



Repositioning the Boundaries between Public and Private Healthcare Providers in the English NHS

Journal:	<i>Journal of Health Organization and Management</i>
Manuscript ID	JHOM-12-2018-0355
Manuscript Type:	Original Article
Keywords:	Corporations, Not-for-profit organizations, Ownership, National health service, Privatization, Public sector reform

SCHOLARONE™
Manuscripts

1 2 3 **Repositioning the Boundaries between Public and Private Healthcare Providers** 4 5 6 **in the English NHS** 7 8

9 10 **Abstract**

11
12 Background and Objectives: Neoliberal 'reform' has in many countries shifted services across the
13 boundary between the public and private sector. This policy re-opens the question of what structural
14 and managerial differences, if any, differences of ownership make to healthcare providers. This
15 paper examines the relationships between ownership, organisational structure and managerial
16 regime within an elaboration of Donabedian's reasoning about organisational structures. Using new
17 data from England it considers:
18
19
20
21
22
23
24
25

- 26
27 1. How do the internal managerial regimes of differently owned healthcare providers differ, or
28 not?
29
30
- 31
32 2. In what respects did any such differences arise from differences in ownership or for other
33 reasons?
34
35
36

37
38 Methods: An observational systematic qualitative comparison of differently-owned providers was
39 the strongest feasible research design. We systematically compared a maximum-variety (by
40 ownership) sample of community health services (CHS); out-of-hours primary care (OOH); hospital
41 planned orthopaedics and ophthalmology providers (N=12 cases). The framework of comparison
42 was the ownership theory mentioned above.
43
44
45
46
47
48

49
50 Findings: The relationships between ownership (one one hand) and organisation structures and
51 managerial regimes (on the other), these relationships differed at different organisational levels.
52 Top-level governance structures diverged by organisational ownership and objectives among the
53 case-study organisations. All the case-study organisations irrespective of ownership had
54 hierarchical, bureaucratic structures and managerial regimes for coordinating everyday service
55
56
57
58
59
60

1
2 production, but to differing extents. In doctor-owned organisations the doctors', but not other
3
4 occupations', work was controlled and coordinated in a more-or-less democratic, self-governing
5
6 ways.
7

8
9 Conclusion: Ownership does make important differences to healthcare providers' top-level
10
11 governance structures and accountabilities; and to work coordination activity, but with different
12
13 patterns at different organisational levels. These findings have implications for understanding the
14
15 legitimacy, governance and accountability of healthcare organisations, the distribution and use
16
17 power within them, and system-wide policy interventions, for instance to improve care
18
19 coordination; and for the correspondingly required foci of healthcare organisational research.
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Repositioning the Boundaries between Public and Private Healthcare Providers in the English NHS

Repositioning the Public-Private Boundary: Supposed Managerial Consequences

Neo-liberal 'Reform' repositions the public-private boundary

Since the 1980s neoliberal 'reform' has in many countries shifted services across the boundary between the public and private sector. In the UK that boundary was successively brought closer, at times even into, the core clinical activity of the NHS (see Box 1).

Box 1: Main stages of repositioning the public-private boundary in the NHS

Privatised hospital ancillary services (cleaning, catering, laundry) (1984).

Creation of an 'internal market' (1991).

Waiting List Initiatives (1990s) introduced a minority of non-NHS providers of hospital services.

The Primary Care Act opened up primary medical care to commercial providers (1998).

The Private Finance Initiative: turn-key projects for non-NHS firms to design and build NHS hospitals, and operate their support services (1994).

Independent Sector Treatment Centres – corporate providers under NHS contract (2004).

Extending the internal market to community health services, which transferred from being Primary Care Trust managed to contractors (2004)

1
2 'Any Willing Provider' policy gave non-NHS bodies the right to bid to supply NHS-funded clinica
3 care (2012).

4
5
6
7 Commissioning Support Units (consultancy-like support for NHS payers) (2012).

8
9
10 Alongside these changes, NHS service providers were reconstituted as 'Foundation Trusts' with
11 more business-like structures and, ostensibly, more autonomy from central government control.
12
13
14

15
16
17
18 The few NHS services denationalised outright were community health services, placed on the
19 public-private boundary as 'social enterprises' (SE: managerially independent non-profit providers
20 whose assets remained state-owned but which could still go bankrupt) rather than as for-profit
21 corporations. More often, NHS services' staff, assets, activity and contract were in effect
22 transferred across the public-private boundary to a non-NHS organisation (rather than expect the
23 latter to assemble a new workforce and physical infrastructure from scratch). The Transfer of
24 Undertakings (Protection of Employment) (TUPE) regulations protected NHS pay and conditions
25 for the transferred staff. Policy statements announcing these changes (Department of Health 2010)
26 repeatedly represented them as (so to speak) 'back-end' changes with no adverse implications for
27 patients because NHS-funded care remained largely free at the point of use. At least for the
28 purposes of persuading patients and voters, the public-private boundary was no longer defined in
29 terms of provider ownership but financially, in terms of the source of payment for NHS services
30 and, insofar as all providers operated under a common regulatory, monitoring and accountability
31 frameworks (Department of Health 2010), in terms of governance. (Perry and Rainey 1988)
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Towards an Ownership Theory of Organisation

This policy re-opens an old question about what differences if any arise between (in this case, healthcare) providers under different ownership, and what these differences imply for the legitimacy, governance and accountability of healthcare organisations, for the distribution and use of power within them, and for system-wide policy interventions, for instance to improve care coordination.

