Steering, knowledge and the challenge of governance evaluation: the case of National Health Service governance and reform in England

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1. Introduction

The challenge of how to ‘steer’ society towards policy goals (Peters and Pierre 1998) in the face of complex, or ‘wicked’ problems’ is a central concern in political science and public administration literatures on governance. There are different understandings of ‘steering’ and the institutional arrangements required to achieve this. Osborne and Gaebler (1992), influential in the early advocacy of new public management (NPM), advocated states ‘steering rather than rowing’. The term ‘steering’ is sometimes used more broadly to acknowledge that not all solutions can be defined centrally and that ‘meta governance’ of networks is required to allow actors scope for decentralised coordinative activity (Torfing et al. 2012). Studies exploring NPM approaches of performance measurement and outsourcing to the private sector in a range of sectors have highlighted the tensions and problems these often entail in the context of complexity (Bevan and Hood 2006; Head and Alford 2015). This has influenced the case for collaborative network arrangements to foster trust, learning and innovation in policy delivery (Ansell and Gash 2008). This paper addresses the need highlighted by these debates for conceptual frameworks to enable closer, more holistic consideration of the effectiveness of different governance arrangements and policy strategies.

The ‘robust political economy’ (RPE) approach to analysing institutions emerged recently from the heterodox, Austrian tradition in economics (Pennington 2011; Boettke and Leeson 2004). Here, we use key RPE concepts to propose and employ a methodology to meet the need for governance evaluation in the context of complexity. Central to RPE is a conception of ‘coordination’ that, like the notion of steering in governance scholarship, is concerned with allowing actors flexibility in how they translate goals into practice. As Section 2 explains, RPE emphasises the epistemological dimension of anticipating impacts, learning and innovation as of integral importance to achieving coordination. The approach highlights the need for detailed attention to the various, often contested, stakeholder understandings of the substantive impacts of governance arrangements and policy strategy. Here, we demonstrate how this approach to institutional analysis, with its rich, outcome-orientated

conceptualisation of coordination, can complement what Hood and Margetts (2007) and author (2016), describe as the process-orientated focus of political science and public administration. RPE has origins in the work of pro-market, classical liberal Austrian economists who were firmly entrenched on one side of a rather dualistic debate with socialists about the strengths and weaknesses of markets and planning as mechanisms for allocating resources. Yet, we argue, the approach is highly applicable to contemporary governance arrangements involving a hybrid of market and non-market processes across multiple scales. Some recent RPE contributions (e.g. Pennington 2011), although primarily conceptual, discuss such contemporary governance applications, particularly in relation to environmental resources. However, there remains a lack of extended, empirically orientated RPE analyses of such hybrid arrangements.

Here, we explain and illustrate the contemporary pertinence of RPE through a focus on health governance, in particular the English National Health Service (NHS) which involves a hybrid of hierarchical structures, networks and quasi-market arrangements. Section 3 introduces key aspects of coordination challenges in the English NHS concerning *scale, mechanisms* and *sectors*. Section 4 reviews the insights into these aspects of coordination challenges offered by various health research approaches. We argue they leave open the need for further, holistic evaluation of the governance arrangements shaping policies and interventions and the inter-relationships they involve between public, private and third sector across different scales. The positivist character of the limited research evaluating health governance means broader approaches are required that are sensitive to a greater range of values and contested understandings of outcomes. Section 5 draws on RPE to set out a methodology for holistic governance evaluation through a focus on coordination. In section 6, we illustrate the potential of this approach, with its strong, detailed epistemological focus, through a case study of diabetes care in the English NHS. This case study illustrates how the RPE conception of coordination enables us to draw together and enrich findings from the currently demarcated sub-fields of health evaluation research, promoting more holistic evaluation. Section 7 discusses potential future

applications of the approach to governance evaluation across a range of scales and policy sectors. Section 8 concludes.

1. Robust political economy and the challenge of coordination in governance

Political science and public administration scholarship have engaged in various ways with the widely recognised challenge of ‘steering’ within contemporary governance. Critics of NPM have highlighted the problems involved in centrally defining performance measures and targets, given the complexities of public services and the multiple, often incommensurable values requiring consideration (Bevan and Hood 2006). The introduction of purchaser-provider splits and outsourcing has also been criticised for increasing administration costs and frustrating collaboration (Head and Alford 2015). Scholars have thus advocated shifts away from the centralised and competitive strictures of NPM towards more ‘collaborative’ or ‘interactive’ network governance arrangements (Ansell and Gash 2008; Torfing et al. 2012) that might be more suitable for fostering decentralised responsiveness to complex challenges through promoting trust and mutual learning.

Prior governance scholarship thus offers important insights into how the challenges of steering might be addressed. Yet, there remains a need for conceptual approaches that more closely evaluate governance arrangements and the inter-relationships they involve between public, private and third sector in the face of complex, cross cutting problems. Reviewing the network governance literature, Torfing et al (2012) identify the need for evaluative approaches that move beyond a positivist approach to performance measurement. They suggest criteria for evaluating governance networks, such as promoting understanding and learning, trust building and coordination of implementation, though they leave open the question of how these criteria can be operationalised. The RPE conception of coordination can potentially underpin such evaluation criteria. Yet, in contrast with

Torfing et al, RPE makes explicit the need to consider how various stakeholders understand the impacts and outcomes of decision processes.

Although the RPE conception of coordination has origins in the work of Friedrich Hayek, RPE scholarship recognises that use of this conception of coordination as a focus for institutional evaluation does not necessarily require agreement with Hayek's own strong, controversial conclusions in favour of market liberalism. In conceptual terms, coordination, for Hayek, is a kind of process in which individuals through multiple decisions, select the most effective means for achieving a balance between and translating into practice their goals. He emphasises the uncertainty that characterises such decisions, given the profound complexity of these means-ends inter-relationships. As a leading member of the Austrian School of economics, Hayek emphasised that these decisions are based on individuals' subjective knowledge, reflecting their epistemological and spatially situated perspective. This emphasis on complexity and uncertainty formed the basis of Hayek's Austrian critique of mainstream, Neoclassical economics models with their focus upon defining an optimal or equilibrium outcome in quantitative terms. Given the inevitable epistemic limits of decision-makers in this context, Hayek emphasises the significant possibility of unintended failures to achieve the balance sought between multiple goals. This fundamental, epistemological dimension of coordination challenges is highly pertinent to contemporary debates about how governance processes can steer actors towards policy goals, while allowing them appropriate flexibility in selecting and discovering means of achieving them. Coordination in such a 'dynamic' sense (Alter and Hage 1992: 83) may lead to better longer term outcomes, even while involving a degree of variation, or 'inconsistency' in options chosen across different times and places which might entail short term 'inefficiencies' (author 2016: 33). Although coordination itself is a process, assessing whether actions promote coordination in this sense requires consideration of their consequences. This is in contrast with the usual process-orientated treatments of coordination in political science and public administration (author 2016: 36).

The second fundamental dimension of coordination challenges highlighted by RPE is motivation. In comparison with the epistemic dimension, motivation has been the subject of especially extensive focus in political science, given the strong influence of public choice and sociological approaches. On epistemology, there is of course strong recognition in political science of the importance of understanding the contested character of knowledge concerning complex governance challenges and the 'bounded' nature of rationality (Head and Alford 2015). Indeed, a key strength of 'network governance' highlighted by some scholars (e.g. Kooiman 2000: 142) is that it can bring together actors' different, potentially complementary forms of knowledge. Yet, the need highlighted by RPE for detailed analysis of the substantive content of complex policy choices, decisions and their impacts is not typically addressed by political science. One reason might be that acquiring evidence about policy impacts inevitably requires potentially difficult engagement with knowledge from a variety of natural and social sciences disciplines.

