3rd International Conference

on Public Policy (ICPP3)

June 28-30, 2017 – Singapore

Innovation and Public Administration Trends

Title of the paper

Innovation and accountability in health care provision? The ambiguous role of Community Interest Companies in the National Health Service in England.

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Date of presentation

Friday, June 30th 13:45 to 15:45

Abstract

It is increasingly common for policy makers to advance the view that health care is better delivered by a type of organisation that is neither public nor private: the Community Interest Company (CIC), This hybrid type of organisation is said to successfully combine social goals with financial stability and autonomy that allows it to pursue innovation and improvement in the design of service delivery. The paper argues that existing analyses tend to overemphases the normative, innovative and institutional aspect of these organisations and therefore ignore the relevance of the wider political and historical frames in which they operate. This means that the process of transforming public health tends to be problematised as a natural phenomenon predicated on the narrative of choice and affected by the evolving needs and wants of society. In this sense, the transfer of responsibility for the delivery of health care provision to alternative providers including CICs has become an unproblematic end point in itself. The paper proposes that a more nuanced debate on CICs in the NHS needs to be cognisant of the political context. To this effect, the paper adopts the Governance and New Public Management perspectives to interrogate changes in the modes of governing of the NHS and to tease out the possible consequences this may have on the provision of health services in the UK.

Key words: social enterprise, Community Interest Company, marketisation, innovation, NHS

Introduction

The challenges for the NHS arising from the demographic shifts, complexity of new conditions and financial constraints, have proved potent ground for experimentation with different policy tools and innovations in the service delivery (The Kings Fund, 2011). Politicians, academics and business professionals have all contributed to this debate by offering different ideas and interpretations on how best to manage the NHS (see for instance Le Grand, 2007; Timmins, 2002, 2012; Ham, 2009; Griffiths, 1983). Many of the key policies that were introduced as a result since the 1980s were implemented via New Public Management (NPM) reforms and privatisation (Osborne & Gaebler, 1993; Hood, 1991, 1995; Ferlie, 1996; Lane, 2000; Osborne, 2010). Recently however, the debate has shifted towards a new phenomenon that can be broadly defined as 'social entrepreneurship' (Nicholls, 2006). The proponents of this trend claim that it is possible to achieve a balanced and 'responsible capitalism' by transferring public services to the independent organisations such as Community Interest Companies (CICs) so that they can be 'commonly (socially) 'owned' and managed by former public servants' rather than privatised by multinational corporation. (Sepulveda, 2014:9; Jenkins, 2012).

The paper contributes to the debate on CICs (Haugh & Paredo, 2011) by situating the analysis between two critical perspectives in public administration, Governance and New Public Management (NPM). This will focus the attention on the wider political and policy dimensions of this new organisational model. In this sense the paper adds to the current debate in three main ways. Firstly, by adopting the Governance and NPM approach the paper highlights path dependent trajectory of CICs in the NHS. This provides a conceptual bridge that connects past policy choices with the present in a way that shows both continuity but also sufficient level of change. Secondly, the paper draws attention to the stabilising and legitimising effect of Governance and NPM in relation to

new mechanisms for delivery of healthcare. It highlights the implication of 'choice' in the activation of CICs in the NHS whereby new arrangements arise by way of contrasts albeit one that generate no obvious solutions. For instance, what would be the opposite of managed and targeted care models: unmanaged and untargeted services? Lastly, the paper considers the implications of Governance and NPM paradigm in transforming perceptions and interactions between state and society. It argues that the tendency to conceive the public sector as inherently inefficient and the private as innovative and customer focused has led to the view that in order to improve the standards in public sector, services need to be marketised and restructured via new organisational models of healthcare.

The paper begins by firstly explaining the policy underpinnings of the CIC as well as theoretical conceptualisation of the term. The second section moves to a short overview of the policy context that facilitated the activation of the model in the NHS. The third section of the paper develops the analysis of CICs by adopting the Governance and the New Public Management perspectives to illustrate the political and path dependent dimension of CICs operating in the NHS. The section considers the impact of the complex arena of public sector reforms and how the governing arrangements of the NHS have been affected by it. The paper concludes by summarising the key debates and the dilemmas introduced in this paper and suggest that CICs are part of the larger and on-going project of transforming the provision of health care in the UK.

