Public–private partnerships (PPPs) have become a prominent feature of contemporary public policy. Although research shows variation in the contractual configuration of partnerships, there is little evidence of how these shape service and workforce organization. Through comparative ethnographic research on two PPP health care providers in the English National Health Service, this article develops the idea that PPPs exhibit “right” and “loose” arrangements that relate to “downstream” service and workforce management. It induces four empirically grounded mediating factors to describe this relationship. The first relates to the “dependence” between partners in terms of financing, strategy, and resource sharing; the second to the “strategic orientation” of leaders; the third to the composition of the “professional workforce”; and the fourth to the “management approach” to service and workforce organization. The article contributes to the research literature by exploring the contingencies in how PPPs are operationalized on the ground.

Public–private partnerships (PPPs) have engendered global interest from policy makers, as exemplified by urban renewal and economic development projects in the United States, long-term infrastructure projects in the United Kingdom, and institutional cooperation for joint production and risk sharing in the Netherlands (Hodge and Greve 2007, 2009; Koppenjan 2005; Noble and Jones 2006). Reflecting this, there has been an upsurge of academic interest in PPPs, especially in regard to local or central government initiatives (Bloomfield 2006; Koppenjan 2005; Noble and Jones 2006) and “upstream” issues of interorganizational cooperation (O’Toole 1997), contracting (Ghere 2001), evaluation of outcomes (Hodge and Greve 2007), and concerns about public accountability (Forrer et al. 2010).

Few studies have examined the “downstream” issues or “implementation stage” of PPPs at the organizational level (Noble and Jones 2006; Osborne and Murray 2000). A review of the literature confirms a tendency toward a broad conceptualization of PPPs rather than their practice and an empirical focus on partnership governance and interorganizational relations rather than comparative analysis of internal organization; that is, an extraorganizational level of analysis appears absent (Marsilio, Cappellaro, and Cuccurullo 2011). Attention to this downstream, extraorganizational level is particularly important for PPPs that are engaged in frontline or direct public service delivery, that is, those not confined to infrastructure or design partnerships. Emerging evidence shows, for example, variation in workforce organization, often in terms of employment conditions and management approach (Hebson, Grimshaw, and Marchington 2003; Smith 2012). However, there remains a lack of research regarding the interaction of observed variations in upstream interorganizational configuration and downstream service implementation. It might be anticipated, for example, that differences in how public and private sector agencies work together in terms of their relative contributions to financing, designing, managing, or producing PPPs have implications for service and workforce organization.

The research presented in this article aims to investigate this “black box” of PPP implementation to empirically induce the mediating factors that might explain how upstream variations in the relationship between public and private sector agencies relate to downstream service and workforce organization.

Empirically, this article adopts a comparative ethnographic case approach within two PPPs involved in frontline public service delivery and purposely selected to illuminate our theoretical question.
The exploratory study, which is empirically grounded and inductive, is located in the United Kingdom, one of the most receptive countries to the PPP concept (Noble and Jones 2006), focusing in particular on the introduction of Independent Sector Treatment Centres (ISTCs) in the English National Health Service (NHS). ISTCs illustrate the wider expectation in U.K. government policy that public agencies and private businesses should work together in partnership to meet contemporary public service goals (Her Majesty’s Treasury 1999). ISTCs illustrate the broad characterization of PPPs because they are based on formal collaboration of public agencies and private sector businesses to meet public goals (Greve and Hodge 2005; Osborne 2000; Yescombe 2007).

The article is structured as follows: First, it reviews key debates in the PPP literature and makes connections with relevant concepts related to the interaction of public and private organizations to develop the broad theoretical proposition that PPP configuration influences workforce management at the intraorganizational level. It then presents the empirical case of ISTCs in the English NHS before describing the study methods and case studies. The results provide detailed empirical accounts from each case study. Finally, the discussion explores the four main points of divergence as induced from the empirical findings across the two cases and relates these to wider conceptual and policy debates.

Public–Private Partnership: Variation in Implementation and Organization

In general terms, PPPs involve formal collaboration between public agencies and private sector businesses with the intention of meeting public goals. They are premised on the idea that partnerships bring together complementary but often disconnected resources and capabilities to share risks and coproduce public services (Hodge, Greve, and Boardman 2010; Lowndes and Skelcher 1998; Teisman and Klijn 2002; Van Ham and Koppenjan 2001). There remains, however, considerable variation—indeed, vagueness—regarding the definition of PPPs (Greve and Hodge 2005; Hodge and Greve 2007; Hodge, Greve, and Boardman 2010; Osborne 2000; Savas 2000; Yescombe 2007). Reflecting on this ambiguity, Skelcher (2005) suggests that underlying sociopolitical assumptions about the role of the private sector in meeting public goals often frame differences in interpretation. In some European countries, for instance, PPPs break with established modes of public sector delivery, whereas in North America, businesses have long been involved in service delivery. In other words, what is considered a PPP is likely to vary with national context.

International experience shows important variations in both the definition and the operationalization of PPPs (Gidman et al. 1995; Hodge and Greve 2005). In some instances, PPPs serve primarily as a basis for risk sharing and financing of large-scale public infrastructure projects that are then leased to or managed by public agencies (e.g., long term infrastructure contracts). In other instances, PPPs involve greater cooperation between public and private organizations in the coproduction of services (e.g., joint ventures). In others still, PPPs involve more arm’s-length forms of contracting in which private firms provide “design and build” or management expertise for public service providers (e.g., outsourcing). On the one hand, it can be argued that PPPs vary in terms of their scale and scope; for example, some are concerned primarily with infrastructure development, whereas others involve more direct or client-facing public service organization and delivery. As such, the impact of some PPPs on services and workforce organization can vary between more indirect influence (e.g., service planning or layout) to more direct and sustained participation in the management of services. The latter are particularly interesting because of the potential for PPPs to transform the organization of frontline services through the influence of more commercial forms of service and workforce management.