By emphasising the need for close attention to the specific roles and inter-relationships between the various public, private and third sector actors, RPE can enable closer engagement with evaluative questions about the specificity of different governance models to be addressed, that, as Davies and Chorianopoulos (2018) point out, tend to be side-stepped by literatures on network governance. As well as the multiple, often cross cutting range of criteria involved in complex policy challenges, RPE highlights the different *scales* of decision-making and allocative *mechanisms* that these models involve and their varying effects on the epistemological and incentives dimensions of coordination challenges. While suggesting coordination is of integral importance to understanding governance processes, RPE does not view politics as somehow reducible to coordination problems. RPE recognises that the broad goals in terms of which we might assess governance arrangements and policy strategies will inevitably be value-laden, hence open to political contestation. Just as norms, perhaps also ideologies, shape stakeholder views about the role of governance and policy in fostering coordination, perceived impacts of governance and policy strategies in terms of fostering coordination

shape the contours of these normative, ideological perspectives. As Lindblom puts it, the selection of means shapes ends, as well as ends shaping means (Lindblom 1959: 81). For example, the aforementioned critiques of NPM might influence the proposals of both social democrats advocating a publicly run health service but also market liberals who take a very critical view of the role of states.

Rather than being impartial, we might expect evaluative research to reflect the normative perspective of the evaluators. Yet, in governance scholarship, there is emerging recognition of the need to combine sensitivity to the contested values and knowledge underpinning stakeholder framings, while seeking to identify widely agreed values that might yield criteria for governance evaluation (Klijn and Koppenjan 2016: 247-50). Such widely agreed values would often seem to be identifiable, even if only in rather broad terms. In the case of health, for example, most stakeholders are committed to the broad goal of promoting healthcare and quality of life for all. Coordination challenges concern how to identify the most suitable means of achieving this. As explored in the following sections through a focus on health, we explore and further explain the potential for this RPE conception of coordination to serve as a focus for governance and policy evaluation.

3. The challenge of health governance in England and the 2012 Health and Social Care Act

The aforementioned challenge of achieving coordination across multiple scales and sectors has been of integral importance to longstanding, often deeply contested, debates about health governance in the UK. In these debates about NHS governance, there is widespread acceptance of the overarching objective of universal healthcare provision that promotes the quality of life of all patients. But the question of the precise policy strategies and forms of governance that are most conducive to achieving this broadly agreed goal is contested. Of fundamental importance to health governance and policy evaluation is the problem of allocating resources for the development, selection and delivery of health interventions and care pathways provided by different NHS sectors. These questions of

allocation are distinguishable from those of the *processes* through which policy is made across different *scales* and delivered locally through particular allocative *mechanisms*. These key aspects of coordination challenges are depicted in Table 1 below, along with key organisational features of the English NHS through which these challenges have recently been addressed.

Table 1: Elements of coordination challenges in the English NHS		
Resource allocation and choice of interventions across sectors	Processes	
	Scale	Allocative mechanisms
Development and selection of interventions and pathways within and across sectors Achieving balance between sectors: • Public health, community care, primary care and secondary care • NHS and local authorities	Role of Department of Health and national organisations in developing policy and monitoring implementation Role of clinical guidelines, quality standards and targets Size and role of regional/local organisations	Networks and partnerships Direct patient, citizen and clinician involvement Direct public administration Quasi-markets (purchaser/provider split and contracting out)

Our case study assesses the effectiveness of NHS governance reforms in the 2012 Health and Social Care Act (HSCA), passed by the UK Coalition Government. The HSCA involved significant changes to the scales and mechanisms through which central government sought to steer local service delivery. The HSCA was one of a series of NHS reforms traceable back to the introduction of NPM approaches under Margaret Thatcher's Conservative government in the 1980s (1979-1990). Assessing such reforms requires a brief overview of the key elements of the UK National Health Service governance, the significance of which has changed and evolved, particularly since the 1980s. This UK governance context, introduced further below, is also important for understanding the various areas of health evaluation research discussed in Section 4, which tend to have a strong UK focus.

3.1 The NHS in historical context

Some key institutional features of the UK NHS have been present since it was established in 1948 with the aim of securing healthcare for all citizens free-at-the-point-of-use (Ham 2009). A fully comprehensive health service was created featuring the main types of healthcare, including public

health, community care and medical services. The original design was characterised by a key distinction between ‘primary’ and ‘secondary’ care sectors that remains in place today. ‘Primary care’ is delivered by General Practitioners (GPs) who are ‘gatekeepers’ to the service, providing some diagnostic and routine services while referring patients on to secondary care for more specialist services when necessary. From 1948, newly nationalised hospitals dominated this secondary care sector. Services that were previously the remit of local government, including a range of public health, environmental and personal health services, were also integrated into the health service. This prompted significant debate, which continues today, about whether such services are more appropriately provided by local government, with its close connection to communities and direct forms of democratic decision-making and accountability.

For decades only minor changes were made to this model (Ham and Smith 2010: 30) until significant reforms were introduced by the Conservative governments in the 1980s and 1990s, New Labour from 1997-2010 and the Conservative-Liberal Democrat Coalition (2010-2015). While these successive governments adopted distinct approaches, their reforms involved two key elements, further explained below: quasi-market processes alongside important elements of centralisation and performance management.

3.2 Key coordination challenges in the NHS

Centralised governance and performance management.

The appropriate scale of decision-making in the NHS has been subject of much, often heated, debate since the organisation was founded (Ham, 2009). In some respects, the NHS has become less centralised since the 1980s, with the Department of Health having less influence in the operational decision-making of organisational units. Yet, in other respects NPM reforms since the 1980s have had the effect of greater centralization through forms of national performance management, including the use of targets, quality standards and financial penalties. Pivotal here was the influence of the global Evidence Based Medicine (EBM) movement, discussed further below, which aimed to enhance

the role of evidence in the selection of health interventions and treatments (Greenhalgh, Howick, and Maskrey 2014). In the UK, New Labour established the National Institute for Health Excellence (NICE) in 1998, whose role was to develop national clinical guidelines for NHS services, in part due to concerns about variations in care quality and inequalities of access. These guidelines included 'disease-specific' clinical governance to set and enforce standards for conditions deemed to be of vital importance, including stroke, cancer and cardiovascular disease. Performance systems were also introduced to monitor the efficiency and patient safety of healthcare delivery, combining with league tables and new regulatory organisations, such as the Care Quality Commission (CQC), for inspecting standards (Ham 2009). As further considered below, the evidence base established by EBM that informed NPM reforms became the subject of some controversy and contestation.

Increased role for markets and the private sector.