This paper considers the relationships between ownership, organisational structure and managerial regime within a larger theory linking those factors with organisational environment and performance. (Sheaff et al. 2004) It elaborates Donabedian's (1980) reasoning about organisational structures to include organisations' ownership, defined as the *de facto* control of that organisation's activity, plant and products: that is, in terms of property, which 'is in fact achieved in many different ways' (Bencherki and Bourgoin 2017), not only through legal or contractual rights. That implies that an organisation's structure embodies, enacts and reproduces that ownership. Through the organisation's structure its owners, or their agents, select, implement and operate work processes (e.g. healthcare processes) chosen to realise the owners' goals, and successively modify them through innovations intended to meet their goals more fully. When differently-owned organisations select different production technologies one would predict the emergence of correspondingly differently-constituted work groups and differently-behaving work groups, insofar as work groups are characterised by their tasks and organisational context. (Hackman 1990) Structures and managerial practices for work coordination would correspondingly differ. Depending on the owners' managerial skill, the organisation's environmental circumstances and perhaps even an element of luck, the work-processes would then produce outcomes which approximated to the owners' original goals. For short we label this conceptualisation an *ownership theory of organisations*. In some ways akin to property-rights theories of the firm (Kim and Mahoney 2005),

1
2 it is however intended as an empirical, explanatory theory outside the normative 'social welfare'
3
4 frameworks of neo-classical economics and therefore of transaction cost or the structure-conduct-
5
6 performance theory.(McWilliams and Smart 1993)
7
8
9
10

11
12 For all save the smallest organisations, it is also a multilevel analysis (Hitt et al. 2007; Gittell and
13
14 Weiss 2004) hypothesising the nested links of causality and constraint between an organisation's
15
16 environment, overall governance structure, sub-units, working practices, and (at all levels) groups
17
18 and individual members. In this paper we focus on the assumption that having different kinds of
19
20 owners would lead organisations to
21
22

23
24 1. pursue substantively different goals, hence;

25
26
27 2. establish managerial regime which differ in:

28
29
30 (a) The organisational structures which select and implement the organisation's work
31
32 processes and transmit the owners' goals to them. Whether hierarchical or non-
33
34 hierarchical, differently-owned large organisations would therefore differ in the agency
35
36 problems arising for the owners at the often-discussed interfaces between owners and
37
38 managers (Berle and Means 1932; Fama and Jensen 1983; Bebchuk 1999; Demsetz and
39
40 Lehn 1985), and between managers and production workers. Within a formal structure
41
42 network-like elements of 'informal organisation' and market-like elements (an 'internal
43
44 market' in the strict sense) might also co-exist.
45
46
47

48
49 (b) What aims and goals they prioritise, i.e. which command the most management attention
50
51 and which the internal incentives (salaries, bonus, equity, status, career advancement
52
53 etc.) target: the 'tight' elements in 'tight-loose' management.(Peters, Waterman, and
54
55 Jones 1982)
56
57
58
59
60

1
2 (c) The combinations of technologies of power (persuasion, material incentives, coercion,
3
4 the 'gaze', technologies of the self (Foucault 1980) etc.) by which the owners, or
5
6 managers as their proxy, control what the other members of the organisation do.
7
8

9 (d) Organisational culture, including professional sub-cultures, i.e. their normative
10
11 requirements for work practices and guiding individual behaviour, justifications of the
12
13 organisation's work, its ownership and managerial practices, all expressed both verbally
14
15 and in artefacts.
16
17
18

19 These assumptions imply that what differentiates differently-owned organisations is above all the
20
21 type of *content* of their goals, focus, exercise of power and legitimations: whether this content
22
23 concerns above all finance, policies, occupational interests etc. as the case might be.
24
25
26
27
28

29 To begin with goals, many studies assume *a priori*, and others report empirically, that 'private'
30
31 organisations' dominant (not their only) objectives are financial, hence univocal and stable, whilst
32
33 public organisations pursue more politically complex, mixed, unstable, vague, ambiguous, often
34
35 predominantly symbolic objectives.(Swiss 2005) This difference has been conceptualised as a
36
37 contrast of internal managerial incentives. 'Private' organisations' managers face, it is said,
38
39 incentives to maximise 'efficiency', 'social welfare' or 'performance', often equated with 'financial
40
41 performance', 'shareholder wealth'(Cragg and Dyck 2003), output-maximisation or profit-seeking;
42
43 hence with maximising income and/or minimising costs *to the provider*. Another conceptualisation
44
45 imputes different 'institutional logics' (each with their own regulative, normative and cultural-
46
47 cognitive 'pillars' (Scott 2008)) to markets, corporations, the professions, the family, religions and
48
49 the state (Greenwood et al. 2010), or distinguishes a commercial from a public service ethos.
50
51 (Kirkpatrick, Altanlar, and Veronesi 2017; Rainey and Bozeman 2000) A third contrasts the
52
53 corresponding organisational cultures. A comparison of public and private managers in Canada and
54
55
56
57
58
59
60

1
2 Japan found that the longer managers had been in post, the more divergent did their 'values'
3
4 become.(Becker and Connor 2005) Boyne's (2002) narrative review of empirical studies of 13
5
6 hypothesised differences found that of the 8 differences about which secondary evidence then
7
8 existed, the evidence supported three: public organizations were more bureaucratic, public
9
10 managers were less materialistic (had a stronger public service ethos) and (partly because many of
11
12 them came from non-managerial professions) had weaker organizational commitment than private
13
14 sector managers.
15
16
17
18
19
20

21
22 Some studies (Kirkpatrick, Altanlar, and Veronesi 2017; Boyne 2002; Alchian and Demsetz 1973;
23
24 Hvidman and Andersen 2014; Meier and O'Toole 2008) attribute differences in internal managerial
25
26 regimes to differently-owned organisations' different operating environments, although further
27
28 studies qualify these findings in various ways (Bozeman, Reed, and Scott 1992; Rainey and
29
30 Bozeman 2000; Knott 1993) or report common features of managerial regimes irrespective of
31
32 ownership. (Knott 1993) However one intention, and to a certain extent effect, of marketisation
33
34 'reforms' has been to give all the differently-owned providers in a particular quasi-market a similar
35
36 organisational environment. Insofar as such 'reforms' succeeded, one effect would be to constrain
37
38 public organisations to mimic corporate structures and managerial regimes even without
39
40 repositioning the public-private boundary.
41
42
43
44
45
46
47

