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Mills, T.

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UNIVERSITY OF WESTMINSTER
SCHOOL OF SOCIAL SCIENCES HUMANITIES AND LANGUAGES
DEPARTMENT OF POLITICS AND INTERNATIONAL RELATIONS

The Political Economy of Coordination Challenges in the National Health Service

A Postpositivist Evaluation of Diabetes Policy and Governance

Thomas Mills

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Abstract

The present PhD thesis develops and applies an evaluative methodology suited to the evaluation of policy and governance in complex policy areas. While extensive literatures exist on the topic of policy evaluation, governance evaluation has received less attention. At the level of governance, policymakers confront choices between different policy tools and governance arrangements in their attempts to solve policy problems, including variants of hierarchy, networks and markets. There is a need for theoretically-informed empirical research to inform decision-making at this level.

To that end, the PhD develops an approach to evaluation by combining postpositivist policy analysis with heterodox political economy. Postpositivist policy analysis recognises that policy problems are often contested, that choices between policy options can involve significant trade-offs and that knowledge of policy options is itself dispersed and fragmented. Similarly, heterodox economics combines a concept of incommensurable values with an appreciation of the strengths and weaknesses of different institutional arrangements to realise them. A central concept of the field is coordination, which orientates policy analysis to the interactions of stakeholders in policy processes. The challenge of governance is to select the appropriate policy tools and arrangements which facilitate coordination. Via a postpositivist exploration of stakeholder 'frames', it is possible to ascertain whether coordination is occurring and to identify problems if it is not. Evaluative claims of governance can be made where arrangements can be shown to frustrate the realisation of shared values and objectives.

The research makes a contribution to knowledge in a number of ways a) a distinctive evaluative approach that could be applied to other areas of health and public policy b) greater appreciation of the strengths and weaknesses of different forms of evidence in public policy and in particular health policy and c) concrete policy proposals for the governance and organisation of diabetes services, with implications for the NHS more broadly.

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Statement of Authorship

I hereby confirm that this thesis is the product of my own work. All sources used are referenced.

September 30th, 2015

Thomas Mills

Date

Introduction

In recent years there has been much interest in new forms of governance, whereby central government adopts a 'steering' role in what is an increasingly 'differentiated polity' (Rhodes, 1997). The shift to 'networked governance' has been accompanied with increased awareness of the different policy tools available to policymakers in their attempts to solve complex economic and social problems, whether hierarchical, market or networked arrangements (Thompson et al, 1991). However, the literature on governance is typically descriptive, identifying, explaining and conceptualising the shift from government to governance (Sorensen and Torfing, 2007: 14). There is a lack of research on the *evaluation* of governance which specifically addresses choices between forms of governance (Sorensen and Torfing, 2007: 311; see also Torfing et al., 2012)¹.

My aim in this PhD is to develop and apply a methodology suitable for addressing evaluative questions of policy and governance in complex policy areas. I do this through a focus on the National Health Service (NHS), where the challenges posed by NHS reform bear all the hallmarks of a complex, or 'wicked', policy problem (Keasey et al, 2011).

1.1 NHS Reform and the Problem of Evaluation

When I began my PhD in September 2011, the NHS was in the news on a daily basis: the changes to the health service initiated by the Conservative/Coalition Government's Health and Social Care Act (2011) represented one of the biggest reorganisations of the health service since it was created in 1948. The Government's White Paper *'Equity and Excellence: Liberating the NHS'* argued that reforms were necessary to end "excessive bureaucracy and top-down control". The reforms would create a "social market" that would provide patients with choice, enhance accountability and stimulate innovation by "liberating" local actors, all the while safeguarding traditional values associated with the health service such as equality and universalism (DoH, 2010). However, the reforms were greeted with unprecedented public and professional protest. The Government's critics claimed its reforms entailed the privatisation of the health service and would compromise core values associated with it. The public nature of the pre-reform NHS purportedly made it uniquely capable of realising equity, quality of care and efficiency (Pollock et al., 2011a).

At the same time, an additional debate on the nature of care was taking place, which was no less significant and occurred sometimes alongside and sometimes apart from the debate on the use of markets in the health service. The decision of the National Institute for Health and Clinical Excellence (NICE) to lower the risk threshold for heart disease at which patients are offered cholesterol-lowering

¹ Eva Sørensen and Jacob Torfing call for research which focuses on the "political choice between different combinations of hierarchy, market and networks in relation to particular policy problems" (Sorensen and Torfing, 2007: 311).

drugs, or 'statins', prompted the concern of some patient groups and health professionals "about the 'medicalisation' of the population" (Boseley, 2014a). These concerns resonate with longstanding criticisms of "industrialised medicine" voiced by the likes of Aldous Huxley and Ivan Illich (Illich, 1976).

These debates raise questions which the present project seeks to address:

- What governance arrangements are appropriate in the health service?
- Is there a role for markets and the private sector in the provision of health services?
- What interventions and forms of care should the health service provide?
- And what research methodologies are appropriate to address such evaluative questions?

I argue that dominant forms of evaluation are inadequate to address such questions. A sign of this inadequacy is the contested nature of the evidence in health policy debates. During the passage of the Health and Social Care Act, the Government and its supporters claimed the reforms were evidence-based (Le Grand, 2013; Le Grand and Cooper, 2013), but the critics claimed they were anything but (Pollock et al., 2011a). Likewise, the evidence underpinning NICE's decision was just as contested. The British Medical Journal (BMJ) sparked controversy when it published two articles – one by Professor John Abramson, of Harvard medical school – that were critical of statins, prompting calls for the articles to be retracted and the resignation of the journal's editor. An independent panel eventually agreed that revisions were required, but disagreed with the calls for the editor to resign. Nevertheless, the controversy continues, with critics continuing to dispute the benefits of statins at a lower risk threshold, amid concerns that trial data has been withheld by pharmaceutical companies (Abramson et al., 2013; Godlee, 2014a; Godlee, 2014b).

These debates reflect a fundamental problem of evaluation that is inadequately addressed by dominant forms of evaluative research: that effectiveness and performance are contested concepts. In what follows, I draw upon literatures in policy analysis, public administration, political economy and the philosophy of social science to develop a qualitative, postpositivist approach to the evaluation of policy and governance. This is applied to NHS reform and in particular diabetes policy and governance. Diabetes was selected because the condition touches most aspects of the health service and is widely considered to be one of the most significant public health challenges of the 21st century (Farooqi, 2012; PHE, 2014). Furthermore, NHS diabetes services have attracted considerable criticism in recent years. A recent inquiry by Public Accounts Committee reported that the state of diabetes care is "depressingly poor" (PAC, 2012: 3). Some stakeholders raise concerns which resemble issues discussed above, regarding the market reform of the health service and the 'medicalisation' of health problems (Yudkin, 2012).

1.2 NHS Reform, Postpositivism and Political Economy

Due to its evaluative nature, the present project is rooted within the discipline of policy analysis, which first emerged in the 1960s. Policy analysis is a broad discipline which includes analytical and descriptive research, where the focus is on the explanation of policies, as well as evaluative research. Policy evaluations enable the identification of appropriate courses of action, through robust, empirical analysis². Evaluation, here, can be understood as a systematic attempt to determine the value or worth of something by judging it against certain criteria. The ultimate aim of policy evaluations is to improve the effectiveness of public policy. Policy evaluation has increased in prominence in recent years following the rise of Evidence-Based Policy, a movement which seeks to spread the practice and use of evaluation throughout the public sector and thus ensure that decisions at all levels are clearly evidence-based (Matthews, 2012: 244). However, since the inception of policy analysis, there has been extensive debate about what constitutes a suitable approach to evaluation.

Frank Fischer, a prominent exponent of ‘postpositivism’ in policy evaluation, criticises the influence of ‘positivist’³ social science and ‘neoclassical’⁴ economics over the discipline. Under these influences, policy evaluation typically involves the quantitative analysis of policy problems and presents choices between different options as a technocratic problem of selecting the most efficient ‘means’. Fischer is concerned that such an approach fails to recognise the essentially normative and contested nature of policy decisions, arguing the discipline has developed along “technocratic rather than democratic lines ... geared more to managerial practices than to the facilitation of democratic government” (Fischer, 2003: 5).

In this PhD, I draw upon postpositivist policy analysis partly to understand the limitations of dominant approaches to policy evaluation and partly to develop an alternative approach. Postpositivists are committed to analysing the different and potentially contested understandings, values and interests of stakeholders which come into play when they analyse and evaluate policy (Dryzek, 1994; Fischer, 2003; Stone, 2001; Shapiro and Schroeder, 2008). Yet I go beyond typical applications of postpositivist *policy* analysis to apply the approach to a set of questions it is not usually applied: to evaluative questions of *governance*, where decision-makers have options between the different ‘governing structures’ of hierarchy, markets and networks (Rhodes, 1996: 653; see also Thompson et al, 1991).

The debate on NHS reform takes place across these two levels. At the level of policy, decision-makers confront choices between different interventions, services and forms of care, whether ‘biomedical’ healthcare, mental health, social care,

² While the literature often used policy analysis and policy evaluation interchangeably (Choudhary, 2009: 4), the current project differentiates between the two on the basis that policy analysis can be used to refer to both descriptive and evaluative research, whereas policy evaluation is always evaluative.

³ Positivism can be usefully defined as ‘scientism’: a general belief that the only genuine knowledge is scientific knowledge (Olga, 1988).

⁴ ‘Neoclassical’ refers to the dominant economics framework (see chapter 3).

public health or alternative/complementary therapies. It is at this level where some stakeholders are concerned about the 'medicalisation' of health problems (Boseley, 2014a). By far the most contentious debate, however, concerns decisions at the level of governance, where national policymakers confront choices between broader policy tools that aim to enhance performance of the health service. At this level, there is significant debate about the use of performance management in the health service (a form of hierarchical governance) and the use of markets and the private sector (a form of market governance) (Meuleman, 2008: 73).

I propose an approach to evaluation which synthesises postpositivist policy analysis with the discipline of political economy. It does this via a focus on coordination, a concept that features prominently in literatures on public administration and policy economy. A central problem of public sector governance is to facilitate coordination, understood as a state where the actions and decisions of relevant stakeholders are consistent with and supportive of each other (Pressman and Wildavsky, 1973: 233). Coordination is particularly important in the context of 'wicked' policy problems, because actors are dependent upon each other to solve them and no one individual or agency has sufficient expertise or resources to solve them alone (Jennings, 1996: 2). The concept also features in heterodox political economy, where it is a corner stone of Friedrich Hayek's analysis of the market as a coordinative mechanism. Though Hayek is famously pro-market in his views, it is possible to extract from his work a concept of coordination which can be used in the evaluation of governance (Greenwood, 2010; Greenwood, 2012).

Evaluating public sector governance in terms of coordination entails focusing on the interactions between stakeholders at different stages of the policy process. Hayek's concept of coordination is consistent with a postpositivist perspective because he recognises the qualitatively distinct and incommensurable values which motivate actors, as well as the fragmented and dispersed nature of knowledge. One of the challenges of governance, viewed through the lens of coordination, is to acquire the knowledge of how to solve policy problems and translate that knowledge into concrete policy and governance arrangements. By exploring and comparing national policy 'frames' with those of other stakeholders, it is possible to ascertain whether coordination is taking place and evaluate policy and governance. Of course, stakeholders might have very different values to those prioritised by national policymakers, suggesting stakeholders have real political differences.

At the same time, however, there may be a degree of common ground which would provide a basis for an evaluation. The analysis might identify values and knowledge that are suppressed by current policy and governance arrangements. Local implementers of policy or recipients of services might highlight issues which arise in the delivery of policy which were unanticipated at a national level. Where policy and governance can be shown to frustrate the realisation of shared values in this way, then policy decisions are resulting in 'coordination problems'. It might also be possible to identify alternative policy options and arrangements which, if implemented, would improve the overall effectiveness of governance. In this way,

via a comparative assessment of stakeholder frames, it is possible to address evaluative questions of public service governance.

The main objectives of the PhD are as follows:

- To gain greater understanding of the interface between politics and markets in general and the marketisation of the public sector in particular;
- To critically examine different frameworks of political economy in order to draw out their implications for governance evaluation;
- To highlight problems with existing evaluative research on policy and governance in public services and the NHS;
- To develop the conceptual tools necessary for the evaluation of policy and governance arrangements in public services and the NHS;
- To identify and understand the nature of “coordination problems” across the diabetes pathway;
- To make concrete policy suggestions for the governance of the diabetes pathway.

2.1 Chapter Overview

Chapter 1 and 2 serve as introductory chapters, providing an introduction to the topics of public service reform and evaluation. They provide historical context and a survey of the issues. Chapter 3, 4, 5 and 6 constitute the main body of the text, involving theoretical inquiry in the fields of the philosophy of science and political economy. Chapter 7, 8 and 9 constitute the case study section: chapter 7 provides an introduction to the debate in health policy, chapter 8 examines the evidence and chapter 9 involves an empirical investigation of diabetes policy and governance. A more detailed overview follows:

Chapter 1 introduces the topic of public service reform. As a central organisation of the welfare state, the NHS has been strongly affected by wider intellectual and policy developments that relate to the structure of the economy and the organisation of public services. The chapter provides some background on these developments. I introduce criticisms of the postwar welfare state and the reform process, exploring the New Right ‘settlement’ and Third Way approaches to governance. The question of the appropriate governance arrangements for public services is very much open, with some controversy over the use of markets in public services and performance management.

Chapter 2 explores the topic of evaluation in the context of public services. As a starting point, it begins by defining policy and governance, which is critical to the chapter and the PhD as a whole. It then critically examines the forms of evaluation used to inform decisions at the levels of policy and governance.

Like the reforms to public service governance themselves, the rise of policy evaluation has proved controversial. Some stakeholders claim that Evidence-Based Policy, in its current form, may actually distort decision-making. A key issue is the use of quantitative metrics to measure performance in policy evaluation, in the practice of performance management, the economic and scientific appraisal of public services and evaluations of governance, which often rely upon data collected through performance management. Ultimately, quantitative evaluation only provides a partial account of the quality of public services and the effectiveness of governance.

The literature on 'networked governance' does recognise failings of dominant economic and scientific forms of evaluation to capture the complexities of governing processes. However, evaluations of 'networked governance' have a process-orientation and do not specifically address whether governance is effective in improving public sector *outcomes*. Furthermore, the literature does not address evaluative questions of public sector governance such as the appropriateness of markets or managerialist policy tools. The question of how to evaluate policy and governance is therefore very much open.

Chapter 3 begins the process of developing a methodology suitable for the evaluation of policy and governance in complex policy areas. The chapter explores in more detail dominant approaches to policy evaluation, most notably the Randomised-Control Trial (RCT) and Cost-Benefit Analysis, as well as the philosophies and frameworks which underpin these methods, most notably 'positivism' and 'neoclassical' economics. After that, the chapter examines a number of postpositivist philosophies of sciences and applications of postpositivist philosophy to policy evaluation. On the basis of these inquiries, I argue that a qualitative, postpositivist approach to evaluation is required, one that provides a more detailed account of the effectiveness of different policy options through an analysis of stakeholder 'framings'. Yet, though postpositivist policy analysis provides useful insights into evaluative strategies at the level of policy, it is rarely applied to evaluative questions of governance.

Chapters 4 and 5 explore the field of political economy which provides invaluable insight into the strengths and weaknesses of markets and the state to affect coordination. Indeed, the debate over public services is in many respects a microcosm of this wider debate at the level of the economy. I analyse a number of perspectives in political economy, each of which has insights relevant to the topic of governance evaluation. Where chapter 4 explores the 'neoclassical' framework in more detail, along with attempts to develop that framework for the purposes of institutional evaluation; chapter 5 explores so-called 'heterodox' economics, which combines a postpositivist appreciation of value diversity and incomplete knowledge with institutional analysis.

The analysis centres upon two key issues which arise in governance contexts: how to acquire and disseminate information regarding the most valued use of resources, i.e. the 'knowledge problem'; and how to elicit the motivation of actors to seek out

and act upon that information, i.e. the 'motivational problem'. While recognising the need to address these issues, I critique the conclusion reached by pro-market commentators that only markets can align incentives and provide signals of valued uses of resources. Ultimately, empirical research is required to explore evaluative questions of governance and appropriate solutions are likely to differ in different policy contexts.

Chapter 6 draws upon the preceding chapters and presents a framework for the evaluation of policy and governance in complex policy areas. I highlight the importance of focusing on the concept coordination, which is central to both public administration and political economy and consistent with a postpositivist perspective on values and knowledge. Coordination orientates analysis to the interactions between stakeholders involved in the policy process and their views on the substantive content of policy and outcomes.

There are two key aspects of stakeholder frames that are important to take into account: knowledge of the policy problem at hand and of specific policy solutions on the one hand; and knowledge of the impacts of governance on the other. Only by considering both levels can the effectiveness of governance be ascertained; for the quality of local services in many respects determines the quality of governance. By exploring and comparing national policy 'frames' with those of stakeholders at a local level, it is possible to establish whether coordination is taking place. The analysis might reveal examples where the decisions of national policymakers are frustrating the realisation of policy goals and objectives and indeed provide insight into more effective options at the level of policy or governance.

Chapter 7 and 8 set the scene for the case study. Chapter 7 begins by presenting the Conservative/Coalition Government's reforms introduced following the passage of the Health and Social Care Act (2011). This serves to identify the values and objectives which the Government has prioritised, as well as the means that have been selected to achieve them. Following that, the chapter identifies and explores the dominant frames in debates in health policy and governance, some of which have clearly influenced the Government's reforms and some of which are more oppositional. Building upon Kor Grit and Wilfred Dolfsma's typology of health policy 'discourses' (Grit and Dolfsma, 2002), I identify five main frames at the level of governance: a 'market' frame, a 'managerialist' frame, a 'medical-professional' frame, a 'progressive' frame and a 'political' frame. Additionally, I identify two main frames at the level of policy: a 'holistic' frame and a 'medical' frame. These framings provide a useful starting point to understand the contours of the debate at the two levels and provide a basis for the subsequent chapters.

Chapter 8 examines the evidence on NHS reform, which is important given the level of contestation which exists in the debates. The chapter examines the evidence on the various policy tools which have been used in attempts to enhance the performance of the health service, including Evidence-Based Medicine, performance management and marketisation. The analysis draws upon the framings set out in chapter 7, which have distinct positions on these policy tools

and approaches. I also reach some tentative conclusions about the effectiveness of the different policy tools, based on areas of agreement between frames and the strength of the evidence.

There is widespread concern that dominant economic and scientific forms of appraisal overstate the benefits of pharmacological therapies relative to the costs. Additionally, performance management appears a potentially useful policy tool provided that performance indicators have been appropriately defined; but the effectiveness of marketisation is more ambiguous. Hierarchically-integrated public health systems appear to have a special claim on equity and universalism due to significant savings from administrative costs. Yet there is a question mark over the capacity of public health systems to realise qualitative criteria such as patient-centred care. Ultimately, more detailed qualitative and postpositivist research is required to address evaluative questions of governance.

Chapter 9 is a case study of diabetes policy and governance. The case study is informed by an analysis of in-depth stakeholder interviews with a range of people involved in diabetes at different levels of governance. The analysis draws upon the frames set out in chapter 7, which are clearly present in diabetes both at the levels of policy and governance. Via a detailed comparative assessment of stakeholder frames, the case study identifies areas of potential and areas of concern arising from the Government's recent reforms. The most promising aspect of the reforms is the new role of local authorities in the health service, which has clear potential to deliver 'holistic' forms of public health that are important in diabetes. However, there were some major issues of concern: key targets in public health and primary care promote what many stakeholders believe are both inefficient and inappropriate forms of care.

Additionally, the research revealed detrimental policy impacts associated with the marketisation of the health service. The creation of Clinical-Commissioning Groups (CCGs), small and specialised commissioning units that purportedly put GPs at the centre of commissioning, frustrates the utilisation of the knowledge and expertise of *all* professional groups in the delivery of healthcare. Furthermore, while offering patients greater choice of provider and improvements in responsiveness through the development of primary care, the reforms appear to have compromised other patient-centred criteria that are vital in diabetes care, including choices over prescriptions, referrals and access to specialists. Further still, the use of economic incentives in primary care appears to place significant pressure on the doctor-patient relationship.

On the basis of these concerns, I make a case for decentralisation in the case of certain targets in public health and primary care, as well as the creation of larger organisations which combine aspects of commissioning and provisioning, based on previous models of NHS organisation. In this way, via a comparative assessment of stakeholder 'frames' at different levels of governance, it is possible to identify issues which frustrate the realisation of shared goals and propose alternatives where appropriate.

NB: the project was approved by the University of Westminster SSHL Research Ethics Committee and the research has been carried out in compliance with good research practice standards⁵.

⁵ See Appendix

Chapter 1: Introducing Public Service Reform

My purpose in this chapter is to provide some background to the topic of NHS reform. As a central organisation of the welfare state, the NHS has been strongly affected by wider intellectual and policy developments that relate to the structure of the economy and the organisation of public services. Though the focus is the NHS throughout the chapter, I situate the topic of NHS reform in wider debates about the appropriateness of different forms of public sector governance. I identify and analyse the main political ideologies which relate to the topic, some of which have remained on the periphery and others that have directly informed policy. In the process, I present the arguments for the provision of public services through the welfare state and the debate over its reform. I conclude by arguing that the question of the appropriate governance arrangements for public services is very much open.

The chapter proceeds chronologically, beginning with a discussion of the 'postwar settlement' and then examining New Left and New Right criticisms of that settlement. The second section presents New Right approaches to governance, most notably privatisation and New Public Management, introducing two Figures to illustrate the reforms introduced during the 1980s and 1990s. The third section examines Third Way approaches to governance, considers their relationship to New Right approaches and presents some criticisms of these approaches.

1.1 The 'Postwar Settlement' and the National Health Service

The history of the National Health Service (NHS) is closely intertwined with changing intellectual and political developments that relate to the structure of the economy and the organisation of public services. It is useful, to gain an understanding of the organisation, to explore the historical context in which it was founded and the ideologies and political movements that have informed its reform.

The NHS was founded after the passage of the National Health Service Act of 1946 and was unique out of all health services, with services paid for and provided by the state. The Act nationalised the nation's hospitals and imposed the duty on the Minister of Health to "promote the establishment in England and Wales of a comprehensive health service to secure improvement in the physical and mental health of the people ... The services so provided shall be free of charge" (Klein, 2006: 1). Widely regarded as the single and most significant achievement of Clement Attlee's Labour government, the health service was the principle organisation of a developing welfare state and reflected wider trends to state involvement in the economy through the nationalisation of public utilities and industries (Leach, 2009: 114).

The settlement which Attlee established would set the intellectual and policy framework until the 1970s. The period is often characterised as one of 'consensus' politics, whereby Labour and Conservative governments pursued broadly the same

agenda (Addison, 1994; Dutton, 1990). Yet, while essential characteristics of the postwar settlement remained in place until the emergence of the New Right in the 1970s, support came from a variety of arguments and ideologies, reflecting a range of values.

Indeed, on the left, nationalisation stood for greater equality and democracy through the transformation of work relationships. Labour Party manifestos advocated the nationalisation of industry in order to democratise the “commanding heights” of the economy and secure high quality work for workers (Sawyer and O’Donnell, 1999). However, nationalisation was also viewed as an answer to inefficiency and a lack of investment in key industries. Both Labour and Conservative governments nationalised industries on efficiency-based grounds (Floud and Johnson, 2004: 93).

Similarly, the welfare state had broad political support, but often for different reasons. Socialists and liberals emphasised the importance of welfare services because they provide the working population with services they desperately need and should be provided *as a right*. Furthermore, because the rich disproportionately pay for services and the poor disproportionately use them, the welfare state redistributes resources from rich to poor, creating a more equal society in the process (Barr, 2012: 40). Likewise, postwar social democrats such as Richard Titmuss emphasised the ‘integrative’ role of the welfare state. For Titmuss, paying for, providing and using public services reinforces a sense of community and citizenship (Reisman, 1977).

The political right appears to have disagreed over the extent the state should be involved in economic life, whether in terms of nationalised industries or the welfare state. According to the historian William Manchester, the right fought Labour’s “cradle-to-grave” legislations not necessarily because of the substance of the bills but the manner in which they were to be provided. Where Labour held that “people had an absolute right to these comprehensive benefits”, the right viewed them as “gifts from a benign upper class to grateful lower classes” (Manchester, 2015). Yet the welfare state still had cross-party support and efficiency based claims were made in its favour, just as efficiency based claims were made in favour of nationalisation (Greve, 2013).

Certainly, the foundation of the National Health Service was bitterly disputed at the time of its creation. Aneurin Bevan, the Welsh Labour Party politician and Minister of Health between 1945 and 1950, faced considerable opposition from the medical profession and the Conservative Party upon setting up the NHS. Bevan’s speeches were littered with references to both the injustices of private medicine and its inefficiencies. The health service was nationalised because it placed a duty on the Minister of Health to ensure the necessary services are in place and would be provided free-at-the-point-of-use, paid for through taxation rather than insurance. Furthermore, echoing the left’s advocacy of nationalisation in order to transform work relationships, Bevan sought democratic organisation which would put doctors at the forefront of decision-making:

After all – I need not remind you of this – I am a Socialist, and, being a Socialist, I believe in industrial democracy, and because I believe in industrial democracy I believe that doctors as a profession must have a greater and greater say in the management of their own services. I want for the miners, the railwaymen, the engineers, a far greater share in the management of their work and the policies that govern it, and I claim no less for the doctors. The doctors themselves must have a recognised status in the new service. Therefore I hope they will not come and meet me as if I were an antagonist on the other side of the table; on the contrary, I am one whose enthusiasm for democratic medicine is as great as their own (SHA, 1980)

As in other areas of welfare policy, the Conservative Party favoured a safety net over a comprehensive and free health service (Webster in Oakley and Williams, 1994: 54). However, there was also widespread acceptance of the waste of the old system and cross-party recognition of the need for its reform, in part because of the positive economic benefits of providing healthcare to the population. The creation of the health service therefore appears to be a combination of pragmatism and idealism (Rivett, 1998).

Initial hostilities among the Conservative Party were muted by the 1950s. A pivotal movement was the publication of the Guillebaud Report in 1956, the result of an official inquiry launched by the Conservative Party into the organisation's performance. This found that concerns over inefficiencies and escalating costs were misplaced, which transformed the terms of the debate:

From now on it became impossible for governments to attack the NHS. Disagreements in future would be about means, not ends (Rivett, 1998)

Yet the topic of NHS reform remains highly contentious. Since the organisation's creation there have been arguments for and against reform. These reflect wider intellectual and political developments.

1.2 Critiquing the 'Postwar Settlement': The New Left and the New Right

From the 1960s onwards, a variety of critiques emerged of the postwar settlement. The emergence and electoral victory of the New Right in the 1980s had a profound effect on the settlement, as is discussed in more detail below. Yet prior arguments of the New Left touched upon similar themes and continue to resonate today. A core feature of the New Left was a critique of professionalism and positivist social science, which had purportedly reduced political discourse to "issues of technical and professional expertise" and failed to hold power to account (Holmwood, 1996: 3). Criticisms of positivism are explored in the third chapter, but it suffices to note here the rising scepticism of professionalism which accompanied the emergence of the New Left and which had been a core feature of the postwar settlement (Wilensky, 1964). Following Talcott Parsons, the 'standard model' of professionalism held that professionals were required to solve complex policy problems and their sense of professionalism was enough to ensure they work in the

public interest. This model gave way to a 'power model' in the 1970s, with professional status and prestige reframed as a project of "self-interested monopolists" (Starr, 2009: 27). Professional claims to knowledge and authority were viewed as synonymous with the exercise of power over people, in keeping with wider postmodern criticisms of Enlightenment notions of reason and progress (Leonard, 1997: 97). Professional power had combined with managerial power and state power in the development of a modern "military-industrial-welfare complex" (Holmwood, 1996: 6).

In health policy, the critique of professional-led medicine had reformist and radical variants. Both criticise a so-called 'biomedical' model of healthcare, which purportedly objectifies the body as if it is a machine (Engel, 1977: 132). The reformist critique sought to complement professional medical practice with alternative or 'holistic' therapies and practices which treat the "whole person" rather than just the body and which seek to improve the quality of life rather than just its quantity (Bakx, 1991).

Box 1 – Holistic Medicine

The term 'holistic' stems from an influential book by Jan Christiaan Smut in 1926 entitled "Holism and Evolution". In 1977 the American Holistic Medical Association was established and Evarts Loomis published another influential book in 1979, entitled 'Healing for Everyone: Medicine of the Whole Person' (Loomis, 1979).

Holistic care is associated with a number of criticisms of the 'biomedical' model. The 'biomedical' model purportedly has a negative view of health as the absence of ill-health, pain and disease. This orientates health services to the treatment of ill-health rather than human flourishing, empowerment and well-being. As such, interventions are favoured which improve bodily functions and the crucial dimensions of psychology and state of mind are not addressed. Additionally, because of its focus on the body alone, physicians are not trained to establish relationships or communicate with patients. As a result, they often miss out on crucial details in the diagnosis and management of conditions. Patients, on their behalf, feel disempowered and lack trust in physician decisions, which is necessary for compliance and successful treatment:

...the physician's role is, and always has been, very much that of educator and psychotherapist. To know how to induce peace of mind in the patient and enhance his faith in the healing powers of his physician requires psychological knowledge and skills (Engel, 1977: 132)

For these reasons, advocates of 'holistic' care seek to reform health services and less hierarchical relationship between doctor and patient. Furthermore, it is argued that alternative therapies should be available for people who seek them, for they can bring about a broader array of health outcomes beyond purely bodily improvements. Examples include psychotherapy, counselling, meditation, yoga, supplements derived from plants and herbs and spirituality (Loomis, 1979).

The radical critique highlighted the power and influence of the medical profession over patients. Professionals have the power to determine who is sick and in need of treatment, which is often arbitrary (Porter, 1993). The job of the Doctor is to apply medical knowledge to any Body that is put before them and cure them of their 'illness', as it is defined by the profession. The centrality of scientific knowledge shores up the profession's position of power because it takes years of training to be able to understand and apply it, while patients are disempowered. Yet it would be a mistake to think that patients and citizens are in some way without agency and do not have a stake in the system themselves. People, by and large, have colluded in the development of the medical model. People like to think that Doctors are all knowing and that there is a treatment for any ailment they have. As Ian Kennedy writes, "it contributes to an illusion of immortality" (Kennedy, 1981: 32).

One consequence of the model is that health problems are framed as if they are only medical issues, when they are often deeply political problems and should therefore be confronted in the political domain. In this way, the 'biomedical' model is biased in favour of the liberal-capitalist status quo because it provides medical treatments to people to enhance their ability to cope with objective society rather than root out the causes of health problems, such as poverty, inequality, patriarchy and exploitative work (Illich, 1976). The result is a medical system characterised by excessive medication, specialist treatments, surgical procedures and the overuse of drugs (Kennedy, 1981). Some identify a 'medical-industrial complex', involving a confluence of corporate, government and professional interests, which results in questionable public benefit in much the same way as the 'military-industrial complex' in defence and war (Relman, 1980; Welter, 1977).

These arguments represent a clear departure from the leftwing thinking of the immediate postwar generation. Where that generation had sought to secure basic rights through access to welfare services, the New Left sought to improve the quality of the services they had access to. The idea of "big state solutions to social problems" was undermined in favour of heterogeneity, local and more personalised forms of service delivery (Leonard, 1997: xii; Pauli, 2014: 6). In health policy in particular, criticisms of 'professionalised medicine' represent a significant challenge to the models of healthcare developed in industrialised nations. However, as I discuss in later chapters, there have been significant academic and professional criticisms of New Left accounts and many continue to favour a professional approach to health problems (Hart, 2006: 60). Nevertheless, the New Left remained on the periphery of policy and the increasingly prominent New Right reframed the problem of professionalised services, bureaucracy and standardisation in terms of individual freedom, consumer choice and markets (Wainwright, 1994).

Indeed, the New Right gained ascendancy in the 1970s and eventually power in 1979, with the election of Margaret Thatcher. The movement sought to break with the 'postwar' settlement by breaking with the "collectivism" of the postwar settlement that had been supported by some (or even many) socialists, liberals and conservatives (Hall, 1979: 16), promoting in its place a "meritocratic and

entrepreneurial model of society” (Williams, 2015: 28). New Right discourse combined moral themes of individual freedom and responsibility with various economic themes that were heavily influenced by prominent economic theories of the time, most notably the Austrian school of economics and Public Choice Theory (Thompson, 2008). These frameworks provided an explanation for an increasingly widespread acceptance that state intervention often results in policy failures (Pressman and Wildavsky, 1973; Lipsky, 1980), which hinged upon two central arguments:

- The ‘knowledge problem’: state involvement is likely to result in inefficiency because policymakers, public sector workers and professionals do not have reliable signals to inform their decisions resulting in the production of the wrong type of goods and services. In markets, these signals are provided by prices;
- The ‘motivational problem’: state involvement is likely to result in inefficiency because the political sphere and the public sector are rife with self-interest groups, lobbyists and corruption. In markets, producers are incentivised to work in the interests of consumers (Jackson and Price, 1994: 5).

These arguments were central to New Right claims that the postwar settlement had been underpinned by “simplistic and romanticized views of how government worked and what government could achieve” (Bovaird and Löffler, 2004: 29). The New Right’s answer was to withdraw the state from involvement in the economy and refashion the welfare state along market lines.

2.1 The New Right ‘Settlement’: Privatisation and New Public Management

The electoral victory of the New Right led to a fundamental restructuring of the public sector and indeed the economy as a whole. During the 1980s, significant sections of the economy was privatised, serving to alter the state’s role in the economy “from provider of services to that of overseer of the market” (HM Treasury, 1997: 15). Similarly, though public services were not privatised, a variety of managerialist and market reforms were introduced through the 1980s and into the 1990s in order to overcome the perceived inadequacies of public bureaucracies.

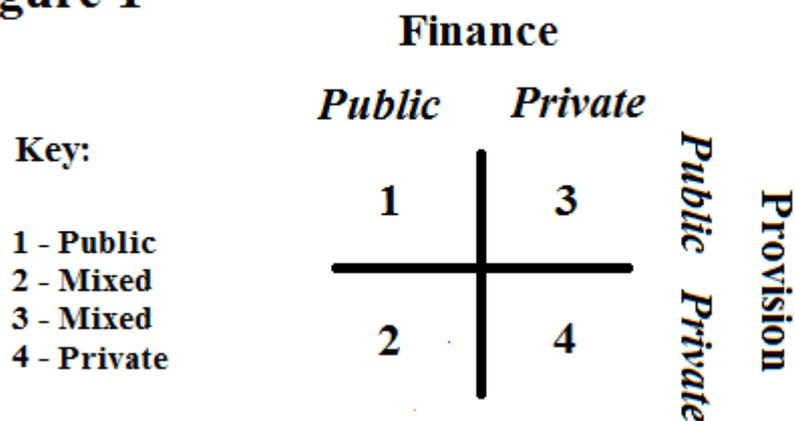
On the demand-side, consumer choice was promoted within the public sector, culminating in the Citizen’s Charter of John Major’s government in 1991 (Robins and Jones, 2000: 238). On the supply-side, systems and processes of performance management were incorporated across the public sector in an attempt to improve the efficiency and accountability of services, providing decision-makers, whether consumers, managers or purchasers of services (i.e. ‘commissioners’), with data on the performance of public bureaucracies. Additionally, attempts were made to restructure public sector organisations in order to mimic the operation of the market. These reforms included the “disaggregation” of units into smaller organisational

units and the introduction of ‘purchaser/provider’ splits across government functions in order to inject market competition through the contracting out of services and quasi-markets, where public sector organisations compete with other organisations (in the public or private sector) to deliver services paid for by the government (Dunleavy et al., 2006).

By the 1990s, the term ‘New Public Management’ (NPM) was used to characterise this combination of markets and managerialism in public service contexts (Hood, 1991). Commentators emerged extolling the benefits of the new approach. David Osborne and Ted Gaebler’s book *‘Reinventing Government’*, published in 1992, provides a prominent rationale for the new reforms. The postwar approach, where governments make policy and implement it through public bureaucracies, had purportedly resulted in widespread inefficiency. The government’s role, according to Osborne and Gaebler, should be restricted to policymaking, purchasing and performance management, i.e. “steering” rather than “rowing”. In place of public bureaucracies, ‘consumer’ facing organisations, whether reformed public providers or private companies, can more efficiently deliver services specified and paid for by governments (Osborne and Gaebler, 1992; see also Kettl, 2000). By the mid-1990s, international organisations such as the OECD were advocating NPM at a global level (OECD, 1995).

NPM has had a profound impact on the governance of public services. Figure 1 presents different forms of governance structure. Point 1 represents public services under the postwar settlement, with services financed by and directly provided by the government. NPM can be summarised as experiments in points 2 and 3 in the figure, amid processes often described as ‘marketisation’. Point 4 represents privatisation, where the government withdraws from both the provision *and* funding of services.

Figure 1

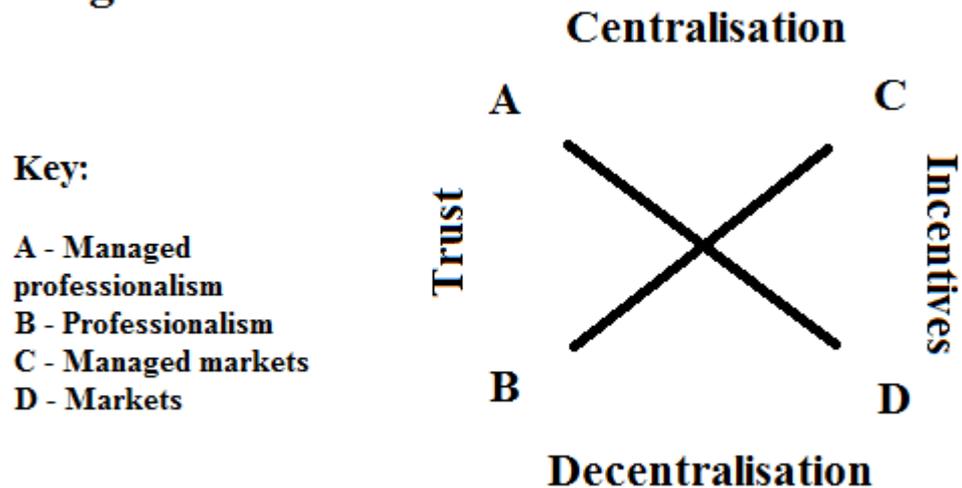


Source: adapted from Klein, 1984: 14

Though Figure 1 presents important dimensions of NPM, it does not capture all of the changes that have taken place. For the emergence of managerialism and

markets in the provision of public service has affected the scale of decision-making and nature of the incentives in the system. These dimensions of governance are expressed in Figure 2.

Figure 2



The centralisation/decentralisation dimensions of the Figure pertain to levels of decision-making in public sector contexts, or the freedom (or not) of local actors to define objectives: where decisions at points A and C are centralised, decisions at points B and D are decentralised. The trust/incentives dimensions pertain to the nature of the incentives in the system, ranging from trust in public sector workers and professionals to fulfil policy objectives (whether set locally or nationally), or the use of managerial or market mechanisms to ensure that they do.

The traditional welfare state operated on the assumption that public sector workers and professionals can be trusted to define and deliver good quality goods and services, i.e. point B in the Figure. Indeed, as we saw, Bevan himself framed this approach as part of wider socialist project of democratising industry. Over the past thirty years, the turn to markets and managerialism reflect a rejection of this assumption of trust (Le Grand, 2006). The increasing use of markets and performance management have shifted contemporary governance to point C in the Figure, where decision-making is centralised and economic incentives are deployed to elicit the motivation of actors⁶. Additionally, the reforms have sought to facilitate service-user choice, thus decentralising some decisions to point D but with the government retaining its role in funding services.

⁶ However, performance management is never total and public sector workers and professionals have some autonomy and discretion in the work. In healthcare, though performance management is pervasive, clinical guidelines are also used to provide guidance to health professionals but which are not specifically linked to incentives, i.e. point A in the Figure.

2.2 New Public Management and the National Health Service

The rise of New Public Management had a profound impact on the health service, involving the incorporation of a tier of non-medical general management, performance management systems and market mechanisms. A key development in the NHS came in 1983, following an inquiry into the performance of the health service by Roy Griffiths, deputy chairman and managing director of Sainsbury's. The Griffiths Report highlighted a lack of general management in the service, resulting in poor accountability and performance. Griffiths lamented the lack of performance evaluation and economic appraisal:

The NHS does not have a profit, but it is, of course, enormously concerned with control of expenditure. Surprisingly, however, it still lacks any real continuous evaluation of its performance against criteria. Rarely are precise management objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare (Griffiths, 1983)

Following the incorporation of general management into the service, the 1980s saw accounting and performance management systems incorporated into the service and eventually a purchaser-provider split was introduced into the service in 1989. Under the new model, regional planning units no longer directly managed hospitals and other provider organisations but become legally separate and financially independent units. Forms of market pricing and contracting were introduced in order to direct the flow of resources and provider organisations had to compete for contracts.

This 'internal market' sought to improve the performance of the organisation across a range of criteria. By introducing competition on the provider side of the market, it would purportedly enhance efficiency. On the purchaser side of the market, purchasers – or 'commissioners', in New Labour's favoured terminology – could concentrate on securing appropriate services for patients, thus improving allocative decisions regarding the appropriate kinds of services that are produced. Decision-making would also improve because of the improved information flows facilitated by performance management. Furthermore, policymakers sought to develop primary care under the GP Fundholding initiative. Under this initiative, some GPs became responsible for the commissioning of certain health services. It was hoped that these initiatives would facilitate more responsive services by bringing decision-making closer to patients and allow the development of patient choice, while also embedding a financial incentive in primary care, leading to further improvements in efficiency and the quality of care (DoH, 1989). This combination of managerialism and markets introduced during the 1980s has largely remained in place ever since⁷.

⁷ Various terms have been used to characterise these combination of managerialism and markets, including 'internal market', 'managed market' and 'quasi-market' (Leathard, 2000: 145; Maynard and Bloor, 1996).

3.1 The Third Way – Towards an Alternative?

The significance of the New Right cannot be overstated for the settlement of the 1980s sets the overarching policy framework today in much the same way as the 'post-war' settlement before it (Cumbers, 2012). Privatisation and New Public Management remain central policy tools of governments worldwide (Sorensen and Torfing, 2007). However, both marketisation and managerialism have been subjected to some fierce criticism. Throughout the reform process, privatisation has been unpopular with the public and critics suggest that the economic potential of the approach has been overstated (see chapter 3). Additionally, the capacity of New Public Management to enhance the performance of public services has been criticised.

A key issue is whether the use of markets in the provision of public services compromises core values associated with the public sector. As Figure 1 above shows, the marketisation of public services does not necessarily entail privatisation because the government remains the funder of services. Yet critics have argued that the distinction is not so clear cut. Market reform has often coincided with privatisation or has served as a precursor to outright privatisation, while there is a question mark over quality of public services which remain free-at-the-point-of-use (Ruane, 1997; Whitfield, 2001; Whitfield, 2006). As discussed in subsequent chapters, this is a major concern in debates over the use of market mechanisms in the health service.

A further set of criticisms of the reform process is associated with the Third Way. During the 1990s, Third Way thinkers such as Anthony Giddens argued for a new politics that would avoid the pitfalls of statism and markets and repair "damaged solidarities" caused by Thatcherism. This would be achieved by embracing a "dialogic democracy" that would recover a concept of citizenship and by reforming the welfare state into innovative, decentralised organisational forms such as cooperatives and employee-owned organisations (Giddens, 1994: 113). At the same time, social capital theorists demonstrated the *economic* importance of common social ties, identities and relationships that were purportedly threatened by bureaucracy and markets (Putnam, 2001). Furthermore, deliberative and participatory democratic theory became increasingly influential, bringing to the fore the transformative potential of democratic participation (Warren, 1992: 10).

In the field of public administration and management, terms such as 'partnership', 'policy networks' (Cloke et al., 2000), 'networked governance' (Torfing et al., 2012), 'post-NPM' (Christensen, 2012), 'Joined-up Government' (Pollitt, 2003), 'interactive decision-making' and 'citizen involvement' (Lowndes et al., 2001) drew attention to the emergence of innovative, collaborative forms of governance which presented new opportunities to deliver public services and solve policy problems. These Third Way strategies were premised on a revision of the New Right's critique of state intervention. Where the New Right had identified policy failures as reason to withdraw the state from economy activity and refashion the welfare state along market lines, Third Way approaches sought to develop new forms of policymaking

and implementation which would one again revise the government's role: from its "steering" role in policymaking and performance management to a "network manager", implying a "more process-type role for political actors" (Koppenjan and Klijn, 2004: 100).

Advocates of the new approach held an ambivalent attitude toward NPM: New Right reformists had been correct to reform public bureaucracies, but the state had continued to take on a hierarchical role. On the one hand, theorists of 'public value' argued that NPM had prioritised values of efficiency and managerial accountability over public values such as democratic accountability, transparency, equality and professionalism. A 'public value' approach entailed orienting public services to the realisation of values that are defined by active and engaged citizens in democratic forums. In this way, the concept redefines the purpose of public services, creating a counterpoint in public value to shareholder value in the private sector (Bozeman, 2002; Moore, 1995; Meynhardt, 2009).

On the other hand, critics argued that NPM had frustrated efforts to facilitate the *coordination* of policy (Dunleavy et al., 2006; Head and Alford, 2013; O'Toole, 1997). Centralised decision-making in the form of performance management may have result in various "untended consequences" by reinforcing a "silo mentality" across the public sector, whereby organisations focus only on immediate policy objectives (Schoubroeck, 2010: 4; see also Guilfoyle, 2012). Likewise, the 'disaggregation' of public sector organisations and increased use of competition and markets may have frustrated efforts to improve collaboration between different organisations (Pollitt and Sorin, 2011: 22). As Brian Head and John Alford argue:

NPM practices have generally been ill-suited to dealing with wicked problems. This is so whether we are referring to its initial intraorganizational focus—sometimes labeled "managerialism" or "corporate management"—or its more contractualist focus entailing purchaser–provider splits, outsourcing and privatization (Head and Alford, 2013: 9)

For this reason, more collaborative approaches to governance were advocated, including outward looking management strategies and the creation of partnerships to actively bring together a variety of organisations (Christensen, 2012: 2).

The forms of governance captured in these accounts undoubtedly present new opportunities for the solution of policy problems. At a time where there is increasing disillusionment with traditional parliamentary processes, more deliberative forms of democracy have the potential to reinvigorate the political sphere. Furthermore, the involvement of multiple provider organisations in networks has the potential to improve the capacity of policy processes to solve complex problems. In theory, networks can overcome collective action problems and facilitate "synergistic learning and problem-solving" that might not have occurred if only single entities had been involved in service delivery (Agranoff, 2003: 3).

However, there remain issues to consider. Policymaking and implementation through networks can involve a variety of individuals and organisations. While this has the potential to improve the legitimacy of policy because a greater number of stakeholders are involved, it also has the potential of muddying traditional lines of accountability (Rhodes, 2000: 77). Furthermore, some question the effectiveness of networks suggesting that, like hierarchy and markets, they can fail to improve policy outcomes (Jessop, 1998). The potential of networks is attested to by the fact many arise spontaneously as participants “fall” into them because market or bureaucratic strategies have failed (Roberts, 2001). Yet this is not the case where networks are called upon in public sector contexts, where they have a distinct purpose and actors are brought together by political actors.

Some claim partnerships have become ‘ends’ in themselves rather ‘means’ to improve outcomes for service-users (Dickinson, 2008: 20). Others go further to argue they constitute a “new bureaucracy”, prioritising processes of commissioning over the actual delivery of services (Blackman, 2013; Travers, 2007):

Commissioning is a bureaucratic activity in the sense that it involves a strong emphasis on process: planning, coordination and monitoring compliance with ‘best practice’. It entails considerable effort devoted to meetings, plans and paperwork, especially if done to excess, which may distract effort from a focus on the outcome (Blackman, 2013: 71)

A further issue is the relationship between ‘networked governance’ and the market and managerialist policies of the New Right. As discussed above, NPM remains central to public sector governance despite significant criticisms of the approach. Eva Sørensen and Jacob Torfing suggest that more collaborative forms of governance potentially fill in for the problems attached to markets and managerialism: while markets can indeed undermine collaboration, the involvement of actors in networks can facilitate trust and collaboration between them. Likewise, though centralised decision-making and performance management can result in unintended consequences, networks provide channels in which local actors can alert policymakers to any issues which arise (Sorensen and Torfing, 2007).

However, this combination of hierarchy, markets and networks has been criticised by others. Guy Peters uses the “Garbage Can” metaphor of policymaking to describe contemporary governance, whereby decisions are not “programmed or predictable” but “the serendipitous confluence of opportunities, individuals and ideas” (Peters, 2002: 7). While this does not necessarily imply that policy failures are inevitable, it does provide a more realistic analysis of the potential of networked governance to facilitate effective public services. Evaluative research is required to explore the effectiveness of the different policy tools and approaches available to policymakers.

3.2 The Third Way and the National Health Service

As with New Public Management, the Third Way had a significant impact on the health service. Centre Left think-tanks, such as the New Economics Foundation (NEF), the Institute for Public Policy Research (IPPR) and Demos challenged marketisation and managerialism on the one hand but sought reform of the health service on the other, through decentralisation and a reformed doctor-patient relationship.

In opposition, New Labour had been hostile to the Conservative's 'internal market', citing inefficiencies and fragmentation. However, in office, the purchaser-provider split remained intact. This was welcomed by Third Way thinkers. Chris Ham, writing in Demos, argued that New Labour's decision to retain the purchaser-provider split was justified "in terms of the organisational politics of healthcare" (Ham, 1996: 28). The introduction of market contracting had purportedly improved accountability and the split would enable purchasers to procure a wider variety of services, which was necessary in order to move beyond the "medical model of healthcare" (Ham, 1996: 13). However, there would be an emphasis on partnership working between organisations to overcome the fragmentation brought on by the market.

Furthermore, various publications outlined proposals for a 'Mutual Health Service' characterised by small and self-governing mutuals (Mayo and Moore, 2001; Leadbeater and Christie, 1998). This would involve reforming the health service through the creation of non-profit organisations, cooperatives and social enterprises (Mayo and Moore, 2002) and relaxing performance management, which had purportedly resulted in various "counting paradoxes" (Lea and Mayo, 2002; Boyle, 2010). It was argued that creating local, decentralised organisations involving democratic forms of governance would improve efficiency because staff would have a stake in their work and legitimacy because members of the public would be involved in decision-making, ensuring that organisations would not exploit "the fact that the service is a local monopoly, with the whole community dependent on it", as might be the case with the private sector (Mayo and Moore, 2001: 33). Yet services would continue to be funded from taxation in order to safeguard the universal ideals associated with the health service (Lea and Mayo, 2002: 14).

These arguments would prove influential in policymaking circles. New Labour's reforms to NHS hospitals under the Foundation Trust initiative and the creation of Primary Care Trusts, which would take over the purchasing or 'commissioning' function of the health service, sought to involve staff and members of the public in corporate governance. However, some Third Way critics argued that these initiatives, while promising, were ultimately undermined by New Labour's use of markets and managerialism in the health service:

These are initiatives modelled on some of the proposals for a more mutual state apparatus that have been developed by the New Economics Foundation. The idea was to provide hospitals with mutual management and an element of local control

— and the ability to raise their own finance — that could set hospitals free to some extent of Whitehall control. In reality, however, the mutual element has been reduced to limited community membership, with an irrelevant right to elect an advisory body, with their exact roles to be determined by each trusts' constitution. Proposals for increasing participation by patients have been set aside by all the original foundation trust managers. This a serious omission: handing over financial powers to local managers, without passing on accountability to patients, staff and local people, is simply creating a new generation of unrepresentative fiefdoms — and this is already leading to a general backlash (Boyle et al., 2004: 6)

The question arises over the compatibility of markets and managerialism in the health service with the values of the Third Way.

4.1 Concluding Remarks

This chapter has provided an overview of reforms to public sector governance. If anything can be taken from the analysis, it is that no panacea is available. Decision-makers confront choices between a range of options in their efforts to design public sector governance and lay the basis for the solution of policy problems. Each option at the level of governance, whether direct public administration, privatisation, marketisation, managerialism or forms of 'networked governance', has attracted significant criticism. Clearly, the question of the appropriate governance arrangements for public services and the NHS is very much open. There is a need for evaluative research to explore just what governance structure and approaches are appropriate for the solution of particular policy problems. However, as I demonstrate in the next section, dominant forms of evaluation are not suited to this task.

Chapter 2: Issues in the Evaluation of Policy and Governance

In recent years, policy evaluation has become an integral feature of the policy process (Palfrey et al, 2012). A central aspiration of both New Labour and the Coalition/Conservative governments has been for most if not all decisions to be clearly evidence-based (Haynes et al., 2012; HM Treasury, 2011a; HM Treasury, 2011b). It is anticipated that the use of evidence will improve the effectiveness of decision-making processes. Policy evaluation is put forward as a solution to the 'knowledge problem' introduced in the previous chapter, which posits that decision-makers will struggle to acquire the knowledge they require to solve policy problems. This is potentially significant because, as we saw in the previous section, there is significant debate over the quality of public services and the appropriateness of different forms of public sector governance. Policy evaluation may therefore provide answers to these debates. However, as this chapter demonstrates, the heightened use of policy evaluation has proved almost as controversial as the process of public sector reform itself.

My purpose in the present chapter is to explore issues in policy evaluation as it has developed in recent years. I argue that dominant approaches to evaluation are problematic as decision-making aids, either at the level of policy regarding choices between specific public services or at a level of governance regarding the design of institutions.

The chapter is split into three sections: the first section explores literature in public administration in order to define terms, focusing on the distinction between policy and governance which is necessary for the subsequent analysis. Sections two and three then explore issues in the evaluation of policy and governance. Section 2 explores forms of policy evaluation, including Evidence-Based Policy and performance management. Section 3 then explores forms of governance evaluation, including evaluations of privatisation, marketisation, performance management and 'networked governance'.

