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

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

Introduction

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

We define marketization as the '… entirety of efforts aimed at describing, analysing and making intelligible the shape, constitution and dynamics of a market socio-technical arrangement' (Çalışkan and Callon, 2010, p. 3). Marketization reforms have taken root in education (Molesworth, Scullion and Nixon, 2011), development (Berndt, 2015) and healthcare systems (Araujo, La Rocca and Hoholm, 2018; Ashburner, Ferlie and FitzGerald, 1996; Cribb, 2008; Moreira, 2012; Sjögren and Helgesson, 2007; Zeiss and van Egmond, 2014; Zuiderent-Jerak, 2009; Zuiderent-Jerak, Grit and van der Grinten, 2015), amongst others.

We propose that the concept of performativity (Callon, 1998; MacKenzie, Muniesa and Siu, 2007) provides a powerful way to understand how policy changes designed to reconstruct social and political relations according to market principles are put into practice. We define performativity as a process by which the introduction of elements

A free video abstract to accompany this article can be found online at: https://youtu.be/k76BVLIxmdM

from one or more expert domains (e.g. a theory, a model) is used to induce changes within a practical domain so that the world envisaged by the theory or model becomes progressively actualized. This process, as Callon (2007, p. 320) reminds us, '… is a long sequence of trial and error, reconfigurations and reformulations'.

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

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

Rather than looking at performativity as the actualization of a single model or a theory and its linear impact on a practical domain, we look at dynamic, non-linear processes, involving multiple stages and using a variety of instruments, to effect changes in a complex domain populated by reflexive agents whose predisposition to comply with change is open to question. This form of performativity is referred to by MacKenzie (2007, p. 55) as *generic performativity*. To broaden the extant perspectives of performativity, we ask: How does a marketization model promoted by public policy become actualized through multiple policy instruments over a period of time, and reconfigure (or fail to reconfigure) the practices of a diverse group of actors embedded in a complex, distributed and hierarchical system?

Our empirical setting is the English National Healthcare System (NHS) and the Health and Social Care Act 2012, the last major reform imposed on the system (Ferlie and McGivern, 2013). Our focus is on three early implementation stages. By unpacking the work different actors accomplish to put the Act into practice, we generate three theoretical contributions. First, we characterize the performativity of policy instruments as a bricolage that incorporates the principled attitude of *making do*. In so doing, we invoke Campbell's (2005, p. 56) definition of bricolage: '… a blending of bits and pieces from a repertoire of elements… the rearrangement of elements that are already at hand, … [and] the blending in of new elements that have diffused from elsewhere'. Second, we identify the mechanisms through which the performativity of the 'Clinical Commissioning' (CC) model of marketization prescribed by the Act operates at multiple scales. Third, we explicate why specific performances result in unintended outcomes. In so doing, we show that the ability of a policy instrument to perform marketization relies not just on the presence of felicitous conditions (Butler, 2010), but on the concurrent development of the original policy's aims *and* the conditions that support the policy's performativity.

Performing the marketization of the NHS

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

MacKenzie (2007) distinguishes between generic and effective performativity. Whereas generic performativity refers to situations where an aspect of economics is used but does not have a discernible effect on practice, in the case of effective performativity an aspect of economics must be shown to make a difference to practice. Borrowing from Austin (1962), Butler (2010) distinguishes

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

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

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

Third, the performative force of a model depends on its origin and epistemic status. Christophers (2014, p. 4) asks: 'Is it an academic economic model, born in academia and confined forever to debates within scholarly journals and among those who read them — an artefact, that is to say, of Mitchell's "caged economics"? Or is it a more worldly model from the very start, one designed, say, by consultants, with a particular policy application in mind — an artefact of Callon's "wild" economics?' The scope of what counts as a theory or models should not be confined to academia but extended to a variety of settings, from government departments to corporate boardrooms (Mitchell, 2005), and include 'folk theories' – models and instruments developed from and widely used in practice, such as those originating from management consultancies (D'Adderio, Glaser and Pollock, 2019).

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

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

The sparse literature on the policy performativity suggests similarities and differences between the two settings. Henriksen (2013b) suggests bureaucracies face different accountability criteria than markets, and new devices will often need to acquire legitimacy in a wider professional–scientific community before they migrate to policy settings. As is the case of economists involved in finance (MacKenzie, 2003) or market design (Mirowski and Nik-Khah, 2007; Nik-Kha and Mirowski, 2019), policymakers are often portrayed as pragmatists, combining ideas culled from a variety of sources rather being than wedded to specific models or theories, a process described as epistemological or policy bricolage (Campbell, 2005; Carstensen, 2011; Freeman, 2007; Stone, 2017).

To study marketization as the process of taking market ideas and devices to policy settings, we focus on legislative texts and policy instruments. Legislative texts represent both outcomes of '… sociopolitical and technoscientific debates and

negotiations' (Faulkner, 2012, p. 754) and once ratified, acquire performative power (i.e. they have the capacity to generate socio-material effects on the world they target). Legislative texts are regulatory performatives, by prescribing what actors can or cannot do, backed up by sanctions for non-compliance, but can also accomplish other functions. For example, they can introduce new actors, reconfigure how actors relate to each other, or define constraints and opportunities for action (Faulkner, 2012). As Davies (2013, 2017) reminds us, market principles can become 'state-endorsed norms' through hard (e.g. legislation) as well as softer means (e.g. audits, rankings).