48
49 Environment apart, boundary-repositioning may also stimulate internal changes in managerial
50
51 regime in consequence of ownership changes. Existing studies give a mixed picture of these
52
53 endogenous differences. Some narrative reviews (Rainey and Bozeman 2000; Kirkpatrick, Altanlar,
54
55 and Veronesi 2017; Knott 1993) doubt whether certain *formal* differences between public and non-
56
57 public management are large. Euske (2003) argues that all organisations need essentially the same
58
59
60

1
2 accounting, costing, IT and 'general' functions' systems irrespective of what those systems are used
3
4 for. Rainey and Bozeman suggest that simplistic contrasts between private organisations' univocal
5
6 and public organisations' complex, 'political' objectives are at best exaggerated. (Rainey and
7
8 Bozeman 2000) Public and private organisations managers have essentially the same capacity to
9
10 reward employees. (Simon 1991) More generally it has been argued (Berle and Means 1932;
11
12 Burnham 1941) that managers are a separate social milieu, even class, with distinct economic
13
14 interests of their own.
15
16
17
18
19
20
21

22 Nevertheless certain differences in 'private' and public organisations' managerial regimes are also
23
24 reported. By its 'managerial regime' we mean the ensemble of methods by which those who
25
26 ultimately control an organisation do so (through what structures, strategies, incentives, managerial
27
28 practices, ideologies and cultures), and in pursuit of what substantive goals. 'Private' organisations'
29
30 greater managerial discretion and/or resources allow them:
31
32

- 33 1. To have proportionately more managers, especially finance-managers (Aidemark and
34
35 Lindkvist 2004). Conversely, the 'public firm' structures and management practices
36
37 developed in NHS trusts increased the proportion of 'strategic' managers but not that of
38
39 specialist managers. Indeed NS trusts had a smaller (and decreasing) proportion of
40
41 managers compared with the whole UK workforce (Kirkpatrick, Altanlar, and Veronesi
42
43 2017) (a pattern possibly over-reported by reclassifying clinician-managers so as to claim
44
45 reduced NHS 'bureaucracy' (Hyde and Exworthy 2016)).
46
47
48
49
- 50 2. less formalised, standardised, 'bureaucratic' managerial procedures ('red tape') hence
51
52 quicker completion of managerial tasks (Bozeman, Reed, and Scott 1992); and less risk-
53
54 averse, more entrepreneurial (inventive, innovative, flexible, risk-taking) decisions.
55
56
57
58
59
60

1
2 3. To mount stronger managerial challenges to restrictive practices and other
3
4 'bureaupathologies' (Thompson 1973); and face less pressure to take a short-term
5
6 perspective in decision-making.
7
8

9 Also, evidence that compatibility with existing 'values' (Rogers 1983; Greenhalgh et al. 2004)
10 influences organisations' selection and adoption of innovations implies different innovation patterns
11 in organisations under different types of ownership. Hence innovation serves different purposes in
12 private organisations (e.g. to promote competitive advantage (Hartley 2005)) than in public ones.
13
14

15 On the above assumptions the *content* of managerial decisions would differ qualitatively between
16 differently-owned healthcare organisations, resulting in correspondingly different products, work-
17 processes (hence user experience), technology-adoption, workforces, information-systems, internal
18 incentives (both formal and informal) and managerial regimes.
19
20
21
22
23
24
25
26
27
28
29
30
31
32

33 **Research Questions**

34 Aims

35
36
37 The many correlational studies of organisational differences either side of the public/private
38 boundary cannot, and often were not intended to, explore any such links between ownership and
39 managerial regime. We lack reports of how management decisions, constraints and actions differ
40 *substantively* – or not – between healthcare organisations on either side of the public-private
41 boundary. The present study aimed to contribute to filling that gap, in doing so contributing to
42 testing and as necessary revising an ownership theory of organisation.
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Research Questions / Hypotheses

Here we report some findings from a wider study (Sheaff et al. 2016) addressing the questions:

1. How do the internal managerial regimes of differently owned healthcare providers differ, or not?
2. In what respects did any such differences arise from differences in ownership or for other reasons?

Given the data available to us we address the question in regard to the English NHS which, as explained above, now includes providers of quite diverse ownership.

Methods

In the circumstances of the study, an observational systematic comparison of differently-owned providers was the strongest feasible research design. The framework of comparison was the ownership theory outlined above. The English NHS is well suited to such a comparison because certain care groups are cared for by providers of contrasting ownership, but under the same payment systems. Those conditions control for gross differences in external payment and in *technical* task when comparing differently-owned organisations (but not necessarily for case mix, for differently-owned providers might be expected to select different case-mixes, which would then be a consequence, rather than a confounder, of different ownership). To exploit these conditions we assembled three qualitative sub-samples of case-study sites. In the English NHS different types of provider ownership are concentrated in specific services and therefore care groups. We therefore studied: community health services (CHS); out-of-hours primary care (OOH); hospital planned orthopaedics and ophthalmology. Between them these services covered the 'pure' (i.e. non-hybrid)

types of ownership shown in Table 1. We studied one instance of a provider of each type checked in Table 1.

Table 1: Qualitative sample: Maximum variety by ownership type

	Hospital orthopaedics & ophthalmology	CHS	OOH
Corporate for-profit	♦	♦	♦
Proprietary			♦
Public	♦	♦	♦
Co-operative			♦
'Social enterprise'		♦	♦
Not-for-profit	♦		
Professional partnership		♦	

Each column represents one sub-sample across which we could make a systematic comparison.

Because all these services have high proportions of older patients with complex or multiple health conditions, we made that our focal care group. In each study site we identified a key informant from whom we snowballed to other informants selected for relevance to that care group and to the conceptual framework outlined above. They typically included hospital directors or chief executives, medical directors, operations managers, finance managers, quality and performance managers, service managers and business development or marketing managers together with clinical leads in our tracer services, lead nurses or matrons and contract managers. Where available we preferred informants who had worked in, and could therefore report the differences between, healthcare providers under different ownership. At the time of our fieldwork none of the corporate providers were above ten years old (although the corporations owning them were older) so most of their staff had recently worked for the NHS. The SEs were equally new. The cooperatives, professional partnerships and voluntary hospital were older, but some informants in them had also worked in differently-owned healthcare providers.

