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**Calovski V and Calnan, M (2019) Creeping Privatisation?
Examining Procurement Choices in the 'New' NHS in England
In F. Collyer & K. Willis (Eds.), *Navigating private and public healthcare: Experiences of patients, doctors and policy makers*: Chapter Seven pp. 131–154. Basingstoke: Palgrave Macmillan**

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Abstract

This chapter focuses on the introduction and implementation of the Health and Social Care Act (2012) in England which reignited the debate about the extent to which the government funded National Health Service (NHS) in England is being privatised and/or marketised. It analyses past health service policy developments as they relate to the role of the private health sector, providing a broad sociological and policy context for the most recent legislation and considering the extent to which these represent a radical shift or an incremental policy change. The chapter draws on an ethnographic study of decision-making by the newly created Clinical Commissioning Groups about the extent to which privatisation is taking place. The central argument is that while there has been a considerable change in the commissioning apparatus, private providers have not yet made inroads into the NHS. The chapter concludes by discussing the possible long-term implications of the legislation, considering the extent to which it may have indirectly, rather than directly, encouraged a drift towards privatisation.

Introduction

The NHS is consistently amongst the most popular institutions in the UK (King's Fund 2017a) and has continued to have strong public support for its tax-based funding and the model. The NHS appears to be resilient to radical changes although it is vulnerable because it is tax funded and subject to continued financial crises which requires central government control, regulation and monitoring (Klein 2018). Hence, governments have felt the need to intervene but been hesitant to introduce policies which appear to radically reform the NHS, particularly those that suggest privatisation (Calnan 2000; Shaw 2003). However, despite this need for political wariness, numerous reforms (Tuohy 2018) have taken place, the latest of which occurred in 2012. These most recent changes proposed an entirely new commissioning framework, which placed General Practitioners (GPs) in new Clinical Commissioning Groups (CCGs). In addition to the creation of these groups, the Health and Social Care Act (UK legislation 2012) included clauses which suggested an enhanced role for the private sector in the delivery of healthcare, increasing public concern about the issue of privatisation (Timmins 2012).

Debate about the effect of introducing the Health and Social Care Act (2012) emphasised either continuity or change (Ham et al. 2012), and the focus of debate was the impact of the changes. For some, the Act represented a threat to the fundamental premise of the health service of universal care free at the point of access, by encouraging the increased use of private providers (privatisation) (Pollock and Price 2011). Those also opposing the Act viewed it as 'privatisation by the back door' (Peedell 2011). There was a debate about other possible scenarios in which the NHS might become further marketised (Dixon and Ham 2010). On the other hand, those who argued that the reforms were simply an extension of previous Labour neo-liberal health policy suggested that it was just 'a logical, sensible, extension of [changes] put in place by Tony Blair' (Le Grand quoted in Timmins 2012: 84). These proponents claimed the Act simply expanded the neo-liberal principles associated with marketisation laid out by Labour Governments, and cited policy such as Practice-based commissioning (PbC); Total Purchasing; the role of patient choice and the use of private providers to deliver care (Miller et al. 2016). The previous Labour administration had put an emphasis on developing a partnership between the NHS and the private sector (Shaw 2003), where the mantra was 'what works counts', and offered a blurring of boundaries between the public and private sectors, rather than distinct divisions between the public and private sectors as reflected in 'old' Labour discourse (Mohan 2009). This stands in marked contrast to the Conservatives' approach in the 1980s, which aimed to expand the private sector outside the NHS (Calnan et al. 1993).

This chapter examines the potential effects of the Health and Social Care Act (2012) on the extent and nature of privatisation and marketisation in the NHS. Privatisation is understood to involve the 'transfer of assets' (Saltman 2003), from the public to the private, whereas marketisation occurs when there is the insertion of market principles within public services, but does not involve the private sector. It is customary for privatisation to be preceded by a period of marketisation, but this does not always have to be the case. Focusing on the commissioning process in this newly created landscape, the chapter draws on an ethnography of decision-making by the newly created clinical commissioning groups (CCGs) to explore how the new powers gained by the CCGs might have influenced decisions about the selection of providers. These new CCGs are primarily composed of General Practitioners who function as the key decision-makers in these new bodies. They are responsible for spending around 60 per cent of the NHS budget (The King's Fund 2017a). Under the new commissioning arrangements, in theory, the new commissioning groups were provided with powerful new commissioning tools, allowing them to utilise the market and decommission or fine providers they feel are under-performing. However, the use of these tools may manifest very differently in practice, and the focus of this ethnographic study is on these possible differences – primarily how commissioners use the tools at their disposal on a daily basis and how they select providers. The chapter begins with a brief narrative of the history of commissioning in the NHS, illustrating the extent to which recent reform policies reflect continuity and incremental, rather than radical, change.

The Socio – Historical Context: NHS Commissioning 1991-2010

The NHS was set up in 1948 as a universal healthcare system free at the point of access. The access point or first port of call for patients was primarily a general practitioner, and patients were referred to hospital-based specialist services if and when necessary. However, historically, the NHS service supply and organisation was decided upon by local health authorities for their patient populations. Commissioning as a distinct process was introduced in 1991 when the Conservative government (1987-1992) introduced the NHS and Community Care Act, which split the NHS into purchasers and providers of healthcare. In this context, commissioning is the process where the purchasers selected services from mainly hospital providers (The King's Fund 2015). The purpose of this was for the NHS to start behaving more like a market. Commissioning was carried out either by GPs or by area Health Authorities responsible for strategy and capital expenditures. From 1991-97, GPs were organised into GP Fundholding (GPFH) groups and given budgets to purchase non-urgent elective and community care for their local populations (The King's Fund 2015). The aim of the process was to incentivise GPs to manage costs and increase competition in their local health economies.

