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

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Abstract

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

1. How do the internal managerial regimes of differently owned healthcare providers differ, or not?

2. In what respects did any such differences arise from differences in ownership or for other reasons?

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

Findings: The relationships between ownership (one one hand) and organisation structures and managerial regimes (on the other), these relationships differed at different organisational levels. Top-level governance structures diverged by organisational ownership and objectives among the case-study organisations. All the case-study organisations irrespective of ownership had hierarchical, bureaucratic structures and managerial regimes for coordinating everyday service

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

Conclusion: Ownership does make important differences to healthcare providers' top-level governance structures and accountabilities; and to work coordination activity, but with different patterns at different organisational levels. These findings have implications for understanding the legitimacy, governance and accountability of healthcare organisations, the distribution and use power within them, and system-wide policy interventions, for instance to improve care coordination; and for the correspondingly required foci of healthcare organisational research.

Repositioning the Boundaries between Public and Private Healthcare Providers in the

English NHS

Repositioning the Public-Private Boundary: Supposed Managerial

Consequences

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

Since the 1980s neoliberal 'reform' has in many countries shifted services across the boundary

between the public and private sector. In the UK that boundary was successively brought closer, at

times even into, the core clinical activity of the NHS (see Box 1).

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

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

Creation of an 'internal market' (1991).

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

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

The Private Finance Initiative: turn-key projects for non-NHS firms to design and build NHS

hospitals, and operate their support services (1994).

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

Extending the internal market to community health services, which transferred from being Primary

Care Turst managed to contractors (2004)

' Any Willing Provider' policy gave non-NHS bodies the right to bid to supply NHS-funded clinica

care (2012).

Commissioning Support Units (consultancy-like support for NHS payers) (2012).

Alongside these changes, NHS service providers were reconstituted as 'Foundation Trusts' with

more business-like structures and, ostensibly, more autonomy from central government control.

The few NHS services denationalised outright were community health services, placed on the

public-private boundary as 'social enterprises' (SE: managerially independent non-profit providers

whose assetts remained state-owned but which could still go bankrupt) rather than as for-profit

corporations. More often, NHS services' staff, assetts, activity and contract were in effect

transferred across the public-private boundary to a non-NHS organisation (rather than expect the

latter to assemble a new workforce and physical infrastructure from scratch). The Transfer of

Undertakings (Protection of Employment) (TUPE) regulations protected NHS pay and conditions

for the transferred staff. Policy statements announcing these changes (Department of Health 2010)

repeatedly represented them as (so to speak) 'back-end' changes with no adverse implications for

patients because NHS-funded care remained largely free at the point of use. At least for the

purposes of persuading patients and voters, the public-private boundary was no longer defined in

terms of provider ownership but financially, in terms of the source of payment for NHS services

and, insofar as all providers operated under a common regulatory, monitoring and accountability

frameworks (Department of Health 2010), in terms of governance. (Perry and Rainey 1988)

Towards an Ownership Theory of Organisation

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

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

it is however intended as an empirical, explanatory theory outside the normative 'social welfare' frameworks of neo-classical economics and therefore of transaction cost or the structure-conduct-performance theory.(McWilliams and Smart 1993)

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

1. pursue substantively different goals, hence;

2. establish managerial regime which differ in:

    (a) The organisational structures which select and implement the organisation's work processes and transmit the owners' goals to them. Whether hierarchical or non-hierarchical, differently-owned large organisations would therefore differ in the agency problems arising for the owners at the often-discussed interfaces between owners and managers (Berle and Means 1932; Fama and Jensen 1983; Bebchuk 1999; Demsetz and Lehn 1985), and between managers and production workers. Within a formal structure network-like elements of 'informal organisation' and market-like elements (an 'internal market' in the strict sense) might also co-exist.

    (b) What aims and goals they prioritise, i.e. which command the most management attention and which the internal incentives (salaries, bonus, equity, status, career advancement etc.) target: the 'tight' elements in 'tight-loose' management.(Peters, Waterman, and Jones 1982)

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(c) The combininations of technologies of power (persuasion, material incentives, coercion, the 'gaze', technologies of the self (Foucault 1980) etc.) by which the owners, or managers as their proxy, control what the other members of the organisation do.