We see policy instruments as going beyond legislative texts by: (i) organizing the relations between a polity (via its administrative structures) and civil society (via the administered subjects); and (ii) combining technical (e.g. legal rules, performance metrics) and social (e.g. representations, values, ideals) elements in support of policy aims (Lascoumes and Le Galès, 2007; Le Galès, Scott and Jacobs, 2010). As Lascoumes and Le Galès (2007, p. 9) note: '… the more public policy is defined through its instruments, the more the issues of instrumentation risk raising conflicts between different actors, interests, and organizations'. Instruments embody their own logic and create '… original and sometimes unexpected effects' (Lascoumes and Le Galès, 2007, p. 10). Voβ (2016) suggests that instruments play a critical role in expanding spaces where envisioned realities are cultivated. These envisioned realities are constantly being made, contested and remade, often over long periods. As Hasselbladh and Bejerot (2017, p. 297) note: 'It is not the case that great ideas crash when faced with a silent, material "reality." A pre-existing reality does not speak for itself, inevitably short-circuiting policy initiatives in advance.'

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

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

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

Method

Our aim is *theory elaboration* – extending ideas from performativity research without the need for inductive analysis (Maitlis, 2005). In a 5-year, longitudinal analysis of the creation, implementation and performance of the large-scale policy change initiated by the Health and Social Care Act 2012, we elected to study the performativity of an instrument, devised to marketize health and social care services. We paid attention to how particular market features from the Act were embedded in policy instruments and how 'Clinical Commissioning Groups' (CCGs) became a key marketization instrument. We mapped out the production and use of key arguments in this process. Our approach treated documents '… as actors that can be recruited into schemes of organized activity and

regarded by others as allies, enemies, or perhaps simply instigators of further actions' (Prior, 2008, p. 828).

Research context

Our research questions required a context where a marketization initiative required practice changes for significant groups of actors with multiple forms of expertise. The research context needed to be typical (Yin, 2017) of wider policy-driven marketization initiatives (cf. Larsson, Letell and Thörn, 2012; Lundahl *et al*., 2013; Petersen and Hjelmar, 2013). The development and implementation of an Act of Parliament envisioning the marketization of a highly visible and critical public service is a particularly suitable context.

Acts of Parliament constitute Statute Law in the UK,[1] and often identify specific groups and areas for change, particularly for the provision of public services. An Act's aim is to bring new worlds into being by setting out, reconfiguring or terminating rights, obligations and setting behavioural expectations for individuals and collectives. We adopted a qualitative approach suited to the study of dynamic processes and the coordinated practices of multiple groups of actors (Denis, Langley and Rouleau, 2007; Mason, Friesl and Ford, 2019).

Case selection

The Health and Social Care Act 2012 was selected to meet the study's aim: to explain how an Act embodying a marketization process has been made performative across a distributed group of actors. The Act followed decades of efforts to open up the provision of public services to the 'benefits of market behaviour' (Freeman III, 1979). In July 2010, a White Paper[2] entitled 'Equity and excellence: Liberating the NHS' was published. It set out a template for transformation of health and social care through the introduction of CC. As envisaged by the Act, local CCGs would be able to *commission* the services they needed from markets. Following the debates surrounding the White Paper, its transformation into a Bill, passing as an Act and enactment presented a tightly framed opportunity to observe the performativity of a policy-led marketization process. It enabled us to trace how the provision of health and social care through CC generated new practices at the junctures where the scenario envisioned in the Act collided with existing socio-technical arrangements.

Data collection and analysis

Through our study of the Act, we soon discovered that policy instruments generated a number of tensions and misfires. This quickly became the focus of our study. From June 2010 to July 2015 we moved abductively between data collection and analysis (Charmaz, 2006; Dubois and Gadde, 2002), using reflexive oscillation (Cunliffe, 2003) to introduce the notion of bricolage and so develop our understanding of the case and related literatures concurrently, progressing our theoretical framework as we went. The data collected are summarized in Table 1.

Our abductive approach followed three overlapping stages.

Stage one: the marketization context

First, between July 2010 and March 2011, we spent time tracing the history of the Act to map out the concerns it was attempting to address. We made use of and followed public discourses using the resources detailed above and drew on the work of healthcare scholars (including Chambers *et al*., 2013; Ham, 2008; Imison *et al*., 2011b; Sheaff *et al*., 2015; Smith and Raven, 2012). We used these observations to sensitize ourselves to how a variety of policy instruments had been used through successive waves of marketization and the effects they produced (Le Grand and Cooper, 2013).