1. The political and legal origins of the CIC

CICs were first established in 2005 by the Companies (Audit Investigations and Community Enterprise) Act 2004 and were affected by the principle legislation of the

Community Interest Company (Amendment) Regulations 2009 and the Community Interest Company Regulation 2005. The latter set out the functions of a new independent body, the Regulator, in relation to making decision on eligibility of CICs, investigating and responding to complaints and giving advice on the governance of CICs (BIS, 2013).

The 2004 Act created the legislative framework for the new type of private company, limited by guarantee (CLG) or shares (CLS), in which profit and social value were given equal consideration (Reiser 2010: 105). To this effect, any surplus or profit generated by the CIC was to be held in perpetuity in a so-called 'asset lock' and used only for the benefit of the community (BIS, 2014). For the purpose of the CIC, the term 'community' was defined to mean the wider population, here in the UK or outside, that extends beyond the immediate members of the CIC and/or section of the population that, for instance, share a common characteristic (age, gender, social status). Where a CIC was incorporated as a company limited by shares, the profits were to be protected through a 'dividend cap' currently set at 35% of the distributable profits of the CIC (BIS). In October 2012, the Regulator in response to the consultation removed the initial 20% limit on dividends per share to encourage wider involvement of investors in the CIC model. To protect the community benefit, applicant organisations had to satisfy a 'community interest test' to show that the proposed activities would meet the social objective (BIS, 2013:17).

The concept of CICs first appeared in the public policy domain in 2002, when New Labour launched a review of the charity and not-for-profit sector. The consultative report *Private Action Public Benefit* (Cabinet Office Strategy Unit, 2002), set out proposals for modernising the law to 'enable a wide range of organisations to be more effective and innovative, whilst maintaining the high levels of public trust and confidence' (Blair, 2002).

It was felt that existing models were no longer fit for purpose and therefore a new legal structure was necessary to bring the sector into the 21st century (Nicholls 2010: 394). The idea of the CIC came directly from two lawyers at Bates Wells Braithwaite for whom the 'decline of the building societies and other alternative forms of business organisation […] led to the monoculture of modern capitalism of the limited liability company' (Lloyd, 2006). They recognised that many entrepreneurs wanted to operate in a socially responsible manner but did not necessarily want to go down the charity route. It was believed that the company law and the limited company status presented an attractive legal framework to social enterprises. This was echoed in the *Public Action Private Benefit* Review (Cabinet Office Strategy Unit, 2002:53):

> 'Company law is well developed, and companies are well understood by professionals such as bankers and lawyers. The company limited by guarantee form in particular is popular, and is used by some very large not-for-profit organisations such as BUPA, the private health provider.'

Consequently, the new legal structure was modelled on company law but was kept simple with only light touch regulation. It was envisaged that the CIC would give social enterprises a strong, recognisable branding and would make access to funding much easier. The special features built into the model meant that CICs would be protected from a risk of demutualisation or unfair redistribution of profits to managers and shareholders.

The CIC model was not for the sole use of social enterprises. Public bodies such as Local Authorities (LAs) and the disbanded Primary Care Trusts (PCTs), administrative and commissioning bodies replaced by Clinical Commissioning Groups (CCGs) in 2013, were all encouraged to consider the new structure. The benefits included the ability to 'ring fence' certain activities or to provide the services 'on a more or less "commercial"

footing' with the important caveat of maintaining a community focus (BIS, 2013). Currently, there are 11,740 CICs in total with 78% of them registered as limited by guarantee and 22% as limited by shares. They operate across all sectors with health, social care, community regeneration and education being the most common for CICs to work in (Third Sector, 2013). They are diverse in terms of size and scale of operation. Many run as a small business or a community group while others are much bigger and comparatively more like charities. The organisations that were created through the transfer of staff from the NHS or Local Authorities and adopted the CIC model often resemble a traditional public sector provider. This is particular true in the NHS where they continue to use the NHS branding.

The diversity of CICs means that they are not a homogenous construct and thus the context in which they operate needs to be taken into consideration if we want to better understand the varying impacts of these organisations. Put simply, CICs that are set up as a community café may exert different pressures than, for example, an organisation that delivers multimillion public sector contracts in the area of health. In this sense, the organisational model should be treated with caution when considering the generalisability of evidence particularly in relation to innovation, organisational efficiency and user engagement.