(d) Organisational culture, including professional sub-cultures, i.e. their normative requirements for work practices and guiding individual behaviour, justifications of the organisation's work, its ownership and managerial practices, all expressed both verbally and in artefacts.

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

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

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Japan found that the longer managers had been in post, the more divergent did their 'values'

become.(Becker and Connor 2005) Boyne's (2002) narrative review of empirical studies of 13

hypothesised differences found that of the 8 differences about which secondary evidence then

existed, the evidence supported three: public organizations were more bureaucratic, public

managers were less materialistic (had a stronger public service ethos) and (partly because many of

them came from non-managerial professions) had weaker organizational commitment than private

sector managers.

Some studies (Kirkpatrick, Altanlar, and Veronesi 2017; Boyne 2002; Alchian and Demsetz 1973;

Hvidman and Andersen 2014; Meier and O'Toole 2008) attribute differences in internal managerial

regimes to differently-owned organisations' different operating environments, although further

studies qualify these findings in various ways (Bozeman, Reed, and Scott 1992; Rainey and

Bozeman 2000; Knott 1993) or report common features of managerial regimes irrespective of

ownership. (Knott 1993) However one intention, and to a certain extent effect, of marketisation

'reforms' has been to give all the differently-owned providers in a particular quasi-market a similar

organisational environment. Insofar as such 'reforms' succeeded, one effect would be to constrain

public organisations to mimic corporate structures and managerial regimes even without

repositioning the public-private boundary.

Environment apart, boundary-repositioning may also stimulate internal changes in managerial

regime in consequence of ownership changes. Existing studies give a mixed picture of these

endogenous differences. Some narrative reviews (Rainey and Bozeman 2000; Kirkpatrick, Altanlar,

and Veronesi 2017; Knott 1993) doubt whether certain *formal* differences between public and non-

public management are large. Euske (2003) argues that all organisations need essentially the same

accounting, costing, IT and 'general' functions' systems irrespective of what those systems are used

for. Rainey and Bozeman suggest that simplistic contrasts between private organisations' univocal

and public organisations' complex, 'political'objectives are at best exaggerated.(Rainey and

Bozeman 2000) Public and private organisations managers have essentially the same capacity to

reward employees.(Simon 1991) More generally it has been argued (Berle and Means 1932;

Burnham 1941) that managers are a separate social milieu, even class, with distinct economic

interests of their own.

Nevertheless certain differences in 'private' and public organisations' managerial regimes are also

reported. By its 'managerial regime' we mean the ensemble of methods by which those who

ultimately control an organisation do so (through what structures, strategies, incentives, managerial

practices, ideologies and cultures), and in pursuit of what substantive goals. 'Private' organisations'

greater managerial discretion and/or resources allow them:

1. To have proportionately more managers, especially finance-managers (Aidemark and

   Lindkvist 2004). Conversely, the 'public firm' structures and management practices

   developed in NHS trusts increased the proportion of 'strategic' managers but not that of

   specialist managers. Indeed NS trusts had a smaller (and decreasing) proportion of

   managers compared with the whole UK workforce (Kirkpatrick, Altanlar, and Veronesi

   2017) (a pattern possibly over-reported by reclassifying clinician-managers so as to claim

   reduced NHS 'bureaucracy' (Hyde and Exworthy 2016)).

2. less formalised, standardised, 'bureaucratic' managerial procedures ('red tape') hence

   quicker completion of managerial tasks (Bozeman, Reed, and Scott 1992); and less risk-

   averse, more entrepreneurial (inventive, innovative, flexible, risk-taking) decisions.

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

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

On the above assumptions the *content* of managerial decisions would differ qualitatively between differently-owned healthcare organisations, resulting in correspondingly different products, work-processes (hence user experience), technology-adoption, workforces, information-systems, internal incentives (both formal and informal) and managerial regimes.

