

Regulatory Capitalism and the UK Labour Government's Reregulation of Commissioning in the English National Health Service

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Today, policy analysts and regulatory governance scholars are sceptical about the capacity of the regulatory state hypothesis to describe change at the institutional level. For many, the hypothesis is a convenient oversimplification that fails to account for the hybridity of institutional arrangements within individual policy sectors and also for the divergence of reform trajectories across different national and sector-based policy contexts. This article assesses the influence of the key themes of the regulatory state on the UK Labour government's reregulation of National Health Service (NHS) commissioning organizations. Following the critics, it argues that these themes are only partially evident in the programme. While the government has codified previously informal relationships with policies like Patient Choice and has also subjected commissioning organizations to meta-regulatory techniques, its reforms have neither displaced public ownership and the direct supply of commissioning services with markets and new mechanisms for rule making and standard setting, nor have the reforms divided labour within the state by creating an independent agency to regulate NHS commissioning organizations via technocratic means. Under the reforms, NHS commissioning continues to take place within a structure of bureaucratic relationships. However, the article suggests that the hybridity of regulatory techniques at work within the UK Labour government's reregulation of NHS commissioning lends weight to the claim that the current era is one of regulatory capitalism. It concludes with a discussion of the consequences of this finding for the public policy and regulatory governance literatures.

HYBRIDITY, DIVERGENCE, AND THE REGULATORY STATE

The term “regulatory state” denotes a coherent style of policymaking under which markets, rule-making and newly independent regulatory institutions

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displace public ownership and centralized administration of public services and utilities (Majone 1994). In the early 1990s, the term gained currency as a useful means for interpreting developments in a wide variety of policy sectors, including local government, environmental protection, transport, water, energy, education, social care, and health care (Hughes, Mullen, and Vincent-Jones 2009). In the United States, the tradition of regulation by independent agencies dates from the late nineteenth century (Majone 1994). In Europe, however, the rise of the regulatory state is associated with the increasing displacement of public ownership and centralized planning with a new array of regulatory governance techniques that shift legal, political, and economic structures away from government and towards governance, from rowing to steering, from providing to facilitating, from a welfare state to a regulatory state. Today, many scholars are sceptical about the capacity of the regulatory state hypothesis to describe change at the institutional level (Lodge and Stirton 2006). Although they acknowledge the influence of certain aspects of structural change, they point to the hybridity of institutional arrangements within individual policy sectors and also to the divergence of reform trajectories across different national policy contexts. For critics, the regulatory state hypothesis is a convenient oversimplification. Evolving institutional forms are more mixed and heterogeneous than the thesis allows (Hughes, Mullen, and Vincent-Jones 2009). Although the regulatory state hypothesis is useful for predicting wider institutional arrangements, it has difficulty explaining the timing and extent of regulatory reform (Lodge and Stirton 2006).

Many suggest that these criticisms are borne out in the UK Labour government's reregulation of the English NHS. For example, analysing changing patterns of public and patient involvement (PPI) in the NHS regulatory framework, Hughes, Mullen, and Vincent-Jones (2009) argue that the oversight and organization of PPI combines hierarchical controls with the delegation of responsibilities to independent regulatory agencies, such as the Care Quality Commission (CQC), and new participatory forums, such as Local Involvement Networks (LINKs). The new regulatory frame comprises a hybrid of market-based and command-and-control mechanisms, under which contractual relationships, statutory duties, and voluntary action play a combined role in the commissioning of NHS services (*ibid.*). Thus, they conclude that the regulatory state hypothesis fails to describe the different combinations of regulatory techniques for hierarchical control, delegation, and the provision of local autonomy (*ibid.*; Deakin and Walsh 1996; Walsh 1995).

Critics also suggest that the regulatory state hypothesis fails to describe institutional change across divergent national contexts. For example, the NHS is a collective term that refers to the four independent publicly financed national health care systems of England, Wales, Scotland, and Northern Ireland. Analysing the forces shaping reform on health care in England and Wales, Hughes and Vincent-Jones report schisms in the national church of

British health care (2008). While market-oriented regulatory governance techniques associated with the regulatory state hypothesis are evident in the English NHS, they are less evident in terms of health care reforms in Wales, Scotland, and Northern Ireland (Hughes, Mullen, and Vincent-Jones 2009). In particular, Welsh policymakers purposefully avoided decentred regulatory governance techniques like Foundation Trusts (FTs), Patient Choice, and independent regulatory commissions. Alternatively, Welsh policymakers improved service integration by enhancing the influence of local representative bodies and providing additional opportunities for patient public involvement (*ibid.*).

In a similar vein, Lodge and Stirton (2006) analyse patterns of regulatory change in the telecommunications and electricity sectors of Jamaica and Trinidad and Tobago, reporting a “withering” of the regulatory state (465). In each context, the trajectories of reform were different, diverse institutional arrangements were employed, and the key features of the regulatory state were substantially modified and weakened in practice (*ibid.*). The problem with the regulatory state hypothesis is that even in policy sectors and national contexts most likely to support the materialization of its basic institutional properties, their emergence is “both partial and patchy” (*ibid.*, 466). Although governments in the Commonwealth Caribbean implemented reforms involving privatization and market liberalization, delegation of policymaking to independent agencies, and the formalization of relationships, the regulatory state hypothesis experienced difficulties explaining the variety, extent, and timing of reforms across national and sector-based policy contexts (*ibid.*).

The failure of the regulatory state hypothesis to describe both hybridity within policy sectors and divergence across national contexts has important consequences for wider structural accounts of regulatory change. For example, health care is among the most rapidly developing policy sectors across the developed world and involves considerable technical and industrial infrastructure. Accordingly, some suggest that national systems of health care provision intersect with international economic activity and that national policy decisions must be taken with substantial reference to global economic considerations (Freeman and Moran 2000). Here, the role of the state is to manage the relationship “between internal and external pressures on the finance and delivery of health care” (*ibid.*, 37). In other words, health care reforms both shape and are shaped by liberal democratic states that are embedded within a global capitalist economy (*ibid.*). National health care systems therefore converge on programmes of policy reform involving “a common functional or technical rationality” (*ibid.*, 42). Some conclude that financial, delivery, and regulatory arrangements for national health care systems are indicative of “wider and deeper social processes of convergence and diffusion” (*ibid.*, 43).

For their part, critics of the regulatory state contest these claimed trends towards the global convergence of health care systems (Hughes, Mullen, and

Vincent-Jones 2009). For example, critics suggest that both the diversity of regulatory governance combinations within the English NHS and the divergent institutional forms across the national health care systems of Wales, Scotland, and Northern Ireland demonstrate that contrasting political contexts—differences in the constitutional mechanisms of multilevel governance and different institutional arrangements—play an important role in divergent policy outcomes (*ibid.*; Jacobs, Marmor, and Oberlander 1999). Certainly, these critics acknowledge that structural factors like unemployment, stagflation, the 1973–74 oil crisis, the rise of neoliberal governments in Britain and the United States—factors commonly associated with the rise of the regulatory state—help explain both broader patterns of welfare reform and the search for new policy initiatives. They also maintain, however, that these factors fail to explain the degree to which initiatives have impacted national contexts. Accordingly, the critics claim that policy debates are largely parochial affairs that address problems, developments, and visions for the future within specific national contexts (Marmor, Freeman, and Okma 2005). Where policy mechanisms arise cross-nationally, the critics suggest that these are representative of “parallel thinking” or “common questioning” in the face of “similarities in circumstances and problem definition” (*ibid.*, 337).

At this point, we reach an important junction in the wider policy literature. Along one avenue, the influence of divergent local contextual factors trumps globalist claims about policy convergence across national contexts. Along the other, national programmes of policy reform represent deeper social and economic processes of convergence and diffusion. There are some major issues to be resolved here: on the one hand, about the autonomy of states in the face of international economic pressure (Freeman and Moran 2000); and on the other, about the persistence of claims regarding system convergence in the face of widespread patterns of hybridity and continuity in national public policy models (Marmor, Freeman, and Okma 2005).

