Chapter 20

Public–Private Partnerships in Health Care

1. Simon Bishop, Nottingham University Business School, University of Nottingham.
Simon.bishop@nottingham.ac.uk and
2. Justin Waring, Nottingham University Business School, University of Nottingham
Justin.waring@nottingham.ac.uk

Introduction

Over the last two decades Since the mid-1990s, public–private partnerships (PPPs) have become a prominent feature of public service reform. Internationally, PPPs can now be found across many areas of public service renewal and development, from major transport or energy infrastructure projects to provision of local libraries and community services. One of the most significant and contentious areas in which PPPs have become commonplace is in the organisationization and delivery of healthcarehealth care. Health care systems across the world are increasingly turning to PPPs as a means of securing new investment and funding, expanding service capacity, fostering competition and choice, bringing about efficiencies and cost savings and for stimulating innovation and improvement. PPPs have come in many guises but generally involve public and private sector actors coming together to jointly engage in one or more of the activities that make up the delivery of healthcarehealth care services. This has included projects focused on infrastructure development with public–privatepublic–private agreements over the

Commented [CE1]: AQ:

financing, design, construction, and/or operation of new ~~healthcare~~health care facilities, as well as projects focused on cross-sector delivery of clinical services. As one prominent example, the ~~Private~~ private ~~Finance~~ finance i~~I~~nitiative (PFI), whereby the private sector is contracted to finance, construct and maintain ~~healthcare~~health care facilities, has been adopted around the world including in Mexico, Australia, Canada, and across Europe (Hodge, Greve, and Boardman ~~et al.~~, 2010). However, many other models of ~~healthcare~~health care PPP have now been developed including for the provision community health programmes such as in South Africa and Botswana (Marek et al., 2010) as well as for the delivery of hospital services such as in Spain, Portugal, Sweden, and the UK (Acerete, Stafford, and Stapleton ~~et al.~~, 2011).

Commented [CE2]: AQ: Should the year be 2005, to match the References?

This chapter provides an introduction to PPPs and outlines key tensions in the management of PPPs in ~~healthcare~~health care, given the influence of established sectoral and professional boundaries, cultures and identities. The chapter draws upon both international literature and findings from the authors' own case studies of two PPPs, both Independent Sector Treatment Centres (ISTCs) operating in the English National Health Service (NHS) (Waring, Currie, and Bishop ~~et al.~~, 2013). The chapter first outlines the policy history and drivers of PPPs, and outlines central concerns and debates at the general level. The chapter then considers PPPs within the context of ~~healthcare~~health care, highlighting particular challenges of governance, innovation, culture, and employment management. These sections include key areas of consideration for ~~healthcare~~health care managers, and public managers more broadly, engaged in the organ~~isation~~ization and delivery of services through PPPs.

Introduction to PPPs

Context of PPP Development

Over the past ~~twenty~~ 20 years, ~~Public Private~~public–private ~~Partnerships~~ partnerships (PPPs) have become part of the mainstream policy approach to addressing myriad challenges of public service finance, governance and delivery (Hodge, Greve, and Boardman ~~et al.~~, 2010; Grimsey and Lewis, 2007). Although PPPs are often thought of as a contemporary phenomenon, prior to the rise of centrally managed economies in the ~~20th~~ twentieth century, the boundaries between public and private were often blurred; economic, humanitarian, and military ventures have involved a mix of state power and private finance over many centuries (Wettenhall, 2005~~;~~, 2010). Contemporary PPPs are, however, most frequently examined as a product of the neo-liberal economic and political trends that rose to prominence in the early 1980s; an era which saw the power and legitimacy of the State to act monopolistically compressed (Davies, 2014). Correspondingly, this period saw an elevated belief in the private sector, via the renewed freedoms of the marketplace, to deliver economic prosperity as well as social value (Palley, 2004). In a number of the world's largest economies this resulted in both the privat~~isation~~ization of national assets and a move towards ~~New~~ new ~~Public~~ public ~~Management~~ management in the remaining public sector (Hood, 1991).

During the 1980s governmental and policy actors in the US~~A~~ began to proclaim efficacy for new forms of collaboration between the public and the private sector to deliver social goods, particularly in projects of urban renewal and for infrastructure development (Osborne, 2002; Yescombe, 2011). PPP began to be advocated at the international level by organ~~isation~~izations such as the World Bank, the International Monetary Fund and the Organisation for Economic Co-operation and Development~~ECD~~

to further the involvement of private capital in public services provision (Parker and Figueira, 2010). This was also supported by international trade agreements and regulatory reforms, which have increasingly opened up national public services to global private sector investment and competition (Price, Pollock, and Shaoul ~~et al.~~, 1999). A further key development came in the form of the p~~P~~rivate f~~F~~inance i~~I~~nitiative (PFI), first introduced in the UK in 1992 as a means of stimulating service development through private investment while controlling short-term public borrowing or tax increases. Early PFI schemes typically involved private financing, design and construction of new buildings and facilities, to be leased back to the public sector in long-term agreements of up to 30 years (Broadbent, Gill, and Laughlin ~~et al.~~, 2003). During the latter half of the 1990s and the early 2000s, these schemes became a central part of both the expansion and "modern~~isation~~ization" of public services, and used to fund transport, health, education, and prison developments (Edward and Shaoul, 2003). By 2009, contracts for 641 PFI projects had been signed in the UK, valued at some £273.8 (Hellowell, 2010).

Outside ~~of~~ the US and UK, other Anglo-Saxon countries including Canada Australia, and New Zealand also saw a rapid growth in the number of PPP projects over the 1990s and 2000s (Flinders, 2010), with long-term "PFI"-like contracts signed for infrastructure developments across a number of public service domains. For example, in Canada 30 PFI type projects were signed between 2000 and 2009, ranging in value from CAD$27 million for a water treatment plant to CAD$1.9 billion for a rapid transit line (Boardman and Vining, 2010). Over the same period, Australia has established 49 projects totalling AUS$32.2 in roads, airports, hospitals and schools as well as other areas (Hodge and Duffield, 2010). Although the UK has been the dominant adopter of PPPs in

Commented [CE3]: AQ: add 'to date'

Europe, (accounting for 57.7% of European projects by value in 2007 (European Investment Bank, 2007)), over the past 10 ten years there has been a general growth in the number of projects across the continent, with southern European and Scandinavian countries more heavily involved than countries in western and northern Europe (Hammerschmid and Ysa, 2010). PPPs have also now been widely adopted in developing and post-communist countries such as in Poland, often seen as an important source of investment and a key route to national development as well as public sector reform (Osborne, 2002).

Meanings of PPP

A number of rationales have underpinned the promotion and adoption of PPPs. These include the need for new sources of public investment, increasing utilisationization of scarce resources, improving efficiency through market mechanisms, importing private-sector knowledge to the public sector and sharing of public risk (Vining and Boardman, 2008). In defining PPPs, some have put forward a normative view of the "true-spirit" of partnership, including characteristics such as high-trust relationships between sectors, collaborative decision--making, joint management, and an equitable sharing of risk (Bovaird, 2006; Entwistle and Martin, 2005; Klijn and Teisman, 2005). Brinkerhoff and Brinkerhoff (2011) propose mutuality, shared responsibility, commitment to shared goals, a common organisationizational identity, and aligning of distinctive and valuable competences as essential elements for partnership working. Many commentators have seen PPPs as indicative of a new "hybrid" form of governance, sitting between purely market-based forms of control on one hand and fully integrated public bureaucracy on the other (Powell, 2005). This has led to suggestions that PPPs are one part of an ongoing

shift towards more “network” forms of public service governance, characterisedized by cross-boundary and multi-agency working and the potential for reciprocity and cooperation between actors of all sectors to provide public goods (Rhodes, 1997; Diamond and Liddle, 2005).