With the election of 'New Labour' in 1997, there were further reforms to the commissioning process. The GPFH schemes were abolished but the purchaser/provider split remained. In their place was a system of Primary Care Trusts (PCTs) which were developed and operational by 2004 (Turner and Powell 2016). These PCTs had a membership of all GPs, which led to the argument that it involved all GPs in some form of commissioning (Klein 2013; Lewis et al. 2003). They would directly contract NHS providers to deliver care for their geographical areas. The PCTs were responsible for commissioning primary, secondary and community services for their local populations. This meant they were responsible for delivering 80 per cent of the NHS budget (Turner and Powell 2016). PCTs also had the ability to commission private and third sector providers and were even encouraged to do so (Klein 2007). Alongside the PCTs, the Department of Health (DoH) retained control and strategic direction of the NHS through the Strategic Health Authorities (SHAs). This ensured oversight of the NHS from the Department of Health.

The New Labour government encouraged the use of private providers within the NHS and during the New Labour years (Mohan 2009), private facilities such as Independent Sector Treatment Centres (ISTCs) were established to carry out surgery on behalf of the NHS (Naylor 2009): primarily to reduce waiting lists. This encouraged the development of a mixed economy of care, as these private providers catered exclusively to NHS patients and were funded with public money. Thus, these previous policy changes, as they relate to commissioning, laid the foundation for the new legislation.

The Health and Social Care Act (2012): New Clinical Commissioning Decision-Makers

The purpose of the Health and Social Care Act (2012), introduced by the incoming Conservative-Liberal Democrat Coalition government, was to develop primary care-led commissioning. The key platform of the reforms involved the creation of GP Consortia with the responsibility for the commissioning of the major part of the NHS budget (Timmins 2012). These new Consortia would replace the PCTs. In the new Consortia, all GPs would be members, but only some would participate in the executive decision-making groups. The initial proposals suggested they would be responsible for the commissioning of '£60-£80 billion of the £100 billion NHS budget' (Timmins 2012:65). The Consortia would retain geographical boundaries similar to that of the PCTs. However, there would be several key differences. The GPs would no longer be responsible to a Chief Executive but would have their own elected Chairperson (a clinician), alongside new public accountability structures and regulatory bodies (Davies 2013). The Consortia were to be reactive to the demands of their populations and increase the ability of clinicians to alter budgets according to needs in a more effective fashion, thus increasing the power of GPs in the commissioning process, whilst marginalising managers (Davies 2013). The Health and Social Care Act (2012) also replaced the regulatory framework, with oversight of the new CCGs handed over to the newly created NHS England (formerly the NHS Commissioning Board) (The King's Fund 2013; Timmins 2018).

The reforms included clauses which mandated the regulatory framework to 'promote competition'. The Act enabled commissioners to use procurement, the process with which the commissioners can turn to the market and invite companies, both public and private, to apply to bid for contracts. This policy created opposition to the Act, as some groups feared it allowed for the increased growth of the use of private providers and thereby potentially opened the service to privatisation (Pollock et al. 2012). The considerable opposition to the Act manifested itself through public protest and resistance from professional bodies led to the dilution of some reforms. For example, that GP Consortia include some allied health professionals, rather than be solely comprised of GPs. Initially, the Act proposed that 'Any Willing Provider' would be able to compete for NHS services, which suggested that private providers would provide more NHS care than before. This was replaced with a clause preventing competition on the basis of price and limited the expansion of the private sector (The King's Fund 2013). The regulatory bodies still had a duty to 'enforce competition', introducing competition law into the NHS meaning that regulatory bodies could enforce rules to ensure fair competition and consideration of private providers (Davies 2013). However, there remained concerns that private providers would be utilised in greater quantity than previously in the NHS (Krachler and Greer 2015).

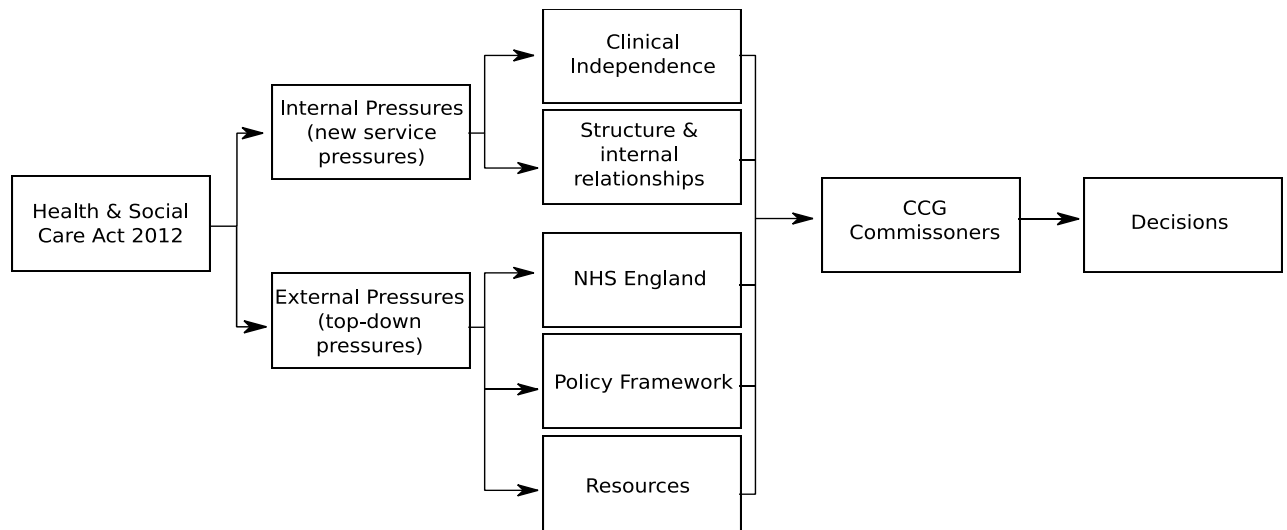
In summary, the Act put an emphasis on primary care-led commissioning, in the form of GP led CCGs as the method by which over two-thirds of the NHS budget is delivered. Being responsible for the dispensation of the largest part of the NHS budget, CCGs could decide to commission a large number of private providers. The CCGs were to operate in a framework that included regulators with additional powers in order to promote competition, while simultaneously being obliged to assist CCGs in integrating public, private and third sector providers in one system.