Typically, the critics of the regulatory state and policy convergence hypotheses meet these issues with concepts of political-regulatory influences, policy transfer, networks, actor constellations, and the interaction of policy and knowledge actors (Hughes and Vincent-Jones 2008; Lodge and Stirton 2006). Essentially, they claim that political, regulatory, and institutional forces structure the agency of actors and thus facilitate hybridity and divergence (*ibid.*). For example, in England, health care reforms have adopted hybrid arrangements to meet the perceived failures of bureaucracy and the market. In Wales, divergent hierarchical command structures have been adapted in order to change relations between the centre and the periphery to improve engagement with local communities (Hughes, Mullen, and Vincent-Jones 2009). In both countries, however, the critics claim that policymakers have developed unique approaches to the reregulation of health care that have imported concepts, institutions, and techniques from other national and sector-based policy contexts. Whereas the English model of reform has been

transferred from the privatization of public utilities, the Welsh model owes much to local government reforms (*ibid.*).

Moreover, critics also suggest that these interactions have been structured and mediated by institutional, political, and regulatory influences (Hughes and Vincent-Jones 2008) In England, health care reform involved the ideological dimension of the Blairite “third way” agenda, which aimed to protect the NHS from economic liberals through modernization via a programme of market reforms (Greer 2004). The government had close relationships with economic experts and management theorists from other policy sectors (Hughes and Vincent-Jones 2008; Barzelay and Gallego 2006; Hall and Taylor 1996). Further, the Blair government also enjoyed three terms in office with healthy parliamentary majorities. In Wales, however, no such relationships existed. Given their historic attachment to socialized health care, Welsh policymakers held deep reservations about the emerging English market reforms (Hughes and Vincent-Jones 2008) In addition, the Welsh Labour party did not command an overwhelming majority and depended on left-leaning Liberal Democrats for support. Thus, powerful contextual influences splintered and separated the UK NHS into four distinct subsystems. Accordingly, critics conclude that both macrohistorical hypotheses, like the regulatory state, and global forces of policy convergence, such as macroeconomic patterns, rising costs of health infrastructure, aging populations, stagflation, and so on, can provide only a general description of changes to national health care systems. They cannot account for regulatory transformations at the institutional level. Across a variety of national and sector-based policy contexts, hybrid arrangements, and divergent national approaches bear the influence of institutional, political, and regulatory factors rather than single-factor or structurally determined patterns (Lodge and Stirton 2006).

HYBRIDITY, DIVERGENCE, AND REGULATORY CAPITALISM

The concept of the regulatory state is grounded in a tradition of thought that emphasizes the importance of political institutions against both the Marxist tradition, which accentuates the primacy of economic processes, and the neoliberal tradition, which stresses the importance of globalization, markets, and the retreat of the state. Alternatively, regulatory capitalism is a historical thesis about contemporary changes in the governance and organization of capitalism (Braithwaite 2008, 2005; Jordana and Levi-Faur 2005; Levi-Faur 2005; Levi-Faur and Jordana 2005a, 2005b).

Like the regulatory state hypothesis, regulatory capitalism is grounded in the notion of a regulatory explosion, under which markets and rule making displace public ownership and centralized administration through privatization and the growth of autonomous regulatory agencies (Vogels 1996; Ayers and Braithwaite 1992). To a large extent, the thesis for regulatory capitalism

is therefore nested inside the regulatory state hypothesis. For example, both share similar themes: the division of labour between state and society, the division of state, the codification of relationships, and the development of metaregulatory techniques for enforced self-regulation (Wright 2009; Levi-Faur and Gilad 2004). Unlike the regulatory state hypothesis, however, regulatory capitalism interprets the expansion of regulation as part of a wider phenomenon within the historical development of capitalism. Regulatory capitalism denotes the opening of a new historical epoch in the development of capitalism. The term serves as a replacement for less specific designators like the new world order, the retreat of the state, and the neoliberal hegemony. Regulatory capitalism holds that the corporatization of business, network governance, and the development of global communications technology have engendered a demand for regulation (Braithwaite 2008). Within this context, any conception of the regulatory state tells but part of the story. Today, regulatory states are as much rule takers as they are rule makers. For example, in sectors like banking, finance, air safety, and shipping, the demand for regulation is inherently global and beyond the romance of control by a town meeting (Braithwaite and Drahos 2000). In the era of regulatory capitalism, functional rather than territorial considerations condition legal forms of domination (Levi-Faur 2008). While the regulatory state hypothesis focuses on activity at the national level, regulatory capitalism marks broader political, social, and economic changes that result from the new division of labour between state and society in an age of globalization rather than the nation-state, an age of governance rather than government. Under the thesis, regulation becomes a central issue across the social sciences and one that does not respect traditional disciplinary boundaries between international relations, public policy, comparative politics, institutional economics, public administration, global governance, international law, and health policy (Braithwaite 2008, 2005).

The aim of this article is to contest criticisms of structural accounts of regulatory change by demonstrating the capacity of regulatory capitalism to accommodate hybridity and divergence both within individual policy sectors and across different national policy contexts. Under the thesis for regulatory capitalism, there is significant potential for national health systems, in particular, to exhibit hybridity and divergence (Levi-Faur 2006a, 2006b). Globalization touches policy sectors, markets, and regulatory regimes to different degrees. For example, in banking and finance, both markets and regulations are global. In the pharmaceutical industry, however, regulations are subject to globalization, yet markets are not. While manufacturing practices for prescription drugs have been standardized, the state is a monopolistic buyer in the biggest markets, and regulations are predominately national (Levi-Faur 2006b). Alternatively, gambling and health care serve as examples in which neither markets nor regulations are global. Different states regulate gambling and health care in different ways and vary over how much and what kind of protection and cover they provide (*ibid.*). Thus, in health

care, there is greater scope for policy innovations to become more political rather than technical, more parochial rather than structural.

The UK Labour government's reregulation of the NHS is an ideal context in which to track hybridity of regulatory arrangements. In England, a basic characteristic of the service is the organizational split between provider and commissioning agencies. Broadly, NHS providers supply health care services, such as hospital, community, and emergency care. The role of NHS commissioning organizations is to assess the health needs of a geographical population and take responsibility for ensuring that the requisite services are available in defined local areas. In terms of provision, the key themes of the regulatory state are evident in the UK Labour government's reform of the service (Wright 2009). To recap briefly, the government has divided labour between the Department of Health (DH) and new organizations like FTs and Independent Sector Treatment Centres (ISTCs). It has also divided labour within the state: between the DH and newly independent bodies such as Monitor and the CQC that regulate provider organizations via technocratic means. The government has codified previously informal arrangements with policies such as 18 Weeks and Payment by Results. It has also subjected FTs to metaregulatory techniques for enforced self-regulation by altering their internal governance arrangements (*ibid.*).

Under the thesis for regulatory capitalism, however, we should expect to see a hybridity of arrangements in Labour's reform of the service. This article assesses the influence of the key themes of the regulatory state on Labour's reregulation of NHS commissioning organizations. It demonstrates that these themes are only partially evident in Labour's programme. Certainly, the government has codified previously informal relationships with policies like Patient Choice and has also subjected commissioning organizations to metaregulatory techniques by installing LINKs and Overview and Scrutiny Committees (OSCs) within their governance arrangements. However, Labour's reforms have neither displaced public ownership and the direct supply of commissioning services with markets and new mechanisms for rule making and standard setting nor have the reforms divided labour within the state by creating an independent agency to regulate NHS commissioning organizations via technocratic means. Under the reforms, NHS commissioning continues to take place within a structure of bureaucratic relationships. It concludes that the hybridity of regulatory techniques at work within the UK Labour government's reregulation of NHS provision and commissioning organizations lends weight to the claim that the current era is one of regulatory capitalism.

An analysis of the influence of the key themes of the regulatory state on NHS commissioning has obvious importance to the wider policy literature. Where regulatory divergence and hybridity can be accommodated under the rubric of regulatory capitalism, critics of both structural influences and macrohistorical hypotheses must reassess their commitment to concepts of policy transfer, networks and actor constellations, and institutional and political-

regulatory influences. Under regulatory capitalism, divergent local contextual factors can no longer trump claims about policy convergence across national contexts. Accordingly, national programmes of policy reform are indicative of deeper processes of convergence and diffusion, of which patterns of hybridity and divergence are an essential component.

But, beyond such a reassessment, why should it matter that the current era is one of regulatory capitalism? Or, in other words, what does regulatory capitalism do?