In practice, the language of PPP has been applied very widely, used to describe many varieties of mixed public–privatepublic–private collaboration “no matter how short term or insignificant” (Field and Peck, 2003,: 496) and regardless of whether “ideal” criteria for partnership have been met (Linder, 1999; Hodge and Greve, 2005). For example, the label of PPP has been applied to consortiums in which public and private sector organisationizations invest and work together on the regeneration of a geographic area (Kort and Klijn, 2011), but it has also been applied to contractual arrangements in which a private contractor provides services to predetermined financial and quality criteria (Hodge and Duffield, 2010). Further, the PPP label has also been applied to instances in which non-government organizations (NGOs) such as UNICEF are supported by private actors through philanthropic donations or resource sharing (Bull, 2010). The meaning of PPP is also confused by the fact that that different countries and industries have their own historical and institutional norms of collaboration between sectors (Hodge, Greve, and Boardman et al., 2010). In countries with relatively market-based welfare regimes, such as in the US, collaboration between public agencies and private business is relatively common; whereas more social democratic nations have traditional maintained a division between public and private sectors in the provision of welfare service (Esping-Anderson, 1990).

To clarify the understanding of PPPs, a number of typologies have been proposed which identify categories of PPP based on how roles, responsibilities and risks are shared between the public and private actors. Gidman~~,~~ (1995) suggests a range of relationships between the public and private sector, from passive private sector investment in the state, through various levels of joint venture and contracting arrangements, to governmental support for private sector growth. Hodge and Greve (2007) distinguish PPPs by the degree to which they involve either "tight" or "loose" forms of collaboration between the public and private partners. For example, "issue networks" involve relatively loose forms of collaboration amongst actors with significant common interests. "PFI" or "contract-based" PPPs on the other hand involve tight financial contracts but looser inter-organ~~isation~~ization~~al~~ operational relationships. Within this latter category, the nature of contractual relationships is further commonly distinguished by which activities are taken on by the private sector, with projects identified by an array of terms such as "Finance, Build Operate" (FBO), or "Build, Operate, Own, Transfer" (BOOT). Waring, Currie, and Bishop ~~et al~~ (2013) develop the tight/loose distinction by identifying three linked dimensions in which PPP activities been seen to vary. The first relates to the relative level of public and private *financing and risk sharing*, the second relates to the level of each partners involvement in *strategic planning and design* and the third relates to additional *resource sharing* such as through joining management capabilities, human resources, IS, or governance arrangements. While such typologies provide the basis of comparison and analysis, it should also be noted that the nature of inter-organ~~isation~~ization~~al~~ relations within any single PPP may be multifarious—as multiple partners from different

institutional backgrounds come together—as well as open to contingent change over time (Lowndes and Skelcher, 1998).

Debates and Controversies

Although now widespread, PPPs have been a controversial policy development for a number of reasons. First, many have questioned the long term value for public money of partnership agreements, particularly those which lock the public sector into long-term contracts, unable to take account of future changes to the market. Although such agreements spread the cost of new infrastructure over the lifetime of the project, this is usually at the expense of an increased cost of borrowing (Yescombe, 2011) and large questions remain about how the overall economic costs and benefits of PPP projects—including externalities—should be calculated (Boardman and Vining, 2010). Underlining this debate, a number of PFI projects have been found to involve inequitable sharing of risk, offering poor value for money and leaving public sector organisationizations with high levels of debt (Shaoul and Edwards, 2003; Toms, Beck, and Asenova et al., 2011). A second area of critique has been around the ability of public and private organisationizations to overcome institutional differences to engage in "true" partnership working. Embedded characteristics of the public sector, such as the need for political control of projects, contrast with those of the private sector, such as profit maximisationization and the avoidance of risk, meaning that there is always likely to be a separation of responsibilities and a reliance on explicit formal contract terms inhibiting open sharing of resources and risks (Klijn and Teisman, 2003). A third area of controversy has been around the values and ethos promoted by PPPs, with some case study evidence suggesting that the growth of PPP contracts have led to a reduction in the

capacity of public servants to work in the public interest, limiting the scope for individual discretion and professional autonomy in the face of strict contractual and performance criteria (Smith, 2012). Alongside other NPM reforms, PPPs have been argued to undermine the moral purpose of public organisationizations by promoting economic rationality above other principles and values (Fevre, 2003; Davies, 2014). Forth, questions have also been raised about the outcome quality in PPPs, particularly in circumstances in which they are seen to promote cost-reduction over maintaining or improving quality (Hebson, Grimshaw, and Marchington et al., 2003)

Given this controversy, PPPs have faced strong political and public resistance leading, in places, to the approach being reined- in. At the same time, many of the long-term PPP projects signed during the 1990s and 2000s have several years left to run. Further, in times of fiscal constraint it appears likely that governments will continue to look to the private sector for both investment and to stimulate cost-saving reform, including through engaging in changing forms of partnership with the private sector. Turning now to the field of health care, we consider the basis and implications for the changing relationship between the public and private sector, and consider the challenges in managing health services within an environment of PPPs.

Introduction to Health Cceare PPPs

In line with the trends identified above, PPPs have become a prominent and contentious feature of health care reform. Health care PPPs are often premised on the idea that neither public nor private sector can adequately meet the manifold challenges of ageing populations, an increase in chronic “lifestyle” diseases, assimilating new treatments technologies and the need to control public health care spending. Through new forms of

collaboration, it is suggested that ~~healthcare~~health care PPPs can expand access, coverage and provision of ~~healthcare~~health care, support investment for the future, engender innovation and improve the experiences of patient and clinicians.

As with PPPs across public service sectors, forms of collaboration between the public and private sector in ~~healthcare~~health care have been highly varied. Significant differences can be observed, for example, in the experience of the developing (low and middle income) and developed (high income) nations. In developing countries across Africa, the Indian sub-continent and the Caribbean, PPPs have been seen as addressing longstanding gaps in ~~healthcare~~health care provision, including a lack of funding, uneven levels of coverage, limited access to specialist clinicians, medicines or technologies and out~~-~~dated hospital infrastructure. Developing new forms of partnership between government actors and both for-profit and non-profit organ~~isation~~izations has been seen as essential for addressing global health challenges, such as vaccines for infectious diseases and improving access to health services (Nishtar, 2004). In India, a range of significant developments in primary, community, specialist and remote (tele-) care services have been established through PPPs (Raman and Bjorkman, 2008). These combine long~~-~~term public financing for public ~~healthcare~~health care, with extended opportunities for private care providers to offer both public and private ~~healthcare~~health care under contract, with some evidence to show improved access and care standards for poor communities (Ganashyam, 2008). Similarly, Downs et al. (2013) argue that partnership working in Lesotho has enabled the country to develop new hospital infrastructure in a relatively short period of time that has enhanced the quality and standards of care for local populations.

In developed countries, PPPs are commonly advocated as a way of addressing the rising demand for ~~healthcare~~health care services (Barrows et al.~~.~~, 2011), adding to the "mix" of available forms of funding and delivery. Here PPPs have commonly taken the form of investment in new acute-care infrastructure, as seen in Spain, New Zealand and Australia (Acerete~~,~~ Stafford, and Stapleton ~~et al.~~, 2011; Barrows et al.~~.~~, 2011), but can also involve novel collaborative approaches to developing, managing and carrying out clinical services (Waring~~,~~ Currie, and Bishop ~~et al.~~, 2013). Differences in the trajectory along which countries have moved to adopt new forms of PPP can in part be related to the established mix of public and private actors involved in the provision of the countries ~~healthcare~~health care services. In countries such as the US or Canada, where ~~healthcare~~health care service have historically been financed and provided through a combination of public and private channels, the premise of partnership working is less considered a divergent break from the past. Similarly, in European countries with public health insurance "Bismark" systems of ~~healthcare~~health care, such as Germany, France, the Netherlands and Belgium, there has traditionally been a wide range of actors, including private, for-profit and charitable organ~~isation~~ization involved in commissioning, funding and providing ~~healthcare~~health care services over the long term. Although the mix between public and private provision in each of these countries has changed over time, for example with an increase in private provision in Germany since reunification (Maarse, 2006), a long~~-~~standing legitimate role for private providers has meant there has been less policy emphasis on PPP to bring new providers into these markets. There are however some exceptions to this with several PFI-type schemes for

~~healthcare~~health care established in France and the Netherlands (Acerete, Stafford, and Stapleton ~~et al.,~~ 2011; Hodge, Greve, and Boardman ~~et al.,~~ 2010).