The conceptual origins of the CIC model

A useful way of thinking about the emergence of CICs comes from Haugh and Padero's four-fold taxonomy (Haugh & Paredo 2011). Four simultaneous and conflicting meta-narratives explain their rise of CICs. Firstly, a political narrative contrasts Conservative neoliberalism with New Labour democratic renewal. Markets, profits and self-interest are

supplanted by the communitarian and pro-social justice agenda. Essentially, the perspective proposes the rise of CICs as a reaction to the New Right's fixation with private property rights and denationalisation. This is a springboard for the emergence of New Labour's social programme dominated by a counter-discourse of civil responsibility, empowerment and engagement. Secondly, an ideological narrative further embeds individualism by contrasting it with broader community benefits. Haugh and Paredo (2011) reiterate the Conservative government's promotion of individualism, ownership rights, and outsourcing of services to private providers with New Labour's discursive emphasis on increasing community participation, localism and the importance of wider public benefit including raising quality standards across public services. A third narrative argues that the emergence of CICs can be traced to the different approaches activated to address existing social problems whereby the role of the individual and family was superseded by the New Labour emphasis on collectivism, social accountability and action. Finally, an economic narrative juxtaposes Conservative neoliberalism promoting free markets, competition and privatisation as the prerequisite to a healthy economy with the contrasting view of New Labour's theme of social responsibility, sustainability and "using assets for social purposes" (Haugh & Paredo 2011: 19-22).

What is important here is that the four narratives indicate how the emergence of CICs stems from the contrasting ideals of the New Right and New Labour. This indirectly implies 'bad' policy acts as a trigger to the development of a new improved policy. While Haugh and Paredo's typology is a useful first step in thinking about CICs two points are worth noting. Firstly, the typology of juxtaposing two supposedly different and contrasting narratives as a definitional yardstick to mark the development of a new discourse oversimplifies far more complex social and institutional changes. Secondly, that this neglects the similarities and continuities between Conservative and New Labour

agendas especially around commissioning in the NHS. Despite the contrasting party rhetoric, Haugh and Paredo do not account for policy convergence. In this sense, both governments were crucial actors in embedding the discourse of social enterprise and entrepreneurship into the realm of public administration. However, it was the New Labour government that made the vital leap in developing the CICs brand and creating an enabling environment that was conducive to its inception and growth. The next section briefly sets out the role of policy in activating the new CIC model in the NHS.

2. Activation of CICs in the NHS

In 2008, following the recommendations of the *High Quality Care for All - NHS Next Stage Review*, the government launched a programme called Right to Request (RtR). The RtR enabled NHS staff providing community health care to request to 'leave' (spin-out) the service and set up an independent social enterprise. It was believed that this would provide the staff with 'flexibility and responsiveness to innovate and improve services and outcomes for patients' (DH 2008:9). Nearly 152 PCTs in charge of approximately 200,000 staff and £10 billion worth of contracts were eligible to apply (DH, 2010). By 2010 it was estimated that by the end of 2011, 10% of NHS staff would be employed by social enterprises and RtR organisations would deliver nearly £1 billion of public services (National Audit Office, 2011). According to Miller et al (2012:277) nearly 90% of organisations that spun out of the service decided to adopt a CIC legal structure (Miller et al, 2012: 277).

What then are the implications of this method of defining CICs? Primarily, an acknowledgement that definitions of the CIC structure are not merely a practical or technical concern, but that we need to consider the potential political aspects. It is

necessary to assess the coercive pressures that played a role in their final design and affected the scope of this new legal form. Indeed once Labour came to power in 1997, a number of initiatives including access to funding, cheap loans and new legislation to ensure that social enterprises could tender for public contracts contributed to the establishment of a more sizeable "portfolio of social enterprise policy than any other administration in the world" (Nicholls 2012: 395) . CICs were strictly embedded and enforced by the space in which a set of unique power dynamics and competing discourses interact "under conditions of cultural, political and technical influence to achieve ascendancy in terms of regulatory outcomes and structures" (*ibid*: 397). These environments are highly politicised, redolent with power relations, and cannot be divorced from the operation of CICs. This provokes ever more blurring of the boundaries between profit, non-profit and public organisations (Dart, 2004: 415).