“Textbooks tend to go out of date,” suggested Mary Douglas. With new scientific discoveries and the “deeper delving of historians,” the linguistic fashions and political susceptibilities of a new age can antique and archaize the received methodologies and approaches of a past generation (Douglas 1986, 69, cited in Hood 2007, 127). Certainly, since the publication of Douglas’ own work, the materials and focus of both policy analysis and political science have shifted significantly: the Soviet Union has fallen, the development of global communications technology has changed the nature of social and economic life, and economic activity and interdependence continue to accelerate. Nevertheless, some scholars question how Douglas’ intuition plays out in such a world. In short, they claim that ideas can also “come back into fashion,” and that “older forms of analysis can stand the test of time” (Hood 2007, 127). In a world of regulatory explosions, stagflation, networks and actor constellations, of regulatory states and regulatory capitalism, they suggest that “technology-free” modes of analysis are all the more necessary as tools of comparison. Today, more than ever, policymakers’ analyses of problems and their prescribed solutions are subject to political and ideological influences. Accordingly, some claim that the fields of political science and policy analysis require “relatively neutral” methods against which “touchy-feely variables” like politics, ideology, and culture can be measured (*ibid.*, 137).

Regulatory capitalism issues a serious challenge to scholarly preferences for analytical frames that stand apart from space and time and apart from variables like politics, ideology, and culture. It suggests that analytical frameworks that have stood the test of time, that are not beholden to any particular technologies or ideologies of governance, might not in fact be very useful.

If the current era is one of regulatory capitalism, then, there are qualitative differences among nineteenth, twentieth, and twenty-first century regulatory contexts that so-called neutral analytical frameworks necessarily neglect—contexts that other scholars of regulation express in terms of *laissez-faire* capitalism, welfare capitalism, the audit society, the British regulatory state, and regulatory capitalism (Wright 2009). Certainly, critics recognize that governmental choices of policy instruments are rarely a case of impartial deliberation. Accordingly, they acknowledge the need for some kind of synthesis or accommodation with qualitative or contextual frames, suggesting that neutral analytic frames serve as fixed measures against which “ideological and other baggage” can be weighed (Hood 2007, 137). In a world of regulatory capitalism, however, where academics, policy experts, and other

knowledge actors play a major role in diffusing regulatory change, where their methodological choices are likewise heavily constrained by requirements to gather funding, to secure positions, and to attract scholarly attention, it is difficult to understand why academic preferences for neutral frames that stand beyond the reach of space and time should enjoy any special legitimacy over governmental choices of policy instruments.

In an age of regulatory capitalism, the point is that apprehensions about variables like the public interest and the equitable distribution of resources do not merely express concerns about linguistic fashions and political susceptibilities, about “cognitive frames, rhetoric, and argumentation” (*ibid.*, 141); rather, they express very real anxieties about the practical implications of fundamental changes to the governance structure of advanced capitalist economies. For example, markets and private enterprises do not make public-interest decisions. If they work more efficiently than public ownership, they will more efficiently produce both desirable and undesirable outcomes (Braithwaite 2008). And, in an era of regulatory capitalism, they will do so in such a way as to afflict our world with unspeakable misery (*ibid.*). Now, more than ever, the fields of political science and policy analysis need to take historical account of their analytical preferences. In other words, they need to ask questions about how policymakers can facilitate innovation and learning cultures, about how they can avoid installing mechanistic blame shifting and ritualism within regulatory regimes. Above all, they need to evaluate the promise of regulatory states to provide an increased range of higher quality services at reduced costs and to deliver more balanced approaches to the distribution of power and resources.

REGULATORY CAPITALISM

Regulatory capitalism differs from the regulatory state hypothesis in four crucial respects. It expands the critique of neoliberalism. It shifts the locus of analysis from the national state to the global capitalist economy. It presents a more nuanced historical thesis. And it also offers regulatory scholarship a different analytical project.

Like the regulatory state hypothesis, regulatory capitalism challenges the widely held belief that neoliberalism has conquered the world (Chomsky 1999). Those who think we live in an era of neoliberalism, argues John Braithwaite (2008), “are mistaken” (4). Regulatory capitalism extends the critique of neoliberalism on two fronts. Firstly, it suggests that neoliberalism fails to describe the course of world economic development since the fall of the Soviet Union. In addition, it argues that neoliberal governments in the United Kingdom and the United States have failed to make a decisive impact on the shape of the modern state.

Under a widely supported chronology, the election of the Thatcher government in the United Kingdom and the Reagan-Bush administrations in the

United States marks the death of the welfare state and signals the rise to dominance of neoliberalism and the new right. Throughout the 1980s and early 1990s, this Chicago-led Washington Consensus, which developed around notions of the “end of history” and Hayekian prescriptions for markets and individualism, also took hold at the International Monetary Fund (IMF) and spread around the globe, with Labour governments in Australia and New Zealand and many European governments initiating wide-ranging programmes for privatization, deregulation, and smaller government.

Regulatory capitalism challenges this chronology, arguing that although neoliberal ideas took hold in the United Kingdom and the United States, they did not take hold in Asia. More specifically, it suggests that the Asian financial crisis of 1997 marks the last gasp of neoliberalism as a coherent ideology that pretended to rule the world. Before the crisis, the Chicago school held that divergent forms of capitalism in China and Indonesia were steps “along a path to neo-liberalism” (Braithwaite 2008, 6). Immediately following the collapse of currencies in Thailand, Indonesia, South Korea, Malaysia, and the Philippines, the IMF demanded that Asia learn the lessons of the Washington consensus and fully liberalize its economies. However, the economies that recovered most quickly from the crisis were those, like South Korea and Malaysia, that most emphatically rejected the IMF’s advice. Regulatory capitalism suggests that the Washington Consensus finally collapsed under the realization that the economies of Asia were not exceptions to the neoliberal hegemony, but, in fact, half the world—and also the half that was performing best economically (Braithwaite 2008). As the 1990s progressed, the Washington consensus began to break down in the United Kingdom and the United States where “third-way” economists, like Joseph Stiglitz and other key intellectual figures in the United Kingdom, were influential in stemming the tide of market fundamentalism and reshaping the thinking of the Clinton administration and the Blair government in the United Kingdom around notions of good governance and the rule of law (Braithwaite 2008; Stiglitz 2002).

Further, regulatory capitalism also argues that neoliberalism failed to alter the shape of Western liberal democracies. Essentially, the neoliberal programme does not accurately represent policy transformations that occurred within advanced capitalist states. Although major policy changes were initiated under neoliberal enthusiasm for markets, smaller government, and privatization; today, any ideological and policy consensus on such a package is all but dissipated. Here, David Levi-Faur and Jacint Jordana argue that regulatory capitalism’s critique of neoliberalism sits comfortably with the revisionist literature in other fields of political science (2005a, 2005b). Within this literature, some political scientists express serious doubts about the influence of neoliberalism on the modern state, claiming that neither globalization nor neoliberalism has significantly undermined the welfare state (Jordana and Levi-Faur 2005, 2004; Levi-Faur 2005; Levi-Faur and Jordana

2005a, 2005b). Across Europe and North America, governments in developed economies continue to spend money on welfare state initiatives. Further, they also maintain a generally stable tax distribution base and persist with efforts to maximize their levels of trade in foreign economic relations (Castles 2004; Swank and Steinmo 2002; Guillén 2001; Weiss 1998).

The failure of neoliberalism to describe the course of economic development in Asia, North America, and Europe admits a conception of markets driven by the practical devices of rule making and rule enforcement as a more useful means for describing recent institutional history (Braithwaite 2008). From the neoliberal perspective, markets are the antithesis of regulation. But for regulatory capitalism, markets are regulatory instruments. Where neoliberalism stresses the virtues of private enterprise, free markets, regulatory capitalism emphasizes hybridity, “the privatisation of the public and publicisation of the private” (Braithwaite 2005, 7–8). Thus, regulatory capitalism is not merely the flip-side of neoliberalism. The instruments of rule making and enforcement can be applied to both constrain and encourage the spread of neoliberal ideals (Levi-Faur 2005).

Regulatory capitalism also involves a sophisticated historical thesis, under which the late-twentieth century development of global megacorporations has engendered corporate, public, and government demands for regulation. Contrary to the neoliberal myth of smaller government and freer markets, the hypothesis argues that the new demand for regulation has enlarged the state and seen it retain several of its old provider functions and also acquire many new regulatory functions. Thus, regulatory capitalism is also about the economic, political, and social evolution of capitalism into its present form. Along this course of development, the thesis suggests that capitalism has passed through four main phases: from an eighteenth-century police economy to the laissez-faire economy of the nineteenth century, and from the state provider economy of the mid twentieth century to the current era of regulatory capitalism.

