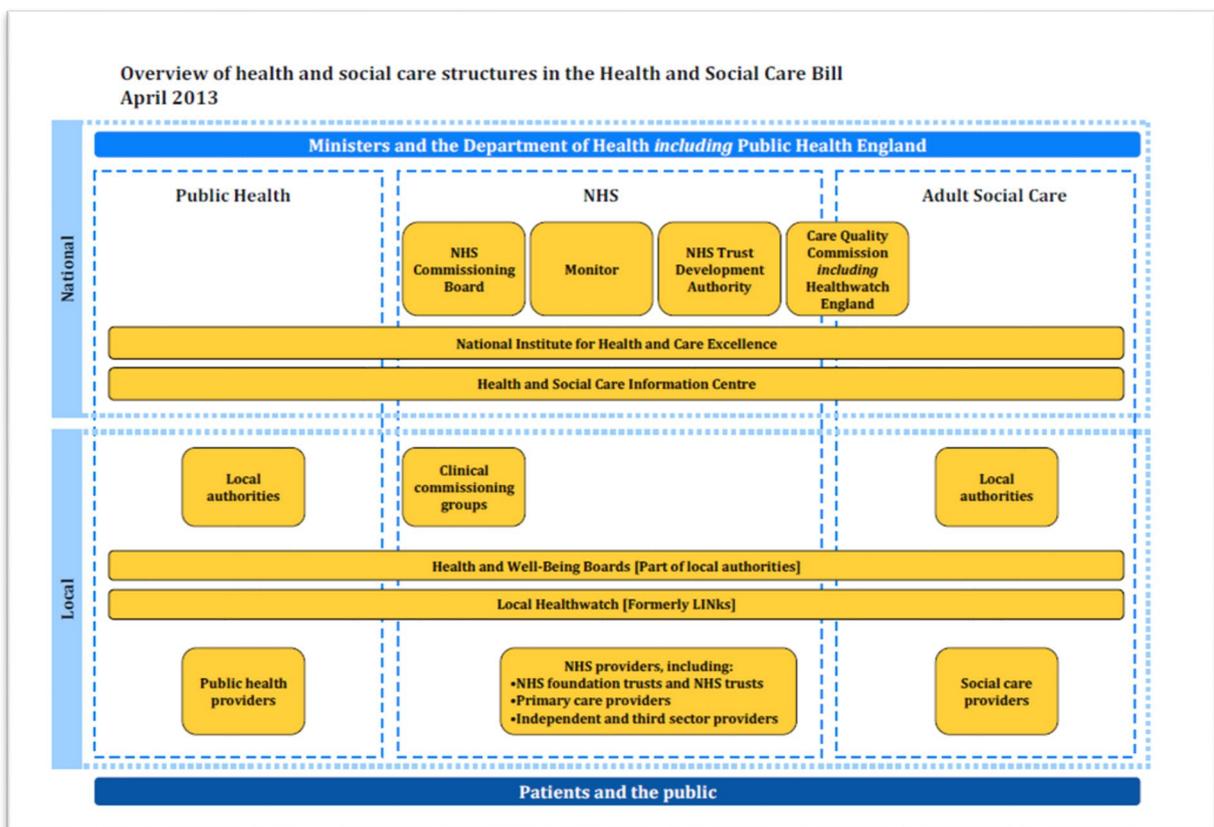
