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# **‘Best of both worlds’? A comparison of third sector providers in health care and welfare-to-work markets in Britain**

## **Abstract**

This paper compares the welfare markets in primary health care and ‘welfare-to-work’ in the UK since the late 1990s. A longitudinal comparison of two different policy areas enables us to study the context in which marketization and the resulting shift of welfare provision takes place. We will outline the general background of the market-based reforms and highlight in what way policy makers have ascribed third sector organizations a number of positive characteristics, particularly the ability to address concerns about well-known market failures. While consecutive governments promoted these organizations as welfare providers, case studies of two illustrative provider organizations in each policy area reveal a number of problems regarding their distinctiveness in increasingly competitive welfare markets.

We conclude that the crisp distinction made by policy makers between the third and other sectors as well as the alleged advantages of the former present a rather naïve picture of a complex reality and argue for a more critical view of third sector characteristics and performance. The third sector is not only characterized by a high degree of fuzziness at the boundaries to other sectors, but even within single organizations who often undergo significant transformations over time. As a result, policy intentions and practical outcomes are contradictory with third sector organizations losing their alleged distinctiveness as players in increasingly

competitive markets. Furthermore, we contend that detailed longitudinal studies of organizations are essential in the advancement of the discussion of the third sector concept as they provide conceptual insights into organizational change and behaviour.

**Key Words:** Third sector; welfare markets; hybridization; public sector reform; primary care; welfare-to-work

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## **Introduction**

The use of independent providers governed through contractual agreements is an essential aspect of the creation of new welfare markets for the delivery of public services. This paper aims to identify the developments of service provision across two new welfare markets in the UK with a particular focus on third sector organizations (TSOs). There is still little comparative research on the new welfare *providers*, particularly in cross-sector perspective and over time. To capture the complexity of variation in this area, we compare the emerging welfare markets and TSOs in primary care (i.e. health care traditionally delivered by GPs) and ‘welfare-to-work’ (also known as ‘activation’) policies. Analysing the development of particular provider forms across policy areas may help to better understand processes of ongoing change and to challenge some of the rather naïve assumptions of policy makers about the distinct characteristics of different types of providers such as TSOs. We draw on and contribute to conceptual discussions in the third sector literature to explore the reality of TSOs in welfare markets. The aim here is to focus on identifying how ideas about the third sector are mobilized in welfare policies and then to consider the development of TSOs in different contexts.

The paper is organized as follows. First, we situate the emergence of markets in health care and welfare-to-work into a wider trend towards more competition and provider diversity within public welfare in the theoretical context of both ‘government failure’ and ‘market failure’. Second, we present legislative and policy changes that led to increased provider diversity both in primary care and activation. Through two case studies of providers operating in these welfare markets we then shed some light on the extent of their activities and complexity of their organizations pointing to problems

that arise when classifying individual providers. In our following discussion we contend that we find a process of hybridization not only across sectors but even within organizations in which the boundaries between public and private become increasingly blurred and sometimes are clearly crossed in the course of time. In line with the literature on the hybridization of TSOs (that is widely ignored by policy makers who rely too much on a demarcated sector based understanding of TSOs) we conclude that it is very difficult to even classify many of the new provider organizations into a simple typology of public, private or third sector, let alone to generalize any of their alleged characteristics and outcomes across such a wide and ill-defined sector. The tendencies in both markets to favour larger, for-profit providers has had various effects on the organizational behaviour and performance of TSOs and led to significant change within organizations in the long run.

### **Welfare markets and third sector providers**

Despite the post-war UK welfare state usually being classified as a liberal regime type (Esping-Andersen 1990), trends of marketization involving the contracting of services via competitive tendering processes and privatization involving the use of non-public sector actors have become a relevant phenomenon only since the late 1990s in both the field of health care and activation (Mays *et al.* 2011; Larsen and Wright 2014). Influenced by ‘New Public Management’ (NPM) ideas, private sector management styles have been introduced in an effort to counter so-called ‘government failure’ and perceptions of public sector inefficiency, unresponsiveness to consumers, and complacency due to the lack of competition. The NPM doctrine comprises the introduction of explicit performance standards and measurement, a focus on results

instead of processes, and the disaggregation of public sector units and services in order to achieve competition and more efficient resource use (Hood 1991; Domberger and Jensen 1997). One mechanism for achieving greater competition is to increase the diversity of providers by facilitating the delivery of public services through the private sector or through the creation of quasi-markets (Le Grand and Bartlett, 1993).

Concerns have, however, also been raised regarding problems of ‘market failure’ related to the provision of key welfare services by private organizations and marketization processes have faced criticisms regarding issues of service delivery and equality. In relation to health care and activation services most serious is the risk that providers engage in quality-shirking or selection bias favouring low-risk/high-profit cases in their pursuit of profit-maximisation (so called ‘cherry picking’ or ‘cream-skimming’) (Koning and Heinrich 2013).

