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The regulatory state and the UK Labour Government's re-regulation of provision in the English National Health Service

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Abstract
Following its election in 1997, the UK Labour Government embarked upon a 10 year program of reform of the National Health Service (NHS). By 2005, Labour had doubled the NHS budget and dramatically transformed the shape of the Service. In England, a basic characteristic of the NHS is the organizational split between provider and commissioning agencies. In this article I argue that Labour's re-regulation of NHS provision is a coherent representation of the influence of the "regulatory state" in restructuring arrangements between government, market, and society. The article offers an account of the regulatory state based on a discussion of five key theses: The Audit Society, Regulation Inside Government, The New Regulatory State, The British Regulatory State, and Regulatory Capitalism. The article unfolds Labour's program of reform across themes common to these accounts: the division of labor between state and society, the division of labor within the state, the formalization of previously informal controls, and the development of meta-regulatory techniques of enforced self-regulation. It concludes that the key themes of the regulatory state are at work in Labour's transformation of NHS provision and it offers a discussion of the implications for both scholars of regulation and the UK and European health policy literature.

Keywords: governance, health care, regulation, regulatory capitalism, regulatory governance, regulatory state.

Introduction

The National Health Service (NHS) is Europe's largest organization (NHS 2009). It employs more than 1.3 million people and offers publicly funded health care free at the point of access for the entire population of the UK. While the NHS is a collective term that refers to the four publicly funded health care systems of England, Wales, Scotland, and Northern Ireland, each system operates independently, and is accountable to the respective devolved government. Founded in 1948, the NHS is a classic institutional embodiment of the ideals of national citizenship, mass democracy, and public ownership commonly associated with the old European welfare state. In postwar Britain, health care, like railways, telecommunications, broadcasting, and essential services, was nationalized

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under the Attlee Government's strategy for Keynesian economic management, full employment, and a broad-based system of social services.

Today, all European Union (EU) member states have some form of national public health system that ensures near universal access to comprehensive services (Hervey 2008, p. 104). While their organizational elements differ markedly, all systems face similar and significant challenges. These challenges are well known: ageing populations, changing taxation bases, changing morbidity patterns, new and expensive technologies, increased patient expectations, and broader welfare austerity (Rhodes & Meny 1998; Freeman & Moran 2000; Pierson 2001; Marmor *et al.* 2005; Newman & Kuhlmann 2007; Österle 2007; Busemeyer *et al.* 2009). Within their individual health systems, member states experience these problems in different ways (Hervey 2008, p. 104). When the UK Labour Government took office in 1997, there was a perception that the NHS was facing a crisis: that buildings and facilities were old, equipment was inadequate, there were relatively few health professionals working within the system, and there was an under-supply of appropriate care and long waiting lists for routine procedures (Stevens 2004, p. 37). Trade unions were protesting staff lay-offs. Patients were worried about economizing on drug supplies (Klein 2006a, p. 409). Confidence in the system was at a low ebb and the gap between public expectations and NHS performance seemed ever widening (Lund 2008, p. 53). There were even fears that the middle classes might use private insurance to buy out of the system altogether, and that the Service would become a residual safety net for lower income earners (Stevens 2004, p. 37).

Following its election victory in 1997, the UK Labour Government embarked upon a 10 year period of reform of the NHS aimed at increasing funding and driving quality improvements consistent with the Service's founding ideal of providing universal health care free at the point of access (Department of Health [DH] 1997). Specifically, Labour introduced new policy mechanisms: National Service Frameworks, the Integrated Market, and the Annual National Survey for Patients and Users. It increased the capacity of NHS organizations: 7,000 new hospital beds, 100 new hospitals, 500 primary care centers, and 3,000 general practitioner (GP) premises (DH 1999a, 2000). It also created new agencies: The National Institute for Clinical Excellence, Monitor, and the NHS Modernisation Agency (DH 1997, 1998a, 1999b). It gave old organizations new institutional roles and forms: Primary Care Groups became Primary Care Trusts, NHS Trusts became Foundation Trusts, and the Commission for Health Improvement became the Commission for Healthcare Audit and Inspection (later the Healthcare Commission, and later again the Care Quality Commission). By 2005, the NHS budget had doubled, growing from £33 billion to £67.4 billion with the average spending on health care per head of population having increased from £680 to £1345 (DH 2004a). Arguably, by the beginning of its third term in office, Labour had fundamentally transformed the shape of the NHS.

In the UK health policy and health services literature the interpretation of the nature and trajectory of Labour's 10 year program of reform is an important issue, one on which there is no shortage of opinions. Some argue that Labour's reforms amount to a program of privatization, or even a return to models of health care provision prior to the introduction of the NHS in 1948 (Hunter 2003; Pollock *et al.* 2003, 2004). Others suggest that the program apes a passing European fashion for decentralization (Allen 2006), or that its elements were "rushed through" the parliament by "impatient politicians" with "one eye on their next high office and the other on the next election" (Walshe 2003, p. 109).

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However, most analysts of UK health care reform generally agree that Labour's program involved two distinct phases.

For example, Rudolph Klein argues that, from 1997 to 2001, Labour aimed at strengthening the Service's already highly centralized command and control structure through centralized targets, performance indicators, and national service frameworks for the delivery of care (Klein 2006a,b). However, Klein argues that Labour changed tack in 2002, pursuing a policy of decentralization aimed at delivering service improvements through the injection into the system of choice, competition, and private providers. For Klein, Labour's reforms therefore constitute an "often confusing mix" of different and overlapping "policy strata" that have produced a "more radical and sophisticated version of the mimic market" introduced by Margaret Thatcher in 1991 (Klein 2006a, p. 410).

Focusing on the political ideas underpinning Labour's program, Brian Lund suggests that Labour initially used "Third Way" political ideals to soften the operation of the existing NHS quasi-market with practical policy mechanisms, such as contracted "partnerships and agreements" between purchasers and providers, and a centrally directed system of performance indicators and national targets (Lund 2008, p. 50). However, Lund argues that in its second term Labour shifted emphasis, revisiting the ideals of the competitive quasi-market between public and private suppliers first envisaged by Thatcher a decade earlier (Lund 2008, pp. 43–44). Lund concludes that Labour's program emphasizes Third Way ideals to consolidate the elements of Thatcher's competition and market based reforms of the early 1990s (Giddens 1998; Lund 2008, pp. 43–44).

Outside this predominantly British focus, Tamara Hervey suggests that Labour's seemingly confusing package of reforms is representative of a common experience across the EU. Under Article 152 of the European Treaty, health care is the responsibility of individual member states, all of which have independent systems for the provision of near universal coverage (European Commission [EC] 2002). However, facing increased budgetary pressures together with the political imperatives of maintaining existing commitments to health care, EU member states are seeking to modernize their systems of provision. Specifically, they are striving to meet the goals of ensuring financial sustainability and providing universal access to high quality care (Hervey 2008, pp. 105–106). Across the EU, these efforts take various forms, but they are united by the common belief that increasing the efficiency of health services and improving the balance of responsibility for health care provision between the state, the market, and society can reconcile these apparently contradictory ends (Le Grand 2003; Giddens 2007). Attempting to account for the various programs by which member states were approaching these significant challenges, Hervey found no evidence of a neoliberal agenda for health care modernization, and furthermore, no evidence that EU member states had abandoned "Continental European" social policy paradigms in favor of "Anglo-Saxon" neoliberal models (Offe 2003; Hervey 2008, p. 115). In order to understand the trajectory of European health care reform, she concluded that the health policy literature needed "alternative explanations" (Hervey 2008, p. 115).

The regulatory state

The purpose of this article is to demonstrate that the thesis for the "regulatory state" might offer such an explanation. In the early 1990s, scholars of regulatory governance began to write about the significant changes gripping the organization of governments and policy

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sectors in Britain and around the world. Collectively, these scholars offered a substantive body of work that reflected on the cross-national and multi-sectoral regulatory changes ushered in by neoliberal governments since the mid-1970s. Regulatory governance scholars were interested in the nature of these changes, why they had occurred, and whether they were particular to individual countries or whether they were witnessing much more fundamental changes to the structure of government and society. Common to all accounts was the observation that neoliberalism and the tide of privatization were not matched with substantial deregulation at the practical level, rather a substantive re-regulation of state, market, and society (Ayers & Braithwaite 1992). On this basis, some regulatory governance scholars suggested that the increasing displacement of public ownership and centralized planning with a new array of regulatory governance techniques constituted the methods and characteristics for the rise of a regulatory state (Majone 1994).