A major problem with all forms of evaluation is a reliance on quantitative metrics in evaluation which are unlikely to capture all dimensions of performance. Furthermore, while the literature on 'networked governance' recognises that quantitative approaches to evaluation do not capture the complexity of governance, evaluations are typically process-oriented and do not address evaluative questions of governance, most notably whether markets are appropriate in the delivery of public services or whether centralised forms of decision-making are appropriate.

1.1 The Distinction between Policy and Governance

As discussed in the introduction, this PhD is a work of policy analysis and more specifically policy evaluation: policy evaluations seek to inform policy decisions by

identifying appropriate courses of action through robust empirical research (Choudhary, 2009: 4). To critically engage with the literature on policy evaluation first requires a definition of policy. Furthermore, because this PhD seeks to go beyond policy evaluation to address evaluative questions of governance, the term governance and its relationship to policy must also be defined.

The Cambridge Dictionary Online provides a useful definition of policy: “a set of ideas or a plan of what to do in particular situations that has been agreed to officially by a group of people, a business organization, a government, or a political party”. This definition of policy as involving a plan that has been agreed upon by a certain stakeholder group is shared in the academic literature on public policy, which emphasises that policy involves both a decision and a course of action. While a plan must be the outcome of a decision, the notion of a plan implies action: “it embodies the idea of action – indeed rational action” (Hill and Varone, 2014: 14). Similarly, Hoshier Singh and Pardeep Sachdeva define policy as involving a means-end relationship: the decision to act in a certain way involves making sense of a problem, defining policy objectives and choosing between solutions to realise them (Singh and Sachdeva, 2011: 336).

These definitions of policy usefully highlight how policy involves a decision to act in a certain way. However, policy is surely more complex than this. As Michael Hill argues, there is a danger of viewing the policy process “as if it exists on a desert island” (Hill and Varone, 2014: 16). Rather than view policy as a result of a single decision, it is more accurate to talk of a “decision network” involving a web of decisions. Furthermore, if policy embodies rational action and involves identifying a solution to some problem, we must also take into account the political processes through which policy problems have come to be defined as problems in the first place and which influence the range of solutions that are considered for adoption. Thus, the process of policy *formation* is complex. Literatures on policy networks, policy communities and issue networks highlight how potentially significant numbers of stakeholders can be involved in shaping the process of policy formation (Moran et al., 2008: 427).

The definition of policy as involving a decision to act in some way also abstracts away from the *implementation* of policy. Writers on policy implementation highlight the role of “street level bureaucrats” who implement policy on the ground. They can and often do redefine and change policies that are decided upon by politicians and policymakers (Lipsky, 1980). As such, it is necessary to take into account the perspectives of local implementers of policy, or adopt a “bottom-up” perspective as opposed to a “top-down” perspective. Furthermore, in part because of the complexity of policy implementation, it is important to recognise that policies can fail.

Christopher Hill and Peter Hupe offer a comprehensive definition of public policy: policy involves decisions and actions, as well as inaction; policy arises from a process over time; policy can involve both internal and external relationships; and policy can result in both intended and unintended effects, or outcomes, upon

implementation (Hill and Hupe, 2014: 4). They also argue that, though the distinction between policy formation and implementation is simplistic, it remains a useful heuristic which captures distinct parts of the policy process:

What can be called 'public policy', and thus has to be implemented, is the product of what has happened in the earlier stages of the policy process ... both implementation and policy formation refer to respectively 'late' and 'early' sub-processes (Hill and Hupe, 2014: 9)

How does this conception of policy differ from governance? The previous chapter introduced the concept of governance, which highlights that the state is just one actor among many and that policy is formulated and implemented in an increasingly differentiated polity (Rhodes, 1996: 653). In some respects, accounts of governance share similarities with expansive conceptions of policy in so far that the latter recognise the complexity involved in the formation and implementation of policy. Thus, governance can be thought of as coming to terms with increased recognition of the complexity of the policy process and the different stages through which policy is defined and delivered.

Yet governance literatures do seek to go beyond the level of policy: the concept is designed "to incorporate a more complete understanding of the multiple levels of action and kinds of variables that can be expected to influence performance" (Peters and Pierre, 2006: 21). Governance theorists recognise the *layered* character of any political-administrative system through which specific policies are enacted (Hill and Hupe, 2014: 16). The top-bottom distinction is replaced with vertical and horizontal institutional relationships. As Hill and Hupe observe, specific policies can be formed and implemented at any one political-administrative layer while some will be formulated and implemented across multiple layers. At each level there are inevitably legitimate politics, official competencies and legal frameworks that will determine whether just implementation or "policy co-formation" is required. Furthermore, the "act of management" becomes central in governance: i.e. the conscious efforts on behalf of policymakers to direct the flow of resources through both the management of implementation and the design of institutions (Hill and Hupe, 2014: 16).

This distinction between policy and governance has implications for evaluation. While it is important to recognise the complexity of processes of policy formation and implementation, the purpose of policy evaluation is to inform decisions by assessing solutions to whatever policy problem is at hand. For policy evaluation to be comprehensive it must explore stakeholders' different understandings of policy problems and whether adopted solutions fail or succeed upon their implementation. As discussed in more detail below, most policy evaluations do neither: evaluations typically do not question dominant definitions of policy problems and the focus is on whether policy options have the *potential* to improve outcomes rather than whether they improve outcomes in practice.

The purpose of governance evaluation, in contrast, is to inform decisions about the design of overall governance environment. This requires an exploration of the decisions and actions across multiple layers in order to inform the “act of management” described by Hill and Hupe (Hill and Hupe, 2014: 16). Indeed, at this level, policymakers confront choices between different governance modes or ‘governing structures’: markets, hierarchy and networks. Each of these constitute distinct mechanisms of exercising control and allocating resources (Rhodes, 1996: 653). Yet, as discussed in more detail below, there is scope to develop research approaches for the evaluation of governance.

2.1 Policy Evaluation: A Survey of the Issues

The reform to the public sector has been accompanied with an increase in the use of policy evaluation, in a variety of forms. The emergence of NPM led to an increase in audit and performance management throughout the public sector, along with appraisal and pay systems, while new quangos such as the Audit Commission and Ofsted have been created to evaluate the performance of public sector organisations. The development of performance management under New Labour further entrenched these forms of audit and evaluation (Clarke et al., 2000: 263). Parallel to these developments, Evidence-Base Policy (EBP)⁸ emerged towards the late 1990s and became a central feature of the Third Way, purportedly representing a break from the ideological policymaking of the past (Plewis in Pantazis and Gordon, 2000: 96). EBP has sought to embed the practice and use of evaluation across all levels of the public sector and a number of organisations have been created with that purpose in mind, such as the National Institute for Health and Care Excellence (NICE) in healthcare and the Social Care Institute for Excellence (SCIE) in social care. It was – and continues to be – anticipated that EBP will improve the effectiveness of public services⁹.

However, dominant forms of evaluation, like reforms to public sector governance more generally, have attracted considerable criticism. Trisha Greenhalgh, a prominent commentator on policy evaluation, observes that the “idea that policy should be based on best research evidence might appear to be self-evident”, but the field has been beset with “problems and paradoxes” which parallel “a long-standing ‘paradigm war’ in social research” (Greenhalgh and Russell, 2009)¹⁰. The next chapter explores this ‘paradigm war’ in more detail, but for now it suffices to note controversies in policy evaluation as it has been developed and applied in recent years. A key problem concerns the quantitative measurement of performance.

⁸ The approach is influenced by Evidence-Base Medicine (EBM), which emerged during the early 1990s. EBM is discussed in more detail in chapter 6.

⁹ The Conservative/Coalition’s governments ‘*Magenta*’ and ‘*Green*’ books provide advice to policy evaluators, commissioners and policymakers on how to undertake or interpret evidence (HM Treasury, 2011a; HM Treasury, 2011b).

¹⁰ Similarly, Peter Griffiths and Ian Norman write that “hostility has not ceased on all fronts and many still act as if they are members of opposing armies, eyeing the former enemies with suspicion and all too ready to take offence” (Griffiths and Norman, 2013: 583; see also Matthews, 2012; Pawson and Tilley, 1997).

2.2 Policy Evaluation as Performance Management

As we saw, performance management emerged as a pivotal part of NPM throughout the 1980s and 1990s¹¹. The approach has its proponents and its critics (Pollitt and Sorin, 2011). The data collected from performance management has a range of potential uses for decision-makers at different levels of the public sector, including civil servants, managers, public sector employee and service-users. It can potentially improve management by providing a point of focus for organisations in the public sector, where sales and profit are not available as benchmarks for their success; it can be used in attempts to improve the performance of individuals and organisations by linking improvements to remuneration; it can facilitate more effective market choices, because commissioners and service-users have more information available to them; and, similarly, it can improve democratic accountability because citizens have more information available to them (Forsythe, 2001; Melkers and Willoughby, 2005).

However, the use of performance management in public service contexts has been criticised. As discussed in the previous section, theorists of ‘public value’ criticised NPM, emphasising the inherently political nature of the process of defining public service objectives and selecting appropriate indicators in performance management. The aim of the ‘public value’ movement is to ensure that process is democratic, with citizens called upon to define objectives and indicators in ways which approximate the “common good” (Horner et al., 2006: 49; see also Scott, 2013)¹². This is an important criticism, underlining the value-laden nature of selecting appropriate indicators. Yet other critics go further, arguing that the very nature of public services complicates the practice of performance management. It is useful to note a key distinction in the policy evaluation literature between *inputs*, *outputs* and *outcomes* (Pollitt and Bouckaert, 2004: 13):

- Inputs refers to the resources that are drawn upon in the delivery of goods and services, such as investment, staff, technology and other overheads;
- Outputs refers to the activities or processes which organisations provide to customers or services-users, such as school lessons, home visits in social work or a ‘consultant episode’ in hospital;
- Outcomes refer to the desirable effects which organisations strive for, such as more educated pupils or healthier patients.

¹¹ Chapter 3 explores governance evaluation, including performance management. The approach receives mixed reviews and there are some major issues in attempts to evaluate it (Pollitt and Sorin, 2011). The focus in this chapter is on performance management as a practical form of public service evaluation, used to inform local decision-making.

¹² Louise Horner and colleagues argue that “(p)ublic value, which is by no means hostile to the idea of performance measurement, re-orientes public managers to find ways to challenge the idea of what constitutes the value of a particular service or policy intervention, to redefine what is socially desirable and then determine how this can be best measured” (Horner et al., 2006).

To date, performance management has focused on activities and processes, in part because outcomes are difficult to measure (Pollitt and Sorin, 2011: 11). For example, there is on-going debate about whether the outcomes of education, including the cognitive and social development of pupils, can be quantified. Policy evaluation in education has typically focused on test results, yet the obvious issue with this is that test results may not correspond to more qualitative dimensions of performance such as critical thinking or life skills (Hammersley in Pring and Thomas, 2004; Volante, 2004).

Linked to this problem is the fact that effectiveness is a contested concept: where some may emphasise critical thinking, others might emphasise the need to acquire qualifications to gain employment. Ultimately, this comes down to the question of one's own values when appraising the performance of public services. As discussed in more detail below, these issues affect the evaluation of policy at all levels.

A further reason why activities and processes are used is because performance management requires that measures of performance are directly linked to the performance of individuals and organisations; for only then would decisions made on the basis of the data actually improve the performance of public services. However, public service outcomes often arise in the long-term and often have multiple possible causes, such as the wider economic factors or the input of service-users. Indeed, they are to a certain extent "co-produced" between public sector workers/professionals and service-users such that either good performance or low performance might only partly reflect the quality of public services (Fukuyama, 2013). In contrast, activities and processes directly relate to the performance of individuals and organisations in a way that measures of outcomes do not.

However, the problem with this is that public services are not standardised consumer items that can be accurately defined, sorted and tested in advance, but are themselves *intangible* (Lewis and Hartley, 2001: 479). A key issue is the labour-intensive and relational nature of public services. To ensure effectiveness, public services require extensive "face-to-face" contact and significant buy-in from service-users in their encounters with public sector workers/professionals (Guy et al., 2014: 69). As noted by Michael Lewis and Jean Hartley, unlike consumer items, public services are heterogeneous: not every consumer or service-user wants or receives the same service, but services come to be defined in the interactions between employees and service-users (Lewis and Hartley, 2001: 479). This poses challenges to the performance management of processes because it is always possible that the wrong kind of public service interventions and practices are promoted.

The potential of performance management to emphasise the wrong kind of actions is recognised in the literature on the "unintended consequences" of performance management. This literature highlights how performance on some measured metric can coincide with declines in additional dimensions of quality which have not been taken into account (see box 1). Examples include "teaching to the test" in schools (Volante, 2004) and the manipulation of patient admissions in A&E departments,

following the imposition of 4 hour waiting list targets (Bevan, 2006). This does not suggest that performance management has no role in the governance of public services, but it does suggest the approach has limitations. As Neil Carter argues, performance indicators only provide a partial view of performance: they are not “dials” but “tin-openers”, always prompting new questions of what is really going on behind the statistics (Carter et al., 1995).

Box 1 – Unintended/Undesirable Consequences of Performance Management

| |
|--|
| Tunnel vision – local actors might focus only on measured outcomes |
| Measure fixation – local actors might focus on arbitrarily chosen targets that have a weak correlation with actual outcomes |
| Sub-optimisation – local actors might pursue local objectives at the expense of broader organisational objectives |
| Myopia – local actors might pursue short-term goals over long-term goal |
| Misrepresentation – performance data may not be accurate |
| Ossification – performance management might reduce the scope of innovation because of rigidities in what is measured |
| Complacency/demotivation – local actors might feel their ranked position is not warranted and does not reflect effort, causing them to withdraw effort |
| Gaming – local actors might alter their behaviour in ways that benefit them but without any benefit to the organisation |

Source: adapted from Smith, 1995

2.3 Policy Evaluation as Evidence-Based Policy

Alongside the increased use of performance management, Evidence-Based Policy (EBP) has emerged which seeks to improve decision-making through the evaluation of public interventions and practices. These approaches recognise some of the limitations to performance management, which beyond a snapshot of performance over time does not provide insight into the efficiency or effectiveness of public services. To that end, a range of scientific and economics form of evaluation have been developed for that purpose.

Proponents argue that the widespread adoption of evaluation would greatly improve decision-making in public service contexts by surpassing ideological political channels (Banks, 2009) and ending a reliance on professional judgement, which is said to be fallible and has resulted in widespread variation and inefficiency (Thornton, 2006: 2; Chalmers, 2003). Ben Goldacre, a contributor to a recent government handbook on EBP, promotes scientific trials in all policy areas (Haynes et al., 2012). The Randomised-Control Trials (RCT) is an experimental form of evaluation which evaluates the *efficacy* of interventions by testing them out in an experimental group and comparing the effects with a control group, which has not been exposed to the intervention. According to Goldacre, this approach is suitable for all policy areas:

Do free uniforms improve school attendance, especially in pupils who don't own one at all? ... Do long prison sentences work? At the moment, sentences are hugely variable anyway: randomise properly and run a trial. Different teaching approaches? Run a trial. Harder exams? Run a trial. Job-seeking support? Run a trial (Goldacre, 2011)

Similarly, Cost-Benefit Analysis (CBA) is advocated to evaluate the economic value of interventions, by weighing up the costs and benefits of interventions¹³.

Yet the widespread adoption of EBP has proved controversial. Somewhat ironically, the approach has not itself been evaluated to show that it improves outcomes or constitutes a worthwhile use of public money relative to alternatives, such as a reliance on professionalism or more flexible interpretations of what constitutes evidence (Greenhalgh and Russell, 2009; Mullen and Streiner, 2004)¹⁴. Critics question the extent that evidence-base policy can improve public service decision-making.

One issue is the difficulties involved in calculating the costs of public services. While some of the costs of public services are easy to obtain, such as the costs of materials and equipment, the cost of labour and any overheads incurred in its production; other costs may be more difficult to quantify. Services-users may themselves incur costs travelling to receive public services. Friends or family members may incur costs in the absence of an intervention, for example from having to take time of work to help someone who is sick or cannot look after their children for whatever reason. Similarly, people can suffer personal traumas from the death of a loved one or a criminal act which are difficult to quantify. These intangible costs are often not taken into account in the economic evaluation of public services (Palfrey et al., 2012: 132).

A further issue is the difficulties involved in calculating the benefits of public services. As with performance management, there are issues regarding the intangibility of public services and outcomes. Many public services are often implemented in combination with each other, making it difficult to attribute benefits to interventions. There is also significant debate over whether less complex and standardised services are favoured in Evidence-Based Policy over more complex interventions. Chapter 6 examines the claims of some commentators that RCTs advantage 'bio-medical' healthcare over other forms of healthcare, in part because it involves singular, standardised interventions which result in an array of easily measurable clinical outcomes (Dickinson, 2008: 11)¹⁵. Similarly, there is

¹³ The RCT and Cost-Benefit Analysis are examined in more detail in the next section. The focus here is the discussion over the use in public service contexts.

¹⁴ Leslie Chapman argues that "although for proponents of EBP its claims are "self-evident truths", there is actually no "evidence" for it, in the sense that there are, and probably never will be, any randomised controlled trials of RCTs" (Chapman, 2012)

¹⁵ Critics argue that social care (Dickinson, 2008), mental health (Chapman, 2012), public health (Rychetnik et al., 2002) and complementary/alternative medicine (Hollinghurst et al., 2008; Jonas, 2001) are all disadvantaged because they can involve complex interventions that produce outcomes that are not easily measurable.

some debate about the incorporation of the evaluation techniques developed in healthcare to other policy areas. Martyn Hammersley argues that experimental forms of evaluation are not relevant for teaching, because pedagogical strategies elude standardisation: part of teaching is to respond to distinctive and changing characteristics of children and outcomes are not easily measurable (Hammersley, 2005: 90).

As in health policy, there are concerns that certain teaching practices are advantaged over others. In phonetic reading, children are taught to read through a focus on the sounds of letters. The approach performs highly in RTCs and is favoured in teaching guidelines. However, critics argue that to teach reading in full requires teachers to draw upon multiple strategies and to teach children both the sound and meaning of words. On its own, phonetic reading promotes a “mathematical understanding” of reading, involving “children simply sounding out made-up ‘words’: this is hardly what we mean by reading” (Smeyers and Smith, 2014: 153; see also Davis, 2013).

In addition, it is difficult to identify and measure all possible benefits of interventions. Colin Palfrey and colleagues use the example of local authorities keeping major roads free of snow and ice in severe winter conditions. The main benefit accrues to the authorities themselves, in the form of keeping the local economy going and avoiding severe congestion. But citizens are also likely to benefit through lower council tax bills because of lower repair costs for road surfaces and reductions in car insurance premiums. Furthermore, other local services, including the NHS, the police and the emergency services, would benefit from reduced demand. A failure to accurately account for all benefit flows would “potentially lead to sub-optimal findings and inappropriate recommendations from evaluations” (Palfrey et al., 2012: 133).

These issues raise similar questions as performance management regarding the intangible nature of both the activities of public services and their outcomes, which elude quantitative measurement. As I shall show in the next section, evaluations at the level of governance tend also to be quantitative and do not explore the quality of services at the level of policy.

3.1 Governance Evaluation: A Survey of the Issues

While the previous section discussed issues in the evaluation of policy, the present section explores the evaluation of changes to public sector governance. This serves to deepen understanding of different forms of public sector governance and identify issues associated with them. But it also provides insight into the weaknesses of dominant approaches to evaluation at this level. The evidence-base at this level is notably weak. As Angela Packwood comments, the “influence of research on governance policies has been negligible” (Packwood, 2002: 268; see also Rosen, 2000). Furthermore, as with evidence-based policy, there is significant debate over the appropriateness of dominant research methodologies to evaluate governing structures and thus inform decision-making accordingly.

Evaluations of governance are typically quantitative and descriptive, tracking the performance of organisations before and after a change in governance. Much of the data is performance management data and as such takes the form of measurable outputs, such as activities and processes (Pollitt and Sorin, 2011). Furthermore, the overarching value of evaluations is productivity, or x-efficiency: evaluations typically examine the relationship between inputs and outputs, assessing whether a governance change has increased outputs. Yet this is a narrow conception of performance which does not consider the appropriateness of the goods and services produced or the wider costs and benefits attached to changes to public sector governance. Without taking into account these wider questions of evaluation, governance evaluation risks obscuring the full costs of governance policies.

3.2 Evaluations of Privatisation

Though the focus of the present project is public services, it is necessary to consider privatisation because the “spectre of privatisation” looms large in debates on public services (Newburn, 2003: 70). Furthermore, privatisation is as contested as the marketisation of public services and there is significant methodological debate about dominant approaches to evaluation.

Of the academic evidence on privatisation, three studies stand-out, each of which adopt the same methodology and have similar titles: *The Financial and Operating Performance of Newly Privatized Firms*’ (Boubakri and Cosset, 1998; D’Souza and Megginson, 1999; Megginson et al., 1994). Combined, these studies analyse a total of 211 firms in a range of industries from around the world, including banking and finance, electric utilities, telecommunications, petroleum, steel and airlines. The studies analyse accounting data before and after privatisation and find that privatisation has been an overwhelming success. Significant increases are reported in efficiency, profitability and dividend payments, while the impact of privatisation on employment – said to be the “most politically-charged performance measure” – were inconsistent: two of the studies reported found that employment had increased, while one had reported that it had decreased (D’Souza and Megginson, 1999: 20).

The three studies are widely cited as evidence for privatisation¹⁶. However, various other reviews of the evidence suggest that the efficiency gains of privatisation were not always forthcoming. This is particularly true of the UK where a more varied account emerges (Sawyer and O’Donnell, 1999; Cumbers, 2012; Whitfield, 2001)¹⁷. Furthermore, critics question the appropriateness of the evaluations which

¹⁶ Motasam Tatahi and Almas Heshmati refer to them as the “most comprehensive studies”, which demonstrate across multiple firms in a variety of industries “significant improvements after their privatisation” (Tatahi and Heshmati, 2009: 3; see also OECD, 2003).

¹⁷ This is said to reinforce the possibility of ‘market failure’ in some industries, a concept explored in more detail in the next section.

dominant the field, suggesting they overstate the performance potential of privatisation policy (Ganesh, 1998; Jackson and Price, 1994; Whitfield, 2001).

A key issue concerns the attribution of causality between privatisation and performance. The above-mentioned studies are not experimental, like RCTs, but descriptive or observational. Privatisation is evaluated by analysing certain measures of performance before and after the change in governance. Unlike other forms of observational study, no attempt is made to isolate the effects of additional causal factors. Yet the period of widespread privatisation, from 1980 into the 1990s, was characterised by benign global conditions and extensive technological advance. Performance gains may therefore have occurred in the firms without a change in ownership and indeed often occurred in similar firms that had not been privatised and in the industries of countries that did not engage in privatisation (Parker, 2004).

A further issue concerns the measures of performance themselves. Some of the measures discussed in the studies, including profitability and dividend payments, are poor measures of performance, for they are clearly weighted in favour of shareholders and leave open the question of the effects of privatisation on consumers, employees, managers and society more broadly. Furthermore, given that a core argument for nationalisation is that markets are not always efficient (see chapter 4), the question arises whether privatisation can really be said to have improved performance or whether increases in profitability and dividend payments represent the exploitation of market power.

The studies do include measures of x-efficiency, but this does not address the problem. Crucial evaluative questions remain regarding the appropriateness of the goods and services produced and the wider spread of costs and benefits. The quality of the goods may have decreased or the price may have increased, as was the case in some industries. Furthermore, prior to privatisation, nationalised firms and industries were typically constrained by various policy objectives such as to maintain high levels of employment, keep prices low, sell at uniform prices or maintain socially useful but unprofitable services. The purported gains associated with privatisation may have come at the cost of any of these different objectives (Ganesh, 1998: 94; see also Jackson and Price, 1994; Sawyer and O'Donnell, 1999).

Certainly, privatisation has been linked to an increase in unemployment (Tickell, 1998), inequalities – both internally within firms and externally in the broader society (Price and Hancock, 1998: 311) – and a decline in pay and working conditions (Sawyer and O'Donnell, 1999). This is not to imply that privatisation is not an appropriate policy tool for some firms and industries, but it would appear that dominant approaches to evaluation overstate the benefits relative to the costs.

3.3 Evaluations of New Public Management

There is an extensive array of evaluations of New Public Management and far too many to consider here in any detail. Nevertheless, it is possible to identify some core characteristics of the literature. As with evaluations of privatisation, the evaluations do not use the RCT but take the form of observational studies. Unlike the entirely descriptive evaluations of privatisation, however, econometric techniques are used to examine causal relationships between variables.

A key distinction is between prospective and retrospective observational studies: in the case of prospective observational studies, performance criteria are identified and measured prior to a change in governance, with the data compared with the same data at the end of the period of study; in the case of retrospective observational studies, statistical techniques are used to analyse existing data sets to isolate the effects of the change in governance. Out of these, prospective observational studies are considered to be superior because they are more transparent: researchers set out the terms of the study prior to it commencing¹⁸. Retrospective observational studies, in contrast, typically involve the analysis of existing data sets. While they can be useful where the time and resources for setting up an experiment or a prospective observational study are not available, the analysis can take the form of complex regression analyses and invite the criticism of “data dredging”:

...when subsequent ‘hypothesis testing’ is based on having seen the results – or worse, on selectively retraining those hypotheses that support a favoured direction (Williams et al., 2002: 106)

Nevertheless, retrospective observational studies dominate most areas of policy¹⁹. Despite the use of more scientific forms of evaluation, there is some debate whether the use of statistical techniques overcomes the problem of causation in evaluation (Fukuyama, 2013: 9). Studies are often critiqued on the basis that the outcomes identified are down to some other factor than the proposed cause. As Christopher Pollitt and Sorin Dan note in their literature review on the topic, evaluations of NPM are characterised by widespread “problems of attribution” (Pollitt and Sorin, 2011: 16), with few evaluations adopting “the RCT model” (Pollitt and Sorin, 2011: 22).

A further issue concerns the measures of performance used in the studies. As with privatisation, the focus is on x-efficiency, that is, the relationship between inputs and outputs; actual public service outcomes are rarely explored (Pollitt and Sorin, 2011: 15). This is due in part to the difficulties involved in the measurement of outcomes, discussed above. The problem with this approach is that the change in governance might result in negative outcomes that are not captured in the evaluation. In this way, quantitative evaluations of governance proceed on the same assumption of performance management and scientific/economic forms of

¹⁸ RCTs are always prospective in this sense.

¹⁹ An exception is health policy, where RCTs, prospective and retrospective observational studies are common (Le Grand, 1998).

appraisal typical of EBP: that performance can be captured in simple quantitative metrics.

The pros and cons of performance management have already been discussed above and chapter 6 examines the evidence on performance management in health policy. As such, the focus here is evaluations of contracting out and quasi-markets.

Contracting out

During the 1980s and 1990s, the Conservative Government sought to compel reluctant councils and other public sector bodies to contract out basic services through Compulsory Competitive Tendering (CCT) in order to improve efficiency. Unlike privatisation, contracting out does not necessarily entail a change in ownership but the public sector can be in competition with the private sector to win contracts.

There is a large body of evaluations of CCT, most of which focuses on catering and refuse collection. Overwhelmingly, the policy is found to have successfully improved efficiency, thus indicating that the previous regime of in-house delivery was inefficient (Cope, 1995; Hartley and Huby, 1985; Domberger et al, 1986; Szymanski and Wilkins, 1993; Gómez-Lobo and Szymanski, 2001).

However, once again, there are potential criticisms of these studies. Due to the absence of a control group, the reported improvements could have resulted from additional factors, such as technological development or improved working practices that would have occurred irrespective of contracting out (Boyne, 1998). Furthermore, evaluations do not consider the wider spread of costs and benefits. As a public service, the change in governance would not have increased the price of the service to the service-user, but nonetheless quality may have declined.

A key issue is the measures of performance used in the studies. Evaluations of refuse collection typically focus on the *frequency* of collections because it is easy to measure and seemingly uncontroversial:

Inputs are basically unskilled labour and trucks, output is measured simply by the volume of waste collected and quality of service does not tend to vary widely because: either the garbage is taken away or it isn't (Gómez-Lobo and Szymanski, 2001: 107).

However, even in the case of seemingly basic services such as catering and refuse collection, there is a question mark whether performance can be captured in performance metrics. In the case of refuse collection, performance could be evaluated across an array of measures, such as whether garden waste and bulky waste is collected, or whether special arrangements are available to help disabled people (Boyne, 1997: 34). Furthermore, new challenges arise and the definition of 'performance' changes with them. Recycling has added new complexity to refuse

collection, while increased recognition of the importance of healthy food adds to the complexity catering.

Finally, as we saw in chapter 1, a key argument of theorists of 'networked governance' was that NPM has reinforced a "silo" approach to the delivery of public services. While catering and refuse collection may not involve much in terms of collaboration between providers, nonetheless a main criticism of CCT at the time was that it was creating an adversarial relationship between councils and providers which was preventing them from collaborating to achieve complex public service outcomes (Davis and Walker, 1997). Ultimately, quantitative research of this type will not capture these wider effects of enforced competition.

Quasi-markets

Like CCT but unlike privatisation, quasi-markets do not always involve a change in ownership. But they differ from CCT because the aim is not only to improve efficiency but also to promote other values such as service quality, responsiveness and choice. Reforms to the health service (discussed in chapters 6 and 7) and education have sought to enhance performance through the development of quasi-markets.

In education, the development of the market has involved providing service-users with greater choice over their schools. While constituting a value in itself, for people are said to value choice of public services; choice is also expected to improve efficiency because resources follow pupils. The development of national curriculums, standardised testing, performance tables and inspection regimes have buttressed the operation of the 'market', safeguarding the quality of services and providing parents with information to enable them to make informed choices (Levačić, 2004).

The headline statistics suggest quasi-markets have been successful in boosting the performance of schools. Between 1992 and 1999, the proportion of 16 year-olds in England achieving 5 grades A* – C rose substantially from 35.5 % to 45.8% (Adnett and Davies, 2003: 14). By 2004/05, this figure rose to 55.7% (Green et al., 2005: 1). Evaluations explore whether this increase in results is down to the introduction of the quasi-market. As with contracting out, quasi-markets are found to have improved performance, in terms of academic standards as reflected in test results (Bradley et al, 2001; Bradley and Taylor, 2010; Burgess and Slater, 2006; Gibbons et al, 2006; Gibbons and Silva, 2007).

Yet there are a number of issues to consider. Once again, it is difficult to conclusively attribute outcomes to the change in the governance structure: quasi-markets are purported to have the strongest positive effect in urban areas where competition between schools is at its highest, but other possible explanations include urban development and increased gentrification (Bagley et al., 1998: 6). More problematically, the studies rely upon data collected through processes of performance management: school test results. The problem with this approach is

that issues which can accompany performance management, discussed above, will not be picked up by the evaluation. Indeed, the close relationship between performance management and quasi-markets means that both are susceptible to similar problems.

The incorporation of choice in public services stands to improve the responsiveness of services to the needs and preferences of service-users. Yet service-users (parents) are provided with performance data in order for them to make choices. The problem here is that performance management data can provide a misleading view of the quality of schools. The performance of schools and individual teachers may have more to do with the social composition of schools than the quality of teaching (Allen and Burgess, 2010). Grades may have been inflated by teachers teaching 'to the test' or by schools focusing attention on people who are on the D/C grade borderline to the detriment of other students (Levačić, 2004). Or, schools admissions policies may have been manipulated to ensure that only students with better prospects are admitted (West, 2010).

Furthermore, the choices of service-users are constrained. While service-users can choose their schools, the absence of a fully developed market ensures that choices are limited to what is available (West et al, 2009). Many patients choose "rationally", on the basis of schools they believe their children will gain a place at rather than their genuine preference (Reay and Lucey, 2003).

A further issue is that service-users lack choice over the performance indicators. It is pre-empted they will choose in terms of academic performance alone, conveyed as test results. However, research suggests parents choose schools in light of a variety of criteria such as the demographic of the schools and the happiness and preferences of their children (Bagley et al, 1998: 46; Wilson, 2008). The centrality of academic standards may therefore "skew the responsiveness of schools" away from their values and preferences (Bagley et al, 1998: 195)²⁰.

The development of national curriculums also represents a constraint on choice (Apple, 1993: 222; Whitty, 1989), as does the increasing involvement of EBP in determining policy at the level of teaching and learning strategies. Nick Adnett and Peter Davies criticise the notion that quasi-markets in education entail choice, when in fact the development of the quasi-market has entailed heightened central control:

...through choice of school performance data, control of the curriculum, retention of funds and active control of large scale innovation (e.g. through the introduction of strategies for literacy and numeracy) central government has pre-empted parental

²⁰ For this reason, there have been attempts to develop more complex performance indicators but these have foundered because parents continue to use GCSE results as they are easier to understand (Allen and Burgess, 2010: 5). Furthermore, studies have shown that parents who have a higher level of education have a better understanding of performance league tables, suggesting that developing more complex indicators may exacerbate inequality (West and Pennell, 2000: 428; see also Coldron et al, 2010).

influence. In some respects it has reduced parents to the role of agents, putting pressure on other agents (schools) to achieve the outcomes that the government, as principal, has determined (Adnett and Davies, 2003: 20)

These counterexamples not only raise questions regarding the effectiveness of managerialist and market forms of governance to ensure the provision of effective public services, but they also question the capacity of quantitative, x-efficiency studies to provide a comprehensive evaluation of public sector governance. Many of the issues discussed here would lead to the adoption of 'networked' arrangements²¹.

²¹ New Labour would eventually abolish CCT in 1998/9, citing various problems with the initiative, including "uneven and uncertain efficiency gains", costs for employees which resulted in high staff turnover and unnecessary antagonism between local authorities and the private sector, all of which were preventing the realisation of the full benefits of partnership working (DEFRA, 1998: 6).

3.4 Evaluations of 'Networked Governance'

As discussed in chapter 1, recognition of the limitations of NPM led many commentators to advocate more collaborative approaches to public sector governance (O'Toole, 1997; Staw and Cummings, 1990). But even here there is recognition that 'networked governance' can fail. Some commentators are critical of the approach, arguing that collaboration has become an end in itself and that 'joined-up' processes and procedures constitute a new form of bureaucracy which skews attention away from a focus on achieving policy outcomes (Blackman, 2013; Travers, 2007).

For this reason, evaluations are required to assess the performance of networks; for otherwise there is a danger that public funds are wasted supporting this form of governance when other forms of service delivery are more efficient. Yet there is a notable absence of literature on the evaluation of networks. Initial literature on changing forms of governance during the 1990s was more descriptive than evaluative (Sorensen and Torfing, 2007: 14). A second-wave of literature explored the political implications of networks and their performance, but the emphasis here is on policy processes and crucial questions are left open regarding the *effectiveness* of networks to improve policy outcomes (Kenis and Provan, 2009; Torfing et al., 2012; Turrini and Cristofoli, 2009).

Indeed, evaluative claims, when they are made, typically identify the potential of networks to improve various process measures, such as commitment, trust and communication amongst network participants, which serve as a proxy for performance (Kenis and Provan, 2009: 442). A typical example is provided by Nancy Roberts, who makes the case for networks – or collaboration, in her schema – over authoritative strategies (hierarchy) and competitive strategies (markets), with a case study of international aid and development in Afghanistan following on from the 1980s conflict in that country. While entailing some drawbacks for participants (such as the time and effort it takes to participate), networks are said to be particularly appropriate for "wicked problems", resulting in increased collaboration, new and improved relationships, regular meetings, agreement on difficult issues and the development of a common mechanism for coordination (Roberts, 2001: 11). Roberts concludes by espousing a new approach to "wicked problems", one in which stakeholders "trust the process" without guarantees of a particular outcome (Roberts, 2001: 16).

Similarly, research explores the *conditions* of effective networks and *strategies* for successful network management (Kickert et al., 1997; Koppenjan and Klijn, 2004). These approaches provide useful guidance for policymakers in the design and management of networks. Yet they do not explicitly evaluate the effectiveness of networks. It remains possible that well managed networks characterised by high levels of trust and communication do not result in tangible improvements in public service outcomes.

The absence of evaluations which focus on the effectiveness of networks may be explained by the fact that the challenges which confront any form of policy evaluation are exacerbated when it comes to network evaluation. Given that networks are considered particularly appropriate in the context of ‘wicked’ policy problems, the nature of the policy problem to be addressed will, by definition, be difficult to define. Furthermore, the temporal gap between the formation of the network, processes of policymaking/implementation and outcomes will be even longer than typical public service interventions and multiple stakeholders will be involved (Provan and Milward, 2001: 416). Additionally, networks are characterised by what Jacob Torfing and colleagues call “pluricentric negotiations” among stakeholders, which lead to “imprecise and competing goal formulations” and changing policy objectives due to “mutual learning and shifting power relations”:

Indeed, a flexible adjustment of policy objectives to changing preferences and circumstances is often one of the primary reasons why interactive forms of governance are invoked (Torfing et al., 2012: 169)

For these reasons, it is difficult to define objectives prior to policy implementation, making it difficult to establish whether or not the network has demonstrably improved whatever it is that requires improvement (Torfing et al., 2012: 169). Torfing and colleagues have sought to address this absence by developing a framework of process and outcome criteria derived from the specific promises of networks identified in the literature (see Box 2).

Box 2 – Criteria for the Evaluation of ‘Networked Governance’

1. Facilitate a clear and well-informed understanding of the policy problem (by formulating a broad and inclusive story line that can subsequently be developed into specific objectives and tasks)
2. Generate innovative yet feasible solutions (by drawing upon views from inside and outside the network)
3. Reach joint policy decisions which go beyond the least common denominator (by facilitating agreement through a result of significant change in values and perceptions on behalf of one or more network actors)
4. Ensure smooth policy implementation and creating acceptable results (by avoiding serious problems, duplication of efforts and practical/political conflict)
5. Provide flexible adjustment of policies and services (by regular assessments of performance which identify early problems if they emerge and which can be translated into adjustments of policies and services)
6. Improve the conditions for future cooperation (by developing a common frame of references which facilitates on going communication and collaboration)

Source: adapted from Torfing et al., 2012

As a guide for evaluations, this framework usefully highlights what should be expected of networks to justify the use of public funds. Stages 1, 2 and 3 relate to

policy processes, whereas stages 4 and 5 relate to policy implementation and outcomes. Like 1, 2 and 3, stage 6 is a process measure corresponding to heightened collaboration and trust which potentially result from the use of networks and which are assumed to improve policy process and outcomes in the future.

Nevertheless, the framework does not provide any guidance as to the precise empirical methodology that might be used to acquire and analyse data across the criteria. Further still, the focus is on networks alone: it is unclear how other evaluative questions which arise in public sector governance might be addressed. What, for example, is the role for centralised forms of decision-making and performance management in 'networked governance'? And what should be the relative roles of the public sector and the private sector? The question of how to address these evaluative questions of public sector governance remains very much open.

4.1 Concluding Remarks

This chapter has provided a critical analysis of dominant approaches to policy evaluation in public sector contexts. I began by examining policy evaluation, both as a practice of performance management and a mechanism to improve decision-making via the appraisal of public services and interventions. I also examined the main approaches to the evaluation of governance, including privatisation, New Public Management and 'networked governance'.

I have argued that dominant approaches to the evaluation of policy and governance are problematic and have criticised in particular the dominance of quantitative research. Quantitative evaluation, while undoubtedly important, nevertheless only provides a partial view of performance. Neil Carter's "tin-opener" analogy (Carter et al., 1995) can be generalised to all forms of quantitative evaluation. Indeed, the sociologist Robert K Merton warns against confusing measurement with performance (Meyer, 2003: xiii).

Over the next three chapters, I develop an alternative approach to the evaluation of policy and governance. I begin in the next chapter by examining issues in policy evaluation in more detail, exploring the philosophical underpinnings of dominant approaches and their postpositivist critiques. In the process, I begin to outline a qualitative, postpositivist approach to policy evaluation. Chapters 4 and 5 then explore governance evaluation in more detail.

Chapter 3: Positivism, Postpositivism and Policy Analysis

The level of contestation over public sector reform and indeed dominant approaches to policy evaluation suggest that an alternative approach to evaluation is necessary. My purpose in the present chapter is to begin the process of developing one such approach. I do this by first exploring the philosophical underpinnings of dominant forms of policy evaluation, before examining the central methods of Evidence-Based Policy in more detail: the Randomised-Control Trial (RCT) and Cost-Benefit Analysis (CBA). This serves as a basis to go onto explore, in the second section, postpositivist criticisms of positivism and postpositivist forms of policy analysis. In the process, I outline the methodological position of the project. I make a case for a qualitative, postpositivist approach to policy evaluation which recognises the incomplete and partial nature of knowledge and the incommensurability of values.

Section 1 introduces the philosophical perspective of 'positivism' and section 2 examines both 'positivist' and 'neoclassical' approaches to policy evaluation, in the form of the RCT and CBA. Section 3 presents the main criticisms of 'positivism', identifying a number of distinct perspectives – including postmodernism/poststructuralism, interpretivism and critical realism – each of which identifies particular issues with the positivist framework. Section 4 draws out the implications of these criticisms for the topic of policy evaluation.

1.1 Positivism and Policy Evaluation

Defining positivism is somewhat precarious because few researchers consciously describe themselves as 'positivists', with the term read onto some peoples' work as a "term of abuse" (Ishiyama and Breuning, 2010: 461). Nevertheless, positivism is generally associated with a view of science as the ultimate source of knowledge and associated belief that the social sciences should emulate the methods of the natural sciences.

To understand positivism, it is useful to situate it in the context in which the perspective arose and the intellectual issues with which positivist philosophers debated. In Agnes Heller's account, positivism emerges as a response to a fundamental paradox of the Enlightenment: between 'universal' and 'reflected' consciousness (Heller, 1989: 292). The Enlightenment project promised a new epoch for mankind free of dogmatism and tradition. Yet, despite this explicit universalism, the project was self-aware. It alone was capable of freeing mankind. But this tension between universalism and reflexivity was difficult to reconcile: "How can one know that one's knowledge is true?" (Heller, 1989: 292).

For positivists such as Auguste Comte, the way out of this quagmire was the emulation of the natural sciences. The natural sciences had had demonstrable success, evident in the increasing mastery of the natural world and unparalleled

technological development. By emulating the natural sciences, social researchers would be able to step out of their own particular worldviews and acquire objective knowledge of the social world. This required the development of social scientific methodologies modelled on the methods of the natural sciences (Niiniluoto et al., 2004).

There are three basic premises to positivist research:

- Objectivity (neutrality);
- Measurement (quantification);
- Causality (determinism) (Hagan, 2012: 177).

The first premise – objectivity – is the defining characteristic of positivist epistemology: that objective knowledge is possible. This, in turn, operates on the assumption that values are at least potentially separable from facts. Facts, for their part, can be ascertained through observation and can indeed be measured and quantified. Only data that are directly observable should be considered in research and “what is observable also includes what is measurable or possible to register through some kind of instrument” (Alvesson and Skoldberg, 2009: 17). Once data has been collected, researchers can examine causal relationships between variables. Indeed, the third premise corresponds to positivist ontology holds that reality is characterised by causal relations in which effects have causes. The collection and analysis of data enables the testing of hypotheses which, if verified, assume the status of scientific laws²². This, in turn, implies a ‘successionist’ conception of causation based on the following form: if B follows A, then A causes B (McLaughlin and Newburn, 2010: 205; see also Pawson, 2008).

Positivism has had a profound impact on the social sciences in general and policy evaluation in particular, resulting in the prioritisation of quantitative research over qualitative research to understand social phenomena and the elevation of scientific experiments in the study of causality; for these methods are the surest guarantee of objective knowledge. It is for this reason that Eileen Loudfoot characterises positivism as a reduction of “epistemology to methodology”: complex philosophical questions regarding the status of knowledge are reduced to questions about methods (Loudfoot, 1973: 170).

A brief consideration of public sector governance suggests that the influence of positivism is pervasive. As we saw in the previous section, New Public Management involves the quantitative measurement of performance on the positivist assumption, shared by neoclassical economics, that value can be quantified. Also,

²² There are differences within positivism regarding the role of theory in developing hypotheses and the status of hypotheses once they are tested. Karl Popper, for example, allows an extensive role for theory in the development of hypotheses and has argued that rather than proceed on the basis of *verification* – implied by the positivist notion of ‘laws’ – science proceeds on the basis of *falsification*: all that science can establish is “the creation of, as yet, unfalsified laws” (Gray, 2009: 22).

Evidence-Based Policy is premised on the notion that the objectivity of knowledge depends upon the rigour of the methods applied in research. Lucie Rychetnik and colleagues observe a general “reliance on the study design as the main criterion of credibility of evidence” (Rychetnik et al., 2002). It is assumed that the application of rigorous and value-free research will improve decision-making, which has purportedly relied too heavily upon a combination of ideological political judgement or fallible professional judgement.

1.2 Positivism and Evidence-Based Policy

As we saw in the previous section, policy evaluation has become a central feature of policy processes and, via so-called Evidence-Based Policy, seeks to improve decision-making across all levels of the public sector. It is important to examine the methods of EBP in detail, both to understand limitations to EBP as it has developed in recent years and to begin the process of developing an alternative approach to evaluation.

The EBP literature identifies a number of core questions for evaluation (Palfrey et al., 2012: 128; see also Haynes, 1999):

- Can it Work?
- Does it Work?
- Is it Worth It?

The first is a scientific question, which refers to attempts to establish the *efficacy* of a policy, public service or intervention; the second question is a practical question, which refers to attempts to establish the *effectiveness* of such interventions in real life, policy contexts; and the third question is an *ethical* question, involving a consideration of the values that are sought by an intervention and the relative *efficiency* of different options to realise those values. Indeed, establishing the value or worth of a policy option concerns the economic dimension of policy evaluation.

The influence of positivism is most apparent with the application of experimental methods to policy evaluation in the form of the Randomised-Control Trial (RCT). The logic behind the elevation of the RCT is essentially the same as that outlined in the 1960s by Donald Campbell and Julian Stanley. Then, Campbell and Stanley called for more rigorous forms of policy evaluation and identified the RCT as the most rigorous method that was available. Early evaluations had taken the form of the ‘one-shot case study’, whereby research subjects were simply exposed to an intervention and outcomes were measured. For example, a new method of teaching might be evaluated by measuring student achievement in exams, thus providing evidence of its effects. However, evaluations of this type, according to Campbell and Stanley, have “almost no scientific value” because a counterfactual is required in order to establish that the effects would not have arisen without X (Campbell and Stanley, 1966: 6). Alternatively, students might be tested before and after they are exposed to the new method of teaching, a ‘one-group pre-test-post-

test study'. Though this is an improvement on the 'one-shot case study', confounding factors may still have caused the outcome: remaining with the teaching example, students

...may have grown older, hungrier, more tired, more bored ... the difference observed may reflect this process rather than X (Campbell and Stanley, 1966: 8)

By selectively exposing research participants to either an experimental or a control group, RCTs solve this problem. Figure 1 presents the structure of the RCT, where O represents an act of measurement and X represents exposure to an intervention. Once measuring is completed, the difference can be attributed to the intervention, thus providing insight into its efficacy²³.

Figure 1 – The Randomised-Control Trial

| | Pre-test | Intervention | Post-test |
|--------------------|----------|--------------|-----------|
| Experimental Group | O1 | X | O2 |
| Control Group | O1 | | O2 |

Source: adapted from Pawson and Tilley, 1997

Similar arguments to Campbell and Stanley's are expressed in policy documents and evidence manuals today, where studies which do not feature a control, randomisation or a 'blind' – whereby participants and occasionally researchers are unaware of the status of each group – are considered inferior to those that do (Haynes et al., 2012).

The RCT potentially solves the problem of causation in policy evaluation, providing insight into the efficacy of policy interventions to bring about a desired end. Yet it does not provide any insight into the value of the outcome(s) or the relative efficiency of an intervention relative to others, which is precisely the purpose of economic evaluation in policy analysis. The next section explores the 'neoclassical' economics framework, which has been highly influential in policy analysis. It suffices to examine here the principle form economic evaluation, Cost-Benefit Analysis (CBA).

CBA gained prominence in the US in the 1960s, where it was applied to the management of water quality and land conservation, among other services (Hoch, 1965)²⁴. The procedure aims to inform decision-making when decision-makers are confronted by two or more options and involves a number of steps. First, the nature of the policy problem is defined. Following that, all stakeholders affected by

²³ This is still dependent on a number of further criteria, such as the size of the sample (to ensure that outcomes are not affected by the peculiar characteristics of a minority) and duration of the study (to ensure that interventions are sufficiently evaluated) (Campbell and Stanley, 1966: 13).

²⁴ Early developers of the procedure sought to improve decision-making which was deemed synonymous with side-lining "rule-of-thumb and arbitrary standards" (Hoch, 1965: 1034).

the policy issue are identified, who may experience either a cost or a benefit from a policy decision²⁵. Also, the relevant options are identified, which include the status quo and whatever other options are deemed viable. The next step is to predict the outcomes of the different decisions and assign a monetary value to any costs and benefits which might arise. This can be done by three main options: market valuation, revealed preferences or stated preferences (see box 1)

Box 1 – Techniques of Monetary Calculation

Market valuation – where goods or services are valued vis-à-vis market prices. In one variant of the approach, the value of a service can be derived from the estimated costs that would occur in the absence of a policy intervention, such as the damage caused from flooding in the absence of flood defences. An additional variant measures the production function of a service. Improvements to water quality, for example, might increase the catch of fish, thus benefiting fishermen and consumers through lower prices and/or improvements in the quality of the stock.

Revealed preferences – where goods or services are valued vis-à-vis consumer behaviour in proxy markets. The hedonic pricing method derives the value of services by measuring prices in related markets, such as the effect of environmental quality on house prices. Likewise, the travel cost method derives the value of services provided for free by quantifying the resources that consumers expend obtaining it, such as the time and money spent attending a health service that is provided for free (McIntosh, 2010: 11).

Stated preferences – where values are derived through consumer surveys in which individuals are asked what price they would pay for a good or service in a hypothetical situation. Thus, respondents might be asked to express what they would pay to improve the water quality of a nearby lake so that they can enjoy activities such as swimming and fishing (Kumar, 2010: 205).

The monetised costs of a policy option constitute the cumulative amount of money that people who are disadvantaged would require as compensation for accepting it; the monetised benefits constitute the cumulative amount of money that the people who are advantaged would pay in return for securing the benefit (Adler, 1994: 1373). Once the costs and benefits of different options have been assigned a monetary value, it is possible to compare the different options because they now have a commensurable value attached to them. The option which produces the most benefit at the least cost is proposed for implementation (Hanley and Spash, 1994: 9).

As with the RCT, the procedure is highly influential and is central to Evidence-Based Policy (HM Treasury, 2011a; HM Treasury, 2011b). Nevertheless, as discussed in the previous section, the emergence of EBP and these dominant forms of scientific and

²⁵ Data from RCTs and other forms of scientific evaluation can be used to estimate the possible consequences of policy options. This is particularly the case in health policy, where RCTs are in abundance (Cairns, 1998).

economic evaluation has proved controversial. The criticisms of EBP today resemble more general concerns of postpositivist scholars of positivism and neoclassical economics in policy analysis. The next section explores a number of postpositivist perspectives, each of which has important insights into specific weaknesses of the positivist paradigm. The following section then draws out the implications of postpositivist philosophy for policy analysis and evaluation.

2.1 Postpositivist Perspectives of the Sciences

The philosophical perspective of positivism has come under sustained criticism in recent years, both in the philosophy of science and policy evaluation. Though a variety of perspectives are associated with the term, postpositivists share a belief that knowledge is always partial, incomplete and value-laden. It is not possible for social researchers to entirely step out of their own particular worldviews and acquire objective knowledge of the external world. In different ways, these perspectives criticise the positivist view that science is the ultimate source of knowledge and the associated belief that the social sciences should be modelled along the lines of the natural sciences (Alvesson and Skoldberg, 2009).

A central point of contention between positivism and postpositivism is the role of theory in science. Where positivists hold that only theories that can be empirically verified can be accepted as true, postpositivists argue that theory, judgement, belief and ultimately values have a role in the construction of scientific theories and the collection and interpretation of empirical data (Alvesson and Skoldberg, 2009). A particularly 'radical' view of the relationship between theory and facts is provided by Thomas Kuhn, who argued that the background assumptions, beliefs and theories of the scientific community determine what is accepted as true. For Kuhn, science does not develop in a linear manner but is characterised by "periodic revolutions" in which the conceptual apparatus underpinning science and which inform how scientists think about reality, or "paradigms" as they would come to be known, are called into question and replaced with alternatives. These paradigms are incommensurable and shifts in paradigms are accompanied with shifts in the notion of "truth" which pertains at any point in time. Objectivity, then, is a misnomer because it is ultimately founded upon the background assumptions of the scientific community which change over time and characterised by sharp ruptures or 'revolutions' (Kuhn, 2012).

A less radical view of the role of theory in scientific research is provided by Michael Polanyi. For Polanyi, all activities depend upon a background of beliefs, values and mental models that are difficult to articulate in propositional form. Such 'tacit' knowledge tends to be learnt through association, experience and practice, rather than through language. Science itself depends in large part on the 'tacit' knowledge of scientists acquired through years of training. Furthermore, guesswork and heuristics are just as important to the development of scientific knowledge as reasoned interrogation and the testing of hypotheses in scientific experiments. In

this way, tacit knowledge – that which “we know but cannot tell” – is foundational to scientific knowledge and all other forms of knowledge (Polanyi, 1962: 601).

Where these works unsettle positivist epistemology, other postpositivists have critiqued positivist ontology. Thomas Cook has argued that developments in the natural sciences, most notably around quantum theory and chaos theory, unsettle the positivist assumption of an orderly natural and social world which is amenable to scientific inquiry. This, in turn, suggests the ‘successionist’ conception of causality is untenable. Reality is not made up of simple cause/effect relations, but causes can have multiple effects (and vice versa) and intervening variables complicate efforts to test hypotheses. This is particularly true of society:

Human relationships are more like pretzels than single-headed arrows from A to B ... more like convoluted multivariate statistical interactions than simple main effects (Cook, 1985: 25).