On the other hand, it might also be argued that PPPs can be understood as operating along some form of spectrum based on the relative roles of and relationship between partners (see figure 1) (Gidman et al 1995; Hodge and Greve 2009; Yescombe 2007). One way of elaborating this is to think about partnerships as either

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**Figure 1 Spectrum of Public–Private Partnerships**

Source: Gidman et al. (1995).
“tight” or “loose” (Greve and Hodge 2005). A tight arrangement highlights more horizontal resource sharing and collaboration, whereas a loose relationship involves more vertical contracting between a public purchaser and a private provider. For example, partnerships based on financial investment or outsourcing might be considered more loose than those based on joint working. These ideas have parallels in the work of Keast, Brown, and Mandell (2007), who propose three forms of integration within public service networks. These range from “cooperation,” with low-intensity interaction and information sharing, to “coordination,” in which resources and activities are aligned to meet common goals, to “collaboration,” with higher degrees of resource sharing in the coproduction of services.

Developing this tight/loose distinction, differences in the relationship between public and private sector partners might be elaborated along three linked dimensions. The first relates to the relative level of public and private “financing and risk-sharing,” that is, whether the PPP involves primarily private, public, or shared financing (Gidman et al. 1995). The second relates to the level of collaboration in “strategic planning and design,” that is, whether the partners are involved in long-term policy making or act primarily as external contractors (Hodge and Greve 2007). The third relates to the level of “resource sharing” above and beyond finances, that is, where governance systems, specialist technologies, management capabilities, and human resources are combined (Teisman and Klijn 2002; Van Ham and Koppenjan 2001). These three dimensions are by no means exclusive but help to develop the tight/loose dichotomy by elaborating the particular roles and relationship between partners. As an example, some PPPs have relatively tight relationships in the way they are cofinanced, codesigned, comanaged, costaffed, and, in turn, coproduced. Conversely, others involve looser relationships in which partner roles are more diverse, differentiated, and arm’s length; for example, they may be cofinanced but managed, staffed, and delivered by only one partner. This picture can become complicated because PPPs can involve multiple public agencies with distinct roles for planning, commissioning, and regulation and, similarly, multiple private agencies with responsibilities for finance, design, or construction. As such, the precise partnership definition and arrangement is contingent, depending on the relationships between partners, as well as the wider political, regulatory, and market factors—hence the burgeoning research on these upstream topics (Hodge and Greve 2009).

The idea that the upstream configuration of PPPs can vary depending on the relationship and relative roles of public and private sector partners represents a key theoretical and empirical issue.

Literature that examines employment relationships within PPPs largely casts change in a negative light (Grimshaw, Vincent, and Wilmott 2002; Hebson, Grimshaw, and Marchington 2003; Marchington et al. 2005; Rubery et al. 2002; Smith 2012). It shows that many PPPs are associated, for example, with cost-cutting and work intensification, which, in turn, reduce workforce commitment and opportunities for learning and, correspondingly, dilute the public service ethos. In short, this literature argues that PPPs are associated with “low-road” human resource management (HRM) strategies that treat “employees as a variable input and a cost to be minimised” (Legge 1995) and in which jobs are regimented and subject to hierarchical systems of management control. However, such research rarely considers whether comparable public sector organizations are necessarily characterized by “high-road” HRM strategies, with higher wages, skill levels, trust, and mutual working between managers and staff (Milkman 1998). Moreover, the existing research gives little indication of whether HRM strategies vary among PPPs being studied or whether downstream service and workforce organization might be a reflection of wider upstream partnership arrangements.

Evidence on downstream PPP implementation, specifically service and workforce organization, highlights the importance of the upstream relationship between public and private partners. However, there remains limited understanding of how these upstream interorganizational factors relate to downstream intraorganizational implementation. The aim of the research presented in this article is to identify the mediating factors that might explain how upstream PPP configuration (i.e., tight/loose) relates to downstream service and workforce organization (i.e., high/low road). Specifically, it investigates the tentative proposition that a PPP’s tight or loose configuration, as expressed in terms of finances, strategic planning, and resource sharing, will shape subsequent downstream service and workforce organization. For example, a loose partnership configuration gives private sector partners greater scope to enact more rationalized, commercially oriented, and low-road management of employees given the limited constraints of resource sharing and joint working. Conversely, a tight PPP configuration that involves greater cooperation between partners in terms of cofinancing, strategy, and resource sharing is likely to involve more high-road management of employees given the need to meet shared agendas and mutual interests.

Transforming the Organization and Management of NHS Care

Taking inspiration from European and North American “surgi-centers,” Treatment Centres were introduced to the English NHS in the early 2000s to increase service capacity, tackle excessive waiting times, and enhance patient choice (U.K. Department of Health 2001). Many of these were developed in partnership with the private sector as Independent Sector Treatment Centres, which policy described as providing additional investment in new
infrastructure, expanding the mixed economy of care, and enabling the private sector to innovate services (U.K. Department of Health 2005). Although owned and managed by the private sector, policies continually emphasize that patients are still to be treated in line with the principles of the NHS, with care “free at the point of use,” but that they benefit from modes of care delivery that are more commonly found in the private sector (U.K. Department of Health 2005).