Since the 1990s consecutive UK governments have supported a variety of mixed public-private bodies and TSOs as potential providers of welfare services as an alternative to the state and the market in an attempt to promote welfare pluralism (Alcock 2010). While TSOs are seen as innovators just as other entrepreneurs, these organizations are supposed to have the added advantage of instilling trust in their business conduct due to their defining non-distribution constraint and ‘social mission’ (Hansmann 1980). The issue of trust is pivotal in welfare markets that are characterized by significant information asymmetries between providers and consumers or purchasers, i.e. under conditions where there is the possibility that profit-oriented firms would decrease quality, charge inflated prices for simple services or prescribe unnecessarily expensive treatments or programmes in order to increase

manager salaries or dividends for shareholders (Toepfler and Anheier 2010). The notion that TSOs act differently to private and public sector providers is therefore an important facet of government rhetoric and its justification for the market based reforms of key welfare services. However, Damm (2012: 21) recently identified the ‘dearth of more basic, descriptive data’ and stated that ‘[t]oo little is known about the third sector organisations that are involved in [welfare-to-work] delivery, and those who are not, either through their own choice or having failed to win any contracts’. In part this reflects the limited availability of academic research that has considered the reality of TSO characteristics and behaviours, or the issues of organizational change in these new welfare governance arrangements. This paper seeks to address such deficiencies.

### *Defining and delineating the third sector*

The concept of the ‘third sector’ is utilized in both policy and academic literature with a general acceptance that TSOs occupy a space between the public and the private for-profit sector – hence their label ‘third sector’.

As the academic literature has shown, in reality it is an ill-defined and imprecise term and the exact boundaries between the third sector and other sectors in the MEW are in practice difficult to determine. Evers and Laville (2004) spoke of a ‘tension field’ while Billis (2010) problematized the ‘hybridity’ resulting from the overlap of the sectors that constitute the MEW. Similarly, Brandsen *et al.* (2005; 750) contend that the impression of demarcated sectors do not hold up empirically where ‘it is far easier to find arrangements that are hybrid or “fuzzy” than those approximating ideal types.’ They propose that we understand hybridity and change as one of the defining features

of the concept of the third sector and draw on the metaphors of a griffin and chameleon to describe the existence of organizations whose nature is based on a combination of unexpected parts or where change is an essential and distinguishing characteristic. Partly this is due to some organizations changing motivations and goals over time, but partly also due to organizations crossing the boundary between the third and private sector (Westall 2009). This problem is exacerbated by the diversity in form and function and the lack of a clear definition of the third sector (Kendall and Knapp 1995; Salamon and Anheier 1997).

While conceptual discussions of the third sector are rife in the academic literature, government rhetoric is comparatively more pragmatic. On the one hand, government rhetoric all too often employs a language of a crisp distinction between the public, private and third sector. On the other hand, it also acknowledges and praises the diversity of organizations that comprise the third sector and the contribution they can bring to improve the new welfare markets (HM Treasury 2004a and 2004b; Cabinet Office 2011).

Government policy uses the term 'third sector' in a perhaps deliberately vague fashion in order to claim that they were addressing various social problems using new providers (Teasdale 2011). However, demarking the sector from private firms has become even harder since the government subsumed so-called social enterprises under the third sector banner (Westall 2009). As there is no specific legal form for social enterprises these can vary from registered charities to private limited companies and may refer to 'local community enterprises, social firms, mutual organisations such as co-operatives, and large-scale organisations operating nationally or



internationally' (DTI 2002: 7). The Cabinet Office (2011: 12) defined social enterprises as profit-making businesses, but which *principally* invest their profits into a *social* purpose (our accentuation) rather than private reward, although they can pay a dividend to their shareholders or directors. The ambiguous prefix 'social' refers to a variety of things, such as local ownership, regeneration, combating forms of disadvantage, environmental or cultural values or simply to public service delivery (DTI 2002; Westall 2009).

### **The promotion of TSOs in UK Government rhetoric**

Despite the definitional complexities, the postulation that the third sector represents 'the best of both worlds' by combining the efficiency, quality and innovativeness typically ascribed to the private sector with the social responsibility that should be guiding the public sector became popular in the context of New Labour's 'Third Way' reforms since 1997. In addition, the third sector was seen as having comparative advantages over both sectors through its strengths in relation to 'empowering users and promoting community engagement' and their 'personalised approach and public trust' (Office of the Third Sector 2006: 9). The fostering of the third sector as 'a key partner in delivering government policies' and public service provision was driven across government departments in the early 2000s through a number of Treasury reports (HM Treasury 2002:5; 2004a; 2004b). An amendment to the Companies Act in 2005 introduced a new corporate form called 'Community Interest Company' (CIC), designed for use by social enterprises wishing to contract for public services. In 2006, an Office of the Third Sector was created in the Cabinet Office with a

Minister responsible for charities, social enterprises and voluntary organizations. Social enterprises were promoted on the premise that there need not be a conflict between creating an inclusive society and encouraging entrepreneurship (DTI 2002: 6), i.e. between ‘doing good’ and ‘doing well’.