These rejections of positivist epistemology and ontology share similarities with post-modern and post-structuralist schools of thought which reject any notion of objectivity and causation (Atabor, 2014). Post-modernists and post-structuralists argue that modern science and the Enlightenment project more broadly are closely bound up with the exercise of power, lending authority legitimacy to powerful individuals and groups. Positivism is criticised for valorising the knowledge of some individuals, groups and cultures over other, localised, subordinate and indigenous forms of knowledge. It is precisely these radical epistemologies which were influential among the New Left, discussed in chapter 1.

Yet these more radical rejections of positivism have themselves been criticised in recent years. A key criticism of postmodernism and poststructuralism is that they leave a weak basis for progressive research agendas (Collier, 1994). Certainly, the outright rejection of science closes down the possibility of utilising science for progressive ends²⁶ and is also self-refuting, since it depends upon truth claims established through research (Putnam, 1982).

An alternative framework is interpretivist philosophy. Interpretivists argue that the natural and social sciences should be entirely different because they pertain to different object domains: whereas natural science explores the natural world, the social science explores the social world. The fundamentally different makeup of society implies that different methods are required to study it. Whereas natural science proceeds via the testing of hypotheses, the social world is not reducible to simple cause/effect relations but is constituted by conscious beings who ascribe meanings to their actions and to social events. Furthermore, researchers are part of the social world and cannot simply observe it as a phenomenon external to them. To establish truths about the social world requires that researchers drop prior assumptions and categories and establish a dialogical relationship with their subject

²⁶ This argument is often made in the field of environmental scholarship. Science, though seemingly bound up with industrialisation, also provides knowledge of climate impacts that are vital to advance environmental causes (Jones, 2002).

matter, exploring, as in phenomenological thought, how social phenomena appear in the consciousness of research subjects²⁷.

Interpretivist philosophy provides a powerful criticism of positivist attempts to construct the social sciences along the lines of the natural sciences and in particular the elevation of quantitative methodologies. Qualitative methods breakdown the relationship between researchers and the researched, enabling researchers to tap into multiple understandings which people have of reality (Englander, 2012). Nevertheless, interpretivism raises questions of the status of social scientific research and that of quantitative, 'positivist' science (Lin, 1998; Roth and Metha, 2001). As in the case of outright rejections of science, a concept of objectivity is difficult to uphold if the social sciences are geared towards identifying and exploring multiple 'realities'. Furthermore, quantitative methods in the social sciences, in their various guises, have undoubted benefits, greatly enhancing the administration of society and performing an important role in the pursuit of social justice (Cokley and Awad, 2013)²⁸. Rather than argue for a fundamentally different kind of science for the social sciences, a balance of quantitative and qualitative research may be more appropriate. Statistics have valued as background material in qualitative research (Alvesson and Skoldberg, 2009: 4).

A further issue with interpretivist philosophy is that its sharp demarcation between the social and natural sciences may have the effect of immunising the (positivist) natural sciences from critique (Mitchell, 2003).

An important development in recent years has been the emergence of critical realism, a further post-positivist perspective. Critical realism serves as an "under-labourer" for researchers, clarifying epistemological and ontological issues. Central to the framework is a concept of epistemic relativism, which suggests that all knowledge is a social product and fallible²⁹. Furthermore, critical realism provides an account of reality as complex, structured and emergent (Bhaskar, 2008). These assumptions usefully clarify the status of both qualitative research and scientific research.

On the one hand, the complexity of society is precisely why there are different interpretations of it. People have different interpretations of reality because of the different positions they occupy in the social milieu. In this way, different interpretations of reality can be recognised without rejecting a concept of

²⁷ Magnus Englander writes that "the relationship subject-object is different from subject-subject, making the evaluative, methodological criteria of the research procedure different as well. Due to this difference, the phenomenological, human scientist's challenges throughout the entire research process will also be very different from that of the natural scientist's. And most important of all, this difference demands a distinctly different methodology based on a distinctly different theory of science" (Englander, 2012: 15).

²⁸ Indeed, certain aspects of society can only be grasped via quantitative methods. Statistical analyses of large data sets provide insight into relatively durable social structures which exist irrespective of the awareness of actors who reproduce them, such as class or patriarchal relations (Olsen, 2009: 8).

²⁹ The concept of 'epistemic relativism' is distinguishable from 'judgemental relativism', according to which there are no grounds to evaluate truth claims and which informs the postmodern and poststructuralism position.

objectivity. Qualitative research improves our understanding of objective reality by providing insight into the different interpretations of reality which can be more or less correct (Maxwell, 2012).

On the other hand, critical realism clarifies the status of scientific knowledge, following a reconstruction of the nature of scientific inquiry. The complexity of reality limits positivist attempts to generalise research findings. Critical realists replace the 'successionist' conception of causality with a 'generative' conception which recognises that causes can have multiple effects (and vice versa). Scientific research proceeds by engineering "closed systems" in the form of scientific experiments in order to acquire knowledge of causal relationships. Yet cause-effect relationships uncovered in scientific experiments may not occur in the real world, where multiple other factors come into play. Research findings may therefore fail to translate into the "open systems" of the real world (Pawson, 2008). For this reason, the positivist attempt to establish generalisable truth in the form of scientific laws is misguided. Rather than assume the status of 'laws' if verified (or, indeed, not falsified), scientific insights take the form of *tendencies* that may or may not occur (Bhaskar, 2008: 11).

As discussed in the next section, critical realism, along with the other postpositivist perspectives discussed here, have significant implications for policy analysis.

2.2 Postpositivist Policy Analysis

Postpositivist perspectives of the sciences have significant implications for policy analysis. Postpositivism suggests there is no value-neutral framework or procedure to establish the veracity of truth claims, problematising the "hierarchies of evidence" which characterise Evidence-Based Policy (Gabriel, 2008). For Sandra Nutley and colleagues, the use of evidence "hierarchies" serves only to suppress the values and knowledge of certain individuals and groups in society:

Quality judgements are contested because ultimately 'evidence' and 'good evidence' are value labels attached to particular types of knowledge by those able to assert such labelling. In any decision-making setting there will be people with greater power than others to assert what counts as good evidence, but this does not mean that the less powerful will agree (Nutley et al., 2013: 7)

While this provides grounds to question and reappraise positivist criteria of what constitutes evidence, postpositivist philosophy has also provided the theoretical impetus for a range of empirical approaches to policy evaluation. Interpretivist philosophy has been drawn upon to orientate policy analysis to the different perspectives, or 'framings', which people have of policy issues. Far from objective social facts, policy problems have an important discursive dimension and people often define them differently, in accordance with their particular values and knowledge. Qualitative research is considered uniquely capable in exploring

different perspectives, for the reasons discussed above (Rein and Schon, 1996; Yanow, 1997).

Frank Fischer has developed a form of postpositivist form of *process* evaluation. He argues that, when policy actors deliberate about policy, they make both empirical and normative claims. Policy evaluation must seek to integrate the two. Policy actors make claims which correspond to two orders of discourse: first order discourse includes claims about efficiency and the balance of criteria when establishing policy priorities; second order discourse includes claims about fundamental values and ideological principles which characterise the social order. Exploring the kinds of claims that stakeholders make through qualitative research can clarify the nature and significance of disagreement (Fischer, 1995).

Fischer's approach is specifically geared towards evaluating processes of policy formation rather than its effectiveness upon implementation. Mona Choudhary usefully applies the approach to debates over proposals for a controversial dam in India, where she clarifies the nature and significance of the disagreement between stakeholders (Choudhary, 2009). Other postpositivists have sought to develop forms of outcome evaluation, more directly criticising positivist methodologies in the evaluation of policy in terms of its efficiency and effectiveness. Peter Mathews demonstrates that concepts like efficiency and effectiveness are contested and have different meanings attached to them. He evaluates two government urban regeneration schemes and brings to fore the different accounts of effectiveness that stakeholders have, informed by the different criteria they prioritise in their evaluations (Matthews, 2012: 5).

These kinds of interpretivist policy analysis pose significant challenges to CBA, which seeks to inform choices between policy options by weighing up the monetised costs and benefits attached to them. Interpretivist policy analysts claim that only qualitative research can tap into the values of stakeholders, which can be qualitatively distinct. Additionally, values can be incommensurable and thus not suited to monetary calculation. Joseph Raz uses the example of an offer of payment to leave one's spouse for a month, which would surely incite indignation. For Raz, this suggests "companionship is incommensurable with money" (Raz, 1986: 350).

In similar ways, significant social or cultural services can be incommensurable with money. Furthermore, assigning monetary values to certain objects can damage or corrupt them, such as education, public service and citizenship: paying someone to take part in democratic elections, for instance, corrupts notions of citizenship which hold that people have a responsibility to engage in civic duties regardless of any economic return they might gain (Sandel, 2012). These examples imply the presence of significant ethical and social values which cannot be reduced to monetary terms.

The incommensurability of value has been a central issue in environmental economics, where individuals and communities can assign significant value to environmental 'services' such that costs or benefits in this area of policy cannot be

easily monetised (O'Connor and Spash, 1999). Critics of CBA highlight negative reactions of people when asked to put a price on environmental services through consumer surveys, which is said to imply the impropriety of valuing such items in monetary terms:

...many respondents – up to a half in some surveys – become very angry when asked how much they would take in return for some degradation of the environment, saying that they are not in the business of accepting bribes. Quite a few are so indignant that they throw the interviewer out as soon as the question is asked (Barry, 1995: 156)

Environmental economics has been at the forefront of the development of alternative decision-making aids such as Multi-Criteria Analysis (MCA). MCA recognises that policies have more than one goal to achieve and policy choices will involve trade-offs between different and sometimes incommensurable values. Furthermore, the actual measurement and valuation of policy impacts does not proceed upon monetary terms alone, but is based on a “wide range of qualitative impact categories and criteria” (Epstein and Harrison, 2010: 21). Where significant trade-offs are apparent, these are identified for political discussion and deliberation (Hajkowicz and Higgins, 2008).

The theory of incommensurable values serves as a reminder that choices between policy options are not simply technocratic issues. It is important for policy evaluation to explore peoples’ potentially qualitatively different values and identify any trade-offs that are apparent. Yet postpositivism also has implications for the choice of particular policy ‘means’ even where values are seemingly shared; for technical forms of knowledge are similarly fragmented and dispersed.

It is interesting here to note the contribution of critical realism to policy evaluation. Invoking Roy Bhaskar’s distinction between ‘closed systems’ and ‘open systems’, critical realist researchers have criticised the priority attached to the Randomised-Control Trial in policy evaluation. The RCT is a “closed system”: the researchers, the research participants, the research environment and possibly the interventions themselves are likely to differ from actual policy practice. While RCTs provide researchers with the ability to control variables in order to establish the intrinsic efficacy of interventions, research findings will to a certain extent be specific to the experiment and may not translate into the real world (Blackwood, 2010)³⁰.

This would suggest a disjuncture between two of the central questions of policy evaluation discussed above. The RCT tests out interventions under scientific conditions, which corresponds to the question *Can it Work?* However, it remains to be seen whether the intervention *does* work in the practical world of policy implementation (Haynes, 1999). Researchers working within a critical realist framework are also critical of attempts in observational studies to deploy statistical

³⁰ This issue is recognised by EBP, which distinguishes between the internal and external validity of studies. Yet much of the emphasise of evaluations remains on whether interventions can work under ideal, experiment conditions, rather they do work in actual practice (Haynes, 1999)

techniques to uncover causal relationships between phenomena; for there is always a danger of confusing correlation with causation (Layder in Lopez and Potter, 2005). Both of these forms of evaluation amount to “black-box” approaches, which provide little insight into *why* or *how* an intervention has produced an outcome; only that it has or has not had an effect. Only qualitative research can provide the level of detail required to explore causal pathways in complex social environments and tap into contextual factors which enable or constrain interventions (Pawson and Tilley, 1997; Pawson, 2006).

Once again, this is important because it highlights the difficulties involved in deciding upon ‘means’ to attain certain ‘ends’. Clearly, complex environments make it difficult to infer policy recommendations based on even the most robust scientific studies. This orientates policy analysis to stakeholders’ precise knowledge of policy options and policy impacts. But it also highlights the importance of taking into account the messy world of policy implementation and governance.

Indeed, the postpositivist perspectives outlined here imply clear limits to centralised forms of decision-making within public sector governance. As we saw in the previous section, the rise of Evidence-Based Policy has been controversial, in part because it is associated with managerialism. Yet, given that knowledge is dispersed and incomplete, even decisions which are clearly evidence-based may not encapsulate the knowledge required to solve policy problems. Even the most robust scientific studies produce knowledge that is to a certain extent specific to particular experiments, suggesting that professional judgement may be required to interpret and adapt the evidence to particular cases and circumstances. This resonates with Michael Polanyi’s views, discussed above, for this act of interpretation will require the exercise of ‘tacit’ knowledge, intuition and theoretical reasoning (Burns and Grove, 2008: 6).

However, if post-positivism undermines managerialism, it also undermines professionalism, because professional knowledge is just as partial and professional interpretations are just as normative and potentially contestable as any other.

The issue of the appropriate balance between centralisation and decentralisation relates to the motivational question of the interests and motives of public sector workers and professionals. Studies of implementation have highlighted how policies are shaped, interpreted and redefined at each stage of the process by different stakeholders, often resulting in very different outcomes from what was originally intended (Lipsky, 1980; Pressman and Wildavsky, 1973). Michael Lipsky’s work in particular highlights a fundamental question of public sector governance: is poor implementation caused by local actors subverting policy goals because they have pursued their own interest? Or is it that the goals set for local actors were incorrect, poorly defined or that local actors were asked to do too much, without the requisite resources?

NPM appears to favour the first interpretation: “embedded within it is a suspicion of professional autonomy and a desire to create public organizations in which

discretion is curbed” (Hill, 2014: 320). Yet the limitations to centralised forms of decision-making described here and in the previous chapter caution against an uncritical adoption of such a view. Indeed, the second interpretation implies the need for greater autonomy for public sector workers and professionals in their work and is aligned with efforts to breakdown the distinction between policymaking and implementation in “networked governance” (Sorensen and Torfing, 2007: 5).

These issues raise broader questions about the appropriate governance structures and arrangements in the public sector. However, as we saw in the previous chapters, these evaluative questions are contested and there remains a question mark over how to evaluate governance. In the absence of scientific conditions, statistical techniques are used to track the performance of public services over the course of governance changes but there is significant debate whether these techniques overcome the problem of causation in evaluation (Fukuyama, 2013: 9). Furthermore, the use of quantitative metrics in evaluation provides only a partial view of performance and do not address the problem of incommensurable values. Clearly, the postpositivist critiques described in this section have a lot to contribute to debates in the field of governance evaluation. Yet postpositivist policy analysis tends to refrain from addressing broader questions of political economy and the design of governance (Lynn, 1999: 413).

3.1 Concluding Remarks

This chapter has explored the dominant philosophical perspectives and research methodologies of policy evaluation. It has made a case for a qualitative, postpositivist approach to policy evaluation as a complement to the positivist and neoclassical approaches which dominate the discipline. Nevertheless, while postpositivism provides insights at a policy level, it typically does not address questions of governance and institutional design. At this level, national policymakers confront options between different governance structures and approaches: between variants of markets, hierarchy and networks. There remains scope to develop postpositivist policy analysis to evaluate policy options at this wider level of governance.

Chapter 4: Evaluation and Institutions 1 – the Neoclassical Framework and its Extensions

My purpose in the present section is to explore theoretical perspectives in political economy to identify concepts that are relevant to the topic of governance evaluation. Indeed, a central debate within political economy is the appropriateness of markets and centralised forms of decision-making in the economy. In many ways, debate about marketisation and managerialism in the NHS and the public sector are a microcosm of this wider debate at the level of the economy. The analysis centres upon the key problems introduced in first section: the 'knowledge problem' and the 'motivational problem'.

Recent scholarship in political economy is highly sceptical of the capacity of political processes and the public sector to address these twined problems. It is argued that only markets can provide signals about what kind and type of goods that are to be produced, while also aligning the motivation of actors (Boettke and Leeson, 2012; Pennington, 2010). I argue against this avowedly pro-market position. While markets are indispensable mechanisms for society and efficiently deliver many consumer items, there are instances where markets are both inappropriate and inefficient. There are a range of possible governance arrangements and their appropriateness can only be determined through empirical research.

Over the following two chapters, I take a different economic framework in turn, critically analysing them for their relevance and potential for the evaluation of governance, in particular public sector governance. Where chapter 5 explores the field of heterodox economics, the present chapter explores the neoclassical framework and its extensions. Section 1 explores the neoclassical system and in particular the concept of market failure, which provides the central justification for public policy today. While the concept of market failures is undoubtedly important to take into account when evaluating governance, it does not provide a comprehensive account of how market failures are to be solved.

Section 2 examines efforts to extend the neoclassical paradigm to address issues of institutional design, in Public Choice Theory and Transaction Cost Economics. Once more, these frameworks provide important concepts for the evaluation of governance, highlighting the importance of taking into account the 'motivational problem' in public policy and transaction costs. Nevertheless, the frameworks share questionable motivational assumptions which lead them to overstate the importance of market mechanisms and/or hierarchical management strategies in the solution of policy problems.

1.1 The Neoclassical Framework and the Theory of Market Failures

The neoclassical economics framework is the preeminent economics framework (Caldwell, 2003). The framework is important to consider because, as we saw, it has been influential in the field of policy evaluation, informing the development of methods which evaluate policies in terms of their impact on human welfare. Additionally, the framework provides the central justification for public policy today, providing an objective basis for public policy interventions in the form of the theory of market failure.

The starting point of the framework is a conception of the perfectly competitive economy, consisting of utility-maximising consumers on the one hand, and profit-maximising firms on the other. Voluntary exchanges between the two are assumed to be welfare-enhancing, for otherwise they would not have entered into them.

On the demand-side, each person has a set of preferences and a budget derived from their initial resource endowments and their labour. Each person increases their utility through the purchase of consumer items and the more purchases they make, the greater their utility. However, because consumers have limited resources at their disposal, they have to make choices between different options. Such choices are made on the basis of calculations of the net costs and benefits attached to incremental changes to consumption. Additionally, the value of consumer items declines for the individuals who buy them, providing ever-smaller increases in utility (Blaug, 1997: 381)³¹.

On the supply-side, firms seek to maximise profits by efficiently converting factor inputs (such as land, labour and materials) into consumer items that are demanded by consumers. Like consumption decisions, investment decisions are made on the basis of calculations of the net costs and benefits attached to incremental changes. At best, firms can only convert inputs into consumer items at a rate that equals the production of the preceding unit, such that it is always costlier to produce more of the good (Weimer and Vining, 1999: 59).

Both consumers and producers are incentivised to seek out efficient ways to maximise their utility and profits respectively. Through their interactions, a set of prices emerge which distribute factor inputs (goods used in the creation of consumer items) to firms and consumer items to consumers. In the perfectly competitive economy, these prices vary until the quantity of goods and services purchased by consumers equals that supplied by producers, at which point equilibrium is attained and there is perfect coordination between purchases and sellers (Levačić in Thompson et al., 1991: 21). This levelling out potentially takes place in markets for consumer items, factor inputs and labour, where individuals

³¹ Mark Blaug uses the example of wallpaper to elucidate this 'law' of declining marginal utility: though it would appear that for someone decorating a room the second piece of wallpaper is equally if not more important than the first, the unit of analysis has to be scaled up to cover the whole wall or the whole. Once one such unit is purchased, the utility derived from extra units declines for the individual (Blaug, 1997: 381).

weigh up the cost of working in terms of effort with the benefits they might accrue from spending their wages. At the point of equilibrium, it is impossible to change the patterns of consumption and production without disadvantaging some person³².

The widespread acceptance of the laws of supply and demand towards the end of the 19th century increasingly saw economics take on a mathematical orientation geared towards an analysis of the determination of prices (Rutherford, 2007). This mathematical turn also provided an objective basis for public policy: where markets could be shown to have failed to attain equilibrium, policy interventions are justified on the basis that they might improve upon market outcomes. Indeed, though the neoclassical framework is consistent with a range of policy positions, from support for a centrally planned economy to a market economy³³, a common position is support for a mixed economy in which policy interventions seek to correct market failures. This provides the central justification for policy interventions today:

...states should be allowed to intervene when markets, the preferred allocative mechanism, fail to produce optimal outcomes (Haglund, 2011: 26)

But what exactly is it about markets which necessitate policy interventions?

- Public Goods and Externalities

A key factor is the characteristics of the goods or services that are produced and exchanged. Two main criteria are used to define goods and services – rivalry and excludability – which affect the likelihood of market failures. Excludability refers to the extent that individuals can be excluded from goods, while rivalry refers to the extent that goods, once consumed by one individual, cannot be used by another (see box 1) (Cornes and Sandler, 1996).

Box 1 – Classical Typology of Goods

| | Excludable | Non-Excludable |
|----------------------|-------------------|-----------------------|
| Rivalrous | Private goods | Commons goods |
| Non-rivalrous | Collective goods | Public goods |

Private goods are typical consumer items that are rivalrous in consumption and from which people can easily be excluded. The ideal of the perfectly competitive market assumes that all goods are private goods. Markets in such goods will tend to equilibrium because if people want to have them, they have to purchase them; in turn, the provider receives full price for selling the item. In this way, incentives are

³² This is a state of so-called ‘Pareto-optimality’, after the Italian economist Vilfredo Pareto.

³³ For the free market neoclassicals associated with the Chicago school the actually existing economy is characterised by equilibrium, or is as close to it as could possibly be. In contrast, neoclassical socialists argue that in a planned socialist system prices could be manipulated so that equilibrium would be attained (these thinkers are discussed in the next section) (Pennington, 2010).

aligned and consumers and producers are motivated to act in each other's interests, and ultimately the interests of society as a whole.

However, incentives issues arise if goods are characterised as anything other than a private good and may be under- or over-supplied in markets. Goods can be undersupplied if it is difficult or costly to exclude people from enjoying them. For example, since it is difficult to exclude people from street lighting and national defence, few would be willing to pay money for them out of their own pocket, resulting in little incentive for producers to provide them. These goods are also non-rivalrous in consumption, since they do not deteriorate when consumed and would therefore be under-supplied by the market. Yet street lighting and national defence are important for society. Providing 'pure' public goods through public policy would improve the level of social welfare in society.

A special case is goods that are rivalrous in consumption but are non-excludable such as fish stocks and open parks, i.e. 'commons goods'. These may lead to the 'tragedy of the commons' scenario where resources are eroded and depleted, as people plunder resources or pollute without accounting for the costs they are incurring on others (Hardin, 1968). Once again, state intervention may be provided to provide the goods³⁴.

A closely related concept is externalities, which arise when there are third party costs to a market transaction. Examples of externalities and public goods tend to overlap as both concepts concern goods with a non-private element. When two individuals or parties come together in a market transaction they do not consider the costs or benefits of that transaction for third parties. Rosalind Levačić uses the example of coal mining to explain the notion of external costs. These arise from the burning of coal because the emission of sulphur dioxide causes air pollution, for which sufferers receive no compensation (Thompson et al., 1991: 36). However, just as market exchanges can have negative spill-overs, so too can they have positive spill-overs. Keeping with the example of coal mining, external benefits accrue from keeping coal pits open as mining communities retain high quality employment and there may be benefits to future generations of leaving them cheaply workable coal seams (Thompson et al., 1991: 37). Where externalities can be identified, the state can be called upon to intervene, here a possible policy may be to subsidise coal mining.

- Asymmetric information

Up to now, we have considered the characteristics of goods and their implications for political economy: the market may under- or over-supply goods that have non-private aspects. Part of the reason for this is misaligned incentives which result in market actors either failing to invest in socially-useful goods or investing too much

³⁴ "Collective goods" are less problematic. They are often called "club" goods because they include goods that are associated with clubs such as live music or access to a golf course: goods that are non-rivalrous in consumption but are easy to exclude people from (Karagiannis and Madjd-Sadjadi, 2007: 29).

in socially-harmful goods because the value of the good differs from its actual price. A further source of market failure concerns information. Market actors often do not have the requisite information available to them to get the most out of their transactions. George Akerlof, writing in the 1960s, uses the examples of a second-hand car to demonstrate this issue of information asymmetry. Sellers may know full well the quality of the car, but buyers generally do not and will reduce the price they are willing to pay. This, in turn, deters sellers of high quality cars from the market and results in a market dominated by low quality cars. Sellers could seek to convey information to buyers about the quality of the car or buyers might seek out such information before they buy, but either of these solutions is costly to undertake and there is always the risk that buyers will not buy or the product is poor quality (Akerlof, 1970: 489).

- Imperfect competition

Finally, market failures can arise when conditions are such that perfect competition is unlikely. Competition will be greater the more firms there are in a market and/or the more opportunities there are for new entrants to a market. Where competition is imperfect, there is a risk that firms will charge higher than marginal costs in a bid to maximise profits or operate at inefficient rate. These examples of x-inefficiency result in higher prices for consumers (Levačić in Thompson et al., 1991: 40). Industries such as electricity, gas and water are considered natural monopolies because it is difficult and costly for a firm to replicate their supply networks. Imperfect competition might also arise due to increasing returns to scale: this occurs when the average cost of production falls as the scale of production increases, which affords large firms with a competitive advantage. Firms might also collude to fix prices, restrict sales outlets or enforce tie-in sales (Levačić in Thompson et al., 1991: 43).

1.2 Appraising the Neoclassical Framework

The theory of market failures provides a central argument for public policy interventions and is important to take into account in the evaluation of governance. The concepts of public goods and externalities potentially justify a range of policy interventions, including the direct provision of goods and services through the public sector, taxes, subsidies and regulations (Le Grand, 1991). Similarly, the concept of imperfect competition was a central argument in the nationalisation of public utilities and the provision of some welfare services, such as education and health, where the costs of entry into the market, in terms of building schools and hospitals, are high (Fuchs, 1996: 278). Finally, the concept of information asymmetry suggests that consumption decisions made by consumers are not always welfare-maximising. This potentially justifies a range of interventions to improve consumer choices and indeed provides a central justification for professionalism in the provision of services (Broadbent et al., 2005).

However, while it is important to take into account the presence of market failures when evaluating governance, the framework has a number of limitations. A key

issue is the emphasis on efficiency and market failure, which suggests that policy interventions are appropriate only where goods can be objectively shown to be undersupplied, oversupplied or inefficiently produced. Yet some goods have social, political and moral import such that markets can fail to produce an optimal amount even when operating efficiently. Elizabeth Anderson refers to a distinct category of “political goods”: goods that individuals ought not to be excluded from and which speak to the kind of society that we seek as a community (Anderson, 1990). This issue reflects wider concerns about Cost-Benefit Analysis and whether all values relevant to decisions can be measured in quantitative, monetary terms.

Related to this issue, neoclassical economics is neutral with regards to inequality. Its purpose is to enhance economic outcomes. Yet this assumes an initial distribution of resources. For the early neoclassical thinkers, it was necessary to avoid issues of distribution and inequality because they involve value-judgements and therefore cannot be studied scientifically (Rosenberg, 1992: 23). Yet this move has meant the neoclassical economics is consistent with vast inequalities in income and wealth, inviting allegations that the framework “is a protection of the status quo” (Gowdy, 1998: xvii).

Besides these issues of values, the approach presupposes a ‘positivist’ conception of knowledge which does not take into account market actors’ potentially very different perceptions of reality or the fragmented and incomplete nature of knowledge. In the market, consumers are assumed to have full knowledge of their preferences and any consumer items that exist; vice versa for producers, who are fully aware of changes to demand and respond accordingly. The market has a tendency towards equilibrium because each party reacts to market signals in equilibrium-enhancing ways. But the inherent frailties of human cognition make it likely that consumers will make questionable consumption decisions or that producers will fail to produce goods of the appropriate quality or quantity (Zafirovski, 2002: 564).

The concept of information asymmetries does relax the assumption of perfect information, but where this issue arises the state is said to be well placed to intervene and restore the proper functioning of the market: the perfect knowledge and rationality of policymakers fills in for the cognitive frailties of market actors on the ground. However, policymakers, who make decisions in centralised positions in society, may also lack knowledge of the quality of goods and services or, indeed, consumer demand (Zappia, 1999). Indeed, this is precisely the ‘knowledge problem’ in public policy.

Finally, the neoclassical framework does not take into the ‘motivational problem’ in public policy (Rabin, 2003: 573). As we saw, the neoclassical ideal of the competitive economy contains within it a concept of incentives: all things being equal, markets tend to equilibrium because individuals actors are incentivised to operate in ways that maximise social welfare (Laffont and Martimort, 2009). The flip side of this is that market failures arise in part when markets fail to provide appropriate incentives, say to invest in an appropriate amount of a good, seek out

product information or operate efficiently in contexts of imperfect markets. However, the political sphere and the public sector also lack any obvious economic incentives of this sort.

Indeed, chapter 1 provided some background on changing intellectual and political shifts regarding the structure of the economy and the organisation of public services. We saw how increasing disillusionment with state intervention in the 1970s led to a shift to market forms of governance in the 1980s, following the electoral success of the New Right. This disillusionment with state intervention was accompanied with an increasingly influential criticism of the neoclassical framework from within the economics profession: that it only analyses market failures and leaves open the question of whether the state can actually solve them. For some commentators, the framework makes unrealistic assumptions about the capacity of policy processes to solve policy problems³⁵.

2.1 Public Choice Theory and the ‘Motivational Problem’

Public Choice Theory extends the neoclassical framework to the political sphere, which is found to contain few mechanisms to align incentives, creating the potential for inefficiencies on the supply and demand sides of the political ‘market’. A key text of the framework is Mancur Olson’s *The Logic of Collective Action*. Olson argued that motivating people to engage in political action to influence policy is easy when a small group is affected: individuals will either benefit a great deal if a policy decision goes their way or be harmed a great deal if it goes against them. Their motivation can be assured because their contribution is vital to the cause. However, as numbers increase, political organisation gets more difficult. The costs and benefits accruing to each member are smaller and each person could reasonably think that their contribution would not make a difference: the so-called “free rider” problem (Olson, 1974).

Public choice theorists have applied the “free rider” concept to the political sphere more broadly. Because the costs and benefits of political involvement are shared, citizens in liberal democracies are unlikely to get involved in politics in any meaningful sense. They are unlikely to vote in the first place or, if they do, unlikely to seek out information required to make rational choices. Furthermore, there is little incentive for them to put sufficient pressure on elected representatives once they are in office. Ultimately, this will result in ambiguous and irrational political signals and the election of people who do not reflect the public interest³⁶.

³⁵ For Ronald Coase, this assumption “has led economists to derive conclusions for economics policy from a study of an abstract of a market situation ... Until we realize that we are choosing between social arrangements which are all more or less failures, we are not likely to make much headway” (Coase, 1960: 145).

³⁶ There is a similarity here with Kenneth Arrow’s work on the problematic nature of voting procedures to arrive at a coherent social choice (Arrow, 1970). But whereas Arrow stresses the logical problem of social choice – a problem that has arguably been addressed by deliberative democratic theorists (Dryzek and List, 2003) – public choice theorists stress motivational reasons. Recent accounts suggest that a combination of motivational and knowledge problems combine to ensure the irrational nature of democratic procedures (Brennan and Lomasky, 1997; Caplan, 2008).

The lack of informed choices and pressure on the demand-side may translate into inefficiencies on the supply-side. Politicians, seeking power and reelection, promise and deliver wasteful and inefficient public programmes: without excessive promises, they will not get voted into office. The political process is also corrupted by vested interests, while for their part politicians are open to such corruption in order to further their careers and ultimately their power. Meanwhile, the civil servants who are called upon to put public policies into practice cannot be relied upon to do so efficiently. Sheltered from market competition, they maximise their utility by maximising the budgets of their organisations which in turn increases their salaries and power (Niskanen, 2007). As a result, government intervention through the public sector is likely to result in widespread inefficiency.

Market solutions to public policy problems

While Public Choice Theory provides a range of criticisms of state intervention, the framework is also associated with the promotion of market-oriented policies. A prominent theorist of market-oriented policy is Ronald Coase, a thinker closely aligned with the framework. Coase argued that market failures would not arise if all services were assigned well-defined property rights: where a factory is polluting a nearby lake, for instance, having some person or organisation own the lake would ensure the factory is made to pay compensation for its pollution. In this way, economic problems can arise because markets are not developed enough (Coase, 1937; Coase, 1960; Coase, 1974).

Coase also criticised the neoclassical concept of market failures. For Coase, situations in which externalities arise are ambiguous: keeping with the example of the lake, it may be the case that the pollution is justified if it is a side-effect of the production of a unique and popular product³⁷. Only by assigning property rights to the lake and having its owners discuss with the polluters (and other interested parties) can the direction and significance of the externality be established. The polluters could choose one of three options: cease their activities, pay the owners of the lake compensation or buy the lake outright. Other interested parties could bid for the lake if they feel the current owner is underselling it. Either way, competitive market processes will ensure that the most valued use of resources, in this case the lake, is identified and aligns incentives to ensure this knowledge is acted upon.

In any case, policymakers are unlikely to be aware of the most valued use of resources (an example of the ‘knowledge problem’) and a system of well-defined property rights creates a clear incentive for goods and services to be used in socially-beneficial ways (thus overcoming the ‘motivational problem’).

³⁷ According to Coase, neoclassical economics asks: “how should we restrain A?” But a more appropriate question is “should A be allowed to harm B or should B be allowed to harm A?” (Coase, 1960: 2).

2.2 Appraising Public Choice Theory

Public Choice Theory provides a significant challenge to advocates of greater state involvement in the economy and identifies a major weakness in neoclassical economics: that it does not demonstrate exactly how market failures can be solved. The framework provides some important insights that are necessary to take into account the evaluation of governance, particularly with regards to the issue of incentives. However, it remains to be seen whether markets are appropriate in all policy sectors.

In public sector governance, the issue of incentives is mainly relevant to the motivation of individuals and groups involved in delivery of public services, including public sector employees and service-users. Given the absence of markets, Public Choice Theory is sceptical that these groups will work in the public interest. Public sector workers are likely to shirk because they are not subject to market discipline like their private sector counterparts. The users of public services do not have influence over public sector employees because the government pays their incomes and many are unionised (Le Grand, 1991: 433). As such, service-users, unlike consumers in markets, have very little influence over public sector employees and have to accept substandard services. But problems can arise among service-users, for they do not have to pay for the services they receive and may take advantage of them.

However, as we saw in chapters 1 and 2, while the marketisation of public services has in large part sought to address these motivational problems, the reforms have had an ambiguous impact on performance. These issues at a practical level reflect wider concerns with Public Choice Theory that the framework overstates the capacity of markets to improve the performance of public services.

Below, I explore Transactions Costs Economics, which operates on similar assumptions to Public Choice Theory but offers a more realistic appraisal of market mechanisms. Nevertheless, a major criticism of Public Choice Theory is that it ignores the potential of market mechanisms to exacerbate incentive-based issues. The adoption of market contracting across the government and public sector creates opportunities for undue influence and bribes (Chang, 2008: 169).

Additionally, the framework operates on the basis of questionable motivational assumptions. In the neoclassical framework, though a concept of incentives underpins the model of the perfectly competitive economy, the actual content of consumer preferences is left open. It does not matter whether individuals have benevolent or malevolent goals; whatever their preferences, they aim to fulfil them in their market transactions (Dearlove, 1989). Yet this differs markedly from Public Choice Theory, which assumes a concept of universal avarice. Within politics, citizens do not fulfil their duties *qua* citizens because it is not in their material interest to do so. Politicians, meanwhile, are oriented towards votes and power. Within bureaucracies and public sector organisations, civil servants, professionals and public sector workers are oriented to promotion, status, budget maximisation and malingering.

By inserting malevolent intentions into the model, public choice theorists make significant assumptions about the nature of people. While it is undoubtedly true that incentives issues can arise in the delivery of public services, there is need for empirical research to explore the presence of these issues and identify possible solutions. Yet the assumptions of Public Choice Theory close down the possibility that incentives issues do not arise in non-market contexts or that markets may be inappropriate in their solution. Making a similar point, Sidney Shapiro and Christopher Schroder argue that Public Choice Theory not only lacks the “means to establish the objectivity” of its approach but is itself “not neutral”, imposing a “vision of society in lieu of other visions of society” (Shapiro and Schroeder, 2008: 443; see also Shapiro et al., 1996).

3.1 Transaction Cost Economics: Towards a Compromise?

Whereas Public Choice Theory propounds market solutions to policy problems, Transaction Cost Economics provides a more nuanced analysis of the potential of the market mechanism. The framework draws extensively from Ronald Coase who, though a prominent theorist of market solutions to policy problems, recognised limitations to those very solutions. Observing that much of economic activity is coordinated through firms rather than markets, Coase argues that the very existence of firms is testament to the imperfections of markets. Firms and industries are organised in different ways. Some operate on the basis of long-term employment contracts, whereas others employ workers on a day-to-day basis in a manner more akin to a market. According to Coase, this is because market exchanges can incur costs. It is necessary for buyers to search for and identify suitable producers of the products they require, to conduct contract negotiations, to draw up contracts and to monitor them to ensure that the terms of the contract are observed. When such costs are high, it can be more efficient for a buyer to directly employ producers rather than engage with them in the market place (Coase, 1960).

Oliver Williamson has developed Coase’s insights. Mirroring Coase, Williamson distinguishes between hierarchy and markets but he also identifies various hybrid forms of governance modes which sit between the two, including networks and long-term contracts. The purchaser of a good or service confronts a ‘make-or-buy’ decision: where markets are developed, they are likely to buy the good, as in standard commodity markets. Or they may seek to ‘make’ the good themselves. In imperfect markets, purchasers and providers decide among themselves what governance arrangement is appropriate, in order to minimise transaction costs³⁸. The appropriate governance arrangement will be determined by the varying degrees of three characteristics that feature in all transactions:

³⁸ Costs include *ex ante* costs incurred prior to an exchange (such as the costs of negotiating and drafting contracts and the collection of relevant information) and *ex post* costs incurred after the two parties have agreed on the terms of the exchange (such as the costs of setting up the governance structure, monitoring performance and seeking redress if the expected outcomes are not forthcoming) (van Genugten, 2008: 28).

- *Asset specificity* – the degree to which the physical and human assets involved in a transaction are specific to the good or service that is exchanged;
- *Frequency* – the frequently the transaction is carried out;
- *Uncertainty* – unanticipated changes to the environment in which a contract is delivered and/or difficulties in the measurement of outcomes, resulting in problems with performance evaluation (Tomassen, 2004: 29).

At one extreme, market transactions are likely to be the most efficient option when uncertainty is at a minimum, the exchange is infrequently carried out and asset specificity is low, as in the case of standardised and mass-produced goods. At the other extreme, hierarchical production is likely to be the most efficient option when uncertainty is high, exchanges are frequent and assets are specific to them. Indeed, where goods and services are complex and highly customised, production may require specialist equipment or involve uncommon professional skill and high levels of ‘tacit’ knowledge (Mendenhall and Kühlmann, 2001: 45). This, in turn, will mean the parties to an exchange are to a large extent dependent on each other: the costs of terminating the relationship and exchanging with another party are high (Mellewigt et al., 2006: 32).

The efficiency potential of hierarchical production stems in part from the flexibility which direct employment provides. Employment contracts are more flexible than market contracts, which is particularly important when goods are complex and heterogeneous (Hodgson, 2004: 411). Direct employment can also reduce costs when goods and services are frequently exchanged because multiple contracts will not be required (although the cost of each contract will itself be determined by the complexity of the good exchanged). Furthermore, through direct employment, purchasers – now employers – can monitor their employees, which is particularly necessary where uncertainty pertains. Yet hierarchy is attached to significant costs, for the reasons identified in Public Choice Theory:

Incentives are unavoidable compromised and added bureaucratic costs are unavoidable incurred upon taking a transaction out of the market and organizing it internally. The upshot is that the move from market to hierarchy is attended by trade-offs (Williamson in Menard and Shirley, 2008: 51)

3.2 Appraising Transaction Costs Economics

The conception of transaction costs is highly relevant to the study of public sector governance. There is the possibility that public sector provision saves upon transactions costs in public service contexts, just as firms save upon such costs in market contexts, since the decision to produce in-house or contract out is essentially the ‘make-or-buy’ decision as formulated by Williamson (Dollery, 2001). As we saw in chapter 1, a range of market mechanisms have been incorporated into the public sector and the efficiency potential of such mechanisms have been called

into question precisely because they have often incurred significant increases in transaction costs (Boyne, 1998). There is a need to explore the fit between the goods and services provided by providers of services and the governance arrangements in place.

In market or quasi-market contexts, consumers (which may include commissioners or service-users) and producers might incur excessive administrative costs which would be unnecessary if production was organised internally. Yet the inverse of high administrative costs in market and quasi-market contexts is excessive monitoring costs in hierarchical contexts, which arise due to information asymmetries between employer and employees. It might be the case that public sector employees are not working in the public interest and alternative services are available for purchase on the market, in which case it would be more efficient for the government to buy from a private provider rather than procure it through the public sector.

Nevertheless, while the concept of transaction costs is important to take into account in the evaluation of governance, the framework, like Public Choice Theory, assumes questionable motivational assumptions which result in it favouring certain policy strategies over others. While recognising the efficiency potential of hierarchical production in certain cases, the framework assumes a concept of universal avarice – “opportunism”, in Williamson’s terminology – which implies that hierarchical production must involve hierarchical management strategies in order to ensure the compliance of employees. The efficiency potential of hierarchical production stems predominantly from the capacity it provides employers to monitor employees.

However, as Geoffrey Hodgson makes clear, transaction costs can also arise due to limited knowledge on behalf of parties to an exchange and the difficulties involved in verbally articulating the specificities of complex goods and services. Hierarchical production, in this context, could potentially improve the efficiency of transactions by minimising “distortions in cognitive and communicative transitions”, for the buyer and seller of a product now work together in the same organisation. TCE, by emphasising opportunism, assumes a ‘Taylorist’ model of management in which managers are in full possession of all relevant product information and the role of employees is merely to follow instructions. Yet in the case of complex and heterogeneous goods and services the efficiency role of management

...may not be principally a gendarme, but equally if not more an educator, concerned with the minimization of misunderstandings and the development of a common corporate culture where—as much as possible—shared aims and conceptions dominate sectional interests (Hodgson, 2004: 411)

The upshot of this alternative analysis is that added bureaucratic costs need not follow if a transaction is organised internally, at least not from the monitoring of employees. This is a particularly important insight in public service contexts where

goods and services are complex and a potential source of efficiency is public service motivation, as discussed in the next chapter.

4.1 Concluding remarks

This chapter has explored a number of frameworks which provide useful concepts for the evaluation of governance. The theory of market failure and associated concepts – public goods/externalities, information asymmetries and imperfect competition – highlight failures of market mechanisms, providing justifications for policy interventions. In a similar vein, the ‘motivational problem’, as theorised by Public Choice Theory, serves to explain inefficiencies resulting from government intervention which can arise from a failure of policy processes or public bureaucracies. Additionally, Transaction Cost Economics highlights the wider costs of production and exchange. A failure to select an ‘efficient’ governance arrangement can result in costs which would not arise under an alternative governance arrangement. I have argued that empirical research is required to explore the presence and significance of the issues identified by these different frameworks.

Chapter 5: Evaluation and Institutions 2 – the Austrian School and ‘Old’ Institutionalism

This chapter follows on from the previous chapter, exploring various schools of ‘heterodox’ political economy. In different ways, heterodox schools reject the positivist assumptions of neoclassical economics in favour of a concept of incommensurable values and incomplete knowledge. The chapter assesses the strengths and weaknesses of these frameworks, drawing out the themes that are relevant to the evaluation of governance and public service reform.

Heterodox economics is itself a diverse field and I focus on two main frameworks: the Austrian School of Economics and ‘old’ institutionalism. As is well known, the Austrian School was highly influential over the New Right. The framework provides a significant challenge of advocates of greater state involvement in the economy. The ‘knowledge problem’, as theorised by one of the Austrian School’s key figures, Friedrich Hayek, constitutes a fundamental challenge of any governance arrangement and places limitations on what centralised forms of decision-making can achieve. However, Hayek’s pro-market conclusions do not necessarily follow on from his analysis of market processes. ‘Old’ institutionalism suggests markets often have an uneasy relationship with the encapsulation and discovery of knowledge and may indeed exacerbate motivational problems due to a proliferation of individualist and materialist values. Nevertheless, Hayek concept of coordination is potentially useful for the purposes of governance evaluation, orienting analysis to the interactions of stakeholders and the effective discovery and utilisation of knowledge.

The first section examines the Austrian School and the ‘knowledge problem’ in more detail, before considering some criticisms of the School and its relevance to the topic of public service reform. The second section examines ‘old’ institutionalism, before likewise considering the framework’s relevance to the reform of public services. The analysis paves the way for chapter 6, which outlines an approach for the evaluation of governance.

1.1 The Austrian School and the ‘Knowledge Problem’

The Austrian School of Economics has an ambivalent relationship with the neoclassical framework. On the one hand, it shares an emphasis on consumer preferences as the ultimate source of value and begins at the same starting point: scarcity and choice. On the other hand, whereas neoclassical economics is positivist and is based on the statistical analysis of markets in relation to equilibrium, the Austrian School is based on more theoretical analysis which explores the evolution and historical development of economic institutions. This results in a view of market processes as never attaining equilibrium but always unfolding in unpredictable and uncertain ways.

Carl Menger, widely regarded as founder of the School, developed the concept for the purposes of economic theorising in order to capture the essence of economic phenomena, which he believed was not possible through mathematical analysis (Caldwell, 2008: 31). Menger's approach was to analyse the emergence of economic phenomena in terms of the conscious and unconscious decisions of individuals. Money, for instance, evolved from an agreement between two individuals to trade with a third commodity that would hold its value. Gradually more and more individuals realised that it is expedient for them to exchange goods with a commodity capable of holding value, usually gold. Eventually, money was institutionalised by the state through legislation. Yet this legislative act is coincidental to understanding the origin of money (Menger, 1985: 155).

Others institutions arise in a similar manner, such as language, law, morality and professionalism (Menger, 1985: 157). Like money, these institutions dramatically improve the welfare of society but are not purposefully pursued. They "come about as the result of individual human efforts (pursuing individual interests) without a *common will* directed toward their establishment" (Menger, 1985: 133). Institutions that are created through conscious social action are unlikely to improve welfare in this way because they encroach upon the developmental process and often fail to achieve what they intend to achieve (Menger, 1985: 157).

This approach, of counter-posing institutions that emerge out of unconscious and conscious activities, is adopted by Frederick Hayek in his more detailed analysis of the market mechanism. Hayek developed his views in the 'Socialist Calculation Debate' during the 1920s, when the economist Oscar Lange outlined a model of socialism based upon the neoclassical framework. Lange's model permitted markets for consumer items and labour but production was to be planned, informed by guidelines based on analysis of data on consumer preferences and production possibilities. According to Lange, such an economy would result in more egalitarian distributions and achieve greater efficiency because the full benefits and costs of market transactions could be incorporated into the price mechanism, ensuring that market failures would not arise (Roberts, 1971).

Hayek strongly rejected Lange's proposals, arguing they exposed more issues with neoclassical economics than they did establish the feasibility of a centrally planned economy (Boettke in Feser, 2006: 56). A key issue is the neoclassical analysis of the market as a system governed by laws of supply and demand, in which individuals respond to prices in equilibrium-enhancing ways. Yet processes of preference formation and entrepreneurship, in which producers seek out knowledge of profit opportunities and develop new consumer items, are left under-theorised (Kirzner, 2006).

Indeed, Hayek's criticism of Lange's system hinged upon the concept of coordination (Farrant, 1996: 3). The market facilitates coordination, not by central direction, as with the case with state intervention, but via price signals which emerge spontaneously from the buying and selling of multiple individuals dispersed across society. Market participants engage in market processes freely, buying and

selling goods and services in accordance with their own values and preferences. The prices which emerge from this process encapsulate, in simple numerical form, highly complex information regarding supply and demand in the economy. These signals provide guidance to economic actors – whether consumers or producers – who can assess the value of products as means to achieve their ends, which may not have been immediately apparent to them before. Producers engage in a process of discovery whereby they respond to profit opportunities indicated by price signals by converting factor inputs into consumer items in innovative and unpredictable ways, utilising their own knowledge and expertise in the process. As prices change and profit opportunities diminish, they are led into new ventures, in an on-going process which facilitates innovation and ultimately economic growth. Likewise, as the process unfolds, the nature of demand changes, consumers discover knowledge of their own preferences and the capacity of goods to satisfy them (Caldwell, 2008: 33).

Analogous to this appraisal of the market is Hayek's critique of policy processes. Where market processes are decentralised, policy processes are highly centralised: decisions are not made by individuals dispersed across society, but individuals or groups of elite policy actors. These actors confront a profound 'knowledge problem': even assuming a concept of universal benevolence, it is unlikely that centralised decisions will be congruent with the values and objectives ('ends') of individuals dispersed across society. Furthermore, even if there is broad agreement regarding the objectives which policy should pursue, decision-makers are likely to lack knowledge of the precise 'means' through which they might be fulfilled.

Indeed, central planning is prone to inefficiency because knowledge is always partial, incomplete and cannot be centralised. As we saw, in markets, price signals coordinate the actions and decisions of consumers and producers, "telling people what they ought to do in particular circumstances" (Hayek in Pizano, 2009: 5). Market actors do not need to understand why prices change but are nevertheless free to respond in ways which benefit them and society. In this way, the market system is uniquely capable of facilitating coordination in spite of human cognitive frailties and incomplete knowledge:

The whole acts as one market, not because any of its members survey the whole field, but because their limited individual fields of vision sufficiently overlap (Hayek, 1945: 526)

For planning to be efficient it would require full knowledge of consumer demand and production possibilities which would be difficult to access at any one point in time. What is more, market processes are dynamic and unpredictable. The values and preferences of participants change as the market unfolds and new production possibilities emerge. Even if data could be made available at any one point of time, it would soon be out of date, which places further constraints on central planning. On this issue, Hayek notes a divergence between his views and advocates of central planning concerning "the significance and frequency of changes which will make substantial alterations of production plans necessary". Yet the contra view holds

only if “things continue as before, or at least as they were expected to, there arise no new problems requiring a decision, no need to form a new plan” (Hayek, 1945: 523).

But the final and insurmountable flaw of central planning is the ‘tacit’ nature of much of economic knowledge (Boettke, 2000: 18), or what Hayek calls the “knowledge of the particular circumstances of time and place” that is dispersed throughout society:

(P)ractically every individual has some advantage over others in that he possesses unique information of which beneficial use might be made, but of which use can be made only if the decisions depending on it are left to him or are made with his active cooperation ... central planning based on statistical information by its nature cannot take direct account of these circumstances of time and place ... the central planner will have to find some way or other in which the decisions depending on them can be left to the ‘man on the spot’ (Hayek, 1945: 522)³⁹

For Hayek, only the market system can facilitate the utilisation of this knowledge. Its prices “act to coordinate the separate actions of different people in the same way as subjective values help the individual to coordinate the parts of his plan” (Hayek, 1945: 526).

1.2 Appraising the Austrian School

The Austrian School has been highly influential in policy circles, providing much of the theoretical impetus for the New Right and the increased use of markets in all policy areas. However, the effectiveness of markets is a highly contested topic and, as with Public Choice Theory, critics argue that the Austrian School overstates the potential of market mechanisms to solve policy problems.

Indeed, the Austrian case against central planning as the major form of economic coordination is widely accepted today and taken to explain the collapse of state socialist systems such as the Soviet Union (Scharpf, 1999: 31). Yet, this criticism of centralised planning aside, it remains to be seen whether markets can always efficiently coordinate activity. The neoclassical concept of ‘market failures’ has already questioned the capacity of market prices to accurately convey information about supply and demand. In the next section, I also consider the Marxist argument that the market system has centralising tendencies of its own.

A number of commentators have sought a reappraisal of Hayek’s work in this regard. In different ways, they accept Hayek’s critique of central planning but reject the notion that markets are the only mechanisms to facilitate the coordination of

³⁹ This closes down the possibility of Paul Cockshott and Allin Cottrell’s concept of socialist planning based on “modern computer technology”, outlined in their *‘Towards a New Socialism’* (Cockshott and Cottrell, 1993: 25).

economic activities and ('tacit') knowledge (Cumbers, 2012: 68; Gamble, 1996: 1; Greenwood, 2010: 37; O'Neill, 2013: 193; Wainwright, 1994).

For example, John O'Neill remarks that it is "odd" Hayek references Michel Polanyi's work on 'tacit' knowledge when making a case for market coordination; for Polanyi developed the concept with the practices of the scientific community in mind⁴⁰. Science is, for O'Neill, one of the achievements of the modern world and is testament to what can be achieved by decentralised, non-market coordination. What is more, the increasing marketisation of science – involving the incorporation of intellectual property rights regimes – poses a threat to science and slows the rate of scientific innovation (O'Neill, 2013: 191). In this way, markets can actually hinder the encapsulation and discovery of knowledge, suggesting at least some forms of knowledge have public good characteristics and will be under-supplied by markets (Stiglitz in Kaul et al., 1999: 311)⁴¹.

The debates are highly relevant to the topic of public service reform, where policymakers have sought to incorporate market mechanisms into the public sector under NPM. While in some respects this process can be seen as further evidence of the influence of the Austrian School, in others respects it is not. For the process of marketisation has been accompanied with heightened managerialism. The rise of Evidence-Based Policy is at odds with Hayek's epistemology, which in many ways resembles postpositivism⁴². Furthermore, the incorporation of markets into the public sector has coincided with increasingly centralised forms of decision-making. Some commentators note a similarity between the public sector bureaucracy which exists today and the system of central planning in the Soviet Union. These commentators recognise the potential for performance management to result in unintended and undesirable consequences (Bevan and Hood, 2006; Hood, 2006; Ann et al., 2009; Propper et al., 2008). Such accounts highlight tensions between centralised and decentralised decision-making which resonate with Hayek's work, serving to emphasise the epistemological problem of "choosing the right indicators in the first place" (Levačić, 2004: 188)⁴³.