The development of capitalism from a police economy of the eighteenth century to the nineteenth century laissez-faire economy involved a shift of regulatory responsibilities for commerce and wealth creation from local police constables to specialist government offices (Braithwaite 2008, 2005). In the early modern era, the function of police constables differed from their current role of crime prevention. From the sixteenth to the eighteenth century, constables were charged with responsibilities for regulating trade and commerce, specifically: security, labour, vagrancy, the poor, weights and measures, consumer protection, road and traffic regulation, liquor licensing, building, health, and fire safety. However, the rise of a more laissez-faire economic environment characterized by independent factories, the middle class, and an itinerant labouring class, displaced the commercial role of police constables. After 1832, paramilitary police forces were made responsible for crime prevention in the major cities and responsibility for business regulation fell to the state: specifically, to specialist regulatory offices such as

“factories inspectorates, mines inspectorates, liquor licensing boards, weights and measures inspectorates, health and sanitation and food inspectorates” (Braithwaite 2008, 13). Underresourced, lacking sophisticated regulatory techniques, and with their ambit limited to the major population centres, many of these offices were vulnerable to corruption or capture. Under the laissez-faire economy, governments were still learning to regulate. Although their offices enjoyed some success regulating commerce within concentrated areas, like large factories and mines, most nineteenth-century commerce existed as disparate small businesses, which diluted the regulatory capabilities of these new offices (*ibid.*). Thus, the laissez-faire economy of the nineteenth century was unregulable.

Following the economic crisis of the early part of the twentieth century, the unregulable economy gave way to the state provider economy, under which government assumed responsibility for the provision of a wide range of services previously left to private companies. Supported by the requirement for total war and also given impetus by the spread of socialist ideology, the first half of the twentieth century saw the nationalization of a wide array of services: public transport, electricity, water, gas, fire fighting, sewerage, and industries like steel, coal, and nuclear power (*ibid.*). In the United States, however, the weaker influence of socialism and trade unions saw a narrower scope for nationalization. With American business culture moderating the growth of the provider state economy, the institutional features of the regulatory state grew much more rapidly in the United States than in Europe (*ibid.*).

The current era of regulatory capitalism has its origins in the development of American business culture. In the late nineteenth century, American concern over restrictive business practices related to the concentration of corporate power in business cartels, or trusts, witnessed the passing of anti-trust laws in several states. While the antitrust laws successfully outlawed cartels, they had the side effect of encouraging the development of major corporations. With cartels outlawed, businesses discovered new efficiency savings in corporatization or the simultaneous acquisition of production facilities and means for marketing and distribution (Braithwaite 2008; Hannah 1991; Chandler 1977). Ultimately, this American model of megacorporate capitalism was globalized across Europe, Asia, and the developing world in the aftermath of World War II (Braithwaite 2008).

Corporatization produces a threefold demand for regulation that enables the development of regulatory states and the era of regulatory capitalism. The development of regulatory capitalism is a case of reciprocal causation, under which corporations actively lobby government for regulations that small businesses find impossible to satisfy (Braithwaite 2008; Braithwaite and Drahos 2000). Given the efficiency savings in tax collection and the significantly increased revenues that follow from dealing with large organizations, governments readily cede to corporate demands for increased regulation. Thus, under regulatory capitalism, the locus of analysis is both inside and

outside the state. Large corporations regulate medium-sized states. Many states simply forfeit entire regulatory domains to corporations with “superior technical capability” and “greater numbers of technically competent people” (Braithwaite 2008, 25). Moreover, the size of megacorporations also creates a public demand for regulation. Oil spills, reactor leaks, and unsafe products, for example, all have the potential to harm and kill thousands and thus consolidate public concern. Contrary to the neoliberal chronology, regulatory states create megacorporations, but large corporations also enable regulatory states. With the swelling tide of tax revenue, regulatory states grow larger and acquire many new additional functions (*ibid.*)

The project of regulatory capitalism is to track fundamental changes in the governance structures of late capitalist economies, under which regulatory solutions, conceived as combinations of regulatory techniques and mechanisms, shaped in North America and Europe have been projected internationally. Regulatory capitalism is about the spread, or contagious diffusion, of regulatory demands and techniques across global networks of policy experts and international knowledge actors and the subsequent impact on national and sector-based policy contexts. Its notion of contagious diffusion is analogous to the Weberian distinction between social action and structural action. Some people, says Weber, open their umbrellas because it is raining; others open theirs, either partly or mainly, to follow suit (Levi-Faur 2005). The former react to a structural condition, the rain. The latter react to what other people are doing, the condition, hence “contagious diffusion” (*ibid.*, 22). In terms of the new regulatory order, the diffusion perspective suggests that regulatory solutions to the problems of developed world economies were postulated in advanced countries and subsequently diffused around the world. Specifically, advanced capitalist economies experiencing internal difficulties manufactured regulatory solutions that not only altered their own internal governance structures, but that also changed the way they saw the rest of the world (*ibid.*). Subsequently, they projected their own order globally as a “universal rationality” (Meyer et al. 1997, cited in Levi-Faur 2005). Here, the wider project of regulatory capitalism shares much in common with that of third-way economists like Hall and Soskice, Stiglitz, Sachs, and Rodrik, who are interested in identifying the institutional combinations that “make capitalism buzz and collapse in the context of specific states” (Braithwaite 2005, 36).

Given that its concept of contagious diffusion is coterminous with notions of policy transfer, policy learning, network governance, knowledge actors, actor constellations, and lesson drawing, all of which broadly suggest that administrative, institutional, and ideological knowledge shaped in one setting can be transferred to other political settings, regulatory capitalism is relevant to these important questions within the policy literature (Dolowitz and Marsh 2000; Rose 1991; Sabatier and Jenkins-Smith 1988). Essentially, its diffusion perspective accommodates diversity and variety (Jordana and Levi-Faur 2005). New regulatory instruments do not eradicate earlier state

structures and competing modes of governance. Rather, these structures are augmented with “new techniques of political, social, and economic control” through networks of experts and policy actors (Levi-Faur 2005, 15). Under a diffusion perspective, new regulatory mechanisms can be added to the already “crowded and complex administrative structures of modern capitalist nation-states” (*ibid.*). In short, regulatory capitalism accommodates variety because regulatory innovations, mechanisms, and practices can be diffused to various degrees. Moreover, the diffusion perspective also complements regulatory capitalism’s wider research programme, namely, to track and study both the degree and extent to which its core regulatory mechanisms have been diffused across different policy sectors and national contexts, and to observe the often contradictory and unintended results (*ibid.*).

THE DIVISION OF LABOUR BETWEEN STATE AND SOCIETY

The shift from bureaucratic governance structures to those of the regulatory state involves a new division of labour between state and society that reflects the classic metaphor of steering not rowing (Osborne and Gaebler 1992). Under the regulatory state, government adopts the role of guiding, thinking, and directing. It leaves the business of service provision to market and society. Thus, the regulatory state is defined by a shift of emphasis from the old bureaucratic model of taxing and spending towards rule making, ruling at a distance, and allowing other organizations to provide services (Levi-Faur and Gilad 2004; Braithwaite 2000). While this division of labour between a steering DH and rowing organizations, like ISTCs and FTs, is evident in Labour’s reform NHS provision, its reregulation of NHS fails to make such a division. As a result, NHS commissioning takes place within a hierarchical structure of bureaucratic relationships.¹

Structurally, the NHS is divided between commissioner and provider organizations. In many ways, the division is a consequence of the earlier Conservative government’s introduction of the internal market. Before 1991, the NHS was structured on a bureaucratic model. Both NHS hospitals and community health services operated under the auspices of District Health Authorities, which received an annual budget from consolidated revenue allocated on needs basis principles. The District Health Authorities defined the needs of residents, then planned services and allocated funds accordingly. Hospitals and community services received lump sums negotiated in advance with the Health Authority and the NHS Regional Office (Pollock 2005).

In the early 1990s, the Conservative government reorganized the NHS on the basis of an internal market between purchaser and provider organizations. Hospitals and community services were established as provider-side organizations, or Trusts, required to break even by selling their services to purchaser organizations. NHS purchasers consisted primarily of general practitioner clinics (GPs) that received budgets from the Department of

Health. These were known as fund-holding GPs. GP fundholders negotiated and purchased elective services from Trusts, and settled prices and volumes of service in annual contracts (*ibid.*). The Conservatives argued that contracting and the internal market allowed the money to follow the patient. More substantially, the policy represented a decisive break with the old bureaucratic structure of the NHS. After 1991, the old model of direct planning and provision of services had been displaced by legally binding contracts between purchasing and providing organizations.