ISTCs illustrate the growing role of PPPs in public service organization and delivery that go beyond financial partnerships or infrastructure renewals (U.K. Department of Health 2005). Specifically, private businesses are encouraged to develop, own, and manage public health care services through collaboration with other public sector organizations, including family doctors and other hospitals. While this presents opportunities for new sources of financing, management capabilities, and new ways of working, it also aims to ensure that ISTCs are appropriately integrated within existing NHS commissioning and regulatory frameworks. However, ISTCs vary in terms of their scope and scale (Pope et al. 2006), and, like other PPPs, these variations are often a reflection of the upstream arrangement of public and private sector partners (U.K. Department of Health 2005).

Specifically, early or “first-wave” ISTCs were developed as largely privately financed and independently managed providers of additional or “supplementary” NHS services (U.K. Department of Health 2001). In many ways, they functioned as private hospitals operating within the NHS and had limited public investment or participation in their design, staffing, or operations. As such, partnership working was largely confined to agreeing and monitoring levels of service, sharing of specialist NHS infrastructure (e.g., booking systems), and integration within existing NHS commissioning systems.

In contrast with the aspirations of policy makers, however, research reveals a more complex picture of ISTC organization. For example, stark enhancements in physical surroundings and technology are not always reflected in changed working practices, care pathways, or new clinical roles (Gabbay et al. 2011). More critically, some commentators see private sector attempts at process redesign and role configuration as involving work intensification and deskilling; for example, nurses’ roles are aligned to meet a limited number of high-volume tasks, or specialist roles are substituted for more generic and low-cost employees (Bishop and Waring 2010). Linked to this, research also shows how the organization of clinical teams and communities within ISTCs can have negative implications for professional training and learning (Turner et al. 2011). More broadly, research suggests that ISTCs involve important changes in employment relations, the emergence of a two-tier workforce, and the erosion of public sector ethos (Hebson, Grimshaw, and Marchington 2003). Therefore, there is a dissonance between the picture of ISTCs presented by policy makers and the business community and the growing body of research that critiques ISTCs. The aim of this article is to investigate whether variations in downstream service and workforce organization might be a reflection of upstream variations in partnerships arrangement and to induce the factors that might account for this relationship.

**Study Setting and Methods**

**Case Selection**

The research involved a comparative ethnographic case study of two ISTCs undertaken between 2006 and 2010. This approach was taken to provide contextual insight and depth of analysis within the cases, paying particular attention to the ways in which these services
were organized, while also enabling comparison between cases to develop conceptual arguments (Eisenhardt 1989; Yin 2003). The study sites were purposely sampled with the intention of exploring variations in ISTC configuration as described earlier.

ISTC A was selected to reflect a loose PPP with greater levels of private financing and limited risk sharing (i.e., both profits and losses resided with the private partner), limited collaboration in strategic planning (i.e., private interests shaped strategy), and limited sharing of resourcing (i.e., staff and equipment were sourced from outside the NHS). Owned and run by a North American company, it was opened in 2006 as a provider of additional or “supplementary” health care services to address extensive waiting times for certain surgical procedures (orthopedic, ophthalmic). It employed a largely non-NHS workforce who had previously worked either outside the United Kingdom or in existing private sector hospitals, except for some specialist administrators recruited from the NHS to support contracting with the wider NHS.

ISTC B was selected to reflect a tight or joint venture PPP that involved financial investment and risk sharing by both public and private sector agencies, sustained collaboration in strategic planning, and resource sharing in service delivery. Opened in 2008, this was a “substitute” service provider, whereby a European private health care company assumed responsibility for the management and delivery of preexisting NHS services (orthopedic, ophthalmic, vascular). As well as coinvestment and collaboration in service planning, this also involved the transfer of NHS clinicians, including nurses, auxiliaries, and support staff who were seconded full time; and physicians, surgeons, and specialists who were seconded on a session basis (retaining their NHS positions for additional clinical commitments).

Data Collection
Nonparticipation ethnographic observations were undertaken over 18 months to explore the organization and management of work within each site. This involved an initial exploratory period of six months within each ISTC and a further six months for follow-up observations. In total, more than 600 hours of direct observations were undertaken in clinics, operating theaters, wards, recovery, reception areas, staff rooms and rest areas, management meetings, and team briefings. Descriptive observations were recorded in handwritten field journals, together with reflective interpretations, which were complemented by informal conversations with managers and clinicians. In addition, 72 semistructured interviews were conducted with representatives from managerial and clinical staff groups (see table 1). Interviews followed a common thematic guide related to (1) the financial, contractual and operational relationship between the ISTCs and the other NHS organization and agencies; (2) ISTC strategy; (3) the organization and management of work; (4) the development of operational guidelines and procedures; and (5) communication and group working issues.

During the course of the study, documentary evidence was also collected, including strategic documents, policies and procedures, memos, and routinely collected service data. This was used to contextualize and extend analysis with observations and interviews. The study received ethical approval through the standard NHS research governance framework, as well as local management approvals.