Developing A Conceptual Framework: Exploring New CCG Decision-Making Structures

The legislation formally gave commissioners greater levels of autonomy in the selection of providers than their colleagues in previous incarnations of primary care-led commissioning (Miller et al. 2016). However, this autonomy may be limited by various internal and external pressures, bringing into question their ability to select the most suitable provider. Figure One offers a conceptual framework to explain what might shape the decision-making process. It identifies the external and internal pressures (Checkland et al. 2013) that may have resulted from the new organisational structure of the NHS as stipulated by the Act. The external pressures (also called 'top down pressures') relate to the regulatory framework created by the Act, where new bodies were created and some previously existing regulators had expanded responsibilities. For example, the newly formed body, NHS England, was tasked with ensuring that targets on competition and efficiency are met. This was to be accomplished through its control over CCG budgets and its power to place any under-performing CCG under special financial measures (NHS England 2016), thus placing pressure on CCGs to generate savings (which could mean making greater use of public providers). The internal pressures (also called new service pressures), relate to the structure of the CCG and how commissioners operate within them. This includes the preferences of the commissioners, as some may look more favourably on private providers than others. It also identifies how decisions are reached, as there are different decision-making structures in the CCGs, with some placing more emphasis on group decision-making, while others focus on decision-making by key actors (McDermott et al. 2017).

The framework draws on theories of decision-making in organisations which highlight the influence of different system, organisational and professional interests in the shaping of the implementation of health policy (Pettigrew et al. 1992). Adapted from Pettigrew et al. (1992), the framework informed the ethnography. Which explored possible internal and external contexts, and whether or not top-down or local internal influences can assist in explaining the success or failure of structural change_(Williams, Brown and Healy 2018).

Figure One: Internal/External Conceptual Framework



Source: Calovski (2018)

The Ethnography

An ethnographic study was undertaken to understand how, in their new role, commissioners reach decisions about the providers they select for the commissioning of services and what effect internal/external pressures may have on these decisions. The ethnography was designed as a single case study across two different sites. The two sites were CCGs with access to a variety of providers and services with some history of use of private provision. The research data comprised approximately 215 hours of observations and 21 interviews with key decision-makers and providers across both CCGs (See Table One).

	<i>Site One</i>	<i>Site Two</i>
<i>Interviews</i>	12 Interviews (Chair, Vice-Chair, Deputy Managing Director, Lead Service Commissioners, GP commissioners, Assistant Directors of Commissioning)	8 Interviews (Chair, Vice-Chair, Deputy Managing Director, GP Commissioners and managers)
<i>Observations</i>	150 hours	65 hours

(Clinical Board, Governing Body and Finance and Performance Committee)

(Governing Body, Finance subcommittee and Transformation and Redesign Group)

Table One: Decision-makers interviewed and meetings observed

The commissioning of specific services was tracked at both CCGs. Under the new commissioning arrangements, the commissioners at the two CCGs had the ability to choose a public, private or third sector provider to deliver that service. At site one, the first service to be examined was elective procedures where there is a mixture of both public and private providers (NHS Digital 2012), and in the second, physiotherapy services were examined. Both electives and physiotherapy services are commissioned by CCGs, but there has been an increasing involvement of the private sector (Iacobucci 2013). Mental health services were examined across both sites. In this case, there is a mixture of providers, although there may be a slightly greater number of non-state/third sector providers of mental health services than private providers (Peck and Hills 2000). During the data collection phase, there was a particular pressure on commissioners at both sites to secure additional mental health services.

The researchers utilised an inductive thematic data analysis (Guest et al. 2013) aided by Nvivo. The data were used to understand how commissioning decisions were reached and whether or not commissioners preferred to use public/private/third sector providers. Once key themes were identified, they were explored in more depth at the sites through further observation and interviews. This process was repeated with the data from site two. The differences and similarities between these two sites were then contrasted before addressing the overarching questions of the study.

Decision-Making Within CCGs: What Shapes It?

Both CCGs were located in large urban areas covering around 300,000 people each. Within these urban areas, both sets of commissioners have access to private providers which tend to be concentrated in such areas (King's Fund 2017a), so commissioners were able to choose providers from what can be characterised as an active 'marketplace', i.e. one in which they have the ability to choose various types of providers for the same service.

