

HEALTH POLICY TRANSFER FROM THE US TO THE UK:
UNDERSTANDING THE RATIONALE OF POLITICIANS
AND POLICY-MAKERS

by

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Abstract

Since the mid-1990s 'policy transfer' emerged and developed as an important construct in public policy analysis. In 2000, Dolowitz & Marsh (D&M) developed a path-breaking theoretical framework largely, though not entirely state-centric, for policy transfer. In 2010, Sable & Zeitlin (S&Z) developed experimentalist governance, evolved from a theory of policy learning in the European Union, which took the theory of policy transfer to a novel level of policy-making in the shadow of hierarchy. Both are employed in this study as theoretical lenses to view health policy transfer from the USA to England. In the domain of health care, anecdotally, English health policy stakeholders from various backgrounds/interests undertake initiatives to acquire policy ideas, learning, and ultimately policy or programme transfer from United States' health care institutions, practitioners, and innovators. The question of whether the US predominates in health policy transfer to England among all other countries and, if so, why, has not been systematically explored. This qualitative study explored these questions with one-on-one indepth semi-structured interviews of elite English health policy stakeholders: NHS executives or managers; politicians or former politicians; political advisors; think tank officials; academics; and clinicians. A 'passive consciousness,' tantamount to acceptance, of the US as a privileged source of health policy or programme innovation was apparent. However, data collected in response to research questions demonstrated universal rejection of any aspect of the US at a system level. There was, however, enthusiastic interest in acquiring specific tools and techniques from the US. It was clear, however, that policy transfer in England was not a coordinated function. The D&M and S&Z theoretical frameworks were validated and, in combination, offer new insights. Policy transfer has important implications for cost, quality, access, equity, and system improvement, and can change the character and values of a system. In light of these findings, this study aims to provide insights for English health policy stakeholders to improve the oversight, steering, or management of policy transfer.

Dedication

To Diane, my constant encourager and supportive spouse, for her forbearance during the demands for my physical or mental absence from so many routine activities of our daily life and special occasions during this great journey, I am forever grateful.

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TABLE OF CONTENTS

	Page
CHAPTER 1 INTRODUCTION	1
1.1 Background	
1.2 Rationale for the study	
1.3 Dolowitz & Marsh	
1.4 Sabel & Zeitlin	
1.5 Atlantic crossings	
1.6 US health policy Atlantic crossings	
CHAPTER 2 LITERATURE REVIEW	7
2.1 Introduction	
2.2 From lesson drawing to policy transfer	
2.3 Dolowitz and Marsh model	
2.4 Policy transfers across boundaries	
2.5 Health policy ideas and policy transfers	
2.6 Policy learning and networks	
2.7 Experimentalist governance	
2.8 Co-creation and policy transfer	
2.9 How policy transfer occurs	

2.10 Decision-making for policy adoption

2.11 Summation

CHAPTER 3 THEORETICAL FRAMEWORK45

3.1 Introduction

3.2 Intellectual roots of lesson drawing

3.3 The policy transfer framework

3.4 Dolowitz & Marsh model

3.5 Who are key actors in policy transfer?

3.6 What is transferred?

3.7 Where are lessons drawn?

3.8 When does transfer occur?

3.9 Why transfer?

3.10 How does policy transfer occur?

3.11 Experimentalist governance

3.12 Network governance

3.13 Open method of coordination

3.14 Fast policy

3.15 Path dependency

3.16 Summation

CHAPTER 4 METHODOLOGY77

4.1 Introduction

4.2 Rationale for research approach

4.3 Epistemology: constructionism

4.4 Design: basic qualitative study

4.5 Overview of information sought

4.6 Research design overview

4.7 Research sample

4.8 Data collection methods

4.9 Pilot study

4.10 Data analysis and synthesis

4.11 Theory core principles

4.12 Procedural steps

4.13 Ethical considerations

4.14 Trustworthiness of the research

4.15 Validity

4.16 Credibility

4.17 Transferability

4.18 Dependability

4.19	Confirmability	
4.20	Reflexivity	
4.21	Summation	
CHAPTER 5 FINDINGS, PART I		111
5.1	Introduction	
5.2	Theme: US a privileged source	
5.3	Theme: differences across macro, meso, micro levels	
CHAPTER 6 FINDINGS, PART II		149
6.1	Theme: framers and brokers	
6.2	Theme: US influence across governments	
6.3	Theme: Selective tools and techniques	
CHAPTER 7 DISCUSSION.....		184
7.1	Foreword	
7.2	The questions	
7.3	The theoretical frameworks	
7.4	The sample	
7.5	The literature	
7.6	The responses	