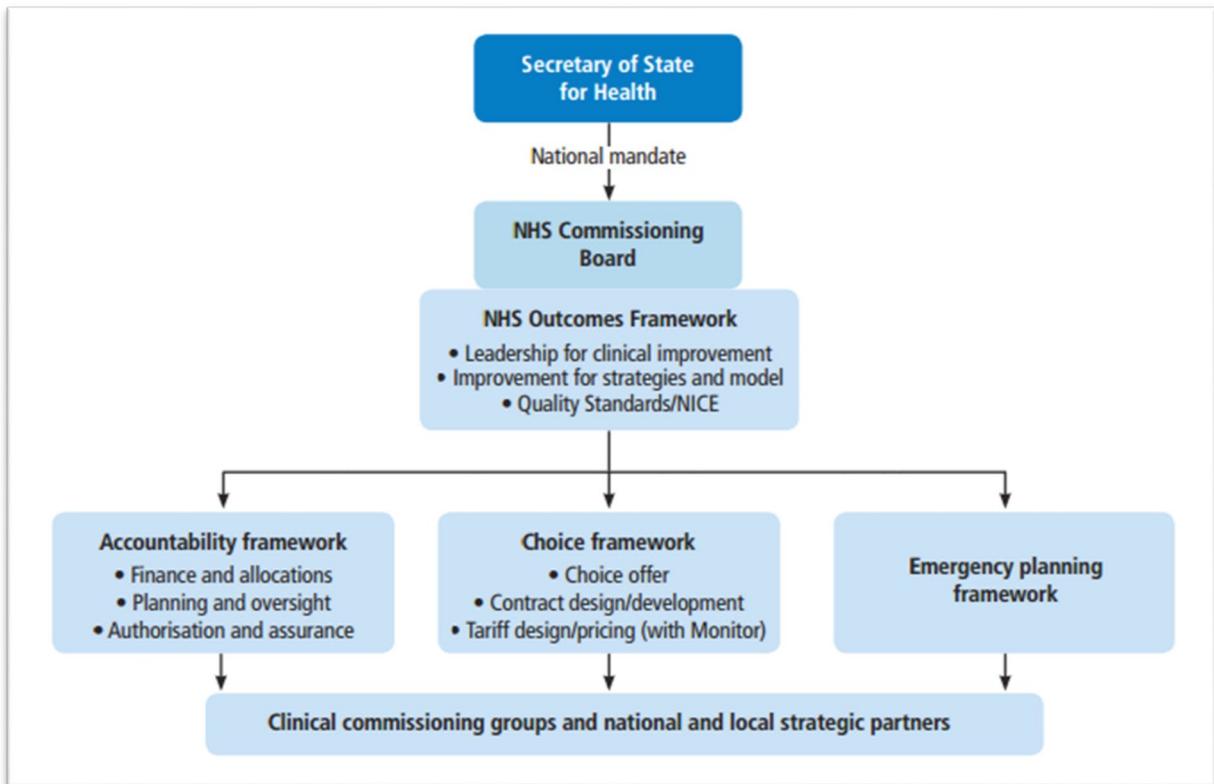