Research Questions

Aims

The many correlational studies of organisational differences either side of the public/private boundary cannot, and often were not intended to, explore any such links between ownership and managerial regime. We lack reports of how management decisions, constraints and actions differ *substantively* – or not – between healthcare organisations on either side of the public-private boundary. The present study aimed to contribute to filling that gap, in doing so contributing to testing and as necessary revising an ownership theory of organisation.

Research Questions / Hypotheses

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

1. How do the internal managerial regimes of differently owned healthcare providers differ, or not?

2. In what respects did any such differences arise from differences in ownership or for other reasons?

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

Methods

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

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

marked in Table 1.

Table 1: Qualitative sample: Maximum variety by ownership type

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

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

Because all these services have high proportions of older patients with complex or multiple health

conditions, we made that our focal care group. In each study site we identified a key informant from

whom we snowballed to other informants selected for relevance to that care group and to the

conceptual framework outlined above. They typically included hospital directors or chief

executives, medical directors, operations managers, finance managers, quality and performance

managers, service managers and business development or marketing managers together with

clinical leads in our tracer services, lead nurses or matrons and contract managers. Where available

we preferred informants who had worked in, and could therefore report the differences between,

healthcare providers under different ownership. At the time of our fieldwork none of the corporate

providers were above ten years old (although the corporations owning them were older) so most of

their staff had recently worked for the NHS. The SEs were equally new. The cooperatives,

professional partnerships and voluntary hospital were older, but some informants in them had also

worked in differently-owned healthcare providers.

During 2015-17 we assembled the data summarised in *Table 2*. We used an omnibus semi-

structured interview schedule, selecting for each interview the items that we particularly wanted to

probe in light of what data we already had, and any ambiguities or contradictions in our data so far.

We included informants' accounts of other organisations provided that the informant was speaking

from first-hand working experience. Taking the key informants' advice as to which managerial

documents were seminal to our research questions, we obtained those documents and content-

analysed them.

Table 2: Data collected

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

The meetings included contract meetings (between provider and payer), clinical quality review

meetings and combined quality and performance meetings (sometimes more than one per provider).

With the interviewees' consent we audio-recorded and transcribed the interviews, and pseudonysed

the data throughout. Observations were recorded in contemporaneous field-notes. Two researchers

independently read the transcripts and field-notes. A common coding framework was then applied

to all data. Using a `framework' approach (Gale et al. 2013; Ritchie and Spencer 1994) we

identified commonalities and differences in our data so as to explore inter-connections between

different levels, occupations and interests. We drew descriptive inferences based on *a priori* and

emergent themes before elaborating conceptual perspectives. The empirical themes explored

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informants' descriptions of the effects of changes in provider ownership and of how others reacted to it, and their interpretation of its significance. Under each relevant main heading of our analytic framework, we present these themes below.

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

An NHS Ethics Committee approved the study (reference 10/H0206/71) subject to informant anonymity

Findings

Following the above schema we trace the main connections between types of ownership and the corresponding differences – and similarities - in managerial regime. The differences were mainly at the top ('governance') levels of organisational structures, the similarities mainly at the lower ('work coordination') levels.

Goals and Governance Structures

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

Convergent Aims, Divergent Objectives

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

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

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with their line manager, covering quality, patient outcomes, patient experience, audits , result scores

against national norms '*And of course the numbers comes into it as well*' (hospital director

CS2/M18). But as long as financial targets were met there

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

The not-for-profit hospital chain also had explicit financial targets, but to finance service

developments not targets set by a holding company. The out-of-hours SE's objectives similarly

included making enough financial surplus to grow its 'core business'. The voluntary hospital's

strategic objectives more vaguely stipulated a '*reasonable'* profit. Ex-NHS informants described

both corporate and not-for-profit hospital budget management as being more rigorous than in the

NHS.

The NHS trusts' main objectives were also financial, but the opposite. Our case study NHS hospital

had a £33 million 'Cost Improvement Programme' as its main objective. With a falling income and

rising workload, the OOH trust planned to evolve into:

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

Self-dismemberment was quite the opposite to the non-NHS organisations' objectives.