In countries where health services have traditionally been funded, owned and provided directly by the state, such as the UK, Australia, New Zealand and Scandinavia, there has been a greater presure on governments to plural~~ise~~ize supply and bring new actors into the health economy. These countries have been particularly active in trialing PPPs and have introduced a range of new intersectoral arrangements. This has commonly included PFI-type contracts for new ~~healthcare~~health care facilities but has also included a number of country specific developments (Hodge, Greve, and Boardman ~~et al.,~~ 2010; Maase, 2006; McKee et al., 2006). For example in Sweden there has been an emphasis on hospital franchsing whereby entire public hospitals have been taken over by private companies to manage both the estates and the clinical services as part of the publicly funded health provision (Sveman and Essinger, 2001). Similarly, southern European countries such as Portugal, Spain and Italy have also been active in adopting PFI schemes for hospital building, partially as a response to severe restrictions in central government borrowing. Among these, Spain is notable for developing the "Alzira" model of PPP service provision, named after the area of Valencia in which this was first established. In this model, the private sector finances, builds and operates hospital and/or primary care facilities as well as provides clinical services under contracts of commonly 15 to 20 years (Global Health Group, 2009). These are funded by capitation payment from the public health budget based on the size of the population served by the facilities. The first of these opened in 1999 led by further contracts in Valencia, Madrid and Portugal as well as several developing countries, albiet with significant variation in the nature of contracts

Commented [CE4]: AQ: there is no reference in the 'References' section to support this citation. Please add a full reference.

and services provided in each itteration (Acerete, Stafford, and Stapleton ~~et al.,~~ 2011). The Alzira model has been seen to have played an important role in the development of ~~healthcare~~health care specific PPPs, including as part of the inspiration for the UK Independe Sector Treatment Centres (Acerete, Stafford, and Stapleton ~~et al.,~~ 2012), which are discussed further below.

Although the adoption of PPPs in ~~healthcare~~health care is widespread, the institutional~~ised~~ized boundaries between public and private sectors can pose particular challenges to policy-makers and service managers. These challenge of organ~~ising~~izing and managing across sectoral boundaries are exemplified by the English NHS. Somewhat ironically, the UK is one of the world's leading exponents of ~~healthcare~~health care PPPs, despite widespread public concern about the threat to core service principles and the possibilities of privat~~isation~~ization (Pollock, 2006). The NHS was founded in 1948 and since that time has been predominately funded through central taxation, with universal care provided through a largely national~~ised~~ized care system. For the first forty years of operation public resources were allocated to public providers through forms of bureaucratic planning, but for the previous twenty years resources have flowed through contracts between commissioners and providers, with an increased emphasis on mixed market provision. Looking back at the history of the NHS, it is important to also recogni~~z~~se the long~~-~~-standing role of the private sector in care organ~~isation~~ization and delivery. This can be seen, for example, in the role of community pharmacies who provide a first point-of-contact for patients, providing medicines advice and dispensing prescriptions. Furthermore, general practitioners have provided primary care service to the NHS under an independent contract since the inception of the service, meaning that

(in technical terms) the majority of patient contacts within the NHS have been provided by private contractor. In addition, specialist NHS doctors can maintain private practice and are able to use both private and public ~~healthcare~~health care facilities to provide this care. As such, the linkages between the public and private sector in the English NHS are perhaps more complicated than often perceived.

That said, over the last thirty years the NHS has been at the forefront of using PPPs as vehicle for service modern~~isation~~ization. During this time, the form and function of PPPs has evolved over what we describe as three distinctive time periods, each building on the former. The first period is found in the 1990s where partnership working was primarily concerned with securing new lines of investment in NHS infrastructure without requiring additional taxation or public borrowing. The PFI approach to funding support the construction of new hospital buildings, such as the Norfolk and Norwich University (see Example ~~box~~ 1). Under long term contract, the PFI programme allowed consortia of private contractors to fund, design and construct new buildings (National Audit Office, 2005). This model has since been extended to include major infrastructure projects, such as University College Hospital London.

The second period corresponds with the 2000s where the PFI model was extended to allow for new forms of partnership working in the management of infrastructure as well as the co-delivery of frontline services including pre-existing NHS care pathways and clinical teams. This was initially outlined in the *NHS Plan* (Department of Health (DH), 2001) which set out a long term strategy to tackle the endemic problems of under-capacity, lack of choice and lack of competition within the NHS though allowing private providers to work within the NHS system. A prominent example is the introduction of

Independent Sector Treatment Centres (ISTCs) for the delivery of high-demand, low-risk elective diagnostic and treatments services, such as day surgery. These could be wholly or partly owned and managed by a private provider, who were also under contract to provide clinical services in coordination with the wider public ~~healthcare~~health care system. Approximately 50 such centres were set up in the 2000s during two distinct waves of contracting, with most contracts set to run for an innitial period of five years.

The third stage of PPPs in the NHS follows reforms outlined in the 2010 White Paper *Equity and Excellence* (DH, 2010), which effectively creates a more open and competitive market of care provision within the NHS. Since this point, a large number of primary and community ~~healthcare~~health care services have been made available for open tender to private and social enterprise providers. This has seen both a significant re-designation of services, especially community services as social enterprises, as well as a number of private contractors winning contracts to provide a range of specialist support services, such as Care UK and Virgin Healthcare. The central government emphasis is now less on collaborative working and more on competition between public and private organ~~isation~~izations, with sections of the NHS workforce often being transferred to the management of private or social enterprises. At the same time, the nature of ~~healthcare~~health care service delivery across complex pathways of care necessitates close ongoing relationships between organizations of all sectors.

The evolution of ~~healthcare~~health care PPPs over time means that examples of PPP projects can be found across the range of partnership configurations, from relatively "loose" financial or funding arrangements providing acute and primary care infrastructure to more "tight" joint ventures where there is "full service" partnership working across

service financing, planning and delivery. The wide spectrum of arrangements now in operation provides an opportunity to examine a wide range of issues central to a critical analysis of PPPs at a more general level, including "upstream" governance issues, such as how contractual obligations are determined or risks allocated, as well as "downstream" management and organisationization issues, such as how care pathways are configured or clinical teams managed. Focusing particularly on the context of the English NHS, the remainder of the chapter considers these issues by outlining four organizational and management challenges brought about by the introduction of PPPs in healthcarehealth care; governance and accountability; management culture and identity; managing workforce and employment; and managing learning and innovation.

[Examples of PPPs in text boxes below fit around main body text of sections 3 and 4]

1 Example 1

Norfolk and Norwich University Hospital

Norfolk and Norwich University hospital was the first example of a large-scale PFI arrangement for the construction of new hospital facilities within the NHS. In 1996 approval was given for partnership between the NHS Trust and Octagon Consortium to construct a new 809 bed hospital, with a second stage approved in 2000. The consortium comprised a number of private sector design, construction and support service providers, including John Laing plc, Anshen and Allen, WSP Group, Hoare Lea and Serco. The new hospital was opened 2001 ahead of schedule and on budget, and has since attracted several awards for its design. Under the arrangement, Norfolk and Norwich University Hospital NHS Trust pays the private consortium an annual fee for the use of the facilities

which include charges for estates management, maintenance and support services, such as catering, portering and cleaning. In 2004 the Association of Chartered Certificed Accountants estimated that over the 35 life of contractual arrangement the cost of the partnership could reach over £1.1billion, as compared to the £229million required to build the hospital.