*Putting Clinical Commissioning Organisational Structures into Practice.*

Once the Act and guidelines were published, the second stage was to put into practice the organisational structures it prescribed. By April 2013 the new structures began to make a difference. The NHS Commissioning Board was formed, and a new hierarchy combined local healthcare and social care provision through horizontally connected national bodies (figure 5). The National Commissioning Board sat above but worked with local CCGs, *"supporting, developing and holding to account an effective and comprehensive system of clinical commissioning groups"* (NHS 2011, p.5). The aim was for the local CCGs to be *"responsible for commissioning the majority of healthcare services... [and to] have a dual role in that it will both deliver its own commissioning functions and ensure that the whole of the architecture is cohesive, coordinated and efficient."* (NHS 2011, p.6).

The National Commissioning Board provided templates for the constitution of commissioning groups, factsheets, organisation charts and 'evidence' (see for example, Ham 2008). The Department of Health launched the World Class Commissioning Programme to educate GPs in commissioning practices. The focus was on 'value-based purchasing' (NCB website) where actors were encouraged to explore innovative and complex service-bundles. These multiple instruments all worked to put the Act into practice in a *"show and tell"* (Poppy) approach to clinical commissioning structures and processes.

Figure 5. Slides circulated by the NHS National Commissioning Board



As the CCGs began operating, they encountered problems. For example, rather than generating a 3.4% growth in the resource (a commitment presented by the NCB), GPs' experienced a deficit. Statutory contributions to Adolescent Mental Health Services, the Better Care Fund and GP IT, together with other regulatory obligations meant that the resource to commission innovative health and social care service bundles from the market were, in practice, extremely limited. GPs and other commissioners formed discussion forums to share war stories and resources, reporting that they "*...could not find the market*" (Tony) or "*there was no alternative*" (Andrew). The NHS Clinical Commissioning is a membership group that sees its role as helping CCGs, "*... get the best healthcare and health outcomes for your communities and patients.*", acting in the interest of CCGs and giving "*... a strong, influencing voice from the frontline to the wider NHS, national bodies, government, parliament and the media. We're building new networks where you can share experience*". It published an infographic (figure 6), using the 'constraints' argument to contest the Department of Health's evidence that the reforms were working.

As new structures were put into place, new practices, flows of knowledge and resources emerged leading to multiple elements of the CC model being questioned – funding was not as generous as it first seemed, and regulatory constraints restricted innovative commissioning, "*market choice seemed to be surprisingly absent*" (Andrew). Some new structures were specified by the Act, others were not. The world *became* more like the CC model but claims of innovation and transformation of patient care were contested.

Figure 6. Contested Commissioning Provision and Practice

Source: NHS Clinical Commissioning



### *Clinical Commissioning Projects in Action*

In the third stage of implementation CC projects were put into action. Sheaf et al.'s (2015) suggest that although commissioning worked in certain respects it was often found to be a laborious and uncertain process. The attempt to turn GPs into hybrid agents, combining multiple valuation schemes in their decisions to use secondary care, appeared to be failing with little "...*clinician involvement on the financial side*" (Sheaff et al. 2015: 103). Instead, commissioners engaged with providers through negotiations and discussions about evidence, even if they regularly checked providers' performances against national and regional benchmarks. Trust and commitment between NHS actors with long experience of working with each other trumped the competitive mechanisms the Act had envisaged.

Through workshop discussions, and interviews with GPs and other service providers, we came across descriptions of locally based initiatives that had changed (or were changing) the commissioning of services at the group level. A recurring theme was the confusion and frustration caused by the multiplicity of roles and conflicting values that the new commissioning structure vested in GPs, particularly where finance aspects were considered.

One former GP, Kate who became an NHS Trust Director, explained:

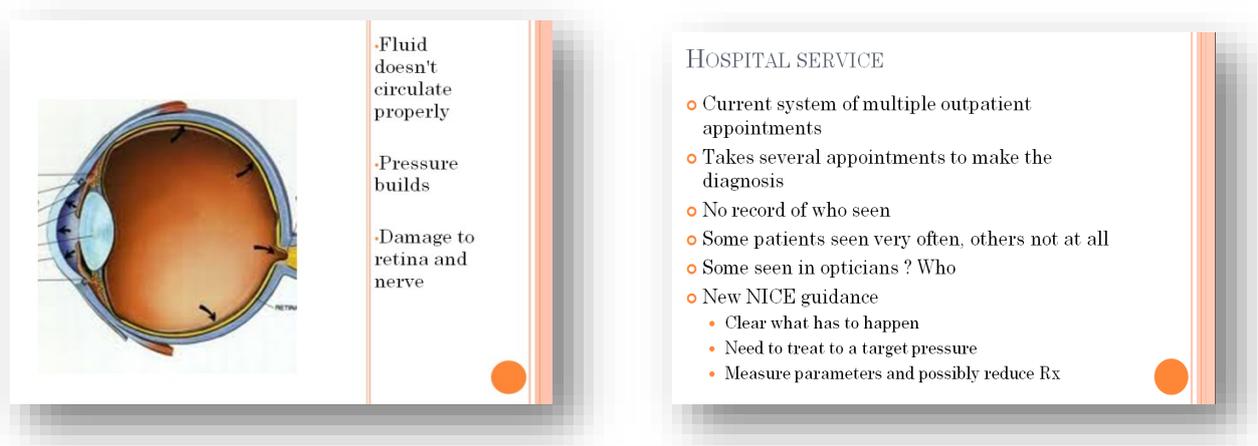
*"I was running our practice, and one day I had a patient in front of me, and I knew the treatment she needed, and I knew that it wasn't cost effective for us to buy that – and I realised I was thinking of acting in the interest of our practice, in securing value for money rather than in the interest of the patient, and I knew it was time to change my job."* (Kate)