During 2015-17 we assembled the data summarised in *Table 2*. We used an omnibus semi-structured interview schedule, selecting for each interview the items that we particularly wanted to probe in light of what data we already had, and any ambiguities or contradictions in our data so far. We included informants' accounts of other organisations provided that the informant was speaking from first-hand working experience. Taking the key informants' advice as to which managerial documents were seminal to our research questions, we obtained those documents and content-analysed them.

Table 2: Data collected

	Interviews	Other material
Organisational case studies	83	212 documents, 226 media reports
Commissioning meetings		15 Observations (27 hours)
Patients	89	5 focus groups (38 participants), 5 individual patients/representatives (one further LHE)
Contextualisation data	N/A	HES, OPCS
Secondary data	N/A	283 published papers, 34 research reports

The meetings included contract meetings (between provider and payer), clinical quality review meetings and combined quality and performance meetings (sometimes more than one per provider). With the interviewees' consent we audio-recorded and transcribed the interviews, and pseudonymised the data throughout. Observations were recorded in contemporaneous field-notes. Two researchers independently read the transcripts and field-notes. A common coding framework was then applied to all data. Using a 'framework' approach (Gale et al. 2013; Ritchie and Spencer 1994) we identified commonalities and differences in our data so as to explore inter-connections between different levels, occupations and interests. We drew descriptive inferences based on *a priori* and emergent themes before elaborating conceptual perspectives. The empirical themes explored

1
2 informants' descriptions of the effects of changes in provider ownership and of how others reacted
3
4 to it, and their interpretation of its significance. Under each relevant main heading of our analytic
5
6 framework, we present these themes below.
7
8
9

10 Each 'case' (unit of analysis) was one type of provider (by ownership) for a given service (CHS,
11
12 OOH or hospital specialty). For data integrity, we collated and triangulated all the data for each case
13
14 from the sources listed in Table 2. We used these case studies to populate a framework analysis
15
16 whose categories reflected the ownership theory outlined above. This method was conceptually
17
18 equivalent to a tabulation wherein each row was an ownership type and each column a category
19
20 from the analytic framework. Data which did not fit into the framework were coded and separately
21
22 analysed inductively to expose relevant themes which the initial framework omitted. Finally we
23
24 compared the resulting patterns against the analytic framework outline above, so as to expose any
25
26 false or redundant assumptions: a falsificationist approach.(Bitektine 2008)
27
28
29
30
31

32 An NHS Ethics Committee approved the study (reference 10/H0206/71) subject to informant
33
34 anonymity
35
36
37
38
39
40

41 **Findings**

42
43
44 Following the above schema we trace the main connections between types of ownership and the
45
46 corresponding differences – and similarities - in managerial regime. The differences were mainly at
47
48 the top ('governance') levels of organisational structures, the similarities mainly at the lower ('work
49
50 coordination') levels.
51
52
53
54
55
56
57
58
59
60

Goals and Governance Structures

Our study organisations' governance structures reflected their diverse ownership. A pan-European private equity group owned one for-profit corporation, an offshore holding company owned another, an American finance company the third. The NHS trusts were state-owned. One of the community health services providers was an SE in the peculiar NHS sense noted above. In contrast, the out-of-hours provider which also called itself a 'social enterprise' was essentially a cooperative in ownership, structure and internal management (and therefore categorised as such in this paper). The professional partnership was a partnership of (i.e. owned by) a group of GPs. The not-for-profit hospital chain was collectively owned by its membership. Their Annual General Meetings elected the Board, and the Board decided who became members. In this circular way its owners were self-selected.

Convergent Aims, Divergent Objectives

All the case-study organisations irrespective of ownership had rather similar sets of broad, rather rhetorical aims about benefitting their patients and staff. Additionally they had more specific *objectives*, stated by managers themselves, in managerial documents (e.g. annual reports), on websites and in other published materials. Where the case-study organisations differed by type of ownership was in what objectives they had, the balance of emphasis between objectives, and the patterns of 'tight-loose' control (Peters, Waterman, and Jones 1982), i.e. which aspects of managerial performance were closely monitored, heavily incentivised and preoccupied managers in practice; and what was left to local discretion.

Both the for-profit corporation and the non-for-profit providers had clear, and prioritised, financial targets. The for-profit corporation hospital directors had a monthly business review by telephone

1
2 with their line manager, covering quality, patient outcomes, patient experience, audits , result scores
3
4 against national norms *'And of course the numbers comes into it as well'* (hospital director
5
6 CS2/M18). But as long as financial targets were met there
7

8
9 *'was quite a lot of autonomy on sites to make investment'* (operations manager, CS1/M07).
10

11
12 The not-for-profit hospital chain also had explicit financial targets, but to finance service
13
14 developments not targets set by a holding company. The out-of-hours SE's objectives similarly
15
16 included making enough financial surplus to grow its 'core business'. The voluntary hospital's
17
18 strategic objectives more vaguely stipulated a 'reasonable' profit. Ex-NHS informants described
19
20 both corporate and not-for-profit hospital budget management as being more rigorous than in the
21
22 NHS.
23
24

25
26 The NHS trusts' main objectives were also financial, but the opposite. Our case study NHS hospital
27
28 had a £33 million 'Cost Improvement Programme' as its main objective. With a falling income and
29
30 rising workload, the OOH trust planned to evolve into:
31
32

33
34 *'a sort of network of arm's length business units that sit within a wider structure ... our*
35
36 *organisation won't exist, and our board is absolutely clear [name] will not exist in a two to*
37
38 *three year timescale because there will be a new entity that delivers an integrated primary*
39
40 *care offer'* (CS15/M25).
41
42

43
44 Self-dismemberment was quite the opposite to the non-NHS organisations' objectives.
45
46

47
48
49 The other SEs' objectives tended to focused more on non-financial matters. The CHS example
50
51 formulated its objectives through workshops of 40 or 50 people that took up issues that emerged
52
53 locally, which our informants thought made the SE 'ethical'. At the OOH co-operative:
54
55
56
57
58
59
60

1
2 ‘[O]ur only concern is that patients are getting the best possible treatment, and if we can
3
4 keep the cost to our GP members to a minimum, then all well and good’ (CS20/M55).