7.7 Limitations of the study

CHAPTER 8 SUMMATION AND CONCLUSIONS 200

LIST OF TABLES

1. Prime ministers' memoirs on health
2. Epistemology and research approach
3. Overview of information sought
4. Multiple career roles of participants
5. Thematic map

LIST OF ABBREVIATIONS..... 204

REFERENCES207

APPENDICES232

APPENDIX A – Dolowitz & Marsh framework

APPENDIX B – Thematic map

APPENDIX C – Interview schedule

APPENDIX D – Letter of invitation, information sheet, consent forms

APPENDIX E – Ethics approval

CHAPTER 1 INTRODUCTION

1.1 Background

Since the mid-1990s 'policy transfer' has emerged, matured, and expanded as an important concept in political science and the sub-field of public policy analysis. In the domain of healthcare, there are many anecdotal accounts of policy stakeholders in England, undertaking various initiatives, to acquire health policy ideas, learning, or actual transfer of policies or programmes from the United States (US).

At the same time, however, it is singularly important, and crucial to the purpose of this study, to recognise there is no discernible research which takes a measure of English health policy stakeholders' apparent 'default' position for United States' (US) health care institutions, practitioners, or innovators. This study explores the question of whether England looks predominantly to health policy ideas, policy processes, or programmes developed and implemented in the US. What has not been investigated, explained, or reported in the literature are explanations for this possible central tendency. There are many factors which would intuitively militate against it, thus raising a number of interesting questions. Hence, the central research question for this study emerges: how do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States for health policy and programme ideas, learning, or transfer?

Exploring this question can aid with understanding "why," as well as elucidate the implications of imported policy or programmes for efficiency, effectiveness, and, importantly, values underlying the English National Health Service (NHS), for current and future system reforms. This research on policy transfer in the health sector aims to characterise agents and processes for transfer beyond official actors and networks, institutional and organisational tools, and not simply counting policies transferred. Finally, a contribution of these understandings might extrapolate to policy transfer processes in domains other than health care.

1.2 Rationale for the study

Innovative health policy ideas, learning, and transfer have important implications for systems improvement, cost, quality, access, and equity of health care services. They can also incrementally change the fundamental nature of a system, particularly in systems of care which

are wholly divergent in organisation, planning, financing, and provision. This is notably the case of England and the US.

Both anecdotal and literature reporting of English initiatives to acquire health policy or programme ideas, learning, and transfer predominantly from the US are limited, and explanations for this perceived tendency are as yet unexplored in primary research. However, the Thatcher government's use of Stanford economist Alain Enthoven's ideas to design the NHS internal market (Dolowitz and Marsh, 2000; Enthoven, 1985), Tony Blair's then-new payment mechanism for hospitals drawn from the US prospective payment system (PPS), and systems for management of chronic disease, are notable examples. (Ham, 2005) The expansion of academic health science centres was a case of health policy transfer to England from the US. (French, 2014) Nudge policies to reduce obesity originated in the US, and were transferred to the UK. (Oliver & Ubel, 2014) A joint report from Nuffield Trust and King's Fund addressed the stress on primary care in England, and looked to new models in the US. (Smith, et al, 2013) The King's Fund produced a report on accountable care organisations (ACOs) in the US because of implications for development of integrated care in UK. (Shortell, et al, 2014) The arrival of Simon Stevens, a former NHS executive, Blairite special advisor, and top executive of a mammoth American health insurance company, as chief executive of the NHS, was perhaps (cynically) viewed by some at the time as a 'direct' transfer of competition policy in health services from the US. (Davies, 2013)

Commonalities of language, culture, ideology, and even personal relationships contribute to policy affinity. However, interestingly, a pilot study revealed policy transfer in one direction -- from England to US -- is virtually non-existent. This study therefore aims to explore the role of key agents or brokers of policy learning and transfer, and how personal experiences or relationships might influence a preference for US policies.

Building on pilot study results (see 3.9 below), the researcher was not be content with exploring only wholesale, intact policy transfers at the national level, which was much less likely to occur in any event. The activities of policy learning, ideas, and transfer was conflated under the rubric of policy transfer, yet separately characterised, as these activities were isolated. They were qualitatively examined and matrixed across multiple policy levels – national (macro), regional (meso), and programmatic/clinical (micro). This is important because the actors, processes, aims, and applications of transfer likely differ at each of these levels. Hence, there was an attempt to differentiate roles of mediating policy influences, ie, actors at the different levels.