There are some notable differences between the Labour government’s promotion of the third sector and the Conservative-led Coalition’s policy approach (see Macmillan, 2011). However, there is a continuation of third sector involvement within the context of public service outsourcing and the new government remained committed to strengthening TSOs. For example, the ‘Big Society bank’ Big Society Capital was installed with £600 million in April 2012 and in February 2013 an ‘Investment Readiness Programme’ worth £20 million was set up (Cabinet Office 2013).

The Coalition government continues to convey the impression that it supports the involvement of all types of organizations in public sector outsourcing and contracting, and actively seeks to remove barriers to involvement ‘so that a diverse range of providers can deliver the public services people want, ensuring a truly level playing field between the public, private and voluntary sectors’ (HM Government 2011: 9). This active promotion of the third sector as a provider of public services was mirrored at departmental level as the following sections will show.

## **2. Legislative changes and programmes to support the third sector in primary care and welfare-to-work**

### *2.1 Changes in the provision of primary care*

The NHS and Community Care Act 1990 introduced a range of market mechanisms, including the outsourcing of a number of public services, and a certain extent of competition into the NHS. In accordance with NPM principles, a purchaser-provider split was introduced by dividing the NHS into autonomous sub-units who trade with each other in an internal market.

While the incoming New Labour government in 1997 abolished this quasi-market, the split between NHS purchasers and providers remained as newly created local arms of the Department of Health (Primary Care Trusts, PCTs) commissioned care from NHS providers. However, the government also announced its intention to develop partnerships with the voluntary sector for the provision of health care services in an attempt to meet newly set targets of increased accessibility and choice and a shift from secondary to primary care (Department of Health 2000). This was followed by a number of legislative reforms that ended the public sector's monopoly in primary care as well as initiatives designed to remove barriers for private companies and TSOs into the new primary medical care market (see table 1).

**Table 1: Primary care market reforms 1998-2013**

Phase	Reform	Key change	Providers	Features
1997-2003	Primary Care Act 1997	Introduction of Personal Medical Services (PMS)	NHS providers	Locally agreed alternative to General Medical Service for specific populations
2004-2007	New General Medical Services (GMS) Contract	Fragmentation of range of services to be offered by GPs and introduction of new contract forms (PCTMS, APMS) in addition to GMS and PMS	NHS GPs and non-NHS 'Alternative Providers'	APMS provides the opportunity for locally negotiated contracts with non-NHS bodies, such as voluntary or commercial sector providers (or with GMS/PMS practices) to supply enhanced and additional primary medical services
2008-2010	Equitable Access to Primary Care	Introduction of at least 100 new general practices in the 25% of areas with the poorest provision and 151 GP-led health centres	NHS GPs and non-NHS providers	APMS as the recommended contracting route, boosting private sector providers
2010-	Health and Social Care Bill [Health and Social Care Act 2012]	All GP contracts decided by competitive tendering process. GPs gaining control over commissioning of non-primary care services	'Any willing provider' (later on 'any qualified provider')	Break-up of former nationally standardised GMS. Increased choice for patients and competition amongst providers.

Each reform involved an increasing potential for competition for primary care contracts from outside the NHS.

#### *New GMS contract*

The new General Medical Services (GMS) contract in 2004 provided for greater flexibility in the range of services delivered by fragmenting the contract into a limited 'essential' service that can be topped up with locally negotiated 'additional' and 'enhanced' elements, e.g. specialist services formerly provided in hospitals,

immunisation services, etc., allowing PCTs to be more sensitive to their local population's health needs while offering an entry point into primary care for new providers (Pollock and Price 2006). Another major market opportunity for the private sector and so-called 'GP entrepreneurs' arose from the separation of out-of-hours services, that is, GP service cover outside regular surgery opening times.

This break-up of the GP's monopoly of providing NHS care and the fragmentation of primary care services into different components has to be seen in the context of growing concerns about so-called 'under-doctored' areas (referring to often deprived areas where it was hard to persuade GPs to work, resulting in an increased burden on secondary care) and that existing contracts were inadequate for achieving ambitious NHS targets (Department of Health 2007; 2008). At the same time, GPs were increasingly frustrated about their workload including their evening and weekend hours (Heins and Parry 2011).

The emergence of new providers of primary care has furthermore been enabled by the introduction of three new contract forms in addition to the standard GMS contract. Relevant for increasing provider diversity and enabling primary care 'entrepreneurs' to enter the new market was the Alternative Provider Medical Services (APMS) contract form. Commissioned through competitive tendering processes and regulated through individual contracts between the PCT and provider, APMS permits primary care services to be delivered in a flexible way by a wider range of providers than NHS doctors, including the independent sector, voluntary sector, CICs, and social enterprises (Pollock and Price 2006; Pollock *et al.* 2007; Heins *et al.* 2009).

### *Programmes to foster the diversity of primary care providers*

While believing in the advantages of competition and provider diversity, the government remained somewhat hesitant regarding the role of for-profit health care companies. Hence they tried to extend the diversity of providers by supporting organizations such as CICs or social enterprises in health and social care (Department of Health 2006; Third Sector Commissioning Task Force 2006) ‘to ensure a patient-centred service’ (Department of Health 2000: 5). In addition, a number of Department of Health programmes offered significant extra investment into primary care to support the entry of new providers (Department of Health 2005; 2007). The aim was to achieve ‘a level playing field’ for these organisations in the face of competition from the established NHS providers and much larger and commercially more experienced for-profit health care providers (Department of Health 2006: 175-176).