But there were problems. Under the market and the contract, transaction costs were high and the financing and contracting departments of all NHS organizations swelled. Smaller purchasing agencies suffered from both an inability to absorb transaction costs and a lack of capacity to manage their operations in a more complex market environment. While larger GP practices thrived, both the smaller GP fund holders and the practices that opted out of fund holding all together found themselves unable to purchase necessary services for their local areas. In general, fund holding and the internal market produced unacceptable variations in the standard of service, or in common parlance, a “post-code lottery,” under which the quality of service depended largely on the post-code in which residents lived.

The problem for the regulatory state is that it cannot reconcile Labour’s subsequent abolition of the internal market with the displacement of both public ownership and the direct provision of commissioning services. Under Labour’s reform of NHS commissioning, there is no division of labour. Commissioning takes place within a structure of bureaucratic relationships. While this structure differs fundamentally to the more bureaucratic pre-1991 structure, it does not represent a distinction between steering and rowing organizations. Although services are commissioned and money is spent at the local level, budgets and priorities are decided at national departmental level, and the performance of local commissioning bodies is managed at the regions.

In 1997, Labour introduced a new distinction between provider and commissioning organizations. It abolished the internal market and made the Health Authorities responsible for commissioning services from providers on the basis of a simplified contracting process. Labour replaced fund-holding GPs with Primary Care Groups (PCGs), which consisted of local GPs, community nurses, social services officers, and lay members. The new PCGs functioned as a committee of the Health Authorities and provided advice on the commissioning of NHS services in local areas. In 1999, Labour invited PCGs to apply for elevation to Trust status. The new Primary Care Trusts (PCTs) had the same overall functions as PCGs but existed as freestanding statutory bodies, possessed of their own budgets, premises, and staff, and tasked with directly commissioning health services in their local areas (Department of Health (DH) 1999). Consistent with the new role for PCTs, Labour replaced Health Authorities with ten Strategic Health Authorities (SHAs), which it tasked with performance managing all PCTs commission-

ing in their regional area. By 2004, some 100 PCTs were spending almost 80 percent of the NHS budget. However, PCTs were not autonomous. They remained accountable to both the new SHAs and to the DH. They were required to settle annual accountability agreements with the SHA that outlined aims and targets for improving health in each locality and to agree on arrangements for the transfer and lodging of resources (DH 2008a; DH 1999). PCTs also received instructions from the DH through the introduction of National Service Frameworks, which set out the annual financial rules, the management principles, the revenue and capital allocations, and the national health priorities and targets to which SHAs hold them accountable (DH 2008a).

Labour's reform of NHS commissioning also involves the introduction of Practice Based Commissioning (PBC). PBC transfers responsibilities for the commissioning of local health services from PCTs to primary care clinicians (DH 2005a). Like the Conservative policy for fund-holding, PBC attempts to align clinical and financial responsibilities, to encourage GPs to think more about referral patterns and to understand the cost implications (DH 2004). However, the policy does not represent a division of labour between policy-making and fully autonomous rowing organizations. Critically, this transferal of commissioning authority does not include a transferral of financial resources (*ibid.*).

GP commissioners are not autonomous. They hold only an indicative budget. The actual budget remains in the hands of the local PCT. Under PBC, Commissioning GPs receive management and administrative support from PCTs, which settle contracts and service-level agreements with secondary care providers on their behalf. Further, PCTs also monitor and performance manage GP referral activity (*ibid.*). Thus, PBC involves close cooperation between GPs and NHS commissioning organizations. Under the policy, the government requires GP practices and PCTs to develop shared agreements to clarify the obligations for each party (DH 2005a). While the nature of these is for local partnerships to decide, the government expects that they should detail how the delegation of the budget to the practice will deliver all national and local planning framework targets (*ibid.*). Moreover, the government also expects that PCTs will regularly and proactively monitor referral activity against the actual budget. Where referral activity exceeds the indicative budget, PCTs are required to meet the excess expenditures, with commissioning GPs expected to balance that budget over a three-year cycle (DH 2004). Thus, under PBC, commissioning takes place within a hierarchal structure of bureaucratic relationships.

THE DIVISION OF STATE

Labour's transformation of NHS commissioning does not represent a division between steering and rowing organizations. Today, NHS commissioning

takes place within a structure of roles and relationships between four key bodies: GPs, PCTs, SHAs, and the DH. Within this structure, neither GPs nor PCTs are fully autonomous commissioners of health services. While PCTs are responsible for spending almost 80 percent of the NHS budget, they are not only required to performance manage commissioning GPs within their area; their own performance is managed by the local SHA, which reports directly to the DH (DH 2009a).

The division of state refers to a separation of policymaking and regulatory functions, whereby government retains the role of thinking and guiding, and transfers responsibility for regulation to independent organizations (Levi-Faur and Gilad 2004). In the regulatory governance literature, the division of state is a consequence of the division of labour between steering and rowing organizations. A division of labour engenders the establishment of new agencies, like Monitor and the Care Quality Commission, that evaluate and regulate the performance of rowing organizations via technocratic means of control. Typically, regulatory states divide authority for policymaking and regulation because the old bureaucratic machinery that consolidated these functions under ministerial control becomes irrelevant where the risks of service provision are shared (Braithwaite 2000). Reciprocally, where labour is not divided, where steering and fully autonomous rowing organizations do not share the risks of provision, the bureaucratic machinery of the old Keynesian state remains relevant, and governments lack a rationale for transferring regulatory functions to independent bodies. Thus, the absence of a division of state within Labour's reform of NHS commissioning is a consequence of its reluctance to divide commissioning labour between steering and rowing organizations, or, in other words, to create fully autonomous commissioning organizations on the model of FTs and ISTCS. Put simply, where commissioning activity is consolidated within government agencies, there is no rationale for the creation of an independent agency to regulate commissioning via technocratic means. Instead, the government regulates NHS commissioning through a practice of System Management, or, in other words, in the careful detailing of the individual roles and responsibilities of each agency within the bureaucratic structure.

SYSTEM MANAGEMENT

System Management consists of a "rigorous approach" to clarify "roles, functions, competencies, expected behaviours" between both commissioning organizations and their providers (DH 2007a, 3). According to government, System Management is an integral component of the wider programme of reform, a consequence of the shift from the system of tight controls over provision towards one involving greater autonomy and a purchaser-provider split (DH 2007a). Government guidance advises that the diverse roles and increased autonomy of NHS organizations require a coherent structure to

prevent perverse incentives, the duplication of tasks, and inconsistent decision making (*ibid.*). System Management is about providing this structure. Essentially, it is about harmonizing interactions between semiautonomous agencies and balancing national and local priorities (DH 2006a).

The government conducts System Management through several key mechanisms. It publishes Service Frameworks that set out the roles, responsibilities, and relationships between commissioning organizations. It has developed an NHS Constitution that establishes the values and principles within which all organizations must work. It has also introduced a Cooperation and Competition Panel to provide advice on the settlement of disputes between organizations. And, most importantly, it has introduced a legally enforceable Standard Contract for Acute Hospital Services that restricts and outlines the activity of all NHS organizations.

The NHS Operating Framework sets out an annual agenda for NHS organizations. More generally, the framework consists of service priorities, expectations about the delivery of key national policies like PBC and Patient Choice, and rules for Payment by Results (DH 2006b). In addition, it also sets out roles and levers for system management and regulation (*ibid.*). In terms of the Operating Framework, System Management is about describing the governance and accountability relationships between key commissioning organizations, namely SHAs and PCTs, and GPs. Here, the framework recognizes the potential for conflict between these semiautonomous bodies and aims to harmonize their interactions by setting the parameters within which they must work (DH 2005b). For example, the Framework recognizes that, with GP commissioners having more influence over the delivery of services, there is a potential for conflict with PCT commissioners. Accordingly, it advises that PCT commissioning and PBC are “not alternatives” (*ibid.*, 26). PCTs “bring a wider view of the overall needs of people living in their communities.” They “work with practices” to commission local services that “fit with wider service plans” (*ibid.*, 26). Thus, PCT commissioning and PBC are “essential components of an effective commissioning process” (*ibid.*, 26).