While the CC model was producing effects, it was also interfering with clinical work and judgements. Patients were no longer automatically referred to NHS Centres of Excellence "...*expert health professionals... com[ing] together to provide the very best care and treatment ...*" (Genetic Alliance). The logic behind these stable investments was best patient outcomes

(not market competition or population health). GPs began to make different judgements. Others struggled to make the system work for them, despite their persistence and enterprise. The Act and the ‘caged’ CC model had taken little account of extant clinical practices. One GP, Andrew, told of a specific issue he encountered when trying to commission glaucoma patient care. Glaucoma is a disease of the eye. Pressure in the eye builds to a point where permanent and irreversible damage is caused to the retina and optical nerve (figure 7). Eye drops or surgery can keep the pressure to a level that preserves sight but requires careful monitoring. GPs do not have glaucoma equipment in their surgeries, so patients are treated in dedicated eye clinics. Andrew explained:

*"...it had been bugging me for a while. Patients at my surgery kept telling me that their clinic appointments kept being deferred. They'd wait three months for an appointment, have it cancelled, wait three months for a new appointment then that one would be deferred as well. .... a little audit ... found that one patient had been seen ten times and 30% of patients had not been seen at all within a year".*

Figure 7. Part of a GPs representation of the Glaucoma problem for the Commissioning Board



One of the key devices used by GP surgeries managing care is *'the disease register'* (Andrew): listing all patients diagnosed with a specific condition. GPs are incentivised

through performance measures to keep people out of hospital by monitoring and managing diseases:

*"In secondary care<sup>vii</sup> there aren't any disease registers. So, the only way [the hospital] could do their audit was as a manual audit. Because there is no register, the hospital really has no idea when it sees patients.... They cannot tell who's been seen... if your appointment is deferred for some reason, you just go to the bottom of the list."* (Andrew).

Andrew's first move was to try and help the hospital deliver the service levels needed. He spent a day at the eye hospital clinic observing and talking to administrators, consultants and patients. Initially, the clinic suggested *'hiring more staff'*, employing another consultant, more secretaries and *'revamping the building'*. Through discussions with the CCG, the problem was reframed as a *patient management problem* and eventually the appropriate software was commissioned. But the software was ignored by hospital record keepers. Andrew worked with the administrators to understand what kind of IT system would fit into their existing working practices and then commissioned an IT consultancy to adapt the software interface. The expertise of the GP had to be extended to administrative work practices, patient management and IT consultancy. Commissioning services from another clinic was *'not an option'* (Andrew) as no other organisations in the region had equipment.

We heard similar stories about efforts to commission other services. In each case the GP had identified a problem, collected data to support claims, spoken to other GPs in the area to check if they faced similar problems and then approached the commissioning board. On each occasion the commissioning process had been collaborative, across many GP surgeries, with new and current service providers, patients who had experienced problems and members of the commissioning boards.

In short, while the commissioning process was interpreted and shaped in practice through a multitude of distributed efforts, the new system could hardly be considered to be operating as envisaged by the Act. The Act's envisioned structure collided with both well-established practices within the NHS as well as the conflicting interests that Enthoven (1985) had long ago identified as plaguing the NHS.

## **ANALYSIS AND IMPLICATIONS**

Our interpretation of the findings is synthesized into three observations which describe the characteristics of performativity of the Act and more specifically, the CC model; the mechanisms through which these performatives operated; and the performances achieved.