Influenced by NPM theorists (Enthoven 1985), successive governments have sought to improve performance through 'marketisation'. This was a marked shift away from the previously central role of health authorities who planned health services for particular regional populations (Pollock and Price 2013: 8). With the introduction of the internal market in 1990 (Le Grand, Mays, and Mulligan 1998) health authorities retained a planning function but their role now became mostly one of purchasing care for local populations from separate provider organisations who managed their own separate budgets. NHS hospitals became NHS Trusts with a corporate structure modelled on the private sector. In opposition, New Labour pledged to dissolve this purchaser-provider split but once in power their 2001 'NHS Plan' implemented the split with new rigour. Highly performing NHS Trusts were allowed to become 'foundation trusts' with new financial freedoms. Health authorities were replaced by Primary Care Trusts (PCTs) also modelled on corporate lines, although initial plans for PCTs to give up their role of direct providers of certain services, such as community nursing services, were dropped because of trade union opposition, reflecting the contested nature of the reform process (Ham 2009: 67). Private sector involvement in health services delivery was also increased by creating

‘independent sector treatments centres’ for elective surgery. These NPM market-oriented reforms were justified on the grounds that simulating markets, or ‘quasi markets’, within a public sector context would improve performance without compromising the NHS as a universal service free-at-the-point-of-use (Le Grand et al 1998). However, in ongoing debates, some defend the original NHS based on direct public administration as uniquely capable of delivering efficient and truly universal health services. Direct government funding and delivery, they argue, saves costs of administration, billing and marketing, allowing resources to be directed to frontline services (Pollock and Price 2013: 8). Meanwhile, pro-market thinkers question whether direct public administration or even quasi-markets can meet the challenges of dynamic coordination in the absence of genuine market signals and incentives (Niemietz 2016).

The HSCA, the key reform to the English NHS introduced by the Conservative-Liberal Democrat Coalition (2010-2015) government, can be seen as an extension of these NPM reforms, although with some important differences in approach. The HSCA sought to stimulate efficiency gains, patient-centredness and innovation through various scale- and mechanism-related changes. Diagram 1 depicts the institutional arrangements in the English NHS after the Act’s passage, from national level organisations to local commissioners and providers, and across sectors (public health; primary care; secondary care). The straight arrows indicate the devolution of authority and finances to a lower-level organisation while the dotted arrows indicate the upward direction of accountability. The main

performance management protocols introduced are also shown.

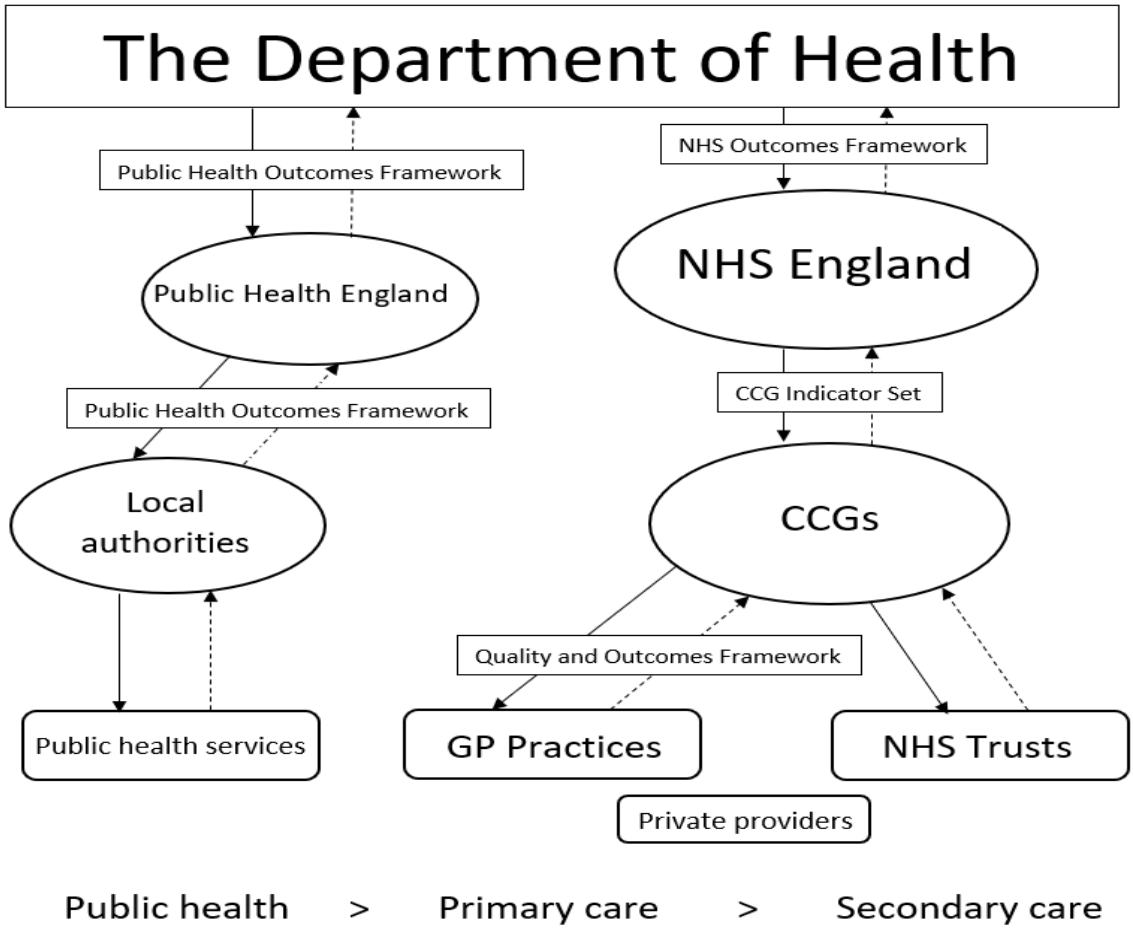

Diagram 1: The English NHS following passage of the Health and Social Care Act (2012)

In relation to scale, the various 'outcomes' frameworks listed in Diagram 1 were introduced to foster evaluation and accountability of services. These represented a break from New Labour's 'disease specific' approach, which the Conservative party opposition amongst others criticised for interfering with local planning decisions and professional judgement (Conservative Party 2008). Two new national agencies were also established. NHS England took over some responsibility for health governance from the Secretary of State for Health, in a controversial move justified on the basis it would free the health service from political interference. Public Health England was established to provide greater visibility for the public health sector, seen by the Coalition as having been side-lined

by the original NHS. It would also oversee effective public health service delivery for promoting the wellbeing of the population.

The main ‘mechanism’ change under the HSCA was the introduction of Clinical-Commissioning Groups (CCGs). Comprised primarily of GPs, CCGs replaced PCTs as commissioners of health services. This was also a scale-related, decentralising move because CCGs were smaller and responsible for commissioning services for fewer people. CCGs were designed to foster quasi-market processes, representing an extension of the purchaser-provider split in the NHS. Unlike PCTs before them, CCGs do not directly provide any services. It was anticipated that CCGs would contract with greater numbers of providers with diverse ownership arrangements. This, in combination with elevating the GP role in commissioning, was expected to achieve the long-standing objective of successive governments to develop primary care and lessen the dominance of hospital-based, secondary services in the NHS. The Coalition advocated this goal in the context of an aging population and an increase of chronic, lifestyle conditions. As the first point of call with patients, GPs were deemed well-placed to develop health services around patients while also transforming the care ‘pathways’ which patients go through to receive treatment from diverse NHS sectors and professional groups (Robertson et al. 2016). In addition, responsibility for local public health service provision, previously with PCTs, was moved to local government. Along with the creation of Public Health England, this was part of an effort to develop the public health sector. Local government involvement, the Coalition, argued would improve responsiveness and democratic accountability, facilitating the development of “holistic solutions to health and wellbeing” such as investment in cycle lanes and green spaces (DoH 2011: 4).