This hybrid logic may at first appear to offer a plausible solution to bridge both the conceptual and practical gaps between the social, efficiency and delivery aspects of welfare provision; however, there are serious concerns that need to be addressed. The next section focuses on the role of two paradigms, New Public Management and Governance, to illustrate as the wider context, which facilitated the emergence of CICs.

3. Delegated Governance for public services: New Public Management and Governance

The backdrop to understanding the emergence and development of CICs rests on the political transformations of governance whereby governing is increasingly taking place through dispersed networks occupied by multiple actors located in diverse sites *other than the traditional bureaucracy* (Pierre, 2000). Central to this is the notion of social change

exacerbated by globalisation, in which micro problems have macro consequences and vice versa necessitating responses that transcend national borders. This results in the shift towards a more mixed welfare economy (Jessop, 1999).

There are two important narratives in public administration that lend themselves to the discussion on CICs, New Public Management (NPM) and Governance. These two paradigms provide a useful framework to link together the evolving role of government's 'steering' mechanisms to the changing patterns and forms of its delivery particularly in the area of health (Andresanui & Ferlie 2006: 416). Both trends while conceptually different are also complimentary and reinforcing one another. Their different chronology corresponds with the change of governments giving an impression of a smooth transition, a paradigm shift, by which governing through markets (NPM) is necessarily succeeded by a system of networks and partnerships (Governance). In reality, however, the separation is neither easy nor indeed helpful for understanding CICs.

The rise of CICs in the NHS shows considerable continuity and convergence with the practices and ideas of NPM and Governance. Likewise, the trend also suggests diversification from the existing norms and routines. I draw on the role of Governance and NPM as processes and practices in public administration but also as theory-building models that comprise of distinct ideological repertories. By observing the interplay of different dimensions of NPM and Governance, we can appreciate the emergence, legitimisation and normalisation of new organisations such as CICs is part of a complex and interconnected process between the past and present.

Two narratives: New Public Management and Governance

The period of 1980s constitutes an important backdrop to the changes introduced under NPM. High levels of unemployment, inflation and the increasing cost of welfare during that time was a 'fertile setting for the transfer of business models of management' into the area of social policy (Marmor, 2012: 158). The economic crisis facilitated a 'critique of monopolistic forms of service provision and an argument for a wider range of service providers and a more market-oriented approach to management' (Stoker, 2006: 45). The reforms reflected a market-based ideology of the New Right with its commitment to free markets and competition (Savoie 1994; Greener & Powell, 2009, Le Grand, 1999; Giaimo, 2002).

The conventional wisdom of the time was that the traditional bureaucratic model was inefficient, 'inflexible and insensitive to changing human needs and novel circumstances' (Caiden, 1991:1). The mistrust of administrative structures lent itself to the critique of its agents whose motivations were put to question. The focus of analysis shifted towards a wider society based on individual freedoms and choice (Buchanan, 1986). In this sense, the intellectual origins of NPM can be traced to public choice theory, the 'theory of governmental failure', which replaced '…romantic and illusory…notions about the workings of governments [with]…notions that embody more scepticism' (Buchanan and Tollison, 1984:11). Yet, NPM remains a loose term that hosts many labels and interpretations. While Lane (2000:3) conceives the movement as first and foremost 'contractualism', for Pollitt (1995) NPM is more like a 'shopping basket' of managerial ideas and market-based tools. For others NPM is not a one phenomenon but a *melange* of many (Ferlie et al., 1996). It is a theory of governing that is necessarily shaped by 'new institutional economics', principle – agent theory and organisational theory (Gruening, 2001). Alternatively, some claim that NPM was merely a fad in public administration with distinct right-wing rhetoric.

The implementation of NPM took many forms. On one hand, it shifted the attention from rules to practices and the more horizontal form of coordination. Public servants were encouraged to exercise autonomy in their pursuit of mission-centred goals (Osborne and Gabler, 1993). On the other hand, the main aim was to improve standards and efficiency across the public sector through marketisation and privatisation. Under NPM governments were to become more entrepreneurial and community focused, empowering their citizens to self-govern (*ibid*, p.80). In practice, these translated into a set of broad administrative doctrines based on contracting out of state functions, privatisation and quasi-privatisation, automation and internationalisation of the 'local' public context (Hood 1991: 3).