5
6
7 In the last year of our fieldwork it returned its surplus to its member practices. Rather than having
8
9 formal objectives, the GP partnership said

10
11
12 ‘[w]e have more of an ethos about how we want to practise medicine, and we would want
13
14 partners to join us who share that ethos and ... continue doing what we do’ (CS31/M55).

15
16
17 Although they had no financial incentive to do so they had developed an MSK pathway because
18
19 ‘[GP] and I looked at it, we know we can do so much better’ (CS31/M55).

20
21 In this case a professional institutional logic prevailed over market logic.

22 23 24 25 26 *Divergent Governance Structures*

27
28 Top-level governance structures diverged by organisational ownership and objectives among the
29
30 case-study organisations. As noted, the corporate examples all had a ‘financialised’ (Montgomerie
31
32 and Williams 2009) structure designed to transfer payments from an operating company into a
33
34 separate holding (owning) company. Our questions elicited that there was no direct interaction
35
36 between the managers at provider (hospital, clinic, call centre etc.) level and the owning companies,
37
38 which in all cases seemed rather distant from the service provider managers’ day-to-day practical
39
40 coordinational activity.
41
42
43
44
45
46
47

48 Strong ‘quasi-hierarchical’ (Exworthy, Powell, and Mohan 1999; Sheaff and Schofield 2016)
49
50 accountability chains (Day and Klein 1987) linked our case-study NHS trusts to NHS and local
51
52 authority payers, NHS England, the Department of Health and ultimately Parliament. NHS Chief
53
54 executives’ careers and continuity in post depended above all upon achieving the targets (including
55
56
57
58
59
60

1
2 cost control) most important to government, the so-called (*Bevan 2009*) ‘targets and terror’ regime:
3
4 a politicised structure. Informants at one SE described how in their NHS days they were:

5
6
7 ‘required to report every nut and bolt back through an accounting chain and back through
8
9 the performance management chain’ (CS23/M37)
10
11
12
13
14

15 Having no *external* governance structure the voluntary hospital, not-for-profit chain and community
16 health services SE could pursue whatever ‘mission’ their members chose: a mission-based structure.
17
18 Doctor-owned organisations had correspondingly doctor-controlled structures. Two-thirds of the
19 OOH cooperative’s Management Council was elected by the GP members, who included every GP
20 working for this provider, and appointed a medical director, chief nurse, chair, two non-executive
21 directors and various sub-committees. The general practice providing CHS was jointly controlled
22 by its GPs, one of whom (the ‘managing partner’) managed the employed non-medical staff.
23
24
25
26
27
28
29
30
31
32
33
34

35 Convergent Coordination Structures

36 37 38 *Convergence on hierarchy*

39
40
41 Doctor-controlled organisations half-expected, all the case-study organisations had an hierarchical,
42 bureaucratic structure for coordinating everyday service production, hence largely similar daily
43 managerial work for that. Former NHS managers said their day-to-day work had changed little with
44 the change in ownership. Marketing apart, the range of management functions (HR, finance, IT etc.)
45 and ‘line’ management (of operations, nurse, therapy, administrative and ancillary services
46 managers) was similar. Although ex-NHS informants often described some NHS-trust decision-
47 making as slower, labyrinthine, frustrating and more cumbersome it nevertheless did not always
48
49
50
51
52
53
54
55
56
57
58 achieve tighter control:
59
60

1
2 *'in an NHS organisation you just carry on overspending or without there being proper*
3
4 *demand and controls in place'* (CS23/M34).

5
6
7 Most of our ex-NHS informants described themselves, and their subordinates, as being more
8
9 accountable than before in organisations under corporate, not-for-profit and voluntary ownership.
10
11 They meant *internally* accountable to their own managers. However Checkland et al. (2013) also
12
13 found that the emergence of CCGs increased the complexity – rather than the clarity - of the
14
15 *external*, inter-organisational accountability chains in which NHS-funded providers found
16
17 themselves, both 'upwards' (quasi-hierarchically) and horizontally to collaborative parties which
18
19 would include other statutory bodies and commercial partners.
20
21

22
23
24
25
26 Because it requires fewer tiers of management, a smaller organisation can have a 'flatter' structure,
27
28 shorter chains of command and simpler management arrangements than a large organisation with
29
30 just the same spans of control. Interviewees described how the corporate providers' smaller size
31
32 meant that
33

34
35
36 *'the medical and nursing staff, and everyone else for that matter, but for the clinicians to*
37
38 *actually be much more involved in the running and the change management of a smaller*
39
40 *organisation'* (CS2/M19)
41
42

43
44 Corporations, non-profit and voluntary organisations' hierarchical coordination structures
45
46 accommodated doctors in three different ways. NHS-employed consultants most often had
47
48 admitting rights, but one corporate hospital also directly employed its orthopaedic surgeons and
49
50 sub-contracted its ophthalmologists from a medical 'chamber'.
51
52
53
54
55
56
57
58
59
60

The Semi-Democratic Exception

The controlling bodies of the SE OOH provider, cooperative and partnership CHS democratically represented the doctors in them. In effect they collectively coordinated their own work by volunteering for shifts and finding other doctors to fill any gaps. All three organisations coordinated the non-doctors' (receptionists, drivers, administrators, managers, nurses, mental health workers, counsellors, psychologists) work by employing them in a hierarchy managed by a chief executive (or equivalent), hence ultimately the member-doctors. Our informants saw this structure as able to make quick decisions, '*able to evolve and adapt quickly*' (CS20/M55), and with low management costs (below £150,000 annually for the GP cooperative).