Equally, the Operating Framework recognizes the potential for conflict between the DH and SHAs over the performance management of GPs, Trusts, and PCTs. SHAs, it advises, are responsible for managing performance and resolving disputes between these organizations (DH 2006a). The DH, however, remains ultimately accountable for the effective use of taxpayers’ money (DH 2006a; 2005b). Generally, the DH must work with the SHAs to ensure “a clarity of roles and a lack of duplication,” but where the performance of an individual locality or region “differs significantly from the agreed plan on any of the key national deliverables,” the Framework advises that the DH pursue “a more intensive performance regime between SHAs” (DH 2006b, 22–23).

With its Framework for Managing Choice, Cooperation and Competition, the government further outlines that “good service management” or “clarity

about the responsibilities, roles, rules and redress” is not only an important element of the wider NHS reform programme, but critical to managing “choice, cooperation and competition” within the system (DH 2008b, 3–5). The Competition Framework explicitly details the roles and functions of each organization. PCTs deliver national policy and regional strategy. They are responsible for holding providers to account via contracts and by making referrals to regulators (*ibid.*). SHAs translate national policy into regional strategy. They are responsible for holding PCTs and Trusts to account through intervention in exceptional cases. The role of the DH is to set policy and rules, to create institutional mechanisms and levers. The DH also holds SHAs to account for managing choice and competition. Ultimately, the Competition Framework emphasizes that all organizations remain under the “direct control” of the Secretary of State for Health, that responsibilities outlined are “not exhaustive,” and that even “broader roles and responsibilities” would be outlined in the forthcoming NHS Constitution (*ibid.*, 7).

In 2009, the government also established a Cooperation and Competition Panel to complement the practice of system management. Supplementary to the rules-based approach set out in the Service Frameworks, the purpose of the Panel was to “get the balance right in different services and in different geographies” (DH 2009a, 1). It would offer support and advice on effective governance and oversight (*ibid.*, 2009b). The Panel would promote transparency and trust across the system. It would also advise SHAs and the DH about the compliance of individual organizations with the overarching rules in specific cases (DH 2008b). Although independent, the Panel did not function as a court of appeal. Its role remained strictly advisory and SHAs retained responsibility for holding PCTs and NHS trusts to account.

THE STANDARD CONTRACT

In 2006, the DH began developing a new commissioning framework controlled by a Standard Contract for Acute Services (DH 2008a). Introduced in 2008, the Standard Contract created legally binding agreements between PCTs and providers and thus offered an important tool for assuring accountability across all commissioning organizations. Under the regulatory state hypothesis, the Standard Contract is the key mechanism within the wider process of system management. The Standard Contract replaced an existing range of contracts and service-level agreements, which, the government argued, were not fit for purpose in the context of greater plurality of provision and more autonomous providers (*ibid.*). While the Standard Contract retained the basic function of settling agreements about the volume and flow of acute hospital activity, it differs from earlier agreements in so far as it was a *standard* rather than a *model* contract.

The Standard Contract comprises both mandatory elements and elements subject to local negotiation and agreement (DH 2008c). The contract is a key

instrument of system management because it harmonizes the interests of disparate organizations in a legally enforceable way. Essentially, the mandatory and negotiable elements of the contract balance the national agenda against local priorities. As guidance advises, mandatory components are centrally set. They cannot be altered or removed, even by agreement of the contracting parties. Where they prevent the settlement of a workable local agreement, contracting PCTs are required to consult their SHA. Conversely, negotiable elements are subject to local definition, and where parties conclude local agreements, the basic structure of the contract prevents them from undermining the mandatory elements. Typically, local agreements cover issues of care pathways, treatment protocols, quality standards, and incentive schemes (*ibid.*)

Beyond this more basic function, the process of contracting, or concluding agreements under the Standard Contract, also establishes roles and responsibilities of individual organizations. SHAs are required to oversee the agreement of contracts between PCTs and providers. They are required to arbitrate disputes between PCTs and NHS Trusts (DH 2006b) They are responsible for giving permission for variations in contract duration and for ensuring consistency of local agreements across the SHA (DH 2007b). Equally, GPs do not engage in contracting. Instead, they advise PCTs of commissioning priorities and agree plans for service redesign, which PCTs use to provide shape to the contracts concluded on their behalf (DH 2008d).

Most importantly, the Standard Contract enables the government to control demand within the NHS. Under the new contract, parties must agree on an activity plan (DH 2008c). An activity plan sets planned activity levels, profiled across the year, and ensures that commissioners and providers do not become financially exposed. The activity plan also sets the wider financial parameters within which national standards and local priorities must be achieved (DH 2008a). Once agreed, all parties to the contract are obliged to work towards the activity plan. Within this set limit on hospital activity, they must deliver on national priorities like Patient Choice, 18 Weeks, and also on any locally agreed targets. Thus, the government requires PCTs and providers to monitor activity plans and contracts closely. If activity plans are being exceeded, there is a joint responsibility on the PCT and the provider to take action to ensure affordability. Essentially, the activity plan and the contract function to limit demand in a legally enforceable way. Indeed, the government maintains tight controls on any planned annual increase in activity. In 2007, for example, it estimated that the increase across the country as a whole should not exceed three percent (DH 2008c).

The point is that the wider practice of System Management and its mechanisms of Service Frameworks, the NHS Constitution, the Cooperation and Competition Panel, and the Standard Contract are necessary because NHS commissioning organizations consolidate responsibilities for policymaking and service provision within a single bureaucratic structure. There is no division of state in terms of NHS commissioning and no independent regu-

latory body to evaluate the performance of NHS commissioners via technocratic means. Their absence is a consequence of the government's reluctance to divide commissioning labour between steering and rowing organizations and, perhaps, its desire to control demand within the system. Moreover, the presence of public ownership and the absence of technocratic regulatory bodies to govern commissioning activity also challenge the ability of the regulatory state to account for Labour's reform of NHS commissioning, and thus the wider reform of the NHS.

THE CODIFICATION OF RELATIONSHIPS

Regulatory states codify or formalize relationships in order to subject the internal governance structures of regulated organizations to modern notions of transparency, accountability, and social responsibility (Levi-Faur 2005). The formalization of relationships can include the introduction of internal rules and codes of conduct; for example, environmental management systems, corporate reporting systems, and third-party certification schemes. Under the regulatory state, codifying relationships is also about breaking down the oligarchic, informal, and secretive workings of bureaucratic and professional elites that characterized the operation of the old welfare state. Regulatory states replace these elite structures with new mechanisms for surveillance, public scrutiny, and democratic accountability (Moran 2003, 2001; Power 2003). In terms of NHS provision, the Labour reform programme had codified clinical and bureaucratic relationships with policies like 18 Weeks and Payment by Results (Wright 2009). These policies, it argued, delivered increased transparency and accountability both to NHS organizations and to clinical decision making by ensuring that patients received treatment within an appropriate period of time and at standardized costs. In the following section, I briefly discuss a further policy mechanism designed to bring the same transparency and accountability to commissioning relationships, namely, Patient Choice.

Patient Choice is a means for providing patients with increased say in when and where they are referred for treatment. Introduced in 2003, Patient Choice originally offered any patient referred for acute hospital care the ability to choose from a list of four providers in his or her local area. By 2008, however, the policy had been expanded to the point that patients were able to book GP appointments, outpatient, and elective treatment with any provider that met NHS eligibility criteria (DH 2008e). Labour introduced Patient Choice as a means for empowering individuals to drive service improvements within the system. But, by giving patients greater control over the services they received, Labour had also significantly altered the relationship between patients and commissioners, and between patients and clinicians. After Patient Choice, commissioners were required to design and commission care pathways around the preferences of patients, not the needs of professionals and organi-

sations. Moreover, Patient Choice also shifted the patient clinician relationship away from a professional client-based approach towards a partnership approach. Thus, Patient Choice is an attempt to break down the oligarchic structures of clinical and organizational elites, to codify and formalize a previously informal professional and bureaucratic culture.

A PATIENT LED NHS

For Labour, Patient Choice was about delivering a cultural change broadly compatible with notions of breaking down elite structures. Citing public demands for a more personalized NHS, Labour's early policy documents on Patient Choice argued that the uniform health service created in the middle of the twentieth century needed to adapt to a more diverse modern environment, one in which individual ideas and expectations of quality and personal service had changed and grown (DH 2003a). Under the old bureaucratic structure, the NHS had often subordinated the needs of individuals to the needs of the service. It had delivered a "one size fits all" approach that was "neither responsive, equitable or person-centred" (*ibid.*, 17). Within this structure, clinical and bureaucratic elites worked along "professional and organisational boundaries" to create "barriers and blockages" (DH 2005c, 7). Given the rise in modern living standards and greater public expectations of the service, Labour argued that the NHS needed to change. Specifically, it needed to meet the demands of a "new generation" of patients for "more control and flexibility" over the manner in which those patients were treated (DH 2003a, 12). Patient Choice was a means for delivering this "fundamental cultural change" (*ibid.*).