Hence, the scale- and mechanism-related reforms introduced by the HSCA were part of an ambitious attempt to change the interventions and services provided by the NHS, in response to newly emerging health challenges. Evaluating such governance reforms in the face of complex, cross

cutting health challenges requires close consideration of the inter-relationship between sectors, scales and mechanisms.

4. Coordination challenges and evaluation research in health

The different areas of health policy research offer various insights of relevance for understanding coordination challenges for health governance and for assessing the HSCA reforms. A diverse span of research has emerged since the global EBM movement started in the 1970s (Cochrane 1973), ranging from the type of intervention research promoted by EBM to approaches assessing the organisation and management of health service delivery (Fulop et al. 2003). Below, we review how different fields each offer important insights into the three aspects of coordination challenges – scale, mechanisms and balancing the choice of interventions across sectors. However, there is little engagement between these different research fields, which tend to be demarcated into distinct subfields causing the inter-connected nature of coordination challenges to be obscured. As explained below, a more comprehensive assessment is required of the governance arrangements through which policies are formed and delivered.

4a. Scale

A vast body of research exists on the question of scale, most notably about the centralisation that NPM reforms entailed. While much of the research emphasises the benefits of this shift (Mays 2006), the use of performance management has come under significant recent criticism for crowding out important aspects of care quality (Ham, Berwick, and Dixon 2016; Lamont and Waring 2015). Contrasting methodological assumptions are apparent in this debate. Outcome-oriented research is dominated by positivist analysis of the impacts of performance management protocols on some measurable performance criteria. This approach tends to provide a supportive account of how performance management can improve health outcomes and reduce variation in quality (Mays 2006). However, critics highlight examples where centrally-defined guidelines and standards, often informed by the methods of EBM further discussed below, have failed to capture significant forms of relevant knowledge (an epistemological issue) and where targets and penalties combine with this problem to

motivate local actors to deliver inappropriate care (an incentives issue). For example, NICE's decision to lower diagnostic thresholds for the use of the cholesterol-lowering drugs 'statins' for patients at risk of stroke or heart disease caused controversy. Critics warned that new guidelines incorporating the revised thresholds would expose patients to excessive drug use (Godlee 2014). A further example was the Francis Inquiry findings at Mid-Staffordshire NHS Trust involving shocking levels of negligence between 2005-9 in part because of managements' focus on clinical and financial targets crowding out care and compassion (Mid Staffs Public Inquiry 2013).

The problems have prompted a shift away from the "measure and manage" NPM orthodoxy among quarters of the research community, particularly in health services and quality improvement research which focus on improving services locally (Lamont and Waring 2015). Increasingly, participatory research and improvement methods are advocated to improve performance, utilizing the knowledge of patients and professionals locally, said to be suppressed by NPM. Yet, a coordinating role for performance management is still recognized, even by critics of NPM, as a guide for these local, collaborative processes (Ham et al., 2016). Further assessment of the impacts of centralised governance on local healthcare requires more detailed exploration than is provided by the positivist-influenced, outcome-oriented research addressing scale. This research is also limited because it does not explore linked questions about the impacts of different policy delivery mechanisms. As reviewed below, these are only addressed by a separate, rather isolated body of research.

4b. Mechanisms

Research on quasi-market mechanisms explores their effectiveness in isolation rather than their interconnection with questions of scale. A range of theoretical and empirical approaches have sought to evaluate NHS quasi-market reforms, yielding conflicting accounts of whether they improved performance (Le Grand, Mays, and Mulligan 1998). The positivist, outcome-oriented research has proved controversial. A study by Cooper et al (2011) which showed that New Labour's quasi-market

reforms improved performance, approvingly cited by Prime Minister David Cameron during the passage of the HSCA, was criticised by some academics as having confused a correlation with causation (Pollock et al. 2011). Qualitative, process-oriented research has explored the impact of quasi-market reforms on the processes and relationships which underpin healthcare delivery, often finding significant incentive-related problems. The purchaser-provider split and the financial imperatives this entails have been criticised for perversely dis-incentivising inter-organisational and cross-sectoral collaboration, sometimes resulting in fragmented care pathways (Ham and Smith 2010; Flynn, Williams, and Pickard 1996). Closely related research on the contractual arrangements for allocating resources and risk across the purchaser-provider split emphasise how the complexity of healthcare results in inevitably incomplete contracts. Performance thus hinges on relational norms and trust rather than competition (Allen 2002). While these studies suggest grounds for questioning the performance-enhancing potential of quasi-markets in health, they offer little engagement with the dynamically changing, epistemological dimension of coordination challenges highlighted by RPE. The HSCA is only the most recent example where policymakers have sought to utilise quasi-market processes to stimulate innovation and achieve the longstanding aim of developing the primary care sector. This suggests the need for closer evaluation of healthcare outcomes viewed in terms of dynamic coordination instead of more static, process criteria. Some disruption to existing processes and relationships may be desirable if this improves outcomes in the longer-term, given new health challenges, once new arrangements are more settled.

4c. Resource allocation: interventions and sectors

A further weakness of these literatures on scale and mechanism is that they do not evaluate in detail how changing forms of governance affect the kinds of interventions, services and care pathways received by patients. By contrast, the field of intervention research, heavily influenced by EBM, engages directly with such evaluation. However, the implications for assessing health governance are not typically drawn out. Despite this demarcation between research fields, considerable recent

methodological debate and innovation in intervention research usefully elucidates some of the key health governance challenges.

EBM, being closely concerned with the reliability of policy recommendations, was highly positivistic when it first emerged, classifying evidence by the perceived rigour of the methods through which it is created (Ho, Ling, and Masoudi 2008). Positivist methods assume the possibility of establishing objective proof concerning the degree of efficacy of specific interventions. However, EBM's claim to value neutrality has been criticised for suppressing the values and trade-offs involved in developing treatment plans for patients (Upshur 2003). Furthermore, researchers in various areas, including nursing, psychology and public health, have criticised EBM for biasing decision-making towards medical interventions, derogatively termed 'biomedical'. A key issue concerns how the broad goal of quality of life is operationalised. Critics argue that positivist research obscures the importance of caring and relationships in healthcare delivery and the potential of more holistic approaches addressing lifestyles and socioeconomic factors affecting public health. Such multi-faceted interventions and their outcomes are not easily measurable, hence a scientific experimental analysis of them is inappropriate (Hollinghurst, Shaw, and Thompson 2008). Yet, these public health approaches are of vital importance in the context of an aging population and a rise of chronic, lifestyle conditions (Wilkinson and Marmot 2006).

This problem reflects the Hayekian point regarding the limitations of quantification given the conditions of uncertainty and complexity in which researchers and policymakers operate. Significant methodological innovation across the field of intervention research reflects a recognition of the limitations to positivist EBM and the subjectivity of knowledge Qualitative evaluation of patients' 'lived experiences' within clinical trials is now more widely undertaken. Furthermore, economic evaluation in intervention research has evolved to provide more user-friendly information that is sensitive to diverse patient values. So-called 'Shared Decision-Making' tools provide information on the health outcomes and the side-effects of different treatment options, allowing patients and professionals to make

decisions about treatment plans that are sensitive to each patients' condition and life goals (Tamhane et al. 2015).