Discussion

This study was empirically limited to just one sector in one country, although within that sector our case-study organisations were typical of their kinds. Other studies corroborate that financialised structures are common among UK healthcare corporations, especially the largest, and the seven largest take 88% of the NHS-funded inpatient work which is not done by NHS trusts.(Appleby 2015) Governance structures for NHS trusts and SEs are nationally prescribed. Professional partnerships are by far the commonest form of general practice organisation.(Sheaff 2013) The ownership and structure of the OOH cooperative described here was also similar to others,(Sheaff et al. 2012; Hallam and Henthorne 1999) as were the not-for-profit and voluntary hospitals we studied. An analysis of the study sites' catchment populations and case-mix [reported elsewhere] showed that none of our hospital study sites were outliers in those respects. (Such data are not collected for OOH and CHS services).

1
2 A second empirical limitation is that we have focussed on formal structures, omitting to varying
3
4 extents other technologies of power within differently-owned organisations: informal organisation;
5
6 ideology (including culture, organisational identity and disciplinary control); technologies of the
7
8 self; the interactions of multiple cultures and institutional logics (Reay and Hinings 2009); and
9
10 resistance to managerial and owners' control. We have focussed on 'downward' influence rather
11
12 than any reciprocal 'upwards' (e.g. technological) relationships between organisational ownership
13
14 and managerial regime (for instance, whether cooperatives or partnerships are more resistant to
15
16 becoming corporations than public organisations are), or influences across formal organisational
17
18 boundaries.
19
20
21
22
23
24
25

26 Neither does this paper consider how far these differences affect different organisations' work
27
28 processes, outputs and interactions with their environments, and with what consequences. All these
29
30 topics merit further comparison across differently-owned organisation. In these ways the present
31
32 study points towards a wide-ranging further research. Participants' narratives of organisations'
33
34 formation and development – an historical approach - would be a strong research design for testing
35
36 and revising an ownership theory of organisation. Testing a multi-level theory would also appear to
37
38 require a multi-level research design.(Hitt et al. 2007)
39
40
41
42
43

44 Nevertheless our findings tend to support the idea that even insofar as managerial structures of
45
46 differently-owned organisations have *formally* similar structures (managerial 'functions' or
47
48 specialisms, uniprofessional sub-hierarchies, project teams etc.), the *substantive* uses to which they
49
50 were put differ in important respects. Such differences might explain why superficially similar
51
52 managerial actions may have different impacts in differently-owned organisations. For instance,
53
54 publicly-owned schools in Denmark adopted performance management earlier and more widely, but
55
56 to less effect in terms of pupils' educational grading, than private not-for-profit schools.(Hvidman
57
58
59
60

1
2 and Andersen 2014) Such findings give further, indirect corroboration. Contrary to our initial
3
4 expectations, and perhaps those of the cruder theories about the relationships between ownership
5
6 (one one hand) and organisation structures and managerial regimes (on the other), these
7
8 relationships differed at different organisational levels.
9

10 11 12 13 14 **Conclusions**

15
16
17 So far as we are aware this study is one of very few to compare systematically the internal
18
19 managerial consequences of diverse ownership of healthcare providers. On balance, our data
20
21 supported the assumption that the management of differently-owned organisations (e.g. those on
22
23 different sides of the public-private boundary) remains ‘fundamentally alike in all unimportant
24
25 respects’ (Sayre 1958), *provided* we take hierarchical coordination structures and their associated
26
27 managerial functions (accounting, IT etc.) as the unimportant respects. Even then, ‘alike’ would be
28
29 an overstatement because hierarchical coordination was not ubiquitous in the doctor-owned
30
31 organisations. So far as coordination structures are concerned our data suggest that whilst
32
33 ownership does make a difference to coordination activity, the larger difference is not the one
34
35 between organisations on either side of the private/public ownership boundary. Rather, the boundary
36
37 that makes a difference to it is the boundary between organisations owned by at least some of those
38
39 who directly produce the organisations’ outputs (goods or services), and organisations which are
40
41 not. In the former case their (in this case, doctors’) work was controlled and coordinated in a more-
42
43 or-less democratic, self-governing ways. Conversely, the ‘important respects’ would be taken as the
44
45 differently-owned organisations’ governance structures, managerial regimes and their
46
47 operationalised, most tightly managed objectives (those upon which internal managerial incentives
48
49 are brought to bear rather than their broad, rhetorical aims).
50
51
52
53
54
55
56
57
58
59
60

1
2 Together these conclusions offer some *prima facie* evidential support for one part of an ownership
3
4 theory of organisation. Type of ownership does appear, overall, to make a difference to at least some
5
6 important aspects of an organisation's governance structures and managerial regime. For the
7
8 broader field of health organisational research, these findings highlight the importance of the
9
10 owners' agency in explaining organisational change. Healthcare organisational research which
11
12 sufficiently recognised that point would involve studying, firstly, power within organisations i.e. the
13
14 ways in which the default assumption that the owners are the most powerful actors within a given
15
16 organisation has to be understood, nuanced or modified, case by empirical case. It would attend to
17
18 the ways in which managerial legitimations of organisational change simultaneously express the
19
20 owners' interests *and* formulate them so as to persuade non-owners to accept and pursue them. Also
21
22 it would attend to how the legitimations of externally proposed system interventions (e.g. policy
23
24 demands for greater care 'integration') relate to the relevant organisations' owners' interests and
25
26 wishes, and whether, therefore, these legitimations motivate these owners to implement, ignore or
27
28 resist the proposed changes. In these ways organisational ownership bears upon the governance and
29
30 public accountability of health systems as a whole. Our findings also call into question the practice
31
32 of copying managerial techniques (and 'fads') across the public-private boundary, and the idea that
33
34 re-positioning that boundary is purely a 'back-end', policy outcome-neutral change.
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Acknowledgement

This report is independent research funded by the National Institute for Health Research Policy Research Programme («Diverse Healthcare Providers: Behaviour in response to commissioners, patients and innovations», «PR-X03-1113-11005 »). The views expressed in this publication are those of the authors and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health, arms length bodies or other government departments.