Labour claimed that almost 90 percent of respondents to its public consultations had sought more information to make decisions and choices about their treatment (DH 2003a). Accordingly, Labour introduced Patient Choice as a means of passing power and information outwards and downwards, of redressing perceived power imbalances between patients and health professionals (*ibid.*) Patient Choice provides patients with more information, and thus more control and flexibility over the care they receive, through three mechanisms: HealthSpace, Choose and Book, and NHS Choices. These mechanisms are aimed at altering the dynamic of health care delivery and at codifying the patient clinician relationship on the basis of a partnership approach, by providing greater access to information (DH 2008f).

Introduced in 2003, HealthSpace is part of an online suite of patient services that helps users make decisions about their treatment (*ibid.*). HealthSpace provides patients with access to high quality clinical and organizational information, including their individual medical records, in order to "improve communications between clinicians and patients" (*ibid.*). Through HealthSpace, patients can receive information about their appointments and

discuss their medication and ongoing treatment in a secure online environment (*ibid.*). Patients can also view and store test results and send self-monitored information to clinicians.

Similarly, Choose and Book is a national electronic booking system that “gives patients greater involvement in the decisions about their treatment” (DH 2008a, 89). Choose and Book enables patients to select the time, date, and place for hospital treatment and GP appointments. In 2007, the DH introduced an Extended Choice Network to the facility. Through the network, patients can select from a national list of providers that includes NHS Foundation Trusts, NHS Trusts, and Independent Sector Treatment Centres (DH 2007c). Significantly, Choose and Book also requires commissioners to alter the way in which they purchase services (DH 2005c). Where the older practice of settling block and fixed-cost contracts with local providers gave commissioners few incentives to understand and respond to the needs and preferences of patients, mechanisms like Choose and Book, together with Payment by Results, enable individual transactions to attract a payment (DH 2005b). Thus, commissioners must develop new skills to understand the needs and preferences of patients in planning their activity.

NHS Choices is an online information service that assists patients in making choices about both their health and health care needs. Essentially, it provides patients with up-to-date clinical and organizational data. Launched in 2007, NHS Choices provides users with a library of quality-assured clinical information on healthy living, smoking, drinking, and exercise, much of which was previously only available to clinicians (DH 2008f). It includes self-assessment tools and information to help the healthy to stay fit and those who are unwell to manage their conditions (*ibid.*). NHS Choices also offers information on organizations. It provides hospital waiting times, service quality reports, infection rates, and readmission rates for common treatments. It also includes a free review facility for people to feedback on their experiences as an NHS patient. HealthSpace, Choose and Book, and NHS Choices are not only means for devolving information to patients; they are also about bringing transparency and accountability to relationships between patients, clinicians, and commissioners. In other words, they are mechanisms that attempt to break down the oligarchic and secretive operations of Keynesian-style elites and to replace them with formalized relationships more suitable to public expectations for a personalized and responsive health service.

METAREGULATION

Under the regulatory state, organizations are metaregulated when they are required to conform not only with external pressure from regulators but also pressure exerted from within their own governance structures. Metaregulation involves the development of new techniques for enforced self-regulation and their incorporation within the governance arrangements of regulated

bodies (Levi-Faur and Gilad 2004). These new actors or bodies function as gatekeepers and whistleblowers or, in other words, as employees positioned within regulated organizations able to counter misconduct by withholding cooperation. Metaregulation bears some resemblance to Foucault's later work on governmentality, but there are some important differences (Wright 2009). Governmentality is a conceptual tool, a product of Foucault's wider genealogical project. It is about the internalization within individuals of the modes of control first discovered in the eighteenth century (Foucault 1991). Governmentality is concerned with power, legitimacy, and the structuring of being and identity. Metaregulation, by contrast, is a regulatory technique that addresses the failure of the old Keynesian state to grapple with the development of more complex global economies. Metaregulation involves the notions of communities of fate and knowledge gathering for the purpose of obtaining market prices that more accurately reflect local preferences (Braithwaite 2000).

The UK Labour government has been interested in involving partner organizations in the wider structure of commissioning for some time. For example, section 11 of the Health and Social Care Act 2001 places a duty on NHS Trusts and PCTs to make arrangements to involve and consult patients and the public in the planning and development of health services and in how the services operate. In 2003, however, Labour explicitly altered the governance structure of commissioning agencies by establishing patient forums in all NHS Trusts and PCTs. Labour's policy of World Class Commissioning introduces several metaregulatory techniques for enforced self-regulation within the new commissioning structure. These are patient forums, LINKs, and OSCs, but these have been introduced on the basis of acquiring knowledge for making service improvements not otherwise possible under the old Keynesian structure.

Patient Public Involvement Forums (PPIF) were an early attempt to empower locals, acquire knowledge, and drive service improvements. The forums are comprised of lay members, including patients and representatives from community and voluntary organizations. They were independently funded and managed but hosted within individual NHS organizations. PPIFs were installed to monitor and review NHS service delivery, to seek public views about services, and to make recommendations (DH 2003b). Moreover, under the NHS Reform and Health Care Professions Act 2002, PPIFs were given power to refer issues to OSCs (DH 2003c). Speaking on Patient Involvement in 2001, Alan Milburn, Secretary of State for Health, announced that the purpose of installing participatory mechanisms within the NHS was to give local communities "a greater say over the local health service" and "to make services more responsive to patients" (Milburn 2001). More generally, it was about breaking down "the monolithic structures of the NHS." It reflected the contention that "a modern health service cannot be run like an old style centralized bureaucracy but should instead devolve power and resources to frontline services" (ibid.).

PPIFs failed to live up to government expectations, however. Following a review of patient and public involvement in 2005–2006, the government found a lack of meaningful engagement in the planning and commissioning of services (DH 2006c). The views of local people were not being acted upon and had had little impact on decisions. In 2006, the government announced its intention to restructure the governance arrangements of commissioning organizations by abolishing PPIFs and replacing them with LINKs and the policy for World Class Commissioning.

LINKS

For Labour, commissioning is the primary vehicle for delivering an improved range of “modern, high quality, equitable” services (DH 2009a, 17). World Class Commissioning is a “statement of intent” about the way these services are commissioned (DH 2008a, 85). World Class Commissioners make better informed choices “about local priorities and how to deliver them” (DH 2008a, 85). Central to the policy is the installation of LINKs within the governance structure of NHS commissioning organizations.

A LINK is a network of local people that aids NHS commissioners in shaping services and making them more responsive to local communities. LINKs consist of user groups, local voluntary, and community sector organizations, or even of interested individuals (DH 2006c). LINKs have a dual role: they have formal responsibilities to monitor and advise commissioners; they also have representative functions. Ideally, a LINKs should represent everyone in the community (DH 2007b). Moreover, LINKs differ from PPIFs. They are independent from PCTs and Trusts and are strategically positioned within geographical areas. Unlike NHS providers or other agencies, LINKs are hosted by local community or voluntary organizations, which receive funding from the central government and provide the LINK with administrative support (DH 2006c). In time, the government hopes to establish a LINK in every local authority area.

Thus, NHS Commissioning organizations, GPs, and PCTs, are not only subject to System Management; they are also subject to informal checking and monitoring through OSCs and LINKs. The government describes LINKs as being “at the heart of the new arrangements to strengthen the voice of local people” (*ibid.*, 14). LINKs are designed to make commissioners and providers more accountable to the public (DH 2006c). They are positioned within the commissioning structure as gatekeepers and whistleblowers; their function is to help “commissioners make informed decisions about what people in the area need, and assist them in their role as contract managers” (*ibid.*, 15) In practice, LINKs gather information about the needs, experiences, and preferences of local people regarding health and social care services (*ibid.*). They pass this information on to both commis-

sioners and providers. Essentially, they go into some types of services to see what those services do, they make reports and offer recommendations, and they are entitled to receive a reply within a set amount of time (DH 2007b). In addition, the information they gather aids OSCs in carrying out their functions (DH 2006c).