The term "regulatory state" denotes a coherent style of policymaking under which markets and rulemaking displace public ownership and centralized administration (Majone 1994). The concept of the regulatory state is grounded in a tradition of thought that emphasizes the importance of political institutions against both the Marxist tradition, which accentuates the primacy of economic processes, and the neoliberal tradition, which stresses the importance of globalization, markets, and the retreat of the state. In the US, the tradition of regulation by independent agencies dates from the late 19th century (Majone 1994, p. 193). In Europe, however, the postwar wave of nationalizations and municipalizations overwhelmed the development of autonomous regulatory functions. Consequently, Europeans have generally interpreted regulation as an administrative function, or in other words, as the responsibility of government ministries and departments (Majone 1994, p. 193). Given Europe's greater experience of nationalized public services, the rise of a peculiarly European regulatory state is associated with the application of a range of new governance techniques that shift legal, political, and economic structures away from "government" and toward "governance;" from "rowing" to "steering;" from "providing" to "facilitating;" and from a "welfare state" to a "regulatory state" (Wincott 2006, p. 743). Today, some scholars argue that the rise of the regulatory state marks the "dominant trajectory" for contemporary European governments (Wincott 2006, pp. 750–751).

If the NHS is a classic institutional embodiment of the old European welfare state, and, if the regulatory state marks the dominant trajectory for European governments, then its themes and institutional techniques ought to be visible in Labour's reform of the Service. Accordingly, this article assesses the influence of the regulatory state on the UK Labour Government's reform of provision in the English National Health Service. The article builds an account of the regulatory state based on a discussion of key theses within the regulatory literature: The Rise of the Regulatory State (Majone 1994), The Audit Society (Power 1997), Regulation Inside Government (Hood *et al.* 1999), The New Regulatory State (Braithwaite 2000), The Government of Risk (Hood *et al.* 2001), The British Regulatory State (Moran 2003), and Regulatory Capitalism (Braithwaite 2005, 2008; Levi-Faur 2005; Levi-Faur & Jordana 2005). Unfolding Labour's program across the themes common to these accounts – the division of labor between state and society, the division of state, the codification of relationships, the development of meta-regulatory techniques for enforced self-regulation – the article argues that Labour's reform of NHS provision is a coherent representation of the influence of the regulatory state in restructuring arrangements between state, market, and society.

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An assessment of the regulatory state's influence on Labour's reforms of the NHS is useful on a number of levels. Some of these are obvious. Certainly, such an assessment would be useful in the context of the UK health policy and health services literatures. But perhaps most importantly, an assessment of the influence of the regulatory state on Labour's program of reform is important to the future of regulatory studies. In the regulatory literature, the roles and purposes of macro-level descriptors, such as the regulatory state, the audit society, and regulatory capitalism, are key points upon which the wider projects of some important regulatory governance scholars turn. For example, some regulatory governance scholars question the utility of "macroscopic," "world-historical" notions such as the regulatory state to the understanding of regulatory regimes (Hood *et al.* 2001). While they concede that these concepts might draw attention to features that make today's world different from the past, they contend that these descriptors have only little relevance to the practical business of analyzing regulatory change. Macroscopic labels, they suggest, do not "explain, or even describe, variety within the putative regulatory state, risk society or audit society" (Hood *et al.* 2001, p. 5). More specifically, they cannot account for how regulatory regimes actually work or the forces that give them shape (Hood *et al.* 2001, p. 9). Questioning the existence of the regulatory state, the risk society, the audit society, these scholars approach the analysis of regulatory reform from the nexus between the macro whole-society characterizations of the regulatory state and the micro level of single case studies – or, in other words, the "meso level" – with the concept of "risk regulatory regimes" (Hood *et al.* 2001, pp. 12–23).

Conversely, macroscopic descriptors, such as the regulatory state, are central to the work of other regulatory governance scholars. Given that "rulemaking" is an important institutional mechanism for enabling and constraining markets and globalization, some regulatory governance scholars argue that regulation enjoys an element of independence from economic processes and political ideology (Braithwaite & Drahos 2000; Levi-Faur 2005, p. 17). From this perspective, they represent the history of economic development as a history of the growth and expansion of regulatory techniques. Accordingly, they claim that notions such as "the regulatory state," "the audit society," and "regulatory capitalism" can serve as replacements for less specific designators such as "the new world order," "the retreat of the state," and "the neo-liberal hegemony" (Levi-Faur 2005, pp. 14, 22). From this point of view, it follows that the institutions of the nation state are central to the analysis of political economy; and that regulation is a fruitful topic around which to build intellectual communities and even wider social science theory (Braithwaite 2005, 2008).

From the regulatory state to regulatory capitalism

The thesis for the regulatory state is grounded in the paradoxical observation that the ideological enthusiasm of governments of the mid-1970s and the 1980s for deregulation was not matched with a similar program at the policy level. Rather, neoliberal governments in Europe and the US embarked upon a substantive re-regulation of state, market, and society. In 1992, Ayers and Braithwaite contested the widely held belief that "we live in an era of deregulation." The view that markets were reasserting their primacy and that business was fighting back against overbearing government intervention was not, they suggested, a very perceptive account of what was happening in Western capitalist democracies (Ayers & Braithwaite 1992, p. 7). After a decade of fiercely deregulatory administrations in the UK and the US, Ayers and Braithwaite observed that the regulatory balance

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had hardly shifted away from state intervention. Consequently, they claimed that the current era was one of regulatory flux: an age in which "dramatic regulatory, de-regulatory and re-regulatory shifts" were occurring at the same time (Ayers & Braithwaite 1992, p. 7).

Other scholars have made similar observations. In a cross-national study of regulatory reform in Japan and the UK, Stephen Vogels found little evidence that governments were forfeiting their control over business. Paradoxically, the ideological enthusiasm of neoliberal governments for markets, choice, and deregulation, he argued, had only succeeded in swelling the tide of regulation (Vogels 1996, p. 5). Likewise, Giandomenico Majone argued that regulation had become the new border between the state and the economy; the background for questions and ideas on how the economy should be run (Majone 1994, p. 192). Moreover, in Europe, the question of "what, how, and at what level" governments should regulate had proved itself to be the core issue of compromise between the EU and member states. Essentially, it was the question that had made the common market possible (Majone 1994, p. 192). Based on this expanding role of regulation, regulatory governance scholars argued that modern capitalist democracies were moving away from national majoritarian practices associated with the welfare state and toward political and economic structures infused with a new array of regulatory governance mechanisms, which they associated with the rise of a regulatory state (Majone 1994; Wincott 2006, pp. 750–751).

The wider point is that the term "regulatory state" is a convenient designator that offers an analytically insightful way of describing recent institutional history. However, the regulatory literature's account of the expansion of regulation has also produced a number of other substantive macro-level world-historical theses with similar ambitions: The Audit Society (Power 1997), The New Regulatory State (Braithwaite 2000), The British Regulatory State (Moran 2001), and, most recently, Regulatory Capitalism (Braithwaite 2005, 2008; Levi-Faur 2005; Levi-Faur & Jordana 2005). Where scholars of regulation aim to provide insightful ways of describing recent institutional changes, they are grasping at related empirical phenomena (Braithwaite 2005). Accordingly, this article builds an account of the regulatory state on the themes common to these important works: the division of labor between state and society, the division of state, the codification of relationships, and meta-regulation.

In 1994, Michael Power outlined a thesis The Audit Explosion, which he later developed as The Audit Society (Power 1997). Power's account of the re-regulation of state, market, and society claimed that government had extended the practice of external financial auditing to regulatory purposes across a variety of policy sectors: health care, education, finance, and welfare (Power 2000, 2003). For Power, the adaptation of financial audits to regulatory purposes involved an expansion of formal monitoring mechanisms. However, due to "increased demands for managerial accountability" and "supply side pressures from accountants and other advisers," these mechanisms also held potential for adverse behavioral consequences – gaming and ritualism – on the part of both regulators and regulatees (Power 2003, p. 192). Power suggested that the appeal of audit practices lay in their potential for delivering transparency and accountability while also allowing governments to play a non-interventionist supervisory role (Power 2003, p. 191). Moreover, the thesis also contained sociological elements. Society, he argued, felt "more comfortable and secure" in the presence of formalized surveillance and concrete regulatory assurances than with past regulatory practices that left a wide scope for professional

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judgement" (Power 1997, pp. 1–3; Power 2003, pp. 199–200). People are always "checking up on each other," he argued (Power 1997, p. 1). The Audit Society marks one "engaged in constant checking and verification," one in which "a particular style of formalised accountability" has become "the ruling principle" (Power 1997, p. 4).