These shifts in intervention research highlight the epistemological challenges involved in selecting interventions and achieving sectoral balance in a dynamically changing social context, given the different forms of knowledge requiring consideration. Yet, intervention research (including its positivist and post-positivist variants) is notably silent on questions of governance design and evaluation. There is an affinity between recent postpositivist criticisms of EBM and calls for more decentralised governance (an issue of scale) to facilitate more direct professional, patient and public involvement in healthcare delivery. Yet the question of what forms of governance would be conducive to this are not directly explored in this research field.

5. Coordination as a focus for health governance evaluation

A focus on coordination challenges as conceptualised by RPE offers a holistic approach that can draw from the insights of the different sub-fields of health evaluation research. As is evident in the review of these sub-fields in Section 4, evaluation in terms of the broad goal of universal healthcare and quality of life requires recognition of the various, specific evaluation criteria involved in achieving this. These include the need to balance the selection of medical interventions with preventative strategies across varying socio-economic contexts, while considering patient preferences and the broader criterion of well-being. This breadth of criteria entails the need for health governance evaluation to consider the range of stakeholder perspectives, expertise and locally situated knowledge. As has been highlighted by the interpretivist turn in policy analysis (Fischer, Fischer, and Forester 1993; Hawkesworth 1988), different stakeholder views will inevitably reflect contrasting subjective understandings and norms. In the case of health, this applies firstly to stakeholder views about the development and selection of health strategies and interventions. Secondly, this applies to

the question of the effects of governance and policy reforms concerning the inter-related questions of organisational *scale* and *mechanisms* for decision-making. RPE highlights the need for detailed exploration of these inter-related aspects of governance and its outcomes.

As interpretivists emphasise, contrasting stakeholder views might reflect fundamentally different values. This poses a challenge for research seeking to make evaluative claims that would inevitably prioritise some values over others. Yet, there could still be significant common ground, either in terms of broadly agreed ends, or in understandings of the impacts of specific means for achieving them, that can inform governance evaluation. Identifying the extent of such common ground requires detailed analysis of stakeholder perspectives. Interpretivist methodologies, analysing policy discourses, or 'framings' (Rein and Schön 1994) have tended to focus on uncovering fundamental differences between stakeholder perceptions in terms of their underpinning values or assumptions. Yet, they tend to lack a detailed focus upon how various stakeholders understand the complex choices and trade-offs involved in defining governance arrangements and policy strategies and tools at various scales for translating goals into practice. As well as establishing the degree of common ground between stakeholders, such a detailed analysis can also offer insights into especially contested areas. Contestation might reflect fundamentally different values or understandings. Yet, as is made clear by RPE with its epistemological focus, disagreements might also highlight where particular stakeholders offer knowledge and insights not held or fully understood by others. In the case of health governance, examples of such 'knowledge gaps' might include where the definition of performance targets causes key aspects of local practice to be neglected or where fragmentation of services results in a lack of knowledge sharing between service providers. Where there is broad agreement that such actual or potential unintended consequences are negative, this provides grounds for questioning governance and policy effectiveness in coordinating attainment of the sought balance of policy goals. Again, standard interpretivist approaches do not offer the kind of detailed analysis of complex coordination challenges required for such evaluation.

Uncovering the nature and extent of such coordination problems demands detailed analysis and comparison of stakeholder views. This can be achieved by asking stakeholders, through semi-structured interviewing, to appraise 'strengths, weaknesses, opportunities and threats' (SWOT). This approach can uncover unforeseen themes and capture locally situated stakeholder knowledge and expertise concerning governance and policy processes and their outcomes. SWOT fosters a sufficient focus on evaluation while allowing a degree of openness, allowing stakeholders to highlight issues of particular concern to them that the researcher may not have anticipated. Our case study below adopts this approach to data collection, identifying key coordination problems highlighted by a significant number of stakeholders. Reflecting the dual focus of RPE, SWOT can identify both epistemological and incentives-related issues, according to what stakeholders view as significant. The interview method allows for exploration of the potentially close inter-relationship between these two dimensions shaping governance outcomes. One's understanding of the most effective solutions to complex problems will affect perceptions of the suitability of particular incentives. In this respect, a focus on perceptions of outcomes can enrich our understanding of processes.

6. Case study: impacts of the HSCA on diabetes care in England

6a. The case of diabetes care

Our case study focuses on diabetes because it is a complex challenge, recognised to be of increasing global significance (Farooqi 2012). Successful management of the condition requires coordination across various NHS sectors where questions concerning scale and mechanism are of integral importance. To understand this, the two main types of diabetes require consideration. Type 1 (DT1) typically starts in early adolescence, with links to hereditary factors. Type 2 (DT2), by contrast, usually occurs in later life, being linked to unhealthy lifestyles. Without effective treatment, both can cause a range of complications that greatly reduce life expectancy, including cardiovascular disease, stroke, kidney disease, diabetic retinopathy and foot ulcers leading to leg amputations. Given these

diverse causes and consequences, different types of interventions across health sectors can combat the condition:

- Public health – a primarily preventative role for addressing DT2, given the links of this condition to lifestyles. These range from medical-oriented interventions (e.g. the NHS Health Check for screening individuals at risk of diabetes) to 'socio-economic' measures promoting community health (e.g. building cycle lanes, taxing unhealthy foods, etc.).
- Primary care – mainly a dual treatment and preventative role for people newly diagnosed with DT2 or DT1 patients with good control of their diabetes. A key treatment goal is to prevent harmful complications that reduce quality of life and require either emergency hospital admission or a referral for costly hospital services.
- Secondary care – treating diabetes patients, whether DT1 or DT2, with complex health needs or complications requiring specialist input. The goal here is to improve the management of diabetes and treat complications to prolong life. Care is provided by teams of diabetes specialists, including diabetes nurses, podiatrists, nephrologists and ophthalmologists, often based in diabetes clinics attached to NHS hospitals.

6b Method of data collection and analysis

Our study explores coordination challenges in diabetes governance across these diverse sectors, identifying key themes in stakeholder views about the impacts of the HSCA reforms. We firstly analysed policy documents and other materials published by governmental and third sector stakeholder organisations involved in debates about diabetes care. With the HSCA taking effect in February 2012, 26 qualitative stakeholder interviews using SWOT techniques began in February 2013 to allow the reforms a year to become established, ending in September 2015. Interviewees included local practitioners from the main health professional groups involved in diabetes, including GPs (n=4), diabetes specialists (n=5) and public health professionals (n=4), as well as patient and

charity representatives (n=6). Participants were selected initially via “opportunity sampling,” followed by “theoretical sampling” in which specific stakeholders are sought to substantiate an emergent theme (Braun and Clarke, 2008). Given the illustrative purpose of this case study, the number of stakeholders interviewed from each group was determined qualitatively, ending once thematic saturation was achieved. The data was analysed using inductive, thematic analysis techniques (Braun and Clarke 2006) in order to ensure that emergent categories and themes reflected stakeholder views. Five themes were identified, each expressing a key coordination challenge in diabetes services. From these five themes, we draw evaluative conclusions regarding the impact of the HSCA on the capacity of the NHS to achieve coordination in the face of these complex, inter-related dimensions.