Data Analysis
Data analysis was informed by the principles of interpretative grounded theory (Lincoln and Guba 1985; Strauss and Corbin 1990). It involved an iterative process of close reading of data, coding, constant comparison, elaboration of emerging themes, and reengagement with the wider literature. In the first instance, two authors open-coded data through close reading of transcripts and observation records. Analysis centered on the relative histories, configuration, organization, and management of each ISTC. Empirically grounded concepts and coded items of data were wide ranging and reflected the detail of each case study. To ensure the reliability of this process, all codes were cross-referenced for interpretation and internal consistency between coders, while another author provided an additional level of interpretation to test the consistency of agreed codes. Using the computer software Atlas ti, these codes were applied to all interview, observational, and documentary data, while still being open to the identification of additional issues. Categorized data were constantly compared for internal consistency, grouping, thematic relationship, and relevance to existing research.

Through this iterative process, 17 second-order codes were identified and developed that subsumed the concepts identified from the data. The computer software was used to further analyze second-order codes, looking in particular for internal consistency, thematic relationships, and grouping. At this stage, specific attention was paid to the similarities and differences between organizational case studies to develop an empirical basis for describing of convergence and divergence in their configuration and organization. This led to the identification of eight oppositional (dialectical) third-order codes that provided the basis for characterizing the differences between research sites. Through repetition of the coding process, these oppositional codes were aggregated into four thematic dimensions that could provide the basis for our model of the relationship between upstream partnership arrangement and downstream service and workforce organization.

In line with the research aims, analysis sought to induce from the data grounded concepts and categories that describe and elaborate the mediating factors that could account for how the upstream ISTC configuration relates to downstream service and workforce organization. These are described and explained later and relate to the level of “dependence” between partners, the “strategic orientation” of private sector partners, the composition of the “professional” workforce, and the “management approach” taken to service and workforce organization (see figure 2). These themes have the potential to provide the foundations of subsequent theoretical elaboration and testing.

Findings
This section provides a rich descriptive and interpretative account of each ISTC case. It describes the local context of implementation,

<table>
<thead>
<tr>
<th>Table 1</th>
<th>List of Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Group</td>
<td>ISTC A</td>
</tr>
<tr>
<td>Executives/senior managers</td>
<td>2</td>
</tr>
<tr>
<td>Middle/business managers (nonclinical)</td>
<td>6</td>
</tr>
<tr>
<td>Clinical managers/department leaders</td>
<td>4</td>
</tr>
<tr>
<td>Doctors</td>
<td>8</td>
</tr>
<tr>
<td>Nurses</td>
<td>8</td>
</tr>
<tr>
<td>Health care assistants and theater practitioners</td>
<td>3</td>
</tr>
<tr>
<td>Other clinical and therapists (physiotherapists, occupational therapists, radiographers)</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
</tr>
</tbody>
</table>
Executives sought to establish “proof of concept” (Executive 2) with a view to securing future contracts and market position within the United Kingdom. Working toward these aspirations, service leaders were primarily concerned with maximizing operational efficiency through increased throughput and reduced unit cost, which was associated with operational surplus, market expansion, and shareholder return. Although PPPs are premised on mutual benefit to both the public service and the private provider, for ISTC managers, the balance between the two was, on occasion, precarious.

We treat each patient fairly based on clinical need. We are not changing the principles of the NHS or anything like that, but we are showing that we can do it more efficiently and make a return on the investment we have made. (Executive 1)

The realization of these commercial aspirations centered on the appropriate configuration and management of clinical services “from the blueprints up” (Manager 1). This involved applying “tried and tested” (Manager 3) “operational templates” (Operational Handbook) used by sister services in North America. These comprised highly specified and standardized procedures for organizing administrative and clinical activities. These, it was claimed, were based on “evidence of clinical outcomes” and would improve patient throughput “between 15 and 25 percent” in comparison to existing NHS services (Manager 1).

Figure 2 Coding and Thematic Analysis

the rationale and approach taken by service leaders, the organization of work, and the experiences of the clinical workforce on the ground. To substantiate these rich descriptions, significant and noteworthy extracts of data, including verbatim quotes, are provided throughout, and further illustrative examples are provided in table 2, organized to reflect the second order and thematic analysis of data as described earlier. Cross-case analysis builds on these accounts to describe the points of divergence between the ISTCs and the four thematic mediating factors induced from the data.

**ISTC A:** The “Independent” Provider of Supplementary Services

ISTC A was wholly financed through private investment, which was used to fund new hospital infrastructure, the procurement of specialist resources, and the recruitment of clinical, technical, and administrative staff. It had limited collaboration with the wider NHS (e.g., use of NHS referral pathways, access to emergency services, and use of wider NHS information technology infrastructure). Therefore, it operated with a high degree of independence from, and in direct competition with, existing NHS services, and financial risks were largely held by the private partner, although risks to service continuity were arguably underwritten by the NHS in cases of service failure. Illustrating this competitive aspect, ISTC executives were strongly committed to creating a revolutionary model of care that compared favorably with existing NHS services in terms of waiting times and patient experience.