This potential for centralised decision-making to result in unintended consequences is recognised by advocates of 'networked governance'. As we saw in chapter 1 and

⁴⁰ In *'The Tacit Dimension'*, Michel Polanyi argues that science is a non-hierarchical sphere that operates on principles of "mutual adjustment and mutual authority" in which scientists coordinate their activities and regulate one another, with groups of scientists linked together in "chains of overlapping neighbourhoods" (Polanyi, 2009: 72).

⁴¹ This is also a theme which emerges in Marxist theory, most notably among labour-process theorists, discussed in more detail below (Braverman, 1998).

⁴² Theodore Burczak draws a similar parallel, arguing that Hayek's work resembles the application of "postmodern notions of indeterminacy, open-endedness, incompleteness and social constitution to the study of ordinary life and the knowledge of ordinary people" (Burczak, 2006: 390).

⁴³ Yet the literature frames problems attached to performance management in terms of the 'motivational problem' in public services. Titles include *'Gaming in Targetworld'* (Hood, 2006) and *'What is Measured is What Matters: Targets and Gaming in the English Healthcare System'* (Bevan and Hood, 2006). Yet they can also be framed in terms of the 'knowledge problem': i.e. as a failure of policymakers to define performance management protocols in such a way as to encapsulate local values and knowledge.

2, there is increasing recognition of the importance of more collaborative forms of governance. In many ways, there are similarities between Hayek's account of coordination in markets and accounts of networks, in which actors collaborate with each other to achieve changing objectives, while utilising their own knowledge and expertise in the process. Nevertheless, networks in the public sector do not emerge spontaneously and require governance frameworks to function (Torfing et al., 2012: 169). Hayek's problematic poses evaluative questions of these governance frameworks: what policy tools, strategies and organisational forms facilitate the coordination of actors and the effective use and discovery of knowledge?

In the next chapter, I outline a framework for the evaluation of governance which draws upon Hayek's concept of coordination. A focus on coordination would entail examining the interactions between stakeholders at different stages of the policy process, while also identifying issues arising from the use of specific policy tools. Indeed, given the potential for centralised decision-making to result in unintended consequences, there is a need to explore stakeholder accounts at a local level to identify where such consequences arise and how they might be avoided.

2.1 'Old' Institutionalism: Revisiting Issues of Knowledge and Motivation

Where Hayek's work identifies clear limitations to centralised forms of decision-making, other forms of 'heterodox' economics are more critical of the use of markets in society. 'Old' institutionalist economics⁴⁴ in particular emphasises limitations to the market system and assigns a positive role to policy processes and other organisations, such as professional organisations and trade unions, in facilitating the coordination of economic activities. The framework has insights that are relevant to questions of institutional design in public services.

A central concept of the framework is institutions, defined in broad terms as "habits of thought" or the "common sense of the community" (Knoedler et al., 2007: xviii). Individuals are conceptualised as socially embedded in the culture and institutions which surround them. The knowledge individuals have at their disposal is also fallible, incomplete and their values, preferences and motives are partly moulded by their environments. These assumptions share similarities with Austrian economics (Lewis and Chamlee-Wright, 2008), but the frameworks reach very different conclusions about the appropriate roles and inter-relationships between state and markets.

A central 'institutionalist' criticism of economic theory, including neoclassical economics and the Austrian School, is that it provides an ahistorical account of markets. This is somewhat surprising given the explicit attempt of Austrian economists to explain economic phenomena in historical terms vis-à-vis the concept of 'spontaneous order'. However, as noted by Geoffrey Hodgson, this

⁴⁴ The term 'old' institutionalism is taken to refer to Karl Marx and Karl Polanyi, the German Historical School (GHS) and American institutionalism. Contemporary adherents include Geoffrey Hodgson, John O'Neill, Wilfred Dolfsma and Robert MacMaster.

approach universalises a concept of *homoeconomicus*, for evolution is understood in terms of individual choice. Theoretically, this is problematic because individuals are explained in terms of such individuals and so on into infinite regress (Hodgson, 2001: 146). But it is also important politically because, if market processes, in which individuals make choices in light of available alternatives, are themselves a product of history rather than its cause, the market becomes one economic institution among many. Hodgson suggests that it is the political preference of Austrians for the market system that has resulted in this problem: their desire to safeguard the market system has meant that the core features of the market place – most notably, *homoeconomicus*, private property and indeed markets – are assumed to exist since the dawn of humanity (Hodgson, 2001: 211)⁴⁵.

Institutionalists also criticise the individualist theory of value which underpins neoclassical economics and the Austrian School. Where these frameworks share a concept of consumer sovereignty, institutionalist economists have analysed how individual preferences and motivations are shaped by that society (Hodgson, 1989). What is more, while individuals may be socially embedded and operate in contexts of significant uncertainty and complexity, nevertheless they are capable of adopting a higher rationality and evaluating the status quo in terms of the community impersonally, in terms of a conflict between *what is* and *what ought to be* (Bush, 1987: 1076). It is this form of rationality which is expressed in the political sphere and which has the potential to steer economic activities.

Nevertheless, while the framework is more critical of markets than other economic frameworks, there is widespread agreement that central planning is untenable as an all-encompassing mode of coordination and that markets have a positive role to play in the economy. Geoffrey Hodgson argues that it is necessary to take into account what he calls the “impurity principle” when designing and evaluating institutions. All systems, according to Hodgson, depend in large part on impurities, whether they are elements passed down from history, such as remnants of feudalism in Europe; or whether they emerge and combine at the same time, such as the case of Britain’s capitalist and colonialist systems, which operated in unison during the 18th and 19th century. Hodgson argues that it is illegitimate to abstract impurities from the analysis: all development is a process of “making do” with the historical legacy of institutions and the successful design of institutions requires the toleration of impurities (Hodgson, 2001: 334).

The “impurity principle”, when applied to the question of the appropriate roles and inter-relationships between state and market, implies that some form of mixed economy is required but it does not specify what form that would take, providing a theoretical guideline rather than a set of policy proposals (Hodgson, 2001: 335). Institutionalists have held different views on this question, ranging from models of “guild” socialism, consisting of state ownership, worker and consumer associations

⁴⁵ More recent developments in institutionalist theory, such as Public Choice Theory, Transaction Cost Economics and other “new” institutionalisms, similarly fail to account for the historical emergence of markets. This is recognised by Oliver Williamson, who states “I assume, for expositional convenience, that ‘in the beginning there were markets’” (Ankarloo, 2002: 1).

and regulated markets for consumer items (Polanyi, 1924); to something approaching the welfare state settlement, with a mixed economy, a strong welfare state and some democratic participation in economic decision-making (Hodgson, 2002).

As has already been argued, there is a need to explore these questions through empirical research. Nevertheless, 'old' institutionalist critiques of markets highlight issues that can arise from an over-reliance on market mechanisms which other frameworks do not recognise and are important to take into account in governance evaluation.

Critiques of the market system

Karl Marx⁴⁶ and Karl Polanyi provide significant insight into the topic of the appropriate relationship between the state and markets. Central to their thought is the concept of commodification, which in turn presupposes a concept of incommensurable value. As is well known, Marx begins his analysis of capitalism with the commodity. Throughout the history of mankind, production has been geared towards the production of objects of use-value. However, under capitalism, production takes the form of commodity production, where commodities are produced for sale on the market and thus have both a use-value and an exchange-value. Thousands upon thousands of objects are produced which, though qualitatively different, are rendered commensurable via their exchange value assigned to them in market exchange. Each commodity's exchange value enables it to be brought into quantitative relations with any other commodity on the market⁴⁷.

One of the main consequences of production for market exchange is what Marx calls 'commodity fetishism', whereby people no longer relate to each other directly as human beings but human relationships are expressed through commodities. The operation of the market renders producers, the relationships which organise the workplace and the conditions in which people work invisible. Labour is treated as a commodity like any other and exchange-value dominates over use-value. Profits are now the sole purpose of production and the remorseless drive for profits is satisfied either through the streamlining of production or extending the boundaries of capitalism, regardless of its impact for individuals and society (Prodnik, 2012: 278).

A similar account is provided by Polanyi, whose critique of market capitalism centres upon the concept of 'commodity fiction'. Where Marx had a particular

⁴⁶ Karl Marx's status as an institutionalist is disputed. Some argue that his conceptual schema is ahistorical and overly rigid to be considered an institutionalist, whereas others view his account of the historical specificity of the market system as an example of institutionalism (O'Hara, 2000). It is for this reason that he has been included in this section.

⁴⁷ Where does that exchange value come from? While supply and demand does have a role in the short-term, the determining factor is what Marx calls "socially necessary labour time", which refers to the average labour required to produce the commodity, given the average level of skill and technological development in society at that point in time. This constitutes the major value system in capitalist society (Foley, 2000).

concern with the commodification of labour, Polanyi emphasises the problem of reducing all objects to the status of commodities. Many objectives, including labour but also land and capital, are not produced for sale on the market and treating them as if they are commodities implies the total subordination of society and nature to the market logics. The concept “commodity fiction” highlights a theoretical failure of economists to appreciate the very definition of a commodity, which something that is made for sale on the market.

Marx and Polanyi’s critique of commodification, like Hayek’s work, anticipates the postpositivist concept of incommensurable values, implying the inappropriateness of assigning an exchange value to human beings and other non-commodities, either for the purposes of market exchange or rational planning. But it also has implications for the twinned problems that are central part of governance challenges: the ‘motivational problem’ and the ‘knowledge problem’.

Revisiting Issues of Knowledge and Motivation

For Marx, capitalism differs from previous economic systems in part because production takes the form of commodity production and is underpinned by exploitative relations between the owners of capital – the capitalists – and the workers – the proletariat (Marx and Engels, 2003). But an additional differentiating characteristic is the division of labour under capitalism. Marx argues that all societies have included a “social division of labour”, which has its roots in the differences of sex and gender. As societies developed, this division of labour increased with the specialisation of labour, resulting in the creation of the craft industries. Yet capitalism is based on a “manufacturing division of labour” which differs “not only in degree, but also in kind”. The degree of specialisation of labour under capitalism is so extreme it results in “the lifelong annexation of the worker to a partial operation, and his complete subjection to capital” (Marx, 1990: 477).

The development of this “manufacturing division of labour” has implications for the ‘motivational problem’ of public policy. Indeed, for Marx, work is critical to the development of individuals, a full sense self and the formation of social relationships. Yet the specialisation of labour denies individuals meaningful work, resulting in workers’ alienation from their work, themselves and each other. Increasingly, workers work only for pecuniary rewards rather than other motives, such as an intrinsic desire to engage in creative labour or to work for the sake of the community (Sennett, 2009: 28).

In a similar way, Polanyi also emphasises the historical uniqueness of the market system, but from the perspective of market exchange rather than production. Polanyi demonstrates that market exchange, in which two people exchange something for something in return (corresponding to the form A-B-A), is historically peripheral as a form of coordination. Throughout much of history, goods and services have either been exchanged on the basis of *redistribution*, characterised by the movement of goods to and from a strong centre, such as a feudal system or a strong administrative state (corresponding to the form B-A-C-A-D-A); or *reciprocity*

in so-called 'gift' economies, whereby exchanges are deferred (corresponding to A-B-C-D-A) (Osti, 2007).

Polanyi's contribution to the 'motivational problem' stems from his view of the integrative functions that economic activities perform. Redistribution (B-A-C-A-D-A) and reciprocity (A-B-C-D-A) create lasting social relationships: either through coercion in the case of redistribution or pro-social activity in the case of reciprocity. In 'gift' economies, goods are provided to a member of a community by another member who in turn receives goods at a deferred time, either from the same person or another member of the community. These forms of coordination integrate individuals into society, providing individuals with distinct norms to follow if they are to be a member of the community.

Market exchange (A-B-A) does not perform an integrative function because it leaves no lasting social relationships and unsettles the common identities, values and social norms that are necessary for the reproduction of society, having a "disintegrative" effect. As Janet Knoedler and colleagues put it:

...market transactions are similar to so-called 'blind barter' where individuals in one social group exchange with members of another social group without ever actually meeting them. They place goods in a prescribed location and leave that place. They return to that place and see if there has been an acceptable return for their initial offering. If so, they take it and the transaction is complete. If the return for their offering is not acceptable, they do not take the counter-offer and their original offering is returned (or the original counter-offer is supplemented). Either way the transactors never meet and no social ties or connections are created (Knoedler et al., 2007: 115)

Increasingly, individuals act in terms of their own wants and preferences, irrespective of standards of moral behaviour and the consequences for society (Polanyi, 2002: 163).

While these critiques of the market system are mostly relevant to the 'motivational problem', Marx's analysis of the "manufacturing division of labour" is also relevant to the 'knowledge problem'. Subsequent Marxists have analysed the development of the factory system, characterised by standardised production, centralised decision-making and hierarchical controls over workers. A key factor in the shift was the emergence of the scientific management, spearheaded by Frederick Taylor. Scientific management sought to improve the efficiency of enterprises through the scientific analysis of work processes and the development of algorithms to instruct workers how to undertake job tasks. Taylor assigned a new role to management:

...the burden of gathering together all of the traditional knowledge which in the past has been possessed by the workmen and then of classifying, tabulating, and reducing this knowledge to rules, laws, and formulae (Taylor, 2004: 20).

Though Taylor believed his approach would benefit both capital and labour, Marxists have argued that the application of scientific management serves to convert high pay, high skill jobs into low pay, low skill jobs, removing employers' reliance on the skills and knowledge of employees and ultimately serving the interests of capital over labour. Scientific management is said to constitute a fundamental practice of the capitalist system (Braverman, 1998; Cooper and Taylor, 2000; Marglin, 1974).

Why is this problematic? Marx's analysis suggests that, besides facilitating exploitation and denying workers meaningful work, capitalist production has an uneasy relationship with the effective utilisation of knowledge, providing a possible rejoinder to Hayek's account. This has been highlighted by recent commentary. Andrew Cumbers comments on the disparity between Hayek's view of the market and the reality of actually existing market economies. The modern economy is constituted by extremely large corporations characterised by centralised decision-making structures and often highly standardised production processes, some distance from "the devolved market utopia of innovation, knowledge discovery, diversity and experimentation that Hayek envisioned" (Cumbers, 2012: 68).

The standardisation of work points to additional forms of market failure, including losses of the knowledge and skills attached to high skill jobs and effects of the low skill jobs which replace them:

These myriad jobs offer so little opportunity for the exercise of either manual or mental skills that the very capacity for these skills atrophies (Murphy, 1993: 1)

Yet it would be a mistake to suggest that it is only low pay jobs that are affected. New technologies enable the standardisation of the service industries and even so-called 'knowledge work' through processes that Philip Brown and colleagues describe as Digital Taylorism (Brown et al., 2008: 11, see also Head, 2005):

...Digital Taylorism takes the form of a power struggle within the middle classes, as these processes depend on reducing the autonomy and discretion of the majority of well qualified technical, managerial and professional employees. It encourages the segmentation of expertise based on 'talent', in ways that reserve the 'permission to think' to a small proportion of employees responsible for driving the business forward (Brown et al., 2008: 11)

2.2 Appraising 'Old' Institutionalism

'Old' institutionalism provides significant insights that that are necessary to take into account for evaluation and design of governance. The notion of the "impurity principle" warns against the reliance on any one governance mechanism, suggesting that the key to solving policy problems is establishing the right balance between different mechanisms. Additionally, problems may arise when policymakers attempt to "purify" systems, through the excessive reliance on a

particular mechanism (Hodgson, 2002: 334). As with a Hayekian perspective, this orientates policy evaluation to the exploration of unintended consequences of policy but it allows for unintended consequences to arise from an overuse of markets in public policy, as well as the use of hierarchical policy tools.

As Marx and Polanyi demonstrate, the overuse of markets in society can result in a failure to realise significant political, social and environmental values. It can also complicate the knowledge and motivational dimensions of public policy. Marx's analysis of the 'specialisation of labour' complements the argument that certain forms of knowledge and skills have public goods characteristics (see above), while the depletion of knowledge and skills via the application of scientific management is a form of market externality.

The critique of Taylorism and scientific management is highly relevant to the topic of public service reform (Holmes and Evans, 2013). Besides the use of centralised forms of decision-making in performance management, NPM has also been linked to the creation of precarious jobs, the standardisation of work processes, work intensification and the incorporation of "technologies of surveillance" into the workplace (Patterson and Pinch, 1995: 1431; see also Chapman, 2012: 40; Hoggett, 1994; Hoggett, 1991; Holmes and Evans, 2013). These processes may diminish the capacity of public services to solve complex policy problems. One case study of local government environmental services found that the application of NPM involved the standardisation and streamlining of work, the end of apprenticeship training schemes and the replacement of older, more experienced and more skilled workers with younger and less skilled workers. While this secured efficiency savings in the short-term, the new workforce was not equipped to respond to new policy objectives associated with climate change and sustainable development (Patterson and Theobald, 1996; see also Patterson and Pinch, 1995).

The process of standardisation also seems to be affecting professionalised public services such as education and health, where it is aided and abetted by Evidence-Based Policy (EBP). Indeed, as we saw in chapter 2, EBP is partly viewed as a way to lessen reliance on professional judgement. But it may also be facilitating the standardisation of services. For Angela Packwood, the application of EBP has facilitated a view of "professionalism as performativity, teaching as technicist delivery"; which stands in contradistinction to "professionalism as freedom to engage critically in debates regarding practices", with teaching understood "as a reflexive, dialogic process" (Packwood, 2002: 267). Likewise, Leslie Chapman uses the term Digital Taylorism to describe New Public Management, implying increasingly standardised services for consumers, the deskilling of work and work intensification. EBP has partly facilitated this:

EBP encourages the development of metrics or measurements which can be used to evaluate the efficacy of a particular intervention. This is an important part of Digital Taylorism: measurement is linked to evaluation, which is linked to standardisation and routinisation (Chapman, 2012: 40)

While this suggests that at least some public sector employees experience declining pay and working conditions as a result of NPM reforms, it also implies that the objective of responsive, consumer-oriented public services may yet be elusive, as work is increasingly standardised and geared towards the production of goods and services that are defined at the centre.

Similarly, the use of markets and managerialism may exacerbate the 'motivational problem' in public services. There is a significant literature which suggests that significant majorities of public sector workers and professionals are motivated by values of public service, civic duty, professionalism and social justice. Yet this stock of 'public service motivation' may have declined with the shift from employment relationships based on trust to the use of economic incentives (Andersen, 2009; Bellé and Ongaro, 2014; Francois, 2000). Both providers of services and services-users themselves may be affected.

Indeed, one unintended consequence of marketisation was anticipated by Richard Titmuss in his early criticism of the use of markets in the provision of welfare services. Writing in the 1970s, Titmuss used the example of blood donation to warn against marketisation. Having people donate blood as a civic duty, though no direct relations between people are established, creates a common resource open to the community that is there when people require it. Both the giver and the receiver accept this notion and both gain from the sense of being part of a community. Introducing payment, however, incorporates a transactional component to the relationship which compromises the sense that giving blood is a civic duty. The result is a diminution in the community's moral horizon. People who did donate blood out of civic duty no longer donate. If stocks decline, the receivers of blood will now have to pay for it or have their family and friends give it up. Stocks may stay level due to increases in blood paid for in cash but monitoring systems are required because there is an incentive for people with problems with their blood to donate just to get paid (Titmuss, 1971).

In Polanyian terms, this is precisely the dynamic of the switch from integrative forms of coordination, in the form of redistribution and reciprocity, to market exchange, which leaves no lasting social relationships and ties. Titmuss' arguments suggest that marketisation can compromise core social and economic values associated with public services, providing a significant rejoinder to public choice arguments for the use of markets in the delivery of public services.

3.1 Concluding Remarks

The present section has examined heterodox economics and the different views within that field regarding the appropriate roles for and interrelationships between state and markets. This complemented the previous section, which did the same vis-à-vis neoclassical economics and its extensions. I have argued that empirical research is required to address evaluative questions of governance and identified various concepts that are important to take into account in the evaluation and design of governance. In particular, Friedrich Hayek's pro-market conclusions aside,

his theorisation of coordination as a problem of the effective discovery and utilisation of knowledge presents a major challenge to any governance arrangement. In the next section, I develop an empirical approach for the evaluation of governance which focuses on coordination.

Chapter 6: A Framework for the Evaluation of Policy and Governance

My purpose in this present chapter is to summarise the preceding chapters and provide an outline of an evaluative approach suitable for the evaluation of policy and governance in complex policy areas. As we saw in chapter 1, there is extensive debate over the quality of public services and the appropriateness of different policy tools and organisational forms in their delivery. Yet questions remain over how to address these evaluative questions of public sector governance. In chapter 3, I suggested that postpositivist philosophy and policy analysis have important relevant insights but there is scope to develop these approaches for the purposes of governance evaluation. To that end, chapter 4 and 5 have examined various theoretical perspectives in political economy which provide insights into the strengths and weaknesses of different institutional arrangements in the coordination of economic activity.

In this chapter, I propose a postpositivist approach to evaluation which evaluates governance in terms of its capacity to facilitate coordination. Section 1 makes a case for a postpositivist focus on coordination. It begins by outlining what coordination entails in the context of the governance of public services, before setting out a postpositivist approach to the evaluation of coordination, involving an assessment of stakeholder 'frames'.

1.1 Governance and the Challenge of Coordination

Before outlining an approach to governance evaluation, it is important to first consider what the challenges of governance actually entail. Chapter 2 introduced a distinction between policy and governance. Though the process of policy formation and implementation are complex, involving a complex web of decisions and actions, policy can nonetheless be usefully conceptualised as involving a decision to adopt a course of action in order to solve a problem. Thus, decisions over policies are somewhat singular or linear, involving choices between specific interventions, services and programmes which address problems.

The concept of governance brings to the fore the multiple layers or scales through which particular policies are implemented. Decisions over governance are more complex than policy decisions: they pertain to the management of implementation and the design of overall institutional environment (Hill and Hupe, 2014: 16).

How, then, might governance be evaluated? Governance can be evaluated in terms of its capacity to affect the coordination of actors. Chapter 1 explored the increasing prominence of the concept of coordination in the field of public administration amid heightened recognition of the complexity of policy problems. In public administration, the verb refers to a process through which actors at different scales combine to deliver public services. Similarly, the concept is central

to political economy, informing Friedrich Hayek's praise of the market system as a superior coordinating mechanism than central planning.

Indeed, Hayek's conceptualisation of coordination is a useful starting point for the evaluation of governance (Greenwood, 2010; Greenwood, 2012). Coordination, for Hayek, is a process through which actors, operating in contexts of great uncertainty and complexity, obtain and act upon knowledge of ends and means dispersed throughout society. Consumers seek out and acquire knowledge of new consumer items which enable them to fulfil their ends, which may not have been immediately apparent to them before. Producers seek out and acquire knowledge of the most valued use of resources, given consumer demand. In the process, they utilise their own knowledge and expertise.

Of course, Hayek had strong views about the superiority of the market system to affect coordination via market prices. However, while the Hayekian 'knowledge problem' clearly renders untenable an economy coordinated entirely on the basis of central planning, the neoclassical concept of market failures and the more fundamental criticisms of the market system of 'old' institutionalists suggest that the superiority of the market system has been overstated. Nevertheless, to address the 'knowledge problem' requires the development of governance arrangements which facilitate innovation and the successful utilisation of knowledge and expertise.

Indeed, national policymakers confront a number of challenges in their efforts to facilitate coordination due to the considerable uncertainty and complexity in which they operate. They have to define political priorities and policy objectives in ways which reflect a rough approximation of stakeholder values. Furthermore, national policymakers have to acquire knowledge of the means through which these values are to be realised in practice. This will require making decisions about appropriate policy strategies and the governance arrangements through which policy is delivered. There is always the possibility that the wrong policies and governance arrangements are chosen, resulting in issues in the delivery of policy which frustrate the realisation of policy objectives.

A central aspect of this challenge is to strike the right balance between centralised and decentralised forms of decision-making; i.e. the scale of decision-making. There is a need to ensure that actors at different levels of policy implementation have knowledge of the most valued use of resources. Although Evidence-Based Policy has emerged in recent years and has potential to address this problem, there are clear limitations to what alone evidence can achieve (see chapter 2). Excessive centralisation can restrain the scope of actors to fashion effective local solutions. Yet excessive decentralisation may result in local actors being unaware of effective policy options. Additionally, different stakeholder groups should have an appropriate degree of influence over local decision-making, whether professional, manager, service-user or citizen.

A further aspect of this challenge is to ensure that the appropriate incentives are in place to ensure that actors implementing policy are motivated to seek out and act upon the knowledge they require to deliver effective public services. It may be the case that the implementation of policy is undermined by public sector workers/professionals acting in their own interests or by corporate bodies acting in their commercial interests. Alternatively, the motivation of actors may be adversely affected by an overuse of economic incentives, as market mechanisms or excessive performance management reduce the 'intrinsic' or 'pro-social' motivations of actors. In this way, policymakers must attend to the different dimensions of the 'motivational problem', as outlined in previous chapters.

A still further aspect of this challenge is to ensure that *transaction costs* are kept to a minimum. As discussed in chapter 4, transaction costs do not refer to the quality of goods and services or the direct cost of production, but rather the costs attached to an exchange. Oliver Williamson has argued that market actors who desire a good or service face a "make or buy" decision: to either to 'make' it themselves (or, more accurately, to employ someone directly to 'make' it for them) or to 'buy' it from the market place. Either option is associated with transactions costs: direct employment can be cheaper than market transactions when the skills and technology required for the production of a good or service are specific to them and the transaction is frequently carried out because it cuts down on the costs of writing up contracts and monitoring completion. But direct employment can also be costly because extensive monitoring is required to ensure employees work in the interests of the employer.

Just as firms confront this "make or buy" decision, so too do national policymakers. One of the challenges for national policymakers therefore, besides the issues of the scale of decision-making and incentives, is to ensure that transaction costs are minimised. It may be the case that hierarchical delivery through the public sector creates excessive management costs that would be exempt if goods and services were purchased on the market. But it might also be the case that consumers (whether commissioners or service-users) and producers incur excessive administrative costs in market or quasi-market contexts which would be unnecessary if production was organised internally.

What methodological approach might be used to evaluate whether coordination is taking place? Chapter 2 explored the dominant approaches to the evaluation of policy and governance. Evaluations are typically quantitative and fail to provide a comprehensive evaluation of both policy and governance. A major issue with quantitative evaluation is the measurement of outcomes, which invariably only provide a partial account of performance. Furthermore, particularly at the level of governance, the complexity of the overall environment makes it difficult to conclusively attribute outcomes to a change in governance, such as the adoption of competitive tendering or performance management.

An advance on these quantitative approaches are the evaluations of 'networked governance' discussed on page 48. The literature on networked governance

recognises the complexity of policy formation and implementation: knowledge is said to be partial and incomplete which necessitates governance arrangements that foster innovation and mutual learning. Furthermore, the literature recognises the importance and the complexity of the incentives problem: governance arrangements should facilitate collaboration between stakeholders (Agranoff, 2003).

However, where this literature seeks to evaluate networked governance, it adopts a process-orientation which focuses on identifying successful management strategies to manage the process of policy delivery. Proxies such as commitment, trust and communication amongst network participants serve as indicators of performance (Kenis and Provan, 2009: 442). This is clearly problematic when we consider the criticism of contemporary public sector governance that collaboration has become an end in itself and has skewed attention away from working to achieve policy outcomes (Blackman, 2013; Travers, 2007). The possibility that emphasising processes can actually interfere in the delivery of policy suggests that evaluations should adopt an outcome-orientation to ensure policy strategies and governance arrangements have a discernibly positive effect on public service outcomes.

Hence, to ascertain whether coordination is taking place requires a qualitative approach to evaluation which has an outcome-orientation. This entails a focus on stakeholder accounts of the precise details of policy and the decisions and choices made when selecting between policy strategies and the design of the overall governance arrangement. Indeed, as discussed in chapter 2, evaluations of 'networked governance' do not specifically address evaluative questions of governance related to the scale of decision-making and incentives, focusing instead on network management.

An outcome orientation is in-keeping with Hayek's analysis of coordination: for though Hayek brings to the fore the complex processes of adaption and learning through which coordination is achieved in markets, he ultimately praises markets for realising outcomes and thus realising the values which motivate market participants. Furthermore, like contemporary commentators on 'networked governance', Hayek recognises that stakeholder values can be qualitatively distinct and are not reducible to monetary measurement, while technical knowledge is also dispersed and fragmented. This would suggest that a postpositivist perspective is required to evaluate whether or not coordination is taking place. A postpositivist evaluation of outcomes could explore and compare the values and understandings of stakeholders at different levels of governance and policy, from the national to the local. Such an approach would provide insight into the effectiveness of public sector governance, possibility identifying problems which frustrate the realisation of policy objectives.

Indeed, as we saw in chapter 1, the topic of public service reform is highly contested. While the New Right were sceptical of the capacity of public bureaucracies to solve the twinned problems of knowledge and motivation, NPM reforms have themselves been criticised. NPM reforms can be evaluated in terms of

their capacity to affect coordination. To what extent do performance management protocols and quasi-markets enable or constrain the achievement of policy objectives by facilitating innovation and the successful utilisation of knowledge? To what extent, indeed, does Evidence-Based Policy provide information to actors regarding the most valued use of resources? To what extent does the overall incentive-environment elicit the desired motivation of actors? And to what extent are transaction costs kept to a minimum? In the next section, I outline a postpositivist approach that is specifically geared towards the evaluation of governance through a focus on coordination.

1.2 Frame Analysis and Coordination

Postpositivist policy analysis provides a number of methodological approaches that are suitable for the evaluation of governance. A variety of forms of ‘discourse’ or ‘frame’ analysis exist, each of which recognise the potential of multiple interpretations of reality, value diversity and the fragmented nature of knowledge (Stevenson and Dryzek, 2014: 41). Frame analysis in particular has been developed specifically for the purposes of policy evaluation⁴⁸. Like discourses, frames organise experience and provide something of a narrative that interprets the world, determining what is sayable. They are relatively durable, are grounded “in the institutions that sponsor them” (Schon and Rein, 1995: 29) and serve a political function, seeking to elicit particular responses from actors (Payne, 2001: 29). They contain both diagnostic and prognostic elements, identifying what is wrong and how problems might be solved (Lombardo et al., 2009: 141). Policy conflicts can be understood as “disputes among institutional actors who sponsor conflicting frames” (Schon and Rein, 1995: 29). The purpose of frame analysis is to identify and analyse different frames in policy conflicts, in order to gain an understanding of the policy problem and the debate (Peuhkuri, 2002: 158).

However, frame analysis does have to be developed for the purposes of governance evaluation. As discussed in the previous section, to evaluate governance in terms of coordination requires an exploration of stakeholders’ appraisals of the precise details of policy and the effects governance. This differs from most postpositivist approaches which typically seek to elucidate the nature of contested, moral debates. Frank Fischer’s approach, for example, provides a useful approach to explore the nature of policy disputes at the stage of policy formation (see page 60). Yet to evaluate outcomes requires a more specific exploration of stakeholder appraisals of the choices and trade-offs involved in the delivery of policy and the design of governance.

Furthermore, frames are ideal-types and the process of identifying and analysing them inevitably involves a degree of abstraction and simplification (Eckerberg and Nilsson, 2013: 59). On one level, this is useful because it provides insight into the

⁴⁸ Though similar to ‘discourse analysis’, ‘frame analysis’ is more specific to policy analysis and evaluation, where discourse analysis is used both in policy analysis and a far wider range of purposes, including Foucauldian approaches, critical discourse analysis and cognitive linguistics (Hope, 2010)

nature of policy conflicts and debates. While this is important to gain an understanding of the nature and extent of agreement and disagreement between frames, it has a disadvantage of abstracting away from the precise details of the content of different frames, as well as the nuance and contestation within them. It is precisely this level of detail which is important to take into account in the evaluation of coordination. For this reason, the analysis should begin by identifying and analysing frames at an abstract level, before going onto a more detailed exploration of frames and also how stakeholders combine elements of different frames in their evaluations of policy and governance.

There are three key dimensions that are necessary to take into account in the evaluation of governance:

1. Values

It is first necessary to explore the value component of stakeholder frames. This provides insight into the fundamental values and interests which motivate stakeholders. In turn, it is possible to ascertain the extent to which there is agreement on policy priorities and whether national policymakers have succeeded in defining political priorities in ways which reflect dispersed stakeholder values. As discussed in more detail below, the presence of shared values has important implications for evaluation.

2. Knowledge

It is also necessary to explore the knowledge component of stakeholder frames. Though the approach set out here is for the evaluation of governance, the effectiveness of governance is defined to a large extent by the quality of local decision-making and actions. It is therefore necessary to take into account both levels and consider the complex chains of means-ends relationships which interlink and interact across different scales of governance. Two specific kinds of knowledge are required for the evaluation of governance:

- Knowledge of the substantive policy problem – this kind of knowledge pertains to the nature of the policy issue at hand and includes knowledge of possible solutions, i.e. the policy tools, interventions and services stakeholders believe are required to solve the problem at a local level. The analysis must examine how stakeholders frame the complex choices and uncertainties involved in decisions at this level.
- Knowledge of the impacts of governance – this kind of knowledge pertains to the wider governance arrangements in place. The analysis must examine how stakeholders frame choices at the level of governance. They might have knowledge of the impact of centralised forms of decision-making, the effects of the incentives-environment on them and others or the transaction costs attached to a governance arrangement.

An analysis of these specific kinds of knowledge is important to consider because it provides insight into the efficiency of decision-making at different scales of policy and governance, providing a basis to evaluate whether policymakers have selected the right policy tools and governance arrangements to realise policy goals and objectives.

3. Interests

Finally, it is necessary to consider the interests which underpin frames. The concept of 'interest' is closely aligned to values, but it also concerns the concealed interests of actors in favouring certain options over others. Indeed, the values and knowledge content of stakeholder frames will be closely intertwined with their interests. Yet the process of uncovering interests is complicated because stakeholders are unlikely to speak frankly about the interest they have in particular policy positions. One possibility to overcome this problem is to infer stakeholder interests from the content of other stakeholder frames. Specifically, stakeholders' knowledge of the effectiveness of governance (see above) may provide insight into the interests which underpin other stakeholder frames, whether professional interests or commercial interests. It is important to consider interests because it provides some insight into why stakeholders harbour the views they do.

1.3 Evaluating the Coordinative Capacity of Governance

Once frames have been identified and analysed across these dimensions, it is possible to evaluate the coordinative capacity of governance and policy by comparing and contrasting frames at different levels. A starting point must be 'policy' frames at the national level, which can be identified in policy documents and the discourse of senior policymakers and incumbent politicians. Comparing and contrasting policy frames at this national level with those of other stakeholders can provide insights into excluded values or knowledge.

Of course, it might be the case that stakeholders do not highlight any major issues, suggesting they share both a similar definition of the policy problem and an understanding of how it can be solved with national policymakers. Here, policymakers have defined appropriate goals and selected efficient means to achieve them. There are few options which would improve the effectiveness of governance, for coordination is taking place. However, given that policymakers operate in contexts of profound uncertainty and complexity, perfect coordination of this sort is unlikely. The diversity of society and the fragmentary nature of knowledge suggest that stakeholders will disagree with some aspect of governance or policy.

Indeed, policy conflicts are likely and exploring their nature is important in the evaluation of governance. Policy conflicts are likely to take one of two forms. National policy frames may have excluded values that are significant to some individual or group. While this may be down to a lack of awareness on behalf of national policymakers, contestation over policy priorities most likely reflects real

political differences. As such, the issue is not of coordination but possibly divergent stakeholder values and interests. There are unlikely to be any solutions available that might ameliorate the conflict, at least in the immediate term. Where conflict of this nature is apparent, the analyst can identify the values at stake in the problem, so they might be discussed openly in the political sphere. Where national priorities have been defined in ways which clearly conflict with some stakeholder groups, questions must be asked about the legitimacy of policy processes; for it would appear that stakeholders have differential access to what John S. Dryzek and Hayley Stevenson call “empowered spaces”, where collective policy decisions are made (Dryzek and Stevenson, 2014: 131).

Policy conflicts over values of this type are an inextricable characteristic of political processes and likely to arise in most disputes over governance. Still, a further category of conflict is where national policy frames have excluded some individual or groups’ knowledge. Here, stakeholders broadly share values but have contrasting understandings of how to realise them.

Indeed, the attempts of national policymakers to facilitate coordination may result in unintended and undesirable consequences at a local level. Local actors might possess knowledge of policy solutions that are not widely known or criticise some aspect of governance for constraining them in the pursuit of their objectives, perhaps due to misaligned incentives or unnecessary transaction costs. Where values are shared, these issues can be defined as ‘coordination problems’, for policy and governance appears to be failing to utilise stakeholder knowledge in the pursuit of policy objectives. The presence of shared values has important implications for policy evaluation because there is scope for the analyst to draw out that local knowledge and propose alternative policies and arrangements if appropriate. In the process, stakeholders’ contrasting understandings may begin to converge if problems with specific policy tools and approaches are made apparent to them.

2.1 Appraising the Approach

The proposed approach seeks to evaluate governance and policy in terms of both the appropriateness of policy objectives and the efficiency of means to achieve them. As a postpositivist form of evaluation, the approach can complement ‘positivist’ and ‘neoclassical’ forms of policy analysis by specifically orienting analysis to uncovering values and knowledge suppressed in governance processes and which may have been neglected by these forms of analysis. Moreover, the focus on stakeholders’ views on the effectiveness of policy and governance differs from the process-oriented evaluations of ‘networked governance’. Issues regarding processes may of course be highlighted by stakeholders, but these are relevant only where they are shown to frustrate the realisation of policy goals.

Nevertheless, there are issues with the proposed approach that are important to consider. Most significantly, it is important to recognise that a fully objective account of stakeholders’ values, knowledge and interests is impossible to ever

obtain. While this is precisely why a detailed, postpositivist exploration of stakeholder frames is required in the first place, it also raises a number of issues. The process of identifying and analysing frames is subjective and care must be taken to ensure that frames accurately reflect the views of stakeholders. Additionally, there are issues regarding the accuracy and indeed integrity of stakeholders' frames, for values, knowledge and interests are closely intertwined. Stakeholder frames may simply express their concealed interests in a particular solution to a policy problem.

A key issue is that the expressed commitment of national policymakers to a value may not be sincere. Where some detrimental consequences of a policy decision are identified which appear to compromise a stated policy objective, this may simply reflect a conscious political decision at a national level to prioritise some other objective. While the extent of the undesirable effects may not have been known, the problem appears to be one of priorities rather than a lack of knowledge. This is significant because the issue is no longer a 'coordination problem', for coordination may indeed be occurring as intended just in a way that some stakeholders find objectionable. Nevertheless, while issues of this nature raise questions of the legitimacy of policy processes, in order to evaluate the *effectiveness* of governance it is necessary to bracket the intentions of national policymakers and thus assume that issues identified at a local level are indeed unintended consequences.

The inverse of this problem is that stakeholder reports of unintended and undesirable consequence of policy may wilfully misrepresent the issue because it suits them and thus the problem may not represent a policy failure at all. As discussed above, stakeholders are unlikely to speak frankly about the interest they have in particular policy positions.

The main strategy to overcome this problem is to consider multiple stakeholder frames. Stakeholder frames can be triangulated with other stakeholder frames in order to assess the veracity of particular accounts of local policy issues or the overall governance environment. Certain stakeholders may have a unique perspective vis-à-vis the claim of another. For example, consumers or service-users may be uniquely placed to account for the claims of providers of services. Additionally, though evidence is itself often disputed, stakeholders might have some particularly compelling evidence to back up their case, including relevant statistics or positivist forms of evaluation. In this way, quantitative research can provide useful background material for qualitative research (Alvesson and Skoldberg, 2009: 4).

3.1 Concluding Remarks

In this section, I have set out a proposal for a postpositivist approach to the evaluation of policy and governance in complex policy areas. The proposed approach is a detailed comparative analysis of stakeholders' framings of the choices and uncertainties which exist at different levels of policy and governance. The identification of policy problems due to unintended consequences provides a

strong basis for evaluation and the proposal of policy options. For, if values are indeed shared, there is scope for stakeholders' contrasting understandings of policy issues to converge where new solutions are identified which stand to more effectively realise shared objectives and goals.

In the following sections, I further apply the proposed approach to the topic of NHS reform and in particular diabetes policy and governance. In chapter 7, I introduce the Government's recent reforms of the health service, brought about by the Health and Social Care Act (2011). Though the passage of the Act was accompanied with unprecedented public and professional protest, the Government is committed to certain core principles associated with the health service, including universalism and free access to services. Additionally, policy documents recognise the importance of a number of widely shared values, such as efficiency, quality of care, patient-centred care and responsiveness (DoH, 2010; DoH, 2011b; DoH, 2012; DoH, 2013). This apparent presence of shared values provides a basis upon which to evaluate the reforms.

Following the introduction of the Government's reforms, I explore the wider debates in health policy and governance, developing a set of frames. At the level of policy, I identify a 'holistic' frame and a 'medical' frame which exhibit different understandings of the substantive problem of health policy and which favour particular interventions and forms of care. At the level of governance, I identify five main frames which advocate distinct approaches to the organisation and governance of the service: a 'market' frame, a 'managerialist' frame, a 'political' frame, a 'medical-professional' frame and a 'progressive' frame.

At this stage, my analysis of the different frames follows the logic of a typical frame or discourse analysis. The framings provide a useful starting point for understanding the different perspectives in debates in health policy and governance. But I also draw upon the frames in chapter 8 and chapter 9. In chapter 8, I examine the evidence on the various policy tools which have been used to enhance the performance of the health service, including Evidence-Based Medicine, performance management and marketisation. Some of the framings have distinct positions on these policy tools which are identified and discussed in the analysis. Furthermore, I draw upon the frames in the analysis in the case study research. For stakeholders' appraisals of policy and governance often resembled the frames. But I also go beyond the level of typical frame or discourse analyses in the case study to examine the content of stakeholders' framings in detail in order to gain a fuller understanding of the choices and trade-offs which exist in designing policy and governance arrangements.

Chapter 7: The NHS and its Reform 1 – Introducing Governance and Policy Frames

The creation of the National Health Service (NHS) remains one of the most ambitious reforms ever embarked on by a UK government: the National Health Service Act of 1946 sought the wholesale reform of the nation's health services, bringing health services across the country under the control of the Department of Health and establishing rights of access to health services, free-at-the-point-of-use. The NHS would become a centrepiece of the postwar welfare state and it remains the core provider of health services in the UK today. Yet, as we saw in chapter 1, the NHS has been the subject of sometimes highly volatile debate. The past thirty years have witnessed extensive efforts to enhance its performance, involving a range of market and managerialist policy tools.

My purpose in this chapter is to introduce the topic of NHS reform and identify the main frames of health governance and policy. It is possible to identify frames across two levels of debate: at the level of governance, where there is extensive debate over the use of markets and performance management in the health service; and at the level of policy, where there is debate about the services and forms of care provided by the health service. Most recently, there has been significant debate about the use of pharmacological therapies, following NICE's decision to lower the threshold of heart attack risk at which patients are to be offered 'statins', a cholesterol-lowering drug.

I begin by examining the Conservative/Coalition Government's recent reforms of the health service, initiated by the 2011 Act. Following that, I identify and analyse the main frames of health governance and policy. In the final section, I compare and contrast the different frames across the two core questions of political economy; i.e. the appropriateness of markets in the health service and of different forms of centralisation and decentralisation.

1.1 The Health and Social Care Act (2011)

The Health and Social Care Act (2011) is widely held to have initiated the largest reorganisations of the health service's history. Its passage also proved one of the most controversial pieces of legislation of the Conservative Party/Coalition government's term in office, coinciding with widespread professional and public protest. A number of professional organisations declared their hostility to the Bill, including the Royal College of Nurses, the Royal College of General Practitioners, the Royal College of Physicians, the Royal College of Surgeons and the British Medical Association. The key health policy think-tanks the King's Fund and Nuffield Trust warned of the consequences of the "sheer scale of change and potential disruption" (Timmins, 2012: 69). Critics highlighted how the reforms had not featured in the Conservative Party manifesto, but the electorate were repeatedly promised "no more top-down reorganisations". Nicholas Timmins, Senior Fellow of the King's Fund and former Public Policy Editor at the Financial Times, remarks in

his detailed analysis of the Act's passage, that it is "widely regarded as a 'car crash' of both politics and policymaking" (Timmins, 2012: 5).

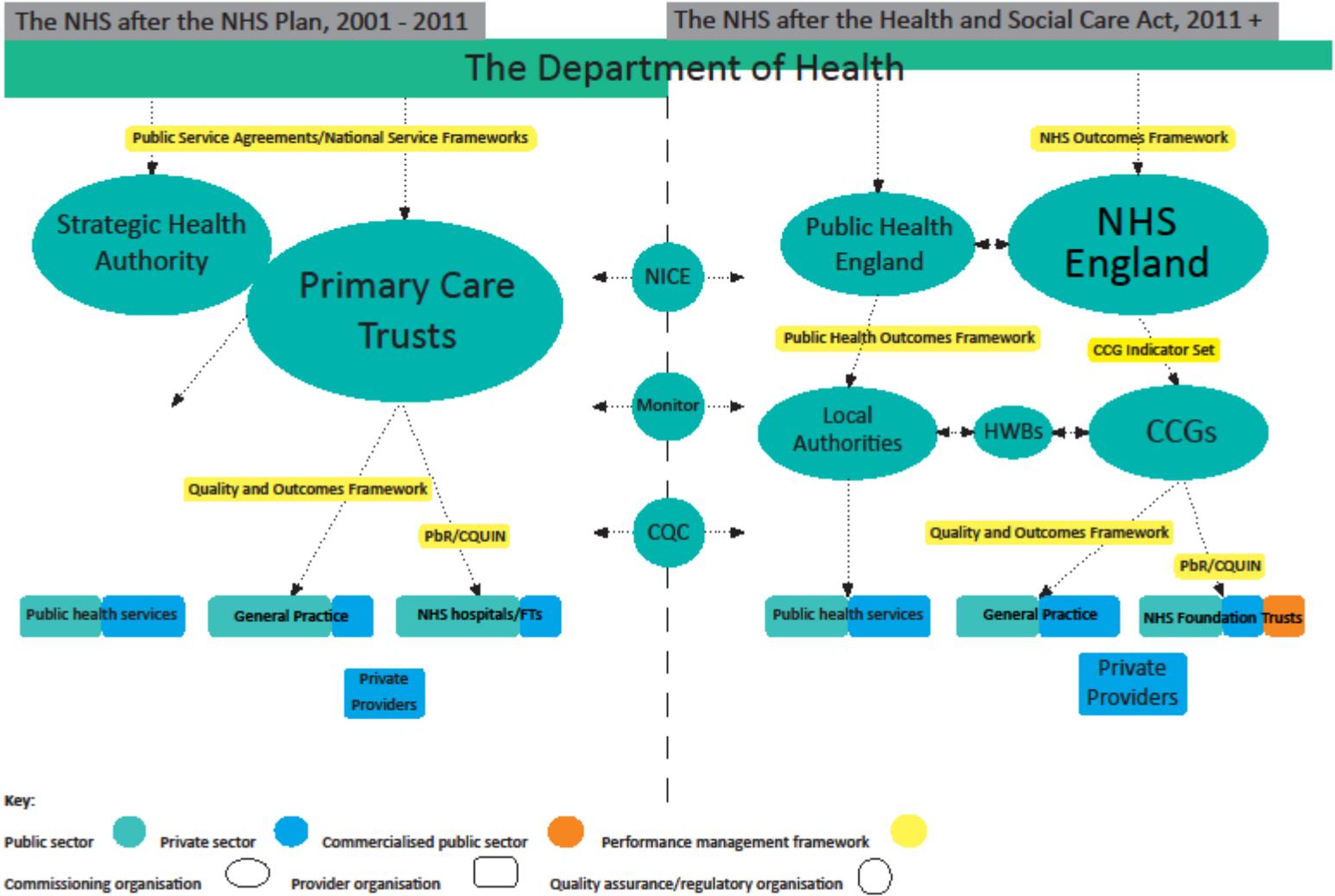
Yet the Act has its supporters who emphasise continuity between the Conservative's approach and previous attempts to reform the health service. Influential commentators such as Julian Le Grand, a former health advisor to Tony Blair, supported the Act (Le Grand, 2013). Likewise, Simon Stevens, another former health advisor to Tony Blair, then a president of the American health corporation United Health and now Chief Executive of the NHS, welcomed the reforms. In an article in the FT entitled '*NHS Reform is a Risk Worth Taking*', Stevens writes that the New Labour's market reforms had improved efficiency and quality and this would continue under the Conservative's model, which represents a continuation of New Labour's approach:

While the risks are substantial, there are grounds for optimism. The proposals come 10 years after Tony Blair, then prime minister, took the first steps down this path. What makes the coalition's proposals so radical is not that they tear up that earlier plan. It is that they move decisively towards fulfilling it – in a way that Mr Blair was blocked from doing by internal opposition within his own 'virtual coalition' government (Stevens, 2010)

What, then, are the key characteristics of the health service under the Health and Social Care Act? And how does the health service now differ from what it was under New Labour?

Figure 1 below sets out the current shape of the health service alongside New Labour's model. At the top of the service, there are to be fewer roles and responsibility for the Department of Health in directly managing and overseeing the health service. A new national organisation has been created, NHS England, which is in charge of the day-to-day management of the health service. An additional organisation has been created alongside NHS England, Public Health England, which is involved in the formation of national public health strategies and for ensuring the quality of public health services across the country. Below this tier, a new organisation has been created which is responsible for the commissioning of health services, Clinical-Commissioning Groups (CCGs). These replace New Labour's Primary Care Trusts (PCTs), which were larger and had responsibility for more people across a wider area (there are 211 CCGs, relative to 150 PCTs). New Labour's Strategic Health Authorities, large regional bodies responsible for overseeing regions and implementing Department of Health policy, have also been dissolved, with many of their functions incorporated into NHS England.

Local public health functions, which were once the responsibility of PCTs, are now under the control of local authorities, in what is a new role for local authorities in the health service. Through Health and Wellbeing Boards (HWBs), local authorities and CCGs are to determine the needs of local areas and commission services in healthcare and public health accordingly.



The reforms represent an extension of previous efforts on behalf of the Conservatives and New Labour to construct a market in healthcare. The purchaser-provider split, introduced first by the Conservatives in 1991 and sustained through the New Labour period, has been extended by the current reforms. Whereas PCTs had combined the purchasing and providing functions for certain services, in public health and in community services, CCGs are exclusively commissioning organisations. On the ‘provider’ side of the market, the Conservatives have extended New Labour’s Foundation Trust initiative, which provided managerial and financial freedoms to NHS hospitals. Furthermore, New Labour’s policy of promoting private sector involvement in the health service is to be extended, both in the provision and commissioning of services through involvement in the back office functions for CCGs⁴⁹.

Similarly, a number of organisations created by New Labour for the purposes of quality assurance and regulation remain in place. These include the National Institute for Health and Care Excellence (NICE), whose role it is to approve “health technologies”, standardise treatments and inform clinical guidance/performance management protocols; Monitor, the economic regulator, whose role it is to ensure that local actors abide by competition rules; and the Care Quality Commission (CQC), the quality regulator, which regulates providers of care, including GP surgeries and NHS hospitals.

The Conservative’s approach to performance management differs in important respects. In opposition, a central Conservative criticism of New Labour’s health policy related to its use of performance management. Where New Labour had purportedly relied upon the excessive use of process targets such as waiting list times and ‘disease-specific’ frameworks in the form of National Service Frameworks – which contained detailed quality standards for key conditions, such as heart disease, strokes and diabetes – the Conservative would take a broader approach which would focus on the achievement of actual health outcomes rather than process targets (Conservative Party, 2008). In office, this has translated into the development of various ‘Outcomes Frameworks’, which take their name from the Quality and Outcomes Framework developed by New Labour and used in the performance management of GP practices from 2001.

Each year, the Department of Health provides NHS England with a Mandate which informs the development of an NHS Outcomes Framework and includes various performance indicators for NHS England to work toward. Under NHS England, CCGs are performance managed via the CCG Outcomes Indicator Set – which expands upon the Mandate – and local authorities are performance managed by Public Health England through the Public Health Outcomes Framework (PHOF). Finally, GPs in primary care continue to be performance managed through the Quality and

⁴⁹ Under the NHS Plan of 2001, New Labour announced a “concordat” with the private sector and encouraged private sector involvement in the health service through the management of hospitals under Private-Finance Initiatives and the direct provision of care through Independent Sector Treatment Centres (ISTCs), which provided basis elective treatments. The Conservative Party’s has extended the role of the private sector still further.

Outcomes Framework (QOF). The government claims that the Outcomes Frameworks represent a break from “top-down targets” (DoH, 2011a: 51):

The whole system will be refocused around achieving positive health outcomes for the population, rather than focused on process targets and will not be used to performance manage local areas (DoH, 2011b: 10)

1.2 Improving the Performance of the Health Service

The system has been designed to enhance the performance across a broad range of criteria. The key organisational reform – the creation of CCGs – will purportedly improve the responsiveness of the service to patients and local areas because they are responsible for smaller numbers of people. Additionally, CCGs place GPs at the centre of the commissioning of healthcare and their creation will enable the achievement of a long-standing goal of policy, shared by New Labour and the Conservatives alike: the development of primary care. While primary care is more responsive to patients, it is also said to be more efficient. The care provided by NHS hospitals, by contrast, is often specialist-led and expensive. The reforms should facilitate the further development of the market in healthcare and thus improve quality of care and efficiency, through a combination of patient choice and a diversity of providers. Local authorities, too, will link the health service up with local government services and improve what is perceived to be lack of democratic accountability in the health service.