The launch of the Equitable Access to Primary Medical Care (EAPMC) programme represented the biggest opportunity for social enterprises in primary care. The aim was to set up at least 100 new surgeries in the 25 per cent PCTs with the poorest provision in addition to one GP-led health centre in each PCT. The Department of Health (2008) recommended the use of APMS contracts as the preferred contracting route for EAPMC procurements, thus enabling competition for these new contracts among providers from different sectors and emphasized the potential for ‘GP entrepreneurs’ to submit innovative tenders.

The Social Enterprise Investment Fund (SEIF), set up in 2007, has been the most important funding source for TSOs in health care. SEIF continues to provide capital

for start-ups and already running social enterprises also under the Coalition government (Miller and Millar 2011). In addition, under the ‘Right to Provide’ scheme, public sector workers in the NHS are given the opportunity to form employee-owned or joint-venture based mutuals, co-operatives or social enterprises to deliver public services (HM Government 2011). The aim is ‘to create the largest social enterprise sector in the world’ (Department of Health 2010: 5).

The potential for non-public sector organizations to provide tax-funded primary care services has increased dramatically with the passing of the Health and Social Care 2012 Act. The new NHS Commissioning Board is authorized to arrange contracts with ‘any qualified provider’ that meets NHS standards and prices and health, in other words, the previously rather exceptional use of competitive tenders under APMS has been rolled out widely (Heins 2013). As a consequence, it has been estimated that a £20bn opportunity for private companies is opening up (Catalyst Corporate Finance 2012).

## ***2.2. Changes in the provision of activation***

In the late 1990s the Labour government introduced the ‘New Deal’ welfare-to-work programmes that aimed to provide jobseekers with employment assistance after a certain period of unemployment (Finn 2011). Unlike previous national activation programmes the government created contractual relationships with non-public sector organizations and moved the delivery of services away from the public employment service and towards a marketized system. Key features of this new welfare-to-work

market included payment by results, provider competition pre and post contract, and more recently a reduction in regulation and state prescription of activities.

As part of the rationale for contracting outside of the public sector the virtues of both the financial management and flexibility of the private sector, and the expertise of the third sector were stated (DWP 2006; 2008). The Department of Work and Pensions (DWP) claimed that ‘these organisations can bring a distinctive approach to service delivery, based on their specialist knowledge, experience and skills’ (DWP 2006: 76) and that ‘they can also offer more scope for innovation, developing new and creative ways of working with customers’ (DWP 2007: 7). The welfare-to-work market was also portrayed as a pragmatic and innovative policy that would ensure services were provided by a diverse range of organizations best suited to meet the needs of jobseekers (DWP 2006). This overarching rhetoric and the activation policy parameters surrounding the purpose of welfare-to-work programmes shifted little over time. The Conservative/Liberal coalition since 2010 maintained the policy rhetoric and continued to emphasize the role of both private sector organizations and TSOs as delivery partners.

*‘There is a unique opportunity to combine the best of the third sector, the voluntary sector and the private sector to reinvigorate our welfare-to-work system’ (Freud 2010, no page number).*

The premise that contractualism was the best option for the provision of employment services was not only continued under the new government, but efforts to escalate the marketization of welfare services increased (DWP 2006; 2007). This was mainly due to experimenting with the contractual arrangements including the introduction of new



variations of welfare-to-work programmes targeting specific groups and increasing contract sizes. Table 2 outlines a summary of some of the main programmes introduced between 1997 and 2010 (for a detailed discussion of the programmes see Bennett 2011; Finn 2011; Damm 2012).

**Table 2: Welfare-to-work programmes from 1997-2010**

Phase	Programme	Institutional arrangement	Providers	Features
1997-2002	New Deal Programmes; Programme Centre	Employment Service, Local Partnerships, Jobcentre Plus	Public partnerships with TSOs, Small number of invited bidders and private sector organisations	Local and city-level contracts, On-programme payments, with some outcome payments
2002-2010	Employment Zone (EZ); Multiple Provider EZ; Pathways to Work	DWP contractor, Jobcentre Plus involvement	Partnerships remain, but increasing competition between providers; increase in private sector organisations	On-programme payments and some payment by results City-wide and/or small sub-regional contracts
2008-2010	Flexible New Deal	DWP Multiple contractor (bypasses Jobcentre Plus)	Private and Third Sector bidders Multi-national organisations,	Medium sized sub-regional contracts, Larger shift towards payment by results, Five year contract
2010-	Employment Related Service Framework (ERSS) Work Programme	Prime Contractor (independent provider)	Selected prime contractors and preferred bidders predominately private sector managing complex supply chains	Large regional contracts, £20million turnover requirement, Increased payment by results, Weighted payments across benefit groups, Increased scope (inclusion of health benefit claimants)

Each new welfare-to-work programme involved a slight (but increasingly market-based) variation on the contracting process, rewards system and levels of competition. Noticeably, the content of the contracts also shifted over time. Whilst the early welfare-to-work programmes required contract providers to offer specific support mechanisms and meet jobseekers at stipulated stages, in 2008 the prescriptive measures outlined within the contracts were reduced. The reduction in regulation was based on the assumption that competitive markets based on payment-by-results

inclined contractors to provide minimum standards to meet their targets. Increasing provider discretion regarding the appropriate support for jobseekers was considered the most effective way to create greater innovation in service delivery (Rees *et al.* 2013).