The Salience of Financial Pressures

One of the key challenges commissioners have faced since 2012 is the need to generate additional savings that were to be enforced by the sector regulators, such as NHS Improvement and NHS England (Appleby et al. 2014; Health and Social Care Act 2012). This task was made more complex by the financial pressures on the provider side (i.e., the hospitals) of the NHS, which reported a deficit of £1.85 billion (King's Fund 2017b). Thus, commissioners have to seek to continue to improve services, whilst they are under pressure to spend less.

The two sites which were selected to be part of the research reflected these financial pressures. Site one had been able to generate a recurrent surplus. As a result, commissioners were able to explore how to best select providers, and focus on the clinical needs of their populations in the selection of providers. These commissioners were not forced to select any type of provider. They had the ability to choose how to improve their services and this included developing existing services. At site two, the situation was considerably different. The commissioners faced an annual deficit and this meant that the focus of commissioners was on generating savings to prevent sanction by NHS England.

These financial pressures had implications for the internal processes of the CCGs. Commissioners value their autonomy (Iacobucci 2016), and believe they are best placed to deliver providers for their local populations (Checkland et al. 2013). The reasons for commissioners becoming involved in CCGs are numerous, but the predominant one appears to be a desire and belief that they can affect positive change. There is evidence that in previous primary care-led arrangements, commissioners disregarded external pressures and pursued their own commissioning arrangements which favoured local providers (Smith et al. 2004). Often this took the form of working alongside local providers (Flynn et al. 1997).

Commissioners sought to utilise arrangements which they had prior experience of, rather than seeking new providers. These sort of commissioning priorities were enabled by the financial surplus at site one. Commissioners could focus on developing local providers, which were mostly NHS Trusts. They were able to select to utilise procurement in some instances, but chose to do so only when existing providers may have been unable to provide a service. They sought to circumvent centrally imposed rules and focus on these existing relationships (Hunter et al. 2015). At site two, the pressures were much more severe and this affected the commissioning priorities of the CCG, which resulted in a greater use of private providers.

The financial pressures that the CCGs faced also affected how they approached commissioning. The tools available to commissioners when exercising choice over the selection of providers were transformation, procurement and decommissioning. Transformation involves the purchasing of additional services from providers with whom the CCG has some existing form of contractual arrangement. There is an obligation that commissioners should do this for contracts in excess of £100,000 (NHS Commissioning Board 2012). Commissioners could also decommission providers if they were deemed to be failing.

The Nature of the Provider Marketplace

The most significant issue faced by commissioners with regard to the provider marketplace, is the behaviour of large NHS hospital Trusts. These Trusts are the major providers in the English NHS, representing most hospitals and by extension secondary care within the system. The majority of patients in the NHS are treated by such institutions. They dominate this marketplace by virtue of their sheer size (i.e., budget, number of patients). There is some competition within the system, where these Trusts compete with smaller private and third sector providers. CCGs struggle with the behaviour of the Trusts as, in their view, Trusts are seeking to maximise the amount of money they can get out of the system:

I was leading on the Urgent Care Centre [UCC]... [Local Hospital Trust] had it, they actually came to us and said, we don't want to do this anymore, as they were having lots of issues with subcontractors... and they thought they weren't making money on it, so we looked at it, and realised we were paying a lot of money for it compared to other UCCs... [Local Hospital Trust] realised they were making money and wanted to change their mind, but it was too late (Commissioner 3, Site One, Interview).

Commissioners perceived that the Trusts were focusing on their own financial priorities, even if that meant that the CCG would be put under increasing financial strain. This strain was exacerbated by the use of Payment by Results (PbR) contracts, which meant commissioners had to pay hospitals for the number of patients they saw, even if this outstripped available resources as evidenced in a Transformation and Redesign group (TRG) meeting:

The discussion in the meeting is about how commissioners can adjust existing resources to address the unexpected increased cost of the PbR contracts with the local Trusts. Had to deploy reserves to meet control totals for the month (Observation, Site Two, March 2017, Field notes).

The commissioners are faced with the challenge of finding a balance between the best possible care for their populations and working alongside existing providers. With the provision of beds considered to be a key descriptor of the overall performance of the NHS (Smith et al. 2014), the commissioners have to dedicate the majority of their budgets to the NHS Trusts, which are the only provider of beds. They provide the majority of the care to NHS patients, however, as a result of this, when there are contractions in the NHS budget, they tend to be affected as they are reliant on public funds. Under the new regime, they receive their money from the CCGs. Trusts, therefore dominate the landscape, providing the majority of care, but are also very vulnerable to changes to funding. This dominance of the Trusts, due to their size and scope of services, makes them vulnerable to financial pressures which characterise the current environment (Ibid 2014). In response to these financial pressures, the Trusts are exploring various solutions and methods. Commissioners, on the other hand, have no alternative providers that they can utilise to replace the Trusts. So, while competition is encouraged by the new reforms, there is a lack of provider diversity (Allen et al. 2012). Commissioners are also unable to affect the cost of their contracts as the mechanism through which changes are conducted favours the provider (Allen and Petsoulas 2016). Commissioners therefore have limited options that they can utilise to relieve

the pressures that they face when it comes to the NHS Trusts. NHS Trusts remain key partners, but there is a general perception amongst commissioners that they do not represent good value for money.

These financial pressures are best illustrated by the situation at site two, where the commissioners were facing these severe resource constraints. Over the course of the 12-month ethnography, the CCG had focused on attempting to eradicate a deficit in excess of six per cent of its annual budget. Commissioners entered voluntary 'turnaround', in which they agreed on a plan to reduce the deficit with NHS England and thus managed to remove the threat of sanction. The CCG Chair was elected on a platform of bringing the finances into order:

Yes, we had to change direction because we were in the... in a financial hole, and the only way of getting out of that financial hole was to... bring the clinicians in the practices on board, and say look, you are the solution to this, if we go on doing the same, we will be a problem, so how can we do it? I think the previous Chair, probably [um] hadn't got the confidence that... of their peers that they were going to do that (Chair, Site Two, Interview).