At a policy level, the reforms are designed to facilitate certain services and forms of care. A key part of this is the further development of primary care and public health. Both of these moves are believed to be particularly important today due to the increased prevalence of long-term conditions and an ageing population, which necessitate a turn to prevention. In primary care, better management of long-term conditions will prevent complications from arising, thus improving health outcomes and reducing costly hospital admissions. Likewise, Public Health England will raise the profile of public health across the health service and more broadly, across other government departments. This is again particularly relevant due to the rise of lifestyle conditions:

Public Health England will be responsible for stopping people becoming ill in the first place (DoH, 2011: 36)

Finally, the reforms are designed to facilitate a qualitative shift in the nature of care. Alluding to ‘holistic’ criticisms of ‘biomedical’ health care (see chapter 1), the development of primary care will facilitate ‘holistic’ and ‘patient-centred’ care, because GPs are the first point of call for patients and are therefore uniquely positioned to commission care around their needs and preferences. Furthermore, public health professionals, now operating in local authorities, will be closer to local politicians and the communities they serve, enabling the development of “holistic solutions to health and wellbeing” (DoH, 2011b: 4). The medical care provided by

the NHS will be complemented by “a 21st century local public health system, based on localism, democratic accountability and evidence” (DoH, 2012: 1).

Nevertheless, the controversies which greeted the Health and Social Care Act (2011) continue, as does the use of market mechanisms in the health service more generally. The new Labour leader Jeremy Corbyn has called for the repeal of the Act and an end to the ‘internal market’ in healthcare, a move welcomed by the British Medical Association (Roberts, 2015).

2.1 Introducing Frames of Health Policy and Governance

In this section, I identify the main frames of health policy and governance, some of which are reflected in the current reforms and some which are more oppositional. The frames were identified over the course of my background research and document analysis, which I undertook prior to undertaking the case study research in chapter 9. I have also drawn upon previous attempts to apply postpositivist analysis to health policy, most notably Kor Grit and Wilfred Dolfsma’s frames⁵⁰ of healthcare reform in the Netherlands. Grit and Dolfsma identify four main frames: the ‘economic’, ‘political’, ‘medical-professional’ and ‘caring’ frames (Grit and Dolfsma, 2002). In my analysis, I identify five main frames. I differentiate between a ‘market’ and a ‘managerialist’ frame within a broader ‘economic’ frame and introduce a ‘progressive’ frame. I also identify frames at a policy level, most notably a ‘holistic’ frame and a ‘medical’ frame, which relate to services and treatments. Though I haven’t used Grit and Dolfsma’s category of the ‘caring’ frame, it resembles my ‘progressive’ frame and ‘holistic’ frame.

I have drawn upon the work of John S. Dryzek and Helen Stevenson to develop a ‘Coding Scheme’ which serves as an aid to the process of identifying frames. The Coding Scheme seeks to capture the essential characteristics of each frame. Each frame has a concept of an ideal health system which it seeks to establish, constructs certain objects and entities which feature in that ideal system, emphasises certain core values and favours specific governance arrangements or policy strategies to realise them (see box 1)⁵¹.

Box 1 – Coding Scheme

| |
|---|
| Ideal healthcare system |
| Basic entities whose existence is recognised or constructed |
| Core values |
| Governance/policy proposals |

⁵⁰ Grit and Dolfsma use the term ‘discourses’ but their analysis bears clear resemblance to analyses of frames.

⁵¹ John S. Dryzek and Helen Stevenson develop and apply a ‘Coding Scheme’ to environmental policy and debates (Dryzek, 2013: 17; Stevenson and Dryzek, 2014: 41). I keep their category ‘Basic entities whose existence is recognised or constructed’, but replace their category ‘Assumptions about natural relationships’ with ‘core values’. I also introduce the categories of ‘Core values’ and ‘Governance/policy proposals’ which are particularly

2.2 The Market Frame

A key frame in health debates is the 'market' frame. Adherents of this frame include some health campaigners; politicians among the Conservative Party and New Labour; influential academics, such as Julian Le Grand and Alan Enthoven; commercial actors within the healthcare market, including health corporations and consultancy firms; and, finally, a range of think-tanks, including centre-left think-tanks such as the Institute for Public Policy Research (IPPR) (Ruane, 2010), centrist think-tanks such as Civitas and right-wing think-tanks such as Policy Studies and the Adam Smith Institute, which advocate for the use of markets in the health service (Wellings, 2012).

A central value of the frame is consumer and patient choice. Patient choice is considered to be a value in its own right, for patients should have a right to choose what health services they receive. One of the problems with the original design of the NHS was the power it afforded the medical profession, who were free to determine what services patients were provided with. In this way, the frame does not have a strong preference for particular services or forms of care at a policy level, but rather emphasises that the choice of health services should be determined by patients.

A further core value of the frame is efficiency, which is inextricably connected to patient choice. In the absence of market mechanisms, health professionals lack an incentive to search out and identify effective services and provide them efficiently. Introducing patient choice in the context of a plurality of providers should enhance efficiency both in terms of x-efficiency and allocative efficiency: greater competition will produce efficiency savings, while patient choice, or at least decentralising decision-making as close to patients as possible, will ensure that appropriate services are produced (Enthoven, 2000; Le Grand, 2003).

The 'market' has been highly influential over policy and is clearly reflected in the Conservative/Coalition Government's reforms, in the promotion of patient choice, the extension of the purchaser-provider split, increased provider competition and the continuation of Monitor's role as the economic regulator. Nevertheless, there is a clear dividing line among certain adherents of the 'market frame'. New Labour and the Conservative Party claim that the use of markets does not risk compromising core values associated with the health service, such as universalism, equity and comprehensive care. Though this is disputed (see below), the position implies an extensive role for policy in funding and regulating the healthcare 'market'. This position has been criticised by some pro-market commentators who argue that inefficiencies will remain unless more radical market reforms are adopted. The group *'Doctors for Reform'*, consisting of 500 hospital consultants and headed by Professor Karol Sikora, took out a full-page advertisement in the Times on the 25th of February 2004, issuing calls for market reforms that would genuinely empower patients:

The NHS as we know it has had its day. You can fiddle about with it and patch it up, but with an ageing population and high-tech healthcare, something has to give. Everything else we need today we can get very easily: air travel, holidays, cars. Why can't we get healthcare that easily? The form of funding is the key. To change it is a radical step. Politicians are very nervous. But we have to do it if we want a system that is focused on the patient and open to innovative ideas (Phillips, 2008: 33)

Proponents of privatisation argue that having patients directly pay for their care, either through the use of co-payments or insurance schemes, would provide genuine patient choice, improve efficiency and ensure that health professionals have to respond to patient choice. This may compromise the health service's ideals of equity and universalism, but the government could still provide a safety net and the poor would benefit from the innovation and medical advances which markets would stimulate (Pincock, 2004).

Outright privatisation would also ensure that patients are directly accountable for their health expenditures. Indeed, adherents of the market frame can also be critical of the choices of some individuals. Some people act irresponsibly and make choices that are detrimental to their health, causing unnecessary expense to the health system. The problem arises because, with health services provided free-at-the-point-of-use, service-users are not financially accountable for their actions, suggesting a possible incentives problem arising in the absence of market mechanisms.

In sum, the 'market' frame strongly favours the incorporation of markets into the health service. In economic terms, the frame clearly draws upon Austrian economics and Public Choice Theory which emphasise the superiority of markets over other forms of coordination. Markets are believed to be unique in their capacity to align incentives and provide signals of what is to be produced, through the exercise of consumer choice. The main characteristics of this specifically 'market' frame are outlined in box 2.

Box 2 – The Market Frame

Ideal health care system

A health care system that efficiently meets consumer demand

Basic entities whose existence is recognised or constructed

Consumers with preferences

The market in healthcare, pricing and payment mechanisms, market contracts

Private providers and insurance companies

Monitor (the economic regulator)

Core values

Quality of care

Patient choice/individualism/consumerism

Market accountability

Efficiency
Utilitarian ethics

Governance/policy proposals

Markets in healthcare improve efficiency by facilitating competition between providers of care

Empowering consumers enables them to exert influence over providers and determine what health services are provided

This interplay between supply and demand facilitates innovation

2.3 The Managerialist Frame

Besides the various market reforms that have taken place, the reform process has involved the incorporation into the health service of a range of managerialist mechanisms and a distinct framing can be identified in the arguments for the use of these mechanisms. Adherents of this 'managerialist' frame suggest that problems in the health service stem from variations in standards and a lack of managerial accountability. To improve the system, fully developed performance management systems are required in order to provide guidance to health professionals and monitor their performance. Furthermore, the data collected through performance management can be used for a range of purposes, including choices of provider. In this way, managerialist mechanisms can be used as a complement to market processes.

While the core values of this 'managerialist' frame are quality of care and efficiency, managerialism is also promoted as a way to ensure equality and universalism through the standardisation of services and an end to the 'postcode' lottery in care. During the 1990s, New Labour introduced a new, national system of clinical governance and regulation. The National Institute for Clinical Excellence (NICE) was created which would take charge of approving medical technologies and by 2005 all NHS organisations were required to follow the organisation's recommendations (Gottwald and Lansdown, 2014).

Additionally, performance management in the form of targets, star ratings and league tables became central to the governance of the health service and the system was underpinned by the Commission for Health Improvement, which became the Care Quality Commission as of 2009. Further centralising measures include National Service Frameworks (NSFs) which laid out treatments and pathway configurations for specific conditions and the Quality and Outcomes Framework for GPs, which linked pay to performance in line with centrally-defined targets. While the Conservative Party has moved away from NSFs and is adopting a policy of outcome rather than process evaluation in performance management, many of these centralising forces remain. The various Outcomes Frameworks are central to the governance of the health service, while the roles of NICE and the CQC remain.

The use of managerialist mechanisms in the health service has a number of influences. The first is the Evidence-Based Medicine movement, which developed in Canada with the Cochrane Collaboration. EBM purportedly represented a “new paradigm” in healthcare, which sought to replace “tradition, anecdote and theoretical reasoning” in healthcare with evidence-based decision-making (Greenhalgh et al., 2014)⁵². The second is the marketisation of health services in the US during the 1980s and 1990s, which saw attempts to apply business process-engineering to healthcare. In that country, the predominantly market system witnessed a huge increase in medical costs during the 1970s and 1980s, which was blamed on fee-for-service arrangements that incentivised physicians to carry out medical procedures. The government, employers and insurance companies sought ways to control costs, coming up with the concept of ‘managed care’: corporate entities would manage healthcare through a new structure – the Health Maintenance Organisation – which would enable patient pathways to be designed and monitored to ensure that the most efficient forms of care were provided (Kongstvedt, 2001: 3; see also Kirk, 1997).

Proponents of ‘managed care’ identify a weakness in traditional health systems: an over-reliance on professional judgement. The development of information systems means that medical decisions can be made by computerised algorithms on the basis of “clinically significant subgroups” of patients. Quality is purportedly assured because the “fallible human judgement” of the physician gives way to “scientific judgement” (Head, 2005: 141).

The development of these managerialist mechanisms is potentially significant because it suggests that the need for highly skilled medical professionals has been overstated and increasingly so. A 2012 article by the Economist entitled ‘*Squeezing Out the Doctor*’ reports increasingly widespread use of computer-based healthcare, promoted by global health corporations, McKinsey & Company and the Bill and Melinda Gates Foundation in the context of international development. The process will purportedly improve efficiency, quality and empower patients because the role of the physician is side-lined:

Resources are slowly being reallocated. Nurses and other health workers will put their training to better use. Devices will bolster care in ways previously unthinkable. Doctors, meanwhile, will devote their skill to the complex tasks worthy of their highly trained abilities. Doctors may thus lose some of their old standing. But patients will clearly win (The Economist, 2012; see also Ehrbeck, 2010).

In sum, as with the ‘market’ frame, the role of the medical profession is problematised but the solution to an excessive reliance on professional judgement is centralisation through the incorporation of performance management systems. In economic terms, the frame is influenced by Taylorism, neoclassical economics and public choice theory, emphasising the importance of centralised forms of

⁵² Though Evidence-Based Medicine has been critical to the development of managerialism, it does not necessarily equate to managerialism but it depends upon how research is implemented, as discussed in more detail in the next section.

decision-making, clear performance standards, incentives and monitoring mechanisms. Additionally, the frame similarly does not have a strong preference for particular services or forms of care at a policy level. But where the ‘market’ frame emphasises the importance of patient choice, the ‘managerialist’ frame emphasises the importance that all interventions and services should be clearly evidence-based (see box 3).

Box 3 – the Managerialist Frame

Ideal health care system

A health care system that efficiently secures managerial objectives

Basic entities whose existence is recognised or constructed

‘Clinically significant subgroups’ of patients

Performance management systems and protocols

QANGOs – National Institute for Clinical Excellence, The Care Quality Commission

Core values

Quality of care

Efficiency

Equality/social justice

Managerial accountability

Governance/policy proposals

Performance management protocols improve performance by providing clear performance standards and incentives for health professionals

Performance data provides patients, commissioners, managers and regulators with the information they require to make effective decisions

Scientific and economic evaluation techniques can improve decision-making

2.4 The Progressive/Holistic Frame

As we saw in chapter 1, Third Way thinking has had some influence on health policy debates. During the 1990s, Third Way thinkers associated with centre-left think-tanks such as Demos, IPPR and the New Economics Foundation criticised the marketisation of health service and advocated for its reform along more democratic lines, including the creation of democratic organisational forms and a reduction in performance management. Similarly, today, the Government has criticised what it views as New Labour’s excessive reliance on performance management, while its use of the term “social market” (DoH, 2010: 51) to describe its market reforms resembles Third Way discourse.

The term ‘progressive’ frame can be used to describe these Third Way themes, which are clearly distinct from the content of the market and managerialist frames. This ‘progressive’ frame emphasises the importance of democratic values and citizen and patient involvement in decision-making. Though primarily concerned with the governance of health services, the ‘progressive’ frame is closely associated

with particular services and forms of care at a policy level: namely, holistic care. A distinct 'holistic' frame can be identified at a policy level which promotes a particular understanding of the substantive problem of health policy: it is argued that ill-health is not just a problem of conditions and diseases, but a lack of empowerment, inequality and access to community resources. Rather than treat ill-health, health services should promote health in a positive sense. Once again, the 'holistic' frame features in the Government's reforms, as its reforms seek to facilitate the development of more holistic forms of care in public health and primary care.

Adherents of this 'holistic' frame have advocated for a greater role of public health in the health service to tackle the "social determinants" of health, including social inequalities, the physical environment, social relationships and opportunity (Greenhalgh, 2009). Furthermore, while recognising that the role of the medical profession has been problematic, adherents of the 'holistic' frame do not promote patient choice but a qualitative change in the doctor-patient relationship through initiatives such as 'patient-centred care', 'expert patient initiative' and 'co-production' in health (Hardy, 2004; Slay, 2013; NESTA, 2013). Improved relationships between doctors and patients are said to be important because patients are more likely to comply with treatment, overcoming part of the incentives-issue in healthcare. Additionally, the quality of health services improves because both the doctor and patient are "two experts":

When the contribution of each participant is recognised, the consultation becomes relationship centred, and the main purpose is to create a meeting that is informative, receptive, facilitative, medically functional and participatory (Realpe and Wallace, 2010: 12)

Besides clearly featuring in the Government's reforms, the frame is apparent in the controversy over NICE's decision to reduce the threshold for the use of 'statins' in the treatment of obesity, with critics arguing the decision has effectively "medicalised" healthy people (Boseley, 2014b). While there is significant debate within the medical profession over the use of pharmacological therapies in healthcare (Abramson et al., 2013; Godlee, 2014a; Godlee, 2014b), adherents of the 'holistic' frame promote exercise and health eating as a way to solve the problem of obesity, whether delivered at a public health or a primary care level. Such interventions purportedly improve medical outcomes through improved body fat and cholesterol profiles; but also facilitate holistic outcomes, such as wellbeing and empowerment (Bot and Unachukwu, 2014).

In sum, the 'progressive' frame has strong implications for debates at the level of policy and governance. In economic terms, the emphasis on relationships aligns the frame with the 'old' institutionalism of thinkers such as Karl Polanyi. At the level of governance, the frame promotes local forms of accountability and democracy to align incentives and improve decision-making. At the level of policy, the frame promotes 'holistic' forms of care in primary care and public health. Decisions should be arrived at through deliberation between physicians, patients and local

communities, rather than planning on the basis of need, managerial directives or consumer choices (see box 4).

Box 4 – the Progressive Frame

Ideal healthcare system

A locally-based healthcare system that provides patient-centred, ‘holistic’ care and public health

Basic entities whose existence is recognised or constructed

Human beings with rights, needs and preferences/opinions

Local communities and democratic organisations

Relationships between physicians and patients

Wider “social determinants” of health

Core values

Democratic accountability

Citizen involvement

Patient involvement

Governance/policy proposals

Community involvement in healthcare ensures that organisations operate in the public interest and that local solutions are identified that meet local needs

Patient-centred care is important because it improves patient compliance and patients are also a vital source of knowledge in the clinical encounter

Holistic forms of care promote broader health outcomes such as wellbeing and empowerment

2.5 The Medical-Professional/Medical Frame

A further frame which can be identified in health policy debates is the ‘medical-professional’ frame (Grit and Dolfsma, 2002). Indeed, a unique feature of the policy area is the presence of a relatively homogenous collective of actors which together make up the medical profession. Its adherents share a belief that professional judgement and skills are vital in the provision of care. Health professionals acquire knowledge and skills through years of training, after which they become fully-fledged members of the profession. Only then can they deliver good quality health services. A corollary of this is that others lack the knowledge and skills to deliver healthcare. Patients lack knowledge of their conditions and thus require professional help, but so too can other stakeholders, such as managers and policymakers. In this way, the ‘medical-professional’ frame alludes to widespread information asymmetries in healthcare.

The ‘medical-professional’ frame contrasts sharply with the above frames. Adherents of the ‘market’, ‘managerialist’ and ‘progressive’ frames in different ways seek to reduce reliance on professional judgement: encouraging consumer, evidence-based decision-making and patient empowerment respectively. Yet the

'medical-professional' frame provides a counterpoint. Its adherents point to problems which arise if professionalism is side-lined (Starr, 2009: 27). Indeed, given the complexity of healthcare, there is always a danger that patients, managers or clinical guidelines/computer algorithms make a wrong diagnosis and select a wrong treatment.

Nevertheless, the frame is consistent with a range of governance and policy positions. At a policy level, it is closely associated the 'medical' understanding of illness and treatments which can itself be conceptualised as a 'medical' frame. The frame assumes that humans have needs, of which the preeminent need is health. Illness and disease pose threats to human life and the overarching purpose of health services is to extend life by treating and curing illnesses and disease (Wade, 2009). Yet, while this 'policy' frame is closely associated with 'medical-professional' frame, medical services do not necessarily require professionals to deliver them; the key for the 'medical-professional' frame is that the medical profession retains a prominent position in the health service and are free to define and deliver medical services.

The 'medical-professional' frame is not aligned with any particular type of care, whether public health, primary care or secondary care. Yet services and forms of care have to be clearly evidence-based and have demonstrable impacts upon individuals' health. On this basis, the profession has found many 'holistic' forms of care wanting (Bakx, 1991). Nevertheless, though adherents of the 'medical-professional' frame assert the importance of evidence, there is some concern within the profession that Evidence-Based Medicine is often implemented in such a way as to undermine professional judgement, resulting in poor quality care:

Today EBM is a loaded gun at clinicians' heads. 'You better do as the evidence says' it hisses, leaving no room for discretion or judgment. EBM is now the problem, fueling overdiagnosis and overtreatment (Goswami, 2014)

Similarly, there is some concern over the emergence of the algorithm based models of care promoted by adherents of the 'managerialist' frame. Algorithms purportedly direct the "gaze" of physicians away from embodied patients to their "physiology and chemistry", directing the "flow and purpose of an encounter that once unfolded organically according to the particular needs of the patient" (Loxterkamp, 2013). There is a danger that physicians, under pressure to make efficiency savings, will simply respond to computerised aids and no longer "understand the total dimensions of a patient's needs" (Ludmerer, 2005: 384; see also Groopman, 2001).

The combination of markets and managerialism is also said to have an uneasy relationship with the on-going development of medical knowledge. Medical training and practice requires on-the-job learning (Annandale, 1989; Navarro, 1988). Yet the process of marketisation, which has involved the creation of multiple organisations, has led to an increasing detachment of medical teaching and training from the delivery of care, while hospitals have outsourced many of the basic services that

are required for training purposes. Furthermore, the algorithm model of care has meant that patients are admitted to hospital with their diagnosis made and their treatment plans already determined, making it harder for “learners to acquire problem-solving skills”(Ludmerer, 2005: 358).

Such hostility to markets and managerialism, though certainly not shared by all health professionals, is significant and resonates with Marxist criticisms of Taylorism and scientific management (Braverman, 1998). Medical work, like craft work, is viewed as a highly skilled activity which requires the full immersion of individuals into the profession which is understood along the lines of syndicate or guild (see box 5).

Box 5 – The Medical-Professional Frame

Ideal health care system

A healthcare system which produces high quality care that is defined and delivered by professionals

Basic entities whose existence is recognised or constructed

Patients with needs

Medical professionals and professional bodies

Healthcare treatments and procedures

Core values

Quality of care

Professionalism

Governance/policy proposals

Governance arrangements should be designed to ensure maximum autonomy and discretion among health professionals for only they possess the knowledge and expertise necessary for the delivery of good quality care

The desire to do a good job is sufficient to ensure health professionals work in their patients’ interest

Scientific evaluation techniques can aid decision-making but should not replace professional judgement

2.6 The Political Frame

The final frame I identify is the ‘political’ frame. This frame is shared by health campaigners, health professionals and political actors who assert the rights of individuals to healthcare and defend the original design of the health service. The original model, which lasted between 1948 and 1989 when the ‘internal market’ was created, is said to be uniquely capable of realising universal, public health ideals. However, the model has been systematically undermined by repeated marketisation policies enacted by first the Conservatives, then New Labour and now the Conservative/Coalition Government. It is argued that these attempts of

the main political parties to construct a market in healthcare is not evidence-based and does not have a democratic mandate (Leys and Player, 2011; Pollock, 2005).

Adherents of the frame include members of the National Health Action Party (NHAP), a single-issue party set up by Dr Richard Taylor and Dr Clive Peedell in the aftermath of the Health and Social Care Act to “save the NHS”. Other key figures include Julian Tudor Hart, a retired GP and prominent health campaigner, Allyson Pollock, professor of public health research at Queen Mary University of London, and Colin Leys, of Goldsmith’s College. Pollock and many other researchers also contribute to the academic journal *Radical Statistics*, which has provided detailed statistical analyses and critiques of Conservative and New Labour policy on the NHS since the 1980s (Macfarlane, 2014; *Radical Statistics*, 1989). Furthermore, a number of activist websites and blogs publish regular critiques of NHS policy, including *38 Degrees* and *False Economy*. The ‘political’ frame sets the terms of discussions at public meetings and is apparent in the formal and informal publications of these individuals and groups.

Central to the ‘political’ frame is a belief that access to the highest quality healthcare should be guaranteed as a right. Campaigners draw upon language of ‘needs’ and ‘rights’: human beings ‘need’ healthcare, regardless of whether they have a preference for it or have the money to buy it. Because of this, the state ought to provide citizens with healthcare as a right (Anand and Wailoo, 2000). It is the responsibility of political actors to provide citizens with comprehensive care of the highest quality care over the life-course. As a right, care is to be provided universally and free-at-the-point-of-use, embodying other values such as equality and social solidarity.

Establishing care as a right is also said to be uniquely efficient because it means that health organisations operate solely for the purposes of providing healthcare rather than having to compete for contracts, charge patients or contact insurance bodies to collect fees. In this way, an entire tier of non-medical personnel is rendered superfluous by direct public administration (Hart, 2006: 205). It is this which is taken to explain the relatively low health expenditures on the NHS relative to the American market model or mixed European systems:

No other Western country could match its costs, largely because no other country had so radically eliminated market mechanisms within the system (Pollock, 2005a)

This point anticipates Transaction Cost Economics and the concept that some goods and services are too complex to be delivered through market mechanisms, requiring extensive administrative and contractual activity. However, the efficiency potential of the public sector is also said to stem from the very different motivations present in healthcare ‘markets’, including professional and altruistic orientations (Brindle, 2007). Some accounts correspond to Karl Polanyi’s notion of a ‘gift economy’. Julian Tudor Hart suggests the health service can have a “civilising influence” on society, connecting people who pay for it, use it and work in it together in solidarity with each other (Hart, 2006).

Finally, adherents of the frame emphasise the importance of developed systems of data collection in decision-making. While this resembles the 'managerialist' frame, the content and purpose of data collection systems differ for the two frames. Whereas for the 'managerialist' frame data is collected for the purposes of performance management, for the 'political' frame it is collected for the purposes of planning services and for holding governments to account (Macfarlane, 1994; Radical Statistics, 1989).

The Critique of Marketisation and Privatisation

A central feature of the 'political' frame is its critique of the marketisation and privatisation of the NHS, which are viewed as intimately connected. Privatisation, referring not only to the use of private providers to deliver health services but to charges for services, is said to be inevitable because of the inefficiency of market mechanisms in healthcare. Where the original NHS was hierarchically integrated, marketisation has involved the introduction of a purchaser-provider split and creation of financially and legally separate organisations within the health service which operate on a competitive basis. While adherents of the 'market' frame promote these reforms on efficiency-based grounds, for adherents of the 'political' frame the process has greatly increased inefficiency and ultimately taken money away from patient-care. The market system, for its critics, is "an unaffordable ideological luxury" (Paton, 2014a).

While some services, such as dentistry, geriatric care and adult social care, have already been privatised (Ruane, 1997), the continued development of the market system under the Health and Social Care Act (2011) is said to pave the way for further privatisation, as legal duties upon the Secretary of State to provide comprehensive services have been removed (Pollock and Price, 2013a).

A further issue is the structure of the commissioning bodies now in charge of a large proportion of the NHS budget, Clinical-Commissioning Groups (see above). It is argued that CCGs are incompatible with the values and objectives of a national health service. Whereas PCTs, their forerunners, operated on a geographical-basis – and were legally responsible for the citizens residing in their areas – CCGs are responsible only for their members, who become members by virtue of their membership of GP practices. This poses the question of what is to happen to people who are not members of a GP practice. Homeless people, migrants and anyone else who are not in the system may find it difficult to access health services. Additionally, new found freedoms to determine how resources are spent will result in decisions being made on cost considerations and older people or people with complex conditions may find it increasingly difficult to access care (Pollock and Price, 2013b). Far from facilitating patient choice, the bill facilitates "provider choice of patients ... to pick and choose the profitable cases and discard the rest" (Pollock, 2014). What is more, the process of marketisation has unsettled systems of data collection such that the scale of the health problems resulting from the reforms will go unnoticed (Pollock et al., 2012).

In sum, the ‘political’ frame is strongly committed to public administration and ownership, viewing the arrangement as uniquely capable of realising core values associated with the health service, including quality of care, equity, efficiency and comprehensive coverage. Marketisation has compromised these core values and makes it almost inevitable that access to good quality health care will be determined more and more by the ability of people to pay due to the inefficiency of markets in healthcare and increased financial pressures (Ali and Pollock, 2015). Nevertheless, though hostile to markets, the frame is less concerned with other questions of governance, such as the role of performance management. Like the market and managerialist frames, moreover, the frame is not concerned with the relative balance between medical and holistic care at a policy level. However, its adherents do argue that NHS Hospitals are being undermined by market policies and emphasise the importance of publicly-owned and administered hospitals in the provision of care (see box 6).

Box 6 – the Political Frame

Ideal healthcare system

Entirely public healthcare system, with services provided free-at-the-point-of-use

Basic entities whose existence is recognised or constructed

The State/Department of Health

Citizens and populations with rights and needs

Core values

Human rights

Equality and social solidarity

Political accountability

Efficiency

Governance/policy proposals

Public ownership and administration is uniquely capable of delivering efficient and effective healthcare through savings on administration and marketing

Pro-social motivations and sense of professionalism ensure that the healthcare system operates effectively in the absence of market mechanisms

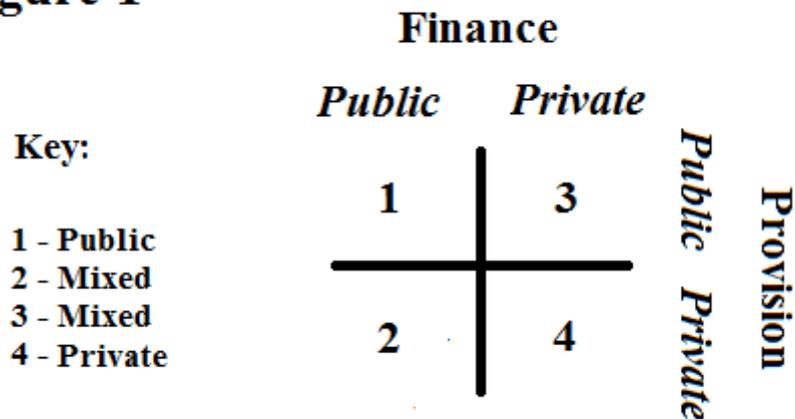
Nationally-based data sets provide the information that is required to plan services and hold decision-makers to account

3.1 Comparing and Contrasting the Framings

Where the above section identified and analysed various frames in health policy debates, the current section compares and contrasts them. I utilise the two figures set out in chapter 1 which represent different governance structures and approaches.

Figure 1 presents a diagram of different forms of ownership and administration. The frames support different points of the Figure. As we saw, the ‘political’ frame is strongly aligned with domain 1, claiming that only direct public ownership and administration can realise both efficiency and equity. The reform process has incorporated the use of market mechanisms, whether via the commercialisation of public organisations or the direct use of the private sector, taking the health service firmly into domain (2) of the diagram. Additionally, Foundation Trusts, which remain in the public sector, have enlarged freedoms to sell services to private individuals in order to supplement their role as NHS providers, domain (3) in the diagram.

Figure 1



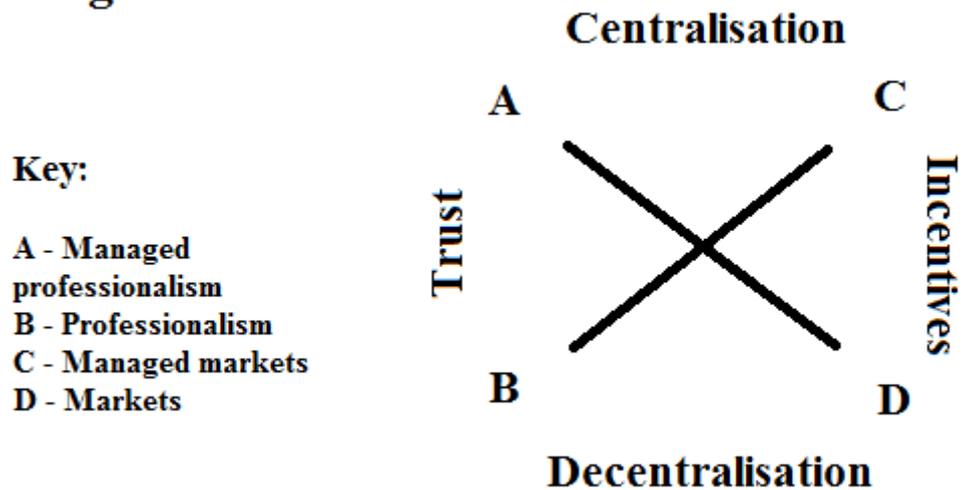
Source: adapted from Klein, 1984

The ‘market’, ‘managerialist’ and ‘progressive’ frames have influenced and justified the direction of policy from (1) to (2) and (3). Though managerialism could be practiced in an entirely public sector context – and thus is not aligned with a domain in the graph – it is a combination of the ‘market’ and ‘managerialist’ frames that have informed the claim that markets can be governed for public aims and objectives. The use of markets – and the use of mutuals and social enterprises, for the ‘progressive’ frame – is said to improve the performance of the system in terms of a range of efficiency and patient-centred criteria, while at the same time safeguarding the organisation’s founding ideals.

The assumption that marketisation is compatible with public health ideals is fiercely challenged by adherents of the ‘political’ frame. They view marketisation as a process, with privatisation an end result of the process. First provider and commissioner units are set up to operate in a commercial basis – (2) and (3) – and then the privatisation of finance follows (4), in part due to the inefficiencies of markets in healthcare. Though some services will always be available for free, particularly those where there is a clear economic case for the NHS to provide them; access to free and comprehensive care is no longer a right and access to the highest quality of care will only be available for those who can pay for them. The reform processes proceeds from (2) and (3) to (4) because of economic expediency.

A further debate is apparent regarding the scale of decision-making and the use of different forms of incentives, which arise whatever ownership arrangements are in place. Figure 2 presents the different dimensions of this debate.

Figure 2



The current system corresponds mostly to point C, in a combination of the ‘managerialist’ and ‘market’ frames: clinical guidelines are set centrally and a variety of managerial and market incentives are deployed in order to facilitate performance. Of course, not all decisions are made centrally. Current arrangements exhibit elements of point C and A: professionals operate in a managed context but there remains some scope for professional judgement and expertise. Furthermore, through patient choice, some decisions have been decentralised to patients, point D on the Figure. However, as we saw, some adherents of the ‘market’ frame criticise the extent that current arrangements can facilitate patient choice, calling for more outright privatisation. These criticisms are countered, in different ways, by adherents of the ‘medical-professional’ and ‘progressive’ frames, who question whether patient choice is appropriate in healthcare.

The ‘medical-professional’ frame is mostly aligned with point B of the figure, which corresponds to the original design of the health system, whereby decisions are decentralised in a professional context⁵³. The frame is associated with a critique of patient choice and managerialism, for interfering with professional judgement and expertise. In similar ways, the ‘progressive’ frame favours decentralisation, arguing

⁵³ That decision-making can be decentralised in public sector contexts is not always recognised. Often, the original NHS is criticised as being a highly centralised, bureaucratic organisation, but policy is in many respects more centralised today than it has ever been (Harrison et al., 2002). Even critics of privatisation equate decentralisation in healthcare with privatisation, as if lessening central policy control automatically equates to a removal of government responsibility for the healthcare needs of the population (Mills et al., 1990; Saltman et al., 2006). In fact, due to the absence of insurance companies, public systems appear to afford health professionals the most autonomy in their work and are thus highly decentralised in this sense (Light, 2003).

that patients (supported by medical professionals) and local communities should be free to define the health services they receive. Yet there remains a question mark over the precise governance arrangements through which the 'holistic' and 'patient-centred' care sought by progressives may be achieved.

4.1 Concluding Remarks

The present chapter outlined the Conservative/Coalition Government's recent reforms of the health service, before going onto identify the various frames in health debates on health policy and governance. The Government's reforms seek to improve the performance of the health service, exhibiting a range of market, managerialist and progressive elements. One objective is to facilitate more 'holistic' forms of care by decentralising decision-making to GPs in primary care and local authorities in public health. However, as we have seen, the use of markets continues to be contentious and NICE's decision to lower the threshold at which people are offered statins has invited criticisms that pharmacological therapies are overused by the health service. Questions remain over the appropriateness of the Government's combination of policy tools. While the final chapter evaluates the Government's reforms through a focus on diabetes, it is necessary first to examine in detail the evidence on these issues and debates.

Chapter 8: The NHS and its Reform 2 – Evaluation and Evidence in NHS reform

The level of contestation in debates on the topic of NHS reform necessitates a thorough examination of the evidence. My purpose in the present chapter is to explore the evidence on the various policy tools and governance approaches deployed to enhance the performance of the health service. In the process, I critically analyse the forms of evaluation which feature in health policy and governance, further making a case for a postpositivist focus on coordination. But I also arrive at some tentative answers to the questions posed by the debates in the previous chapter.

At a governance level, clinical governance and performance management appear to have clear potential to improve performance, on the proviso that guidelines and performance indicators have been defined correctly and that professionals have the requisite resources to implement them. Nevertheless, this only begs the question of how guidelines and indicators have been defined and the appropriateness of the evidence used in the process. A key issue is the increasing dominance of Evidence-Based Medicine. I explore criticisms of Evidence-Based Medicine which suggest that decisions will be distorted if made on the basis of the evidence alone. There is significant concern that dominant methods of appraisal overstate the value of drugs, or pharmacological therapies.

The benefits of marketisation are far more uncertain. A number of literature reviews suggest that the market reform of the health service has had few discernible benefits and few discernible costs. Nevertheless, there is strong evidence for the claim of adherents of the 'political' frame that hierarchically-integrated public health systems have a special claim on efficiency and equity due to savings from administration and contractual activity. Yet questions remain regarding the precise organisation and governance of health services. There is a need for more detailed, qualitative and postpositivist research in the evaluation of policy and governance.

The first section presents the dominant model of health policy and governance evaluation in 'health technology research' and 'health services research' respectively. The second section explores the debates over the quality of health technology research, where a number of criticisms are explored which suggest dominant methods have the potential to distort decision-making. Some of these criticisms are themselves firmly evidence-based, while others take the form of theoretical critiques.

The third section explores the evidence on clinical guidance and performance management, while the fourth section explores the evidence on marketisation. Evaluations in health service research are typically quantitative and focus on x-efficiency. But this leaves open crucial evaluative questions, namely the quality of local level services.

1.1 Evaluation in Health Policy and Governance

Dominant forms of evaluation in health policy and governance are notably 'positivist' and 'neoclassical', operating upon similar lines as policy evaluation in other areas of policy outlined in chapter 2 and 3. The literature is split between health services research and health technology research, which correspond to the distinction between governance and policy respectively. Health technology research evaluates health interventions such as diagnostic techniques, preventative measures such as screening, pharmacological therapies or surgical procedures. Health services research, in contrast, evaluates broader policy tools, such as service reorganisations, competition, central guidelines and performance management protocols (McPake et al., 2006: 1).

Health technology research is the most developed of the two and is indeed an integral component of the Evidence-Based Medicine movement. As in other areas of policy, the Randomised-Control Trial (RCT) is considered the "gold standard" of primary research and is situated at the top of the an evidence "pyramid" (Ho et al., 2008) or "hierarchy" (Habour and Miller, 2001). Yet even superior to this is the systematic review, which synthesises data from multiple research studies, ideally RCTs, in order to provide a more comprehensive evaluation than could ever be the case with a single research study. The Cochrane Collaboration provides highly influential systematic reviews on health interventions which are used in medical and policy decisions (Sackett and Wennberg, 1997).

Nevertheless, these scientific forms of evaluation provide only a partial account of the effectiveness of an intervention. The data is typically on health outcomes in a quantitative sense, such as mortality and survival rates or disease specific-effects, such as a symptom of a disease.

To ascertain whether an intervention is appropriate or desirable requires a consideration of its wider cost and benefits. To that end, an influential approach has emerged which combines different forms of data to provide a more comprehensive evaluation than the typical RCT provides. While clinical data is drawn up to ascertain the quantity of life which treatments provide, surveys of patients are used to ascertain their effects on quality of life. Patients with a condition are asked to indicate where they perceive themselves to be on a utility scale between a point below zero, zero and one, where below zero represents a situation that is worse than death, zero represents death and one represents perfect health. Through this procedure, all conditions, whether mental or physical, can be assigned a utility rating, which in turn can be used to evaluate the contribution of treatments to quality of life, significantly broadening the criteria used in the evaluation of treatments:

By moving away from a purely biological model, the overall concept of health is enriched and a need arises to focus on areas such as the individual's ability to operate in society, disability, access to health services or the individuals' subjective perception of general well-being, among others (Prieto and Sacristan, 2003)

The combination of the two data sets is used to construct a single measure which can be used to compare different treatment options, Quality-Adjusted-Life Years (QALY). If clinical data suggests that a treatment contributes ten years of extra life but the quality of those extra years scores a 0.5 utility rating, then the treatment contributes 5 QALYs. Furthermore, the QALY rating of a treatment can be divided by its cost to establish the price of each QALY, providing a further point of comparison. The evaluation of treatments in this way enables decisions to take into account a variety of criteria, including efficiency, the quality of care (from a medical perspective) and the quality of life (from the patient perspective) (Jones, 2012; Whitehead and Ali, 2010).

RCTs, systematic reviews and QALY evaluation constitute the main approaches to evaluation in health technology research. Yet it is recognised that health policy environments are complex and multifaceted, involving patients, health professionals, organisations, care pathways, payment systems and governance. The expected benefits attached to a treatment may not occur if services are poorly designed or medical staff do not have the requisite resources or training. It is here where health technology research is complemented by health services research (McPake et al., 2006: 1).

Once again, the Cochrane Collaboration has been influential in the development of health services research through its Effective Practice and Organisation of Care (EPOC) group, which provides guidance for the appraisal of research studies in the field (Higgins and Green, 2008). As in other forms of governance evaluation (see chapter 2), health services research does not involve Randomised-Control Trials but rather forms of observational study. Furthermore, the emphasis is on activities and processes rather than outcomes. In certain respects, this is complementary: where health technology research evaluates health interventions across a range of health and economic criteria, health services research explores the efficiency of health services to produce those very interventions (McPake et al., 2006).

However, as discussed in the next section, there is significant concern over the quality of the evidence-base at the level of health technology research. Without an evaluation of the quality of services and forms of care at this level, evaluations in health services research could provide a skewed account of the performance of health services in general. Indeed, Kabir Sheikh and colleagues criticise the focus on efficiency in health services research, calling it the evaluation of “predetermined programmatic solutions” (Sheikh et al., 2011: 4; see also Gilson et al., 2011). In what follows, I examine debate over the quality of health services research; the subsequent section goes onto explore health services research in greater detail.

2.1 Debates in Health Technology Research

As we saw in the previous chapter, clinical governance emerged during the mid-1990s along with Evidence-based Medicine (EBM). Through the development of evidence-based quality standards and performance management protocols, NICE would put an end to “postcode prescribing” and spread the adoption of “best practices” (NICE, 2008a). However, though this seems innocuous, EBM has attracted some fierce criticisms. Some decisions made by NICE on evidence-based grounds have provided controversial, most notably the recent controversy following NICE’s decision to lower the threshold at which people are offered statins. There are a number of criticisms of Evidence-Based Medicine which align with the different frames introduced in the previous section.

Indeed, for adherents of the ‘market’ frame, only patient choice or patient choice of physician – who in turn choose on their patients’ behalf – should determine what types of services and forms of care should be available (Moreira, 2013: 66). This ‘market’ view opposes the ‘managerialist’ view that the development of evidence-based guidelines and performance management protocols stands to improve the quality of care for patients by ensuring that all professionals adhere to high quality performance standards. Others meditate between these two positions, emphasising problems with current forms of Evidence-Based Medicine but recognising also the need for evidence in decisions.

The Political Frame

Some critics highlight problems with the evidence that is available in the public domain. In ways that resonate with the ‘political’ frame, these critics argue that the pharmaceutical control of medical research and investment represent significant problems for the development of clinical guidelines. Writing in the popular press, Ben Goldacre, a practicing GP and campaigner on public health issues, argues that pharmaceutical corporations distort and manipulate the research agenda (Goldacre, 2009). Likewise, Trisha Greenhalgh, a prominent analyst of EBM in academia, has argued that the evidence-based “quality mark” may have been “misappropriated and distorted by vested interests” (Greenhalgh et al., 2014: 1).

According to these critics, problems arise because pharmaceuticals are free to define what constitutes an illness and determine what treatments are tested, the methods used to test them and the outcomes that are measured (Greenhalgh et al, 2014). Some of the consequences of this are discussed in more detail below, where various ‘medical’ and ‘progressive’ criticisms of EBM are explored. A further issue relates to the governance of the research process. Following lobbying campaigns during the 1970s, pharmaceuticals are not obliged to publish research studies and have a clear incentive to withhold negative findings or engage in fraud and misconduct when undertaking studies, whether altering, fabricating or omitting research data (Gupta, 2013).

A number of studies have explored these problems, including comprehensive systematic reviews of all of the research carried out on the topic. The research findings overwhelmingly suggest that whether or not the pharmaceutical industry undertakes or funds research has a significant effect on its quality and/or the availability of research findings (Bekelman et al., 2003; Bourgeois et al., 2010; Heres et al., 2006; Lexchin et al., 2003). One case study of anti-psychotic drugs found that industry-backed publications reported positive results 90% of the time. Many publications reached contradictory conclusions when drugs favoured by one company were assessed by other companies in head-to-head studies⁵⁴, resulting in an anomaly whereby Drug A (olanzapine) beat Drug B (risperidone), Drug B (risperidone) beat Drug C (quetiapine) and Drug C (quetiapine) beat Drug A (olanzapine) (Heres et al., 2006).

Further studies have explored the extent that ‘negative’ publications are withheld by pharmaceutical companies. In one study the trials of new antidepressant drugs registered to the Food and Drug Administration agency in the US were examined, finding them to be quite evenly positive and negative: of a total of 74 trials, 36 had negative results and 38 had positive results. However, only 3 of the negative results were eventually published, in comparison to all but one of the positive results. Furthermore, 11 of the negative results were written up and published as “if the drug had been a success”, resulting in 3 published negative results and 48 published positive results (Goldacre, 2009: 19; see also Turner et al., 2008).

This research implies the presence of a significant information-asymmetry between the pharmaceuticals and both physicians and policymakers. Other accounts have highlighted the influence of pharmaceutical companies over drug-approval agencies and their use of advertising and marketing to influence physicians, the budget for which vastly outweighs investment in medical research. A number of policies have been proposed to solve this problem, including the nationalisation of the pharmaceuticals (Ali and Pollock, 2015); greater involvement of the NHS, as a public body, in medical research; or changes to the regulations governing the research process to require that all studies are published (Goldacre, 2009)⁵⁵.

The Medical-Professional/Medical Frame

A further set of criticisms is aligned with the medical profession. As we saw in the previous chapter, though many health professionals support the use and practice of Evidence-Based Medicine, there are increasingly vocal criticisms of what is perceived to be a suppression of professional judgement and expertise. Some evidence for the need for professional judgement and expertise in medical decision-making comes from the analysis of RCTs themselves. In a paper entitled

⁵⁴ The development of medical knowledge has meant that traditional treatments are increasingly outdated. So-called “second-generation” drugs are increasingly tested against traditional treatments and each other in head-to-head studies.

⁵⁵ Even the quality of systematic reviews of RCTs, considered to be the ultimate form of evidence by the orthodoxy, will be compromised by the bias in favour of positive studies because health treatments will receive exaggerated scores (Moher et al., 1998). The quality of economic evaluations is also dependent on the quality of the clinical data which underpin them (Cohen et al., 2008).

'Complexity and Contradiction in Clinical Trial Research', Ralph Horwitz examined 200 RCTs on 36 topics where contradictory results had been reported. These had been put down to methodological deficiencies of the trials or the size of the sample sizes. Yet Horwitz found that many of the contradictory results were not down to methodological deficiencies, but rather the complexity of healthcare itself. Often, slightly different treatments were admitted or different outcomes were analysed. Furthermore, some trials had different eligibility criteria and patients could have different characteristics and states of health. Contradictory results therefore had little to do with methodological rigour but reflect the complex reality of treatments in healthcare. For Horwitz, this implies the need for "enhanced flexibility" when interpreting and applying data from RCTs to ensure its clinical relevance and applicability (Horwitz, 1987).

The implications of Horwitz's research for EBM are quite profound. Even assuming that the best evidence is available, clinical guidelines may still promote the wrong treatments due to the idiosyncrasies of each individual case. In healthcare, treatments combine with a host of factors which ensure that outcomes are always to a certain unpredictable:

...there is uncertainty as to whether any benefits gained (in experiments) can be extrapolated to 'usual' patients (of all ages, both genders, differing severity of disease, having diverse risk factors, assorted co-morbidities or varied socio-economic status) (Blackwood, 2010: 513)

This does not necessarily entail a rejection of Evidence-Based Medicine but necessitates flexibility in the design of clinical guidelines and certainly performance management protocols, which risks closing down the scope for professional judgement. Nawab Qizilbash praises the evidence-based medicine movement where it supports professionals, but highlights the "grey zones of practice" where the evidence is incomplete, contradictory or irrelevant to specific cases. Under such circumstances, there is no substitute for clinical reasoning, with its "reliance on experience, analogy and extrapolation" (Qizilbash et al., 2008: 5; see also Groopman, 2001; Head, 2005; Meldrum, 2000)⁵⁶.

Where these concerns mostly relate to the extrapolation of research findings from clinical trials to practical environments, there is also some relevant methodological debate regarding 'preventative medicine'. Indeed, with the development of medical knowledge, medical advances no longer entail the eradication of diseases, or even significant advances in their management, as with the case of insulin for diabetes or

⁵⁶ In philosophical terms, these arguments resonate with realist criticisms of positivist understandings of science. Realists emphasise the artificial nature of scientific experimentation and the simplicity of positivist conceptions of causality, which proceed along the lines of David Hume's law: A caused B so when A occurs B occurs. For realists, scientific experiments are akin to "closed systems" which enable researchers to control and manipulate variables in order to establish cause/effect relationships. Yet these relationships may not arise in the "open systems" of the real world because additional mechanisms can complicate them, preventing the cause from activating the effect. For realists, scientific hypotheses that have been verified in experiments do not pertain to positivist laws but refer to tendencies which may or may not occur in the real world (Bhaskar, 2008).

antiretroviral therapy for HIV. Increasingly, preventative medicine is advocated in order to identify and manage conditions and diseases in their infancy. Proponents argue the approach will improve health outcomes and save money in the context of increasing lifestyle conditions and an aging populations (Russell, 1993).

However, critics argue that medical care is reaching a nadir. The only new therapies are pharmacological therapies which are replacement treatments, with clinical trials evaluating which treatment out of different treatments (as with the case of head-to-head studies), or which combination of treatments, produces minor health gains. Only marginal gains can be expected in the prevention and management of conditions, in what is a “near saturated therapeutic field” (Greenhalgh et al., 2014: 2).

There are two versions of this criticism. Advocates of ‘holistic’ care, discussed in more detail below, argue that the so-called ‘biomedical model’ of healthcare has become a victim of its own success, prompting the need for alternative forms of care (Duerden et al., 2013). But some medical professionals are also critical of the use of drugs in preventative medicine. Writing from a medical perspective, Dr David Sackett criticises what he calls the “arrogance of preventative medicine” which has as its target “symptomless individuals”. This, according to Sackett, is entirely different to “curative” medicine which is delivered to “symptomatic patients who seek healthcare”:

...the 2 disciplines are absolutely and fundamentally different in their obligations and implied promises to the individuals whose lives they modify (Sackett, 2002: 363)

A key controversy over preventative medicine is the use of increasingly precise outcome measures in clinical trials. Health interventions can be evaluated across a range of health outcomes, including the so-called ‘hard endpoints’ of mortality and survival rates, as well as the more precise and detailed measures of disease-specific outcomes and clinical effects. An even more precise measure of outcome is biomarkers or *surrogate* outcome measures, which are risk factors for complications. The rise of long-term conditions has meant that surrogate outcomes are increasingly central to healthcare: examples include cholesterol levels in heart disease, blood pressure levels in hypertension and blood glucose levels in diabetes.

In preventative medicine, treatments are often evaluated in terms of their effects on surrogate outcomes alone. It is argued that evaluations across ‘hard endpoints’ are unnecessary, taking many years to complete at great cost and ultimately resulting in poor quality health care because existing and less effective drugs and treatments will continue to be prescribed. Furthermore, many drugs – particularly those developed from older generations of drugs – have a well-established molecular structure and mechanism of action. With a clear theoretical understanding of the causal chain between intervention and health gains in the long-term, it is less important for clinical trials to evaluate treatments in terms of hard endpoints and researchers can instead focus on disease-specific outcomes and ‘surrogate’ outcomes (Burzykowski et al., 2006: 4; Cohn, 2004).

However, the evaluation of treatments in terms of surrogate outcomes alone has caused significant controversy amongst the medical profession for the simple reason that improvements across surrogates do not necessarily translate into improved health outcomes. Some drugs and treatments that improve surrogate outcomes are poorly correlated with actual health outcomes, even detrimental to them (D'Agostino, 2000; Fleming and DeMets, 1996; Psaty et al., 1999). There have been some high profile cases where drugs have been approved on the basis of surrogate evaluations alone, only to be withdrawn from the market when subsequent research has shown them to be harmful (box 1).

Box 1 – The Use of Surrogates in Medical Research

| Drug | Outcomes |
|--------------------|---|
| Estrogen-progestin | Initially marketed as a preventative drug for coronary heart disease (CHD) amongst postmenopausal women because of its positive effect on lipoprotein levels – a surrogate for CHD – a subsequent research trial found that the drug did not reduce coronary events in the long-term and increased thromboembolic events and gallbladder disease (Hulley et al., 1998). |
| Doxazosin | Doxazosin was marketed as a possible solution for hypertension because of its capacity to lower blood pressure levels. But a subsequent research trial linked the drug to increased stroke and cardiovascular disease (Psaty and Pahor, 2000). |
| Rosiglitazone | Rosiglitazone was marketed for the use in Type 2 diabetes because of its capacity to reduce HbA1c – a measure of blood glucose which is a surrogate for diabetes complications. However, the drug was banned in Europe and limited in the US when a subsequent research trial linked it to increased cardiovascular mortality (Nissen and Wolski, 2007). |

The criticism of the use of surrogates is not restricted to health technology research but is also relevant to their use in the commercial marketing of drugs and performance management protocols, where they are increasingly used as indicators of health service outcomes and influence the remuneration of health professionals (Greenhalgh, 1997; Weston, 2008). The issue is a central controversy in diabetes care where blood glucose is used in the evaluation of policy at all levels of decision-making, as discussed in the next chapter.

The Progressive/Holistic Frame

The ‘progressive’ and ‘holistic’ frames are also present in the debate on the quality of health technology research in general and the use of pharmacological therapies in particular. Part of the problem with pharmacological therapies is that drugs are approved for treatment for singular conditions and diseases, both in terms of their

cost and health effects. But the effects of different combinations of drugs are rarely evaluated, either scientifically or economically. In the context of aging populations and comorbidities, which are increasingly the norm, the result is polypharmacy, whereby individuals are provided with multiple drugs for the different conditions they have. But drugs have side-effects and these are likely to increase when multiple drugs are used, resulting in health complications and increased cost (Duerden et al., 2013; Munger, 2010).

While this would imply that dominant forms of appraisal overstate the value of pharmacological therapies, advocates of 'holistic' care argue that lifestyle interventions, such as diet and exercise, Alternative and Complementary Medicine (CAM) and holistic forms of public health are disadvantaged by dominant forms of economic and scientific appraisal.