Collectively the incremental changes spearheaded by the Labour Government and the somewhat larger change pushed forward by the Coalition Government can be summarized under four key features: First, a reduction on contract numbers across the UK and an associated increase in contract size as regional replaced local contracts. Second, the larger contracts were higher in value and over time some increased in contract length. Third, a turn towards payments by results and targets including competition and provider ‘shift’ whereby numerous contracts were awarded in one locality facilitating the loss of market-share for poor performing providers. Fourth, a move towards more provider discretion increased flexibility and innovation.

Early welfare-to-work contracts were often secured by public sector partners, specially created welfare-to-work organizations, and some TSOs (Bennett 2011; Damm 2012). However, by 2007 a range of organizations were involved in the welfare-to-work market. This was partly due to an intentional drive by the DWP to increase competition and allow new entrants into the market. It was also a reaction by private sector organizations to the increasing size and value of the welfare-to-work contracts outlined above. Although both TSOs and private sector organizations were encouraged to compete for contracts in political statements, the programmes increasingly emphasized concepts associated predominately with private sector principles such as quantitative performance measurement and profit orientation. For

example, provider's capital and resource levels had 'to ensure that bidders that proceed have sufficient resources to successfully deliver the contract with a minimum risk of failure' and 'that bidders have a sufficient size to sustain minimum contract values and an outcome focussed payment model' (DWP 2010: 11). Arguably, this approach began to favour those organizations with access to large amounts of upfront capital, in particular companies funded by private investors (Bennett 2011; 2012).

In the following we will explore the impact of this increasing marketization on TSOs delivering primary care and welfare-to-work programmes.

### **3. Case studies of third sector providers in primary care and welfare-to-work services**

As a result of the changes to the contracting mechanisms for public services described in the previous sections, a range of organizations are now involved in the delivery of primary care and welfare-to-work programmes in the UK. Some have been registered charities, others straightforward private sector organizations with shareholders and investors with many different provider forms, including an increasing number of hybrid organizations, in-between. As such, it would be difficult to present one single organization's narrative as representative of others and we do not imply that the two selected case studies stand for a typical development within the specific policy area in which they operate. Instead, both organizations are considered instrumental cases (Stake, 1995) of well-known and successful organizations through which a number of insights might be gained to illuminate the behaviour and organizational change occurring within the general context of marketization of formerly publicly provided

services. The value of the instrumental case study does not depend on being able to defend the typicality of the case (Stake, 1995: 4), instead the exploratory nature (Yin, 2003) enables us to critically engage with the aforementioned assumptions of some of the theoretical literature and particularly the policy rhetoric about the specific value of TSOs in welfare markets. A case study approach instead provides the benefit of ‘thick description’ (Geertz, 1973) in a relatively unexplored research area to inform our understanding of the impact of markets on provider organizations in different policy areas and enables us to reflect on the third sector concept.

The case study of Harmoni, a leading provider in the primary health care market, has been chosen as an example of an originally mutual organization owned by its members that clearly crossed the contentious boundary to the private sector. It is mainly based on publicly available company reports, the company’s website, health care practitioner and business magazines as well as data collated under the Freedom of Information Act 2000. The Wise Group, in contrast, represents an initially successful, but now declining player in the welfare-to-work market that became more business-like over time while still firmly remaining in the TSO domain. The data on the Wise Group were collected as part of a wider study on organizational change and data collection methods included accounts and document analysis, interviews with employees and partners, and a short ethnographic period within the organization.

### *3.1. Harmoni – a local GP co-operative turned into a multi-million pound business*

Following the new GMS contract in 2004, only around 10 percent of GP practices have retained their out-of-hours responsibilities (NHS Commissioning Board 2012). As a result of their separation from the routine contractual GP duties, out-of-hours care is now provided by a variety of providers, including NHS trusts, local GP co-operatives, private firms or partnerships between different types of private sector organizations. Often formally classified as ‘GP-led’, such companies actually resemble more a medium to large-size commercial enterprise than a traditional GP practice. The example of Harmoni illustrates this very clearly.

Led by two local doctors, Harmoni (Harrow Medics Out of hours Network Inc) was formed in 1996 as a GP co-operative, covering the out-of-hours services for the Harrow area in Northwest London. As one of the founding GPs claims, the out-of-hours coverage arrangement in the area until then had been very inefficient and the founding partners had the vision to vastly improve local health care coverage. Within 18 months of Harmoni’s foundation, GPs from three neighbouring areas had joined the Harmoni fleet (Harmoni, 2013). The founding doctors of Harmoni embodied an ‘entrepreneurial’ spirit amongst GPs that the Department of Health some years later pledged to promote. When legislation ended the GP monopoly on NHS primary care, Harmoni was therefore well equipped for the new market and enjoyed the advantages of a first mover.