In the NHS, NPM introduced organisational changes and established the internal market by splitting the purchaser and provider roles. The model created a performance audit culture with managers and private consultants exercising their technocratic knowledge. The advocated marketisation meant that health was treated more as a commodity, which like any other could be purchased, privatised and competed over. As a consequence the relationship between the state, society and the public sector acquired a new meaning with citizens becoming customers of public goods. In the *Citizen's Charter* (1991) the government further embedded the principle by committing public services to be more responsive to the 'customers' needs. Likewise, the *Caring For People — Community Care In The Next Decade And Beyond* (1989), made a necessary provision for voluntary and private sector to be involved in competing for public contracts to ensure choice and better value. The process subsequently led to the fragmentation of the services and the establishment of a mixed economy of welfare.

The effect of NPM and NPM type reforms is a contested area of research. There is still a lot of uncertainty if NPM indeed improved the standards in the public sector or

produced costs savings (Hood, 2011). However, it is generally accepted that NPM did not necessarily reduce the government's function per se, although, it undoubtedly had altered it. For instance, in the NHS the complexity of commissioning processes led to a rapid growth of the regulatory and monitoring frameworks (Pollitt, 2007). Furthermore, the overall public sector spending in the developed economies remained relatively high with most countries becoming more interventionists rather than less (Navarro, 2006:12). Equally, the reforms of the 1980s did not significantly accelerate the pace of institutional change or result in full privatisation of the NHS. This may explain why some academics consider NPM to be long 'dead' or irrelevant in the contemporary discussion (Dunleavy et al., 2006). However, there are some important considerations that deserve attention specifically in relation to the emergence of CICs in the NHS.

Firstly, the faith in a bureaucracy triggered by the economic downturn was apparently not to be restored at a time of economic upturn. NPM created a powerful rhetoric that private business is almost always better and more efficient than the public sector. The shift resulted in traditional values of equity and universalism to be replaced by new qualities of NPM such as efficiency, innovation and individualism (du Gay, 2000). Indeed it is now widely accepted to think of a business 'as the innovative force, while the State […] as the inertial one', necessary but only to deliver essential services (Mazzuccato, 2014:1). The notion projected outward by government itself, has also contributed to the wider questioning of public sector workers' job commitment and motivation (Moon, 2000). Bureaucracy is conspicuously associated with a key characteristic of the public sector and viewed in entirely negative terms. Interestingly, however, the citizens' perceptions of efficiency, responsiveness and equity of local service performance show a negative relationship between public and private (Andrews and van de Walle, 2012:20).

The NPM rhetoric that the 'state is too big, that the public sector hinders economic development' continues to shape policy discourse today (Flynne, 2002:58). The emergence of CICs in the NHS has not challenged this perception but instead offered an alternative institutional route to reconcile the apparent conflict between private, public and non-profit governance. Ostensibly for NPM the CIC model provided a technical and normative solution to a political problem. As a blended variant of the profit and non-for-profit type of organisation, CICs gained legitimacy in the NHS by expanding on the NPM notion of citizens' choice, engagement and empowerment (Windrum and Koch, 2008). CICs came to be representative of a modified version of NPM in which the focus of attention had been shifted from solely markets towards wider societal concerns.

The evidence of continuity, however, is more visible in the reading of Osborne and Gaebler's ten principles of public entrepreneurship (1993). According to them, the successful government must champion 1) steering in place of rowing, 2) empowering rather than serving, 3) competition, 4) mission rather than rules, 5) outcomes and not inputs alone, 6) customer rights and preferences, 7) earning in place of spending, 8) planning and prevention, 9) decentralisation, and finally 10) markets relations (ibid). The concept of CICs is strictly embedded and enforced by the space in which past and present discourses are interacting 'under conditions of cultural, political and technical influence to achieve ascendancy in terms of regulatory outcomes and structures' (Nicholls 2012: 395). These environments are highly politicised, redolent with power relations, and cannot be divorced from the operation of CICs.