1.3 Dolowitz & Marsh

In 1996, Dolowitz & Marsh (hereafter, D&M) published a stock-take of policy transfer studies, which was largely based in comparative politics and policy, lesson drawing, and diffusion studies. D&M contributed significantly to broader identification of actors and processes in policy transfer. However, it was largely a state-centric and hierarchical framework. In 2000, the authors published a path-breaking framework with the essential addition of non-state actors, eg, consultancies, think tanks, supranational organisations (like the EU), added in response to changes in forms or modes of governance. (Dolowitz & Marsh, 1996; 2000)

1.4 Sabel & Zeitlin

This theoretically-informed study will also use a second lens of Sabel and Zeitlin's (hereafter, S&Z) experimentalist governance (Sabel & Zeitlin, 2008), rooted in policy learning in the EU. In essence, the theory is concerned with the exchange of best practices through informal networks, parallel with policy transfer, and offers several relevant concepts: collaboration, a multi-level nature, informality, networking, open coordination, product/process improvement, and mutual learning. Essentially, experimentalist government embraces movement of what works in one setting to a different setting through informal networks. (Sabel & Zeitlin, 2010) This study will contribute the first known application of these concepts in the health policy domain.

Potential analytical and practical significance of study findings may include : 1) explanations for English health policy stakeholders looking predominantly to the US, 2) highlighting for UK health policy communities the implications of introducing US private, for-profit health care concepts in the NHS, whether for good or ill, and 3) differentiating the role of key agents or brokers of policy transfer, and how their personal experiences might influence the preference for US policies.

1.5 Atlantic crossings

Policy transfer in the context of this study engages with the movement of ideas, learning, policies, or programmes in health care across international borders; in this case, US and England, across the Atlantic Ocean. Daniel T. Rodgers' Atlantic Crossings provided an intellectually deep background for the foundation of social politics that may have been fertile soil

for policy transfer to evolve, as it chronicled “social politics in a progressive age.” (Rodgers, 1998)

In the late-1800s, America and Americans were ‘geocentric,’ little awareness of the broader world, provincial in its perspective. However, if all nations are complicit in world historical forces, outpost nations like the United States, that began as imperial projects of other nations (like the United States), are particularly to be included in those forces. (Baker, 1945)

From the earliest European settlements in North America forward, the Atlantic functioned for its newcomers less as a barrier than a connective lifeline – a seaway for the movement of people, goods, ideas, and aspirations. A key outpost for European trade and a magnet for European capital, the eighteenth- and nineteenth-century United States cannot be understood outside the North Atlantic economy of which it was a part. (Rodgers, 1998)

There was a distinct era in the past when American social politics were connected to social political debates and efforts in Europe through a web of rivalry and exchange. Between the late 1800s and the First World War, cosmopolitan progressives tried to carry over the Atlantic network a ‘laboratory’ rare in history. (Rodgers, 1998)

Each imported measure had to be disposed of, from old-age insurance to subsidised workers’ housing, from city planning to rural reconstruction. Some made the crossing to the United States with relatively little difficulty. Others sank in mid-passage. Still more were transformed, their “Americanisation” leaving a precise and revealing trace of the forces and circumstances they had come up against. Follow these processes through, from foreign model to domestic outcome, and there are surprises as well as confirmations to be found. (Rodgers, 1998)

John Kingdon’s agenda setting model, addressed real world politics:

. . . ideas and problems, and solutions and potential crises, circulate remarkably independently through the political stream. (Kingdon, 1984)

These come from myriad sources but their futures depend on finding each other.

Just as a political idea becomes politically viable only when it is successfully attached to a sense of need and urgency, no less do problems become politically significant only when they become attached to politically imaginable solutions. The framers of solutions do not come into the act at the last minute. They are present at the moment of creation, transforming a tragic but

incurable condition into a politically solvable problem, and by that very act, defining the field within which legislators and executives will ultimately maneuver. (Rodgers, 1998)

It was this agenda-setting role of ideas that gave political consequence to the new world of transferable social experience and appropriate policy models thrown open at the end of the nineteenth century. (Rodgers, 1998)

Indeed, there arose a hitherto unknown plethora of solutions, and a vast number of them came across through the Atlantic connection. (Rodgers, 1998) The social politics of 'Atlantic crossings' encompass great insight into how, as a foundational matter, policy transfer from US to England feasibly evolved 100 years later.