In 1999, Christopher Hood and co-authors offered a related account of Regulation Inside Government. However, Hood's account of re-regulation of state, market, and society represented the phenomena as the development of "new modes of control" under which a range of independent regulatory agencies could "shape the activities" of regulated bureaucracies across a number of sectors: prison, local government, health care, and so forth (Hood *et al.* 1999, p. 8). Hood and his co-authors did not intend the work as a macro-level thesis on recent institutional history. Accordingly, they did not discuss the wider sociological, historical, or ideological inferences of re-regulation. Their interest was in the variety of formal mechanisms – command and control techniques, competition, informal peer control or mutuality, and contrived variation – that had increased the "relational distance" between regulators and regulatees in terms of frequency of contact and interaction (Hood *et al.* 1999, pp. 14–16).

Nevertheless, the theses The Audit Society and Regulation Inside Government bear some similarity. For Power, the technocratic audit functions as a substitute for both the failure of public trust in professional judgment and the ideological retreat of neoliberal governments from society. The audit is a "convenient technology" for advancing the neoliberal agenda of markets, competition, and surveillance. It is a technocratic device that consists of prescribed rules and regulations that replace anachronistic devices of professional assurance and discretion. For Hood and co-authors, regulation is likewise a mode of control, but only in the presence of the increased relational distance between regulators and the regulated. The key difference is that Hood and co-authors de-emphasized the significance of the sociological, ideological, and historical components of re-regulation.

In 2000, John Braithwaite offered a thesis – The New Regulatory State. Braithwaite's account of re-regulation involved a wider historical thesis. Braithwaite identified major developmental trends in government policy from the 19th century to the late 20th century. Specifically, he identified a shift from a "night-watchman state" to a "Keynesian state" to a "new regulatory state." In the 19th century, government functioned as a night watchman, looking over professionalized policy sectors – policing, banking, health care – and allowing society to do most of the steering and rowing (Braithwaite 2000, p. 224). Following the stock market crash of 1929 and the emergence of the New Deal, the night-watchman state gave way to a Keynesian state, in which national regulatory agencies assumed a degree of expert control over these formerly unregulated sectors and activities (Braithwaite 2000, p. 224). The failure of the Keynesian state and the subsequent emergence of the regulatory state were marked by the decentering of government, the increasing distance between regulators and regulatees, and the "reliance on self-regulatory organisations, enforced self-regulation and other responsive regulatory techniques that substitute for direct command and control" (Braithwaite 2000, pp. 224–225). For Braithwaite, the regulatory state is the consequence of the decline of industrial society, the arrival of advanced modernity, and the risk society. At issue, however, is not the neoliberal agenda of markets, privatization, and deregulation, but "the nuts and bolts of a regulatory design" for a new kind of world where Keynesian pump priming no longer works (Braithwaite 2000, p. 234).

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In 2001, Michael Moran outlined a thesis for The British Regulatory State. Moran's account of re-regulation emphasized the displacement of British systems of governance built on trust and professional self-regulation with formal laws and new institutions (Moran 2001, 2002, 2003). Like Braithwaite's, Moran's thesis also involved a historical component. He argued that the British regulatory state was the product of a deep crisis of club government, or the oligarchic, hierarchical, and obscure operations of the British civil service and the professions, which had preserved the British elite from the democratic shifts of the modern era. In the 1950s, the British government exercised tight administrative controls over production, consumption, and the direction of the economy. But it left other areas of economic life virtually untouched. For example, regulatory standards covering the production of food and the regulation of workplace health and safety were either skeletal or non-existent (Moran 2001, pp. 19–20). The rise of the British regulatory state, Moran claimed, was uniquely grounded in British history and culture and involved a transformation in these old forms of state control and social organization. Essentially, the British regulatory state forfeited control of production, consumption, and the economy and intervened only to prevent market failure. Equally, it hollowed out the hierarchical structure of the civil service into distinct public agencies and also "colonised by law" the vast areas of public life it had previously left untouched (Moran 2001, p. 20).

The theses for The British Regulatory State and The New Regulatory State bear similarity. Although Moran emphasized the predominantly British historical aspects to the phenomena of regulatory reform and Braithwaite the predominantly global aspects, both theses were intended as macro-level world-historical descriptors of recent institutional change. For Moran, the locus of transformation is the national arena. In other words, the character of the regulatory state is contingent on the national setting (Moran 2003, p. 412). For example, the American regulatory state "is synonymous with a huge expansion of public authority in the decades after the New Deal;" however, "the British regulatory state is emblematic of the famed contradictions of Thatcherism" (Moran 2003, p. 412). Alternatively, Braithwaite's focus is international. While he accepts that regulatory states exhibit significant variety, he also cautions against losing sight of the fact that many of the fundamentals of regulation are global (Braithwaite & Drahos 2000, p. 3). In *Global Business Regulation*, Braithwaite and Drahos argue that the extent to which "states have become rule takers rather than rule makers is greater than most citizens think," especially outside Europe and the US (Braithwaite & Drahos 2000, p. 3). Offering the example of a middle-sized country, Australia, they observed that Australian national air safety standards were written by the Boeing Corporation in Seattle; Australian ship safety laws were written by the International Maritime Organisation in London; and Australian motor vehicle standards were written by Working Party 29 of the Economic Commission for Europe (Braithwaite & Drahos, p. 3). Accordingly, they concluded that the development of regulatory states, especially in sectors such as finance, telecommunications, and air safety, is "inherently global," "extra terrestrial," and "beyond the romance of control by a town meeting" (Braithwaite & Drahos 2000, p. 604).

With *The Government of Risk*, however, Christopher Hood, Henry Rothstein, and Robert Baldwin issued a serious challenge to macro-level approaches at both the national level and the international level. Using the concept of "risk regulatory regimes," they approached the analysis of re-regulation from a "meso-level" or institutional level, with the intention of describing, comparing, and explaining "regulatory variety" in "risk regulatory regimes" (Hood *et al.* 2001, p. 9). At the meso-level, the analysis is situated

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between the macro whole-society notions of the regulatory state and the micro level of single case studies of policy settings appropriate for particular risks (Hood *et al.* 2001, p. 12). Here, risk regulators locate the intellectual origins of their approach in regime theory across several other fields of social science, notably international relations (Krasner 1983), public policy (Elkin 1986), political science (Dowding 1996), systems theory (Beer 1966), and organizational and institutional theory (Stringer 1967).

For Hood and co-authors the essence of regulation is interference in markets and social processes (Hood *et al.* 2001, p. 29). Accordingly, governments regulate only "risks," or the potential for adverse health consequences within these markets and social processes (Hood *et al.* 2001, p. 3). By "Risk Regulatory Regimes" they marked the institutional machinery and "the complex rules, practices and animating ideas" associated with a particular risk or hazard (Hood *et al.* 2001, p. 9). At base, risk regimes were control systems that performed three essential functions: standard setting, information gathering, and behavior modification (Hood *et al.* 2001, p. 23). Analyzing these functions across the dimensions of context, or the type and nature of the risk being tackled, and the content, or the organizational structure and operating conventions of the existing regulatory institutions, they aimed to "pick up regime features that are central to a range of debates about how regulation is, or should be conducted" (Hood *et al.* 2001, p. 23). Therein, Hood and co-authors communicated their deep suspicion of macroscopic world-historical notions, such as the regulatory state, the audit society, and the risk society, to deliver useful analyses of regulatory regimes. Critically, they offered no historical thesis; rather, they offered a meso-level framework as "a middle way approach to institutional analysis" for providing an understanding of how regimes worked and the forces that gave them shape (Hood *et al.* 2001, p. 9).