Stage two: following the Act

Next, we observed how the Act progressed through Parliament. The Act had its first reading in the House of Commons on 19 January 2011 and received Royal Assent, passing into law on 27 March 2012. A key observation was that a version of a market was '… fitted into something that might be called "theory-based" policy making' (Timmins, 2013, p. 266), with concepts being plucked from

[1]https://www.parliament.uk/about/how/laws/acts/ provided details of the UK government institutions and processes. For a comparison of 13 contemporary government systems, see Pollitt and Bouckaert (2017).

[2]In the UK, a White Paper is an official paper issued by the government as statements of policy, and often sets out proposals for legislative changes, which can then be debated before a Bill is introduced.

Table 1. Summary of data collection between June 2010 and July 2015

Policy instruments, debates and evidence presented at Select Committees	Interviews and workshops	Reviews and evaluations: 2health and social care system research	Other documentary evidence illustrating concerns and controversies
White Paper: 'Equity and excellence: Liberating the NHS' (Jul 2010) Health and Social Care Act (2012) Debates where the White Paper and the Bill are presented and discussed in the House of Commons and House of Lords, March 2011 to March 2012 including: ■ 3× Readings of the Bill in House of Commons ■ 3× Readings in House of Lords ■ 40× Debates in House of Commons ■ 15× Sittings in House of Lords Much of this work is filmed and/or audio-recorded, and is available on the Parliamentary website: Parliamentlive.tv Health Select Committee Evidence includes: ■ 3rd Report: oral and written evidence HC 513-I HC 513-II (Jan 2011) ■ 5th Report: further issues HC 769-II (Apr 2011) ■ 11th Report: appointment of the Chair of NHS Commissioning Board HC 1562-I (Oct 2011) ■ 14th Report: social care (Feb 2012, 3 vols) ■ Social care oral evidence HC317 (Feb 2013)	17× GPs on Commissioning Groups (Jan 2012–Jul 2015) 3× Directors NHS Trust (Jan–Aug 2013) 4× Workshops on NHS reforms (Sep 2012; Jan 2013) and selling to the NHS (Jul 2013; Jan 2014)	Smith and Mays (2012) Sheaff *et al*. (2015) Chambers *et al*. (2013) Imison *et al*. (2011b) Ham (2008) 1× King's Fund time line of the history of the Health and Social Care Act incorporating 35× data points, including media reports, video footage of the Bill being discussed in the media and by politicians (Apr 2013)	5× Fact sheets published by Department of Health: ■ Overview of the Health and Social Care Act factsheet ■ Health and care structures factsheet ■ Scrutiny and improvement factsheet ■ Clinically led commissioning ■ Provider regulation to support innovative and efficient services 7× Slide decks published by Department of Health describing new structures and organizations King's Fund blogs, including: ■ Aug 2012: How do the Commissioning Outcomes Framework indicators measure up? Veena Raleigh ■ Oct 2012: How can we deal with the financial pressures in health and social care? Professor Sir Chris Ham ■ Nov 2012: Is the NHS entering treacherous waters? Professor Sir Chris Ham ■ Dec 2012: Clinical Commissioning Groups: what do we know so far? Chris Naylor ■ Dec 2012: Measuring accountability for outcomes: Is transparency enough? Veena Raleigh ■ The Health Foundation Policy Navigator: Blogs and timeline (https://navigator.health.org.uk/) ■ The Nuffield Trust blogs

the private sector and economics textbooks without supporting evidence that they might actually work in a public service system: '[T]he policy was, in a sense, a leap of faith founded in theory, rather than hard evidence from existing health policy' (Timmins, 2013, p. 266).

Stage three: following the Act's implementation across multiple sites of practice. We wanted to understand the performative effects of the Act at the scale of both programmatic actions and situated practices, so we traced its implementation between March 2012 and January 2017. Although the targets of policy interventions often have no option other than to comply with what is prescribed, reactions to those interventions are neither passive nor bound by existing rules – they fall under what De Certeau (2011) called the 'tactics of consumption'.

The economist Alain Enthoven, often credited as the inspiration for marketization reforms (Timmins, 2013), observed that the NHS structure relied '… on dedication and idealism. It is propelled by the clash of interests of the different provider groups. But it offers few positive incentives to do a better job for the patients, and it has some perverse ones' (Enthoven, 1985, p. 18). This observation sensitized us to the notion of bricolage as a way to heighten our awareness of the tensions between the world envisaged by the Act and the work performed to overcome its limitations, misfires and unintended consequences. A significant part of this work was carried out by healthcare practitioners who had to improvise, make do and use what was at hand in order to work *with* as well as *around* what the Act asked of them.

The Health and Social Care Act in practice

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

A programme of action: developing market representations as guidelines

The first stage of implementation of the Act was to introduce it to key constituents and set expectations about what the Act aimed to achieve. The Act was the largest piece of health legislation since the creation of the NHS and was subject to 50 days of debate.[3] Over 2,000 amendments were agreed (Cambell, 2012).