~~2~~ Example 2

University College Hospital, London

University College Hospital is one of several hospital sites managed by University College London Hospitals (UCLH) NHS Foundation Trust. The state-of-the-art 665~~-~~ bed hospital was opened in 2005 providing an extensive range of acute and specialist services, such as emergency medicine, hyper-acute stroke, and cancer care. The new hospital facilities were developed through one of the biggest ~~public-private~~public–private partnership arrangements in the English NHS, initially comprising a Private Finance Initiative to fund, design and build the hospital and now includes an on-going contractual arrangement with a private partner for the provision of support and facilities management. The PPP was established in 2000 between UCLH and a newly formed partner organ~~isation~~ization Health Management (UCLH) plc. This partner organ~~isation~~ization involve a consortium of several leading private sector contractors including AMEC, Balfour Beatty and Interserve, and invested over £4,200 million in developing the new hospital. This partnership arrangement ensured the provision of the necessary financial resources to fund the project together with specialist services design and construction, project management and facilities management. Interserve continues to provide a range of services to the NHS Foundation Trust as a part of its role in facilities

management, including restaurant and café services, portering, domestic services, laundry, waste management, and security.

~~3~~ Example 3

Circle Partnership

Circle Partnership was formed in the late 2000s. It was established on the basis of mutual ownership, through an initial investment partnership of ~~healthcare~~health care professionals, mostly doctors working in the NHS. As the partnership expanded additional private equity investment was secured and the partnership was rebranded as Ciricle. The partnerships early activities focused on the provision of low-risk, high volume elective services within Independent Sector Treatment Centres. These centres were introduced in the mid-2000s with the aim of reducing waiting and expanding NHS provision for high demand services based upon contractual partnership with private providers. Circle Partnership acquired the contracts of existing private provider and assumed operational responsibility for three ISTCs. In most instances the facilities and resources involved are co-finance or subsidized through public ~~healthcare~~health care agencies. In addition, many of these services involved the transfer or secondment of NHS employees to the management of Circle partnership. Since this time, the partnership has secured the contracts for several other NHS acute and diagnostic services and opened its own private ~~healthcare~~health care facilities. In 2012, Circle Partnership made history within the NHS by winning the management franchise contract to operate an established NHS acute hospital. Under existing NHS management arrangements the hospital had been identified as poor performing and the decision was made to give Circle Partnership

to assume management responsibilities, but where the estates, facilities and workforce remain NHS.

~~4~~ Example 4

Care UK

Care UK are a well-established private sector provider of ~~healthcare~~health care in the UK, being founded in 1982, especially in the development and management of primary care services. The scale and scope of their services have increased significantly since the early 2000s to become one of the largest private provides on health and social care, often working in partnership with local NHS commissioners and provider organ~~isation~~izations. There areas of service provision include a range of NHS service under contract with commissioners, including GP and diagnostic service; health and social care for the elderly, such as care homes and day care centres; a range of learning disability services; and community mental health services, such as eating disorder clinics.

~~5~~ Example 5

Virgin Care

Virgin is a well-known global brand in the area of aviation, rail, telephony, and media and leisure services. In the mid-2000s, Virgin acquired a stake in Assura Medical services, a company that special~~ised~~ized in developing primary and community estates and facilities. By the late 2000s, Assura Medical Service brought within the Virgin Group and started managing walk-in centres to expand the provision of urgent care. In 2011, Assura Medical was rebranded as Virgin Care and since this time has grown to manage and provide over 200 community health and social care services across England under

contractual arrangement with NHS commissioners. This includes for example, an extensive range of community services, younger people's service, sexual health services, GP and urgent care services and prison health services. Virgin Care illustrates a contractual partnership arrangement whereby it competes with, or acquires existing NHS providers to secure contracts with local care commissioners.

Management Cchallenges

Governance and Accountability

The challenge of governance has been a central concern in the adoption of PPPs. Involving private sector organisationizations in the provision of public services requires a degree of authority to be distributed outside the bounds of integrated public bureaucracies. Forms of governance are therefore required which on one hand allow private actors sufficient autonomy to develop innovations and introduce change in line with public interests, but on the other hand provide adequate controls to protect each party from opportunistic behaviourbehavior of others in the partnership (Skelcher, 2010). In a number of high profile healthcarehealth care PPPs it has been seen that asymmetries of information have lead the public sector to over-pay for services provided by the private sector (Shaoul, Stafford, and Stapleton et al., 2008), or have even locked the state into paying large sums for services for which there is insufficient demand or are no longer required (Pollock and Godden, 2008). Equally, examples have been identified in which public managers engage in restrictive or controlling forms of contract management over private contractors (Grimshaw, Vincent, and Willmott et al., 2002). A key governance challenge therefore is the equitable balancing of risk and reward, with managers on both sides required to evaluate exposure to risk and remain cautious in evaluating partners

(Grimsey and Lewis, 2007). This has required significant changes to the skills and knowledge of public managers, who are obliged to operate in an increasingly commercial~~ised~~ized and contract-based environment and to scrutin~~ise~~ize financial and contractual terms (English, 2005).

Skelcher (2010) identifies four distinct facets of governance important to consider. First, the legal basis for the partnership, with a number of potential forms available including limited company, public consortium or memorandum of association. Choosing a suitable legal form requires consideration of the aims of the parties involved and sets the character collaborative working, whether open ended or tightly proscribed. Second, the regulatory rules and systems which control the relationship between partners require consideration. These are commonly enshrined in the PPP contract which details the agreed obligations, systems of interaction and reporting, incentives and penalties. Here there has been an advocacy of "relational" or partnership contracting which emphasi~~z~~s~~es~~ mutual interests and allow greater scope for informal settlements and shared ~~decision-making~~decision-making (Bovaird, 2006). Studies have though also shown how embedded institutional differences between NHS organ~~isation~~izations and private ~~healthcare~~health care providers lead to difficulties in establishing such open ended, trusting relationships, with contract management frequently involving recourse to contractual terms (Hebson, Grimshaw, and Marchington ~~et al.,~~ 2003). The third important facet of governance is the democratic aspect, which relates to the degree of accountability and transparency extended to private actors. In ~~healthcare~~health care, there has been a strong critique that external providers are not open to the same level of scrutiny as public bodies, with commercial confidentiality limiting public access to information on

organisationizational processes and decision--making (Pollock, 2006). Fourth, PPPs are also affected by the distinct corporate governance of the partners involved. A number of private healthcarehealth care companies working with the NHS, such as Circle HealthcareHealth care Partnerships, have sought to emphasiseize forms of socially orientated corporate governance and codes of ethics which align them with the interests of patients and staff. However, there has so far been little research in this area.

In the authors' own studies of ISTCs, we have also seen how the divisions of accountability and control can emerge informally in the development and operation of partnership arrangements (Waring, Currie, and Bishop et al., 2013). While elements of contract governance were established in the planning phase of the ISTCs, there remained considerable scope for norms of interaction and reporting, as well as divisions of accountability and control, to be shaped over the course of the agreement. For example, the extent to which legal or punitive aspects of contracts needed to be enforced was dependent on the nature of relationships between contract managers in the NHS and counterparts within the private providers. These relationships in turn were dependent on a number of locally contingent factors, including the opportunities for interpersonal communication, the changing local political attitudes to private sector involvement as well as the market positioning of the ISTC companies. As new service providers, the private companies involved in our study sites were each keen to demonstrate compliance with central government audit and local contractual requirements in order to establish legitimacy as NHS partners. However, we also saw how the approach to achieving this compliance varied between ISTC sites and over time. Moreover, in other circumstances private partners' aims and interests may be served by following other approaches to

contract engagement (Edwards and Shaoul, 2003) and engaging in PPPs requires public managers to consider appropriate forms of governance to promote the equitable sharing of risk (Skelcher, 2010).