In the Atlantic connection, it is also worth noting that the term "Special Relationship" may have gone some distance to rhetorically and culturally, at least, reinforce the US-UK relationship across time, as the term is still in use today. The term was notably mentioned in a statement by Prime Minister Churchill in 1944 regarding the necessity for the two countries to continue cooperation to maintain world peace. In 1945, he used it again to describe not the Anglo-American relationship alone but Britain's relationship with both the Americans and the Canadians. Later, in a 1946 speech given by Churchill in Fulton, Missouri, it was popularised. However, its existence and even the term itself had been recognised since the 19th century, not least by rival powers of the two countries. However sincerely, the special relationship may have been held by many, it was so often repeated that it could function as a rhetorical device to continually reinforce a cultural norm, and serve to set the table for US-UK relations. (Baylis, 1998)

The level of cooperation between England and the US in trade and commerce, military planning, execution of military operations, nuclear weapons technology, and intelligence sharing has been described as "unparalleled" among major world powers. The close relationships between British and American heads of government such as Margaret Thatcher and Ronald Reagan, as well as between Tony Blair and both Bill Clinton and George W. Bush have been noted. At the diplomatic level, characteristics include recurring public representations of the relationship as "special", frequent and high-profile political visits and extensive information exchange at the diplomatic working level. (Baylis, 1998)

1.6 US health policy influence across the Atlantic

The American researcher for this study, after a long career in multiple facets of US health care, also made an Atlantic crossing to pursue a doctoral programme in health policy at a British university. The motivation was admiration for the National Health Service, a desire to learn as much as possible about it, and to contribute to its support, defending and improving it by whatever opportunity might make it possible. Having just entered the programme, the researcher was struck, even surprised, at how much discussion of US health care abounded in the English context. After initial research, a connection between those anecdotal discussions and the construct of policy transfer emerged, and became a passionate pursuit of research to understand the US-England nexus in health care.

Exploring US to England policy transfer from the viewpoint of elite English health policy stakeholders who observed and experienced it, the interesting, untold story emerged of an intuitive awareness of US to England policy transfer but which was not generally revealed beyond anecdotally, and certainly never systematically explored.

This introduction was intended to provide a scene-setter for exploration of the policy transfer concept in play in England. Now, with this background, a systematic study will continue the journey of exploration, explanation, and furtherance of understanding of health policy ideas, learning, and transfers as to how and why they travel across the Atlantic. Contents which follow in sequence after this introduction are:

Chapter 2- Literature Review

Chapter 3 – Theoretical Framework

Chapter 4 - Methodology

Chapter 5 - Findings, Part I

Chapter 6 – Findings, Part II

Chapter 7 – Discussion

Chapter 8 - Summation and Conclusions

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

A review of literature preceded the development of research questions, and a rationale for selection of a methodology to answer them. Peer-reviewed literature were explored through web searches using PubMed, Web of Science, and Google Scholar. The objective was to discover a narrative or story, which could be followed through in a proposed study. Useful key search words were crafted to encompass a variety albeit relevant content. Good keywords were also obtained from relevant articles as they were accessed, similar to 'snowballing.' Searches were original for references, ie, references were not obtained from the references themselves. Filters were used to obtain the most recent references, and names of notable authors.

Literature search strategy. A search strategy was organized with a combination of keywords, phrases, subject headings, and limiters used for searching a database. The search strategy also took account of:

a) variations in search terms (synonyms, suffixes, British-American spelling variations) b)

Boolean operators

In some instances, to optimise use of researcher's time, the strategy employed:

c) truncation (use of asterisk [*] where permitted by a database)

d) search phrases (where applicable)

e) limiters (date, language, age, publication type, etc.)

The strategy, of course, required numerous iterations, testing, and refinement. Periodic testing determined if the strategy was finding relevant articles, in what quantity and quality.

The strategy was built by writing down as many terms as possible that related to the research questions. To begin this process, a few good articles in 'cited references' were reviewed for relevant terms. In curating terms, consideration was given to terms or concepts that might be expressed in different words, or spelling between British and American sources.

In addition to the use of terms, an attempt was made in some instances to search for phrases. It was noted, however, that the number of results produced was actually more limited.

Using appropriate subject headings enhanced the search and helped find more results on the topic. This is because subject headings find articles according to their subject, even if the article does not use your chosen key words. Subject headings and keywords were sometimes combined in the search strategy.

Boolean logic was used to combine search terms. Boolean operators (AND, OR and NOT) allow different combinations of search terms or subject headings. The main Boolean operators used were:

- a) OR – to find articles that mention either of searched topics
- b) AND – to find articles that mention both of searched topics
- c) NOT – to exclude a search term or concept

A search for records that have cited a published work ('cited reference searching') enabled an efficient means of discovery of how a known idea or innovation has been confirmed, applied, improved, extended, or corrected, in addition to providing an initial set of key search terms. In other words, this tool was useful to assess the impact of research, hence, seminal works on the topic, and is available on various databases, including Web of Science. Specific applications include:

- a) keywords or terms you may need to include in your search strategy
- b) pivotal papers the same or similar subject area
- c) pivotal authors in the same or similar subject area
- d) tracking how a topic has developed over time (MD Anderson Cancer Center, 2022)

The literature review formed the basis for developing the research questions, including identified gaps in the literature, and an explanatory framework for the results. The review proceeded from the general to the specific literature. First, a review of studies which were generally related. Second, studies assessed to be similar to the present one, if any. Third, studies varying from this one. This process led to identification of research gaps, which again were addressed with the research questions.