OSCs

LINKs are also required to develop formal relationships with OSCs (*ibid.*). In 2003, Local Authorities were given power to scrutinize local health services through OSCs. Under section 7 of the Health and Social Care Act 2001, which also amended section 21 of the Local Government Act 2000, local authorities with social services responsibilities must establish OSCs for the purpose of monitoring the planning, provision, and operation of health services (DH 2003c). OSC members are local councillors. Thus, OSCs also have representative functions. They allow democratically elected community representatives to scrutinize the provision and development of local services. They also allow community representatives to voice the views of their constituents and require local NHS bodies to listen and respond (*ibid.*). Specifically, the government has instructed OSCs “to focus their attention on the work of commissioners” (DH 2006b, 7). OSC are required to confirm that they are commissioning services requisite to the needs of local populations and that also reflect public priorities in the communities (*ibid.*).

LINKs and OSCs are not a part of the bureaucratic structure of NHS commissioning. Although OSCs have formal legitimacy as democratically elected councillors; they do not have formal regulatory powers over NHS commissioners. OSCs do not performance manage commissioners (DH 2003c). They have neither the power to require commissioning clinicians to attend a committee for the purpose of answering questions, nor to act as officers of a PCT or NHS body (*ibid.*). LINKs and OSCs do not make decisions. They cannot compel other bodies to act upon their suggestions. Rather, they function to ensure an open and transparent public dialogue (*ibid.*). They can ask commissioners about whether the services are appropriate to the needs of local people. They can ask whether decisions are based on evidence. They can confirm whether “the experiences of patients and users of services are leading to improvements in the way services are delivered” (DH 2006c, 17–18). They can ask about how they have involved local people in their decisions and how they have decided on local priorities. At best, LINKs and OSCs can require commissioners to respond in writing. Herein, they are mechanisms for enforced self-regulation. Their reviews focus “on the decision-making activities of PCTs” (*ibid.*). They monitor how well commissioners have met the “requirements of the revised duties to involve, consult and respond” (*ibid.*).

CONCLUSION

The reregulation of NHS commissioning exhibits a hybridity of hierarchical and devolved regulatory arrangements. The programme maintains a hierarchical structure of bureaucratic relationships between NHS commissioning organizations. In other words, its reforms do not displace public ownership and the direct supply of commissioning services with markets and new institutions for rule making and standard setting. However, it does involve mechanisms for codifying relationships and breaking down professional and bureaucratic power structures. Further, it also employs metaregulatory techniques for enforced self-regulation. While the hybridity of arrangements across the wider reform of the NHS represents a challenge to the regulatory state hypothesis, it lends weight to the claim that the current era is one of regulatory capitalism. Under Labour's reforms, new regulatory instruments have not eradicated earlier structures and competing modes of governance. Rather, networks of policy experts and knowledge actors have augmented these structures with new techniques of political, social, and economic control. As in other policy sectors, these techniques have become part of an already crowded and complex administrative structure (Vincent-Jones 2006; Scott 2003, 2000). From a diffusion perspective, the reregulation of the NHS involves contradictory elements because regulatory instruments have been disseminated to different degrees in different policy sectors and across different national contexts.

This finding holds obvious consequences for the global health policy literature. Put simply, the policy literature is an important component of regulatory capitalism. Academics and policy experts are knowledge actors whose existence and authority is enabled by the rapid expansion in the reach and influence of global networks that have recently developed around specific policy sectors, issues, and specializations. Under regulatory capitalism, these networks and agents are integral to the diffusion of regulatory solutions. They comprise "world societies," linked both formally and informally by information, cooperation, and competition, that manufacture common understandings of challenges, problems, and solutions (Levi-Faur 2005; Slaughter 2004; Meyer et al. 1997; Haas 1992). These understandings shape both the agents' own internal, or national, order and also their international outlook. Moreover, experts and knowledge actors project these perceptions, understandings, and solutions outward as a universal rationality (Levi-Faur 2005; Meyer et al. 1997; Meyer and Rowan 1977).

Certainly, the global policy literature reflects these observations. Currently, a major concern of the health policy literature is the question of how competent learning from one nation to another can take place (Marmor, Freeman, and Okma 2005). In health care, international organizations are described "as platforms for debate and potential sources for comparative studies" for the purpose of bringing learning opportunities to other countries" (ibid., 331). Key knowledge actors not only report being bombarded

with cross-national studies and information (Klein 1997), but also with the “extraordinary imbalance between the magnitude and speed of the information flows and the capacity to learn useful lessons from them” (Marmor, Freeman, and Okma 2005, 331). The increasing flow of information is a recent phenomenon, one that is much more prominent at the turn of the twenty-first century than the mid-1970s or early 1980s (*ibid.*). It results in heightened levels of data production that solidify cooperative and competitive links between knowledge actors. In the health care sector, analysts and policymakers look increasingly across borders “to search for the latest policy fashion” (*ibid.*, 333). “No one wants to be caught wearing yesterday’s ideas” (Klein 1996, cited in Marmor, Freeman, and Okma 2005, 333). Policy transfer is both a horizontal and vertical process (Levi-Faur 2005). In other words, there is both diffusion and a rational appreciation of knowledge across these networks. There is “much mis-learning and misrepresentation by omission” (Marmor, Freeman, and Okma 2005, 344). While key knowledge actors might complain that existing research largely ignores the important differences between the process of learning about other countries’ experience, in terms of why change takes place and how learning can occur, they also admit that knowledge networks contain the basic ingredients for improved policy learning, namely, statistical databases, descriptive country studies, reported experiences of knowledge actors, and global institutions (*ibid.*).

Here, regulatory capitalism suggests that global policy literatures need to develop a sense of self-awareness. For example, key knowledge actors suspect that there is little time or willingness within policy networks and processes for critical assessments of cross-border experiences (*ibid.*). Under regulatory capitalism, however, it is neither surprising that knowledge actors would privilege rational policy learning over policy diffusion nor is it surprising that, given the constraints of policy contexts and processes, a great deal of policy diffusion yet takes place. Here, regulatory capitalism offers the literature a chance to make a useful differentiation between its preferences and some of its more substantive and largely erroneous claims.

For example, elements of the literature suggest that policy debates are largely “parochial affairs” that take place within national borders and address problems and developments relevant to specific national contexts (*ibid.*, 334). However, regulatory capitalism suggests that such claims underestimate the extent to which a great many policy sectors have become globalized. Applied to the specific case of Labour’s reregulation of the NHS, these claims discount the significant extent to which Labour’s reforms converge on the themes of the regulatory state. At the structural level, the rub is that the question of whether health care reform is, or is not, transferable from one context to another is not a very important one. Today, policy change is becoming less and less a discreet and independent event across different national and sector-based policy contexts (Levi-Faur 2005). Thus, the health policy literature’s substantive claims to this effect should yield to more useful inquiries about the kind of learning that ought to take place from one

national context to another. In other words, whether diffused regulatory technologies successfully promote learning cultures, avert regulatory ritualism and blame cultures, whether they contribute to quality and productivity increases, and whether they affect a more balanced distribution of power and resources.

Finally, there are also some related implications for the regulatory governance literature. Although regulatory governance scholars correctly observe the limitations of the regulatory state hypothesis, the problem with their critique is that the regulatory state tells but part of the story. The hypothesis and the subsequent critique incorrectly locate the nation-state as the locus of change. Both parties understate the degree to which policy sectors have become globalized. By contrast, regulatory capitalism admits scope for diversities of arrangements. New regulatory techniques do not abolish alternative modes of governance; they become part of an already crowded and complex administrative structure. Under a diffusion perspective, national and sector-based policy contexts can exhibit hybridity and divergence because mechanisms have been mediated and disseminated to different degrees. Ironically, the well-rehearsed critiques of the regulatory state would seem to support the thesis for regulatory capitalism. Indeed, under the thesis, the interaction of experts and knowledge actors, findings of hybridity and divergence, are essential components of a structurally determined pattern.

NOTE

1. On the 12th of July 2010, the new UK Conservative Liberal Democrat Coalition Government announced a proposal for major changes to the structure of NHS Commissioning. The government proposed to abolish the existing ten SHAs and 152 PCTs, making GPs responsible for commissioning NHS services. The government also outlined that the new commissioning structure would be made accountable to a fully independent NHS board that would remain free from political interference. The government plans to implement the changes within the next three years (BBC News 2010). While the changes are considered radical; arguably, they would also more fully reflect the regulatory state hypothesis' notion of a new division of labour between state and society—between steering and rowing organizations, providing and facilitating, government and governance—already in operation among NHS provider organizations (Wright 2009).

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