Part of the problem is that medical research side-lines patient expectations and experiences of care. In scientific experiments, 'blinding' procedures seek to reduce the impact of patient expectations because patients do not know if they are taking a drug or a placebo. Placebos, for their part, are deployed negatively, as a stand in for no-effect (Gensini et al., 2005). Additionally, scientific experiments are standardised in order to control the effects of atypical patient characteristics, doctor-patient relationships and medical environments, such that outcomes can be attributed to treatments alone.

Yet these factors have a significant effect on treatment outcomes. How people perceive their treatments significantly effects how they respond, both psychologically and physiologically (Barrett et al., 2006: 181). Holistic interventions such as diet and exercise required significant input from patients. While highly motivated people can significantly change around their obesity and Type 2 diabetes through diet and exercise alone, scientific forms of evaluation will not pick up upon this because they are designed to factor out the subjectivity of patients. Additionally, the emphasis on quantification will not capture the full benefits of holistic interventions between outcomes are "often indirect and may be intangible":

This would include, for example, fulfilling one's potential in life, and increasing personal confidence and self-esteem. Qualitative research with patients who have used some form of CAM suggests that they may experience an array of less tangible benefits, such as a sense of personal empowerment, greater control of one's condition, enhanced 'energy' and opportunities to explore a broader range of 'causes' of ill health. Such aspects of health gain are harder to capture through quantitative measures (Hollinghurst et al., 2008: 48)⁵⁷

⁵⁷ Alternative methods have been developed, called "pragmatic trials". These combine quantitative and qualitative methods and explore what works, under what circumstances and for different types of people, in accordance with a broad range of criteria (Norquist et al., 1999).

A similar debate is apparent in public health. The field itself is divided into 'medical' public health and 'holistic' public health. Marni Sommer and colleagues describe a 100 year "struggle to define the mandate for public health – a struggle that has consumed the field since the early years of the twentieth century" and which poses a question of method: "the question of whether public health, as a science, can also promote fundamental social, economic and political reforms" (Sommer and Parker, 2013: 21). For adherents of 'medical' public health, interventions must be clearly evidence-based and have a clear impact on individuals' health. Broader forms of public health intervention purportedly "stray too far from sober assessment of scientific facts and runs the risk of constituting naked political advocacy", which ultimately undermines the credibility of the profession and its influence over policy (Goldberg, 2012; see also Rothstein, 2002).

For adherents of 'holistic' public health, in contrast, the turn to science has resulted in a retreat from political issues which affect health, such as poverty, inequality, sexism and racism (Fairchild et al., 2010: 58). Furthermore, health is affected by a range of "physical, social, cultural and historical aspects of context" (McLaren and Hawe, 2005). To tackle these factors requires multiple interventions, but RCTs are unable to accommodate this complexity and ultimately reinforce an individual approach (Baum, 1998).

The criticisms of Evidence-Based Medicine and in particular health technology research presented in this chapter are significant because they suggest that medical and policy decisions may be distorted to the extent that they rely on evidence alone. The 'political' frame emphasises the incentives which pharmaceuticals have in withholding negative trial data and only publishing data which paints their products in a positive light. In different ways, the 'medical-professional' frame and 'progressive' frame question the capacity of dominant methods of evaluation to provide a fair and comprehensive evaluation of all policy options. There is widespread concern that pharmacological therapies are overused in contemporary medical practice and part of the problem appears to be dominant forms of scientific and economic evaluation. Professor George Lewith has argued that the dominance of Evidence-Based Medicine represents an "institutional bias" in the NHS in favour of pharmacological therapy (HC, 2013: 4; see also Jenkins, 2001).

3.1 Debates in Health Services Research

The significant problems with dominant approaches to health technology appraisal underline the importance of in-depth qualitative research into stakeholders' framings of the choices between different policy options, services and treatments available at a local level. But the level of detail that is required is lacking in health technology research and health services research also does not address this question of the appropriateness of interventions; rather, it assumes that the content of clinical guidelines and performance management protocols have been defined correctly. In what follows, I explore evaluations in health services research of clinical guidelines and performance management.

3.2 The Evidence on Clinical Guidance

One strand of evaluations in health services research is 'Translation Science' or 'Implementation Science' which compares the activities of health professionals, healthcare organisations and even entire health systems with the best practices embedded in clinical guidelines. This purportedly enables the identification of variations or "evidence-practice gaps" which expose healthcare systems to "unnecessary expenditure resulting in significant opportunity costs" (Grimshaw et al., 2012: 1; see also Grol, 2001). Thus, Trevor Sheldon and colleagues evaluate the impact of NICE guidance through a prospective observational study which is entirely process-based, focusing on the quality of prescribing before and after their publication (Sheldon et al., 2004). The NICE website itself includes an entire section on similar 'implementation reports', including research carried out by NICE and stakeholder organisations that assess compliance with NICE guidelines and health technology evaluations (HSCIC, 2013; RCS, 2013).

Overwhelmingly, the literature paints a positive view of clinical governance. Clinical guidelines in particular appear to be a useful policy tool to enhance the performance of individual practitioners and healthcare organisations. However, it is recognised that for guidelines to be implemented they need to be appropriately funded (such that implementers do not incur costs), clearly evidence-based and resonate with the views of health professionals on the ground (Grimshaw and Russell, 1993; Grimshaw, 2004; Scott, 2007). Yet there is scope to explore *why* health professions do not always implement guidelines. That the views of professionals can conflict with central guidelines prompts questions regarding the precise definition of the guidelines. A more in-depth analysis of stakeholders' frames at a local level is required as a complement to these largely quantitative studies, particularly when considering the limitations of health technology appraisal discussed above.

3.3 The Evidence on Performance Management

Similarly, evaluations of performance management are generally positive of its potential to improve the performance of health services. Nicholas Mays provides a comprehensive evaluation of performance management in England and observes a consensus that the approach can improve performance, provided certain conditions are met:

(M)ost experts in performance improvement in public services argue that carefully chosen, incentivised targets are a useful part of the performance management repertoire when used well (e.g. when sanctions and rewards are proportionate) since they can focus organisations positively on the goals of government (Mays, 2006: 2)

Interestingly, this extends to both process and outcome measures (Mays, 2006: 21), suggesting that criticisms of process-oriented performance management of the Conservative Party may be misplaced.

The caveat that performance management indicators have to be “carefully chosen” highlights the epistemological challenge of acquiring the requisite information to define the indicators. As has been noted previously, there is a significant literature on the unintended and undesirable consequences of performance management in health services research (Bevan and Hood, 2006; Hood, 2006; Ann et al., 2009; Propper et al., 2008). Yet even here the emphasis is on refining the approach rather than rejecting it outright (Bevan and Hood, 2006: 533), suggesting the epistemological challenge is not insurmountable.

Nevertheless, given that indicators may not always be appropriate, detailed empirical research is required to establish whether the correct indicators have been chosen. This is more important than in the case of clinical guidelines. For performance management is linked to incentives such that professionals can be financially penalised for working in the interests of patients if policymakers have selected an inappropriate indicator. Yet the quantitative, x-efficiency forms of evaluation do not provide a level of detail that is required to address this question of the appropriateness of performance indicators.

An example of this issue is provided by Melanie Calvert and colleagues, who evaluate the Quality and Outcomes Framework (QOF)⁵⁸. In a retrospective study, Calvert and colleagues evaluate the QOF by assessing its impact on the quality of diabetes services, where data is available on various activities, processes and ‘surrogate’ outcome measures related to diabetes care: most notably, checks for blood glucose and achievement on blood glucose levels (a ‘surrogate’ outcome, for reductions in blood glucose are assumed to translate into health gain). The initiative is found to have had a positive impact, producing gains across these process and intermediate outcome measures (Calvert et al., 2009).

However, the performance measures included in the study are precisely the measures contained within the QOF. While it appears the QOF was successful in achieving the implementation of the chosen indicators, it remains to be seen whether they are appropriate and whether they have actually contributed to health outcomes. Indeed, as discussed in the case study chapter, the use of blood glucose as a surrogate outcome measure in diabetes care is highly contested, with some arguing that targeted glucose control puts patients at risk (Richter et al., 2011). The issue arises in other areas of performance management. A central performance indicator in secondary care is waiting lists. Waiting lists perform a major function in publicly funded health services in which access is rationed on the basis of queues rather than ability to pay. They provide information about who has been waiting and for how long. This could potentially be used to support local decision-making:

⁵⁸ The QOF is a performance management initiative introduced by New Labour which includes a number of performance indicators in different disease and condition areas. The initiative continues to provide GP practices with a significant proportion of their resources.

in combination with information on patient need, health professionals might draw upon the information to decide across a variety of medical and patient-oriented criteria (experience, responsiveness, etc.) who is to be treated and when (Edwards et al., 2003). Yet the use of waiting lists as a performance management indicator closes down the scope for the exercise of professional judgement in this way. Waiting lists alone are assumed to indicate performance, but this potentially compromises other dimensions of quality (Bradfield, 2008).

Evaluations of the use of waiting times in performance management are overwhelmingly positive. Devolution in the UK provided researchers with a natural experiment to evaluate the effects of targets: post-1997 all nations suspended marketisation policies, but policymakers in Scotland and Wales sought to enhance performance through partnership working and England adopted a regime of targets. With data on waiting times and other aspects of performance collected by all nations, researchers have been able to deploy econometric techniques in retrospective studies to explore relationships between the different policy approaches and performance across the UK. These studies suggest that targets are an effective policy tool to reduce waiting times (Alvarez-Rosete et al., 2005; Besley et al., 2009; Hauck and Street, 2007; Propper et al., 2008). Striking differences reductions in waiting times are reported across the home nations, which declined dramatically in England between 1996 and 2002 but not in other nations, even though all had a similar increases in expenditures (Alvarez-Rosete et al., 2005).

The use of comparative methods in this context, where such different policy tools have been used in what was once a UK-wide service, potentially overcomes the problem of causation in health services research: improvements in waiting times in England can be reasonably put down to targets because improvements were not forthcoming in the countries which did not adopt them. Nevertheless, there remain issues to consider with the studies. As with any form of retrospective study, it is possible that researchers have selected and analysed data in ways which favour their view of the policy. Still, this may not be as much of an issue as it is with evaluations of marketisation policies, which are far more controversial and where retrospective studies have been fiercely criticised in public and political debate (see below).

A key issue is whether quantitative evaluations of governance, which rely upon performance management data, will accurately capture performance. There is the possibility that local actors may have engaged in 'gaming' and have manipulated performance data, thus exaggerating performance levels. Gwyn Bevan and Christopher Hood find a number of discrepancies between official data sets and patient surveys: in 2002/03, official data sets suggest that 90% of patients were seen in less than four hours in 139 out of 158 acute trusts, but only 69% of patients actually reported that experience. The same level of discrepancy was recorded the following year, implying that at least some of the reported improvement in waiting times is down to manipulated data rather than service improvements (Bevan and Hood, 2006: 529).

Furthermore, quantitative approaches are unlikely to pick up any unintended and undesirable consequences which arise in the actual delivery of care. Indeed, one target required that all patients were seen within four hours of admittance into A&E Departments. There are reports this resulted in long queues outside of hospitals, with patients admitted only when hospitals were confident the target could be met, and ultimately poor quality care due to delays in response times to seriously ill cases (Bevan and Hood, 2006: 530). This issue underlines the importance of considering local stakeholder appraisals of the effects of the overall incentive environment in order to ascertain the full impacts of policy and the choices and trade-offs involved in its implementation.

3.4 The Evidence on Marketisation

The creation of a marketised system of healthcare has been accompanied with fierce public, political and professional debate, indeed more so than clinical governance and performance management. The past thirty years has seen the introduction of the purchaser-provider split, the use of market contracting and prices, competition within the health service and increasing use of the private sector. The current section explores the evidence on these market-oriented reforms.

To date, an extensive array of evaluations has been carried out on the different dimensions of the reforms. Though there is far too many to explore in any detail, a number of literature reviews are available which collate, evaluate and summarise the vast amount of material that is available. These reach remarkably similar conclusions. Reviews of the 'internal market' found that neither the predictions of pro-market commentators nor the concerns of their critics appear to be substantiated by the evidence: equity was not compromised and market failures did not appear on a grand scale despite the introduction of economic incentives into the system. Yet neither were the expected efficiency gains forthcoming; productivity remained broadly similar and health services were not transformed. Furthermore, any efficiency gains that did arise have to be set aside an increase in administrative costs involved in setting up and managing the market, i.e. transaction costs (Le Grand, 1998; Mays et al., 2000).

Likewise, the King's Fund review of New Labour's market reforms concluded that the most obvious "negative effects" predicted by critics had not materialised but there had only been a "small, sometimes imperceptible, impact in the desired directions" (Dixon et al., 2011: 159). Other reviews are more damning, suggesting that New Labour's market reforms resulted in a deterioration in the non-quantifiable aspects of performance alongside unprecedented increases in resources (Paton, 2014: 3; Fotaki et al., 2013). A literature review carried out of the entirety of market reforms by the think-tank Civitas concluded with the observation that the NHS may have found itself in a "lose-lose situation": "taking on the extra costs of competition without yet experiencing the benefits" (Brereton and Vasoodaven, 2010: 10).

Despite this ambiguous picture, some evidenced emerged during the passage of the Health and Social Care Act which suggested marketisation had improved the performance of the health service. During the Act's passage, Zack Cooper and colleagues at the London School of Economics published a working paper (Cooper et al., 2012) and a commentary piece (Cooper, 2012) which summarised a number of studies which purportedly demonstrated that New Labour's market reforms had improved performance across a range of criteria. Conservative politicians repeatedly cited the findings of the research, with the Prime Minister stating that "competition is one way we can make things work better for patients. This isn't ideological theory. A study published by the London School of Economics found hospitals in areas with more choice had lower death rates" (Greener et al., 2012). Yet the studies proved highly controversial and there is reason to be cautious when interpreting the findings.

Cooper and colleagues develop economic models based upon data collected in practical medical settings, a form of retrospective observational study. One issue with retrospective studies is that the terms of the study are not defined prospectively, resulting in a lack of transparency. On a topic as controversial and contested as the marketisation of the NHS, this lack of transparency is problematic because there is the possibility that researchers have selected and analysed data in a way which supports their preferred reading of the problem. Even assuming benevolence on behalf of the researchers, research findings are likely to be accepted or rejected along partisan lines. Critics of government policy did indeed claim that Cooper and colleagues had engaged in "data dredging": selecting and manipulating data until a case could be made for marketisation (Pollock et al., 2011b).

A further issue is the question of whether economic modelling is sufficient to assign causality in complex policy environments. Evaluations of performance management were gifted with a natural experiment whereby previously homogenous health systems diverged, with England alone adopting targets. Evaluations of New Labour's market reforms do not enjoy such a clear point of comparison. The Cooper studies suggest that marketisation has improved efficiency, equity and quality (in terms of mortality rates). Yet there is a danger that relationships between the changes to governance and the indicators are statistical rather than causal. The Cooper study on equity does recognise difficulties in assigning causality, noting that attributing the results to a particular reform – whether patient choice, provider competition or expanded capacity – is "impossible"; what can only be said for certain was that the combination of New Labour's reforms did not harm equity (Cooper et al., 2009). Elsewhere, Cooper sites another policy tool that might have caused the outcome: New Labour's use of targets (Cooper, 2012: 3). Yet these significant caveats are only briefly noted in the commentary piece which makes a case for a significantly enhanced role for markets in the health system and was referred to by politicians with that objective in mind.

Similar concerns can be made about the Cooper study on quality. There, choice and competition policy was evaluated in terms of its impact on 30-day mortality rates for patients diagnosed with an acute myocardial infarction (AMI). This is potentially significant because it goes beyond the process-orientation of much of the literature to evaluate the effect of the governance change on actual health outcomes. The study adopts a “cross-sectional” approach which compares the AMI rates of hospitals in areas with high numbers of providers relative to areas with fewer numbers of providers. This should enable the authors to assign causality because different areas experience different levels of competition but all areas are affected by targets and extended capacity. If improvements can be identified in areas with high numbers of providers – and thus competition is high – they can be reasonably attributed to choice and competition policy (Cooper et al, 2011: 229).

However, once again, the study does not explore whether the reforms had actually facilitated patient choice or altered the destination of patients. Other studies have shown that patient choice was limited under New Labour’s reforms. Many patients were not offered choice at all and those who were often chose on the basis of advice from their GPs, which would suggest that the influence of patient choice as a factor influencing performance is limited (Clarke et al., 2007). Furthermore, people who are suffering from a heart attack are not offered choice such that improvements in AMI mortality rates are likely to be unrelated to choice and competition policy (Mordoh, 2011: 30). The then tsar of cardiovascular conditions, Sir Roger Boyle, called the choice of AMI rates “bizarre”:

AMI is a medical emergency: patients can’t choose where to have their heart attack or where to be treated. It is bizarre to choose a condition where choice by consumer can have virtually no effect (Greener et al., 2012)

In their criticism of the study, Allyson Pollock and colleagues identify an alternative factor which may have produced the reported improvement in areas with high numbers of provider. During the study period, the medical treatment ‘Percutaneous Coronary Intervention’ was introduced which has better outcomes than previous treatments. This new medical technology requires specialist input and is therefore more prevalent in urban areas where there is more specialist expertise. Urban areas are also the areas with high numbers of providers. This uneven distribution of skills and new medical technologies may account for the statistical association between competition and improvements in AMI mortality rates (Pollock et al., 2011b). Clearly, there are strong reasons to be cautious when interpreting the Cooper study as evidence for the effectiveness of marketisation.

Further issues arise due to the quantitative nature of the studies. Even assuming that the performance of hospitals has improved across these criteria, there remains a question-mark over the wider effects of the introduction of economic incentives. Some critics claim the creation of Foundation Trusts has frustrated collaboration within local health economies, as hospitals operate in accordance with their own financial interests (Ham and Smith, 2010). Additionally, there is need to consider

the effects of marketisation on wider relevant values, such as patient-centred criteria and universalism.

The Cooper studies do feature patient choice and equity, which are said to have improved following New Labour's reforms. The study on equity, for instance, claims that competition incentivises professionals to be more responsive to all patients:

What choice does is level the playing field – even in systems with no choice people who can navigate the system finds ways to do this. Introducing choice offers more opportunities to those who were excluded from this (Cooper, 2012: 4)

However, as we saw in the previous section, the appropriateness of patient choice is contested as a value and some studies suggest that patient choice of provider is a relatively unimportant criterion for service-users: choices tend to be made on the basis of geography rather than quality of care and some patients do like the option of choice, preferring instead to rely on professional judgement (Clarke et al., 2007; Needham, 2007). Additionally, there is a question-mark over the operationalisation of the value of equity in the study.

Indeed, prior to New Labour's reforms, the study suggests that waiting times for three elective operations – hip and knee replacements and cataract repair – was positively related to deprivation: in 1997 people from lower socio-economic groups had a longer wait than people from higher socio-economic groups. By 2007 the relationship was less pronounced and in some case patients from the most deprived percentile were waiting less time than patients from the most advantaged percentile. The findings, according to Cooper, demonstrated that those who had "feared" New Labour's reforms would "lead to inequity" were proved wrong; for, "if anything, it had decreased" (Cooper et al., 2009: 1).

However, while access to basic, elective surgery is important in any health service, the debate at a political level concerns the objective associated with the NHS to provide comprehensive healthcare over the life course, free-at-the-point-of-use. It remains to be seen whether marketisation does or does not compromise this fundamental objective of the health service.

3.5 Transaction Costs: The Economic Case for Public Health Systems

An additional weakness of x-efficiency studies of this sort is that they do not consider the wider costs of administering market mechanisms in the health service. Indeed, this issue of transaction costs is a major source of contention in debates on the NHS. Adherents of the 'political' frame identify possible savings from transaction costs in their case for an entirely public sector health service. The evidence on transaction costs suggests that public health systems are more efficient than market health systems. Analysis of OECD data by George Schieber and Jean-Pierre Poullier shows that in 1987, prior to the introduction of the 'internal market', the UK had one of the lowest expenditures on healthcare in the

OECD (19th out of 22) at 6.1% of GDP. Furthermore, the country had one of the highest public health expenditures (4th out of 22). In comparison, the US had the highest expenditure (1st out of 22) at 11.2% and the lowest public health expenditure (22nd out of 22). Yet on outcome measures such as infant mortality and life expectancy the systems performed at a similar level (Schieber and Poullier, 1989). More up-to-date analysis reveals a similar picture, putting the NHS first in terms of cost-effectiveness relative to both the US and mixed private and public systems in Germany and France (Pritchard and Wallace, 2011).

The full extent of transaction costs under market systems is revealed in studies in the US, where the issue features in political debates regarding the relative benefits of public and private systems. Steffie Woolhandler and colleagues compare the transaction costs of the American system, characterised by multiple payers (the government, employers, insurance companies and individuals) and a mixture of providers (both public and private), with the Canadian system, characterised by a single payer (the government) and a mixture of providers. In the US, administrative costs amounted to a total of \$294.3 billion in the United States in 1999, accounting for 31 percent of all health care expenditures. In Canada, the comparative figures were \$9.4 billion and 16.7 percent respectively (Woolhandler et al., 2003: 772).

There is clearly a strong economic case for public health systems, which is interesting given that efficiency is also a core value of the 'market' frame. It is possible that two sources of efficiency exist: a market-based one that achieves efficiency through competition and a public sector-based one which achieves efficiency through rational planning and savings on transactions costs. Whereas marketisation results in streamlined organisations, public administration appears to improve the efficiency of the system as a whole.

That there is a strong economic case for public health systems is significant in light of current efforts to achieve efficiency savings. Adherents of the 'political' frame have consistently argued that inefficiencies in the health service are down to the marketisation of the health service. Administration costs under the original model were between 4 and 6% (Pollock, 2005: 30). Studies suggest that such costs have increased during the process of market reform (Tuohy, 1999: 171; Marini and Street, 2007). Yet the Department of Health does not collect comprehensive data on the issue, prompting a recent Health Committee inquiry to allege that the Department is deliberately obscuring the costs of market contracting:

We are dismayed that the Department has not provided us with clear and consistent data on transaction costs; the suspicion must remain that the DH does not want the full story to be revealed. We were appalled that four of the most senior civil servants in the Department of Health were unable to give us accurate figures for staffing levels and costs dedicated to commissioning and billing in PCTs and provider NHS Trusts (Health Committee, 2011: 3)

Nevertheless, given the links between marketisation and increased transaction costs, there is a clear danger that transaction costs will continue to increase under

the Government's current reforms, which create an even greater number of commissioning and provider organisations (chapter 7). The costs of marketisation, coupled with pressures to achieve efficiency savings, make it likely that the amount of services available on the NHS will decline. Some commentators observe a trend towards a two-tier health system, involving basic coverage for all while access to the highest quality of care is rationed via the market (Cortez, 2008; Fotaki, 2007).

This is clearly significant because it suggests that marketisation is incompatible with universal and comprehensive coverage, suggesting a significant trade-off is apparent in the choices made at the level of governance. Nevertheless, while the on-going development of the market system may well compromise the performance of the health service relative to these criteria, it remains to be seen whether public health systems perform across other criteria. In different ways, the 'market', 'managerialist' and 'progressive' criticise outright public administration. Part of the problem appears to be the power and influence which public administration in healthcare has historically afforded the medical profession (Light, 2003). It might be the case that marketisation, while increasing administrative costs and thus inefficiency, may bring about gains across other criteria such as accountability (Donaldson, 1998) and the responsiveness of services to patients (Danzon, 1992; Gauthier et al., 1992).

Indeed, though marketisation may well increase transaction costs, it may also have produced other benefits. Increases in transaction costs should not be dismissed out-of-hand because "some administrative effort is required and desirable in a well-functioning system" (Kahn et al., 2005: 1630). Ultimately, more detailed research is required to explore the performance of the health service across multiple criteria.

3.6 Theoretically-Informed and Qualitative Research

Besides the quantitative research explored up to now, there is a range of theoretically-informed and case study research which engages with this question of the appropriate role of markets in the health service. Much of this research focuses on the 'motivational problem' in public policy and is polarised into public choice and institutionalist variants which reach very different conclusions.

During the mid-1980s, a highly influential piece was published by the American academic Alan Enthoven. Enthoven identified a number of skewed incentives which arise in the absence of market mechanisms: consultants and GPs, he wrote, are "politically powerful and have no desire to yield their autonomy", nurses and other staff are "heavily unionised" and paid on the basis of national agreements, citizens fight to save local services despite this being counter the "public interest" and politicians face "powerful disincentives" to bring about service improvements because gains will not be immediately forthcoming. Furthermore, individuals and organisations have no incentive to work efficiently but are penalised for doing so. Hospitals which performed highly receive greater numbers of patients such that

inefficiencies are inevitable because poor performers are not punished and high performers are not rewarded:

In a rational economic model, those whose quality of service attracts more patients would get paid (for doing the extra work) a negotiated amount that they agree makes the effort worthwhile (Enthoven, 1985: 14)

Other analysts have applied a similar approach. Carol Propper, in her analysis of the incentives facilitated by the 'internal market', argued that efficiency remained elusive because providers do not have a financial stake in their performance and patients do not have the requisite information or power to make informed choices (Propper, 1995). Similarly, Peter Smith identified issues with the "gate keeping" model, whereby care is rationed through waiting lists and GPs refer patients to specialists. The model purportedly fails to provide GPs with an incentive to make cost conscious decisions or respond to increases in waiting lists (Smith, 2000).

These accounts highlight potential sources of inefficiencies which arise in the absence of market incentives. While the original model may have saved on transaction costs, it appears to have been rife with inefficiency. By implication, mimicking market mechanisms may improve its performance, in keeping with the 'market' frame. Nevertheless, as a form of governance evaluation, these studies are problematic because they proceed by highlighting the absence of economic incentives on the assumption that it must translate into inefficiency. This approach has a "speculative flavour", as Propper concedes (Propper, 1995).

A very different perspective is provided by qualitative research informed by institutional economics. An ESRC research programme in 1995 on contracts and markets in the NHS produced a plethora of studies and published articles (Glennister, 1997) and the research has continued into the 2000s at the London School of Hygiene⁵⁹.

Overwhelmingly, this research is critical of the use of markets in the health service, suggesting they exacerbate motivational issues. In an early study of community services, Rob Flynn and colleagues provided extensive empirical detail regarding the difficulties involved in introducing market mechanisms into the health service. The purchaser/provider split severed links between 'planners' and professionals who had previously collaborated, shared knowledge and worked out together what should be provided and how. The complexity and uncertainties of healthcare were managed through 'clan-like' relationships. But the 'internal market' severed relationships between individuals and organisations, creating an 'us' and 'them' mentality (Flynn et al., 1996). Similarly, research by Pauline Allen found that the contracts were often incomplete, with health professionals providing discretionary

⁵⁹ This literature is similar to the extensive research carried out in HR and organisation psychology, which emphasises the importance to performance of organisational culture and values (Scott et al., 2003). But, unlike the HR literature, the focus is on the effect of broader social structures through qualitative research into local interpretations and perceptions of national policies and their implications for performance (Jones et al., 2013).

effort beyond contractual obligations, despite the corresponding belief of 'purchasers' that contracts were complete (Allen et al., 2002; see also Ferlie, 1994).

The greater use of market contracts and economic incentives may have a negative impact on performance because it is possible that collaboration, trust and pro-social motivation decline. Yet it is also anticipated that health professionals react in unpredictable ways to marketisation. David Hughes and colleagues apply Karl Polanyi's concept of the "double movement" which predicts corrective attempts on behalf of actors exposed to market forces to restore social cohesion and relationships. This is taken to explain a dynamic that has accompanied market reform, whereby health professionals have often worked around market mechanisms and spurned legal requirements to compete in favour of collaboration (Hughes et al., 2013; see also Fougere, 2001; Hughes et al., 2011; Jones et al., 2013; Light, 2001).

As a form of governance evaluation, these studies represent an improvement on public choice analyses of the 'motivational problem'. The studies involve in-depth qualitative research of professional perceptions of the effectiveness of national policies and the overall incentive environment. However, the focus on professional perspectives alone is problematic for other stakeholders, whether patients, managers or national policymakers, will also have insight into the effectiveness of governance and policy that is important to take into account.

Nevertheless, the differences between public choice and institutionalist accounts are stark and point to a fundamental discrepancy in the interpretation of relationships between health professionals. As we saw, marketisation has had an ambiguous impact on the performance of the health service: neither the concerns of the critics nor the predictions of pro-market commentators appear to have proved correct.

A public choice explanation of this ambiguous effect of markets might point to the presence of 'sticky' relationships as a hindrance to the reforms, preventing the full realisation of the benefits of competition. Rather than engage in innovation and reform health services, health professionals have relied upon established ways of working and existing relationships, exacerbating the kinds of government failure identified by pro-market commentators.

However, the institutional research discussed here provides an alternative account of the issue, suggesting it is market reform which is the problem. It is possible that health professionals, guided by professional norms and values, resisted the temptation to engage in the strategic behaviour associated with markets, thus preventing the concerns of the critics from arising. Yet this normatively-guided behaviour, stemming as it does from membership of a wider community and shared understandings of how care should be delivered, may prove a precious resource. Marketisation may compromise it if taken further, severing relationships between professionals and organisations.

The public choice explanation is, of course, the dominant pro-market interpretation of the limited success of marketisation to date and underpins calls for greater market reform. However, as we have seen, the evidence for this position is ambiguous.

4.1 Concluding Remarks

The current chapter has examined the evidence and debate surrounding major policy tools that have been applied to improve the performance of the health service, including Evidence-Based Medicine, performance management and marketisation. It has identified some major issues in the research, including widespread concern with the overuse of pharmacological therapy and a trade-off between marketisation and values of equity, universalism and comprehensive coverage. It has also continued to build a case for a postpositivist evaluation of policy and governance. In the next section, I evaluate the Government's reforms of the health service through a case study of diabetes.

Chapter 9: An Empirical Investigation of Diabetes Governance and Policy

Diabetes is widely regarded as one of the most significant public health challenges of the 21st century (Farooqi, 2012). My purpose in this case study is to evaluate diabetes policy and governance following the Conservative/Coalition Government's reforms set out in the Health and Social Care Act (2011). I utilise the framework set out in chapter 6, which made a case for evaluating governance through a focus on coordination.

The case study is based on in-depth interviews with diabetes stakeholders at different levels of governance and across the diabetes pathway. I analyse the empirical data in terms of 'frames', drawing upon the frames set out in chapter 7. There, I identified key framings of health policy and governance which capture the main dimensions of the debates, including a 'medical' and a 'holistic' frame at the level of policy and a 'market' frame, 'managerialist' frame, 'medical-professional' frame, 'progressive' frame and 'political' frame at the level of governance. Stakeholders often expressed these wider framings in their appraisals of diabetes policy and governance. I identify the frames throughout the analysis and draw out their implications for debates in diabetes. However, I also go beyond typical discourse and frame analysis to explore the nuances and detail of stakeholder frames.

The analysis begins by setting out the Government's diabetes strategy, which is informed by its wider reforms of the health service set out in chapter 7. This serves to identify the values and objectives which the Government has prioritised, as well as the policy strategies and governance approaches that have been selected to realise them. Following that, I explore stakeholder frames at different stages of the policy process, identifying areas of potential and areas of concern, where it appears that values and knowledge are suppressed by current policy and governance arrangements.

Indeed, while my analysis certainly reveals some areas of potential following the reforms, it also reveals some significant 'coordination problems'. One type of problem is failures of centralised forms of decision-making. For example, there is significant concern at a local level over the appropriateness of key targets in public health and primary care, namely mandation of the NHS Health Check and targeted glucose control. Despite the Government's commitment to 'holistic' care, current policy and governance arrangements appear to be facilitating an overly medical approach to diabetes geared towards the control of blood glucose, whether at the level of the population or the individual.

A further type of problem is failures of local decision-making, where attempts to reconfigure local services around primary care have resulted in poor quality care in some areas, resulting in a rise in diabetes-related complications and costly hospital

admissions. Furthermore, specialist posts are on the decline in hospitals despite evidence to suggest they are cost-effective.

A still further type of problem is increases in transaction costs following the Conservative/Coalition Government's recent reforms. Organisational barriers between local authorities and CCGs, as well as CCGs and NHS Hospitals, appear to frustrate collaboration between organisations and work against the development of integrated pathways of care.

Finally, while the reforms enhance the responsiveness of services to patients in some respects, in others they do not. The use of economic incentives in primary care appears to be detrimental to patient trust in GPs, the doctor-patient relationship and patient choice. The methodological approach, involving a detailed exploration of stakeholder frames at different stages of the policy process, has been able to pick up upon these examples of coordination problems.

I conclude by making a case for decentralisation in some areas of policy and centralisation in others. Decentralising decisions over the NHS Health Check and targets for glucose control would provide local actors with more scope to fashion their own solutions to diabetes. However, the Government's creation of CCGs, which involves decentralisation in a market context, appears to frustrate the realisation of values that are widely considered important in healthcare. There is a case for larger organisations which combine commissioning and provisioning functions and which have greater resources and expertise at their disposal.

Section 1 presents the methodology of the chapter, explaining the methods through which I apply the evaluative framework outlined in chapter 6.

Section 2 sets the policy context, introducing the Conservative/Coalition Government's diabetes strategy. I also outline significant criticisms of the Government's strategy voiced by the National Audit Office, the Public Accounts Committee and Diabetes UK, which exhibit aspects of the 'managerialist' frame. This sets the scene for the subsequent inquiry.

Section 3 presents the findings of the frame analysis. I begin by exploring different framings of diabetes at the level of policy. I focus on stakeholder's knowledge of diabetes as a substantive policy problem and how they frame choices between different types of intervention and forms of care. In the process, I identify two policy decisions that are particularly controversial: the mandate of the NHS Health Check and targeted blood glucose control in primary care.

Section 4 then explores framings of diabetes governance in more detail. I focus attention on two central aspects of the Government's reforms: the new public health role assigned to local authorities and the creation of Clinical-Commissioning Groups.

Section 5 revisits the debate over the Government's strategy outlined in section 2 and addresses the core evaluative questions of public sector governance: namely the appropriate balance between centralisation and decentralisation and the use of markets in the provision of diabetes care. I conclude by assessing the methodological approach.

1.1 Methodology

The section utilises the case study method in social research. There are multiple definitions of the case study and a range of approaches exist. Positivist case studies seek to investigate singular aspects of a social event to develop or test explanations that may be generalisable to other events (Levy, 2008: 2; see also George and Bennett, 2005). Alternatively, interpretivist case studies pertain to a larger unit of study and investigate phenomena in real life contexts through a focus on stakeholders' understandings (Zucker, 2009: 2). Of these two options, the approach adopted here corresponds more with the interpretivist case study method, but it also seeks to evaluate different stakeholder viewpoints and quantitative data is drawn upon in the research. Edith Balbach has used the phrase "evaluative case study" to characterise mixed methods approaches to evaluation (Balbach, 1999).

The actual 'unit of analysis' of the research is contemporary diabetes policy and governance. As we saw in chapter 7, the Health and Social Care Act (2011) constituted a major transformation of the health service, having a significant impact on diabetes policy and governance. My purpose in the case study is to evaluate the effectiveness of contemporary diabetes policy and governance following these changes, through in-depth interviews with diabetes stakeholders. Though evaluative case studies are particularly suitable for the evaluation of policy in complex environments (Balbach, 1999: 4), case studies have well-known limitations. The findings of case study research are not generalisable to other cases (Pierce, 2008: 53). In this case, any positive or negative outcomes identified in diabetes may not arise in other health policy areas, such as cancer or cardiovascular disease.

The empirical research involved extensive research and document analysis prior to the interviews, in order to gain some understanding of diabetes and relevant issues and debates around it. Following that, the empirical research included a total of 25 in-depth stakeholder interviews and a number of participant observations at professional events and public meetings/protests, between February 2013 and September 2015. For the interviews, the sampling process involved a combination of opportunistic sampling, by contacting diabetes stakeholders I identified on the internet, nomination and 'snowballing' (Pierce, 2008: 92). The Research & Development Manager of one CCG was able to put me in contact with diabetes stakeholders in a local health economy, while some of my interviewees put me in contact with other stakeholders.

Non-probability sampling of this type poses further problems to generalisation. For it is possible that interviewees are not representative of their respective groups (Pierce, 2008: 93). For this reason, I sought to interview a range of stakeholders, including people from similar backgrounds. Of the different specialist groups in healthcare, I achieved an initial target of four public health professionals, four GPs and four diabetes specialists. Additionally, I spoke to representatives of all the major organisations involved in the diabetes pathway (NHS England, Public Health

England, Monitor, Clinical-Commissioning Groups, local authorities, Foundation Trusts and general practices).

One issue I encountered were barriers to interviewing service-users. In order to carry out research with NHS patients, it is necessary to go through a lengthy accreditation process. Due to time constraints, I opted to interview patient representatives instead, interviewing people from diabetes charities, Diabetes Voice and LINK, an organisation which represents patients. Some of the interviewees (including health professionals and patient representatives) also had diabetes and spoke of their experiences of using NHS services as a service-user.

The theoretical framework for the evaluation has already been set out in detail in chapters 3, 4, 5 and 6. I have argued that to evaluate policy and governance in terms of coordination requires an analysis of multiple stakeholder frames and the values, knowledge and interests contained within them. In the empirical research, I was interested in stakeholders' understanding of the problem of diabetes, their views on the quality of local services and the effectiveness of the overall governance arrangements.

Prior to the interviews, participants were provided with an information sheet and a consent form to sign which was subsequently kept in a secure setting⁶⁰. At the start of each interview, I explained the project and made it clear that I do not have any medical training or experience of the NHS. Often, interviewees discussed complex medical or policy issues which I lacked prior knowledge of and I soon realised that making my relative ignorance of the topics known was important because it made it easier to ask interviewees to explain issues in detail. This proved an effective strategy. Some interviewees appear to enjoy the opportunity of speaking freely about the issues they face. One diabetes specialist consultant, in an interview which lasted 1 hr and 40 minutes, likened the interview to a reverse medical encounter. A further interviewee approved of my approach, making the analogy of my starting position with that of someone newly diagnosed with diabetes:

*You say you have no medical training but I'm sure you are becoming quite an expert. I'm sure you will agree you have the same starting point as those being diagnosed with type 2 diabetes (T2DM), trying to make sense of the condition can be quite difficult!*⁶¹

In the interviews, I wanted to gain as full an understanding of stakeholder perspectives as possible. I adopted the SWOT methodology, asking stakeholders for their analysis of the Strengths, Weaknesses, Opportunities and Threats of current policy and governance arrangements. This unstructured approach was useful because it meant stakeholders often identified issues which I had not countenanced before. But I also had some set questions I developed through my prior reading and document analysis which I asked all stakeholders.

⁶⁰ See Appendix

⁶¹ Health campaigner and researcher, 13/04/2015 (see Appendix)

At the level of policy, I was particularly interested in the appropriate balance between ‘medical’ and ‘holistic’ care and I asked each stakeholder whether they “agree with the statement that the NHS is getting the right balance in diabetes care between lifestyle interventions and medical interventions”. At the level of governance, I was interested in the effectiveness of the Government’s overall strategy, including the various Outcome Frameworks, the key organisational reforms – most notably, the creation of CCGs and the new role for local authorities in the pathway – and the use of markets and the private sector. I was also interested in stakeholder views of the evidence underpinning diabetes policies. As we saw in the previous section, the centrality of Evidence-Based Medicine to decision-making is controversial and this extends into diabetes policy.

Prior to the interviews, I made it clear to all interviewees their names would not be mentioned in research outputs, only their roles in diabetes and/or the type of organisation they work for. Offering anonymity to interviewees in this way has positives and negatives: on the plus side, interviewees might speak out openly about policy problems but a possible negative is that they are no longer publicly accountable for their views and may exaggerate issues in ways which benefit them. Nevertheless, anonymity was a precondition of involvement for some stakeholders and I decided it was necessary to fully anonymise the data for the sake of consistency. Some interviewees were interviewed twice if they were deemed to be particularly important and agreed to a second interview. I also exchange emails with some interviewees to clarify points and ask further questions.

2.1 Policy Context: Decentralisation or Centralisation?

For many commentators, diabetes is the “the disease of our times” (Farooqi, 2012: 286). Terms such as “explosion” (Diabetes UK, 2008), “epidemic” (Lam and LeRoith, 2012) and “national crisis” (Diabetes UK, 2015) are widely used in the discourse. Statistics demonstrate vast increases in the prevalence of the condition. Each year, the diabetes charity Diabetes UK publishes its *‘State of the Nation’* reports which provide detailed analyses of the problem, coupled with policy advice on how best to deal with it (Diabetes UK, 2010; 2011; 2012; 2013; 2014; 2015). The opening sentence of its 2015 report provides a typical warning of the impending epidemic:

If it was announced that a new condition had emerged that was doubling in prevalence every 17 years, and 13 million people were already directly affected or at serious risk, this would be seen as an epidemic and a national crisis (Diabetes UK, 2015: 3)

In diabetes, policymakers, health professionals and health campaigners/charities alike mostly adhere to Diabetes UK’s account of the challenge we face: diabetes is serious, objective, accurately reflected in the statistics and in need of a policy response. Some stakeholders were more critical, arguing the problem has been exaggerated and reflects the ‘medicalisation’ of health problems. Nevertheless, stakeholder frames contained a broadly shared commitment to the health of people with diabetes and were informed by a number of core evaluative criteria, most notably quality of care, access to care, efficiency and responsiveness. Where there is disagreement is over the precise detail of strategies for policy and governance.

The Government’s diabetes strategy is influenced by its wider changes to the health service introduced by the Health and Social Care Act (see chapter 7), involving a revised form of performance management, along with investment and reform in primary care and public health. It is useful to consider the contrast between the Government’s approach and New Labour’s approach, which involved diabetes-specific clinical governance.

1. Steering through the Outcomes Frameworks

A centre piece of the Conservative Party’s approach to the NHS is a revised form of performance management. In diabetes, this marks a change in direction from New Labour’s approach. Under New Labour, the most significant policy driver was the National Service Framework (NSF) for diabetes published in 2001, which set out guidelines and quality standards⁶². This was informed by additional NICE guidance which covers the entire pathway, from public health to primary care to secondary care. Furthermore, major national surveys were commissioned to gain an

⁶² Besides diabetes, there were NSFs for cancer, coronary heart disease, kidney disease, chronic obstructive pulmonary disease, strokes, long-term conditions, mental health and care for old aged people. Each NSF outlined quality standards for these conditions and outlined strategies to achieve them.

understanding of the problem and the quality of NHS services⁶³ and, in 2006, NHS Diabetes was created to aid the implementation of the NSF.

The Conservative/Coalition Government has sought to move away from disease-specific guidance and performance management. A key argument against New Labour's NSFs was that resources were expended on the major 'killers' to the detriment of other areas⁶⁴. While NICE guidance on diabetes and the national diabetes surveys remain, the NSF for diabetes has finished and NHS Diabetes has been incorporated into an organisation attached to NHS England, NHS Improving Quality, whose task it is to improve the health service's performance in general. There are plans to decentralise performance management further by reducing the significance of the New Labour's Quality and Outcomes Framework as a proportion of GP practice income, while also allowing CCGs to develop their own performance management protocols.

While the Outcomes Frameworks are a managerialist mechanism, the emphasis on decentralisation is consistent with a range of the frames introduced in chapter 7, including the 'progressive' frame, 'market' frame and 'medical-professional' frame.

2. Investment and Reform in Public Health

A further dimension to the Conservative's diabetes strategy is increased investment to public health. This is part of a wider shift towards the prevention of conditions and diseases, which is deemed to be particularly important in the context of increases of lifestyle conditions, an aging population and pressures on public expenditures. As part of the package of reforms associated with the Health and Social Care Bill (2011), the Conservative/Coalition government created a new national quango and increased funds to public health, in a response to a perceived neglect of this type of intervention by New Labour. Additionally, local authorities have taken over public health at a local level. The government has also placed a ring fence on local authority public health budgets (in order to prevent local authorities from spending it on other local services) and has mandated certain services, such as sexual health services and the NHS Health Check, a national screening programme for diabetes and other conditions.

Yet it is also anticipated that the new approach will drive a qualitative change in public health. Public health professionals, now operating in local authorities, will be closer to local officials and the communities they serve, enabling the development of local solutions which tackle the economic and social "determinants" of health,

⁶³ The major survey is the annual National Diabetes Audit (NDA) which reports on key indicators from primary and secondary care settings and is the largest annual clinical audit in the world. Additionally, the National Diabetes In-Patient Audit (NaDIA) is carried out by diabetes teams in hospitals on a randomly selected day, providing a snap shot of the quality of diabetes care offered by hospitals.

⁶⁴ Senior policy advisor to New Labour, 28/02/2014

reduce inequalities and facilitate “holistic solutions to health and wellbeing” (DoH, 2011b: 4; see also DoH, 2011a)⁶⁵:

First and foremost, one of the really powerful things about these reforms is bringing GPs into contact with local politicians. I have heard up and down the country of conversations taking place. Very often these people had never met one another and for the first time they are engaging about place and about the needs of people in that place ... We should not underestimate the power of that (O'Brien in PAC, 2012)

This clearly resembles the ‘progressive’ frame, which emphasises the importance of local democratic processes and the involvement of citizens in decisions regarding healthcare. Furthermore, the Government anticipates that its reforms will facilitate a qualitative change in the nature of the services provided by the health service, in ways which reflect the ‘holistic’ frame.

3. Investment and Reform in Primary Care

A further key policy initiative is the development of primary care – a longstanding but as yet unrealised objective of both New Labour and the Conservatives. As the first point of call for patients, GPs are believed to be best placed to design services around their needs and preferences. Furthermore, with an ageing population and the increase in long-term conditions, healthcare is increasingly about the management of conditions in order to prevent complications from arising, further increasing the importance of primary care. The development of primary care, in this context, will improve health outcomes, efficiency (in part through the avoidance of costly hospital admissions) and facilitate more ‘holistic’ and ‘patient-centred’ care. The aim is to embed a principle of “shared decision-making”: “no decision about me without me” (DoH, 2010: 13).

To that end, the new Clinical Commissioning Groups (CCGs) place GPs at the forefront of the commissioning of health services. Additionally, patient choice will be facilitated by the continued expansion of the market in healthcare through the further development of market pricing and increased provider diversity (DoH, 2010: 26). The approach is expected to facilitate the emergence of new forms of care in primary care and reduce the reliance of the health service on secondary care delivered in NHS hospitals.

As with the Government’s reforms to public health, it is anticipated that reforms to primary care will facilitate the development of more holistic forms of healthcare. Furthermore, a key aspect of this is the greater use of market mechanisms which will provide greater choice for patients and improve efficiency, in keeping with the

⁶⁵ This is in keeping with New Labour’s strategy – see “Our Healthier Nation” (DoH, 1998) and “Choosing Health” (DoH, 2004) – and the Wanless Review (Wanless, 2004). Under New Labour, specific attention was also paid to the “postcode lottery” in healthcare which implies people in some areas of the country have access to higher quality services than other areas of the country (Department of Health, 2001).

'market' frame. Nevertheless, the combination of these different policy tools and approaches has proved controversial.

2.2 Initial Concerns

Just after the passage of the Health and Social Care Act, the National Audit Office published a report into diabetes services which criticised the “depressingly poor” state of diabetes care in England, with “low achievement of treatment standards and a high number of avoidable deaths” (NAO, 2012: 8). This prompted a Public Accounts Committee (PAC) inquiry which resulted in an equally damning report (PAC, 2012).

One of the key indicators cited by the NAO was a failure of Primary Care Trusts (PCTs) to deliver the essential services for diabetes patients, outlined in New Labour’s NSF for diabetes in 2001. The NSF outlined 9 key care processes that each individual with diabetes should have as part of an annual check-up (see box 1).

Box 1 – 9 Key Care Processes for Diabetes

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|---|
| Blood glucose level measurement (HbA1c) |
| Blood pressure measurement |
| Cholesterol level measurement |
| Retinal screening |
| Foot and leg check |
| Kidney function testing (urine) |
| Kidney function testing (blood) |
| Weight check |
| Smoking status check |

Source: Department of Health, 2001

Despite the centrality of the 9 key care processes to the NSF and inclusion of many of the indicators in the Quality and Outcomes Framework, the NAO reported poor implementation and a clear ‘postcode lottery’: PCTs ranged from 6 to 69% in completion rates. Furthermore, over the period between 2006 and 2011, there had been a reported increase in “unnecessary complications”: retinopathy increased by 64%, stroke by 87%, kidney failure by 77%, cardiac failure by 104%, angina by 54% and amputations by 46%. The NHS was also said to be failing to prevent or manage the prevalence of diabetes. Only half of the NHS Health Checks expected to be offered in 2011–12 have been offered and a number of Primary Care Trusts (PCTs) in England had not carried out any Checks whatsoever (NAO, 2012). These failings in diabetes services had allegedly resulted in “excess deaths” of up to 24,000 people a year, who need not have died if the condition were managed more effectively (PAC, 2012).

At the time of publication, considerable debate was taking place over why the NHS was performing so poorly and whether the Conservative/Coalition’s strategy would improve the situation. Diabetes UK, NAO and PAC put the poor performance down

to a lack of central coordination and increasing fragmentation at a local level. Diabetes UK in particular has consistently called for diabetes-specific clinical governance, consisting of clinical guidance and incentives. Although New Labour did have an NSF for diabetes, this purportedly failed to improve the quality of diabetes services because it was not incentivised like the other NSFs. Diabetes campaigners voiced concerns that attention may be lost because the Outcomes Frameworks are broader and diabetes is included as just one of many cardiovascular conditions:

We're really worried that within the new systems there's this dilution of very specific issues at the very highest level at the DH and NHS Commissioning Board (NHS England) and that can only have a knock on effect⁶⁶

Diabetes UK also raised concern about the increased use of the private sector across the pathway. Dame Barbara Young, Chief Executive of Diabetes UK, warned of “fragmentation of integrated services and networks of care, as elements are provided by different providers” (Diabetes UK, 2011b). These arguments resonate with the ‘managerialist’ and ‘political’ frames, which emphasise the importance of clear performance standards and public ownership and administration in the delivery of care. They go against the grain of policy which, as we saw, involves performance management through broader Outcomes Frameworks and the greater use of markets.

Yet the interpretation of the poor performance revealed by the NAO and PAC reports offered by Diabetes UK differs markedly from that of other stakeholders. At the inquiry of the PAC, senior policymakers argued against a more specific focus on diabetes, reiterating the core features of the Government’s diabetes strategy. Specific clinical governance was not required because that would skew attention away from other diseases and conditions, while targets of broader health outcomes, though not specific to diabetes, are clearly relevant:

The Outcomes Framework and the improvement areas is a very new idea. We are trying to set a more comprehensive framework that allows for every locality to ask, ‘What is it that we need to address here to reduce avoidable mortality?’ In some localities, the thing that they can do most significantly is to tackle diabetes, but every locality will have diabetes ... I find it very hard to see how it would not be relevant to that fundamental outcome (O'Brien in PAC, 2012)

Sir David Nicholson, in response to a question about what policies would improve the quality of care, health outcomes and efficiency, replied:

We believe that the investment in community, primary care and preventive services needs to be increased and that the amount of money spent on hospital care needs to go down (Nicholson in PAC, 2012)

⁶⁶ Senior representative of advocacy organisation, 22/03/2013

This debate touches upon key evaluative questions of governance, most notably the appropriateness of centralised forms of decision-making and performance management. Similarly, Diabetes UK's concern about the impact of marketisation prompts questions of the appropriate role of markets and the private sector in the provision of care. In what follows, I address these questions through a detailed analysis of stakeholder framings of diabetes policy and governance.

3.1 Investment and Reform in Public Health and Primary Care

While the Government's proposed reforms raise evaluative questions of governance regarding the appropriateness of the proposed Outcomes Frameworks and various organisational reforms, they also touch upon issues of policy. Indeed, a core dimension of the Government's diabetes strategy is greater investment in public health and primary care. The current section explores debates about the appropriateness of different types of intervention and forms of care, although issues of governance also feature.

Among health professionals, there is widespread agreement that the Government's strategy is broadly correct. Preventing people from getting diabetes through public health interventions in the first place, or improving the management of diabetes in primary care, is likely to improve a range of health and economic outcomes. However, there are also some significant criticisms of the strategy. Adherents of the 'market' frame criticise the proposals for the greater regulation of unhealthy food and drink. Additionally, there is extensive debate over the appropriateness of different types of intervention and forms of care. Adherents of the 'holistic' frame criticise the quality of diabetes services, arguing that pharmacological therapies are overused and are detrimental to patients. Among health professionals, there is also some concern over the use of pharmacological therapies which reflects wider debate within the profession regarding the value of preventative medicine (see chapter 7). Despite a purported commitment to 'holistic' care, the Government's strategy appears to be reinforcing a medical approach to diabetes. There is a strong case to revise certain targets in public health and primary care.

I begin by setting out the difference between the 'medical' and 'holistic' frames in diabetes, before going on to explore issues in public health and primary care in more detail.

3.2 'Medical' and 'Holistic' Frames of the Problem of Diabetes

As discussed in chapter 7, there is significant debate in health policy between advocates of 'medical' care and 'holistic' care. This debate extends into diabetes. As we saw, the 'medical' frame exhibits a particular understanding of health and ill-health, orienting health services to the extension of life through the treatment of illness and disease. In diabetes, this is viewed as synonymous with the control of blood glucose.

Indeed, the term 'diabetes' itself refers to a group of diseases characterised by raised blood glucose, or 'hyperglycaemia', caused by an absence of, deficiency in or lack of sensitivity to insulin – a hormone which regulates glucose levels. After each meal, the body breaks down sugars and carbohydrates into glucose which is released into the blood for energy. When functioning normally, the pancreas produces insulin in order to regulate levels of glucose, but when the pancreas fails to produce insulin, or when the body's sensitivity to it is reduced, high levels of

blood glucose build up in the blood. If unnoticed or poorly managed, hyperglycaemia can be complex to treat and lead to serious complications, reduced quality of life and life expectancy (Tan and Cheah, 1990).