The founding members clearly recognized the business potential that the new contracts offered and in September 2004 Harmoni became incorporated as a private

limited company. This change of legal status became possible as under the APMS contract GP services could be provided by 'any qualified provider'. In 2005, by which time it was the largest GP co-operative in the UK with over 600 GP members, Harmoni formed a joint venture with a healthcare investment company. Harmoni had annual sales growth of 39 per cent since the introduction of the EAPMC in 2008. The company almost tripled its workforce over the same period (ECI 2012). In the context of the diagnosed vast growth potential of the primary care market due to the introduction of the Health and Social Care Act, in November 2012 Harmoni was sold off for £48 million to Care UK, one of the largest for-profit health care providers in the UK that originally started off as a provider of nursing homes. By that point, Harmoni itself had become a leading provider of outsourced healthcare services including out-of-hours, GP-led health centres, prison healthcare, telehealth, IT services and 12 of the newly introduced NHS 111 emergency call contracts (ECI 2012). This sell-off of an originally NHS-funded company reportedly turned five GPs into millionaires (Ramesh 2012).

The boundary between third sector and business sector had thus clearly been crossed, yet the overall picture of the company's activity remains complex as Harmoni is involved in various joint ventures with other GPs and social enterprises and has stakes in multiple other companies that have won GP contracts (NHS Support Federation 2010: 10, see Harmoni's website at [www.harmoni.co.uk](http://www.harmoni.co.uk) for examples of their joint ventures and partnerships). For example, in 2009 Harmoni, at that point an independent sector company with over 400 GPs as shareholders, formed a social enterprise with GPs in Newham. The GPs held 60 per cent of the shares and Harmoni the remaining 40 per cent. The company could be classified as a social enterprise in

the understanding of the government because its activities were aiming to provide services in an ‘under-doctored’ area in which the community had problems accessing primary care physicians. The highly complex ownership structure thus makes it difficult to track who controls the actual public service and where tax money is going.

Through a number of mergers, acquisitions and partnerships with diverse GP co-operatives Harmoni to date has become the largest private provider of out-of-hours GP care in England with hundreds of contracts across the country. Its company structure resembles that of a typical medium-sized enterprise with different executive directors, employing agency staff to provide actual front-line services. In this regard, it has achieved a good deal of media attention as some of the services were seriously under-staffed or only run by nurses (Roberts 2013), causing serious concerns about unsafe practices that are very much in contradiction to the ethos on which the original co-operative was once founded and that the conceptual literature regards as a defining characteristic of the third sector.

### ***3.2. The Wise Group- squeezed out despite substantial organizational change***

The Wise Group is a registered charity based in Glasgow founded in 1983. Throughout the 1980s and 1990s The Wise Group’s activities centred on the provision of employment support for the long-term unemployed through the creation of temporary employment opportunities predominately in environmental and housing regeneration (Bennett 2013). The approach adopted was described as an ‘intermediate labour market’ (ILM) model (Finn and Simmonds 2003) and involved a complex arrangement of a number of local, regional and national public funding sources. The

model was an important part of the organization's identity and method to reducing issues of deprivation and unemployment.

Whilst it has continued to deliver a range of its local, small, specialized employment and environmental programmes, its main income from 1999 to 2010 derived from the delivery of many of the welfare-to-work programmes outlined in Table 2. The Wise Group was one of only a few TSOs which won a large number of welfare-to-work contracts between 1998 and 2010 and attracted praise and attention for its work from EU funding bodies and local political organizations.

Using income surpluses from welfare-to-work contracts and other employment support work (along with third sector capacity development grants) The Wise Group underwent a gradual process of internal organizational reforms in order to maintain and enhance their involvement in this policy context. Some of the changes were instigated directly by the introduction of new contract prerequisites and conditions set by the DWP, others were an indirect result of the interaction and competition with other organizations in the market (Bennett 2013).

One of the notable changes was a shift in employment support provision. In the earlier welfare-to-work programmes individuals within the organization connected the delivery of New Deal programmes with their traditional activities. Over time this approach was no longer facilitated due to the contract requirements and eligibility rules. Furthermore, there was an increasing need to move individuals more quickly into the labour market making extended periods of support and temporary



employment impossible. This led to a shift away from the ILM model and the organization's core activities towards a more typical work-first delivery approach.

As the organization continued to deliver welfare-to-work contracts quite separately from its other employment support activities, a number of organizational changes were introduced in direct response to DWP requirements. First, The Wise Group developed a series of audit and data recording systems to meet the basic requirements of DWP contracting. Second, a number of internal departmental changes were introduced, including the professionalization of contract bidding and an increased emphasis on meeting targets throughout the organization (not limited to welfare-to-work contracting). This also involved an increase in the number of permanent staff (from 265 in 1996 to 516 by 2010) and an increase in total income of £8.5 million in 1996 to £32.1million by 2010.