In 2004, David Levi-Faur and Sharon Gilad produced a review article that compared and contrasted the views of the UK based scholars Power, Hood, and Moran, asking to what extent the British experience of re-regulation could be generalized. Assuming that the three authors were grasping at largely the same phenomena, Levi-Faur and Gilad identified four common themes within their work: the division of labor within state and society, the division of the state, the codification of informal control mechanisms, and meta-regulation. Levi-Faur and Gilad argued that determining the extent to which these characteristics were present in other countries was an open question that required cross-sectoral and cross-national analysis. However, given the increasing potential for the global diffusion of regulatory change, they suggested that it would be surprising if Britain's experience was exceptional. Certainly, regulatory reform might serve different purposes in the UK. Furthermore, the UK might be a pioneer of change. Nevertheless, the analysis of regulatory reform needed to move beyond individual states (Levi-Faur & Gilad 2004, p. 121). Regulatory governance scholars needed to explore alternative notions of the regulatory state alongside each other and examine the ways in which "they transform and constitute one another" (Levi-Faur & Gilad 2004, p. 121).

It was a recommendation that led to the development of a new macro-level thesis. In 2005, David Levi-Faur, Jacint Jordana, and John Braithwaite opened a new and explicitly globalizing perspective on the phenomena of re-regulation: namely, "regulatory capitalism" (Levi-Faur 2005, 2006a; Braithwaite 2005; Levi-Faur & Jordana 2005; Braithwaite 2008). Involving a historical thesis broadly compatible with that of Braithwaite's regulatory state, regulatory capitalism denotes a fundamental change in the governance structures of late capitalist economies, in which regulatory solutions shaped in North America

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and Europe have been projected internationally. Levi-Faur and Jordana (2005) intended "regulatory capitalism" as a substitute for less specific terms such as "new world order," "retreat of the state," and "the rise of a neo-liberal hegemony" (Levi-Faur 2005, p. 27). To some extent, the thesis for the regulatory state is nested inside regulatory capitalism. For example, the key themes of regulatory capitalism bear similarity to those of the British regulatory state. Under regulatory capitalism, Levi-Faur argues that the changing governance structures of capitalist economies can be summarized in terms of "a new division of labor between state and society", an "increase in delegation", the spread of "meta-regulatory technologies", the "formalization of inter-institutional and intra-institutional regulatory arrangements", and a "growth in the influence of experts and international networks of experts" (Levi-Faur 2005, p. 12).

Certainly, the thesis for regulatory capitalism chimes with Braithwaite's new regulatory state and Braithwaite and Drahos' *Global Business Regulation*. Like these, regulatory capitalism suggests that, in the context of globalized national economies, any conception of the regulatory state tells but part of the story. It is precisely because individual states are as much ruletakers as they are rulemakers that regulatory capitalism is the more appropriate designator of the current age. However, with globalization touching specific sectors, markets, and regulatory regimes to different degrees, Levi-Faur suggests that sectors such as health care exist on the frontiers of regulatory capitalism (Levi-Faur 2006b, p. 501). For example, in banking and finance, both markets and regulations are global. In the pharmaceutical industry, however, regulations are subject to globalization, yet markets are not. While manufacturing practices for prescription drugs have been standardized, the state is a monopolistic buyer in the biggest markets and regulations are predominately national. Alternatively, health care serves as an example in which neither markets nor regulations are global. Different states regulate health care in different ways and they vary in how much and what kind of cover they provide (Levi-Faur 2006b, pp. 501–502). Thus, notions of the regulatory state are more appropriate in some policy sectors than in others.

In summary, the substantive body of scholarship that has built up around the phenomena of re-regulation offers a number macro-level world-historical theses for describing recent institutional history. Moreover, there is also an element of tension within the literature regarding the capacity of these theses to account for the practical operation of regulatory regimes at the institutional level. In the remaining sections, the article opens a detailed discussion of Labour's program, arguing that the themes of the regulatory state are at work in its reform of provision in the English NHS. Assuming that scholars of regulation are grasping at related phenomena, the article explores different notions of the regulatory state alongside each other (Levi-Faur & Gilad 2004). By carefully linking the key themes of the regulatory state with changes at the institutional level, the article assesses the potential of macro-level world-historical notions to describe the details of individual regulatory regimes. The article concludes with a discussion of the consequences for both the regulatory literature and the UK and European health policy literature.

The division of labor between state and society

The shift from bureaucratic governance structures to those of the regulatory state involves a new division of labor between state and society that reflects the classic metaphor of "steering not rowing" (Osborne & Gaebler 1992). Under the regulatory state,

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government adopts the role of *guiding*, *thinking*, and *directing*, and leaves the business of service provision to market and society. Thus the regulatory state is defined by a shift of emphasis from the old bureaucratic model of taxing and spending toward rule making at a distance, and allowing other organizations to provide services (Levi-Faur & Gilad 2004, p. 112; Braithwaite 2000, p. 225). Such a division is readily observed in Labour's re-regulation of NHS provision.

In England, a basic characteristic of the NHS is the organizational split between provider and commissioning agencies. Put simply, NHS providers supply health care services, such as hospital, community, and emergency care. In contrast, NHS commissioners assess the health needs of a geographical population and take responsibility for ensuring that the requisite services are available in that area. Since the election of the Labour Government in 1997, the UK Department of Health (DH) has been devolving responsibility for the provision of health care to independent bodies and cultivating a role of thinking, guiding, and directing; in other words, of ruling health care providers from an ever widening distance. The DH is responsible to the Secretary of State for Health. It consists of a Permanent Secretary, responsible for the broad management of the Department's business; the NHS Chief Executive, responsible for the management of the NHS; and the Chief Medical Officer, who is the government's medical adviser and the professional head of all medical staff in England (DH 2007a, p. 172). The aim of the DH is to improve the health and wellbeing of the people of England. But since 1997, its role and responsibilities have changed considerably.

In 1998, the DH was responsible for "overall policy on all health issues," "public health," "the health consequences of environmental and food issues," and the "provision of health services" (DH 1998b). Responsibilities for service provision were carried out through the NHS Chief Executive, which managed the performance of the wider NHS and held health authorities and NHS trusts (hospitals) accountable for performance against their statutory responsibilities (DH 1998b). By 2007, however, the DH was mainly responsible for setting policy on public health and social care. Although the DH remained responsible for the provision of services through the NHS Executive, the volume of care diminished significantly. Since the passing of the Health and Social Care Act 2003, the DH has been in the process of divesting itself of responsibility for the provision of health care services. Here, we observe the influence of the regulatory state. In other sectors, such as telecommunications, transport, finance, and policing, the regulatory state divides labor between the market and society. Government becomes responsible for steering and rule making, and society and the market for rowing. In the transformation of the NHS, we can observe this division of labor in the DH's divestment of responsibility for service provision to NHS Foundation Trusts (FTs).

FTs were established under the Health and Social Care Act 2003. They are a new form of NHS organization that replaces the older NHS Trust. At present, there are 122 FTs in operation, most of which are acute hospitals, but some are mental health units. The government's intention is that by 2011, FTs will be responsible for the delivery of all acute and mental health care in England (House of Commons Health Committee [HCHC] 2008, p. 45). FT status provides NHS organizations with an array of new financial and management freedoms together with altered accountability arrangements. FT status was established as part of the Government's "earned autonomy" policy for the NHS, which offered "high-performing NHS trusts greater financial and management freedoms" aimed at "improving quality and financial performance" (HCHC 2008, p. 45).

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Adopting the classic metaphor, FTs are "rowing" organizations. They were introduced under the Act as independent not-for-profit public benefit corporations. They differ from the older NHS Trust in several key respects. FTs are free from central control and are no longer directly accountable to the Secretary of State for Health, but to the newly independent government regulator, Monitor. FTs are also locally accountable to members drawn from the general public, and to staff and local stakeholders who elect representatives to the FT's Board of Governors. Importantly, FTs also enjoy a new array of financial freedoms. They are permitted to hold and retain financial surpluses. They are allowed to invest in new facilities and equipment and to reward their staff with more competitive salaries. They can borrow money and manage their own assets. While they are required to meet national targets like any other trust, they have more freedom in deciding how to go about achieving them. FT status is granted to high performing trusts after the successful completion of an application process. The Government's intention is that older NHS Trusts that are unable to achieve the necessary standards to become FTs will be merged with, or bought out by, existing FTs.