Secondly, NPM played an important role in reconfiguring the state-society relations along the lines of choice based consumerism (Le Grand, 2007). It placed an emphasis on individual customer satisfaction to transcend collective interests and values characteristic of public sector (Aberbach and Christensen, 2005). In healthcare, the shift not only

bestowed a novel status onto a citizen but also contributed to the perception of health as a commodity that could now be sold, purchased and competed over. Moreover, the introduction of the purchaser-provider split resulted in institutional embedding of markets within the service area that previously was out of reach. For consumers that meant empowerment insofar as to voice their opinion and express preference, but equally constraining as competition is effectively limited by the virtue of access to perfect information. In consequence, the markets developed unevenly and imperfectly.

In health care, for instance, competition was managed via regulation and commissioning processes leading to quasi-markets and henceforth quasi-privatisation (Exworthy, 1999). In the consultative document, Enterprise for Communities: Proposal for Community Interest Company, the government made clear that CICs were not intended to 'deliver essential public services in core sectors such as hospitals and schools' (DTI, 2003:3). Presumably this was because some of the hospitals were already run as semi-autonomous, non-profit organisations, e.g. Foundation Trusts. Instead, the government laid out its ambition for CICs to 'develop to meet the needs of local communities, complementing core government services in areas such as childcare provision, social housing, leisure and community transport' (ibid). A decade later, nearly 60% of CICs operate in the health and social care market, with Bristol Community Health CIC, for instance, recording 34,000 patients a year and a turnover of £46milion (CIC Report, 2015:17). However, the total number of social enterprises active in the health and social care remains small, around 8% of all social enterprises, although, new starts ups are 15% more likely to be operating in healthcare compared with 5% of older social enterprises (SEU, 2013:18).

The crux of the matter is that CICs function in the space that is open to competition and managed by a complex system of top-down rules set at local, national and European levels with contracts routinely awarded on the basis of lowest cost (efficiency) rather than

social value (The Kings Fund, 2011:6). The procurement practices necessitate certain behaviours and a degree of conformity implying that the claimed autonomy of CICs is over exaggerated. Recently, the CICs Regulator and Monitor signed a Memorandum of Understanding that laid out an 'agreed framework for co-operation and collaboration to help the parties fulfil their respective duties' (CIC Regulator, 2015:2). Since the introduction of the Health and Social Care Act 2012, Monitor has gained additional responsibilities 'including expanding its role beyond Foundation Trusts to the licensing of non-exempt independent providers of NHS services, including certain CICs' (ibid, p.3). In this sense, the CIC remains 'the object of managerial ideology' necessarily intertwined with bureaucratic administrations and subjected to constant implicit and explicit checks and regulations (Dey et al, 2010:92).

Finally, NPM normalised the need for on-going programme of reforms. The concern with performance targets necessitated constant checks and managerial efforts to monitor and evaluate their progress and effectiveness (Coleman et al, 2013). This often generated the whole range of new measures and targets on top and instead of the existing ones. It also created an expensive economy with private consultants, managers and so called experts involved in advising and overseeing various improvement programmes. The NHS is case in point. Another important aspect to consider is the NPM preoccupation with what matters is what works. This supposedly objective and technical output mitigates any concern one may have with the delegated process of governance specifically in relation to public services. In the NHS, for instance, as long as the service remains free at the point of delivery, who provides it is largely irrelevant to patients. Not only is such an approach problematic insofar as it obfuscates the real scale of irrevocable divestment of public goods but equally in ignoring the issue of power and accountability of new providers. The important implication, however, is not the out-and-out privatisation but the fragmentation that is institutionalised in the contract practice.

According to the Kings Fund 'the separation of responsibility for commissioning health care and providing services […] and the requirement that primary care trusts divest themselves of responsibility for directly providing services under the transforming community services policy' had led to fragmentation of the service (The Kings Fund, 2011:6). The complexities of the procurement law also mean that new organisations such as CICs may find it difficult to embed new and innovative models of care before the contract is up for renewal. Furthermore, unlike other large companies, CICs do not have the same economies of scale making competition harder (Birchall, 2012:155). As the government does not recognise the CIC 'to be in the public sector', despite overtly emerging from it, the responsibility for failure or success of its operation rests solely with the organisation itself (DTI, 2003). This may present a challenge particularly for those CICs that left (spun out from) the NHS with contracts that offered special terms and conditions for the initial period of 3 to 5 years after which the new arrangement had to be renegotiated under the competitive procurement regulations. However, even if CICs do succeed the benefits that come from the novel ways of working may not be universally shared. This is because CCGs commission services locally and hence some patients may benefit from new and innovative models while others would not. This raises the question of how the reformed service can remain universal and comprehensive.