The other SEs' objectives tended to focused more on non-financial matters. The CHS example

formulated its objectives through workshops of 40 or 50 people that took up issues that emerged

locally, which our informants thought made the SE 'ethical'. At the OOH co-operative:

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

In the last year of our fieldwork it returned its surplus to its member practices. Rather than having

formal objectives, the GP partnership said

> '[w]e have more of an ethos about how we want to practise medicine, and we would want
>
> partners to join us who share that ethos and … continue doing what we do' (CS31/M55).

Although they had no financial incentive to do so they had developed an MSK pathway because

> '[GP] and I looked at it, we know we can do so much better' (CS31/M55).

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

Divergent Governance Structures

Top-level governance structures diverged by organisational ownership and objectives among the

case-study organisations. As noted, the corporate examples all had a 'financialised' (Montgomerie

and Williams 2009) structure designed to transfer payments from an operating company into a

separate holding (owning) company. Our questions elicited that there was no direct interaction

between the managers at provider (hospital, clinic, call centre etc.) level and the owning companies,

which in all cases seemed rather distant from the service provider managers' day-to-day practical

coordinational activity.

Strong 'quasi-hierarchical' (Exworthy, Powell, and Mohan 1999; Sheaff and Schofield 2016)

accountability chains (Day and Klein 1987) linked our case-study NHS trusts to NHS and local

authority payers, NHS England, the Department of Health and ultimately Parliament. NHS Chief

executives' careers and continuity in post depended above all upon achieving the targets (including

cost control) most important to government, the so-called *(Bevan 2009)* 'targets and terror' regime:

a politicised stucture. Informants at one SE described how in their NHS days they were:

> '*required to report every nut and bolt back through an accounting chain and back through*
>
> *the performance management chain*' (CS23/M37)

Having no *external* governance structure the voluntary hospital, not-for-profit chain and community

health services SE could pursue whatever 'mission' their members chose: a mission-based structure.

Doctor-owned organisations had correspondingly doctor-controlled structures. Two-thirds of the

OOH cooperative's Management Council was elected by the GP members, who included every GP

working for this provider, and appointed a medical director, chief nurse, chair, two non-executive

directors and various sub-committees. The general practice providing CHS was jointly controlled

by its GPs, one of whom (the 'managing partner') managed the employed non-medical staff.

Convergent Coordination Structures

Convergence on hierarchy

Doctor-controlled organisations half-excepted, all the case-study organisations had an hierarchical,

bureaucratic structure for coordinating everyday service production, hence largely similar daily

managerial work for that. Former NHS managers said their day-to-day work had changed little with

the change in ownership. Marketing apart, the range of management functions (HR, finance, IT etc.)

and 'line' management (of operations, nurse, therapy, administrative and ancillary services

managers) was similar. Although ex-NHS informants often described some NHS-trust decision-

making as slower, labyrinthine, frustrating and more cumbersome it nevertheless did not always

achieve tighter control:

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

Most of our ex-NHS informants described themselves, and their subordinates, as being more

accountable than before in organisations under corporate, not-for-profit and voluntary ownership.

They meant *internally* accountable to their own managers. However Checkland et al. (2013) also

found that the emergence of CCGs increased the complexity – rather than the clarity - of the

external, inter-organisational accountability chains in which NHS-funded providers found

themselves, both 'upwards' (quasi-hierarchically) and horizontally to collaborative parties which

would include other statutory bodies and commercial partners.

Because it requires fewer tiers of management, a smaller organisation can have a 'flatter' structure,

shorter chains of command and simpler management arrangements than a large organisation with

just the same spans of control. Interviewees described how the corporate providers' smaller size

meant that

> '*the medical and nursing staff, and everyone else for that matter, but for the clinicians to*
>
> *actually be much more involved in the running and the change management of a smaller*
>
> *organisation'* (CS2/M19)

Corporations, non-profit and voluntary organisations' hierarchical coordination structures

accommodated doctors in three different ways. NHS-employed consultants most often had

admitting rights, but one corporate hospital also directly employed its orthopaedic surgeons and

sub-contracted its ophthalmologists from a medical 'chamber'.