Managing Innovation

In various ways, PPPs are advocated as bringing about innovation and improvement in the organisationization and delivery of public services. As well as being presented as an innovation in themselves, PPPs are also described in policy documents as engendering innovation through the opportunities afforded for public and private organisationizations to share previously siloed resources and capabilities. Public sector partners can contribute specialist professional or technical expertise or greater appreciation of public need, and private partners can offer the business acumen and experiences in commercial sectors. From this view, PPPs are indicative of a form of innovation through hybridity; that is the recombination of character traits into a new mode of service organisationization (Billis, 2010; Waring, 2014).

Further, PPPs are described as fostering on-going innovation and improvement in the day-to-day organisationization of public service, in part because private businesses are assumed to be dynamic and responsive to external change, and also because PPPs are expected to create new opportunities for knowledge sharing between public service professionals and providers. A significant body of research shows how sectoral, organisationizational and professional boundaries within "traditional" healthcarehealth care organisationizations can stymie innovation and implementation of new technologies or evidence (Cooksey 2007; Ferlie et al., 2005). PPPs are seen as a means of stimulating the formation of new clinical communities through which more productive, integrated

and patient-centred services can be developed. For example, the Confederation of British Industry (CBI, 2008) describe a number innovations brought about by partnership working between the NHS and private industry including reduced "backroom" administration in areas such as patient booking, realigned human resources to develop more productive clinical processes, and util~~ised~~ized quality assurance methodologies to reduce waste and enhance productivity.

Despite these claims, whether ~~healthcare~~health care PPPs do indeed represent a radical innovation and improvement in ~~healthcare~~health care organ~~isation~~ization requires critical examination. In their study of Independent Sector Treatment Centres, for example, Gabbay et al. (2011) suggest radical building designs, stark aesthetic improvements and the abundance of the new technologies are not necessarily reflected in new ways of working. In other words, innovation might be more "style over substance" aimed at giving the impression of being distinct from traditional NHS services and like other retail sectors, but without necessarily changing the core business of care. Similarly, case studies by the authors suggest innovation in ~~healthcare~~health care PPPs can be limited to establishing more efficient, standard~~ised~~ized and low risk services; where care service become less special~~ised~~ized or differentiated but align instead with highly standard~~ised~~ized service models and templates (Waring, Currie, and Bishop ~~et al.,~~ 2013). In these cases, radical innovation was not necessarily welcomed by PPP leaders because of its potentially de-stabil~~ising~~izing effect on relatively standard~~ised~~ized services, and opportunities for change were only welcomed when directed towards increased management control.

Looking further at the nature of innovation within PPPs, the author's studies also describe a difference between those based upon the "top-down" transfer of business and management practices, and those based upon "bottom-up" learning amongst clinical teams Waring, Currie, and Bishop ~~et al.~~ (2013). Our research found a greater proclivity for PPP leaders to introduce strategies or approaches that had been tried and tested in other settings and, as suggested above, aligned primarily to the goal of enhanced productivity rather than creating space for bottom-up learning and innovation. By promoting more standard~~ised~~ized approaches to care, PPPs can have the effect of potentially de-skilling staff in more narrow roles rather than encouraging broader development and advanced learning. Where this has been specifically studied, ~~healthcare~~health care PPPs have been found not to engender the type of learning environment anticipated by policy makers (Turner et al., 2012). Somewhat paradoxically, Turner et al.'s (2012) comparative study found PPPs did produce innovation, but not within the new organ~~isation~~izations; rather it was the existing NHS hospitals who sought to innovate existing service models and care in the face of new competition.

Commented [CE5]: AQ: there is no reference in the 'References' section to support this citation. Please add a full reference.

Managing C~~c~~ulture and ~~v~~Values

A significant challenge faced by PPPs relates to the underlying cultural and ideological characteristics that have distinguished public and private sectors and potentially inhibit collaboration. Public and private sectors are typically associated with having distinct funding arrangements, accountability systems, client relations and modes of working. These are reflected in, and reinforced by, the idea that each sector is character~~ised~~ized by a particular culture, manifest in systems of meanings, beliefs, values, norms and routines. Although public service reforms over the last three decades have arguably blurred these

distinctions (Boyne, 2002), it remains the case that PPPs face intractable differences in managing cultural difference and conflict. In the US, Perry and Wise (1990) suggest public service employees are motivated by an attraction to public governance, civic duty, compassion and self-sacrifice. In the UK context, Pratchett and Wingfield (1996) describe public sector organisationization as characterisedized by an ethos of political accountability, bureaucratic behaviourbehavior, public interest and loyalty. These cultural attributes potentially conflict with the beliefs, motives and values that inform private sector work, such as competitive behaviourbehavior, enterprise and entrepreneurship, accountability to shareholders and private value.

A key challenge faced by PPPs is therefore how to recogniserecognize, cope with and manage cultural differences. For example, inherent differences between sectors mean that building sufficient trust for meaningful cooperation can take significant time and effort (Klijn and Teisman, 2005); a number of case studies in healthcarehealth care organisationizations have shown productive relationships have failed to develop resulting in significant frustration and waste on both sides (Grimshaw et al., 2003). Public sector managers have been found to act defensively in light of perceived profit-motivated behaviourbehavior of private sector counterparts and private sector managers may be faced with the need to foster behaviourbehavioral and identity change amongst resistant public sector professional-grade employees (Waring, Currie, and Bishop et al. 2013).

Looking at the experiences of public sector clinicians involved in healthcarehealth care PPPs, the authors studies found four prominent points of cultural difference between NHS staff and their private sector partners (Waring and Bishop, 2010; Waring, Currie, and Bishop et al., 2013). The first related to the perceived goals or purpose of the service.

Commented [CE6]: AQ: Should the yaer be 2002, to match the References?

Public sector clinicians advocated individual patient care as an end in itself, they perceived private partners as motivated to make a profit, with patient care a means to this end. Second, public sector clinicians often perceived the broader ethos or ideology of care as a public good, and contributing to societal wellbeing. In contrast, PPPs can be experienced as advancing private interest and value ahead of the public good. In other cases, PPPs have been seen as displacing or subverting the underlying goals and ideals of public sector workers (Hebson, Grimshaw, and Marchington ~~et al.~~, 2003). Third, clinicians described a shift in the norms and customs of day-to-day work with a shift from more collegial and team based practices towards more standard~~ised~~ized, machine-like modes of working. This shift towards standard~~isation~~ization and rational~~isation~~ization was seen as reflecting the pursuit for efficiency at the expense of service quality and patient safety (Waring and Bishop, 2011). Finally, work in these PPPs was also felt to change patterns of accountability and responsibility, with emphasis given to contractual obligations and performance indicators ahead of patient experience of professional judgements (Bishop and Waring, 2011). Again, this was seen as stemming from the PPPs more consumerist and commercial approach. Together these cultural differences were seen as transforming the sense of public professionalism shared by many frontline clinicians (Waring and Bishop, 2010).

Managing Employment

The rise of PPPs has been seen to have a number of implications for both the management of work and the nature of employment in ~~healthcare~~health care. Prior to market reforms of the 1990s and 2000s the NHS was traditionally seen as both a highly integrated and centrally governed employer. This picture has changed in recent years to

one character~~ised~~ized by increasingly local flexibility for management to shape employment within national frameworks. For example, the New Labour government's programme of "workforce modern~~isation~~ization" included general guidelines for "best practice" employment while advocating the rational~~isation~~ization of work roles with increased emphasis on organ~~isation~~izational level management actively aligning technical skills with tasks in ways which broke from traditional professional groupings. In bringing new private sector organ~~isation~~izations into the ~~healthcare~~health care economy, PPPs could be seen as furthering a move away from nationally standard~~ised~~ized employment conditions and practices towards a system with increasing flexibility for the nature of employment to be determined within the organ~~isation~~ization. This potentially allows management greater control of employment and allows them to "fit" human resource management practices to the nature of activities being undertaken, local operating circumstances, available resources, ambitions for organ~~isation~~izational culture or strategic intent. However, while reforming public service employment has been stated as one of the policy aspirations for expanding the PPP programme (DH, 2006), research has also shown how a number of complexities and operating difficulties surface as relationships between the public and private sector are established.