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

> The scale of ambition [of the Act] should ring alarm bells. Sir David Nicholson, the NHS chief executive, has described the proposals as the biggest change management programme in the world—the only one so large 'that you can actually see it from space'. (More ominously, he added that one of the lessons of change management is that 'most big change management systems fail'.)[4]

The Act decreed a significant reorganization of the health and social care system, relocating the responsibilities of the Secretary of State to society and the healthcare system. This generated a major point of entry for private service providers by modelling new market engagement structures – the CCGs (Krachler and Greer, 2015). CCGs were to access competitive markets to provide alternative, innovative and affordable healthcare provision.

The Act redefines the roles and responsibilities of the different organizations that constitute the NHS and the broader health provision system which, through CCGs, aims to engage the NHS with markets. The political desire to develop this approach had been evident for a while, motivated by the need to alleviate pressures and contain costs of secondary care (cf. Sheaff *et al*., 2015).[5] General Practitioners (GPs), given their gatekeeping roles in access to secondary care and their knowledge of patient lists, were seen as being in a pivotal position to commission the right type of healthcare on behalf of their patients (Smith and Mays, 2012). The assumption was that if GPs were made accountable for large referral and treatment budgets, they would become more cautious in accessing secondary care and would be incentivized to alternative routes such as patient self-management and prevention (Imison *et al*., 2011b). This model is captured in Section 6E (presented as amendments to Section 6D of the National Health Service Act 2006 'insert'; Figure 2) and is summarized by our visualization (Figure 3).

[3]Secondary care is medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialized knowledge, skill or equipment than the primary care physician can provide.

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

[5]See Timmins (2010).

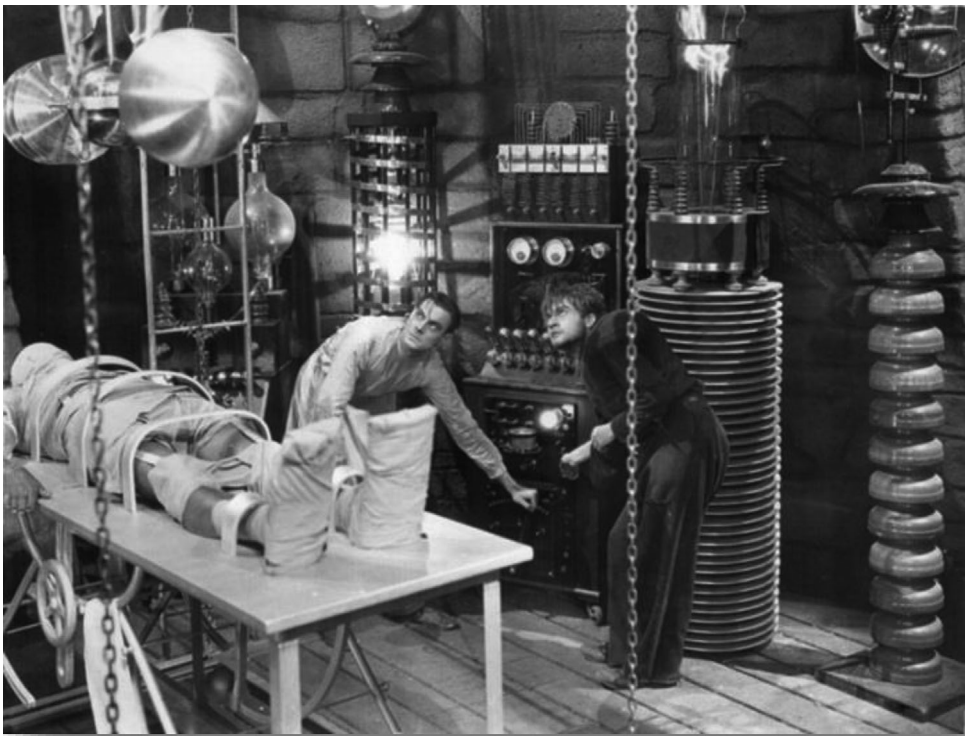


Figure 1. An image taken from the 1931 Frankenstein *film (Universal Pictures), used in the* British Medical Journal *to represent feelings about the Health and Social Care Act 2012. Colin Clive (left) and Dwight Frye (right). Directed by James Whale. © 1931 Universal Pictures Company, Inc. Photograph from a private collection*

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

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

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

Unsurprisingly, given the well-documented past failures in commissioning,[6] management consultancies looked at the NHS reforms as heralding opportunities to provide commissioning support. The National Association of Primary Care (NAPC)/KPMG guide *Good Governance for Clinical Commissioning Groups* (Imison *et al*., 2011a) suggested a hybrid partnership between different types of organizations, identified a host of issues with tips concerning governance and management,

[6]See the PwC Report for the Office of Fair Trading entitled 'Understanding Commissioning Behaviour: Commissioning and Competition in the Public Sector', 2011.

20 Regulations as to the exercise of functions by the Board or clinical commissioning groups

(1) After section 6D of the National Health Service Act 2006 insert—

"6E Regulations as to the exercise of functions by the Board or clinical commissioning groups

(1) Regulations may impose requirements (to be known as "standing rules") in accordance with this section on the Board or on clinical commissioning groups.