6c Findings

All five inter-connected themes concern how governance processes shape the selection of interventions and formulation of care pathways, highlighting the significance of the epistemological and incentives-related issues and their inter-connectedness. The first two themes primarily concern the issue of scale, particularly the desirability of nationally defined, diabetes-specific clinical governance. The subsequent three themes relate to mechanisms shaping local healthcare delivery. Each theme highlights the inter-relationships between allocative issues and the questions of scale and mechanism respectively. As further explained in section 6d, our findings concerning the weaknesses and limitations of the 2012 reforms anticipate how the reform process has subsequently evolved, with policy-makers now acknowledging the need for governance arrangements to more strongly foster an integrated approach to addressing such a complex policy challenge.

(i) Establishing a national framework while fostering local collaboration

The Coalition's plan to move away from disease specificity and focus national performance management frameworks on broad health outcomes was the subject of considerable disagreements, in which both the epistemological and incentives-related dimensions of coordination challenges were evident. The prominent charity Diabetes UK was strongly critical of the policy shift, arguing that variations in the quality of NHS diabetes services, estimated by the National Audit Office to cause 24,000 avoidable deaths each year (NAO 2012), necessitated national level diabetes-specific clinical governance. In making this case for greater centralisation at a House of Commons Public Accounts Committee inquiry into the issue in 2012, Diabetes UK also highlighted anecdotal evidence, discussed in more detail in themes (iv) and (v), that the HSCA had further compromised NHS capacity to address the challenge of diabetes due to the limited knowledge of CCGs. The national, diabetes-specific framework they proposed would consist of quality standards, resources and financial penalties. There was an epistemic dimension to their argument, concerning the need to ensure that local commissioners know how to act, as well as having the incentive to do so (PAC, 2012). However, these calls for more centralised governance became less pronounced following publication of evidence in 2013 that found the UK to have some of the highest quality diabetes services internationally, including the lowest rates of early death (NHS England 2014). The shift away from diabetes-specific clinical governance was also welcomed by other stakeholders, whose criticisms of New Labour's approach alluded to the epistemological challenges of developing detailed central guidance. Reflecting the wider critiques of EBM approaches, he evidence-base underpinning diabetes policy was criticised for assessing diabetes interventions in isolation when most patients have multiple conditions, or 'comorbidity.' To treat these more complex cases requires, according to this group, collaboration across disease areas and thus central guidance that is more flexible, rather than focusing on particular diseases and conditions.

Given these alternative views, there was significant justification for the approach of NHS England to seek a compromise between these calls for more and less diabetes-specific central guidance. Best

practice guidance for local service provision gave local actors significant discretion in how exactly to implement this (NHS England 2014). In 2015, a diabetes specialist interviewed welcomed this renewed attention on the condition after an initial “dilution” in the immediate aftermath of the HSCA reforms. As part of the Coalition’s move away from diabetes-specific governance, diabetes improvement networks were dissolved and replaced by larger cardiovascular networks. This new approach was argued to be enhancing collaboration with other professional groups on diabetes:

There’s been an awakening interest and understanding of diabetes among the clinicians in the other cardiovascular disease areas as a result of the grouping together. That’s been interesting to observe and in the long-run that may be beneficial. What they’ve woken up to is the proportion of their core business which is actually attributable to diabetes[1]

[1] Diabetes specialist, 04/12/2014

(ii) The definition and role of performance measures

This debate about how far guidance for selecting suitable interventions for tackling diabetes can be suitably defined at the national scale was reflected in contrasting views about the suitability of nationally defined diabetes-specific performance indicators as revised by the Coalition's outcomes frameworks. Epistemological questions were strongly evident in these debates. Again, particularly in public health and primary care, there were disagreements about whether specific diabetes targets were conducive to utilising relevant information and knowledge concerning community conditions and the needs and preferences of patients guiding the selection of interventions. The new 'Public Health Outcomes Framework' (PHOF) was widely viewed favourably by stakeholders for raising the profile of public health and facilitating discussions at a local level about public health priorities. More controversial was its use as a performance management tool and in particular the decision to include, in the PHOF, a target for the delivery of the NHS Health Check. Opinions were divided amongst patient representatives and diabetes professionals, including public health professionals, about the desirability of the NHS Health Check, which seeks to detect cases of elevated blood glucose (or HbA1c) in at-risk individuals. Those supportive of the decision to performance manage the delivery of the NHS Health Check emphasised the critical importance of detecting and treating diabetes before the onset of complications. Yet others stakeholders preferred a socioeconomic approach to combating T2 diabetes that, in contrast with the individual biomedical approach, focused upon the health and wellbeing of the population in general. These stakeholders criticised the Coalition's decision to mandate delivery of the NHS Health Check to everyone aged over 40 as a waste of resources, favouring a more targeted approach for engaging hard-to-reach communities.

Debates about the system of performance monitoring and incentives in primary care similarly highlighted the significant epistemological problems involved in centrally defining targets in a way that allows sufficient scope for various forms of locally situated knowledge to be reflected in service delivery. The national performance protocol for GPs, the Quality and Outcomes Framework (QOF),

was widely seen as having driven improvements in primary care since it was introduced by New Labour in 2002. Early editions of the QOF featured a range of diabetes 'process' indicators seen as vital for good patient care, such as annual checks for HbA1c and foot complications. Once the delivery of these processes was embedded in most GP practices, policymakers decided to incorporate into the QOF measures of biological risk factors for diabetes, with HbA1c levels being most significant. It was anticipated that this would incentivise GPs to pro-actively adopt measures for reducing the HbA1c levels of diabetes patients. However, critics, including some GPs and diabetes specialists included in our sample, argue that HbA1c control targets limit the scope of professional judgement and patient involvement in the development of treatment plans.

As an example of the problems with defining performance targets on the basis of positivist scientific evidence , emerging findings gave cause for questioning biomedical HbA1c reduction strategies. Where initial scientific evidence from the 1990s had shown that intensive blood glucose control through the use of pharmacological therapies improved health outcomes newly emerging evidence revealed a more nuanced picture, suggesting it could actually increase the risk of heart failure among elderly and frail patients (Yudkin and Montori 2014). This prompted the revision of the QOF target from a HbA1c reading of 7.5 to 8.5 mmol. Yet, advocates of a patient-centred approach still viewed this target as distorting the doctor-patient relationship and driving the overuse of pharmacological therapies:

The physician becomes the agent of the state (laughter). It's her or his job to get those guidelines implemented. Initially it's guidelines, later it becomes quality performance measures and credits, money as in QOF. And it's this whole thing about, if you've got a financial incentive to do something, that may or may not benefit the individual patient, that is a bit fascistic.[2]

[2] Diabetes specialist, 24/04/2015

(iii) Selecting mechanisms for fostering local service responsiveness

There were significant grounds for questioning whether the allocative mechanisms under the HSCA promoted the effective use of locally situated knowledge of patients and communities. Stakeholders broadly agreed that in some areas the HSCA had improved the effectiveness and responsiveness of local services. The new role of local authorities in public health was especially significant, providing a forum for community representatives, public health professionals and other local authority officials to develop locally sensitive public health policy. The PHOF, when used as an informational device rather than a performance management tool was seen as complementary to this localizing shift. Its quarterly reports provided a basis for discussions between public health, other local authority departments and the public through local media. More controversial was the question of whether the newly introduced CCGs and the associated further extension of the purchaser-provider split was the appropriate mechanism for promoting responsiveness to patients.