The Semi-Democratic Exception

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

Discussion

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

A second empirical limitation is that we have focussed on formal structures, omitting to varying

extents other technologies of power within differently-owned organisations: informal organisation;

ideology (including culture, organisational identity and disciplinary control); technologies of the

self; the interactions of multiple cultures and institutional logics (Reay and Hinings 2009); and

resistance to managerial and owners' control. We have focussed on 'downward' influence rather

than any reciprocal 'upwards' (e.g. technological) relationships between organisational ownership

and managerial regime (for instance, whether cooperatives or partnerships are more resistant to

becoming corporations than public organisations are), or influences across formal organsiational

boundaries.

Neither does this paper consider how far these differences affect different organisations' work

processes, outputs and interactions with their environments, and with what consequences. All these

topics merit further comparison across differently-owned organisation. In these ways the present

study points towards a wide-ranging further research. Participants' narratives of organisations'

formation and development – an historical approach - would be a strong research design for testing

and revising an ownership theory of organisation. Testing a multi-level theory would also appear to

require a multi-level research design.(Hitt et al. 2007)

Nevertheless our findings tend to support the idea that even insofar as managerial structures of

differently-owned organisations have *formally* similar structures (managerial 'functions' or

specialisms, uniprofessional sub-hierarchies, project teams etc.), the *substantive* uses to which they

were put differ in important respects. Such differences might explain why superficially similar

managerial actions may have different impacts in differently-owned organisations. For instance,

publicly-owned schools in Denmark adopted performance management earlier and more widely, but

to less effect in terms of pupils' educational grading, than private not-for-profit schools.(Hvidman

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

Conclusions

So far as we are aware this study is one of very few to compare systematically the internal managerial consequences of diverse ownership of healthcare providers. On balance, our data supported the assumption that the management of differently-owned organisations (e.g. those on different sides of the public-private boundary) remains 'fundamentally alike in all unimportant respects' (Sayre 1958), *provided* we take hierarchical coordination structures and their associated managerial functions (accounting, IT etc.) as the unimportant respects. Even then, 'alike' would be an overstatement because hierarchical coordination was not ubiqutious in the doctor-owned organisations. So far as coordination structures are concerned our data suggest that whilst ownership does make a difference to coordination activity, the larger difference is not the one between organisations on either side of the private/public ownership boundary. Rather, the boundary that makes a difference to it is the boundary between organisations owned by at least some of those who directly produce the organisations' outputs (goods or services), and organisations which are not. In the former case their (in this case, doctors') work was controlled and coordinated in a more-or-less democratic, self-governing ways. Conversely, the 'important respects' would be taken as the differently-owned organisations' governance structures, managerial regimes and their operationalised, most tightly managed objectives (those upon which internal managerial incentives are brought to bear rather than their broad, rhetorical aims).

Together these conclusions offer some *prima facie* evidential support for one part of an ownership theory of organisation. Type of ownership does appear, overall, to make a difference to at least some important aspects of an organisation's governance structures and managerial regime. For the broader field of health organisational research, these findings highlight the importance of the *owners'* agency in explaining organisational change. Healthcare organisational research which sufficiently recognised that point would involve studying, firstly, power within organisations i.e. the ways in which the default assumption that the owners are the most powerful actors within a given organisation has to be understood, nuanced or modified, case by empirical case. It would attend to the ways in which managerial legitimations of organisational change simultaneously express the owners' interests *and* formulate them so as to persuade non-owners to accept and pursue them. Also it would attend to how the legitimations of externally proposed system interventions (e.g. policy demands for greater care 'integration') relate to the relevant organisations' owners' interests and wishes, and whether, therefore, these legitimations motivate these owners to implement, ignore or resist the proposed changes. In these ways organisational ownership bears upon the governance and public accountability of health systems as a whole. Our findings also call into question the practice of copying managerial techniques (and 'fads') across the public-private boundary, and the idea that re-positioning that boundary is purely a 'back-end', policy outcome-neutral change.

Acknowledgement

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