(2) The regulations may, in relation to the commissioning functions of the Board or clinical commissioning groups, make provision—

(a) requiring the Board or clinical commissioning groups to arrange for specified treatments or other specified services to be provided or to be provided in a specified manner or within a specified period;

(b) as to the arrangements that the Board or clinical commissioning groups must make for the purpose of making decisions as to—

(i) the treatments or other services that are to be provided;

(ii) the manner in which or period within which specified treatments or other specified services are to be provided;

(iii) the persons to whom specified treatments or other specified services are to be provided;

(c) as to the arrangements that the Board or clinical commissioning groups must make for enabling persons to whom specified treatments or other specified services are to be provided to make choices with respect to specified aspects of them.

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

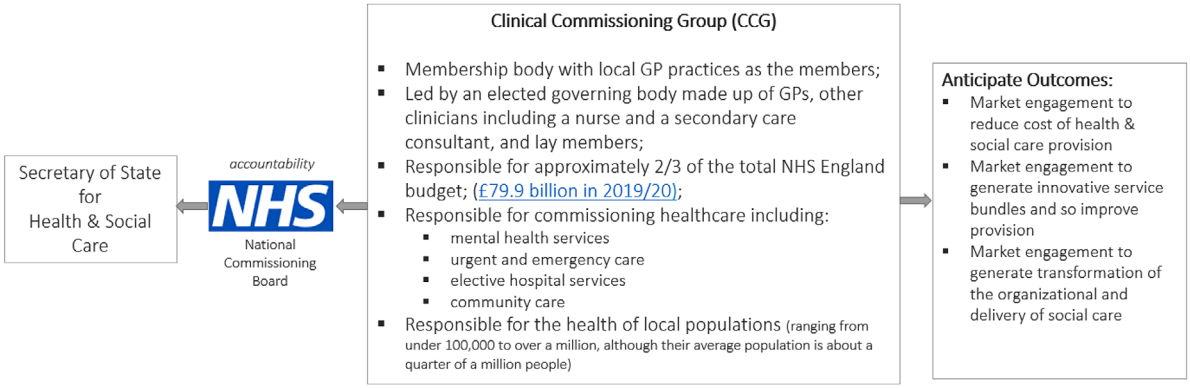


Figure 3. Our visualization of the 'Clinical Commissioning' model described in the Health and Social Care Act 2012 [Colour figure can be viewed at wileyonlinelibrary.com]

and referred to the 'model constitution for Pathfinder CCGs' (Imison *et al.*, 2011a, p. 8):

> [CCGs] will need to combine the nature of a statutory body with that of a membership organisation if they are to achieve their full potential in improving the health of their population. This is genuinely an opportunity to break new ground internationally in the pursuit of greater value health care. This guide provides a solid foundation on which emergent CCGs can build and as such should be regarded as an invitation to innovate. (Imison *et al.*, 2011a, p. 3)

These observations show different worlds engaged with the performance of the Act. They reveal how the CC model gets represented for various purposes: as 'impossible' by clinicians contesting

the programme of action and as 'an opportunity' by clinical bodies and management consultancies. These expectations shaped new relations as actors attempted to mobilize others to perform a particular version of the model, where 'Clinical commissioning groups (CCGs) … combine the nature of a statutory body with that of a membership organization…' (Imison *et al*., 2011a, p. 3). This novel bricolage included actors from worlds external to the model and assembled experience from clinical and non-clinical settings to guide the operation of CCGs. A number of devices were introduced – comparability, accountability and transparency – and openness to market engagement activities was encouraged. The flow of funding to CCGs was modelled, along with the CCGs' relations with multiple agencies including the 'public and patients' (Figure 4).

Putting clinical commissioning organizational structures into practice

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

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

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

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

Clinical commissioning projects in action

In the third stage of implementation, CC projects were put into action. Sheaf *et al*. (2015) suggest that although commissioning worked in certain respects, it was often found to be a laborious and uncertain process. The attempt to turn GPs into hybrid agents – combining a bricolage of valuation schemes in their decisions to use secondary care – appeared to be failing, with little '… clinician involvement on the financial side' (Sheaff *et al*., 2015, p. 103). Instead, commissioners engaged with providers through negotiations and