The reforms of the 1980s and 1990s emanated from a narrow concern with economic efficiency and cost which was fuelled by an 'axiomatic assumption of the ubiquity of organisational [hierarchical] inefficiency' (Robinson and Le Grand, 1994:14). In contrast, Governance developed as a new way of thinking about processes and 'governing styles in which boundaries between and within public and private sectors have become blurred' and hybridised (Stoker, 1998:18). Similarly to NPM, though, Governance refers to multiple and often conflicting approaches, which are dynamic, evolving and relational. The perspective provides a 'challenging dimension to our understanding of our

contemporary social, economic and political world' (Chhotrary & Stoker 2008:1). Yet it remains elusive and multifaceted concept, explanans and explanandum; a theory, organisational structure and framework of analysis that has the ability to obfuscate but also to interpret a changing political order (Jessop, 1995). Governance means different things to different people, spurring positive and negative associations all at the same time. It is an essentially contested concept (Gallie 1956).

The dominant account of governance, the society-centred approach, conceives the change in interactions as 'a new process of governing; or the new method by which society is governed' (Rhodes, 1996:652). The focus here is on societal steering and coordination within networks and partnerships (Kooiman 2003). For Treib, the shift 'denotes a process of governing which departs from the traditional [hierarchical] model' and is cognisant of societal actors who are increasingly more involved in the formulation and implementation of policies (Treib et al. 2007:3). Put differently, governance is 'an elaborate system of third party government in which crucial elements of public authority are shared with a host of non-governmental or other-governmental actors' (Salamon, 2002:2).

Similar account suggests that public management is conducted through the pluricentric negotiations, which are based on 'trust and jointly developed [via] rules, norms and discourses' (Sorensen and Torfing, 2008:3). The important theme within this account is 'its focus on governing mechanisms which do not rest on recourse to the authority and sanctions of government' (Stoker, 1998:17). However, the diversity of interactions between state, market and civil society has also resulted in the blurring of boundaries between public and private and led to the hollowing out of the state (Rhodes, 1994). The dispersal of power, as some suggest, means that the 'government is not actually the cockpit from which society is governed' (Klijn and Koppenjan, 2000:136). By contrast

the state centric perspective problematises the government as 'the key political actor in society and the predominant expression of collective interests' (Pierre and Peters, 2000:25). The account rejects the notion of governance as the zero sum game between the state and society. Instead, it proposes an alternative, 'state-central relational' approach, in which the governments 'expand their governing capacities not only by strengthening central state institutions but by forging new governance partnerships with a range of social actors' (Bell and Hindmoor, 2009:2). Similarly, for Crowford the government continues to intervene and 'micro-manage' all aspects of social life albeit by different governing methods (2006:455). Thus, the state-centric relational perspective conceptualises governance as 'the tools, strategies and relationships [that are] used by governments to help govern' (Bell and Hindmoor, 2009:2). For Newman, the dual logic of governance can be observed in the power of the government that 'is […] retreating – with state institution being slimmed down, hollowed out, decentred and marketised – and expanding, reaching out to non-governable terrains like health' (2005:1). This interesting paradox constitutes an important context for the emergence of CICs in the NHS.

The proliferation of complex interrelationships with private and third sector organisations is generally considered to be 'conducive to particular ways in which innovation is generated and adopted' (Hartley 2010: 29). The shift signifies the development of a new 'social contract' based on partnerships, networks and trust rather than Weberian rule of law (Stoker, 1998). In this sense, the 'old' forms of hierarchical control are 'naturally' displaced by new albeit complex sets of networks, which can be steered but ostensibly not governed (Newman, 2004:71). However, for some the adaptation in areas like welfare reform increasingly reveals a common direction of change, whereby 'levelling the playing field between the different sectors actually reduces

consumer participation and restricts choice' (Pollock et al, 2007: 50). Thus, the effect of Governance on the development of new forms of healthcare delivery can be problematised in three main ways.