Two of the four patient representatives in the sample reported that CCGs were in some areas more responsive than their forerunners PCTs, particularly in rural areas where CCGs were developing the scope of primary care services. However, there was agreement that this was beneficial only for relatively healthy patients whose care could be overseen by GPs, rather than more complex diabetes cases in need of specialist input. Specialists and patient representatives accused CCGs of constraining access to hospital-based, specialist services for this patient group, because of the incentive for them to keep patients in primary care. Besides this incentives question, the epistemological challenge was evident in the debate about whether the purchaser-provider split, as a mechanism, was conducive to capturing patient preferences. Greater choice of provider allowed patients to shape services by choosing from a range of options that the NHS had been slow to provide. Yet, there are limits to how far patients, particularly those with complex health needs, could make such informed choices. One patient representative interviewed, who preferred a more collaborative approach for eliciting patient preferences, put this point as follows:

Something as complex as healthcare and particularly healthcare for conditions that last a life time, health care as shopping, the model doesn't work for me. Quite often people who are seeking care and need support throughout their life, are older, they've got multiple conditions, they're not very well: the idea that they're going to assemble a package of care around themselves by exercising choice and shopping around, and choosing the best quality, it's pie in the sky. They've got to be helped to get the right packages, they've got to be provided and integrated on their behalf, not by them having to do it because they'll just not be able to[3]

(iv) *Utilising existing professional knowledge in local service delivery*

The limits to patient choice as a driver of coordination identified in theme (iii) prompt the further epistemological question of the role of and balance between the various forms of professional expertise from across different sectors in shaping service delivery. As an example of a coordination problem as conceptualised by RPE, various groupings of diabetes professionals expressed concern that their knowledge was not being effectively utilised. Public health professionals may have had newfound influence over local authorities following the HSCA but they had less influence over healthcare commissioning, now the responsibility of CCGs. This was reflected in the emphasis of public health professionals that CCGs tending to fail to commission adequate 'preventative' medical services, such as specialist dietary advice for obese people, because they lacked awareness of their critical importance to long-term health outcomes. There was also evidence of the introduction of CCGs in some respects restricting GPs in their exercise of professional judgement. While the creation of CCGs elevated the knowledge and influence of GPs in healthcare commissioning, local forms of performance management by CCGs could be unduly restricting. Two GPs interviewed who were not involved on their local CCG boards complained of pressure to not refer deteriorating patients onto hospital-based, specialist services, which they warned risked adverse health outcomes in the long-term. Views of specialists suggested a range of concerns about specific elements of their knowledge

[3] Patient representative, 22/03/2013

being under-utilised at various stages of the diabetes pathway, with significant implications for patient outcomes:

- *Advice and support for hospital staff and in-patients* – Wider policy efforts to develop primary care, including the creation of CCGs, were viewed as destabilising hospitals and putting pressure on specialist posts. Consequently, specialist training of junior doctors and nurses about diabetes management was being compromised, as well as specialist care for hospital in-patients with diabetes but who are in hospital for another reason. A spate of prescription errors and episodes of diabetes ketoacidosis among hospital in-patients were blamed on this issue.
- *Oversight of contracted out services* – The quality of private sector provision for more basic services being compromised, not because of the profit incentive in itself but because private, 'high street' providers lack specialist employees to spot early-stage complications. Many diabetes services, including eye and foot checks, are generally simple to deliver but early signs of deterioration can be missed, potentially resulting in adverse health outcomes at a later stage. One diabetes specialist interviewed for this study had been involved in a campaign launched by Diabetes UK to halt the contracting out of diabetes podiatry services for this reason.
- *Input at the point of referral* – Specialists shared GPs' concerns about pressure from CCGs on GP referrals. One specialist spoke of a patient who was referred late by the GP, having had raised blood glucose for two years. His HBA1c was 11.2 percent and he had an infected toe with no pulses. The specialist predicted they would have a range of complications and be on insulin in the coming months "just because it wasn't picked up early enough"[4]. The issue affects patients being treated in primary care who gradually lose control of their HbA1c levels rather than patients experiencing complications:

[4] Diabetes specialist, 02/02/2014

The complications side of things is easy. So, if someone has gone into renal failure it's quite easy to say, 'Yes your kidney has really dropped off. We'll refer you to the diabetes clinic". It's a kind of a no brainer and easy to work out. But if someone's glucose levels are just rising year on year, do you try different therapy, try different therapy, try different therapy, before you refer them back? I'm guessing they (CCGs) probably will[5]*.*

(v) Promoting change and innovation without destabilising the local health economy

All stakeholders interviewed in the study recognised that the NHS requires reform in light of contemporary health challenges and agreed with the core HSCA aim to develop public health and primary care. However, while some successful innovations in these sectors were identified following passage of the Act, major policy failures had also occurred where reform efforts had fragmented services and resulted in harm to patients. Examples of successful innovations were mostly identified in public health, where the new role of local authorities was widely welcomed as offering potential to develop holistic, socioeconomic interventions for improving population health and wellbeing. One public health professional highlighted a new cycling network, developed in collaboration with the local authority transport department, emphasising that it would have been more difficult to deliver without the reforms. By contrast, the impact of the HSCA in primary care was more contested. Here, stakeholders broadly agreed on the desirability of integrated, collaborative models of diabetes care promoted by NHS England and Diabetes UK (Diabetes UK 2014), which span primary and secondary care. These models develop the GP role but retain a role for specialists both supporting GPs in primary care and providing services that require a hospital setting. Service integration of this sort allows patients to flow seamlessly along the diabetes pathway, receiving care from the most appropriate sector. However, there are grounds for concern that the incentive structures accompanying CCGs were not conducive to developing integrated care models. While some GPs saw the introduction of CCGs as creating impetus for reform, integrated models were only being

[5] Diabetes specialist, 02/02/2014

developed in a minority of cases (Diabetes UK 2014). In some areas, CCGs were accused of developing primary care to the extent that secondary care was undermined. In an extreme example, Southampton CCG sought to unilaterally develop primary care, ending investment in specialist services at the local NHS hospital in a move described by a leading diabetes expert, Professor Roy Taylor, as resulting in "the complete disintegration of specialist care to a disgraceful degree" (PAC 2012). The reform resulted in an increase in unplanned emergency hospital admissions for patients experiencing serious diabetes complications, prompting the CCG to recommission parts of the hospital-based specialist service. It was on the basis of Southampton and the examples discussed in theme (iv) of diabetes professional knowledge being underutilised that Diabetes UK called for national diabetes-specific clinical governance to improve the quality of CCG commissioning. However, both the limited knowledge-base of CCGs (i.e. GP knowledge over specialist knowledge) and their incentive to develop primary care suggest the problems apparent in some local diabetes services reflect a mechanism rather than scale issue. Even where CCGs collaborated with NHS hospitals to successfully develop integrated models of care, the incentives across the purchaser-provider split were identified as having complicated their efforts:

The system doesn't create those natural collaborations. They (CCGs and NHS Trusts) are almost set up to compete with each other, not to collaborate with each other. I think negotiating the money and the organisational barriers have been the major challenges in setting this up[6]

6d Evaluation summary

In debates about NHS governance, there is wide acceptance of the overarching objective of universal healthcare provision that promotes the quality of life of all patients. The above themes, each a key aspect of the coordination challenge for health governance, concern the effectiveness of governance and policy strategies and tools for translating this broadly agreed goal into practice. Of integral

[6] Diabetes specialist, 04/12/2014

importance to each theme is the epistemological dimension concerning how to enable the appropriate use of various forms of expertise and locally situated knowledge. Within each theme, this epistemological dimension is closely intertwined with the challenge of aligning incentives. The themes also show the need for questions of scale and mechanism to be considered together.