References

Aidemark, Lars-Göran, and Lars Lindkvist 2004 The Vision Gives Wings: A Study of Two Hospitals Run as Limited Companies. *Management Accounting Research* 15(3): 305–318.

Alchian, Armen A., and Harold Demsetz 1973 The Property Right Paradigm. *The Journal of Economic History* 33(1): 16–27.

Appleby, John 2015 Paid for by the NHS, Treated Privately. *BMJ* 350: h3109.

Bebchuk, Lucian Arye 1999 A Rent-Protection Theory of Corporate Ownership and Control. National Bureau of Economic Research.

Becker, Boris W., and Patrick E. Connor 2005 Self-Selection or Socialization of Public- and Private-Sector Managers?: A Cross-Cultural Values Analysis. *Journal of Business Research* 58(1). *Cross-Cultural Consumer and Business Research*: 111–113.

- 1
2
3
4 Bencherki, Nicolas, and Alaric Bourgoin 2017 Property and Organization Studies.
5
6 Organization Studies: 0170840617745922.
7
8
9
10
11 Berle, A., and G. Means 1932 The Modern Corporation and Private Property. New York:
12
13 Macmillan.
14
15
16
17
18 Bevan, G. 2009 Have Targets Done More Harm than Good in the English NHS? No. BMJ
19
20 338(Jan. 16): a3129–a3129.
21
22
23
24
25 Bitektine, A. 2008 Prospective Case Study Design: Qualitative Method for Deductive Theory
26
27 Testing. Organizational Research Methods 11(1): 160–180.
28
29
30
31
32 Boyne, George A. 2002 Public and Private Management: What's the Difference? Journal of
33
34 Management Studies 39(1): 97–122.
35
36
37
38
39 Bozeman, Barry, Pamela N. Reed, and Patrick Scott 1992 Red Tape and Task Delays in Public and
40
41 Private Organizations. Administration & Society 24(3): 290–322.
42
43
44
45
46 Burnham, J. 1941 The Managerial Revolution. New York: Day.
47
48
49
50 Checkland, Kath, Pauline Allen, Anna Coleman, et al. 2013 Accountable to Whom, for
51
52 What? An Exploration of the Early Development of Clinical Commissioning Groups in the English
53
54 NHS. BMJ Open 3(12): e003769.
55
56
57
58
59
60

- 1
2
3
4 Cragg, Michael I., and IJ Alexander Dyck 2003 Privatization and Management Incentives:
5
6 Evidence from the United Kingdom. *Journal of Law, Economics, and Organization* 19(1): 176–217.
7
8
9
10
11 Day, Patricia, and Rudolf Klein 1987 *Accountabilities: Five Public Services*. Taylor &
12
13 Francis.
14
15
16
17
18 Demsetz, Harold, and Kenneth Lehn 1985 The Structure of Corporate Ownership: Causes and
19
20 Consequences. *Journal of Political Economy* 93(6): 1155–1177.
21
22
23
24
25 Department of Health 2010 *Equity and Excellence: Liberating the NHS*. Cm 7881. London:
26
27 Department of Health.
28
29
30
31
32 Donabedian, A. 1980 *The Definition of Quality and Approaches to Its Assessment*. Ann Arbor:
33
34 Health Administration Press.
35
36
37
38
39 Euske, Kenneth J. 2003 Public, Private, Not-for-Profit: Everybody Is Unique? *Measuring*
40
41 *Business Excellence* 7(4): 5–11.
42
43
44
45
46 Exworthy, M., M. Powell, and J. Mohan 1999 The NHS: Quasi-Market, Quasi-Hierarchy and
47
48 Quasi-Network? *Public Money and Management* 19(4): 15–22.
49
50
51
52
53 Fama, E.F., and M.C. Jensen 1983 Separation of Ownership and Control. *Journal of Economics*
54
55 and Law 26: 301–325.
56
57
58
59
60

1
2
3
4 Foucault, M. 1980 Power/Knowledge. New York: Pantheon.
5
6
7

8
9 Gale, Nicola K., Gemma Heath, Elaine Cameron, Sabina Rashid, and Sabi Redwood
10
11 2013 Using the Framework Method for the Analysis of Qualitative Data in Multi-Disciplinary
12
13 Health Research. *BMC Medical Research Methodology* 13(1): 117.
14
15
16

17
18 Gittel, Jody Hoffer, and Leigh Weiss 2004 Coordination Networks within and across
19
20 Organizations: A Multi level Framework. *Journal of Management Studies* 41(1): 127–153.
21
22
23

24
25 Greenhalgh, Trisha, Glenn Robert, Fraser MacFarlane, Paul Bate, and Olivia Kyriakidou 2004
26
27 Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. *The*
28
29 *Milbank Quarterly* 82(4): 581–629.
30
31
32

33
34 Greenwood, Royston, Amalia Magán Díaz, Stan Xiao Li, and José Céspedes Lorente 2010 The
35
36 Multiplicity of Institutional Logics and the Heterogeneity of Organizational Responses.
37
38 *Organization Science* 21(2): 521–539.
39
40
41

42
43 Hackman, J. Richard 1990 Groups That Work and Those That Don't. Jossey-Bass.
44
45
46

47
48 Hallam, L., and K. Henthorne 1999 Cooperatives and Their Primary Care Emergency Centres:
49
50 Organisation and Impact: Combined Report on Seven Case Studies. *Health Technology Assessment*
51
52 3(7): 118–185.
53
54
55
56
57
58
59
60

1
2
3
4 Hartley, Jean 2005 Innovation in Governance and Public Services: Past and Present. *Public*
5
6 *Money and Management* 25(1): 27–34.
7
8
9