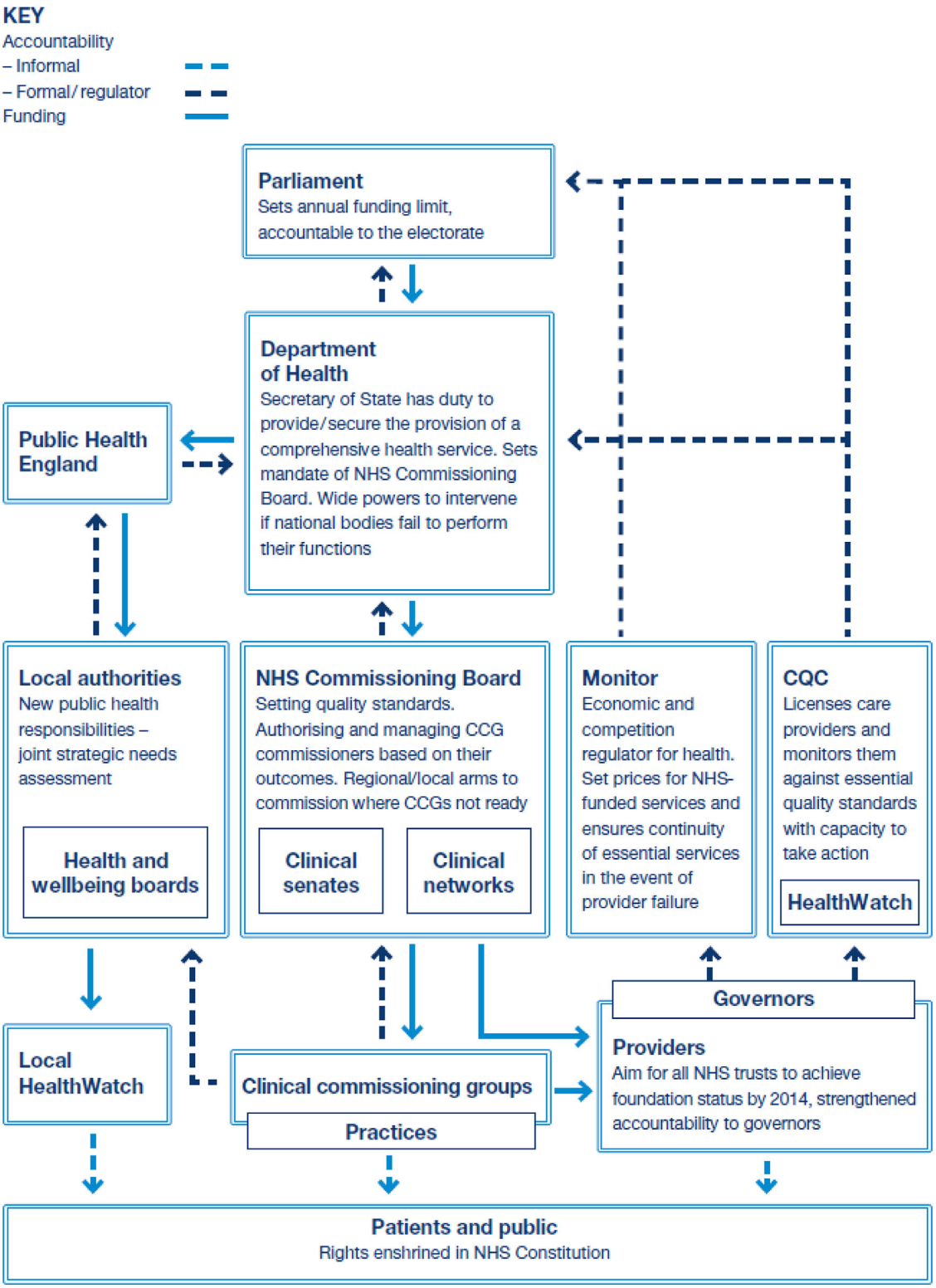
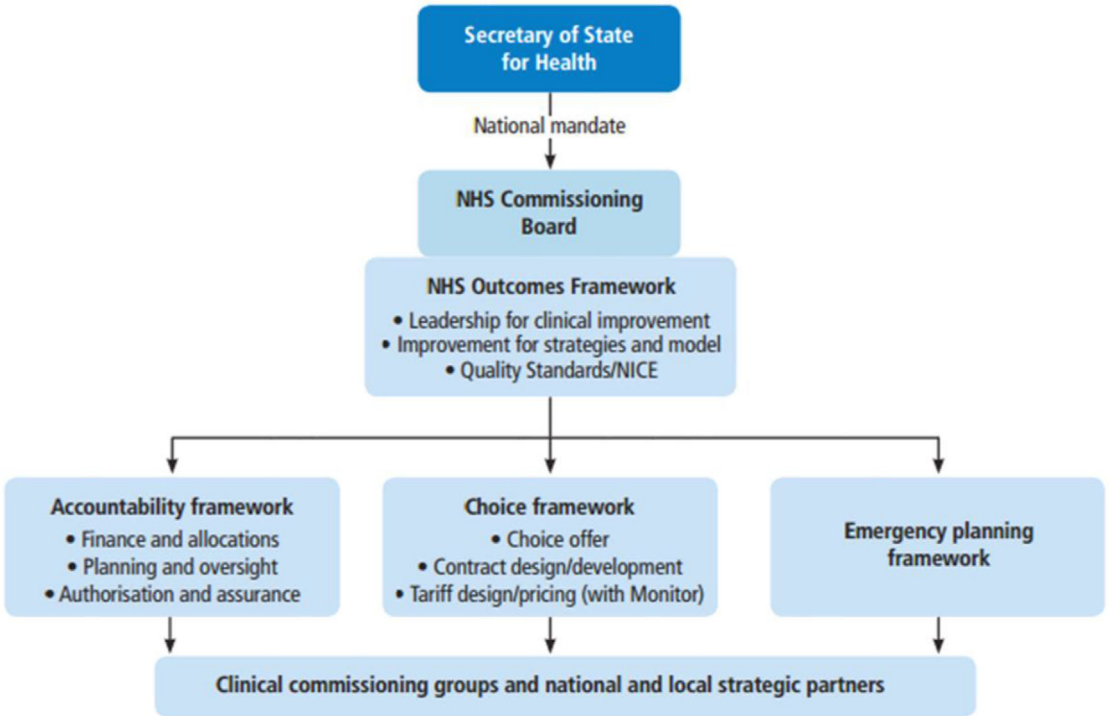