This service is going to be unlike other NHS hospitals. It will build on [company name]’s experiences and track record to do things differently and show patients that we can be trusted. (Executive 2)

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"It was set up with some nominal support from the local NHS but we are an independent company providing independent services." (ISTC A, Manager 1)

"A part from the commissioners we don’t have much to do with the other NHS services. We still have to meet the standard and contracted levels but we don’t answer to anybody else.” (ISTC A, Manager 2)

Focus on competition

"This is a business at the end of the day, we have got to make it work financially. We don’t have the back-up of the NHS and if we fail somebody will just replace us.” (ISTC A, Manager 3)

"The market is getting more crowded and it is essential to maintain a strong position amongst these new competitors, as well as the existing NHS service providers.” (ISTC A, Manager 1)

Priority to shareholders

"At the end of the day this is a business and we need to make a return on the investment. If we don’t then they will just pull the operation and reallocate the staff.” (ISTC A, Manager 1)

"I know they talk about the patient and putting the patient first, but really we are answering to the shareholders. You don’t feel like you are really giving a public service.” (ISTC A, Nurse 3)

Emphasis on commercial performance

"We want to provide the best quality services to our patient at the lowest possible cost and that means always trying to do things differently … it is this drive to do things differently that will make our treatment centre different.” (ISTC A, Executive 2)

"Quarterly performance meeting—CEO, CFO and dept. managers. The review process is informed by score card type model. Each dept. is systematically reviewed in accordance with meeting prescribed metrics. Number of case. Number of cancellations. Number of delayed procedures. Number of re-admitted cases. Number of staff absence. Dept. costs re: Dept. income.” (Extract from field journal, June 2009)

Disparate professional backgrounds

"This country is, compared to other countries and maybe even compared to the NHS, the independent sector has to be extremely forthright. If for example, we looked at our overseas procedures protocols, there is a huge amount of pages, where all the main processes are defined. I implemented and let the quality management system at [a German] University also, that was not even close to this formality.” (ISTC A, Consultant Surgeon)

"I trained in Poland and then worked in Germany before moving here. It is a good opportunity for me to develop my clinical skills.” (ISTC A, Anesthetist)

"Well, I was trained in the NHS but haven’t really worked in the health service for years. I sometimes do some temporary work, but I spent most of my career in the private sector and this seemed like an extension of that really.” (ISTC A, Nurse)

Lack of collegiality

"You just feel so isolated. If you are put in theatre for the day the only people you see are the people you are in theatre with, whereas before…we used to see a lot of people and we used to meet up, especially in recovery you would often be in at the same time as the other theatres.” (ISTC A, Nurse)

"Weekly team briefing. Eye list. Representation from nursing and practitioners— in the meeting the unit manager announced the introduction of a new shift rota reallocating staff roles and tasks—whilst the document was circulated and posted on the notice board there was little group discussion. Nobody seemed agitated or vocalised concern. No collective opposition to change. A few people looked worried.” (Extract from field journal, August 2009)

Standardization of work

"Medicine always has this humanity aspect to it, but in general of course it's a production process, the same as every other product and process and that applies to who pays for it and that also applies to the managerial mechanisms in place.” (ISTC A, Clinical Manager)

"The staff follow explicit Standard Operating Procedures that it really easy for them to do their jobs. The whole thing is set up to make sure patient have a safe and streamlined experience without all the delays and hold-ups, and that the staff do their job to the best of their ability.” (ISTC A, Manager 3)
The whole philosophy behind the company is to export American health care into this country because they do it so well out there. (Executive 1)

These were illustrated in policies in the form of linear flow diagrams and step-by-step standard operating procedures (see Extract 1 and 2). For example, policies in relation to “patient reception” designated approximately three minutes for registration and checks. Similarly, patient assessment was based on formulaic instructions for taking history, drawing necessary bloods, or undertaking examinations.

**Extract 1: Extract from the Clinical Preparation Policy**

To ensure the efficient running of the clinic it is necessary to carry out certain tasks before the day of the clinic:

1. **Referral Letters:** All referral letters are filed after clinical review and scheduling within a designated area. To ensure referral letters are available for the patient’s consultations the clinical team will ensure the referral letter is present five days prior to the date of the consultation. If it is absent it will need to be retrieved either from “Choose and Book” [the U.K. electronic booking system], or at last resort the GP surgery.

**Extract 2: Extract from the Clinical Consultation Standard Operating Procedure**

| Step 1: | The clinician takes the health records in the consultation room, reads the relevant documents prior to and during the patient visit. |
| Step 2: | The clinician confirms they have the correct patient by using demographic details in the health record. |
| Step 3: | Clinician introduces themselves to the patient. |
| Step 4: | Consultation occurs. If patient needs to be consented for treatment, this will occur during the consultation. |

Standardization was described by managers as improving working practices in three linked areas. First, it ensured optimal use of resources, especially theater time and staff capabilities. For example, care pathways were described as reducing duplication, waiting, or delays. Second, it reduced unnecessary variability in clinical practice, especially in regard to deviations from evidence-based practice and safety guidelines. Third, it provided all patients with consistent standards of care. Here, particular reference was made to other service sectors, such as retail or hotels, where customers are located at the center of work processes.

Commitment to predefined service models was reinforced through the use of key performance indicators and a dedicated computer system. For example, procedural and time requirements around patient admission and discharge were both specified and measured through information technology systems, which automatically recorded data on completion of tasks. In addition, clinicians were required to abide by a multitude of checking and read-back procedures that corresponded with the overarching service templates. According to service leaders, these are essential for ensuring clinical standards and controlling for unsafe performance.

These highly structured and streamlined service models had implications for the organization of clinical roles and responsibilities. Although doctors in particular are often associated with high levels of discretionary practice, based on the application of specialized knowledge (Freidson 1970), the configuration of work in the ISTC gave limited opportunity for surgeons and anesthetists to dictate the general flow or organization of work, beyond the highly technical aspects of surgical and anesthetic technique. This included elements of diagnosis and treatment decision making, which were guided by prescribed admission guidelines and operating procedures.