The Use of the Market to Control Financial Pressure

The commissioners at site two utilised procurement much more frequently in order to relieve financial pressures. They sought to move care from hospital settings to community providers. As the only mechanism to introduce new providers is procurement, commissioners at site two used this process more frequently than those at site one. For example, the CCG procured physiotherapy services, which was awarded to a private provider. This private provider undertook the work at a lower price than the previous public provider, alleviating some of the financial pressure faced by the CCG.

Not only did the private provider assist in reducing the financial burden on the CCG, they also provided a more effective service further encouraging the use of private provision. This perception of the provider was shared by the commissioners that were found at site two:

Our best provider of the things that we have commissioned is a private organisation, [Name of private provider], physios, is the best provider, they do everything, everyone is happy with them, because they run things with energy, when there is something that is a threat to my practice, we need to be better and provide a better service, provide better care, because of performance reviews and we need to get big, and that's it, and I think like that, and I think that's what's missing, it's a market out there but you can use it to your advantage but you have to be smart, so the hospitals don't think like that (Commissioner 3, Site Two, Interview).

In securing the contract with the CCG, this private provider then adapted their own practices to prove more attractive to commissioners. After becoming a provider in the local healthcare economy, they were then able to provide additional services if the commissioners wished them to. In this way, private providers can become dominant in certain elements of care in some areas.

The commissioners at site one were able to utilise local providers and focus on the medical aspects of care due to their positive financial situation. At site one, the CCG was able to commission new services and demonstrated it could and would utilise the commissioning tools at its disposal. It managed to achieve this through generating an annual surplus, which was reinvested into expanding existing services or writing procurements for new contracts. Commissioners at site one emphasised using their surplus to address areas of care which they felt they were underperforming in, most notably Child and Adolescent Mental Health Services (CAMHS). After identifying the need, commissioners discussed their options at board level meetings and the simplest method of improving provision was to provide additional funds to existing providers:

...so if you look at CAMHS, so [local Mental Health Trust A] do most of the CAMHS service already, if you want to put another £100k into CAMHS, the most sensible place is to put into that service, or into that existing provider (Commissioner Five, Interview).

The GP Mental Health lead confirmed an availability of resources and claimed that the contracts could be bought from the existing providers:

...it just seems that you know what you want, and if it's just there, why not just get it? If it's more of what's already there and you're happy with the service, why do you need to procure? In this particular... well because the money involved at each different level, for particularly CAMHS, there were lots of them, but they were quite small that it wouldn't have justified a procurement, so we didn't get any pressure (GP Mental Health Lead Commissioner, Site One, Interview).

In addition, working alongside the local providers would also help the commissioners:

...arguments were made that the new Mental Health Provision being commissioned would help generate savings, and relieve pressure on the local Trust which has a deficit (Clinical Board, Observation, April 2015, Site One, Field Notes).

Commissioners exhibited a preference for utilising existing local arrangements rather than turning to procurement. The process is assessed 'blindly', with commissioners rating the applications without knowing which provider submitted which bid. Generally, applications are assessed on the basis of quality but a part of the process is also to do with the financial element, with some providers promising to provide the service at less than the advertised value. Commissioners did not appear to be ideologically opposed to the process, but in some cases were concerned at the length of the process and the amount of staff time required to rate providers:

...procurement is lengthy, and it takes another 18 months once you have a service in to get service implementation up and running to what your vision and your dream is, so it's not easy (Deputy Managing Director, Site One, Interview).

Therefore, the financial situation did affect how commissioners behaved. Those who were facing more severe financial situations were more likely to utilise procurement to target private providers in a bid to alleviate the difficult financial situations they faced.

Contextual Differences: Implications for Marketisation and Privatisation

The adverse financial situation at site two resulted in increased use of decommissioning. The commissioners at site two directly decommissioned and changed services due to the need to generate savings, notably decommissioning a podiatry clinic. The savings generated from the decommissioning of the service were modest - £75,000 annually (TRG Observation, Site Two, February 2017, Field Notes). The challenge in meeting their financial targets was a key factor in the strategies adopted:

...we are coming to that time when it is really difficult, because we are in a deficit position, fortunately not a recurrent deficit position, we will meet our control total for the year, we will still meet some of our [savings] expectations, and Friday before last, in this very room, we managed to persuade NHSE that we were still likely to be better at doing this than any likely alternative that is available to them, so I think we are in as good a place as can be, I think (Commissioner – Head of Finance, Site Two, Interview).

In persuading the NHSE that they could meet savings expectations, commissioners at site two entered voluntary turnaround, a process where they agree to reduce their expenditure with the sector regulator. They agreed to change and potentially eliminate contracts in order to reach financial targets. As a result, the level of marketisation and privatisation increased as commissioners turned to private providers to generate the necessary savings.

With commissioners increasingly using procurement, coupled with their negative perception of Trusts and the financial pressures (at site two), there has been a growing acceptance of the presence of private providers in the marketplace of NHS providers. The success of the private physiotherapy provider at site two left a positive impression on some commissioners. This could signal a deeper cultural shift in the NHS - that the private sector may have a key role in the delivery of some services in future. The private providers seem to have found a niche in the market in which they are comfortable and are proving to be successful in the delivery of services.