Firstly, the governance debate triggered a policy response that facilitated the private and voluntary sectors involvement in public service delivery in a way that was widely accepted as it was focused on generating stakeholder participation, social capital and community cohesion (Borzaga & Defourny 2001: 6). At the same time, the transition was taking place under the premise of free markets, competition and profit maximisation opening up opportunities for greater market penetration particularly in areas previously considered protected from private intervention. This has led to a 'fundamental transformation not just in the scope and scale of government action, but in its basic forms' (Salamon, 2002: 1–2). For the voluntary sector, the importation of the commercial and managerial practices of NPM mainstreamed it into this policy area by contractual obligations rather than traditional grant aid. The sector became a 'product of a new discourse of governance […] constituted as a governable terrain and therefore site for policy intervention and potentially control' (Carmel and Harlock, 2008).

Secondly, the governance discourse underpinning New Labour's Third Way agenda assumed that it was possible to successfully blend two opposing ideas of economic growth, largely embedded in classical economics, with social and communitarian values (Hall 2006: 322). The rhetoric reiterated the need for an active civil society, with clear rights and obligation, to reconstruct the welfare provision from the bottom up (Giddens, 1998:117–18). The rhetoric of governance further expanded the NPM conception of a citizen by employing positive language for what may be unpopular discourse of reforms. Nonetheless, the shift implies the inverse relationship between welfare state and civil society meaning that expanding the former necessarily reduces the latter (Navarro, 2006).

Lastly, Governance like NPM gives way to institutional building to accommodate new practices and ideologies. The process, to greater or lesser extent involves reproduction of existing norms and routines (isomorphism, continuity) as well as degree of experimentation and innovation in the public policy (change). During New Labour, the revival of the civil society necessitated strengthening the links and partnerships with the voluntary sector. Based on the recommendations of the Deakin Report, the government established an official framework, the national *Compact,* to provide public agencies including NHS with clear guidelines and protocols relating to good practice (Deakin, 1996). At the same, time a number of government departments were created to oversee and advance the role of the sector. The Active Community Unit (ACU), Social Enterprise Unit (SEU), Office for the Third Sector (OTTS) all became the 'vertical structures' for support and capacity building (Kendall, 2000). It was also under the New Labour that nearly 100 years since the law was changed, a new legal form of the organisation, the CIC, was created.

Conclusion

This paper drew attention to the role of two narratives in public administration, NPM and Governance. The paper argued that these paradigms have been important instruments and discourses that instituted and normalised changes in the provision of public service provision. The process despite its confrontational and political content was able to develop and evolve without much challenge. The reason for it may be that the ostensibly technical and functional aspect of NPM depoliticised and objectified the need for essentially neoliberal programme of reforms. The development of 'good' governance via consensual partnerships and networks created a perception that involving voluntary

sector in co-production of public good mitigates any perverse consequence of the market. Thus, the important backdrop to understanding the emergence and development of CICs rests on the political transformations of governance whereby governing is increasingly taking place through dispersed networks occupied by multiple actors located in diverse sites *other than the traditional bureaucracy*. Moreover, the trend of outsourcing public services to private and third sector organisation and the increasing delivery of traditional policy functions at arm's length is seen as an integral feature of contemporary governance or dispersed public governance (OECD 2002). It is a "new process of governing, or a changed condition of ordered rule; or the method by which a society is governed" where the state is seen to be steering instead of rowing (Rhodes 1997: 46). This signals a departure from hierarchical conceptions of the state towards more horizontal relations premised on differentiated polities of partnerships and networks (Newman 2005:7).

The paper has shown how something that appears to be targeted at social content, as CICs are, have also been central to the dismantling and marketisation of the NHS. NPM and the Governance paradigm provided useful framework for the reconfiguration of the healthcare sector articulating this as a neutral yet necessary process of 'technical' readjustment to competitive pressures. The utility of CICs for successive neoliberalising governments "lies in their discursive, strategic, and organisational reformulation of liberalism" in response to globalisation, the ongoing construction of permanent welfare crisis (Jessop 2002: 453).

Like all significant political change reform has taken a variety of forms, and as the paper shows is influenced by distinct path dependencies in different locations. In a more concrete sense the process entails significant changes in the scope and content of social

action in both markets and governments. This includes the explosive growth of alternative governance structures like CICs.

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