It’s very orderly. There are few ambiguities about where the patient is, what the nurses are doing or what needs to be done. It runs like clockwork … everything is planned and arranged for you. (Surgeon 5)

In addition, nonmedical clinicians (i.e., nurses and care assistants) became increasingly “generalist” as their roles were organized...
across rather than within clinical task domains, such as assessment, theater, recovery, and discharge. This provided service leaders with flexibility in staff utilization. It might be expected that this mode of working would garner criticism from clinicians, especially around the lack of autonomy, reduced specialization, and extensive management control. However, this mode of working was widely accepted as an inevitable feature of working within the ISTC. For those clinicians recruited from outside the NHS (about 65 percent of the workforce), their unfamiliarity with wider norms and modes of NHS care, together with their desire to secure employment within the U.K. health system, seemed to counter any desire to question this model of work. For clinicians recruited from the U.K. private health sector (30 percent of the workforce), the ISTC was seen as a departure from conventional NHS services, but one that closely resembled other private hospitals within the United Kingdom. Therefore, the large majority of the workforce accepted the mode of working found within the ISTC. Reflecting on their experiences, most did not perceive the ISTC as a threat to an established professional status, especially because more technical duties remained relatively unchanged, while service managers were perceived as organizing services in ways to better support the use of this skill. In contrast to ISTC B, these clinicians made little reference to customary ways of working or established cultures and appeared to advance a highly individualized, noncollegial, view of professionalism. This stemmed from the lack of preexisting relationships or collective identity among the clinicians before they were recruited to this service.

**ISTC B: The “Joint Provider” of Substitute Services**

ISTC B was a jointly conceived and financed partnership between a local NHS hospital, NHS commissioners, and a European health care company. Rather than providing supplementary services, it substituted existing NHS services that were transferred from the local NHS hospital to the ISTC. As a part of its collaborative approach, NHS partners and the private company participated in business planning and resource sharing to ensure continuity and integration with wider NHS services. This was evident, for example, in information technology procurement, service-level agreements for cleaning or support services, contract negotiations over specialist technologies, and overlap of governance arrangements. As such, there was greater sharing of both financial risks, especially where potential losses were distributed across public and private sector partners, and operational risks, where there was limited backup or redundancy within the wider NHS for continued service provision if the service failed. Significantly, the interdependence between partners was further evidenced in the sharing of human resources, where the majority (86 percent) of clinicians and staff (including some middle-level managers) were seconded from the preexisting NHS service. From the outset, ISTC leaders described the challenges of introducing change among an established workforce but suggested that they would work to establish more productive and innovative services.

There are a whole series of service-level agreements between the two organizations that have made it very complicated in terms of working through the issues. (Clinical Director 1)

Despite differences in the partnership configuration, the private sector partner expressed aspirations similar to those of ISTC A, especially for their long-term position and return on investment. These were commonly manifest in managers’ emphasis on performance targets for contracted levels of service, including the volume of patients, waiting times, patient satisfaction, theater and resource utilization, and sickness and absence rates. To realize these aspirations, service leaders talked of their desire to follow exemplary companies, such as the U.K. retailer Tesco, the car manufacturer Toyota, and the airline Ryanair, which illustrated the type of customer-centered efficiency that the ISTC should copy. Like ISTC A, this was initially translated into practice through a variety of operational policies, formulaic care pathways, and standard operating procedures. Similarly, many of these were taken from templates used by the parent company or affiliates, while others were developed to reflect the close relationships with existing NHS services. For example, protocols for the management of specialist diagnostic equipment needed to take into account the fact that some equipment remained the property of the NHS. Similarly, a number of pathology interventions offered by the ISTC continued to be provided by the NHS. So, in one respect, services were transferred to the private sector, but then the private firm contracted elements of these services back from the NHS. Such organizational complexity required service leaders to develop procedures incrementally to meet often unanticipated problems.

A significant operational issue related to the management of the preestablished clinical groups transferred from the NHS. In the early stages of the ISTC’s operation, strenuous efforts were made to audit and reconfigure existing clinical practices and care pathways so that they would be better aligned with new service templates and procedures. In most instances, however, these were met with blunt opposition and resistance from the clinical workforce. This included “go-slows” or “working to rule” and refusing to follow new procedures. Underlying this opposition was widespread concern about private sector managers’ experience of running such services, coupled with clinicians’ belief that they had more appropriate expertise, based on their years of providing these services within the NHS.

I’m not convinced they actually know what they are doing? This isn’t like any other business, this is medicine and it can’t be managed like a factory or production process. (Surgeon 3)

Given such resistance, service leaders altered their approach, giving less emphasis to the reordering of care processes and greater priority to changing staff attitudes. On the one hand, this involved articulating a “new vision” (Manager 4) of the ISTC that downplayed the more commercial aspects of the parent company, while reinforcing the idea that the ISTC benefited from new forms of business expertise, provided high-quality patient care, and made better use of taxpayers money. This was commonly articulated in ISTC induction procedures, internal training events, and staff consultations meetings, where executives would seek to enroll clinicians into the change process. On the other hand, changing staff attitudes took the form of “listening to staff” and “encouraging them to take responsibility for change” (Manager 2). For example, the reconfiguration of several care pathways was delegated to frontline clinicians who audited existing practices and made recommendations for change (See Extract 3).
Members of the clinical workforce were enrolled into the change management agenda in other ways. For example, clinical teams were tasked to undertake “improvement projects” in target-driven areas, such as delays, patient experience, infection control, or absence. To support this new approach, senior executives also created a more equal balance of public and private sector middle-managers to ensure a degree of harmony between the needs of the parent company and the expectations of clinicians.