Figure 4. The new structure of the NHS following the introduction of the 2012 Act: lines of funding and formal and informal accountability
Source: *Imison* et al. *(2011a)*.
[Colour figure can be viewed at wileyonlinelibrary.com]



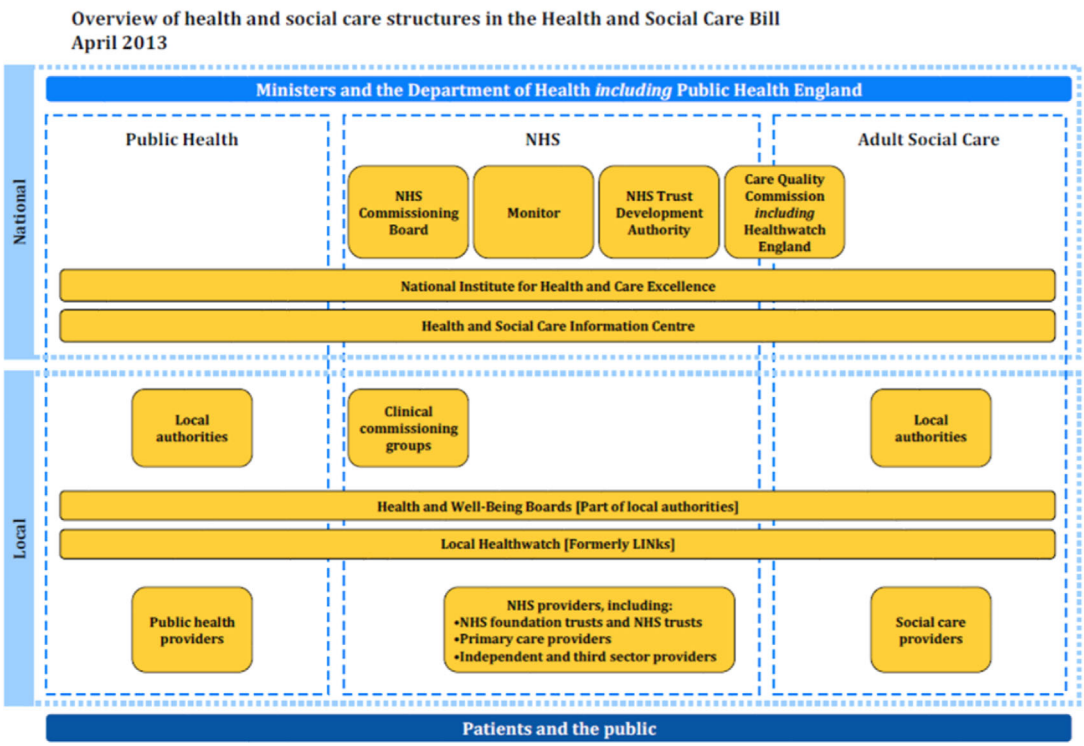


Figure 5. Slides circulated by the NHS National Commissioning Board [Colour figure can be viewed at wileyonlinelibrary.com]

Figure 6. Contested commissioning provision and practice
Source: NHS Clinical Commissioning.
[Colour figure can be viewed at wileyonlinelibrary.com]

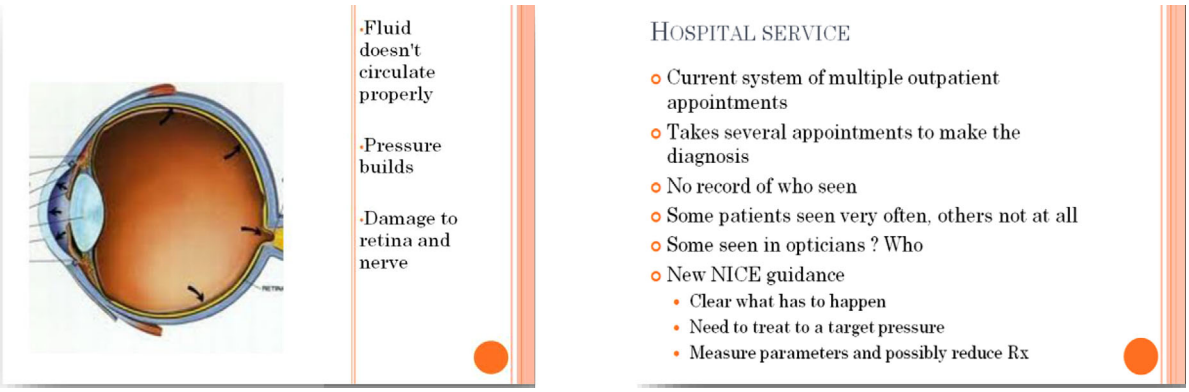


Figure 7. Part of a GP's representation of the glaucoma problem for the Commissioning Board [Colour figure can be viewed at wileyonlinelibrary.com]

discussions about evidence, even if they regularly checked providers' performances against national and regional benchmarks. Trust and commitment between NHS actors with long experience of working together trumped the competitive mechanisms the Act had envisaged.