The contracting arrangements mean that the commissioners have little ability to limit the demand and activity levels of the Trusts. The Trusts are large providers which usually work with several CCGs and thus, one CCG cannot greatly affect the working of a single Trust. The Trusts also compete with other

providers in the marketplace, which further disrupts the work of the commissioners, as the Trusts can win contracts that commissioners have previously decommissioned from them in order to attempt to find a cheaper alternative provider via procurement.

However, the decommissioning of Trust-provided services remains a rare event, primarily due to a view shared by commissioners that they have duty towards the Trusts, and the fact that the provider market is still underdeveloped and incapable of meeting the demands of providing service for a large hospital.

Discussion: A Changing Private/Public Balance in the NHS?

The ethnography provided evidence that the new commissioning arrangements have led to an increase in privatisation, although in a limited sphere in the context of the NHS as a whole. It also confirms a growing use of market mechanisms (e.g., procurements) but a lower level of involvement of the regulatory bodies than was initially expected. It showed that despite the wide powers commissioners are given by the Act, in reality they have very limited choice when commissioning. Depending primarily on the financial circumstances, commissioners are more likely to opt for commissioning tools which end with a private provider being selected when faced with budget deficits (external pressure) as opposed to a situation in which they possess a surplus, which allows them to prioritise quality of care (internal/local demand). The latter is confirmed by the differences in the findings at the two CCGs.

The evidence suggests that as a result of the interplay between the external and internal pressures, the commissioner's autonomy in decision making is limited to the 'periphery' of the commissioning process. Commissioners tend to exercise choice when they use procurement or when they choose to work with existing providers. Often the choice of the method is the major determinant of what type of provider is awarded the contract (procurement is the only entrance to the NHS market for a private provider). With regard to privatisation, commissioners are faced with a limited choice of private providers, as on the whole, they do not have the capacity, either financially or in expertise, to provide complex care. There is a lack of a developed private market, with many of the private providers in the UK focusing on areas of health where they can generate profit quickly (such as physiotherapy). While historically this has been the case in the UK, it is suggested that it may change in the future (Krachler and Greer 2015).

Explanatory Power of the Conceptual Framework

The internal/external framework has proved to have some explanatory power for understanding how commissioners reach decisions. Evidence from this research suggests that a complex network of different elements influences the decisions made by commissioners, particularly their interactions with local hospital trusts and the sector regulators. The framework does not do an adequate job of explaining how and why certain actors may act within the new framework. At both sites, many of the GPs had considerable prior commissioning experience and adapting to new commissioning arrangements took less time than was anticipated (Most of the commissioners previously worked for PCTs or other commissioning bodies). Hence there was a reservoir of commissioning experience which the CCGs drew upon. These clinicians, in their hybrid roles (Checkland, Harrison and Coleman 2009), enhanced their managerial autonomy, discretion and confidence in their decision-making in this setting (Harrison and Ahmad 2000). Thus, given this experience, clinicians were particularly insistent on their independent role and predisposed to maintaining existing relationships to ensure the continuing provision of services. They believe that they are best placed to make the decisions necessary for their population, which helps to explain their willingness to enter agreements such as 'voluntary turnaround'. While these clinicians do have considerable freedom, this remains very constricted due to the financial situation, but they are able to manage this to some degree. The limited resources, however, have had a particularly constraining impact - reflected in the way NHS England involved itself in the affairs of the CCGs. This course of action suggested that NHS England assumed a passive role in regards to most issues, apart from those deemed critical, and is nearly exclusively concerned with financial matters and management, to the detriment of clinical care and best outcomes for patients. The regulator only became involved when it was forced to, providing further evidence of a lack of systematic, central leadership in the NHS (Ham et al. 2015).

In summary, the balance between the public and private sectors has changed in the NHS, but to a limited extent and not to the extent that many of the critics of the Act feared. This change occurred through commissioners utilising their tools to expand the range of providers they use. However, the private sector has not supplanted or become a viable alternative to the existing public providers.

Privatisation, when it has occurred, has appeared only within the scope of certain services. The most effective characterisation of this process would be 'passive privatisation', in which services which have been allocated to the private sector are those in which the treatment of patients is possible outside hospital settings. Commissioners do not appear to have been led or driven by any clear ideological agendas, but have rather used procurement as and when it assisted them in generating savings, whilst still attempting to support local providers. Therefore, it can be concluded that the new regulatory framework has helped to move some smaller contracts from the public to the private sector, but only within certain services.

Future Implications of the Health and Social Care Act (2012)

There has been a continued growth of marketisation in the NHS (Ham et al. 2015). Commissioners feel that the use of procurement is a key tool that can help them achieve their aims. Procurement has become an accepted 'norm' within the CCGs, and commissioners have not been ideologically opposed to the introduction of these mechanisms, or even the appointment of private providers, but are more concerned with the length of the process and other issues (i.e. potential legal challenges). Indeed, if the private sector was developed enough to function as a true alternative to the large NHS Trusts, there would likely have been some movement on behalf of commissioners, exercising their autonomy to shift away from existing arrangements, in order to meet their financial goals. The majority of procurements are awarded to public providers, meaning there is little privatisation but an ever-increasing use of market principles, which represents a significant level of marketisation of the system.