We are trying to create a new culture, a new way of working that is better for the clinicians because they feel like they have the power and for the patients because they feel they are at the centre of everything we do. (Manager 5)

Over time, most (but not all) clinicians participated in this inclusive approach. This was reflected in clinicians’ changed attitudes toward the ISTC, often framed in terms of their realization that they were still providing public health care and, more specifically, in the belief that the ISTC did not compromise existing standards. However, for many, this change in attitude went further, such that clinicians became more active exponents for the model of service organization and levels of care delivery. For these clinicians, it seemed that their involvement in, even ownership of, the change process helped result in services that were an improvement on past NHS modes of working and levels of care.

We have changed the way we work. We have gone through most of our care pathways, looked back over our performance, listened to patients and worked on making changes where we can.… The gastric pathway is quite different from what we started with and you may say that we would never have done this in old place [an NHS hospital]. (Nurse Manager)

This was further evidenced by the gradual reconfiguration of many preexisting work practices and care processes that had been carried over from the former NHS hospital. For example, most care pathways were incrementally realigned to increase patient throughput and reduce delays. Equally, checklist and read-back procedures were developed within the ISTC and used across many surgical specialties. Although many staff remained skeptical about the private sector, there was a clear shift in attitudes about the new work practices, on the grounds that they were shaped by clinicians themselves, even where change came to resemble the service models and pathways originally introduced by managers but resisted by clinicians many months earlier.

Case Comparison and Discussion

The findings highlight two distinct accounts of the ISTC program. They reveal variations in how the ISTCs were framed and arranged as partnerships between different agencies, as well as variations in service and workforce organization. Cross-case comparison gives a deeper appreciation of these differences and brings to light four empirically grounded thematic areas of divergence (dichotomies) that unpack how upstream variations in ISTC configuration played out over time to shape downstream workforce configuration. As outlined earlier, these mediating factors appear to stem from the tight/loose configuration of the partnerships—financial ownership and risk sharing, strategic design and resource sharing—which is reflected empirically in the level of partner “dependence.” From this, the findings reveal differences in terms of the “strategic orientation” or outlook of managers within each ISTC and the character of the “professional workforce,” which then relate to the “management approach” taken to service and workforce organization (see table 3).

An initial observation from the cross-case comparison relates to the type of relationship—specifically, dependence—between public and private sector partners. In line with the dimensions outlined, the ISTCs varied according to their financing (private finance versus cofinanced) and sharing of risk (unequally versus equally distributed), how they were devised and planned (limited versus extensive codesign), and whether other resources were shared (separation of resources versus shared technologies, support services, and staff). In addition to Hodge and Greve’s (2005) tight/loose typology, attention to these dimensions helps us understand differences in the level of dependence between partners (independence versus interdependence).

In summary, ISTC A was characterized by a high degree of independence from both its immediate partners (commissioners and service providers) and the wider health economy, functioning as a self-financed, self-managed provider of NHS services. Although

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>ISTC A</th>
<th>ISTC B</th>
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<tbody>
<tr>
<td>Dependence</td>
<td>Relative independence from partners</td>
<td>Integration and interdependence with partners</td>
</tr>
<tr>
<td>Strategic orientation</td>
<td>Outward facing on competition</td>
<td>Inward facing on partnership collaboration</td>
</tr>
<tr>
<td>Professional workforce</td>
<td>Individualized and task-based professionalism</td>
<td>Collectivized and service-based professionalism</td>
</tr>
<tr>
<td>Management approach</td>
<td>Radical change based on external modeling and “hard” management</td>
<td>Incremental change based on internal engagement and use of “soft” management</td>
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services were still provided in line with prevailing NHS commissioning and regulatory frameworks, ISTC A showed little collaboration or integration with other services and acted largely as a contractor, even as a competitor. In comparison, ISTC B revealed interdependence in financing and risk sharing, planning and design, and sharing of specialist resources, including staff. Services were provided not only in line with NHS frameworks but also in collaboration with local NHS services. As such, the study reiterates the importance of these key upstream factors in underlying differences in PPP configuration, which in this case are empirically manifest as differences in partner “dependence.”

An immediate implication of this dependence, and a further mediating factor in downstream service management, relates to the “strategic orientation” of service leaders. Although both ISTCs aimed to establish productive care services, sustain their market position, and secure return on investment, their approaches to achieving these strategic priorities differed. In ISTC A, service leaders appeared to position their services more directly toward achieving these corporate priorities without needing to engage with their public sector partners in terms of how they planned or delivered services—that is, they had a less constrained and more independent relationship. For ISTC B, service leaders were less able to orient toward their corporate priorities given the need to work in collaboration with their public sector partners, that is, to ensure service integration or resource sharing. Developing this point, it might be argued that PPPs with greater private sector independence are likely to be more “outward facing” in terms of their emphasis on competition and corporate performance, whereas those with greater interdependence might be more “inward facing” given their need to collaborate with local partners and where private interests are moderated by the need to work in collaboration. This represents an important mediating factor in the subsequent downstream configuration of services.