Essentially, the new division of labor between state and society is played out in the language of provider-side reform. According to the DH, provider-side reform consists largely of a further expansion of the FT program together with "more opportunities for voluntary sector, social enterprise and private sector providers" (DH 2007a, p. 179). The pace of the division is gathering momentum. By the end of 2006, there were 54 FTs. The DH expected that, by the end of 2007, there would be at least 100 FTs and it was "committed to providing all NHS trusts with the opportunity to apply for foundation status at the earliest available opportunity" (DH 2007a, p. 180). Today, the DH is anxious to make as complete a division of labor between state, society, and the market as possible. In June 2006, the DH also established a Social Enterprise Unit to stimulate and support increased health care provision in the social enterprise sector (DH 2007a, p. 180). In January 2007, it announced 26 social enterprise pathfinders, which would lead the way in delivering services using a "social enterprise business model" (DH 2007a, p. 180). The Government is also encouraging the independent sector to help provide extra capacity. By 2007, the DH's independent sector treatment centre (ISTC) program had seen the commencement of 23 ISTCs (DH 2007a, p. 179). The DH is also currently working with Monitor, the independent regulator of FTs, to explore the feasibility of extending FT status to providers of community services. As with acute hospitals, Community FTs would be publicly owned organizations that would be part of the NHS, but with greater operational freedom and no responsibility to the Secretary of State (DH 2007a, p. 80).

The division of the state

In the regulatory state, functions that were once unified under ministerial control are shared between different organizations (Levi-Faur & Gilad 2004, p. 112). The thesis for the regulatory state involves a division of labor within the state itself, and between policymaking and regulation. More specifically, regulatory states have a greater willingness to delegate authority to technocratic bodies that enjoy considerable political independence (Levi-Faur & Gilad 2004, p. 113).

Michael Power's notion of the "audit explosion" encompasses this division. Power refers to both a "transformation" of existing public sector institutions and the emergence of new formal bodies for auditing and monitoring the performance of other organizations.

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His term "audit society" denotes the willingness of governments to institutionalize technocratic practices within independent organizations. Typically, these are institutionalized in evaluative and inspectorate bodies that stretch the application of audit practices and use them for "monitoring performance across a wide variety of policy sectors (Power 2003, p. 188). Hood observes the proliferation of new government agencies "inside government." The regulatory state is "diverse, multi-organisational, not monolithic" and comprises a variety of organizations that pursue various and sometimes conflicting goals. These organizations have distinct functions. There is no sense that they belong to "a policy community" (Hood *et al.* 1999, p. 20). Moran also associates the division of roles and functions within the regulatory state with the increased role of the private sector. Privatization engendered not only an economic revolution, but also a constitutional one (Moran 2003, p. 9). With large numbers of industries shifting from the public domain to private ownership, regulatory innovations were necessary to replace outdated mechanisms of control (Moran 2003, p. 10). Braithwaite argues that the regulatory state is decentered and responsibilities are shifted to newly independent agencies because the old centralized state machinery makes little sense where risks are shared. In addition, he suggests that the universalism of the market engenders a mentality of loss reduction, or "a risk focused strategy," which favors the use of technocratic regulatory instruments and measures (Braithwaite 2000, p. 228). For Braithwaite, the division of labor within the state represents a recognition that regulatory states exist within a shared community of fate with other sectors. It prompts both small and large firms, together with governments, to create new and common institutions and techniques of control for the management of risks, which, in a globalized world, can quickly "get out of hand" (Braithwaite 2000, p. 229).

The point is that where regulatory states divide labor between steering and rowing organizations there follows a division of labor within the state itself between policymaking and regulation. Typically, governments remain the rulemakers or policymakers and independent organizations are created to regulate and evaluate performance by technocratic means of control. Labour's reforms of NHS provision also involve a division of state. In 1998 the DH was responsible, through the NHS Executive, for "managing the performance" of NHS bodies, including Trusts and Health Authorities (DH 1998a, p. 1.2). Under the Health Act 1999 these functions were transferred to the Commission for Health Improvement (CHI), a "Non-Departmental Public Body" (NDPB) known colloquially as an arm's length body. Critically, NDPBs were not independent of the Secretary of State; rather, they existed as "stand-alone national organisations sponsored by the Department" to undertake "national functions" (DH 2007a, p. 223). However, under the Health and Social Care Act 2003, the CHI was abolished and replaced with the fully independent Health Care Commission (HC).

The HC is an independent regulatory authority that assesses and reports on the performance of both private and public sector health care organizations. Established under the Health and Social Care Act 2003 as the "Commission for Healthcare Audit and Inspection," the HC is independent of the Secretary of State for Health and reports directly to the Parliament (HC 2007, p. 24). The HC's primary means for regulating health care standards is the Annual Health Check (HC 2007, pp. 72, 87). First conducted in 2006, the Annual Health Check is a risk-based responsive regulatory technique that assesses health care provider organizations for compliance with the Department of Health's 24 core standards, which describe minimum levels of performance (HC 2007). It consists of two component parts: quality of services and use of resources, awarding and

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publishing an overall rating for each under a four-point scale ("excellent," "good," "fair," and "weak"). The purpose of the Annual Health Check is to provide the HC with the necessary information for targeting Trusts at risk of underperforming against the core standards, rather than inspecting every trust in England (HC 2007). For example, in 2006, the HC found that approximately 12 percent of trusts needed risk-based inspections. It also visited another randomly selected 12 percent (HC 2007, p. 11). In addition to the Annual Health Check, the HC publishes service reviews in particular areas of health care in order to further assess Trust performance and to indicate ways in which they might improve their quality and use of resources (HC 2007, p. 14).

The Health and Social Care Act 2003 also created another independent regulatory body: Monitor. Like the HC, Monitor is independent of the Secretary of State for Health and reports directly to the Parliament. Its role is to regulate the financial and governance arrangements of NHS FTs. Monitor assesses, approves, and authorizes Trusts to become FTs. It also regulates their activity through a Compliance Framework. In applying to Monitor for elevation to FT status, Trusts are required to draft a constitution outlining their intended governance structures and operation, and also to provide a five year business plan. In approving an application for FT status, Monitor assesses the constitution to ensure it is legally constituted, and determines whether the Trust's proposed governance arrangements are representative of the local area. Monitor also evaluates whether the Trust is "financially viable," whether it is "well governed," and furthermore, whether the intended board of directors has "the right skills and a comprehensive and realistic strategy to take the trust forward" (Monitor 2007a, p. 5). On approving a Trust for elevation to FT status, Monitor issues each FT with terms of authorization specifying the services the FT is legally responsible for delivering, and holds a copy of the FTs constitution (Monitor 2007a, p. 5).

Monitor regulates FTs based on an in-year monitoring system and a compliance framework that involves an annual risk assessment of the FT's performance. The annual risk assessment covers three areas – finance, governance, and mandatory services – each of which is assigned a risk rating. These ratings determine the level of concern and degree of scrutiny with which Monitor regulates the Trust. The annual risk assessment requires each FT to submit an annual plan, including a forecast of financial performance and details of any risks to compliance with the FT's terms of authorization. The conduct of in-year monitoring is designed to measure and assess the actual performance of the FT against the annual plan. But the frequency and depth of in-year monitoring is determined by the risk rating (Monitor 2007b, pp. 6–7). Monitor uses a responsive approach to regulation. Its compliance framework specifies that potential failures are the responsibility of the FT. When appropriate, Monitor may elect to work with the FT to resolve issues, but it remains reluctant to intervene. Where intervention is necessary, such action might involve "regular reviews of progress" or suggesting "the involvement of other parties;" for example, other FTs that have dealt with similar problems, or even an "appropriate professional adviser" (Monitor 2007b, p. 7). Ultimately, Monitor makes decisions about intervention on a "responsive" or "case-by-case" basis to consider "what action, if any, is appropriate" (Monitor 2007b, p. 7).