A sizable body of work has shown managing employment across networks of close inter-organ~~isation~~izational relationships can cause difficulties for both management and employees (Marchington et al., 2004~~,~~; Rubery et al., 2004). PPP projects have been seen to introduce considerable complexity in the structure of public service delivery with lines of hierarchy and accountability fragmented into increasingly complex sets of inter-organ~~isation~~izational arrangements (Forrer et al., 2010). Engaging in sub-contracting,

outsourcing and tight partnership arrangements can mean that the control of, and responsibility for, employment can become distorted, introducing a break in the link between control of employment, line management and work practice. For example, in certain PPPs arrangements public sector staff see their work either fully or partially transferred to private partners, albeit with their terms and conditions of employment protected by the contractual terms of partnership (through detailing the specifications of staffing levels and skill mix required to maintain quality) and/or wider employment regulations. In these circumstances, managers within the private partner may find themselves unable to make explicit changes to the employment of the staff transferred to them from the public sector and constrained in terms of their ability to shape their ~~HRM~~ human resource management (HRM) systems internally, having to negotiate any changes with "parent" public sector organ~~isation~~ization. This can also lead to confusion over day to day aspects of management, including managers' ability to check the quality of work or manage performance for those employed externally. Even where private partners are able to control employment within their own organ~~isation~~izations, close inter-organ~~isation~~izational working can still introduce complexity into lines of authority, as for example the staff of subcontractors work on behalf of public managers, but not directly answerable to them.

In addition, PPPs have been seen to introduce a number of forms of employment inconsistency across complex ~~healthcare~~health care "supply chains." A common criticism of new PPP arrangements is that they can introduce a "two-tiered" workforce, whereby private sector and public sector employees are subject to substantively different forms of employment. This can be particularly problematic when staff under different forms of

employment share the same work-place, with public and private staff working side-by-side. In early forms of PFI, it was particularly lower status occupational groups such as cleaning, catering and site services staff who saw their work transferred to the private sector. In latter forms of partnership, our own case studies have reported on instances in which private companies directly employ higher status ~~healthcare~~health care professionals, including medical and nursing staff, to work alongside clinical staff who remain on NHS contracts (Bishop and Waring, 2011). These arrangements presented difficulties for management in terms of justifying variations in employment and maintaining the commitment of staff without the ability to harmon~~ise~~ize employment terms and conditions. These problems were particularly acute where staff of the same clinical-professional grading worked within the same teams and on the same patients, but with differing systems of management and employment. It should however also be noted that the legitimacy and acceptance of such multi-employer systems could be dependent on wider industry and sectoral norms, and therefore subject change as more diverse and heterogeneous systems of ~~healthcare~~health care delivery become further established.

Conclusion

In conclusion, various claims for the benefits of PPPs have been made over the years, often centred on notions of efficiency, value for public money, expanding investment or bringing change, and innovation. These claims are particular appealing for leaders in the health sector, facing serious challenges in light of restricted resources and increasing demand. However, after several years of study, the collected evidence for each of these claims is, at best, mixed. While there have been instances in which PPPs have appeared to deliver on promises, there have been many others which have not. Perhaps as

importantly, the appropriate methods of measuring even the economic benefits of PPPs remain disputed (Boardman and Vining, 2010), let alone the wide organisationizational and cultural aspects of partnership. Moreover, there have been several consequences of PPPs that remain controversial regardless of the outcomes of individual projects, including long-term public indebtedness and fragmentation of public services. In our chapter above, we have described how PPPs present several organizational challenges for managers in both public and private sector organizations as they seek to maintain service continuity whilst introducing innovation and improvement. These are important areas of consideration for healthcarehealth care managers given that the penchant for partnerships continues to expand; in a number of countries around the world, partnerships between the public and private sector are now a core part of how healthcarehealth care services are financed, planned, and delivered.

Surveying the current field of research into healthcarehealth care PPPs, a number of important areas for future research can be proposed. At the macro level, current research has tended to focus on policy developments within individual countries, placing national developments within the international context. There is considerable scope for purposeful comparative work to examine how aspects of the political economy, the regulatory environment and approaches to public financing interact with policy formulation around PPPs. At the meso level, studies of PPPs have considerable potential to contribute to debates on how new organisationizational forms are established, for example by considering how tensions between the institutional logics inherent in each sector play out at the inter-organisationizational level. At the micro level, work is needed to report on the evolving character of PPPs as both providers of essential services and as

places of work for public service employees. Both advocacy of and resistance towards PPPs centres on the capacity of new organisationizational arrangements to change behaviourbehavior; detailed work is therefore needed to examine how and indeed whether this takes place. As PPPs are often years in the making and have been found to evolve over time, each of these areas would benefit from longitudinal work that is able to detail and explore the processes and outcomes of change.

References

Acerete, B., Stafford, A., and Stapleton, P. (2011). "Spanish healthcare public private partnerships: The "Alzira model". *Critical Perspectives in Accounting*, vol.22(6): 533–549.

Acerete, B., Stafford, A., & and Stapleton, P. (2012). New development: New global health care PPP developments—a critique of the success story. *Public Money & Management*, 32(4): 311–314.

Anderson, E. (1990). *The three worlds of welfare capitalism*. Cambridge: Polity Press

Barrows, D., MacDonald, I., Supapol, A., Dalton-Jez, O., and Harvey-Rioux, S. (2011). *Public private partnerships in canadian healthcare: Aa case study of the Brampton civic hospital*. Geneva: OECD.

Billis, D. (Ed.ed.) (2010). *Hybrid organizations and the third sector: Challenges for practice, theory and policy*. Basingstoke: Palgrave Macmillan.

Bishop, S., & and Waring, J. (2011). Inconsistency in health care professional work: Employment in independent sector treatment centres. *Journal of health organization and management*, 25(3): 315–331.

Bovaird, T. (2006). Developing new forms of partnership with the “market”in the procurement of public services. *Public Administration*, 84(1)~~,~~: 81–102.

Boyne, G. A. (2002). Public and private management: W~~w~~hat’s the difference?~~.~~ *Journal of management studies*, 39(1)~~,~~: 97–122.

Brinkerhoff, D. W.~~, &~~ and Brinkerhoff, J. M. (2011). Public–private partnerships: ~~p~~Perspectives on purposes, publicness, and good governance. *Public Administration and Development*, 31(1)~~:,~~ 2–14.

Broadbent, J., Gill, J., ~~&~~ and Laughlin, R. (2003). Evaluating the private finance initiative in the National Health Service in the UK. *Accounting, Auditing & Accountability Journal*, 16(3)~~:,~~ 422–445.

Boardman, A. and Vining, A. (2010) ~~“~~Assessing the economic worth of ~~public-private~~public–private partnerships~~”~~. In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public-private~~public–private partnership*, ed. Hodge, G. A., Greve, C., and Boardman, A. E., pp. 159–186. Cheltenham and Northampton, MA: Edward Elgar Publishing.~~ 159–186~~

~~Rubery, J., Carroll, C., Cooke, F. L., Grugulis, I., & Earnshaw, J. (2004). Human resource management and the permeable organization: The case of the multi-client call centre*. *Journal of Management Studies*, 41(7), 1199–1222.~~

Bull, B., (2010). “Public~~–~~–private partnerships: the United Nations experience~~”~~. In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public-private~~public–private partnership*, Hodge, G. A., Greve, C., & Boardman, A. E., pp. 479–498. Cheltenham and Northampton, MA: Edward Elgar Publishing. ~~479–498~~

Confederation of British Industry (CBI). (2008). *ISTCs and the NHS*. London: CBI.

Cooksey, D. (2007). *The Cooksey Review*. London:TSO~~, London~~.