According to an anonymous respondent from the organization the aim was to portray The Wise Group as a 'leading welfare-to-work organization', namely as a large, professional business, capable of delivering the new bigger contracts. For a time this appears to have been a successful approach. In 2010 The Wise Group was the only TSO of the nine organizations accepted onto the Scotland 'lot' of the Coalition government's framework for the pre-tendering phase of the Work Programme. The framework required potential contractors to pass a series of organizational assessments, one of which was to demonstrate an annual turnover of £20m (which the DWP claimed would reduce the risks connected to taking over large value contracts). Of the 128 organizations which made it onto the framework across the UK, only 23 were non-private sector organizations (Bennett 2011).

Although The Wise Group remained operational in some of its traditional work areas, in many aspects it adopted systems similar to other providers in the welfare-to-work market. Arguably, this organizational change was necessary in order to gain contract success and therefore guarantee survival in the changing market. However, despite The Wise Group's organizational change and contract success from 1997-2010, the introduction of the Work Programme increased the risk for providers by introducing a finance model which required organizations to invest their own money in service delivery first and receive income only at a later date (Bennett 2011; Finn 2011; Rees *et al* 2013). It appears that the changes were significant enough to diminish the competitiveness of The Wise Group as two private sector organizations secured the Scotland contract. Where once it was a leading regional provider of welfare-to-work services and a showcase example of a TSO successfully competing against private sector organizations, it has since undergone a large down-sizing process, reducing staff numbers and investment. Despite its transition to become more 'business-like,' by the end of 2010 The Wise Group's involvement was much reduced and its role as a major contributor of innovative employment support had diminished.

## **Discussion**

Our analyses of the developing markets in primary care and welfare-to-work have shown that the general enthusiasm of subsequent UK governments for public service provision by the third sector has been translated into concrete reforms of different policy areas by breaking up former public sector monopolies. Just like the previous Labour governments, the current Coalition government has been supporting

entrepreneurship in the form of TSOs, and more specifically, social enterprises and mutuals and claims to be looking 'beyond the old binary choice of monolithic monopolistic state provision or full-blooded commercial outsourcing – and embracing a new range of models which can happily coexist in the space that lies in between' (Maude 2014; no page number). In doing so, it continues to promote the outsourcing of public services. However, the development of the contracting processes created similar welfare markets in which also independent providers competed for increasingly large and lucrative contracts.

Indeed, as other research has shown, in neither welfare market was it TSOs – even if defined widely and including profit-seeking social enterprises – that seemed to have benefitted the most from the new market opportunities. It was mainly larger commercial entities that won most of the tenders (Heins *et al.* 2009; NHS Support Federation 2010; Rees 2013). In the context of procurement regulations that emphasize size, long-term business strategies or value-for-money that providers need to offer, only those TSOs that to a large extent mimicked the behaviour of for-profit business remained competitive. This trend known as isomorphism has been widely discussed and evidenced in the non-profit literature (e.g. Currie *et al.* 2003; Heins *et al.* 2010; Rees *et al.* 2012). This should not be surprising - even if they are notionally 'third sector', social enterprises have to generate most of their income from competing in markets and thus cannot avoid adapting to the rules of the market. Ironically, there is an inherent contradiction between the simultaneous government policies of rewarding good performance and prescribing certain capacity levels of providers (being conducive to the building of oligopolies) and promoting provider diversity (to ensure competition).

Westall (2009: 12) asked why the crossing of boundaries by third sector groups and the shifting of motivations and goals within organizations happens. We can give some tentative answers to such questions on the basis of our analysis: The very introduction of market mechanisms exerts adaptive pressures on providers trying to compete in these new welfare markets. In our first case study, this led to a conversion of a formerly employee-owned co-operative to a fairly large-scale commercial company over time. In our second case study, it caused a traditional local TSO to change towards a more business-like style while officially not redeeming its status of a charity. However, this legal status and character made it difficult, if not impossible, to survive in the market once the contracting rules became even more business-oriented than before. It is thus no surprise that despite the government claiming they would provide a 'level playing field' for the third sector, empirical evidence of the success of the sector in tendering for primary care and welfare-to-work provision to date has been scarce.

We demonstrated that not only has there been a shift in the types of organizations involved in the new welfare markets, but within some of these organizations there has been much change in terms of their characteristics and structures. Similarly to Aiken and Bode (2009: 220), who claimed that such policies are "killing the golden goose", we find that the changes erode the distinctiveness of TSOs and their alleged strengths. Regarding the example of The Wise Group, it remained a charity, but sought to discourage being perceived as one and portrayed itself as a social enterprise and thus as more business-like (through highlighting its strengths in contract management, employment knowledge and innovation). Internally, it emphasized meeting targets and adopted business planning strategies more akin to private sector organizations.

The example of Harmoni has demonstrated that it becomes difficult to speak of any alleged social enterprise distinctiveness and that there is a strong trend towards full conversion to commerciality.