For this reason, the 'medical' frame advocates interventions geared towards the control of blood glucose. In public health, this entails strategies to detect so-called 'pre-diabetes' – a condition of raised blood glucose – through screening initiatives such as the NHS Health Check; and in primary care, strategies to control blood glucose levels in individual patients, often pharmacological therapies. Intensive blood glucose control is justified by large-scale, randomised clinical trials which demonstrate a correlation between blood glucose and health outcomes (see box 2).

Box 2: The UK Prospective Diabetes Study (UKPDS)

A pivotal moment in diabetes care was the UK Prospective Diabetes Study (UKPDS), a major multicentre randomised clinical trial involving 5,102 patients that ran between 1977 and 1997 (with on-going follow up examinations). The study confirmed what had only been suspected before: that raised blood glucose increases the risk of diabetes-related complications and clinical strategies to control blood glucose reduce such risk. This, in turn, has had a profound impact on diabetes care, orienting medical and policy efforts to the control of blood glucose (King et al., 1999).

Though the 'holistic' frame does not question the essential pathophysiology of diabetes as a condition of raised blood glucose, it nevertheless broadens out the definition of the problem of diabetes to include lifestyle factors, psychology and wider "social" determinants of health: diabetes is as much a problem of unhealthy lifestyles, inequality and a lack of community resources, as it is raised blood glucose. Adherents of the 'holistic' frame argue that medical treatments alone will ultimately fail to improve health outcomes (Wait, 2011).

As with the 'medical' frame, the 'holistic' frame favours certain forms of interventions over others, emphasising the importance of lifestyle interventions in public health and primary care which promote exercise and health eating. There are variants of medical and holistic care in public health and primary care, with significant debate about the appropriate balance between them.

Among health professionals, there are differences of opinion regarding this question of the balance between holistic and medical care. GPs and specialists generally harboured a 'medical' understanding of diabetes, favouring the NHS Health Check as a way to identify cases of 'pre-diabetes' and the tight control of blood glucose in primary care. Yet there were also GPs and specialists who were critical of an alleged overuse of pharmacological therapies. Furthermore, while public health professionals shared an appreciation of both 'medical' and 'holistic' forms of healthcare, they were similarly critical of an overuse of pharmacological therapies. The debate is significant and relevant to decisions at both the level of policy and governance.

3.3 The Case for Greater Investment in Public Health

The case for greater investment in public health hinges upon evidence which suggest an exponential increase of Type 2 diabetes cases. 13 million people are “affected or at risk” (Diabetes UK, 2015: 3) and 1 in 7 adults has ‘pre-diabetes’ (Chatterton et al., 2012). It is argued that only can prevention through public health improve health and economic outcomes. Among health professionals, there is widespread agreement with this strategy. A typical argument is provided by a NHS England civil servant, who cited what she believes is the most pressing area of concern in diabetes today:

The area of most concern is the increasing prevalence of diabetes, year on year. Forget about how we are treating those who have been diagnosed. The pool of people is just going up and up. It's increasing in prevalence every year and then we also have increasing onset of diabetes at a much younger age ... I was absolutely astonished when I came across 12-year old, 13-year old children developing Type 2 diabetes. That was unheard of twenty years ago. It was always Type 1 diabetes, early onset, and then you had Type 2 diabetes. It was always 45 plus. But that age of onset is just getting younger and younger. What was an adult disease is now affecting people in the prime of life

If left unchecked, the increasingly prevalence of diabetes will result in adverse health outcomes and great expense to the health service:

...the complications of diabetes are gross ... We're talking about an impact on their lives, on their work lives, on their, everything⁶⁷

One GP spoke of an explosion of diabetes cases which was putting pressure on doctors and nurses in primary care, with broad implications:

...you can see it right through the system to pressure on A&E and hospitals⁶⁸

Stakeholders also agreed that much of the increase in diabetes is down to increasingly unhealthy and sedentary lifestyles, which necessitates investment in public health because of its capacity to prevent/manage lifestyle diseases. The NHS England civil servant once more:

It's (public health) not done in a systematic way. There's always the debate in Britain about how much does the state intervene, how much the state should stop lard being sold or hydrogenated fats being put into pastry ... Take smoking. We know smoking harms, so why not do the same with fats? “Why not have a curriculum in schools that introduces activity as part of studies and education? Why not prevent schools from selling playing fields? There is room for legislation, there is

⁶⁷ Civil servant, NHS England, 17/02/14

⁶⁸ GP and practice lead for diabetes, 30/09/2014

*room for education, there is definitely room for making sure that schools play a part in not just educating the child but also educating the parents*⁶⁹

Implicit in these calls for greater investment is a moral argument which highlights the importance of public health interventions for the health of individuals. This moral argument is also interlaced with a number of economic themes, implying the presence of market failure (see chapter 4).

Public goods and externalities – the call for investment in public health services that are currently lacking implies that individuals are unwilling or unable to invest in them on their own accord. Many of the examples cited by the NHS England civil servant, such as education and the availability of exercise facilities (school playing fields), have public good characteristics, as have other services designed to combat diabetes and obesity, such as advertising and social marketing campaigns. Furthermore, the wider costs attached to unhealthy lifestyles implies the presence of externalities. The widespread availability of low cost, unhealthy food in effect lowers the cost to individuals of leading an unhealthy lifestyle, while the poor design of the social environment – such as out-of-town shopping malls – increases the cost to individuals of healthy activity. Again, this is implied by the civil servant’s call for greater regulation of unhealthy food stuffs, the cost of which, like smoking, is not captured in the price which consumers pay for the product. The same might be said for the technologies that have contributed to sedentary lifestyles, such as cars, televisions and video games.

Information asymmetries – the call for investment in public health also interpolates consumers as lacking the requisite knowledge of choices and their consequences. It is implied that consumers are ignorant of the precise content of the food they eat and what it is doing to them. They may also be unaware of the dangers of being overweight and what food they should eat to reduce their body weight and their likelihood of developing Type 2 diabetes. Specifically in diabetes, the shift to prevention is justified on an information asymmetry, whereby people at risk of diabetes, or people with undiagnosed diabetes, are ignorant of their raised blood glucose levels, as well as the dangers it can bring. This is also true of people with a significant proportion of the population with ‘pre-diabetes’⁷⁰. Likewise, many health campaigners criticise corporate advertising and marketing that promotes the consumption of unhealthy food stuffs, in an example of “supplier-induced demand” – a corollary of the information asymmetry concept.

In keeping with the ‘medical-professional’ frame, these arguments afford a potentially significant role for public health professionals to define and deliver a range of possible public health interventions. The assumption is that professionals can make informed choices where consumers have failed.

⁶⁹ Civil servant, NHS England, 17/02/14

⁷⁰ A Diabetes UK campaign was entitled ‘*Diabetes: Beware the Silent Assassin*’ (Diabetes UK, 2008)

However, as the NHS England civil servant recognises, there is significant public and political resistance to the regulation of the consumption of unhealthy food and drinks: “There’s always the debate in Britain about how much does the state intervene”⁷¹. Indeed, public health is often criticised in the terms of the ‘market’ frame for interfering in individual freedom and consumer choice. Additionally, critics question the assumption that public health professionals can make more informed choices than consumers, highlighting what is a potentially significant form of government failure:

The major cause of the obesity epidemic is our public health dietary advice. The introduction (1977 USA, 1983 UK) of advice telling us to ‘base our meals on starchy foods’ (foods that we previously held to be uniquely fattening) has made us fat and sick (Harcombe, 2013)

If prior attempts to improve the population’s health through public health messages have contributed to the obesity and diabetes “epidemic”, let alone caused it, this warns against the excessive use of public health interventions in the regulation of food and drink; the epistemological challenge of defining what is a quality food is complex. Furthermore, these kind of public health interventions clearly touch upon significant values pertaining to the balance between individual freedom and state intervention, suggesting a need for public and political debate to establish just how far public health policy should regulate consumption patterns.

A further significant issue is whether the scale of the public health challenge is overstated by the statistics. This issue taps into a wider problem of the use of surrogate outcomes in health policy (see chapter 8). In diabetes, blood glucose is the main surrogate outcome and is central to the planning of services and the diagnosis and treatment of cases. However, there are significant question marks over whether medical strategies geared towards the control of blood glucose translate into improved health outcomes (Richter et al., 2011). Indeed, this is a central argument of proponents of ‘holistic’ care but it is also made by some specialists, who criticise the turn to prevention in medical care.

In public health, critics argue that some of the reported increases in diabetes cases may be down to changing diagnostic thresholds and that the category ‘pre-diabetes’ does not have clinical value (see box 3)⁷².

Box 3 – Uncertainties over Diagnostic Criteria and the Concept of ‘Pre-Diabetes’

Extensive debate has taken place in diabetes over diagnostic criteria. Traditionally, a diabetes diagnosis required tests for fasting blood glucose which, though the most accurate of tests, is also the most cumbersome, requiring that patients fast for 2 hrs prior to the test. An alternative is standing glucose which, though less accurate, is easier to administer because it does not require that patients change their diet. The preferred option is a HbA1c test – a reading of blood glucose. This test is the newest of the three and the most technical,

⁷¹ Civil servant, NHS England, 17/02/14

⁷² Similar arguments are made in obesity policy (Lobstein, 2006).

deemed inappropriate for developing countries which do not have the requisite training and technology. Nevertheless, it is easy to administer, reasonably accurate and corresponds with wider diabetes governance and policy in which HbA1c is the main surrogate outcome.

However, there is uncertainty over what the diagnostic criteria should be for diabetes. Diagnostic criteria for diabetes are defined by analysing clinical data to establish points at which the likelihood of developing complications significantly increases relative to the population. Yet such a point could only be established for diabetic retinopathy, a condition of the eyes which is caused by high levels of blood glucose. Criteria for cardiovascular complications, which are more common among people with diabetes, have never been established. Furthermore, there is a lack of consistency of diagnostic criteria for diabetic retinopathy for each test, HbA1c, fasting glucose and standing blood glucose. Each one identifies different numbers of people as being diabetic and each one can result in 'false positives' (people falsely identified as not having diabetes) and 'false negatives' (people falsely identified as having diabetes). Exactly what constitutes a state of 'pre-diabetes' is even more uncertain. Once again, each test has a 'pre-diabetes' threshold but there is even greater inconsistency in the number of people diagnosed as 'pre-diabetic', with the HbA1c test diagnosing fewer people than the other two (Gale, 2013).

The American Diabetes Association caused some controversy when it broke with WHO recommendations to revise HbA1c diagnostic criteria in an attempt to standardise the numbers diagnosed. But this only widened the pool of potential cases. Inconsistency between the three tests, combined with the issue of false negatives, means that significant proportions of the global population would be diagnosed as "significantly at risk" of diabetes if the new diagnostic thresholds were implemented in full. Yet the links between pre-diabetes, diabetes and diabetes-related complications have not been established (Ford et al., 2010: 1316). A significant number of people diagnosed with 'pre-diabetes' may not go onto develop the condition or suffer any complication (Gale, 2013).

The problem of diabetes and in particular 'pre-diabetes' appears to a certain extent socially constructed. Though this does not negate the seriousness of unhealthy and sedentary lifestyles, it does however have some implications for debates about the choice of services and forms of care in public health policy.

3.4 The 'Holistic' Frame and the NHS Health Check

Adherents of the 'holistic' frame argue that lifestyle interventions are required to solve the problem of diabetes. This includes initiatives which promote exercise and healthy lifestyles, such as taxes on transport and investment in cycle lanes and school playing fields. These interventions, it is argued, are beneficial because they have a broad range of positive effects on society, whereas individualised forms of

public health intervention only benefit individuals. Furthermore, ‘holistic’ interventions are framed as providing opportunities for people to live healthy lifestyles and are not just about regulating consumer choices⁷³.

Debate between adherents of ‘medical’ and ‘holistic’ frames are particularly acute regarding the NHS Health Check, a screening initiative which tests for diabetes and ‘pre-diabetes’. The issue is closely relevant to governance because the NHS Health Check is mandatory for local authorities to implement.

The case for screening is based on the assumption that the early detection of ‘pre-diabetes’ might prompt people to change their lifestyle. Or, with an earlier diagnosis, people who have developed the condition in full could initiate treatment at an earlier stage of their illness. In normal circumstances, people are diagnosed with diabetes via tests after they present to doctors with symptoms or experience an episode of diabetic ketoacidosis⁷⁴. Earlier diagnosis and treatment might reduce the risk of harmful complications and costs to health services⁷⁵. The Check is promoted by Diabetes UK and has support among some health professionals and campaigners:

Everyone between 40 and 75 should get a NHS Health Check. There are 7 million people in this country at high risk and early diagnosis would compel them to reduce their risk of developing diabetes. That would be ideal: to stop that 7 million from getting it ... the earlier you can diagnose somebody, the more likely they will be able to manage their condition well. They don't go on to develop the complications, like blindness and amputation, kidney failure and premature death⁷⁶

A further justification for the Check is that the evidence-base for other forms of public health is considered less robust. The Co-Chair of one CCG viewed it as central to the CCG’s diabetes strategy and highlights the lack of alternatives to screening and interventions in primary care:

It's expensive and difficult. The evidence isn't there. We haven't got the industrial scale interventions that are required and we don't have the socioeconomic interventions either, whether it's taxes on food or driving to encourage people to act differently or cycle lanes and the like. Unless we can do it any other way, that's the only way⁷⁷

⁷³ Health campaigner and researcher, 13/04/2015

⁷⁴ Diabetic ketoacidosis can require hospitalisation and is caused by low levels of blood glucose. People with diabetes can experience both high and low levels of blood glucose, caused by impaired insulin levels. When low, the body obtains its energy from fats which can result in a build-up of acid in the blood and can in turn cause blackouts and even death in extreme cases. A minority of people become aware of their diabetes through an episode of diabetic ketoacidosis.

⁷⁵ For this reason, NICE Guidance advocates screening over the age of 40 or with significant risk factors, including anyone whose BMI is greater than 23 kg/m² and anyone who is over the age of 25 and of South Asian or Chinese descent (NICE, 2012).

⁷⁶ Senior representative of advocacy organisation, 22/03/13

⁷⁷ Co-chair of CCG and local GP, 24/12/2014

However, in line with the wider debate over the use of surrogates in diabetes care, the assumption that the early detection of 'pre-diabetes' improves health outcomes is disputed. A diabetes specialist argued that the treatment of fully-developed diabetes already makes assumptions about the importance of blood glucose control which are magnified when it comes to 'pre-diabetes':

*They are asking people to screen for, diagnose and treat a risk-factor for a risk-factor*⁷⁸

Similarly, proponents of 'holistic' care argue that the Check represents an individualised form of intervention which medicalises the problem of diabetes and potentially exposes people to unnecessary and harmful pharmacological therapies in primary care⁷⁹.

Among public health professionals, there is also some scepticism over the Check. One public health professional argued the Check tells patients and physicians very little that they don't already know. If people lead unhealthy lifestyles, are obese and smoke, then by their 40s or 50s it is likely they will have health problems. This does not require confirmation through a Check. Furthermore, the Check is purportedly taken up by the "worried well": healthy people, who are concerned about their health, are already frequent users of primary care services and would have gone for a check-up with the first onset of diabetes symptoms, with or without the Check in place⁸⁰.

Another public health professional called for a more nuanced implementation of the approach. The Check is purportedly most suitable when used to engage with marginalised groups who do not frequent primary care services, where a medical diagnosis can be first-step to connect people up with health services:

*I'm not certain about the value of a universal 40-74 age group health check. I would say keep the mandate but it would be nice to get permission to target those who most need it, vulnerable groups, the travelling community, the ones who are at risk ... That's a much more decent use of resources than population-level stuff*⁸¹

These accounts are clearly significant because they reveal a major difference between the knowledge of people actually implementing the Check and those who advocate for its universal application. Additionally, although public health professionals recognise the importance of both medical and holistic healthcare, there was some concern that current policy and governance is facilitating an overly medical approach.

A major issue is the evidence which is informing policy in this area. A Director of Public Health argued that the evidence reinforces "the status quo in diabetes

⁷⁸ Diabetes specialist, 04/12/2014

⁷⁹ Health campaigner and researcher, 13/04/2015

⁸⁰ Public health professional, 27/04/2015

⁸¹ Director of public health, 13/05/2015

around lifestyle behaviour change, the disease model way of the world ... At a national level it's still a NHS medical model driven by a conversation about evidence"⁸². This is a direct rejoinder to those who question the evidence-base underpinning holistic forms of care (see above). As we saw in chapter 8, advocates of the 'holistic' frame argue that dominant forms of economic and scientific appraisal do not capture the full benefits of lifestyle interventions or the full costs of pharmacological therapies. As such, there may be a case to relax positivist criteria as to what constitutes good quality evidence in this policy area. Yet even here there is significant debate about the evidence underpinning screening initiatives. There is indeed some concern in the academic literature that evaluations do not capture the full extent of the costs of screening (see box 4).

Box 4 – Appraising the Evidence on Screening for Pre-Diabetes

Evaluations of screening take the form of economic modelling which model possible future outcomes attached to different approaches to screening (at various ages and frequencies) (see, for example, JAMA, 1999; Chen et al., 2001; Hoerger et al., 2004; Goyder and Irwig, 2000)⁸³. Yet economic modelling is widely considered to be inferior to scientific experiments in the evaluation of the efficacy of interventions.

Chapter 2 introduced two key questions to policy evaluation: 'Can/does it work?' And 'Is it worth it?' In relation to the first issue, the economic models used in the evaluation of screening incorporate data from the UKPDS and other clinical trials to model future outcomes. However, clinical trials in diabetes have typically involved relatively healthy populations, indeed healthier than the typical diabetes patient (Wallace, 1999). As such, what 'works' in the model, may not have the same level of benefit in actual medical practice, where people are unhealthier (Richter et al., 2011). (This issue is explored in more detail in the next section, where it arises in the evaluation of the use of pharmacological therapies).

The economic models address the second question – '*Is it worth it?*' – by calculating the costs and benefits of different approaches to screening, in terms of their cost, possible monetary contributions from the added life and the quantity and quality of that added life (i.e. QALYs) (Vaughn et al., 2007). One such study found that screening was most cost effective if initiated between 30 and 45 years of age to all population groups and repeated every 3 to 5 years (Kahn et al., 2010: 1365). However, evaluations of screening typically only factor in the disutilities of diabetes-complications, not the disutilities associated with pharmacological therapy (see next section) or screening itself⁸⁴. There are

⁸² Director of public health, 13/05/2015

⁸³ This is due to the fact that there is such a time-lag between screening and outcomes that it would be difficult to design a scientific experiments and control all relevant variables (Kahn et al., 2010: 1373).

⁸⁴ For example, in their model, Richard Kahn and colleagues only assign disutilities to diabetes complications. Diagnosis through screening scores 0 on the disutility scale – i.e. it has no negative impact on individuals' quality of life – compared to traditional diagnosis, made via tests following presenting symptoms to a doctor, scores -0.035. Likewise, the disutilities of medical treatments (discussed in more detail in the next section) are not factored in (Kahn et al., 2010: 1366).

concerns that economic modelling in diabetes care, not only overstates health gains, but also understates costs associated with health interventions, including economic costs (Desai et al., 2012) and harms to patients (Huang et al., 2007).

Furthermore, screening has been linked to psychological harms on diagnosis (Kralik et al., 2001; Stewart-Brown and Farmer, 1997) and unanticipated health problems, by correctly giving people the all clear when they may have significant risk factors for other conditions. One study found that some people with risk factors for diabetes were sent home “feeling reassured about diabetes but unaware of their increased risk of mortality”, making it less likely that they would adopt healthier lifestyles. That group ended up with a higher level of cardiovascular disease as the group that had been identified as diabetic (Spijkerman et al., 2002).

3.5 Pharmacological Therapies in Primary Care

In public health, the debate between the ‘holistic’ and ‘medical’ frames centres upon the use of pharmacological therapies. Indeed, oral glycaemic drugs and insulin are well established in diabetes care and have a significant evidence-base. NICE guidance for Type 2 diabetes includes decision maps which involve the sequential addition of drugs as their effectiveness gradually declines, starting with oral glycaemic drugs and then onto insulin (NICE, 2008b). However, there is concern that pharmacological therapies are overused and critics argue that lifestyle interventions, including changes to exercise routines and diets, are safer and more effective (Wait, 2011).

Among GP, many supported the use of pharmacological therapy in primary care, suggesting there is no genuine alternative:

I would love to say that changing lifestyle interventions would work. In the population I see trying to change people’s lifestyles is incredibly difficult. Even though you explain to people what to do time and time again they will come back not having changed anything lifestyle wise. It almost becomes an excuse: ‘oh, I can take a tablet rather than doing anything physical’. Lots of people I see have had complex problems for a while, they’ve had impaired glucose for a long time before they get to me. They’re usually overweight, very sedentary, they eat the wrong things. A lot of them come from the Indian subcontinent and simply trying to get them to cook with less oil, you feel like you’re banging your head against a brick wall. You know they’ll be back in a couple of months anyway. You might have started them on the medical treatment anyway⁸⁵

In this passage, there is a sense that lifestyle interventions are the ideal solution but unrealistic. There is also recognition of the unique motivational problem in

⁸⁵ GP and practice diabetes lead, 30/09/2014

healthcare: how to get patients to comply with medical treatments. The availability of pharmacological therapies reduces the incentive for patients to change lifestyles and in any case it makes medical sense to initiate treatment at an early stage. A further argument for the use of pharmacological therapy stems from the absence of an evidence-based alternative. One GP defended the use of pharmacological therapy in part because the evidence underpinning lifestyle interventions is weak:

It's a bit of an interesting debate whether you're medicalising somebody or in fact given them an effective intervention because lifestyle interventions are not effective generally. First of all, we don't really offer it all the time because we haven't got the capacity for all to see a dietician or go on an exercise program. Very few people picked up with pre-diabetes have any sort of intervention. Then the evidence is that a lot of the interventions, unless they're highly intensive, as the research studies were, they won't be effective anyway. Metformin (a type of diabetes drug) is probably more effective. The data isn't pure on that. But I suspect that people with pre-diabetes probably wouldn't take their tablets anyway. You have to be pretty highly motivated to take a tablet every day, wouldn't you?⁸⁶

However, there were GPs who were critical of the use of pharmacological therapies. Some erred to the 'holistic' frame in their appraisals of policy. One GP, when asked if the NHS is "getting the right balance in diabetes care between lifestyle interventions and medical interventions in diabetes care", replied:

No, but maybe I'm just old-fashioned. So NICE has lowered the threshold to offer people statins and it feels they're just throwing drugs at a problem when we could do lifestyle interventions, take them seriously. We've got a well educated population and an anxious population who read in the news about what all these drugs can do to them, so not everybody wants them. But some people do just want to take a pill. Just take a pill. It's easy. But the problem is then someone doesn't need to address their lifestyles. In diabetes it's taking drugs to reduce HbA1c and reduce blood pressure. It's a similar dynamic. And then you have the problem once you start with the sulfonylureas and thiazolidinediones (types of diabetes drug) people gain in weight, then you have to take drugs to control that. It can be a downward spiral⁸⁷

In this passage, the GP favours lifestyle interventions and highlights risks attached to pharmacological therapy. Once again, the availability of drugs exacerbates the motivational problem because it provides patients with an easy option for their diabetes.

Others are more critical, arguing that the use of pharmacological therapies puts patients in danger. Indeed, as in other areas of preventative medicine, there is some debate within the medical profession about the medical value of pharmacological therapies. A diabetes specialist spoke of the need of a consent

⁸⁶ Co-chair of CCG and local GP, 24/12/2014

⁸⁷ GP, 13/09/2014

form for patients to sign to ensure they have had the benefits and risks of pharmacological agents clearly explained to them before therapy is initiated:

You as a physician are initiating a life-long treatment of a drug that causes disutility and risk, hypoglycaemia, but also having to prick your fingers, give injections, once, twice, four times a day and so on. Why should there not be an informed consent form? ... You'll have to take that for the rest of your life. In other words, someone who feels well and you are treating speculatively to reduce the risk of a future event⁸⁸

Here, the motivational problem is placed on the providers of care who are failing to inform patients of possible risks and overusing pharmacological therapies.

3.6 The Quality and Outcomes Framework

The controversy over pharmacological therapy in primary care is closely related to on-going debate about the Quality and Outcomes Framework (QOF). Diabetes has the most performance indicators in the QOF out of all medical conditions. The majority of these are *process* indicators, which outline various activities which GPs have to provide to people with diabetes, including most of the 9 key care processes for diabetes (see box 1, above). However, following concerns that the QOF had facilitated a 'tick-box' approach to healthcare, additional intermediate or *surrogate* outcome measures were included, including blood glucose (HbA1c), blood pressure and cholesterol. Besides having to undertake blood checks for these measures, GPs have to record the readings and the data is used as a surrogate indicator of health outcomes⁸⁹. Furthermore, GPs are remunerated when they achieve surrogate targets, on the assumption that improved improvement across the surrogates will translate into health gain.

Among GPs and specialists, there is some widespread agreement that the QOF has improved the quality of diabetes care in primary care (Farooqi, 2012). The 9 key care processes are considered the basic essentials of diabetes care, serving to alert patients and health professionals to early signs of complications.

However, the surrogate outcome measures are more controversial. There is uncertainty over what target is appropriate in diabetes care. The original QOF target was set at a HbA1c reading of 6.5% mmol, which is also the diagnostic threshold for diabetes. This was revised to 7.5% in 2011 when a number of clinical trials reported that intensive glucose control strategies increase the risk of heart attacks in some categories of patients (Boussageon et al., 2011; Hemmingsen et al., 2011).

⁸⁸ Diabetes specialist, 04/12/2014

⁸⁹ See chapter 6 for a discussion on the various uses of surrogate outcomes in healthcare and controversies surrounding their use

Some GPs and specialists support the new target. One GP and practice lead for diabetes, who also favoured pharmacological interventions in primary care, argued that the current QOF target of 7.5% is “about right”:

What I've been taught is that by getting HbA1c down to 7 as quickly as possible is beneficial for their long-term health. With our newly diagnosed cases that's what we do, aggressively if possible early on ... I think that is an appropriate target. When it was lower, which is was not long ago, I think that was inappropriate. But they've relaxed it to 7.5 and it is about right, actually⁹⁰

Others are more critical, arguing that a 7.5 target is difficult to achieve for patients and unfair for GPs, who are performance managed on an outcome they do not control:

It takes a tremendous amount of work and with some patients it can be an achievement to get the HbA1c level down to 9. And you've put all this effort in only to be penalised. It can be frustrating ... A lot of times people engage with it but do it half-heartedly so your hard work isn't rewarded. The whole thing takes a lot of time. There's diagnosis and a process of drug and life-style changes. There's time in each step⁹¹

Others were more understanding of patients, highlighting the challenges involved in meeting the target, especially in the context of their busy lives:

Diabetes affects every aspect of what you do, especially if you go on insulin. You've got so many factors to work in your daily life that it's just horrendous to imagine how you can be well controlled at every time. It's impossible because it takes such dedication to get the average below 7.5. It sometimes happens in short periods when someone is pregnant. It's 'I've got this nine months to keep it controlled. I can do that'. Then when their baby is born their HbA1c hits the ceiling because the baby is the priority and it's not looking after itself. So you can see why it's difficult. It's about trying to provide support and not be driven by numbers but quality of life that goes alongside those numbers as well through the up and down process that is diabetes. And sometimes it's easy and sometimes it's hard. But you've still got to be there to say, well, what can I do to help?⁹²

Another GP alluded to the ‘holistic’ frame in their appraisal of the target:

The system seems to encourage a short-term fix ... we're on hamster cage and just have to do things in such a short-time scale. Lifestyle interventions take a long-time, you need to explain a lot in detail, make a case for people to change their lifestyles

⁹⁰ GP and practice diabetes lead, 30/09/2014

⁹¹ GP, 13/09/2014

⁹² Diabetes specialist nurse, 07/02/2014

*when maybe they don't want to. And in any case prescribing drugs is a quick easy fix to meet the QOF targets*⁹³

These accounts reveal some of the complexity involved in the management of diabetes in primary care, with treatment decisions and health outcomes affected by a range of factors, including central policy, patient compliance and the complexity of the condition itself. Clearly, the target is difficult to achieve for patients and there are signs that it may put strain on the doctor-patient relationship when patients do not achieve it: this is “frustrating ... A lot of times people engage with it but do it half-heartedly so your hard work isn't rewarded”⁹⁴.

However, even though 7.5 is a difficult target to achieve, GPs and specialists alike appear to agree that it is a worthwhile goal, however difficult it is for patients. Yet some prominent diabetes academics, most notably Professor John S. Yudkin in the UK and Victor Montori in the US, have disputed even this claim. In a series of publications, Yudkin and Montori criticise what they call the “gluco-centric” paradigm of care (Yudkin, 2012: 1), involving the intensive control of blood glucose, which they argue may not improve health outcomes in some patients and constitutes a significant strain on resources. Tight blood glucose control is purportedly vital in Type 1 diabetes and early onset Type 2 diabetes, for these patients face a lifetime with diabetes and there are cumulative risks of exposure to high levels of blood glucose. Yet pharmacological therapies are associated with reductions in quality of life and carry significant risks of their own. Older patients, who also constitute the largest group of diabetes patients, face reduced quality of life but will not live long enough to experience health gain from intensive glucose control and may be put at risk (Yudkin et al., 2010: 2084; see also Richter et al., 2011; Yudkin et al., 2011).

Campaigners refer to these arguments in making a case for holistic interventions, for these are not associated with the harmful side-effects of pharmacological therapies and may be particularly relevant for older patients, who often have comorbidities and thus may have to take multiple drugs, increasing health risks further (Collis, 2014). Furthermore, as discussed above, advocates of more holistic interventions argue that dominant forms of health technology appraisal do not capture the full benefits of lifestyle interventions or the full costs of pharmacological therapies. As in public health, there may be a case to relax strict positivist criteria over what constitutes good quality evidence in this area. But even here the evidence underpinning intensive glucose control is contested on its own terms. It would appear that the evidence overstates the capacity of intensive glucose control to promote health gain in the restrictive, quantitative sense associated with the ‘medical’ frame (see box 5).

Box 5 – Appraising the Evidence on the Intensive Glucose Control

⁹³ GP, 13/09/2014

⁹⁴ GP, 13/09/2014

The UK Prospective Diabetes Study (UKPDS) was critical in establishing the link between glucose control and health outcomes, purporting to demonstrate that blood glucose control reduces the likelihood of diabetes-related complications: for every one percent that HbA1c increases, the risk of a macrovascular complication increases by 15% and the risk of a microvascular complication increases by 37% (ADA, 2002). This, in turn, has informed the world-wide development of treatment plans and performance management protocols which operate on the assumption the “lower the better” (Boussageon et al., 2011).

However, this assumption has proved controversial. One of the clinical researchers on the UKPDS trial who was interviewed for this project criticised the way the trial had been interpreted and applied in clinical guidelines and performance management protocols:

There're all sorts of interdigitating phenomena here. The concept of evidence-base medicine has increasingly become the concept that if you get a significant statistical test in a randomised trial that's evidence that something works and should be implemented regardless ... But often it works on the basis of huge numbers of people being treated for minimal benefit⁹⁵

Chapter 1 identified two key questions for policy evaluation: Can/Does it work? And Is it worth it? The UKPDS trial appears to suggest that intensified glucose control can indeed work. But the question is whether it *does* work, i.e. whether interventions tested under scientific conditions will bring about the same level of health gain in actual general practice. A key issue to consider when appraising clinical trials is whether trial participants match the patients in general practice. The UKPDS study involved people in their 40s who were newly diagnosed with diabetes and had an average of HbA1c reading of 6-7% mmol. As diabetes populations go, this is a “relatively young and healthy population” (Wallace, 1999). There is the possibility that the reported health gains will not arise in general practice, where diabetes patients are typically older, unhealthier and are likely to have damage to their blood vessels and nerve cells. The clinical researcher once more:

The idea is that if you lower HbA1c by that amount, that ought to be fully reversible ... It's like saying that the ex-smoker's lungs are the same as the non-smoker's lungs or that someone who has high blood pressure or high cholesterol for years, and their blood pressure and cholesterol is brought down, that their arteries are going to return to the pristine, virgin state that they were in twenty years ago. Nonsense⁹⁶

Indeed, in 2008, a clinical trial consisting of older patients with more severe diabetes had to be stopped halfway when a statistically significant higher death

⁹⁵ Diabetes specialist, 04/12/2014

⁹⁶ Diabetes specialist, 04/12/2014

rate of 22% was recorded amongst the intensified blood glucose group (Cefalu and Watson, 2008: 1164).

A further issue with the evidence is an absence of the patient perspective, which is significant given the suggestion above that blood glucose control can have significant negative effects on quality of life. In the appraisal of the evidence on screening, I noted criticisms of economic evaluations in diabetes care which do not take into account the disutilities attached to medical interventions. Huang and colleagues note a “striking ... lack of accounting for the quality-of-life effects of treatments” (Huang et al., 2007: 2479). Given the questionable health benefit attached to pharmacological therapy, the failure to account for such disutility is significant because costs for at least some categories of patient may outweigh the benefits.

Certainly, health gains associated with blood glucose control have to be set aside the potential harms of pharmacological therapies. Metformin is the “front-line” drug of choice, due to its low cost (a first generation drug, metformin is past its patent), capacity to control blood glucose and other positive benefits, such as wider improvements in stress management and body fat profiles (Rojas and Gomes, 2013). However, the drug does not always work and its effectiveness, like other oral glycaemic drugs, diminishes over time and therefore has to be replaced or complemented with others (UKPDS, 1998).

There is also some concern regarding the quality of new drugs on the market. As in other areas of healthcare, diabetes drugs need only to demonstrate improvements across surrogate outcomes in clinical trials. Yet it is precisely the assumption that gains across surrogates translate into health gain which is increasingly challenged (Yudkin et al., 2011). A number of drugs have been withdrawn which, having been approved on the basis of their impact on surrogates in clinical trials, were subsequently shown to be harmful for patients on long-term health outcomes (Nissen and Wolski, 2007; Wieczorek et al., 2008). For this reason, Bousageon and colleagues argue that “(m)arketing new drugs based only on evidence that they decrease glucose or HbA1c plasma levels, or both, should not be allowed” (Bousageon et al., 2011: 4).

3.7 The Control of Glucose and Stakeholder Interests

This section has explored debates in diabetes at a policy level, where choices exist between different types and forms of care. There is considerable agreement with the Government’s strategy of greater investment in public health and primary care but disagreement over specific details of the strategy. There is debate about the appropriate balance between medical interventions and lifestyle interventions, which reflects a wider debate between the ‘holistic’ and ‘medical’ frames. However, even within the medical profession there is debate about the capacity of intensive blood glucose control to improve health. There is widespread concern that current

policy and governance arrangements are facilitating an overly medical and pharmacological approach to the problem of diabetes.

The implications of this debate for governance are discussed in more detail in section 5. For now, it suffices to consider why medical forms of care appear to be oversupplied relative to holistic care. Part of the problem may be down to the complex nature of diabetes and thus reflect the epistemological challenge of governance. Certainly, the centrality of blood glucose fits with the requirement of performance management and economic and scientific appraisal for easily measurable performance indicators. But it may also be down to some of the interests present in the policy area. Some diabetes campaigners are critical of the role of pharmaceutical companies in the training of health professionals, arguing that 'holistic' options in primary care are not taken seriously enough:

There is a very short window of opportunity before diet is deemed to have failed and pharmaceutical remedies are commenced. Much of the training of both medical staff and patient-centred diabetes education is conducted by drug companies – a clear conflict of interest⁹⁷

This contrasts with the view of GPs and specialists, who welcomed the role of pharmaceuticals in the training of NHS staff⁹⁸.

Yet the interests of professionals in complex diabetes treatments have also been raised as an issue. John S. Yudkin has argued that it is a confluence of commercial and professional interests which is to blame, resulting in a "glucentric fervour of almost religious intensity ... among diabetologists, the public health community, professional associations and industry" (Yudkin, 2012: 1). Specialists may have an interest in intensive glucose control because it complicates the treatment and management of the condition, making it necessary for specialist input. However, specialists did not all support the approach and some are critical of the overuse of pharmacological therapies⁹⁹.

Finally, there is a question mark over the interests of advocacy groups. As we saw, the American Diabetes Association, which advocates on behalf of people with diabetes in the US, broke with World Health Organisation to unilaterally establish new diagnostic criteria. Ever-increasing numbers, the critics argue, give the ADA more influence over policy in their advocacy role. In the UK, though Diabetes UK has not followed the ADA's lead, there is nevertheless some concern over the organisation's promotion of the concept 'pre-diabetes'¹⁰⁰.

⁹⁷ Health campaigner and researcher, 13/04/2015

⁹⁸ GP and practice lead for diabetes, 30/09/2014; Academic and diabetes specialist, 17/03/2014

⁹⁹ Diabetes specialist, 04/12/2014

¹⁰⁰ Diabetes specialist, 04/12/2014

4.1 Organisational Reforms: Local Authorities and CCGs

The central organisational reform of the Health and Social Care Act (2011) was the creation of CCGs, which purportedly place GPs at the heart of the commissioning of health services. This organisational reform, in combination with increased plurality of providers, is expected to improve the performance of the health service and facilitate the development of new models of care around primary care. Alongside the creation of CCGs, significant reforms have taken place in public health, with local authorities taking over the public health function. Additionally, a new organisation has been created, Public Health England, to lead on public health issues at a national level and to performance manage local authorities in accordance with the Public Health Outcomes Framework (PHOF).

The purpose of this section is to explore the effectiveness of these reforms through an assessment of stakeholders' frames of diabetes governance. I start with local authorities, for public health constitutes the broadest level of intervention; and end with CCGs. Stakeholders identify some areas where the reforms have improved the delivery of diabetes services and some areas where they have not, implying the presence of some significant 'coordination problems'.

4.2 Local Authorities

As we saw, there is broad agreement that public health should be central to any diabetes strategy and the Government's increased investment in this area is widely welcomed. Where there is disagreement is over the precise services that are required. This disagreement at a policy level extends to disagreement over the Government's organisational reforms. Among health professionals, there is some scepticism over the new role for local councils in the health service:

Local politics is coloured by the evidence of local public feeling rather than randomised trials. This makes it hard for local politicians to lead public opinion rather than follow it. And tougher still when the case for change is not well made and seems to be about saving money not lives. The culture of local accountability of councillors through elections is a source of mistrust and suspicion (Humphries, 2013)

This reflects the 'medical-professional' frame, for the reforms may have unsettled the control over decision-making of the medical profession.

Within public health, there is some concern that local authorities are not taking their new responsibilities seriously. The Government has placed a ring-fence on public health budgets to prevent local authorities from using the public health budget for other purposes. However, public health budgets are reportedly being "raided" and the public health dimensions of other council services, such as

education or adult social care, are being cut¹⁰¹. This was a major issue for a Public Health England civil servant who, while recognising the potential of linking up public health with local authorities, criticised the stance of many local authorities on public health and called for greater powers to intervene in poorly performing local authorities. Indeed, while the PHOF could usefully demonstrate poor performance, its performance management component is considered too weak to enforce local authorities to commission appropriate services:

*Local authorities are autonomous and can say 'no'. Many do say 'no'. They say 'no' when it's not a mandated service*¹⁰²

This call for greater centralisation combines aspects of the 'medical-professional' frame and the 'managerialist' frame: heightened performance management is required from the centre to incentivise local actors because of poor performance at a local level.

However, some public health professionals now employed by local councils offer a far more positive appraisal of the shift. These positive appraisals exhibit elements of the 'progressive' frame, which seeks democratic reform of the health service and the greater involvement of citizens in decision-making.

Indeed, in sharp contrast to wider concerns about local politics, a Director of Public Health welcomed the "lines of accountability" at the council, from the department management team, to the lead member, to corporate management, to cabinet and the council, which appear to improve both the effectiveness and legitimacy of policy. At the different stages, people make recommendations. The lead member has been particularly useful in this regard:

*He's been around for many decades so it's actually a useful sounding board. It's been 'you're a local, what do you think?'*¹⁰³

Furthermore, if decisions do go to cabinet or council in the case of the Annual Report, this is necessary to improve the legitimacy of policy:

*I'd much rather have that than basically the lack of transparency and accountability I would perceive, I used to see in reality, in the old PCT days. The board was a public meeting but nobody would turn up. I actually think the political process with the local authority, dare I say it, is something that the NHS could learn from*¹⁰⁴

The new role for local authorities is also praised for opening up new possibilities in diabetes care and other areas of public health. Once again, the Director praised the

¹⁰¹ In one survey 53% of public health professionals believed that public health budgets were not ring-fenced in practice and shortages of funds were impacting upon their ability to plan and deliver health improvement programmes (Royal Society for Public Health, 2014: 6).

¹⁰² Deputy to regional director of Public Health England, 01/06/2015

¹⁰³ Director of public health, 13/05/2015

¹⁰⁴ Surveys of health professionals suggest this view is widespread (LGA, 2013)

reforms, highlighting a new capacity to engage in joined-up working with departments across the council:

I've really enjoyed it. The ability to raise the profile of public health with the County Council and District County Councils in particular, to use that and embed models of prevention and really do a nice bit of service redesign if you like, joining up with children and family services, recognising the role we play with adults in communities and reducing the demand on adult social care, even the colleagues in the Environmental Transport who do cycle proficiency, training, safety, road safety stuff and food waste stuff ... To come in here daily, on a good day, it feels like a bit of a playground really. It's 'wow, I've never worked with you before'. That's been really good. That's the benefit of having public health in a local authority¹⁰⁵

A public health officer at the same council highlighted a joint programme with the council's Environment and Transport Department, involving a bid for funding from the Department of Health. The Public Health Department helped write up the bid, providing expertise on what the scheme would mean for health outcomes. The bid was successful and once the infrastructure was upgraded, more funds were invested on health promotion to raise awareness of the initiative and ensure the new cycle lanes would be used. This purportedly resulted in a 40% increase in cycling activity (measured by roadside counters) and a 2% shift from cars to cycling¹⁰⁶.

This is significant because it suggests the reforms potentially facilitate the development and delivery of holistic forms of public health, viewed by many as critical to combating increases in both obesity and diabetes. In this way, the new relationship between public health and local councils may be facilitating the discovery of new solutions to diabetes which may have not have been apparent before or which may have been difficult to implement¹⁰⁷.

A further concern at a local level is the use of the PHOF for the purposes of performance management. A key issue is the actual purpose of the PHOF. As we saw, the advocates of heightened performance management in public health view the PHOF as a managerialist tool to improve the performance of poorly performing councils. Yet local public health professionals noted a number of different benefits attached to the initiative. It can facilitate joint-up working by providing a "talking point" about mutual interests of different departments and public services. Furthermore, the PHOF's quarterly updates are reported in local media and are the topic of conversations with council members and the wider public about local public health services, serving to facilitate local democratic processes and accountability.

¹⁰⁵ Surveys of health professionals suggest this view is widespread (LGA, 2013)

¹⁰⁶ Public health professional, 13/05/2015

¹⁰⁷ Case study research carried out by the Local Government Association and Public Health England reveals a number of examples of service redesigns which were purportedly made possible by the reorganisation (LGA, 2013)

The arguments again exhibit the 'progressive' frame, highlighting both the value of local democratic processes and the potential of the reforms to contribute to them. Furthermore, local actors disagree that PFOF can effectively be used as a performance management tool. The broad nature of many of the indicators within PHOF, such as rates of child poverty and homelessness, are said to be useful precisely because they provide a "talking point" with other departments. Yet they are also affected by multiple factors that are beyond the control of councils, such as economic growth or migration. It therefore makes little sense to use these indicators in performance management because the reported performance does not necessarily reflect upon the quality of local services¹⁰⁸.

Furthermore, were Public Health England to take on a more interventionist performance management role, this could compromise efforts to work with other departments. Recent Public Health England initiatives have purportedly been unhelpful at a local council level because council departments did not respond to the medical language:

My one fear is centralisation. If you look at the PHOF, it says 'We're going to do something about obesity. We're going to do something diabetes' and so on. From a public health perspective, I can understand what they are getting at but from a local authority perspective we do it in a different way. If I walk around here and say 'let's do something about obesity, let's do something about diabetes', the response is, 'well that's the NHS'. You need to find the language and then have an outcome, rather than just have an outcome and say "what are you doing about it?" That for me is the tension between how some of the national things are expressed and the local stuff¹⁰⁹

4.3 CCGs and the Shift of Diabetes Services into Primary Care

As with the Government's reforms of public health, the creation of CCGs received mixed appraisals among stakeholders. There is widespread agreement that primary care should be central to any diabetes strategy, yet some concern, among health professionals, regarding the quality of CCG commissioning and the ongoing development of the market system. In this section, I explore stakeholder frames of these different aspects of the reforms, beginning with the perspective of CCG members before going on to explore the different professional perspectives. I include patient perspectives where appropriate.

CCG perspectives

Among CCG members and advocates of the reforms, the creation of CCGs stands to improve the performance of the health service across a range of criteria. Their appraisals of the reforms exhibit aspects of the 'market' frame, emphasising the importance of patient choice and responsiveness, as well as the potential of

¹⁰⁸ Public health professional, diabetes lead for a local council, 27/04/2015

¹⁰⁹ Public health Professional, 13/05/2015

markets to create efficiency savings. On the one hand, patients purportedly favour primary care because it is closer to home and delivered by their GP, whom they have better relationships with than specialists in hospital settings. Furthermore, it is said to be necessary to develop primary and community care because hospitals are “dangerous places” and patients should only be referred to hospitals if absolutely necessary¹¹⁰.

On the other hand, CCGs are better placed than PCTs, the organisations they replace, to drive through efficiency savings. An advocate of the reforms highlighted the closer connection between financial and medical decision-making as a key factor:

I think the only way the NHS would survive is if the financial and the medical decisions are together. Because doctors can be in the literal sense of the word irresponsible if they believe there is no financial constraints. Given that there are financial constraints then acting as if there is not is unhelpful for the safety and efficiency of the system ... Imagine if I run a CCG and you're a doctor, you're prescribing very expensive drugs. I have a peer-to-peer discussion with you. It's much better with financial pressures. You can only divorce the financial and the medical if you have limitless money. And some doctors like to believe that in the real world there isn't¹¹¹

The development of primary care may be particularly appropriate for diabetes care. A Co-Chair of a CCG and local GP argued that hospitals absorb too much in terms of resources and most diabetes services could be provided “in the community”. The management of diabetes does not involve expensive hospital equipment and care could potentially be provided in any setting, whether a hospital, a GP practice or the home. The creation of CCGs has the potential of improving the quality and efficiency of care:

The quality of diabetes care is gradually improving. We can finally move care out of hospitals¹¹²

In the future, primary care is expected to provide the bulk of diabetes care, supported by mobile diabetes specialist teams, while more complex surgical procedures provided in smaller concentrations of specialist centres. Indeed, the very distinction between primary and secondary care is said to be outdated:

This divide between primary and secondary care is an artificial one. What you really need to be thinking about who can provide the right level of care and then where can they provide it. Certainly for some diabetes services, you need specialist input. But it doesn't have to be in a hospital setting¹¹³

¹¹⁰ CCG senior management assistant, 12/06/2015

¹¹¹ Senior policy advisor to New Labour, 28/02/2014

¹¹² Co-chair of CCG and local GP, 24/12/2014

¹¹³ Co-chair of CCG and local GP, 24/12/2014

In some areas of the country, integrated models of care have developed which span the secondary and primary care divide and which are widely regarded as successful (Diabetes UK, 2014b). This is clearly significant, as the reforms appear to have provided the impetus for the discovery and development of new models of diabetes services.

Furthermore, though some patient representatives were critical of the reforms, others welcomed them. One LINK patient representative and executive of a local equalities charity praised their CCG for its community outreach schemes and provision of translation services in primary care. The local area has a significant ethnic and recent immigrant population and the CCG has been working to connect these communities up with health services. The CCG's work on health inequalities purportedly far outstrips that of the previous PCT¹¹⁴.

Similarly, a further LINK patient representative and resident of a rural town praised the attempt to develop primary care. The town is 22 miles from the nearest major hospital and transport to and from the hospital is difficult. The development of primary care has enabled local residents to access services far easier than before¹¹⁵. This is important because it demonstrates that not only are patient-centred criteria, such as access and responsiveness, important to patients, but the reforms appear to have enhanced the performance of the health service in this regard.

However, there are some significant criticisms of both the performance of CCGs and the attempt to develop primary care. In keeping with the 'medical-professional' frame, public health professionals, GPs and specialists raised concerns mainly over the quality of care. However, health professionals, particularly GPs and specialists, also drew upon patient-centred criteria in their appraisals and some patient representatives were also highly critical of the reforms.

Public Health Perspectives

A major concern of public health professionals is that the status of public health has been downgraded in the health service, reinforcing a 'medical' model of healthcare. With public health no longer situated in the same organisation as commissioners of healthcare, it is increasingly difficult to influence the commissioning of healthcare:

I think our ability to influence wider policy and local authorities has gone up. But our ability to influence CCGs and the medical component of public health has gone down¹¹⁶

This downgrading of public health in the health service is resulting in the inadequate commissioning of *preventative* medical care. Indeed, while the term 'prevention' is often used to refer to interventions delivered outside of medical settings, medical care also has a preventative component, whether delivered in

¹¹⁴ LINK patient representative, 29/02/14

¹¹⁵ LINK patient representative, 28/02/2014

¹¹⁶ Public health professional, 27/04/2014

primary care or secondary care (Finkel, 2012). This includes lifestyle interventions which require a referral, for example for people with obesity or complex diabetes who require specialist advice on diets and healthy eating. Yet, while this form of care is vital in keeping people out of hospital, it is not being adequately commissioned. Following the dissolution of PCTs and with local authorities having taken on the public health function, CCGs do not have the knowledge and expertise to commission this aspect of healthcare. Many CCGs are said to have neglected it, claiming local authorities were responsible for prevention when this is preventative medical care:

There's a feeling in some CCGs that 'public health and prevention is not something we do now, that's gone to local authorities'. That's something I've been told before in meetings. Most of their work on prevention, and I've looked at plans of all 19 CCGs in xxxxxxxxxx, it's minimal. Its 'local authorities do x, y and z'. Well the job of the local authority is to keep well, people well. It's the job of the NHS to make unwell people well¹¹⁷

This is clearly significant because it highlights a potentially significant failure of local decision-making. Preventative medical care is widely considered as vital to keep people out of hospital and a failure to commission it is likely to result in adverse health outcomes and ultimately costly hospital admissions (Finkel, 2012). The new organisational structures appear to be failing to effectively utilise the existing knowledge and expertise of public health professionals. The issue may well be a problem of incentives, with CCGs imposing costs on others in the form of an externality. However, CCGs will themselves suffer the costs of inadequate preventative services, suggesting the problem could simply be the case of a lack of resources. Indeed, one public health professional argued that CCGs simply did not have the requisite resources to commission adequate care:

...to be fair CCGs are short on capacity so they are struggling to meet all their bases as well¹¹⁸

Indeed, CCGs have smaller budgets relative to PCTs, which means they focus only on the "big contracts with the large providers"¹¹⁹.

The decline in the quality of CCG commissioning appears to reflect a problem of the Government's reforms. Because PCTs combined the commissioning of public health and healthcare, it may have been easier for public health professionals to influence the commissioning of healthcare. A Director of Public Health argued that, while it would not be impossible to commission fully joined-up pathways under the new arrangements, it would nevertheless be "bureaucratic":

It is just more difficult to put in place an end-to-end joined up weight management pathway ... Simple things like getting everyone in a room together to thrash it out,

¹¹⁷ Deputy to regional director of Public Health England, 01/06/2015

¹¹⁸ Director of public health, 13/05/2015

¹¹⁹ Deputy to regional director of Public Health England, 01/06/2015

*let alone the potential for individual organisational commissioning decisions to be made that aren't aware of what others are doing, particularly when capacity is short. If everyone had the cash and the capacity to work together it would be bureaucratic but not unsortable*¹²⁰

In this way, the reforms appear to have increased *transactions costs*, necessitating greater effort and resources on behalf of local actors to ensure that effective services are commissioned.

From a public perspective, therefore, the reforms have had a mixed impact on the quality of care. The new links with local authorities present new opportunities to deliver new and local forms of public health. Yet public health professionals no longer have influence over the commissioning of healthcare, which may result in the inadequate commissioning of preventative care. Indeed, the separation of public health and the commissioning of healthcare raise questions about the effectiveness of current arrangements to utilise existing knowledge and expertise¹²¹. As discussed below, specialists make similar criticisms of CCGs, suggesting the exclusion of specialists from commissioning also results in the inadequate commissioning of specialist healthcare.

GP and Patient perspectives

GP appraisals of the changing reforms differed to a great extent. A GP who sat on a CCG board was firmly in favour of the reforms, viewing them as crucial to the development of good quality care. Yet other GPs raised some concerns. Among all GPs, there was broad agreement that primary care can take on more diabetes services but concern that the requisite resources will not be available. Given increased demand for diabetes services, this constitutes a possible “crises point” for the health service as primary care takes on more cases, delivers more complex services but does not have the resources to maintain quality¹²².

A further issue for local GPs is performance management. The Quality and Outcomes Framework (QOF) has already been discussed above. At a local level, there is some recognition of the importance of the QOF but also concern that it contains too many indicators and the indicators often change, which was confusing both for GPs and patients. Furthermore, local performance management on prescriptions and referrals has purportedly intensified following the introduction of CCGs. One GP complains of “constant churn and directions to change what you prescribe”. In diabetes, the type of Proton Pump Inhibitors (a drug which reduces gastric acid, a possible side-effect of oral glycaemic drugs) frequently changes, which is frustrating for patients:

¹²⁰ Director of public health, 13/05/2015

¹²¹ Although local authorities and CCGs have obligations to work with each other through the Health and Wellbeing Boards, much of the current emphasis of such joint-working is adult social care rather than prevention.