The Act has also had the effect of further marketisation of the system by the opening of the internal market to outside competition. The role of the private sector was entrenched on the 'periphery' of the NHS but, more significantly, has allowed private sector actors to present themselves as direct competitors to public NHS Trusts in certain fields. The private sector could move in the direction of extending its activity to services where they have not traditionally been involved. For example, Virgin Care has purchased 21 primary care services in the UK (Virgin Care 2017). It is possible also, with the recent slowdown in the growth in funding of the NHS (the consequences of which were exemplified in the site two CCG in this study), might mean that a 'broke' NHS could encourage further 'creeping' privatisation (Klein 2013).

Describing GP Fundholding, Le Grand stated: *'the constraints were too strong and the incentives too weak'* (Le Grand 2002). This seems to be an accurate description of the current state of the NHS after the Health and Social Care Act (2012). Whilst commissioners have the powers to change the service radically, they are in fact restricted in doing so by the dynamics of the new regulatory framework. In practice, commissioners do not seem to have an incentive to change the status quo, in seeking to ensure the continued provision of services in an increasingly complex and uncertain environment. However, with regard to the global private healthcare market, the UK remains a predominantly public system. There have been little wholesale shifts and compared to many other health systems, hospitals and most secondary care services remain publicly owned and funded bodies and there is a continued absence of private provision in primary care (Mossialos et al. 2015). This is slowly starting to change with a greater emphasis on using private providers in order to deal with increasing financial pressures on the health system, suggesting the high public control of both funding and provision which characterises the English health service may be shifting provision into greater pluralism (Hunter 2016). The neo-liberal austerity policies introduced over the last decade significantly reducing public investment in the NHS and other welfare services appears to have led to a need to use the market and increase in the use of private providers perhaps indicating either a form of passive or 'creeping' privatisation.

References

- Allen, P., Turner, S., Bartlett, W., Perotin, V., Matchaya, G. and Zamora, B., (2012). Provider diversity in the English NHS: a study of recent developments in four local health economies. *Journal of health services research & policy*, 17(1_suppl), pp.23-30.
- Allen, P. and Petsoulas, C., (2016). Pricing in the English NHS quasi market: a national study of the allocation of financial risk through contracts. *Public Money & Management*, 36(5), pp.341-348.
- Appleby, J., Galea, A. and Murray, R., (2014). The NHS productivity challenge. *Experience from the front line*. London: The King's Fund.
- Calnan, M (2000). The NHS and Private Health Care, *Health Matrix*, 10, (1), 3-11.
- Calnan, M, Cant, S. and Gabe, J. (1993) Going private: why people pay for private health care Open University Press.
- Checkland K, Harrison S, Coleman, A. (2009) 'Structural Interests in Health Care: Evidence from the Contemporary National Health Service' *Journal of Social Policy* 38(4): 607–625.
- Checkland, K., Allen, P., Coleman, A., Segar, J., McDermott, I., Harrison, S., Petsoulas, C. and Peckham, S. (2013). Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS. *BMJ Open*, 3(12), p.e003769.
- Davies, A.C., (2013). This time, it's for real: the Health and Social Care Act 2012. *The Modern Law Review*, 76(3), pp.564-588.
- Dixon, A. and Ham, C., *Liberating the NHS: the right prescription in a cold climate?* King's Fund. 2010.
- Flynn, R., Williams, G. and Pickard, S. (1997). *Markets and networks*. Buckingham: Open University Press.
- Guest, G., Namey, E. and Mitchell, M. (2013). *Collecting qualitative data*. Thousand Oaks: SAGE Publications.
- Ham, C., Baird, B., Gregory, S., Jabbel, J. and Alderwick, H. (2015) *The NHS under the Coalition Government*, London: Kings Fund.
- Ham, C., Dixon, A. and Brooke, B. (2012). *Transforming the delivery of health and social care*. [online] London: The King's Fund. Available at: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/transforming-the-delivery-of-health-and-social-care-the-kings-fund-sep-2012.pdf [Accessed 7 May 2017].
- Harrison, S. and Ahmad, W. (2000). Medical Autonomy and the UK State 1975 to 2025. *Sociology*, 34(1), pp.129-146.
- Hunter, D., 2016. *The Health Debate 2nd edition*. Policy Press.
- Hunter, D., Erskine, J., Small, A., McGovern, T., Hicks, C., Whitty, P. and Lugsden, E. (2015). Doing transformational change in the English NHS in the context of "big bang" re-disorganisation. *Journal of Health Organization and Management*, 29(1), pp.10-24.