### **Bricolage as a Critical Element of Performativity**

Our findings illustrate how the performativity of CC, the linchpin of the Health and Social Care Act was put into practice through the deployment of multiple instruments (e.g. guidelines, organisation charts, templates), attachments to market devices at hand (e.g. prices, alternative market offerings) and theories in use by the existing system of health provision (e.g. clinical care, patient and population health management). This process created a series of nested layers that continuously reconstituted how commissioning could innovate the health and social care system, adding situated knowledge to the prescriptions laid down by the Act.

Performativity, in this context, is not the putting into practice of a single theory that shapes and is shaped by its use in practice (cf. MacKenzie 2006). Rather, our findings show performativity as a continuous process of reconceptualization, distributed across multiple sites of action, achieved by cobbling together elements of theories that attached themselves to the CC model and repeated efforts to enact it. Theories of clinical care, professional behaviour, economy and efficiency, market exchange and management, as well as a *bricolage* of incentives and socio-

technical arrangements were all mobilised to flesh out and realise the Act's prescribed outcomes.

As actors encountered problems, they reached for materials at hand, but their behaviour was also influenced by practical matters such as accessible IT interfaces or resource constraints. Each of these steps connected to the CC model creating novel and increasingly complex and tension-ridden prescriptions. This *bricolage* was essential to transforming the system of provision while simultaneously generating a sense of continuity and 'business as usual'. This was not achieved without unintended effects, namely the constitution of conflicted agencies as illustrated by Kate's attempt to combine her patient care approach with the CC model.

This observation has important implications for understanding performativity. First, it shifts the focus from the designers that developed, represented and prescribed Clinical Commissioning, to the key constituencies that implemented the Act. In so doing, we reveal how multiple constituencies produced new conceptualisations of Clinical Commissioning *in situ*. Thus, we extend conventional understandings of performativity by going beyond the relation of a 'caged' model with extant socio-technical elements of practice already being performed in 'the wild' (Callon and Rabeharisoa, 2003; Mitchell 2005), by uncovering what we might call *working theories* and the conflicts they generate, as they seek to attach to or work around a prescribed model of action. An implication of this finding is that when policy-makers expect key constituencies to resist or become critical of the merits of a programme, they should also expect these constituencies to turn to the theories, expertise and devices *at hand*, to help them through the struggles of putting prescribed models into action (cf. Henriksen 2013a).

As the performativity of policy is directed at the reconfiguration of agencies and their relations, it is important to consider what *agencing* effects policies achieve. Our findings suggest a significant potential for misfires and unintended consequences triggered by ambitious policy

changes, as illustrated by the many conflicted agencies that we encountered. This positions reflexive agencies such as healthcare professionals and the Health and Social Care Select Committee, as central to the success of large-scale change programmes and suggests the need for investments in working with these agencies to carry out marketization initiatives.

### **The Effects of Performativity of the Act at Multiple Scales**

The mechanisms that put the Act into practice were organised at different scales: the national programme of action; the national and regional socio-technical organisational structures and management practices; and the local or regional commissioning projects as part of the healthcare system of provision.

At the scale of the programme, the Health and Social Care Select Committee is set up to review implementation evidence; the National Commissioning Board is established to advise and monitor regional CCGs. At the level of organisational structures, new agencies are setup and/or co-opted to bring in their expertise from other fields of organisation and management – e.g. KPMG’s active role in developing guidelines. At the scale of the commissioning project GPs and CCGs engage with different market and clinical actors – e.g. IT consultants, specialist hospitals.

At each scale, constituents produce a variety of different policy instruments, each of which inscribes elements of the Act to be put into practice: at the scale of the programme, policy instruments relate to how CC fits into the extant system of provision; at the national and regional scale, socio-technical arrangements organise flows of information, resources and accountability; at the local scale the particularities of specific commissioned solutions use market devices (e.g. alternative market offering, prices, competition) to generate and deliver solutions (e.g. user friendly patient management software).