A further significant factor relates to the composition of the “professional workforce.” As a consequence of its contractual arrangement, ISTC A had limited scope for sharing human resources with the wider NHS and recruited staff from other health care organizations, sectors, and nations. The resultant clinical workforce not only had limited experience of the work customs of similar NHS services but was also highly “individualized” given that clinicians had little experience working together. In contrast, ISTC B involved the transfer of clinicians from the NHS, inheriting a workforce with well-established work patterns, teams, and cultures. As such, this “collectivized” workforce had a high degree of solidarity and collective resistance to change. This reveals further how upstream resource sharing, especially of a specialist workforce, can influence whether a PPP has a more fragmented and “individualized” workforce (ISTC A) or a more “collectivized” workforce (ISTC B). Given that established professional communities can often be resistant to change (Fitzgerald et al. 2002), the composition of the professional workforce represents a significant mediating factor in the downstream services and workforce organization.

These two mediating factors influenced the “management approach” to frontline service and workforce organization. From the outset, both ISTCs sought to introduce standardized models of service organization based on templates used by their respective parent companies that were arguably aligned with commercial aspirations. As a consequence of their relative dependence, strategic orientation, and professional workforce, the experience of organizing care along these lines varied, resulting in two distinct approaches. ISTC A might be characterized as involving more “hard” or “low-road” HRM strategies (Milkman 1998), with clinical processes configured around highly standardized and supervised work processes. For ISTC B, such direct management of work was made difficult, given the resistance to change within established professional communities and the need for service managers to work within wider NHS systems. As such, service leaders embarked on a more incremental, “soft,” or “high-road” HRM strategy (Milkman 1998) to service transformation that centered on engaging staff and changing established values, attitudes, and cultures. Over time, these fostered support among clinicians for more standardized and formulaic work practices based on engagement, ownership of change, and consent. The relative independence of ISTC A from its public sector partners, together with its individualized clinical workforce, appeared to afford greater scope to introduce a more radical and nonconformist mode of service delivery based on service models developed in other health systems. For ISTC B, the interdependence with the public sector, together with the transfer of an established and collegial professional workforce, appeared to require a more incremental approach to work transformation based on staff engagement and winning the “hearts and minds” of an entrenched and, at times, resistant professional workforce.

Conclusions

Through two purposive ethnographic case studies, this article developed a descriptive account of how upstream PPP configuration can relate to downstream service and workforce organization. This type of qualitative research offers a level and depth of insight that is particularly useful for understanding the local implementation of major policy initiatives and offers an “inside the box” perspective for developing new descriptive accounts and concepts. As such, it highlights the importance of methodological pluralism and the contribution of in-depth organizational ethnographies to policy evaluations. That said, it is important to bear in mind that any conclusions from two empirical case studies can only be tentative, and empirical findings and concepts should provide the basis for subsequent proposition development and testing.

Through exploring the introduction of ISTCs in the English NHS, the study developed four empirically grounded concepts, or mediating factors, that elaborate the relationship between upstream partnership configuration and downstream service and workforce organization. The first relates to the level of dependence between public and private sector partners, whereby ISTCs based on greater financial and risk sharing, strategic collaboration, and resource sharing might be characterized as being more
the more sweeping claims that PPPs result in low-road HRM strategies. As with the example of the airline industry (Gittell and Bamber 2010; Harvey and Turnbull 2010), our empirical study suggests that PPPs can involve both high-road and low-road approaches. Given the knowledge-intensive nature of the clinical workforce and the professional power wielded by doctors in particular, we should not be surprised by evidence that some PPPs in health care may exhibit a high-road approach, especially when clinical communities are well established. However, we note that the original intention of the private sector partner in ISTC B was a low-road approach to HRM strategy. The employment situation preceding the establishment of interorganizational relations across the private–public divide meant that they deviated from the original intent (Grimshaw, Vincent, and Wilmott 2005), given antagonism from the clinical workforce toward a low-road strategy (Milkman 1998). Although some commentators suggest that health care may be subject to cost competition, which might engender a low-road approach (Gittell and Bamber 2010), this may be more focused on peripheral rather than core staff (Kalleberg 2001, 2003). Even in the case of ISTC A, where work procedures were simplified to reduce skill input, which limited opportunities for learning and development, professional staff accepted this as a consequence of their desire for more flexible employment (though it is noted that the workforce in this case was rather distinctive); antagonism reported in other studies toward low-road HRM strategy (Milkman 1998) appears absent.

Again, it is important to emphasize that these empirically induced mediating factors can only be tentative, but they might provide the foundations for subsequent hypothesis development and testing. More broadly, this research elaborates the idea that PPPs can vary in terms of a “tight” or “loose” relationship by showing how partner roles and responsibilities can differ in terms of participation in financing and risk sharing, strategic planning, and resource sharing. This extends and supports the usefulness of Hodge and Greve’s (2007) typology and calls for further research to elaborate and assess the implications of these differences in PPP configuration.

Understanding how PPPs vary and how such variations contribute to service innovation remains important within the current era of economic uncertainty and austerity. Governments across the world are looking to contain public spending, while maintaining levels of service quality. This has led to increased interest in the diversification and pluralization of public services, including closer working relationships with the private and third sectors. The expansion of private sector involvement in the organization and delivery of public services, together with the aspiration that such competing services will work collaboratively, raises new questions about future partnerships as a mode of organizing public services and the impact on the organization of work within PPPs. Finally, it is acknowledged that the comparative cases are relatively stylized, and thus there is a need for further empirical and grounded research that examines downstream issues, such as the organization of work and the contingencies that frame this in different settings.

References


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