Involvement in the emerging UK welfare markets is therefore not simply about competing for a contract and delivering a front-line service on behalf of the public sector. It requires organizational adaptation and the competitive and regulatory pressures of the market meant that the contracting process controlled both the services delivered and the behaviour of providers, regardless of their original sector, organizational history and ethos. The two organizations that we selected for illustration were praised for what they were doing, but now no longer represent the local, innovative TSOs with 'entrepreneurial spirit' they were supposed to be. Their vastly different experiences challenge a simplified third sector ideal with a crisp boundary to the private sector and highlight that policy-makers' assumptions about what will happen if we bring in the third sector as welfare providers were rather naïve in the context of an increasingly competitive environment characterized by minimum contract values, efficiency, take-overs and mergers favouring large-scale organisations.

Our findings confirm previous research as the two case studies demonstrate the hybridization of the third sector as well as the diversification and metamorphosis of individual entities within the sector which Brandsen *et al.* (2005) regard as essential to understanding third sector involvement in welfare markets. By tracing organizational change in two instrumental cases we go further than the existing literature by demonstrating that there are contradictions between policy intentions and practice outcomes and that such incongruity could be attributed to the lack of recognition of

issues of hybridity and change by policy makers and an oversimplified understanding of the role of the third sector in welfare markets.

## **Conclusion**

We used two policy areas to analyze how the general context of a trend towards marketization plays out in two different welfare areas in order to show how general government guidance coming from the Cabinet Office and the Treasury plays out ‘on the ground’. While there are differences in detail (e.g. the specific problems that led to the use of non-public sector providers), the comparison highlights striking similarities about the claims being made about the value of the third sector and the general direction of development that puts a lot of pressure on TSOs to transform (or vanish).

As we have shown, both the primary care and welfare-to-work markets are complex and characterized by an increasing hybridity of organizations and fuzziness of the boundaries between sectors. This stands in contrast to the commendations of TSOs by policy makers and some of the theoretical literature as being distinct market providers that combine the best of the public and the private sector with the potential to simultaneously address concerns of both market and government failure. The changes in welfare provision since public sector monopolies were ended are as multifaceted as the individual organizations and their adaptations over time.

Detailed longitudinal studies of organizations are essential in the advancement of the discussion of the third sector concept as they provide conceptual insights into organizational change and behaviour. Drawing on instrumental case studies from two

highly marketized public policy areas we contend that policy intentions and practice outcomes are contradictory. Rather than overcoming problems of market failure, the third sector has failed (albeit in very different ways) in the market as the insights into the realities of two of the (previously) most successful TSOs have revealed. If not even ‘poster children’ of the third sector are confirming to the TSO ideal, then who does? This beckons the question as to why the narrow understanding of the third sector continues to be promoted by advocates for the creation of welfare markets and increased public service outsourcing.

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Table 1: Primary care market reforms 1998-2013

Phase	Reform	Key change	Providers	Features
1997-2003	Primary Care Act 1997	Introduction of Personal Medical Services (PMS)	NHS providers	Locally agreed alternative to General Medical Service for specific populations
2004-2007	New General Medical Services (GMS) Contract	Fragmentation of range of services to be offered by GPs and introduction of new contract forms (PCTMS, APMS) in addition to GMS and PMS	NHS GPs and non-NHS 'Alternative Providers'	APMS provides the opportunity for locally negotiated contracts with non-NHS bodies, such as voluntary or commercial sector providers (or with GMS/PMS practices) to supply enhanced and additional primary medical services
2008-2010	Equitable Access to Primary Care	Introduction of at least 100 new general practices in the 25% of areas with the poorest provision and 151 GP-led health centres	NHS GPs and non-NHS providers	APMS as the recommended contracting route, boosting private sector providers
2010-	Health and Social Care Bill [Health and Social Care Act 2012]	All GP contracts decided by competitive tendering process. GPs gaining control over commissioning of non-primary care services	'Any willing provider' (later on 'any qualified provider')	Break-up of former nationally standardised GMS. Increased choice for patients and competition amongst providers.

Table 2: Welfare-to-work programmes from 1997-2010

Phase	Programme	Institutional arrangement	Providers	Features
1997-2002	New Deal Programmes; Programme Centre	Employment Service, Local Partnerships, Jobcentre Plus	Public partnerships with TSOs, Small number of invited bidders and private sector organisations	Local and city-level contracts, On-programme payments, with some outcome payments
2002-2010	Employment Zone (EZ); Multiple Provider EZ; Pathways to Work	DWP contractor, Jobcentre Plus involvement	Partnerships remain, but increasing competition between providers; increase in private sector organisations	On-programme payments and some payment by results City-wide and/or small sub-regional contracts
2008-2010	Flexible New Deal	DWP Multiple contractor (bypasses Jobcentre Plus)	Private and Third Sector bidders Multi-national organisations,	Medium sized sub-regional contracts, Larger shift towards payment by results, Five year contract
2010-	Employment Related Service Framework (ERSS) Work Programme	Prime Contractor (independent provider)	Selected prime contractors and preferred bidders predominately private sector managing complex supply chains	Large regional contracts, £20million turnover requirement, Increased payment by results, Weighted payments across benefit groups, Increased scope (inclusion of health benefit claimants)