At each scale, different theories and market devices enter into circulation as the CC model encounters different forms of expertise and experience and types of problem. This suggests a process of *bricolage* enrolling and attaching theories and devices at different scales, to help interventions in the health and social care provision world. Interventions across all these scales are necessary and have to interconnect in the unfolding transformation of the healthcare system.

While past studies have focused on the performativity of a singular theory with diverse groups of actors, and on the iterative transformation between the theoretical and the practical at a single scale of action (Doganova and Eyquem-Renault 2009, MacKenzie 2006), policy scholars have tended to adopt the opposite perspective: focusing on multiple policy instruments and their performative effects in relation to a single group of actors at a single scale of action (Lascoumes and Le Galès 2007). By drawing on the notion of *bricolage* performed at different scales, we bridge these perspectives to develop a nuanced conceptualisation of the performativity of a parliamentary Act as a mechanism for marketization. In so doing, we show how the scale of action at which *bricolage* is performed directly impacts the kinds of theories that are *at hand* (Hirschman and Berman, 2014), and in turn, how these help construct and sometimes frustrate a prescribed system of provision across different groups of actors.

As we suggested, interventions at different scales do not necessarily cohere. For example, at the scale of the programme, it is those with experience, expertise and working theories of clinical and social care management that are constructed as sceptics by the clashes generated when theories of markets collide with those of healthcare provision. Market theories suggest choice and competition provide access to efficient and affordable provision, while healthcare theories suggest specialist, long term investments in stable centres of excellence generate the most effective outcomes. At the organisational scale, it is the clashes between clinical care and the marketization of population health management that matter. Understanding how and why such tensions become built-in to the performance of the Act at different scales may help policy

makers and practitioners better anticipate the challenges of implementation and mitigate performativity misfires.

### **The Multiple and Situated Nature of Performativity**

The Act envisaged transactional *and* transformative Clinical Commissioning, yet professional clinicians and carers were ill equipped to commission the innovative service bundles envisaged by the Act. When a GP (Andrew) wanted to commission effective glaucoma monitoring and treatment services there was no market at hand: he knew only of a single NHS provider struggling with patient management problems. Only in settings where the socio-technical arrangements enabled the accommodation of the prescriptions contained in the Act did the CC model perform as envisaged. Such felicitous conditions are rare.

Despite these challenges, prescriptions did not cease to be performative in often unexpected ways. When a GP failed to commission the glaucoma services he needed, commissioning practices were adapted: the GP did the work expected of market actors - observing, designing, developing and putting into place the required services. Here, commissioning was modestly innovative and significant efforts were required to perform “*anything that might remotely resemble successful commissioning*” (Andrew). Hostile environments were created by the legacies of the existing healthcare system: few market devices and practices were at hand or could not be easily created from scratch. In this regard, the CC model represented only one, albeit an important element of performing the 2012 Act. The multiple settings where the Act must be performed also played a key role. Thus, the Act had stronger performative effects at higher institutional levels where key concerns about communicating and resituating conceptualisations of the CCGs took place, and much weaker ‘on the frontline’ of commissioning practice.

At first sight, it might appear that the fault lied with the type of markets envisaged by the Act: established and at hand competing service providers. However, as Callon (2007) and Garud et al. (2018) observed, performativity is a process that often unfolds over long periods, with long sequences of trial and error as well as reconfigurations. The 2012 Act generates a vision of a world prescribing which agencies should inhabit that world, how they should interact and what types of system-wide effects those agencies and interactions should generate. However, those agencies do not lie in waiting or pre-exist the implementation of the Act. Considerable effort was expended after the Act came into effect to specify what skills and competences existing agents should acquire to turn themselves into the commissioners and providers envisaged by the Act. In the meantime, ill-equipped and increasingly conflicted agents acted as *bricoleurs*, availing themselves of whatever was at hand to bridge the gaps between what the Act prescribed and what was possible to accomplish. As Mackenzie and Guerra (2014, p.157) suggested: *“To be successful this bricolage has to be oriented towards local situations and immediate problems as well as wider goals, and it sometimes inverts the relationship between ends and means”*.