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

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

While the CC model was producing effects, it was also interfering with clinical work and judgements. Patients were no longer automatically referred to NHS Centres of Excellence: '… expert health professionals… com[ing] together to provide the very best care and treatment …' (Genetic Alliance). The logic behind these stable investments was best patient outcomes (not market competition or population health). GPs began to make different judgements. Others struggled to make the system work for them, despite their persistence and enterprise. The Act and the 'caged' CC model had taken little account of extant clinical practices. One GP (Andrew) told of a specific issue he encountered when trying to commission glaucoma patient care. Glaucoma is a disease of the eye. Pressure in the eye builds to a point where permanent and irreversible damage is caused to the retina and optical nerve (Figure 7). Eye drops or surgery can keep the pressure to a level that preserves sight, but require careful monitoring. GPs do not have glaucoma equipment in their surgeries, so patients are treated in dedicated eye clinics. Andrew explained:

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

One of the key devices used by GP surgeries managing care is 'the disease register' (Andrew): listing all patients diagnosed with a specific condition. GPs are incentivized through performance measures to keep people out of hospital by monitoring and managing diseases:

> In secondary care[7] there aren't any disease registers. So, the only way [the hospital] could do their audit

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

> was as a manual audit. Because there is no register, the hospital really has no idea when it sees patients… They cannot tell who's been seen… if your appointment is deferred for some reason, you just go to the bottom of the list. (Andrew)

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

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

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

Analysis and implications

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

Bricolage as a critical element of performativity

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

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

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

This observation has important implications for understanding performativity. First, it shifts the focus from the designers that developed,

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

As the performativity of policy is directed towards the reconfiguration of agencies and their relations, it is important to consider what *agencing* effects policies achieve. Our findings suggest a significant potential for misfires and unintended consequences triggered by ambitious policy changes, as illustrated by the many conflicted agencies that we encountered. This positions reflexive agencies such as healthcare professionals and the Health and Social Care Select Committee as central to the success of large-scale change programmes and suggests the need for investments in working with these agencies to carry out marketization initiatives.

The effects of performativity of the act at multiple scales

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

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

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

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

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

As we suggested, interventions at different scales do not necessarily cohere. For example, at the scale of the programme, it is those with experience, expertise and working theories of clinical and social care management that are constructed as sceptics

by the clashes generated when theories of markets collide with those of healthcare provision. Market theories suggest that choice and competition provide access to efficient and affordable provision, while healthcare theories suggest specialist, long-term investments in stable centres of excellence generate the most effective outcomes. At the organizational scale, it is the clashes between clinical care and the marketization of population health management that matter. Understanding how and why such tensions become built into the performance of the Act at different scales may help policymakers and practitioners better anticipate the challenges of implementation and mitigate performativity misfires.

The multiple and situated nature of performativity

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

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

At first sight, it might appear that the fault lay with the type of markets envisaged by the Act: established and 'at hand' competing service providers. However, as Callon (2007) and Garud, Gehman and Tharchen (2018) observed, performativity is a process that often unfolds over long periods, with long sequences of trial and error as well as reconfigurations. The 2012 Act generates a vision of a world prescribing which agencies should inhabit that world, how they should interact and what types of system-wide effects those agencies and interactions should generate.

However, those agencies do not lie in waiting or pre-exist the implementation of the Act. Considerable effort was expended after the Act came into effect to specify what skills and competences existing agents should acquire to turn themselves into the commissioners and providers envisaged by the Act. In the meantime, ill-equipped and increasingly conflicted agents acted as bricoleurs, availing themselves of whatever was at hand to bridge the gaps between what the Act prescribed and what was possible to accomplish. As MacKenzie and Guerra (2014, p. 157) suggested: 'To be successful this bricolage has to be oriented towards local situations and immediate problems as well as wider goals, and it sometimes inverts the relationship between ends and means.'

Conclusion

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

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

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

Whereas performativity approaches have implicitly relied on a linear model of innovation, with self-propelled and complete products (e.g. theories, models) diffusing into the world of users with greater or lesser success (D'Adderio, Glaser and Pollock, 2019), we propose an alternative model. Policy is often incomplete and its ability to perform particular worlds relies not just on the presence of felicitous conditions, but on the concurrent development of the aims contained in the original policy and the conditions that facilitate those accomplishments. To use an analogy culled from the innovation literature (Bijker, 1992; Fleck, 1988), policy is further elaborated and reconfigured during the diffusion process. The model and the world become progressively adjusted to each other through multiple, iterative rounds of interaction between designers and users which transformed both the original policy and its distributed translations in practice. As we have shown, these adjustments involved both sides making creative and ad-hoc use of the resources at hand.

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

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