Davies, W. (2014). *The limits of neoliberalism, authority sovereignty and the logic of competition*. London: Sage~~, London~~.

Department of Health (DH)~~.~~ (2001). *The NHS plan~~,~~*. London: TSO.

Department of Health (DH)~~,~~ (2010). *Equity and excellence: ~~l~~Liberating the NHS~~,~~*. London: TSO.

Diamond, J.~~,~~ ~~&~~and Liddle, J. (2005). *Management of regeneration: ~~c~~Choices, challenges and dilemmas*. Psychology Press.

Downs, S., Montagu, D., Da Rita, P., Brashers, E., ~~&~~ and Feachem, R. G. A. (2013). *Health system innovation in Lesotho: ~~D~~design and early operations of the Maseru public–private integrated partnership*. ~~Healthcare public-private partnerships series~~ Healthcare Public–Private Partnerships Series, ~~no~~No. 1. San Francisco, CA: The Global Health Group~~,~~. ~~*Global Health Sciences, University of California, San Francisco, and PwC.*~~ Global Health Sciences, University of California, San Francisco, and PwC.

Edwards, P.~~, &~~ and Shaoul, J. (2003). Partnerships: ~~F~~for better, for worse? ~~.~~*Accounting, Auditing & Accountability Journal*, 16(3)~~,~~: 397–421.

Entwistle, T.~~, &~~ and Martin, S. (2005). From competition to collaboration in public service delivery: ~~a~~A new agenda for research. *Public administration*, 83(1)~~,~~: 233–242.

Commented [CE7]: AQ: Please provide the place of publication.

Ferlie, E., Fitzgerald, L., Wood, M., ~~&~~ and Hawkins, C. (2005). The nonspread of innovations: T~~t~~he mediating role of professionals. *Academy of management journal*, 48(1)~~,~~: 117–134.

Fevre, R. (2003).*The new sociology of economic behaviour*. London: Sage.

Field, J. E.~~, &~~ and Peck, E. (2003). Public–private partnerships in healthcare: ~~t~~The managers' perspective. *Health & social care in the community*, 11(6)~~,~~: 494–501.

Flinders, M. (2010). ~~"~~Splintered logic and political debate~~"~~. In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International Handbook on ~~Public–Private~~Public–private Partnership*, ed. Hodge, G. A., Greve, C., and Boardman, A. E., pp. 115–131. Cheltenham and Northampton, MA: Edward Elgar Publishing.~~ 115–131~~

Forrer, J., Kee, J. E., Newcomer, K. E., ~~&~~ and Boyer, E. (2010). Public–private partnerships and the public accountability question. *Public Administration Review*, 70(3)~~,~~: 475–484.

Gabbay, J., Le May, A., Pope, C., Robert, G, Bate, P., and Elston, M. (2011). *Organ~~isation~~izational Innovation in health services*~~,~~. Bristol: Policy Press

Ghanashyam, B. (2008). Can public~~–~~–private partnerships improve health in India?~~.~~ *The Lancet*, 372(9642)~~,~~: 878–879.

Gidman, P., Blore, I., Lorentzen, J., ~~&~~ and Schuttenbelt, P. (1995). ~~*Public–private*~~*Public–private partnerships in urban infrastructure services*, UMP Working Paper Series, Vol.4. Washington, D.C.: UNDP/UNCHS/World Bank-UMP.

Global Health Group (2009)~~,~~. ~~*Public–private*~~*Public–private investment partnerships*: *An innovative approach for improving access, quality, and equity in healthcare in*

Commented [CE8]: AQ: There doesn't appear to be a citation to match this reference. Shall we delete the reference or will you add a citation?

developing countries. San Francisco, CA: Global Health Group, University of California.

Grimsey, D.~~, &~~ and Lewis, M. (2007). *Public private partnerships: The worldwide revolution in infrastructure provision and project finance*. Cheltenham and Northampton, MA: Edward Elgar Publishing.

Grimshaw, D., Vincent, S., ~~&~~ and Willmott, H. (2002). Going privately: P~~p~~artnership and outsourcing in UK public services. *Public Administration*, 80(3)~~:~~, 475–502.

Hebson, G., Grimshaw, D., and Marchington, M. (2003). ~~"~~PPPs and the changing public sector ethos: C~~c~~ase study evidence from health and local authority sectors. *Work, Employment and Society*, ~~vol.~~17(3)~~:~~ ~~pp.~~ 481–501.

Hellowell, M. (2010). ~~"~~The UK's private finance initiative: H~~h~~istory, evaluation, prospects.~~"~~ In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public–private~~public–private partnership*, ed. Hodge, G. A., Greve, C., and Boardman, A. E., pp. 307–332. Cheltenham and Northampton, MA: Edward Elgar Publishing. ~~307–332~~

Hodge, G. and Duffield, C. (2010). ~~"~~The Australian PPP experience: Observations and reflections.~~"~~ In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public–private~~public–private partnership*, ed. Hodge, G. A., Greve, C., & Boardman, A. E., pp. 399–438. Cheltenham and Northampton, MA: Edward Elgar Publishing. ~~399–438~~

Hodge, G. A. and Greve, C. (2005). PPPs: A policy for all seasons? In *The challenge of public–private partnerships: learning from international experience*, ed. Hodge, G. and Greve, C. Cheltenham: Edward Elgar.

Commented [CE9]: AQ: Please provide page range for chapter.

Hodge, G. A. and Greve, C. (2007). Public–private partnerships: An international performance review. *Public Administration Review*, 67(3): 545–558.

Hodge, ~~Graeme~~ G. A. and ~~Carsten~~ Greve, C. (2009). PPPs: T~~t~~he passage of time permits sober reflection. *Economic Affairs*, 29(1)~~:, pp.~~ 33–39.

~~Hodge, Graeme A and Carsten Greve. 2007. Public-private partnerships: An international performance review. *Public Administration Review*, 67(3): 545–558.~~

Hodge, G. A., Greve, C., ~~&~~ and Boardman, A. E. (2010). *International handbook on public-–private partnership*. Cheltenham and Northampton, MA: Edward Elgar Publishing.

~~Hodge, Graeme A. and Carsten Greve. (2005). PPPs: A policy for all seasons? In Hodge, G and Greve, C. (Eds.)*The challenge of public-private partnerships: learning from international experience*, Cheltenham: Edward Elgar~~

Hood, C. (1991). A public management for all seasons?~~.~~ *Public administration*, 69(1)~~:,~~ 3–19.

Klijn, E. H.~~, &~~ and Teisman, G. R. (2003). Institutional and strategic barriers to public-—–private partnership: An analysis of Dutch cases. *Public money and Management*, 23(3)~~,~~: 137–146.

Klijn, E. H.~~, &~~ and Teisman, G. (2005). Public-–private partnerships as the management of co-production: ~~s~~Strategic and institutional obstacles in a difficult marriage. *The challenge of public-–private partnerships: Learning from international experience*, ed. Hodge, G. and Greve, C., pp. 95–116. Cheltenham: Edward Elgar.

Kort, M., & and Klijn, E. H. (2011). Public–private partnerships in urban regeneration projects: Organizational form or managerial capacity?. *Public Administration Review*, 71(4):, 618–626.

Lowndes, V., & and Skelcher, C. (1998). The dynamics of multi-organizational partnerships: aAn analysis of changing modes of governance. *Public administration*, 76(2):, 313–333.

Linder, S. H. (1999). Coming to terms with the public- –private partnership a grammar of multiple meanings. *American behavioral scientist*, 43(1):, 35–51.

Maarse, H. (2006). The privatisationization of health care in europe: An eight-country analysis. *Journal of Health Politics, Policy and Law*, 31(5): 981–1011.

~~Marchington, M., Grimshaw, D., Rubery, J., & Willmott, H. (2004). *Fragmenting work: Blurring organizational boundaries and disordering hierarchies*. Oxford University Press.~~

McDonough, P. (2006). "Habitus and the practice of public service". *Work, Employment and Society*, ~~vol.~~20(4):~~, pp.~~ 629–647.