10
11 Hitt, Michael A., Paul W. Beamish, Susan E. Jackson, and John E. Mathieu 2007 Building
12
13 Theoretical and Empirical Bridges Across Levels: Multilevel Research in Management. *Academy of*
14
15 *Management Journal* 50(6): 1385–1399.
16
17
18
19

20
21 Hvidman, Ulrik, and Simon Calmar Andersen 2014 Impact of Performance Management in Public
22
23 and Private Organizations. *Journal of Public Administration Research and Theory* 24(1): 35–58.
24
25
26

27
28 Hyde, P., and M. Exworthy 2016 Setting the Workers Free? Managers in the (Once Again)
29
30 Restructured NHS. In Exworthy, M. & Mannion, R. (Eds.) *Dismantling the NHS?: Evaluating the*
31
32 *Impact of Health Reforms* Pp. 257–278. Bristol: Policy Press.
33
34
35

36
37 Kim, Jongwook, and Joseph T. Mahoney 2005 Property Rights Theory, Transaction Costs
38
39 Theory, and Agency Theory: An Organizational Economics Approach to Strategic Management.
40
41 *Managerial and Decision Economics* 26(4): 223–242.
42
43
44

45
46 Kirkpatrick, Ian, Ali Altanlar, and Gianluca Veronesi 2017 Corporatisation and the Emergence of
47
48 (Under-Managed) Managed Organisations: The Case of English Public Hospitals. *Organization*
49
50 *Studies*: 0170840617693273.
51
52
53

54
55 Knott, Jack H. 1993 Comparing Public And Private Management: Cooperative Effort And
56
57 Principal-Agent Relationships. *Journal of Public Administration Research and Theory* 3(1): 93–119.
58
59
60

- 1
2
3
4 McWilliams, Abigail, and Dennis L. Smart 1993 Efficiency v. Structure-Conduct-Performance:
5
6 Implications for Strategy Research and Practice. *Journal of Management* 19(1): 63–78.
7
8
9
10
11 Meier, Kenneth J., and Laurence J. O’Toole 2008 Management Theory and Occam’s Razor: How
12
13 Public Organizations Buffer the Environment. *Administration Society* 39(8): 931–958.
14
15
16
17
18 Montgomerie, Johnna, and Karel Williams 2009 Financialised Capitalism: After the Crisis and
19
20 beyond Neoliberalism. *Competition & Change* 13(2): 99–107.
21
22
23
24
25 Perry, James L., and Hal G. Rainey 1988 The Public-Private Distinction in Organization Theory:
26
27 A Critique and Research Strategy. *Academy of Management Review* 13(2): 182–201.
28
29
30
31
32 Peters, Thomas J., Robert H. Waterman, and Ian Jones 1982 In Search of Excellence:
33
34 Lessons from America’s Best-Run Companies.
35
36
37
38
39 Rainey, Hal G., and Barry Bozeman 2000 Comparing Public and Private Organizations:
40
41 Empirical Research and the Power of the a Priori. *Journal of Public Administration Research and*
42
43 *Theory* 10(2): 447–470.
44
45
46
47
48 Reay, Trish, and C. Robert Hinings 2009 Managing the Rivalry of Competing Institutional
49
50 Logics. *Organization Studies* 30(6): 629–652.
51
52
53
54
55 Ritchie, J., and L. Spencer 1994 Qualitative Analysis for Applied Social Theory. *In* Bryman, A.
56
57 & Burgess, R. (Eds.) *Analysing Qualitative Data* Pp. 173–194. London: Routledge.
58
59
60

1
2
3
4 Rogers, E.M. 1983 The Diffusion of Innovations. 3rd. New York: Free Press.
5
6
7

8
9 Sayre, Wallace S. 1958 Premises of Public Administration: Past and Emerging. Public
10 Administration Review 18(2): 102–105.
11
12
13

14
15 Scott, W. Richard 2008 Lords of the Dance: Professionals as Institutional Agents.
16 Organization Studies 29(2): 219–238.
17
18
19

20
21
22 Sheaff, R 2013 Plural Provision of Primary Medical Care in England, 2002–2012. Journal of
23 Health Services Research & Policy 18(Supp. 2): 20–28.
24
25
26

27
28
29 Sheaff, R., S. Child, J. Schofield, S. Pickard, and R. Mannion 2012 Understanding
30 Professional Partnerships and Non-Hierarchical Organisations. London: NIHR-SDO.
31
32
33

34
35
36 Sheaff, R., and J. Schofield 2016 Inter-Organizational Networks in Health-Care: Program
37 Networks, Care Networks and Integrated Care. In Ferlie E, Pedersen A & Montgomery K (Eds.)
38 Oxford Handbook of Health Care Management. Oxford: Oxford UP.
39
40
41

42
43
44 Sheaff, R., J. Schofield, R. Mannion, et al. 2004 Organisational Factors and Performance. A
45 Scoping Exercise. London: NIHR-SDO. <http://www.sdo.nihr.ac.uk/sdo552003.html>.
46
47
48

49
50
51 Sheaff, Rod, Joyce Halliday, Mark Exworthy, et al. 2016 A Qualitative Study of Diverse
52 Providers' Behaviour in Response to Commissioners, Patients and Innovators in England: Research
53 Protocol. BMJ Open 6(5): e010680.
54
55
56
57
58
59
60

1
2
3
4 Simon, Herbert A. 1991 Organizations and Markets. The Journal of Economic Perspectives
5
6 5(2): 25–44.
7
8

9
10
11 Swiss, James E. 2005 A Framework for Assessing Incentives in Results-Based Management. Public
12
13 Administration Review 65(5): 592–602.
14
15

16
17
18 Thompson, Victor A. 1973 Bureaucracy and Bureaupathology. Organizational Behavior and the
19
20 Practice of Management, Glenview, Ill.: Scott, Foresman and Co., Rev.
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60