The relationship between Monitor, the HC, FTs, and the DH represents a division of state between technocratic regulatory authorities – between rowing health care providers and a steering government managed through risk-based regulatory instruments. For the future, there is evidence that this division of state will continue. In April 2009, the

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Government created the Care Quality Commission (CQC), which will have responsibility for regulating all health and social care in England. The CQC will take over the roles of the three organizations currently responsible for this work: the HC, the Commission for Social Care Inspection, and the Mental Health Act Commission. In addition, the DH intends to reduce the number of arm's length NDPBs, perhaps suggesting that these functions, like those of the old CHI, may be transferred to fully independent regulatory commissions. From 2003 to 2008, the arm's length body change program had already reduced the number of NDPBs from 38 to 19 (DH 2007a, p. 174).

The codification of rules

The third characteristic of the regulatory state is the codification, or formalization, of relationships between regulators and regulated organizations. Scholars of regulation associate this formalization with exponential increases in regulatory instruments aimed at ensuring transparency, accountability, and social responsibility within organizations (Levi-Faur 2005, p. 21). Regulatory instruments of this sort can include internal rules and codes of conduct; for example, environmental management systems, corporate reporting systems, and third party certification schemes. The purpose of these instruments is to open the internal governance structures of organizations to notions of democratic accountability, social justice, and environmental protection (Levi-Faur 2005, p. 21). The issue is not whether the codification of rules is effective in delivering social responsibility, but that regulation of internal governance structures is increasing. Today, "big corporations are just as subject to red tape and excessive internal regulation as they are to external regulation" (Levi-Faur 2005, p. 21).

Moran delivers a broadly similar account of the crisis of English club government and the rise of the British regulatory state. Club government denotes the role of private institutions and professional associations in the running of the state. Moran argues that in the early 20th century, the influence of elite structures, their "oligarchic, informal and secretive" operations and their existence beyond the reach of the state and the law, made the British state one of the most stable and stagnant in the world. However, in the context of globalization and modern liberal democracy, club government became an anachronism (Moran 2003, pp. 3–4). Moran associates the rise of the regulatory state with the construction of new institutions on the ruins of the old club system; particularly the replacement of informal structures of control with systematic mechanisms for surveillance, public scrutiny, and accountability (Moran 2003, p. 7). Similarly, Power's account of change involves the rather amusing picture of these formalized mechanisms on the auditee within his audit society. For Power, the auditees are complex beings, "devious and depressed," "skilled at games of compliance," but "exhausted and cynical about them too" (Power 2003, pp. 199–200). They "loathe the mediocrity of the auditors" who enforce the new mechanisms and they are nervous about "the empty certificates of compliance" that are extracted from them. They sorrowfully watch "the competent and excellent" suffer the indignity of dealing with "the demands of quality assurance," but also accept that this is "what we probably deserve." And above all, after years of professional training, the elite professionals of the Audit Society wonder why they are "no longer trusted as experts" (Power 2003, pp. 199–200).

Labour's reform of the NHS provision has introduced several mechanisms for the formalization of previously informal structures of control into the English health care

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sector. These mechanisms codify relations between and within NHS organizations with a view to increasing transparency, accountability, and surveillance. Significantly, they also formalize clinical relationships, and arguably, render NHS medical professionals in the light of Power's "devious and depressed" auditees. For example, in its 2000 NHS Plan, the Labour Government outlined its vision for an 18 week patient pathway for all NHS patients (DH 2004a). The 18 Weeks policy is a part of the government's ongoing project of tackling hospital waiting times. The policy places considerable pressure on hospitals to alter their internal arrangements for the delivery of services. However, what differentiates the 18 week patient pathway from other initiatives is that it focuses on the entire patient journey, rather than individual parts of their treatment, such as assessment, diagnosis, and intervention. The 18 week pathway begins when the patient is referred for diagnostics by their GP. It concludes when the patient is admitted for treatment.

Although the vision for 18 Weeks was outlined in the 2000 NHS Plan, work on the 18 week patient pathway did not begin in earnest until 2004. The first mention of the plan's practicalities came in the 2004 NHS Improvement Plan. Here, the government announced that by 2007–2008 investment in the NHS would rise to £90 billion and that, in return, the public would receive a number of service improvements, the first of which would be a reduction in waiting times. Specifically, the plan promised that patients would be admitted for treatment within a maximum of 18 weeks from referral by their GP, and those with urgent conditions would be treated much faster (DH 2004a, p. 6). In December 2007, 18 week waiting periods were successfully achieved.

In December 2006, the NHS published an operating framework for the implementation of 18 Weeks (DH 2006a). In effect, the framework formalized clinical relationships between clinicians and managers and between clinicians and GPs. The framework charged local clinicians and managers with taking responsibility for driving the necessary transformations for achieving the 18 week patient pathway. In return they would receive the support of a comprehensive local program of communications (NHS 2007). In 2006, a group of 13 local health communities signed up to pilot the 18 Weeks program as "Early Achievers." By December 2007, these 13 communities had delivered a minimum of 90 percent of treatments for patients who required a stay in hospital, and a minimum of 95 percent for patients not requiring a stay in hospital, within the specified 18 week period (NHS 2007).

Although 18 Weeks was not the first attempt to drive down waiting times, it was the first to formalize cooperative relationships among clinicians, GPs, and service managers across the NHS. Indeed, 18 Weeks does away with the whole notion of institution-based waiting lists. Previous attempts to reduce waiting times focused on specific elements of the patient journey (referral, diagnosis, treatment, outpatient consultation). Thus, waiting lists built up around facilities. However, the 18 week patient pathway attempts to address waiting times from the perspective of patients, not clinicians and waiting list statistics. For example, the DH suggests that hospitals should work in close collaboration with primary care providers. They should develop transfer protocols to ensure delays are minimized and good data flows between providers. They should pursue local Integrated Service Improvement Programmes. They should implement referral to treatment measurement systems in collaboration with health care commissioners (NHS 2007).

The 18 Weeks framework also alters clinical governance within hospitals. For example, with more than two million referrals a year, roughly 14.3 percent of the national total, orthopedics is identified as perhaps the biggest area of challenge for 18 Weeks. In

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December 2005, the National Orthopaedic Project pursued the delivery of the six month inpatient waiting time. In order to reduce this time further, the implementation of 18 Weeks considered reforming waiting periods through integrated pathway management and exploring the potential of primary care to contribute to delivering improvements. These include options for prevention and self-care, pain management, and rehabilitation services as well as for enabling patients to receive treatment closer to their homes (DH 2006a, p. 6). Under 18 Weeks, the NHS will also examine 30 percent of primary care consultations for musculoskeletal conditions and publish a Musculoskeletal Framework specifically designed to achieve the 18 week pathway. The government's intention is that 18 Weeks should form part of the HC's Annual Health Check. In 2006, the HC introduced indicators for the treatment of outpatients in 11–13 weeks and for inpatients in 20–26 weeks. By April, they had introduced a new round of treatment milestones: 11 weeks for first outpatient consultation, 13 weeks for all diagnostics, and 20 weeks for inpatient treatment. The DH had hoped for another stage of milestones by spring 2008: 5 weeks for first outpatient consultation, 6 weeks for diagnostics, and 11 weeks for inpatient treatment (DH 2006a, p. 20).

Relationships within NHS organizations have also been formalized by the government's Payment by Results initiative. Payment by Results (PbR) is a prospective health care payment device that provides a national price, or tariff, for procedures and services for all acute providers across the NHS. The point is, however, that PbR also affects the internal governance of NHS organizations. PbR requires Trusts to review the actual costs of their activity against income derived from the national price. It offers them incentives to manage their activity and "identify future improvement strategies." For this reason, PbR was introduced gradually from about the beginning of 2003. However by 2006–2007 it covered all non-elective, accident and emergency and outpatient and emergency admissions, effectively £22 billion worth of services (DH 2007a; DH 2007b). DH guidance argues that PbR provides a transparent rules-based system for the payment of providers that rewards efficiency, and that it also supports patient choice and the diversity of service provision. Thus, PbR also encourages much of the activity necessary for achieving the 18 week patient pathway (DH 2006a, p. 2).