Marchington, M., Grimshaw, D., Rubery, J., and Willmott, H. (2004). *Fragmenting work: Blurring organizational boundaries and disordering hierarchies*. Oxford University Press.

~~National Audit Office Report (2005). *The refinancing of the Norfolk and Norwich PFI Hospital*. London: NAO; HC 78, 2005-06~~

Marek, T., O'Farrell, C., Yamamoto, C., & and Zable, I. (2005). *Trends and opportunities in public- –private partnerships to improve health service delivery in Africa*. Washington, D. C.: The World Bank.

Commented [CE10]: AQ: There doesn't appear to be a citation to match this reference. Shall we delete the reference or will you add a citation?

Commented [CE11]: AQ: Please provide the place of publication.

National Audit Office Report (2005). *The refinancing of the Norfolk and Norwich PFI Hospital*. London: NAO (HC 78, 2005–06).

Nishtar, S. (2004). Public–private'partnerships' in health–a global call to action. *Health Research Policy and Systems*, 2(1)~~,~~: 5.

Osborne, S. (2002). *Public-–private partnerships: Theory and practice in international perspective*. Routledge.

Palley, T. I. (2005). From Keynesianism to neoliberalism: Shifting paradigms in economics. In ~~Saad-Filho, A., & Johnston, D. (Eds.)~~ *Neoliberalism: A critical reader*, ed. Saad-Filho, A. and Johnston, D., pp. 20–29. London: Pluto Press. ~~20–29.~~

Parker, D. and Figueira, C. (2010). ~~"~~PPPs in developed and developing economies: What lessons can be learned.~~"~~ In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public private~~public–private partnership*, ed. Hodge, G. A., Greve, C., and Boardman, A. E., pp. 526–547. Cheltenham and Northampton, MA: Edward Elgar Publishing. ~~526–547~~

Perry, J. (1997). ~~"~~The antecedents of public service motivation~~"~~. *Journal of Public Administration Research and Theory*, ~~vol.~~7(2): 181–187.

Perry, J. and Wise, L. (1990). ~~"~~The motivational base of public service~~"~~. *Public Administration Review*, ~~Vol.~~ 50~~:~~(3)~~:~~ ~~, pp.~~ 367–373.

~~Pollock, A. M., & Godden, S. (2008). Independent sector treatment centres: evidence so far. *BMJ: British Medical Journal*, 336(7641), 421.~~

Pollock, A. M. (2006). *NHS plc: the privat~~isation~~ization of our health care*. Verso.

Commented [CE12]: AQ: Please add place of publication.

Commented [CE13]: AQ: Please add place of publication.AQ:

Pollock, A. M. and Godden, S. (2008). Independent sector treatment centres: Evidence so far. *BMJ*, 336(7641): 421.

Powell, W. W., White, D. R., Koput, K. W., ~~&~~ and Owen-Smith, J. (2005). Network dynamics and field evolution: The growth of interorganizational collaboration in the life sciences~~1~~. *American journal of sociology*, 110(4)~~:~~, 1132–1205.

Pratchett, L.~~, &~~ and Wingfield, M. (1996). Petty bureaucracy and woollyminded liberalism? The changing ethos of local government officers. *Public administration*, 74(4)~~:~~, 639–656.

Price, D., Pollock, A. M., ~~&~~ and Shaoul, J. (1999). How the World Trade Organ~~isation~~ization is shaping domestic policies in health care. *The Lancet*, 354(9193)~~:~~: 1889–1892.

Radnor, Z. J., Holweg, M., ~~&~~ and Waring, J. (2012). Lean in healthcare: ~~t~~The unfilled promise?~~.~~ *Social Science & Medicine*, 74(3)~~:~~: 364–371.

Raman, A. V. and Björkman, J. W. (2008). *Public–private partnerships in health care in India: Lessons for developing countries*. Routledge.

Rubery, J., Carroll, C., Cooke, F. L., Grugulis, I., and Earnshaw, J. (2004). Human resource management and the permeable organization: The case of the multi-client call centre. *Journal of Management Studies*, 41(7): 1199–1222.

Shaoul, J., Stafford, A., ~~&~~ and Stapleton, P. (2008). The cost of using private finance to build, finance and operate hospitals. *Public money and management*, 28(2)~~:~~, 101–108.

Skelcher, C. (2010). ~~"~~Governing Partnership~~",~~ In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public–private~~public–private partnership*,

Commented [CE14]: AQ: There doesn't appear to be a citation to match this reference. Shall we delete the reference or will you add a citation?

Commented [CE15]: AQ: Please add place of publication.

ed. Hodge, G. A., Greve, C., and Boardman, A. E., pp. 292–306. Cheltenham and Northampton, MA: Edward Elgar Publishing. ~~292–306~~

Smith, A. (2012). “Monday will never be the same again”: T~~t~~he transformation of employment and work in a public-~~–~~private partnership. *Work, Employment & Society*, 26(1)~~,~~: 95–110.

Sveman E.~~,~~ and Essinger K. (2001). Procurement of health care services in Sweden in general, and the example of procurement of acute care in the Stockholm Region. In~~:~~ *European integration and health care systems: A~~a~~ challenge for social policy*. Stockholm: Swedish Federation of County Councils.

Teisman, G. R.~~, &~~ and Klijn, E. H. (2002). Partnership arrangements: G~~g~~overnmental rhetoric or governance scheme?~~,~~ *Public Administration Review*, 62(2)~~,~~: 197–205.

Toms, S., Beck, M., ~~&~~ and Asenova, D. (2011). Accounting, regulation and profitability: The case of PFI hospital refinancing. *Critical Perspectives on Accounting*, 22(7)~~,~~: 668–681.

UK Trade and Investment (2013). *Healthcare UK: Public private partnerships*.~~,~~ London: UKTI.

~~Raman, A. V., & Björkman, J. W. (2008). *Public-private partnerships in health care in India: lessons for developing countries*. Routledge.~~

Vining, A. R.~~,~~ ~~&~~and Boardman, A. E. (2008). Public-~~—~~private partnerships eight rules for governments. *Public Works Management & Policy*, 13(2)~~,~~: 149–161.

Waring, J.~~, &~~ and Bishop, S. (2010). Lean healthcare: R~~r~~hetoric, ritual and resistance. *Social science & medicine*, 71(7)~~,~~: 1332–1340.

Commented [CE16]: AQ: Is this a book? If so, please provide page range for chapter.

Waring, J.~~, &~~ and Bishop, S. (2011). Healthcare identities at the crossroads of service modern~~isation~~ization: T~~t~~he transfer of NHS clinicians to the independent sector?~~.~~ *Sociology of health & illness*, 33(5)~~,~~: 661–676.

Waring, J., Currie, G., ~~&~~ and Bishop, S. (2013). A contingent approach to the organization and management of public–private partnerships: An empirical study of english health care. *Public Administration Review*, 73(2)~~,~~: 313–326.

Wettenhall, R. (2005). The public~~-~~ –private interface: S~~s~~urveying the history. *The challenge of public~~-~~ –private partnerships: Learning from international experience*, ed. Hodge, G. and Greve, C., pp. 22–43. Cheltenham: Edward Elgar. ~~22–43.~~

Wettenhall, R. (2010)~~.~~ ~~"~~Mixes and partnership through time~~."~~ In ~~Hodge, G. A., Greve, C., & Boardman, A. E. (Eds.)~~ *International handbook on ~~public–private~~public–private partnership*, ed. Hodge, G. A., Greve, C., & Boardman, A. E., pp. 17–42. Cheltenham and Northampton, MA: Edward Elgar Publishing. ~~17–42~~

Yescombe, E. R. (2011). *Public~~-~~ –private partnerships: ~~p~~Principles of policy and finance*. Butterworth-Heinemann.

Commented [CE17]: AQ: Please add place of publication.