¹²² GP and practice lead for diabetes, 30/09/2014

*Your patient is like, 'well I don't like this pill. I don't like the red pills; I like the blue pills'. And they don't understand the new treatment they're on*¹²³

Another GP complained about the performance management of hospital referrals, which did not “appear to be very rational”, as the vast majority of cases received medical attention, implying that a referral had been warranted:

*You get this phone call and you know it's the CCG about referrals*¹²⁴

While a stated aim of the Government was to make GPs central to decision-making and enhance the performance of the service across a range of patient-centred criteria, it would appear that many treatment decisions are not decided by either GPs or their patients. This was true of treatment plans and targets, which are set out in the QOF; but it also appears true of decisions over prescriptions and referrals. Indeed, though GPs were mainly concerned with the quality of care, their appraisals were also informed by a concern for their patients and did clearly include patient-centred criteria. Some suggested that the heightened use of economic incentives in primary care was adversely affecting the doctor-patient relationship:

*Patients come in and say 'You're probably going to strike me off the list now because I've got all of these problems'. Or they're on expensive drugs and don't believe they'll continue to receive treatment, no matter if it's not true. So there's this pressure on the doctor-patient relationship*¹²⁵

This was also noted by patient representatives in their appraisals of the reforms. One LINK Representative, who also had diabetes, spoke of their distrust in their GP. A retired teacher, they had witnessed the “erosion of professionalism” in teaching due to market reform and sensed this was happening in healthcare today. Though they hadn't experienced issues with their diabetes care, this was explained by the national attention on diabetes. The quality of care may have deteriorated for other conditions, where there is not such attention:

*Every time I see my GP I see the pound signs flash in their eyes*¹²⁶

Another argued the reforms had transformed the role of the GP from a patient advocate to a rationer of care:

*I want my GP to be my advocate, not weigh my health problems up with Mrs So-and-So*¹²⁷

¹²³ GP, 23/09/2014

¹²⁴ GP and practice lead for diabetes, 30/09/2014

¹²⁵ GP, 23/09/2014

¹²⁶ LINK patient representative, 28/02/2014

¹²⁷ Public health professional, 27/04/2015

This is significant because it suggests not all patient-centred criteria are realisable under the current arrangements. There appears to be a tension between the role of CCGs in driving through efficiency savings and certain patient-centred criteria.

Specialist and Patient Perspectives

Though recognising the importance of primary care and the centrality of GPs to diabetes care, specialists were the group most critical of current attempts to develop primary care and of the role of CCGs in that regard. Specialists emphasise the importance of professional skills and expertise in the management of diabetes. Though diabetes has the appearance of a simple condition and does not typically involve expensive hospital equipment and care, it nevertheless requires specialist input, for otherwise early warning signs are missed and complications arise at a later stage, requiring intrusive and expensive surgical procedures.

On this basis, many specialists criticise the quality of care provided by new private providers and argue there are limits to the extent that primary care can take on complex diabetes services. However, quality of care is not the only criteria which specialists draw upon in their appraisals of policy and governance. For it is also argued that patients are reluctant to receive complex diabetes services in primary care.

A diabetes specialist nurse described various opening evenings at which patients of a specialist centre raised concerns over a local initiative which sought to develop primary care:

That was the biggest thing they raised, it was 'my GP doesn't know how to look after my diabetes. Do I have a say in where I want to go?' Obviously the politically correct answer is 'of course you do, you can go wherever you want'. Whereas in reality what we see is quite different¹²⁸

This issue was also noted by diabetes campaigners and patient representatives. A Diabetes Voice representative, who also had diabetes, criticised efforts to move care in the "community" because the quality of care was "rubbish" and they require access to specialist care, which is increasingly difficult to attain¹²⁹. Another criticised the actions of some CCGs:

There is this heroic CCG that is putting all of its Type 1 services out into general practice. That's pretty catastrophic for someone who may have been looked after for twenty years, who are now told they have to see their GP who knows bugger all about Type 1, probably less than the patient does¹³⁰

This is clearly significant because it provides further examples of constraints on patient-centred criteria.

¹²⁸ Diabetes specialist nurse, 07/02/2014

¹²⁹ Diabetes voice representative, 12/06/2015

¹³⁰ Senior representative of advocacy organisation , 22/03/2013

Developing Integrated Diabetes Services Across Primary and Secondary Care

Disagreement between specialists and CCG members touches upon wider issues regarding the organisation of the health service and the payment mechanisms through which resources are distributed within it. Indeed, CCG members and specialists, most of whom are employed by NHS Hospitals, represent the different sides of the purchaser/provider split. Both raise objections to New Labour's marketised system of payment called Payment-by-Results (PbR), which reimburses providers for their activities. PbR is currently being extended to cover most health services and is purportedly a driver of efficiency because it embeds a financial incentive into the provision of care and facilitates the market, for individual activities are costed and can potentially be outsourced to any provider, whether an NHS provider, a GP practice or a private provider. However, there are concerns that PbR is not appropriate for complex conditions such as diabetes which can involve multiple providers and patients are often in and out of hospital (Diabetes UK, 2014b).

While PbR is criticised by both CCG members and specialists, it is for different reasons. CCG members are concerned that PbR creates a perverse incentive for NHS Hospitals to hold onto work and not support initiatives in primary care and the community. Also, specialists are accused of failing to provide enough support to GPs because it isn't in their professional interests to do so. A CCG Manager identified two major barriers to developing initiatives in primary care:

The biggest major barrier is funding, namely that you can pull services out of hospital but it's very difficult to get the money to follow. Hospitals are reluctant to down size. They are paid on a tariff basis so they're reluctant to release work. There are issues with how we get the resources out, not just the work but the resources. The second barrier is professional barriers. There is still some resistance around releasing work to generalists or coming out into the community¹³¹

However, specialists argue that PbR has contributed to the inadequate commissioning of diabetes services and in particular specialist diabetes services. Part of the problem is that outsourcing of individual activities, facilitated by PbR, serves to fragment pathways. This potentially compromises the quality of care because specialists no longer oversee the different aspects of the pathway. In diabetes, the Government identified podiatry services as candidates for outsourcing under the Any-Qualified-Provider initiative but changed its position following a campaign led by Diabetes UK and health professionals called 'Putting Feet First'. Podiatry services are said to be particularly unsuitable for marketisation because early detection is important to avoid ulcers and amputations (Diabetes UK, 2012b):

It's about specialism. You could be a really highly trained general podiatrist but you're not going to be a specialist diabetic podiatrist. The foot thing is so delicate.

¹³¹ Co-chair of CCG and local GP, 24/12/2014

*It's often the first thing that alerts people to the diagnosis ... You could get lots of recreational toe nail cutting going on*¹³²

PbR also increases the costs of specialist care. Whereas prior to PbR, payment for specialist diabetes services was tied up in block contracts for NHS hospitals, specialist services are now assigned a price like any other service. There is a clear incentive for CCGs to not use specialist services because it is cheaper for them to keep patients in primary care, creating a disincentive for CCGs and GPs to refer onto specialists. Some CCGs have disassembled specialist services altogether. An example repeatedly highlighted by specialists is the case of diabetes care in Southampton, where the local CCG withdrew funding and sought to develop primary care, only for admissions to hospitals to increase. For the Professor of Medicine and Consultant Physician Roy Taylor, the CCG's actions resulted in the "complete disintegration of specialist care to a disgraceful degree" (NAO, 2012).

There is also concern that the increasing tight performance management of GP referral patterns (see above) has meant that patients are kept in primary care for too long, resulting in adverse health outcomes and costly surgery in the long-term¹³³. One diabetes specialist spoke of the "referral police": CCGs who put great pressure on GPs who were seen to be referring on too much. The issue is exacerbated by the uncertainties surrounding diabetes management, which makes it unclear exactly when a referral is necessary:

*The complications side of things is easy. So if someone has gone into renal failure it's quite easy to say, 'yes, your kidney has really dropped off so we'll refer you to the diabetes clinic'. It's a kind of a no brainer and is easy to work out. But if someone's glucose levels are just rising year on year, do you try different therapy, try different therapy, try different therapy, before you refer them back? I'm guessing they probably will*¹³⁴

This is significant because it identifies further examples of failures of local decision-making. In some areas, the development of primary care has clearly been managed poorly, resulting in adverse health outcomes and ultimately costs in the long-run. A further consequence of PbR and the shift of care into primary care is that many hospitals are cutting back on their specialist posts because no longer can these posts be subsidised with profits from more basic services. Some Trusts are now without a multidisciplinary diabetes team¹³⁵. Yet specialists not only provide care

¹³² Senior representative of advocacy organisation, 22/03/2013

¹³³ Inadequate referrals have been linked to diabetes-related complications and inefficiency, as expensive treatments and surgical procedures are required in later years. The NAO estimate that a reduction in late referrals for foot ulcers by up to 50 percent would save £34 million a year by decreasing the amount of major amputation

¹³⁴ Diabetes specialist nurse, 07/02/2014

¹³⁵ The main data source on inpatient diabetes care – the National Diabetes Inpatient Audit (NaDIA) – found that specialist support was unavailable in a number of sites: in 2011 30.9 percent of providers did not have an inpatient diabetes specialist nurse, rising to 32.2 percent in 2012 (Health and Social Centre, 2013). The Diabetes Specialist Nurse Workforce Audits suggest that specialist nursing positions are being frozen or not replaced as vacancies are on the rise (Diabetes UK, 2011) and the

directly to patients but also train staff in the management of diabetes. There is concern that recent cases of insulin prescription errors, hypoglycaemia episodes and foot problems in hospitals may increase if the decline of specialist services is to continue¹³⁶. While this problem relates to wider trends in policy regarding the outsourcing of basic and more profitable forms of care to the private sector and the development of primary care, it may also constitute a failure of local decision-making. For there is evidence to suggest that diabetes specialist teams save hospitals money because they decrease patient stays and hospitals are paid on a per-patient basis (Kerr, 2011):

It's a completely inappropriate allocation of resources. Hospitals all get the same resource under the tariff system for the patients that they see and they're just choosing not to invest in an in-patient specialist team. The evidence is overwhelming that they're cost-effective¹³⁷

Nevertheless, where there are clear examples of inefficiencies at a local level, in some areas the Government's reforms have facilitated the development of new models of care which span the divide between primary care and secondary care, involving collaboration between CCGs and Foundation Trusts and which have support from a range of stakeholders (Diabetes UK, 2014b). For example, in Leicester and Leicestershire, the 3 CCGs in the surrounding area have collaborated with specialists employed by the local Trust to design and commission a diabetes pathway which spans secondary and primary care. Diabetes specialists will provide complex treatment and surgical procedures in secondary care, where there has been significant investment. Furthermore, a mobile specialist team consisting of diabetes-specialist nurses will provide support for primary care. GP practices, meanwhile, have gradually taken on more complex diabetes cases, with the best practices taking on a set of "Enhanced Services" and others practices free to refer complex patients onto specialists or other GP practices in the surrounding area.

The model is widely vaunted among stakeholders and specifically takes into account the perverse incentives in primary care and secondary care, the variable quality of general practice and the destabilisation of NHS Hospitals. Though contractual negotiations are on-going (after three years of negotiations, starting in April 2012), there are plans for providers to be paid through 'block' contracts rather than PbR, removing the incentive for them to hold onto patients, while patients have a 'seamless' pathway between different services and in and out of hospital. Yet the purported benefits of the model have to be set aside the significant administrative burdens involved in setting up the pathway. Both CCG members and specialists highlight significant transactions costs involved in working across organisational boundaries and negotiating the financial arrangements for the project:

annual Consultant Workforce Audit suggests that over the past four years there has been an overall downward trend in the appointment of Consultant Diabetologists (Diabetes UK, 2012).

¹³⁶ The NAO estimate that a reduction in insulin errors alone by 50% could save £3.35 million annually

¹³⁷ Diabetes specialist, 23/04/2015

The system doesn't create those natural collaborations. They (CCGs and Foundation Trusts) are almost set up to compete with each other, not to collaborate with each other ... I think negotiating the money and I think the organisational barriers have been the major challenges in setting this up¹³⁸

Current arrangements, characterised as they are by the purchaser-provider split and Pbr, appear to work against efforts to collaborate across organisational boundaries and facilitate the development of primary care in a way that realises widely shared goals of the health service.

¹³⁸ Academic and diabetes specialist, 17/03/2014

5.1 Evaluating Diabetes Governance and Policy

Section 2 set out the Conservative/Coalition Government's diabetes strategy. As we saw, a central feature of the Government's diabetes strategy is its revised approach to performance management through the Outcomes Frameworks. The strategy represents an attempt to 'steer' local actors to the attainment of policy objectives, with less disease-specific guidance in order to scope for local actors to fashion local solutions to health problems. Additionally, through the creation of CCGs and local authorities, the Government's reforms seek to promote more patient-centred care and holistic forms of public health.

Yet Diabetes UK has consistently campaigned for a nationwide response to solve the problems posed by diabetes. As the NAO and the PAC have shown, diabetes services perform poorly across a variety of measures, including poor implementation of the 9 key care processes, a rise of diabetes-related complications and widespread failure to implement the NHS Health Check, all of which are said to contribute to "excess deaths" of up to 24,000 people a year (PAC, 2012). In keeping with the 'managerialist' frame, some argue that greater centralisation is required, involving diabetes-specific clinical governance.

This section draws out some of the implications of the preceding frame analysis for this debate. I summarise the main issues where it appears that governance and policy is resulting in 'coordination problems' and identify alternative strategies where appropriate. In the process, I address evaluative questions of governance concerning the appropriateness of different forms of centralisation and decentralisation, as well as the use of markets in provision of health services.

5.2 Decentralisation or Centralisation?

The case for greater centralisation hinges upon evidence of poor quality care at a local level. Above, the frame analysis did indeed identify examples of poor local decision-making which suggest that governance is failing to provide local actors with both the knowledge and the incentive required to act on diabetes. Public health professionals highlight examples where CCGs have commissioned inadequate preventative medical care, which may result in complications in the long-term. Specialists highlight examples where CCGs and hospitals have commissioned inadequate specialist services, resulting in a direct increase in diabetes complications and hospital admissions. In Southampton, funding was withdrawn from specialist services altogether, only for investment to return once the rise in complications was apparent. There is also concern about pressures on GP referrals, which may lead to patients being kept too long in primary care, again resulting in complications and unnecessary costs.

Of course, these accounts may well reflect the interests of public health professionals and specialist in reporting them, but they corroborate with the concerns of patient representatives, Diabetes UK, the NAO and the PAC. Greater

centralisation, in the form of diabetes-specific clinical governance, may be required to improve decisions and actions at a local level.

However, since the publication of the NAO and PAC reports, comparative international evidence has come to light which suggests the UK has “significantly lower” rates of early death due to diabetes than the European average, faring better than most other countries (Murray et al., 2013). This is clearly significant because if NHS diabetes services perform well relative to other countries, then reports of poor quality of diabetes services may be overstating the problem. Indeed, some health professionals defend the NHS’ record, claiming that negative performance data merely reflects the enormity of the problem of diabetes and the fact the NHS has developed systems of data collection in diabetes which other health systems do not have¹³⁹.

Furthermore, the analysis above suggests that existing diabetes-specific governance, including targets for the delivery of the NHS Health Check and blood glucose control, does not encapsulate dispersed values and knowledge. Among health professionals, there is significant debate over the appropriateness of the centrality of blood glucose in diabetes care. I identified two understandings of the condition and how it might be solved. Where adherents of the ‘holistic’ frame understand Type 2 diabetes as a social problem linked to unhealthy lifestyles, adherents of the ‘medical’ frame understand it as a medical problem and one that is linked specifically to blood glucose. These frames share a commitment to health gain in a broad sense, although holistic care is associated with qualitative values of autonomy, wellbeing empowerment. Nevertheless, by exploring the content of health professional frames and analysing the evidence, I identified uncertainties over the capacity of medical care to promote health even in a restrictive, quantitative sense.

One implication of this is that, the NHS Health Check and blood glucose control aside, the Government’s attempt to shift away from disease-specific governance to a focus on long-term and cardiovascular conditions is warranted. Similarly, the development of public health and primary care also appears to be warranted. In public health, the new role of local authorities in public health is perhaps the most promising aspect of the Government’s reforms. As we saw, the framings of local public health exhibited aspects of the ‘progressive’ frame, emphasising the importance of democratic values and accountability. These local perspectives provided warnings of excessive centralisation and performance management. Some local stakeholders viewed the NHS Health Check to be both inefficient and inappropriate. Decentralisation over this decision would enable local actors to fashion their own solutions to diabetes. Additionally, local perspectives provide a counterview to the argument that local councils are performing poorly and require greater performance management. While some councils may indeed be genuinely poorly performing, poor performance could also reflect wider financial pressures on

¹³⁹ Academic and diabetes specialist, 17/03/2014

local authorities and greater performance management may undermine collaboration across local council departments.

Plans to cut local councils further and recent cuts to public health budgets highlight the scale of the challenges which local councils and public health departments face (Cooper, 2015). Though there is clear potential for the development of holistic forms of public health, more resources are required if health problems are to be solved in this manner. There is a sense that the medical route to prevention, involving screening initiatives and pharmacological therapy, is easier and cheaper.

In primary care, performance management is viewed more favourably. Specifically in diabetes, the QOF is widely held to have improved the quality of care, providing “organisation”¹⁴⁰. There is broad agreement that the process indicators within the QOF are vital in the provision of care. Some health professionals are concerned over plans to decentralise performance management by reducing the significance of the QOF as a proportion of practice income and allowing CCGs to set performance indicators at a local level. The issue is particularly significant given the entrance into the market of private providers, which have a poor record in the provision of care and data collection (Pollock and Macfarlane, 2014).

However, whereas the process indicators within the QOF are widely regarded as essential to catch complications at an early stage, the use of targeted glucose control is more controversial. The strategy closes down the scope for treatment plans and goals to be tailored to individual needs and preferences, which conflicts with patient-centred care, may put some patients at risk (Vijan et al., 2014) and closes off the possibility of holistic solutions to diabetes. There have been calls to decentralise decisions over treatment plans and goals.

Victor Montori, an American academic and diabetes specialist, has developed what he calls “minimally disruptive medicine”: medicine which is patient-centred and involves the use of individualised treatment plans, set in collaboration between patients and physicians. Patients are provided with information on the benefits and costs of different treatment options and are asked to prioritise upon different criteria. On the basis of discussions with their physician, patients select treatment plans that are conducive to their preferences and values (Montori and Fernández-Balsells, 2009).

“Minimally disruptive medicine” does not favour ‘holistic’ or ‘medical’ interventions but seeks to ensure that choices are made by patients in collaboration with their physicians. Shared decision-making in this way purportedly improves health and economic outcomes. Because treatments do not proceed on universalised targets, there is no pressure on GPs or patients to achieve a certain goal, improving the doctor-patient relationship. Furthermore, patients with complex diabetes, who may find it difficult to meet treatment targets, are more likely to stay engaged with the treatment plan because it is tailored to their needs and preferences. In this way,

¹⁴⁰ Diabetes specialist, 23/04/2015

shared decision-making has the potential to overcome the motivational problem of the compliance of patients. While the approach would improve patient-centred criteria, it may also improve health and economic outcomes because patients with complex diabetes remain engaged (Montori and Fernández-Balsells, 2009)¹⁴¹.

This provides strong grounds to decentralise decision-making in this area, which would allow physicians and patients to decide upon appropriate strategies at a local level. Nevertheless, there remains significant debate over the Government's wider organisational reforms, with stakeholders raising concerns across a range of criteria, including the quality of care and certain patient-centred criteria.

5.3 CCGs and the Development of the Market System

If the new role of local authorities in public health appears to be the most promising aspect of the reforms, the creation of CCGs is by far the most controversial. In some areas, the creation of CCGs appears to have provided the impetus for the development of new and responsive forms of care that are supported by patients, GPs and specialists alike. However, as we saw, there are significant areas of concern. While one option to improve the quality of CCG commissioning is indeed heightened performance management and diabetes-specific clinical governance, the problem may reflect more fundamental issues regarding the design and remit of the organisations. Here, it is useful to revisit wider debates about the appropriate organisation of health services.

As we saw in chapter 7 and 8, adherents of the 'political' frame argue that direct public administration is uniquely capable of achieving both equity and efficiency via planning, integration and reductions in transaction costs. Market health systems, which include multiple commissioner and provider units, may well produce more efficient organisations, but this comes at the expense of the overall efficiency of the system, as ever greater resources are expended on management, administration and marketing. A significant trade-off appears to be apparent because the need to create efficiency savings in market systems comes at the expense of universal and comprehensive coverage (Ali and Pollock, 2015).

In diabetes, there was some widespread recognition of the overall inefficiency of the system. Where PCTs were larger and combined the commissioning of health services and public health, decentralisation through the creation of CCGs has coincided with the creation of NHS England and Public Health England, which sit between them and the Department of Health (see chapter 7). For the Government's critics, this constitutes layers of unnecessary bureaucracy:

¹⁴¹ The economic case for patient-centred care in diabetes stems from studies that suggest the doctor-patient relationship and trust is critical to diabetes outcomes (Lee and Lin, 2009) and in particular that perceptions of treatment burden is related to compliance, which in turn impacts upon the incidence of diabetes-related complications and mortality rates (Ho et al., 2006; Vijan et al., 2005).

They got rid of the middle men and replaced them with more expensive middle men¹⁴²

Furthermore, while access to services remains free-at-the-point-of-use, people with complex diabetes face increasingly restrained access to specialist services. While this would question the capacity of marketisation to realise efficiency and equity, a further issue concerns the quality of care. Adherents of the 'political' frame argue that only direct public administration can achieve public health goals because the planning of services is carried out by regional organisations which integrate public health, primary care and specialist care (Talbot-Smith et al., 2004). The on-going developing of the market system may compromise the commissioning and delivery of good quality care.

Indeed, the Government's reforms further consolidate the purchaser-provider split. In diabetes, this split appears to frustrate the development of integrated care pathways. Both CCG members and specialists report difficulties in working across organisational boundaries to develop such models. The significant challenges involved in designing care pathways and in particular arranging the financial arrangements for the system may have contributed to the collapse of some specialist diabetes services, as the costs of working across organisational boundaries were too great to attempt a reconfiguration of services.

Similarly, while closer linkages between public health and local authorities are undoubtedly beneficial, the organisational divide between CCGs and local authorities, as well as the smaller budgets which CCGs have at their disposal, appears to frustrate the commissioning of preventative medical care. For these reasons, there is a strong case for larger, regional organisations which have greater resources at their disposal and combine aspects of commissioning and provisioning, on the basis of efficiency and quality of care¹⁴³.

Yet perhaps a more surprising finding of the analysis above is the questionable impact of marketisation on patient-centred criteria. There appears to be a tension between the role of CCGs in driving through efficiency savings and at least certain patient-centred criteria. The use of economic incentives in primary care may be linked to a decline in patient trust and has intensified the performance management of prescriptions and referral patterns at a local level, moving decision-making further away from patients and GPs.

Indeed, direct public administration may have a claim to realise certain patient-centred criteria, for financial decisions are taken at a broader level than in market systems. Health risks are shared between citizens in national health systems rather

¹⁴² Public health professional, diabetes lead for a local council, 27/04/2015

¹⁴³ This is consistent with efforts to develop primary care. Colin Leys argues that integration between primary and secondary care can be facilitated through the integration of GP practices (which have never been publicly owned) into the existing NHS architecture, thus ending the administrative and financial difficulties associated with working across the primary and secondary care divide (Leys, 2011).

than between members of insurance schemes, as in the case in CCGs. Of course, public health systems of direct public administration do not facilitate choice of provider, for there is only one provider. But, at least in theory, physicians have a larger pool of resources to draw upon and more scope to tailor treatment plans to individual needs and preferences, suggesting both efficiency and at least some patient-centred care are potentially reconcilable. Patients have choice over health professional (GP or specialist), location of care (primary care or secondary care), treatment plans, prescriptions and referrals; indeed, arguably a more qualitative sense of patient-centeredness than implied by market choice. This concept of choice may be particularly appropriate in diabetes care, where patients lack knowledge and require the support of professionals. One diabetes campaigner criticised the inappropriateness of market conceptions of choice in diabetes care:

I think something as complex as healthcare and particularly healthcare for conditions that last a life time, healthcare as shopping, the model doesn't work for me. Quite often people who are seeking care and need support throughout their life, are older, they've got multiple conditions, they're not very well: the idea that they're going to assemble a package of care around themselves by exercising choice and shopping around, and choosing the best quality, it's pie in the sky. They've got to be helped to get the right packages, they've got to be provided and integrated on their behalf, not by them having to do it because they'll just not be able to¹⁴⁴

6.1 Concluding Remarks

This case study has applied the evaluative approach set out in chapter 6. It adopted a qualitative, postpositivist approach which has potential to complement the quantitative research that is prominent in diabetes policy. Indeed, in chapter 2, I argued that quantitative evaluations only provide a partial account of performance and often prompt more questions than they answer. In diabetes research, the central quantitative metric is blood glucose. This metric informs the calculation of prevalence rates at the population level and is used to evaluate treatments in clinical trials. It is also used in medical practice, in the diagnosis and the management of diabetes in primary care. What is more, the metric provides an easily measurable indicator for performance management, linked as it is to the health of most patients and the behaviour of physicians.

By adopting a qualitative, postpositivist perspective, I have been able to explore the complexities and uncertainties involved in the delivery of policy, revealing significant issues with the use of diabetes strategies geared towards the control of blood glucose at the level of policy. Additionally, by examining decision-making at different levels of governance, I have been able to evaluate the extent that coordination is occurring across these different levels. In particular, by exploring and comparing the values and knowledge contained within stakeholder frames, it has been possible to identify various 'coordination problems' and to propose alternatives where appropriate.

¹⁴⁴ Senior representative of advocacy organisation, 22/03/2013

In diabetes, stakeholders at all levels of policy appear to agree upon certain core values, such as a commitment to the overarching principle of universal healthcare, the quality of care, efficiency, access to care and patient-centredness. This is not to downplay the level of contestation which exists in diabetes and health policy in general; for some stakeholders doubt the Government's commitment to universal healthcare. Nevertheless, the debate is over the effectiveness of different strategies and organisational forms to realise stated policy objectives, rather than a more fundamental debate about the appropriateness of diabetes services provided free-at-the-point-of-use. As such, problems identified by stakeholders are problems of coordination, whereby governance and policy is frustrating the realisation of what appear to be shared values.

By examining the knowledge content of stakeholder frames, it has been possible to both identify and explore these 'coordination problems'. Some stakeholders have different understandings of the nature of the problem of diabetes and favour certain services and forms of care, in accordance with the distinction between the 'medical' and 'holistic' frames. Some possessed knowledge which others lacked about the effectiveness of the different options available at this level. By bringing this knowledge to the fore, it was possible to demonstrate the uncertainties which underpin current strategies to diabetes in public health and primary care. It has also been possible to bring to the fore knowledge of detrimental effects of governance. Examples of ineffectual decision-making were identified at different levels of governance, such as poorly defined targets at the national level and failures to commission adequate healthcare at a local level. Some of these failures appear to be caused by poor understandings of diabetes at a local level; some to misaligned incentives; some to the transaction costs attached to organisational divides; and some simply to a lack of resources.

Following the identification of these issues, I proposed some alternative policy and governance arrangements which have the potential to more effectively realise the values revealed in the analysis. In primary care and public health, there is a strong case to decentralise decision-making over the NHS Health Check and targeted blood glucose control. Shared decision-making in primary care would enable patients and physicians to decide upon treatment plans and goals at a local level. Additionally, while there have been calls for greater performance management due to the poor quality of CCG commissioning, an alternative would be to create larger, regional organisations, based on previous models of NHS organisation. While it is beyond the scope of this project to provide an outline of what these organisations would look like, larger organisations would have a greater pool of skills and resources at their disposal and enable the commissioning of fully integrated care.

These proposals resonate with different aspects of the theoretical framework. While Friedrich Hayek provided the inspiration for the focus on coordination, the research revealed clear limitations to what centralised forms of decision-making can achieve in healthcare, as might be expected from his work. This is most clearly apparent in the use of targets for blood glucose control in primary care, which had

to be revised once it came known that the initial target increased the risk of mortality in some patients (Boussageon et al., 2011; Hemmingsen et al., 2011).

However, as we saw in chapter 7, there are different approaches to decentralisation in healthcare, with decentralisation claimed by both the 'progressive' and the 'medical-professional' frames. Both of these approaches to decentralisation are relevant in diabetes today. In public health, the Public Health Outcomes Framework (PHOF) serves a useful role as a talking point between local council departments and indeed local communities. But its potential as a performance management tool is questionable.

In primary care, there is undoubtedly some role for performance management. The Quality and Outcomes Framework is generally viewed positively among stakeholders and there is widespread agreement that the process measures contained within it are crucial for diabetes care. However, performance management of treatment goals and other aspects of care, such as decisions over prescriptions and referrals, resemble Taylorist management practices, which involve the capture of employee knowledge in performance management protocols and the standardisation of work and its products. In healthcare, the development of Taylorist forms of delivery is aided by Evidence-Based Medicine. Indeed, Stephen Harrison and colleagues claim that Evidence-Based Medicine and performance management in contemporary health governance have combined to create a complex of "scientific-bureaucratic medicine" (Harrison et al., 2002). Yet there are limitations to the extent that professional judgement and expertise can be sidelined in the process of care. The health and economic case for shared decision-making in primary care suggests that more scope for professional autonomy and discretion is required than is allowed by current policy and governance arrangements (Montori, 2014).

A further economic framework that is clearly relevant to debates on the governance of the health service is Transaction Cost Economics. The complexity of healthcare is such that services are intangible and not clearly defined prior to their delivery, while it is difficult to measure outcomes. This poses problems for performance management but also for markets, because complex and heterogeneous services like health care, which involve highly specific assets (see chapter 4), can result in high transaction costs when delivered through markets. The complexity of healthcare ensures that each clinical encounter between GP and patient is unique, while patients can go to and from a number of organisations, with input from a range of professional groups. While larger, regional organisations would enable the pooling of skills and resources in the commissioning and delivery of care, it would also improve efficiency through reductions in the administrative and contractual costs involved in setting up and administering care pathways.

Finally, there is some basis for the argument that the health service has the characteristics of a 'gift economy' and as such very different motivations are present within it. One unintended consequence of the reforms uncovered by the research is their detrimental effect on patient trust and the doctor-patient

relationship. The critical importance of trust and the doctor-patient relationship for securing patient compliance and the successful treatment of complex cases would suggest that markets are fundamentally inappropriate in this policy area. Additionally, while it is difficult to explore the genuine intentions and motivations of actors, health professionals frequently use patient-centred criteria to evaluate and criticise the reforms. Many of their concerns were shared by patient representatives, suggesting that the relationships between producers and consumers are not antagonistic.

This is potentially significant because, as we saw in chapter 1, New Left and New Right ideologies problematise the role of professionals in the welfare state in general and healthcare in particular. In diabetes today, New Left criticisms of 'industrialised medicine' made by the likes of Ivan Illich resonate with concerns regarding the overuse of pharmacological therapies for glucose control. Some stakeholders highlight a perverse specialist interest in intensified glucose control. However, specialists disagree on the effectiveness of the strategy and it was precisely the knowledge of some specialists which exposed some of its uncertainties. Furthermore, for people with complex diabetes, restricted access to specialists is a major area of concern. It would appear that it is the combination of market and managerialist mechanisms in the health service which poses greater challenges to patient-centred care than professionalism.

Chapter 10: Conclusion – Evaluating the Coordinative Capacity of Governance

This PhD has developed and applied a postpositivist approach to the evaluation of policy and governance, applying it in a case study of diabetes. The PhD was structured in three main stages. Chapters 1 and 2 introduced the topic of public sector governance and policy evaluation, highlighting issues with dominant evaluation methodologies; chapter 3 through to chapter 5 started the process of developing an alternative approach to evaluation, concluding in chapter 6 with an outline of the proposed approach. Chapter 7, 8 and 9 then explored debates on the NHS and evidence-based policymaking in health before, finally, presenting a case study of diabetes, where the methodology was applied.

1.1 Contribution to Knowledge

The primary contribution to knowledge is the proposed methodological approach, which was developed through an extensive literature review of existing evaluation methodologies. In chapter 2 and 3, I criticised the influence of positivism over EBP. EBP, in its current form, prioritises the Randomised-Control Trial (RCT) in evaluation, viewing the method as superior over all other forms of evaluation. Drawing upon postpositivism, I argued that knowledge claims are always value-laded, indeterminate and equivocal. Stakeholders are likely to have different interpretations of facts and evidence, particularly where a problem is complex or there is contestation over its meaning.

Indeed, postpositivist policy analysis is fundamental to my proposed methodological approach. A particularly important insight of ‘frame analysis’ is that policy debates are frequently characterised by competing interpretations, or ‘framings’, among stakeholders, informed by potentially conflicting values and particular knowledge. However, the bulk of policy analysis does not specifically seek to evaluate policy outcomes but to elucidate the nature of policy debate and in particular to explore the extent of moral disagreement between actors. It was therefore necessary to adapt postpositivist policy analysis to focus on stakeholders’ framings of the precise detail of policy and the choices and trade-offs involved in deciding between different policy options and strategies.

Furthermore, postpositivist policy analysis tends not to address evaluative questions of governance. At the level of governance, there is a burgeoning literature on network evaluation which does recognise the inadequacy of positivist forms of evaluation: networks bring together stakeholders of different values and interests. Stakeholder values are also mutable, adapting as network processes unfold. Hence, it is difficult to define objective criteria at the outset which might inform the measurement of outcomes.

For this reason, evaluation methodologies developed for networks, or “interactive governance”, typically adopt a process-orientation which seeks to inform the management of network processes. Trust and communication are used as proxies for the performance of networks. However, while this approach provides useful guidance in network management, it remains incomplete as a form of governance evaluation. Process evaluation is problematic on its own because well-managed processes, characterised by high levels of trust and communication, could still fail to improve policy outcomes. Furthermore, process evaluation provides little guidance regarding choices between different governance modes, including the use of hierarchical tools and market mechanisms. There is a need to develop evaluative methodologies in order to inform decision-making at this level, where decision-makers shape the overall governance arrangements in order to influence the delivery of policy.

To that end, I argued that postpositivist policy analysis should be complemented with political economy, in particular heterodox political economy. This combines an appreciation of the indeterminate and contested nature of knowledge and the often qualitatively distinct, incommensurable nature of values which motivate stakeholders, with an analysis of the institutional environment through which knowledge is put to use and values are realised in practice.

The concept of coordination, popularised by the heterodox economist Friedrich Hayek, can be used as a criterion to evaluate governance. Coordination is, for Hayek, a process through which actors seek out and act upon knowledge, in which consumers come to understand their ends in light of available consumer items and producers identify the most valued use of resources and utilise their own knowledge and expertise in the creation of consumer items. Developing this conception of coordination provides an opportunity to overcome issues with existing literatures on policy and network evaluation discussed above:

Evaluating governance in terms of its coordinative capacity is consistent with a postpositivist perspective because it is morally neutral: the focus is not on evaluating actors’ ends but whether actors are enabled or constrained in the pursuit of their objectives, whatever they might be and however diverse they are. Furthermore, coordination usefully brings to the fore the knowledge dimension of public policy. Indeed, Hayek shares with network theorists the concept that governance must utilise and develop dispersed knowledge. Governance must be evaluated in terms of its capacity to utilise existing knowledge and facilitate learning and innovation.

Additionally, Hayek’s concept of coordination implies the importance of taking into account both processes and outcomes; for ultimately he praises the market process for its capacity to realise the ends of its participants. This highlights again the weakness of literature on networks, discussed above, which focuses on process alone. Governance can only be fully evaluated if we take into account the views of stakeholders of the *effectiveness* of the process. Finally, coordination is consistent with a move beyond policy to governance. It orientates evaluation to the complex

and interconnected webs of means-ends relationships across different tiers and layers of governance.

1.2 The Methodological Approach

How, then, do we evaluate governance in terms of its coordinative capacity? It suffices to provide a brief summary of the methodological approach here, because chapter 6 presents it in detail. A central part of the evaluation must be to identify and compare the values present in stakeholders' appraisals of policy and governance. Through this, it is possible to establish the extent of agreement between national policymakers and other stakeholders over the political priorities that are to be addressed. It might be that the problem is truly wicked and stakeholders do not agree over political priorities. The role of evaluation, in this instance, is to elucidate the nature of the disagreement, as in the case of typical postpositivist policy analysis. Yet shared values may also be present that would provide a basis for outcome evaluation. Evaluations can then examine stakeholder appraisals of the precise detail of policy and the governance arrangements in place, hence providing insight into the effectiveness of policy and governance to realise seemingly shared values.

To that end, the evaluation must proceed from an exploration of values to the knowledge content of stakeholder frames across two levels: stakeholders' knowledge of the policy problem and possible solutions on the one hand, and their knowledge of the effects of the wider governance arrangements on the other. Both are equally as important because without the former it would be impossible to establish whether governance contributes to solving the policy problem; and without the latter, the evaluation would not address evaluative questions of governance.

By exploring stakeholders' understandings of policy problems and possible solutions, it is possible to ascertain the level of complexity which decision-makers face and the uncertainties which surrounds different policy options and strategies. Stakeholders might also possess and share knowledge of the wider governance arrangements in place. It is at the wider level of governance where political economy is relevant, because it concerns issues of the scale of decision-making, the use of economic incentives and transaction costs: all of which are explored in detail in chapters 4 and 5. Where seemingly shared values are present and stakeholders identify problems related to these issues, there are grounds to question the coordinative capacity of governance. The evaluation can then proceed to make proposals that would improve the effectiveness of governance. Hence, it is possible to combine the insights of postpositivism and heterodox economics to evaluate governance through a focus on coordination.

1.2 Policy and Governance Evaluation in Health

The proposed methodological approach was further developed in chapter 8, which provided a detailed critical analysis of existing evaluation methodologies in health policy. As in other policy sectors, evaluations in health are predominantly positivist. On the one hand, at the level of policy, 'health technology research' typically involves the use of RCTs and forms of Cost-Benefit Analysis to evaluate health interventions, such as surgical procedures, pharmacological therapies and screening devices, in terms of health outcomes and cost; on the other hand, 'health services research' typically involves observational studies which evaluate changes to governance by tracking the performance of health organisations over time, in terms of performance data on activities and processes.

In some sense, these two forms of evaluation are complementary: where the former evaluates health interventions across a range of health and economic criteria, the latter explores the efficiency of health services to produce those very interventions. Yet 'health technology research', like postpositivist policy evaluation in other sectors, downplays the complexity and uncertainties confronting decision-makers when they develop policy. This was most shockingly apparent in the case study of diabetes, where targets for glycemic control were extrapolated from large, high quality clinical trials, only to be revised when subsequent studies demonstrated they increase the risk of mortality in some patients. Yet the focus of health services research on implementation and efficiency alone will be blind to distortions like this at the level of policy. There is the possibility that governance is deemed effective when it could actually be harmful to patients. Hence, there is a need for in-depth, postpositivist research to explore actors' appraisals of both policy and governance in order to provide greater insight into the effectiveness of decision-making across the two levels.

2.1 Application, Findings and Political Implications

The different perspectives, or 'framings', of health policy and governance were identified in chapter 7. The case study then provided the opportunity to explore these different frames through detailed empirical research and, crucially, test out the claims made by their adherents. While the end of chapter 9 provides a detailed summary of the case study research, it suffices here to note the main issues identified in the research and to draw out some political implications.

The Conservative/Coalition government's Health and Social Care Act (2012) sought to develop the roles of local authorities in public health and GPs in medical care. Clinical-Commissioning Groups, the main organisation reform of the Act, are designed to facilitate the shift from specialist-led hospital services in secondary care to GP-led services in primary care, where a developing market of providers should facilitate efficiency, choice and responsiveness to patients.

In diabetes, stakeholders generally shared the values expressed by policymakers such that debates centred more on the effectiveness of policy strategies and governance arrangements in place rather than the fundamental objectives of the

health service. The new role for local authorities in the health service and the enhanced role for GPs were widely viewed as positive developments, because they open up the potential to develop and deliver improved diabetes policy. In particular, local authorities are uniquely placed to develop broad based public health to improve the health of local populations, such as healthy eating campaigns and the redesign of areas to encourage exercise. Additionally, GPs are uniquely placed to provide patient-centred care because they deliver care closer to home, see patients more frequently and have a broader range of knowledge than specialists. However, there was some concern over other aspects of current diabetes services which highlight problems with particular forms of governance, in particular the use of market and managerialist mechanisms.

The creation of CCGs, which are now the main commissioning organisations in the health service, was particularly controversial. By prioritising the role of the GP, CCGs lessen the influence of public health professionals and specialists over the commissioning of health services. Perhaps unsurprisingly, public health professionals questioned the quality of CCG commissioning when it comes to preventative medical care. Additionally, specialists criticised the commissioning of diabetes specialist services. In some areas of the country, diabetes specialist services based in hospitals have been disassembled in attempts to unilaterally develop primary care. However, this has led to increases in diabetes complications and emergency hospital admissions, as GPs have not had the requisite investment and support to deliver complex diabetes services. Furthermore, while developing primary care stands to improve the responsiveness of services to many patients, this is not the case for people with complex needs because access to specialists is increasingly constrained.

Failures of CCGs commissioning are perhaps down to inadequate resources at a time when the health service and public services more generally are struggling to maintain existing services when budgets are constrained and demand is increasing. However, another possibility is that ineffective commissioning is caused by the marketisation of the health service. Indeed, the divide between CCGs, GPs and primary care – on the one hand – and NHS hospitals and specialists – on the other – is the most recent incarnation of the purchaser/provider split, a key market reform introduced by the Conservatives towards the end of the late 1980s. While in some areas of the country, integrated pathways of care have been developed which span the purchaser/provider split, these are a minority. Furthermore, the creation of ever smaller organisations in order to facilitate market competition increases the transaction costs of the overall system. In diabetes, increased transaction costs were apparent because actors now have to work across organisational boundaries in order to develop integrated pathways of care.

Additionally, though in many respects the creation of ever smaller organisations is a decentralising measure, the reform of the health service has been characterised by heightened managerialism. In diabetes, centralised forms of decision-making associated with managerialism were sharply criticised. Indeed, while the government's reforms certainly open up the possibility to develop broad based

public health and patient-centred GP services, key targets in these areas close down that possibility. In particular, targets for the delivery of the NHS Health Check and glycaemic control have significant criticisms at a local level.

These findings have significant political implications. Problems with marketisation suggest that proponents of outright public ownership in health services are correct when they argue that public health systems have a unique capacity to deliver efficient, comprehensive and universal healthcare services. Public health systems facilitate significant efficiencies from savings on administration, contractual activities and marketing. In a wider context of austerity, the inefficiency of market mechanisms contributes to pressures on resources and makes it likely that increasing numbers of services, particularly specialist services, are no longer available on the NHS. This is clearly significant because it suggests that a major trade-off exists at the level of governance when society decides between a public health system and a quasi-market health system.

The limitations of managerialism in healthcare also have significant political implications. Since the 1970s, the New Left and New Right have been sceptical of the potential of public sector employees to deliver efficient and effective public services. My analysis suggests this scepticism should be revised and that professional judgement is crucial to the delivery of effective public services.

Controversy over targets for blood glucose control in diabetes is testament to the on-going importance of professional judgement. Indeed, much of professional knowledge is 'tacit' and acquired through years of practice; hence it cannot be centralised into clinical guidance or a performance management protocol. Yet professionals, in this case doctors, do not make decisions alone and patients play a vital role in the clinical encounter. Patients possess highly specific information about their condition, values, life situation and the effects of treatment. Shared decision-making between professionals and patients is therefore vital. This is important politically because the combination of markets and managerialism appears to be constraining the ability of health professionals to develop patient-centred care plans with patients who have complex health needs. The development of truly efficient, effective and responsive health services therefore requires a significant change in direction away from the market-managerialist model which is currently en vogue.

3.1 Limitations and Future Research Agendas

Like any piece of research, this PhD has limitations that are vitally important to consider. One issue is the use of the case study method. For example, I have made some evaluative claims about the governance of the health service as a whole. A possible rejoinder is that the findings are only relevant to diabetes and not to other areas of healthcare. Still, it is important to note here that diabetes is one of the most significant public health problems of the age. Issues in diabetes policy and governance are therefore important to address whether or not similar issues arise

in other disease areas. Nevertheless, more research is required to establish whether similar issues do arise in other areas. To that end, the proposed methodological approach would be suited to evaluating policy and governance for other complex conditions like cancer, stroke care and mental health.

A further issue is the size of the sample for the interviews. Indeed, I opted for in-depth, semi-structured interviews over surveys because qualitative research is most suited to researching complexity. Hence, the sample size was quite small, including four public health professionals, four GPs and four diabetes specialists. This enabled me to explore in detail each individual's appraisal of policy and governance, and identify often subtle differences between them. Yet a problem with this approach is that participants might not be representative of their respective groups. This tension between quality and quantity strikes at the heart of methodological debate in the social sciences. And, while for reasons of time and resources I have been unable to do so, future applications of the method could combine qualitative interviews with surveys to establish to what extent the views of participants are indeed representative of their respective groups.

Going forward, the proposed methodological approach could be developed in a number of directions. As we saw, Evidence-Based Policy in health is highly positivist and there is further scope to apply postpositivist insights to the field. Chronic conditions like diabetes, specifically Type 2 diabetes, have a range of causes and interventions can seek to ameliorate a range of possible risk factors, from socioeconomic factors like poverty and inequality to behavioural risks factors and finally biomedical risk factors. Yet scientific and economic methods, like the RCT, are more suited to biomedical care and the evaluation of medical treatments. As such, these forms of evaluation should not be the sole determinant of decision-making.

A future research project could seek to create a framework to contribute to both public debate and policymaking when it comes to developing policy strategies for complex conditions. This could take a condition like diabetes, establish a hierarchy of causes of the condition and complications related to it, and identify the full range of possible interventions and the evidence-base underpinning them. Qualitative interviews could then be undertaken with researchers, professionals and other actors about the choices and options available at this level and to ascertain their appraisals of the evidence-base. Such a framework would improve understanding of the fundamental causes of conditions, which are often political and economic. But also provide easily accessible information on policy interventions, the strength of the evidence underpinning them and also the strengths and weaknesses of dominant research methods, such as epidemiological research, RCTs and observational studies. This would provide greater clarity as to both the potential and limitations of health interventions and the 'positivist' research which underpins them.

The proposed methodological approach could also be developed where it relates to governance and coordination. My approach to the study of coordination was to

take the entire diabetes pathway and interview stakeholders both at a national level and at a local level, along the pathway. At a local level, some operated in the same health economy, while others operated in different health economies. This was important because my aim was to specifically evaluate national governance. Restricting my focus to one geographical area alone would have confined my research findings to that area, making it difficult to evaluate national governance because national governance affects different areas.

I have already discussed how this approach could be combined with survey research to establish the extent that stakeholders' views are representative. But the approach could also be narrowed down to focus on one local economy or indeed one organisation. In particular, the creation of CCGs is undoubtedly the most controversial organisational reform of recent years. Gaining entry to a CCG and undertaking in-depth ethnographic research, including participant observation and semi-structured interviews, would provide insight into policymaking within CCGs as members go about attempting to facilitate coordination. It would provide insight, for example, into the causes of the problems discussed above, regarding the inadequate commissioning of preventative medical care and specialist care: whether these problems are caused by a lack of knowledge and expertise on behalf of CCGs; inadequate or perverse incentives so that CCGs can impose costs on other actors; or simply insufficient resources to commission effective healthcare.

In-depth qualitative research of this sort would provide firmer grounds for my claim at the end of chapter 9 that CCGs are too small and larger organisations are required that combine commissioning and provisioning functions and have greater resources at their disposal. In any case, the dominance of positivism in policy evaluation ensures that there is a range of options to develop postpositivist approaches to the study of performance, efficiency and effectiveness.

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Appendix

Thomas Mills
8 High Acres
Billesdon
Leicester
LE7 9FB

3 November 2016

Dear Thomas,

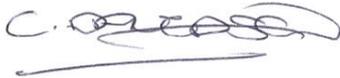
Application Number: 11/12/11A_DPIR
Thomas Mills: School of Social Sciences, Humanities & Languages
Mode: SSHL MPhil/PhD Research

Project title: Markets or Democracy? Examining Hayek Through the Lense of Deliberative Theory

I am writing to inform you that your application was considered by the SSHL Research Ethics Committee (REC) by correspondence in September 2011. The proposal was **approved**.

If your protocol changes significantly in the meantime, please contact me immediately, in case of further ethical requirements.

Yours sincerely



Carmel Davidson
**School Administrator, Research
Secretary, SSHL Research Ethics Committee**

cc Louise Sylvester, (Chair) SSHL Research Ethics Committee
Dr Jeremy Colwill, Dean of SSHL
Mike Fisher, Research Degrees Manager

PARTICIPATION INFORMATION SHEET

Evaluating Policy and Governance for the Provision of Diabetes Services

Project researcher: Thomas Mills

Supervisor: Dr Dan Greenwood

The present PhD research project aims to evaluate the governance of the National Health Service. In recent years, major service reorganisations have taken place and a variety of policy tools have been used in attempts to enhance the performance of the health service. The research will evaluate the effectiveness of current governance arrangements through a case study of diabetes services.

The research will involve semi-structured interviews with diabetes stakeholders who will be asked for their appraisals of current governance arrangements and policies. We are also interested in stakeholder views regarding the evidence-base underpinning diabetes policies. Possible topics include:

- The effectiveness of the new commissioning arrangements to commission appropriate diabetes services;
- The effectiveness of national performance management frameworks to drive service improvements;
- The appropriate balance between secondary care and primary care;
- The appropriate balance between pharmacological interventions – on the one hand – and public health and lifestyle interventions – on the other;
- The impact of marketisation across the diabetes pathway.

The research will involve 4 phases. Phase 1 has been completed, with extensive desk research and a number of scoping interviews carried out. Phase 2 is underway, with case study research being carried out in Leicester and Leicestershire. Phase 3 will involve the analysis and writing up of the report. Phase 4 is the dissemination stage, expected to begin in September 2015. The research will provide the basis for a PhD project and a number of academic journal articles.

We would like to invite you to take part in this project. This will involve an interview with the project researcher lasting between 45 minutes and an hour.

Please note:

- The research is being undertaken as part of a PhD project at the University of Westminster.
- Your participation is entirely voluntary.
- You have the right to withdraw at any time without giving a reason.

- You have the right to ask for your data to be withdrawn and for personal information to be destroyed.
- You do not have to answer particular questions in the interviews if you do not wish to do so.
- Your responses will be made anonymous and will be kept confidential.
- The recording will be transcribed and the data will be kept as part of the research archive for a period of 5 years. The audio recording itself will be destroyed once the interview has been transcribed.
- All computer data files will be encrypted and password protected. The researcher will keep files in a secure place and will comply with the requirements of the Data Protection Act.
- All hard copy documents, e.g. consent forms, will be kept securely and in a locked cupboard on University premises.
- No individuals should be identifiable from any collated data, written reports of the research, or any publications arising from it. As outlined above, quotations from the interviews may be used in the written reports/publications and roles and/or organisations of participants and the Leicester area may be mentioned.
- Stakeholders and participating organisations who have contributed to the project will be offered written summaries of the research findings and/or presentations from the author.
- The researcher can be contacted during and after participation by email (t.mills@my.westminster.ac.uk) or by telephone (07806497970).
- If you have a complaint about this research project you can contact the project supervisor, Dr Dan Greenwood by e-mail (d.greenwood2@westminster.ac.uk) or by telephone (0207 911 5000 ext 68936).

CONSENT FORM

Title of Study: Evaluating Policy and Governance for the Provision of Diabetes Services

Lead researcher: Thomas Mills

- I have been given the Participation Information Sheet and/or had its contents explained to me. Yes No
- I have had an opportunity to ask any questions and I am satisfied with the answers given. Yes No
- I understand I have a right to withdraw from the research at any time and I do not have to provide a reason. Yes No
- I understand that if I withdraw from the research any data included in the results will be removed if that is practicable (I understand that once anonymised data has been collated into other datasets it may not be possible to remove that data). Yes No
- I would like to receive information relating to the results from this study. Yes No
- I wish to receive a copy of this Consent form. Yes No
- I confirm I am willing to be a participant in the above research study. Yes No
- I note the data collected may be retained in an archive and I am happy for my data to be reused as part of future research activities. I note my data will be fully anonymised (if applicable). Yes No

Participant's Name: _____

Signature: _____ Date: _____

This consent form will be stored separately from any data you provide so that your responses remain anonymous.

I confirm I have provided a copy of the Participant Information Sheet approved by the Research Ethics Committee to the participant and fully explained its contents. I have given the participant an opportunity to ask questions, which have been answered.

Researcher's Name: _____

Signature: _____ Date: _____

INTERVIEW DETAILS

| Position/Role/Organisation | Date | Type of Interview |
|---|---------------------------------|--|
| Public health professional, diabetes lead for a local council | 14/02/2013 and 27/04/2015 | In person |
| Diabetes researcher | 14/02/2013 | In person |
| Senior representative of advocacy organisation | 22/03/2013 | In person |
| Senior representative of advocacy organisation | 22/03/2013 | In person |
| Independent diabetes campaigner and blog writer | 12/07/2013 | Telephone interview |
| Diabetes specialist nurse | 07/02/2014 | In person |
| Diabetes specialist | 10/02/2014 | In person |
| Civil servant, NHS England | 17/02/2014 | In person |
| Senior policy advisor to New Labour | 28/02/2014 | In person |
| LINK patient representative | 28/02/2014 | Telephone interview |
| LINK patient representative | 29/02/2014 | Telephone interview |
| Academic and diabetes specialist | 17/03/2014 and 12/06/2015 | In person |
| GP | 23/09/2014 | Telephone interview |
| GP and practice lead for diabetes | 30/09/2014 | Telephone interview |
| Diabetes specialist | 04/12/2014 | In person |
| Co-chair of CCG and local GP | 24/12/2014 | GP practice |
| Health campaigner and researcher | 13/04/2015 and 27/06/2015 | Via email (emails received on dates shown) |
| Diabetes specialist | 23/04/2015 | Telephone interview |
| NHS mental health worker | 24/04/2015 | In person |
| Director of public health | 13/05/2015 | In person |
| Public health professional | 13/05/2015 | In person |
| A deputy to regional director of Public Health England | 01/06/2015 | Telephone interview |
| CCG senior management assistant | 12/06/2015 | In person |
| Diabetes voice representative | 12/06/2015 | In person |
| GP | 12/06/2015 | In person |