- Iacobucci, G.,(2013). Majority of £1.5 bn NHS contracts go to private providers, study finds. *BMJ: British Medical Journal (Online)*, 34.
- Iacobucci, G. (2016). More doctors are engaged in commissioning under CCGs. *BMJ*. [online] Available at: <https://search.proquest.com/openview/cca5178ea2557b1eab9cd3f8aa8e55c0/1?pq-origsite=gscholar&cbl=2043523> [Accessed 6 Aug. 2017].
- Klein R (2013) England's National Health Service-Broke Not Broken, *The Milbank Quarterly* 93,3,455.
- Klein R (2018) The National Health Service (NHS) at 70:Bevan's double-edged legacy Health Economics, Policy and Law, page 1 =10 © Cambridge University Press 2018doi:10.1017/S1744133117000354
- Krachler, N. and Greer, I. (2015). When does marketisation lead to privatisation? Profit-making in English health services after the 2012 Health and Social Care Act. *Social Science & Medicine*, 124, pp.215-223.
- Le Grand, J. (2002) 'Further Tales from the British National Health Service'. *Health Affairs* 21.13 : 116-128.
- Lewis, R., Dixon, J. and Gillam, S., (2003). *Future directions for primary care trusts*. King's Fund.
- McDermott, I., Checkland, K., Coleman, A., Osipovič, D., Petsoulas, C. and Perkins, N., 2017. Engaging GPs in commissioning: realist evaluation of the early experiences of Clinical Commissioning Groups in the English NHS. *Journal of health services research & policy*, 22(1), pp.4-11.
- Miller, R., Peckham, S., Coleman, A., McDermott, I., Harrison, S. and Checkland, K. (2016). What happens when GPs engage in commissioning? Two decades of experience in the English NHS. *Journal of Health Services Research & Policy*, 21(2), pp.126-133.
- Mohan J (2009) Visions of privatisation under new labour, in Gabe, J. and Calnan, M. eds. *The New Sociology of the Health Service*, Routledge, chapter 4 ,p.79-99.
- Mossialos, E., Wenzl, M., Osborn, R. and Sanark, D. (2015). *International Profiles of Health Care Systems*. [online] Commonwealth Fund. Available at: <http://www.issuelab.org/resources/25100/25100.pdf> [Accessed 21 Jan. 2019].
- Naylor, C. (2009). *Briefing: Independent sector treatment centres*. [online] London: The King's Fund. Available at: <https://www.kingsfund.org.uk/publications/briefing-independent-sector-treatment-centres> [Accessed 5 Mar. 2018].
- NHS Commissioning Board (2012). *Procurement of healthcare (clinical) services*. [online] London: NHS Commissioning Board. Available at: <https://www.england.nhs.uk/wp-content/uploads/2012/09/procure-brief-3.pdf> [Accessed 12 Feb. 2018].
- NHS Digital. (2012). *NHS hospitals: new figures suggest 11 per cent increase in procedures carried out by private sector in a year - NHS Digital*. [online] Available at: <http://content.digital.nhs.uk/article/2285/NHS-hospitals-new-figures-suggest-11-per-cent-increase-in-procedures-carried-out-by-private-sector-in-a-year> [Accessed 3 Aug. 2017].
- NHS England, (2016)."Mental Health » Valuing Mental Health Equally With Physical Health Or "Parity Of Esteem"". *England.nhs.uk*. N.p., Web. 2 Nov. 2016.
- Peck, D. and Hills, B. (2000). Provider arrangements for mental health services in 'The New NHS'. *Health and Social Care in the Community*, 8(5), pp.325-335.
- Peedell, C. (2011). Further privatisation is inevitable under the proposed NHS reforms. *British Medical Journal*, 342.

- Pettigrew, A., Ferlie, E. and McKee, L. (1992). Shaping strategic change - The case of the NHS in the 1980s. *Public Money & Management*, 12(3), pp.27-31.
- Pollock, A. and Price, D. (2011a). How the secretary of state for health proposes to abolish the NHS in England. *BMJ*, 342(mar22 1), pp.d1695-d1695. Pollock A and Price D (2011b) The final frontier: The UK's new coalition government turns the English National Health Service over to the global health care market, *Health Sociology Review*, 20,3,294-305.
- Pollock, A.M., Price, D., Roderick, P., Treuherz, T., McCoy, D., McKee, M. and Reynolds, L., (2012). How the Health and Social Care Bill 2011 would end entitlement to comprehensive health care in England. *The Lancet*, 379(9814), pp.387-389.
- Saltman, R. (2003). Melting public--private boundaries in European health systems. *The European Journal of Public Health*, 13(1), pp.24—29.
- Shaw E (2003) Privatisation by stealth? The Blair government and public-private partnerships in the National Health Service, *Contemporary Politics*, 9:3, 277-292.
- Smith, P., McKeon, A., Blunt, I. and Edwards, N., 2014. NHS hospitals under pressure: trends in acute activity up to 2022. *London: Nuffield Trust*.
- The King's Fund (2013). Changes to the Health and Social Care Bill: Competition. [online] Available at: <https://www.kingsfund.org.uk/projects/reforming-the-health-bill-index/competition-reform> [Accessed 22 August 2018]
- The Kings Fund, (2015). *Commission on the Future of Health and Social Care in England: The UK private health market*. Commission on the Future of Health and Social Care in England. London: The Kings Fund.
- The King's Fund. (2017a). *Public satisfaction with the NHS*. [online] Available at: <https://www.kingsfund.org.uk/projects/public-satisfaction-nhs> [Accessed 10 May 2017].
- The King's Fund. (2017b) *Trusts in deficit*. [online] Available at: <https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/trusts-deficit> [Accessed 10 May 2017].
- Timmins, N. (2012). *Never again? The story of the Health and Social Care Act 2012*. London: The Institute for Government.
- Timmins N (2018), '*The world's biggest quango*': First five years of NHS England Kings fund/ Institute for Government.
- Tuohy C H (2018) *Remaking Policy: Scale, Pace and Political Strategy*, University of Toronto, Toronto.
- Turner, D. and Powell, T. (2016). *NHS Commissioning before April 2013*. London: House of Commons Library.
- UK Legislation. (2012). *Health and Social Care Act 2012*. [online] Available at: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> [Accessed 18 May 2017].
- Virgin Care. (2017). *Virgin Care - Virgin Care provides NHS and local authority services across England with a difference* Virgin Care. [online] Available at: <http://www.virginicare.co.uk/> [Accessed 21 Apr. 2017].
- Williams I, Brown H, Healy P (2018) Contextual Factors Influencing Cost and Quality Decisions in Health and Care: A Structured Evidence Review and Narrative Synthesis. *Int J Health Policy Manag.*;7(8):683-695.