In 2002 the DH released a policy document, Reforming NHS Financial Flows, which formally introduced PbR and called for consultation. Central to the new system was a shift from funding provider organizations on a simple "block basis" of contractually settled services toward a system based on payment for the volume and complexity of health care services actually delivered in practice – hence Payment by Results. As outlined in the policy document, PbR is underpinned by the National Tariff, which provides a national schedule of prices for commissioning Healthcare Resource Groups (HRGs); essentially, a range of clinical procedures, treatments, and diagnoses that describe a large proportion of hospital services offered in England (DH 2004b, p. 8). The schedule shows the national average cost for a range of treatments and procedures for the forthcoming financial year (DH 2004b, p. 8). Accordingly, PbR's operation is dependent on having accurate and timely data on each Trust's individual costs (DH 2004b, p. 1). Each year, Trusts submit Reference Costs which form the basis for the calculation of the Tariff for the next year. Thus far, the Tariff has been based on the average of the costs reported by all NHS providers through the Annual Reference Cost Exercise. As costs differ from location to location, the government uses a Market Forces Factor (MFF) through which PbR takes account of local variations in the cost of staff, land, and facilities. Although some respon-

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dents to the government's initial consultation expressed concerns about the use of regional tariffs, most were in favor of this approach (DH 2003, pp. 10–11). However, current policy is that from 2008 every provider regardless of setting will receive the same tariff for the same service (DH 2004a, p. 7).

PbR is an ambitious system for redefining the health care payment process in the NHS and altering relationships between providers and commissioners, and also between clinicians and managers. PbR creates a "data-rich transparent link" between providers and commissioners founded on activity-based reimbursement, which places greater emphasis on the quality and price of the service being provided (DH 2006b, p. 17). Thus, it offers solutions to the major problems with the old system of block payments by removing the restrictions of volume; by paying a set price for services, which provides hospitals with incentives to increase efficiency and the number of services offered; and by eliminating "artful negotiations" between commissioners and hospitals by forging a "link between activity and income" (DH 2006b, p. 5). Furthermore, PbR allows for comparison of prices across Trusts and enables the benchmarking of different services that can aid clinicians and managers in improving cost effectiveness and lifting the quality of care they deliver through comparative data analysis and peer review (DH 2006b, pp. 20–21).

Meta-regulation

The fourth characteristic of the regulatory state is meta-regulation, or the development of new technologies for enforced self-regulation. Under the regulatory state, the effectiveness of regulatory regimes relies not only on outside inspectors, but also on a new domain of internal regulatory techniques that engage a "wider range of actors" in the governance arrangements of regulated bodies (Levi-Faur & Gilad 2004, p. 113). These actors might be gatekeepers, private parties, whistleblowers, or employees positioned within regulated organizations who are able to counter misconduct by withholding cooperation. Organizations within the regulatory state are meta-regulated when they are required to conform not only with external pressure from regulators, but also with internal pressures from within their own governance structures.

The concept of meta-regulation bears similarity to Foucault's later work on governmentality. Both concepts refer to the ability of liberal democratic governments to operate not only through external force, but also through their capacity to compel citizens to regulate their own conduct. Moreover, both meta-regulation and governmentality imply a shift from direct domination, or sovereignty, toward indirect technologies for the self-regulation of behavior. For Foucault, the 18th century transition from the political structures of sovereignty to those of governmentality turned "on the theme of population and hence on the birth of political economy" (Foucault 1991, p. 101). By governmentality, he marked a broad strategy under which the health, security, condition, and general welfare of the population became the targets of a new range of techniques designed to enroll citizens in the projects of the state (Gordon 1991, p. 28). For Foucault, the development of these technologies in the modern age had been stalled by the political, military, and economic crises of the early to middle 20th century (Foucault 1991, p. 97). However, in the later part of the century, neoliberal challenges to the welfare state were about the reactivation of governmentality, "a radical inversion of the economic agent as conceived by the liberalism of Smith, Hume and Furguson" (Gordon 1991, p. 43). In the contemporary era, Foucault argued that governmentality served a dual purpose. It

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reshaped "the recalcitrant material of the dangerous citizen" into an engaged and more pliable social being (Gordon 1991, p. 28). Conversely, governmentality was also involved in the production of legitimacy. Governmentalization, Foucault argued, had permitted the state to survive into the modern era (Foucault 1991, p. 103). "If the state is what it is today," he argued, "this is precisely thanks to this governmentality" (Foucault 1991, p. 103).

Braithwaite suggests that governmentality and meta-regulation grasp at related phenomena (Braithwaite 2000, p. 225). Certainly, Power's notions of verification and regulatory ritualism chime with elements of Foucault's thesis. In the audit society, increased demands for accountability become systemic, "a case of checking gone wild," and technical efficiency is subordinated to the need for control and the production of organizational legitimacy (Power 1997, p. 14). Thus, audits become rituals of verification; formalized systems of surveillance that present opportunities for gaming and blame redistribution (Power 1997, 2003, p. 192).

However, meta-regulation can be distinguished from governmentality in terms of the significant emphasis that regulatory governance scholars place on innovation and knowledge gathering. For theorists of govermentality, the neoliberal project of withdrawal from society is about constructing responsible subjects capable of self-care, for whom the state is no longer responsible. Here, governmentality involves notions of bio-power, or the structuring of individual being and identity. In the regulatory governance literature, however, the shift from direct regulation to self-regulation is associated with the production of knowledge. For example, Hood and co-authors argue that the installation of self-regulatory mechanisms within corporate governance structures aids the management and control of risks. And while they acknowledge that these mechanisms can often have the unwanted effect of augmenting cultures of "blame prevention re-engineering," they also contend that the challenge for regulators is to engender intelligent deliberation rather than mechanistic blame shifting when adapting these techniques for use in the public sector (Hood *et al.* 2001, pp. 176–177; Hood 2002).

More specifically, Braithwaite suggests that the proliferation of new self-regulatory techniques is a consequence of the development of more complex and globalized economies. With Hayek, Braithwaite argues that the centralized Keynesian state could not acquire the necessary knowledge to intervene effectively in a globalized economy. It tried to pick winners, but regularly picked losers (Braithwaite 2000, p. 231; Hayek 1949). Accordingly, new regulatory techniques were necessary to empower local knowledge and ascertain "market prices" that more accurately reflected local preferences. With Power, Braithwaite acknowledges the potential for ritualism, gaming, and blame cultures within these mechanisms; but with Hood and co-authors, he represents these as problems to be overcome – markets in vice – rather than definitive characteristics of the regime itself, and by extension, the contemporary era (Braithwaite 2008, p. 150). For example, Braithwaite offers "a learning culture" as a simple strategy for transcending blame, ritualism, and gaming (Braithwaite 2008, p. 150). Here, meta-regulated organizations engage in deliberative processes with stakeholders that "define the most serious problems the organisation needs to confront and how to measure improvement" (Braithwaite 2008, pp. 150–151).

Labour's reform of NHS provision has injected several mechanisms for enforced self-regulation into the governance structures of provider-side organizations. For

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example, altered governance arrangements are a key factor in distinguishing NHS Foundation Trusts from older NHS Trusts. The basic framework of the new governance arrangements for NHS Foundation Trusts is set out in the Health and Social Care Act 2003. While the DH encourages organizations applying for FT status to alter the details of their proposed governance structures to best reflect local needs, it also stresses that certain fundamentals must be in place. These are the membership, board of governors, chairman, and board of directors (DH 2002, p. 11). In addition, Monitor provides FT applicants with a "Model Core Constitution" and an "NHS Foundation Trust Code of Governance" to assist in drafting each individual constitution (DH 2007c, p. 21).

Government guidance argues that these arrangements comprise "a legal regime" that replaces central accountability to Whitehall with "accountability mechanisms to local people" (DH 2002, p. 9). In other words, they replace direct forms of regulation with meta-regulation. Chairmen, governors, and members are "new actors" formally positioned within FTs to "blow whistles," "withhold co-operation," and "close or open gates." For example, the board of directors remains responsible for the exercise of the FT's powers, for its day-to-day management, for the construction of the business plan, and for its overall performance (Monitor 2006, p. 6; DH 2002, p. 11). The chairman, however, is responsible for the leadership of the boards of both directors and governors, and also for ensuring that the two bodies work effectively and in tandem (Monitor 2006, p. 9). The governors are responsible for holding "the board of directors to account for the performance of the trust," and for representing the interests of FT members and its partner organizations in the local health economy (Monitor 2006, p. 12). FT members elect representatives to serve on the board of governors. In addition, governors are also responsible for "feeding back information" about the trust and its performance to their constituencies (Monitor 2006, p. 12).