The epistemological dimension is prominent in the widespread debates about the appropriateness of national-level guidelines and performance targets in the context of uncertainty and contrasting views about evidence. Some key examples, such as the best practice framework developed by NHS England introduced in 2014 (see theme (i)) and the Public Health Outcomes Framework introduced in 2012 (theme (ii)) highlight significant potential for the epistemological challenges involved in developing a national framework to be addressed. The PHOF, in particular, was welcomed as a useful informational device for facilitating conversations between public health professionals, local authority departments and local communities about public health priorities. Used in such a flexible way, performance frameworks provide scope for locally-situated values and knowledge to shape local services. Yet, while the Coalition's various outcomes frameworks permit greater local discretion than New Labour's disease-specific approach, significant scale-related problems were still identified, suggesting they have not gone far enough. As discussed in theme (ii), one-size-fits-all HbA1c reduction strategies within the NHS Health Check and the Quality and Outcomes Framework, have been criticised for putting some patients, in particular elderly patients with complex health needs, at risk of complications. QOF information can be useful for local clinicians, commissioners and managers for developing and monitoring services locally. However, use of the QOF as a centrally-mandated performance management tool crowded out the locally-situated knowledge required to develop appropriate treatment plans, much of this being possessed by patients themselves (Yudkin and Montori 2014). Highlighting the complexities involved in the selection of interventions, our case study thus resonates with wider calls for the NHS to move away from the use of externally-mandated

performance targets to ensure that local actors have the skills, knowledge and support to deliver high-quality and continually improving services (Ham et al 2006).

Our case study findings highlight the close inter-relationship between these scale questions about centrally defined performance frameworks and mechanism questions about how the introduction of GP-led commissioning consortia influenced the forms of knowledge and incentives that shaped the selection and delivery of interventions. For example, Diabetes UK's call for a return to top-down, diabetes-specific clinical governance in order to improve the quality of CCG commissioning may appear justified in light of some of the detrimental impacts of the HSCA. Yet, change to a more flexible, outcome-orientated national performance framework, the benefits of which are explained above, was not necessarily the cause of this problem. Rather than being a case of too little central guidance, these negative impacts can be viewed as a mechanism issue, reflecting the limited knowledge base of CCGs and the incentives operating on both sides of the purchaser-provider split mechanism. Themes (iii), (iv) and (v) reveal the new variant of this mechanism introduced by the HSCA as having hindered the utilisation of local knowledge by discouraging cross-organisational and cross-sectoral collaboration. The various voices raising this concern, spanning all professional groups and patient representatives, provide strong grounds for questioning the efficacy of the HSCA reforms. Some of the concerns relate to suboptimal commissioning of 'preventative' medical services and increasingly constrained access to diabetes specialists for people with complex health needs in some areas. It is interesting here to note subsequent NHS policy trends from 2016, with the development of Integrated Care Systems (ICS), large forums pooling financial resources from CCGs, NHS hospitals and local authorities. ICS reflect recognition of the need to integrate diverse forms of knowledge in healthcare commissioning and of limitations of quasi-market competition as a driver of coordination (DHSC 2018).

The RPE approach employed here explores questions of scale, mechanism and sectoral balance together through detailed, qualitative analysis of the interconnected epistemological and motivational

dimensions of coordination challenges. Current demarcations in health evaluation research do not provide such a holistic approach. The case study, in particular themes (i) and (ii), builds on the insights of newly emerging ‘postpositivist’ perspectives in the fields of intervention research, applied health research and quality improvement, which indirectly criticise efforts to apply positivist evidence through clinical guidelines and performance protocols. However, these research fields do not explore evaluative questions concerning the choice of mechanism, which themes (iii), (iv) and (v) reveal to be of vital importance. Furthermore, neither positivist research on quasi-markets in terms of single, measurable outcomes, nor process-oriented research on the relationships between commissioning and provider organisations, provide sufficient insights into the multifaceted impacts of mechanisms, or the interlinking effect of the scale dimension of governance. Qualitative, process-oriented studies provide grounds for questioning the performance-enhancing potential of quasi-markets in terms of their impacts on the processes and relationships underpinning healthcare delivery (Flynn, Williams, and Pickard 1996; Allen 2002; Ham and Smith 2010). Our approach goes further, considering their potential to facilitate appropriate innovation in the context of complex, changing health challenges.

7. A future research agenda for robust political economy

Our case study illustrates how detailed qualitative inquiry, with a focus on contrasting understandings of the complex dimensions of choice involved in defining governance arrangements and policy strategy, can greatly enrich established, process-orientated governance evaluation of the kind that predominates in political science and public administration. In providing such analysis, our study has engaged substantively with ongoing debates in health research that straddle both the social and natural sciences. Such inter-disciplinary work would seem to be indispensable for engaging with the pressing evaluative questions that are increasingly being raised and discussed in public administration literatures on network governance more generally, where the challenges of complex, cross-cutting problems have been emphasised. Currently, these literatures not only lack an outcome-orientation but also tend to focus on different strategies and styles of network management (Kickert,

Klijn, and Koppenjan 1997), rather than the political economic arrangements that shape governance networks. While analysis of different approaches to network management is an important contribution in itself, this public administration literature tends to lack a close focus on the inter-relationships between public and private sector that are manifest in various hybrid governance arrangements. As explained above in our study of health governance, the question of the role of both the private sector and the 'quasi market' mechanisms introduced into the public sector for health was of defining importance for the wider debates between stakeholders. Such a political economy focus is vital for achieving a comprehensive evaluation of governance arrangements. RPE, having emerged from fundamental debates in political economy concerning the relative effectiveness of market and non-market processes, is well suited to enabling such evaluation of the wider institutional and market contexts within which governance networks operate. There have been relatively few, if any, studies using an RPE approach for the empirical study of contemporary, hybrid governance arrangements and their impacts. Yet, there is rich potential for such evaluative research across a range of sectors. Aside from health, RPE is applicable to a range of governance areas that involve steering the delivery of public goods and shaping the scope of markets in the face of complex policy challenges.

8. Conclusion

The RPE approach offers significant potential for meeting the need for close, holistic engagement with vital, recently emerging evaluative questions concerning contemporary governance in the face of complex, cross-cutting challenges. A central focus of RPE is the epistemological dimension of coordination problems that is highly pertinent for understanding challenges for governance and policy-making, as well as the closely connected incentives dimension discussed so extensively in political science. We have illustrated this through a focus on health governance, exploring different types of coordination challenge that can arise in contemporary governance, concerning questions of the scale of decision-making, the role of market processes and how these are shaped by governance

arrangements involving various non-market strategies and processes. Through a detailed focus on stakeholders' perspectives towards the difficult, complex substantive choices and trade-offs that these challenges involve, the conception of coordination employed here allows findings from various research fields and disciplines to be drawn together, as our case study illustrates, reviewing contributions from a range of research fields in social and natural sciences. The conceptual approach of RPE prompts close, detailed comparative analysis of stakeholders' views about governance and policy challenges, in a way that yields evaluative conclusions while being sensitive to the, often contested, character of the values and knowledge underpinning these perspectives. Given this outcome-orientation, this approach not only complements the kind of process-orientated analyses that predominate in political science and public administration but also enriches our insights into the effectiveness of these processes themselves. There is great potential and indeed a pressing need for this RPE approach to be applied more widely.

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