## CONCLUSION

Based on the premise that the performativity of marketization models embedded in policy instruments transforms both the model and the world within which it is implemented, we documented how a *bricolage* of theories and socio-technical arrangements at different scales sustained a staged implementation process that acted back on understandings of what the changes were meant to accomplish. We suggest that a nuanced understanding of the performativity of an Act of Parliament provides the basis for understanding how stronger performativity effects occur at the higher institutional level and weaker ‘on the frontline’ of commissioning practice, where critical social-technical arrangements were not at hand or where extant working practices collided with the logic of marketization.

We make two important contributions to the study of policy performativity. First, we question the notion that performativity is restricted to cases where clearly identifiable models or theories emanating from academia produce effects in the world, progressively making it more like the theory. Instead, we have shown that performativity can involve a *bricolage* of models or theories from various provenances that hold only partial and underdetermined views of ends or means.

If the work involved in market (Mackenzie, 2003; Nik-Kha and Mirowski, 2007, 2019) or policy design (Freeman, 2007; Cartensen 2011; Stone, 2017) has been recognised as *bricolage*, less has been said about how policy users cope with the effects of policy implementation. Our findings suggest that the notion of *bricolage* applies equally well to the users as to the designers of policy. But, unlike De Certeau’s (1984) suggestion that usage does not manifest itself through its own products but rather through its ways of using the products imposed by an external order, we witnessed users creating an evolving patchwork, combining elements from existing worlds as well as the new socio-technical world envisaged by the Act.

Whereas performativity approaches have implicitly relied on a linear model of innovation, with self-propelled and complete products (e.g. theories, models) diffusing into the world of users with greater or lesser success (D’Adderio et al, 2019), we propose an alternative model. Policy is often incomplete and its ability to perform particular worlds relies not just on the presence of felicitous conditions, but on the concurrent development of the aims contained in the original policy and the conditions that facilitate those accomplishments. To use a different analogy from the innovation literature (Bijker, 1992), the policy is invented as it is diffused. The model and the world become progressively adjusted to each other through multiple rounds of interaction between designers and users. As we have shown, these iterative, mutual and partial adjustments require both sides to act as *bricoleurs* by making creative and ad-hoc use of the resources at hand.

The core claim from our analysis is that Acts of Parliament that incorporate marketization models, confront and become attached to hostile socio-technical arrangements that were set up to work differently, and additionally to multiple working theories and across multiple sites. By presenting a framework for how policy performativity works, and the associated *bricolage* required to enact policy changes, we hope to stimulate further inquiry into the dynamic interactions between policy instruments, devices, models and theories, as well as the tensions involved in marketizing public services.

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## END NOTES

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<sup>i</sup> <https://www.parliament.uk/about/how/laws/acts/> provided details of the UK Government institutions and processes. For a comparison of thirteen contemporary government systems work see Pollitt, C. and G. Bouckaert. (2017). *Public Management Reform: Into the Age of Austerity*. Oxford: Oxford University Press.

<sup>ii</sup> In the UK a White Paper is an official paper issued by the Government as statements of policy, and often sets out proposals for legislative changes, which can then be debated before a Bill is introduced.

<sup>iii</sup> Secondary care is medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialized knowledge, skill, or equipment than the primary care physician can provide.

<sup>iv</sup> To watch a brief history of the NHS changes that lead up to the Health and Social Care Act 2012, see: <http://www.kingsfund.org.uk/topics/nhs-reform/health-and-social-care-act-2012-timeline>

<sup>v</sup> See Timmins, N. (2010). "Warning on Nhs Budget Pressures." in *Financial Times* Vol. Dec 9. London: Financial Times.

<sup>vi</sup> See the PwC report for the Office of Fair Trading entitled Understanding Commissioning Behaviour: Commissioning and Competition in the Public Sector, 2011

<sup>vii</sup> Secondary care refers to the services provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).