The new governance arrangement for FTs imposes a system of enforced self-regulation that bears greater similarity to the regulatory literature's notion of meta-regulation than to Foucault's concept of governmentality. Indeed, the central purpose of the new bodies is to gather information and produce knowledge that will enable the FT to act more effectively in the local health economy. For example, DH guidance outlines that a large membership base is necessary to provide "the depth of need and diversity of opinion" that will "enable foundation trusts to respond, with more certainty, to the health needs of their local communities" (DH 2007c, p. 22). It is not sufficient that arrangements between the board of governors, members, and directors be workable. The size and composition of the board of governors must also ensure that "the full range of members' interests are represented." Essentially, it must affect a "proper balance" between ensuring that different interest groups are represented and delivering "arrangements that are workable in practice" (DH 2002, p. 10). Moreover, guidance outlines that "modern public services cannot be delivered by monolithic organisations commanded and controlled from Whitehall" (DH 2002, p. 5). In the past, Government "had too much power" and did not always "know best" (DH 2002, p. 5). Staff often felt that "change was something which is done to them rather than done by them" (DH 2002, p. 6). Thus, the health service needed "to become more accountable to local communities" (DH 2002, p. 5). Staff needed to be "more engaged in improving services" (DH 2002, p. 5). The purpose of the new governance arrangements was to offer each "a direct say in how their local services are provided" (DH 2002, p. 9).

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Conclusion

The themes of the regulatory state are evident in Labour's re-regulation of NHS provision. To recap, the government has divided labor between a steering DH and rowing FTs. It has also divided labor within the state: between the DH and newly independent bodies such as Monitor and the HC that regulate rowing organizations with technocratic devices. It has codified previously informal arrangements with policies such as 18 Weeks and PbR. It has also subjected FTs to meta-regulation and techniques of enforced self-regulation by altering their internal governance arrangements.

In Europe and the UK, there are some obvious consequences of this finding for the health policy and health services literatures. First, the UK health services literature would profit by opening its discussion of NHS reform to the regulatory literature's much wider perspective. From this perspective, Labour's reform of the NHS is neither an exercise in privatization nor a return to past models of health care provision. Equally, it is not a passing fashion or the cynical initiative of self-interested politicians. Labour's transformation of the NHS is an attempt to grapple with the serious and common problems confronting the public health systems of member states across the EU through an extensive application of new regulatory governance techniques to a classic institution of the old European welfare state. Essentially, Labour's reform of NHS provision is about the rise of the regulatory state.

Moreover, the existence of two phases to Labour's program, ideological and policy based, is doubtful. As scholars of regulation have long noted, neoliberalism's ideology of deregulation and privatization is not matched at the policy level and rather amounts to a substantive re-regulation of state, market, and society. Thus, Labour's system of targets and performance monitoring is more a case of codifying previously informal relationships than of strengthening a highly centralized bureaucracy, especially considered in the light of the DH's changing role as a steering organization. It is also unlikely that the creation of FTs and the introduction of PbR are indicative of a return to the neoliberal market-based reforms of the Thatcher government. The altered governance arrangements of FTs are more indicative of meta-regulatory techniques for enforced self-regulation than of exercises in privatization. Furthermore, policies such as 18 Weeks and PbR are more about the codification of clinical and management relationships across the NHS than about the creeping influence of markets.

For the health policy literature, the broader point is that debates about privatization, accusations regarding the betrayal of Aneurin Bevan's original vision of equity and universality, concerns about confusing mixes of different policy strata, and notions of "policy unlearning" and the "hidden curriculums" of Anglo-Saxon market-based liberalism may need to yield to what Braithwaite describes as a discussion of the mechanics of regulatory design for a new kind of world where "bedpans rattling in Whitehall" do nothing for the improvement of services (Braithwaite 2000, p. 235). In other words, the health policy and health services literatures might benefit from discussions about how to equip European public health systems with regulatory structures and systems of governance that deliver efficient, responsive, and high quality health care services.

Alternatively, for the regulatory governance literature, there seems little reason to doubt the existence of the regulatory state or its capacity to describe the function and operation of individual regulatory regimes. Critics might argue that the regulatory state hypothesis cannot account for variations in institutional arrangements. Moreover, they

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might also suggest that the analysis of institutional variety only partially supports the thesis (Lodge & Stirton 2006, p. 492). However, where we regard macro-level descriptors as grasping at related empirical phenomena, and thus mutually constituting and informing one another, their capacity to explain variety within regulatory regimes is significantly amplified. And, as the analysis demonstrates, they can be tightly and usefully linked to regulatory innovations at the institutional level – a capacity that can be further evidenced in terms of Labour's re-regulation of NHS commissioning (Wright 2010).

In addition, the influence of the regulatory state on Labour's reform of provision reveals some important weaknesses in the meso-level focus of risk regulation. Certainly, a regime-based approach offers a systematic way for describing how risks are regulated. It provides a means for contributing to middle-level debates about why regulation varies across public policy domains. It has the potential to contribute to the assessment of policy and institutional design (Hood *et al.* 2001, p. 185). And within the wider social sciences, it also enjoys the benefit of standing on sturdy conceptual shoulders (Hood *et al.* 2001, p. 12). However, macroscopic designators have the capacity to draw attention to features that make today's world different from the past. These features have an important bearing on both the design and the function of regulation at the institutional level. Here, the thesis for the regulatory state speaks to a particular style of policymaking. Regulatory states differ from both night-watchman and welfare states. Regulatory states divide labor between state and society because they doubt their capacity to provide efficient, high quality services. They divide labor within the state because their old monolithic structure no longer makes sense where the risks of provision are shared. They codify relationships between agents and organizations in order to deliver transparency, accountability, and social responsibility. They install meta-regulatory techniques for enforced self-regulation both within the governance structures of organizations, and also at various points of the regulatory regime, to empower local knowledge and create sites for innovation. Herein, risk regulation's weakness is its aversion to structurally determined patterns of regulatory change (Lodge & Stirton 2006). For risk regulators, there is no such thing as the risk society, the regulatory state, and the audit society, only different risk regulation regimes (Hood *et al.* 2001, p. 171). Consequently, the problem is that risk regulation lacks the capacity to take a historical perspective on the development of its own analytical framework.

The problem is a serious one. Risk regulation's analytical framework of regime-based content and context is grounded in a conception of regulation as interference with markets and social processes for the control of adverse consequences (Hood *et al.* 2001, p. 29). But if the regulatory state exists, there are qualitative differences among 19th, 20th, and 21st century regulatory contexts that such a framework necessarily neglects – contexts that other scholars of regulation express in terms of laissez-faire capitalism, the welfare state, the audit society, the British regulatory state, and regulatory capitalism. While risk regulators might argue that the paradigmatic features of these contexts "wither," or are significantly modified in their implementation, and are thus less effective in accounting for differences in the extent of reform across a variety of sector-based policy contexts, the analytical focus of their critique remains bounded at the institutional level (Lodge & Stirton 2006, p. 491). At this level, regulation might serve basic functions such as information gathering, standard setting, and behavior modification, but it also does much more. For example, some regulatory governance scholars argue that the emergence of regulatory states hastens the development of more dynamic and

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globalizing economies. They suggest that regulatory states carry the potential to produce greater amounts of wealth and to distribute it in ever more unequal ways. Where they work more efficiently, regulatory states will efficiently produce both "bads" and "goods" (Braithwaite & Drahos 2000; Braithwaite 2008, pp. 197–199).

Thus, the existence of the regulatory state requires regulatory governance scholars to ask a broader range of questions about how regulatory regimes work and how they should work. For example, scholars of regulation need to consider how well regulatory states facilitate innovation and learning cultures and how they can avoid mechanistic blame shifting and regulatory ritualism. They need to evaluate the promise of the regulatory state to deliver an increased range of higher quality services at reduced costs. They need to determine how the structure and operation of regulatory states can be improved to deliver more balanced approaches to the distribution of power and resources. Certainly, issues of institutional coherency, transparency, accountability, and diversity of risk tolerances have their uses and remain important. But, ultimately, they need to be supplemented by more broad ranging questions that account for differences among 19th, 20th, and 21st century realities. Essentially, the existence of the regulatory state requires scholars of regulation to take a historical perspective on the development of their analytical frameworks.

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