The literature does not fall neatly into one category or another. The researcher recognised that lesson drawing, policy learning and transfer are conceptual tools that identify often complex and

overlapping elements involved in policy development. One example would be in the principles and characteristics of experimentalist governance and network governance.

In addition to the signal importance of this review as a foundational building block for the study, an overarching purpose here is to provide a well-rounded view of policy transfer in a global sense, and reduce it to the case of England and the US.

This study will be aimed at systematically exploring, explaining, and further understanding the process by which health policy ideas are learned, and potentially transferred as policy or programmes across the Atlantic Ocean. The learning and transfer of health policy ideas, policy, or programmes often travel across the Atlantic Ocean between North America and Europe, especially with respect to England and the United States, subject of this study. This frequent interchange of ideas and substantive policies and programmes has been attributed to multiple factors in the extant literature, including common challenges, historical ties, politics, values, technological advancement, and expansion of international interaction with respect to shared understandings such as global health. (Dolowitz & Marsh, 2000).

Health policy ideas, policies, and programmes play a significant role in enhancing healthcare systems and impacting the population's overall health. The development of health governance policies, learning, and transfer of internationally applicable health policy and programmes are complex processes and involve different stakeholders, mechanisms, and contexts to strive for the common good. As will be discussed below, systematic studies cover a range of topics including health policy ideas, learning of policy ideas, and transferring health policy ideas across the Atlantic Ocean.

2.2 From lesson drawing to policy transfer

The systematic review aims to synthesise and critically analyse the existing literature on lesson drawing potentially leading to policy transfer. According to Rose (2008a), lesson drawing is conclusion-oriented thinking centred around taking action regarding a programme or programmes implemented in other locations and how the findings can be transferred for effective application locally. The process of lesson drawing involves searching for insights from a historical point or geographical space. The choice is somewhat subjective and relies on a number of factors such as perceived closeness, networks of experts, government interdependence, and the influence of international organisations. Lesson drawing begins with

the closer examination of existing programmes in other places, culminating in a forward-looking assessment of the potential outcomes if those programmes were implemented locally. The lesson drawing process is often political and contentious, with no guarantees that the drawn lessons will be feasible and advantageous (Rose, 2008a).

Rose (2008a) also indicated that a positive lesson can only be derived if the country of reference effectively addressed a specific issue. Conversely, if that performance is deemed inferior, the lesson could likely revolve around what measures or policies to not implement, ie, negative lessons.

Lesson drawing extends beyond retrospective evaluation studies of a particular programme within a single nation. Lesson drawing also involves researching public agency initiatives to gather innovative ideas for managing problems. It transcends national or state boundaries, generating insights beyond data collection or studying foreign cultures for knowledge acquisition. A successful programme is a creative endeavor, requiring modification to accommodate local conditions. Its components can be easily adjusted or combined from multiple countries, with additions improving effectiveness or removals and replacement of functionally equivalent elements (Rose, 2008a). Political aspiration and technical effectiveness may clash when politicians are attracted to a programme's positive outcomes albeit in a different context, but there remains uncertainty of success if implemented elsewhere.

The researchers also reported that the most intriguing conflict between political ambition and technical competence occurs when politicians become enticed by a programme that has produced positive results in another setting. Politicians will always have different viewpoints on what is deemed desirable at any given time. Politics, by its very nature, requires promoting opposing goals, leading to the conception of this divide. Politicians dispute not only the purposes but also the appropriate tactics to be used, presenting opposing arguments on which party can best achieve public goals in lesson drawing. (Rose, 2008a).

In a different study, Rose (2008b) sought to examine the concept of lesson drawing from diverse intellectual standpoints through a cross-national research study utilizing five published articles. The study highlighted that policy transfer has been in practice for centuries now, evinced by Aristotle's assessment of the structures of city-states to enhance civic progress, while the newly independent America examined the English Constitution to avoid its perceived flaws.

Rose (2008b) reported that national governments face difficulties developing entirely new programmes from scratch in a world where information is abundant. Rose (2008)'s study of Giandomenico Majone's regulatory policy development in Europe and the United States illustrated the reciprocal exchange of public policies between the two countries. In addition, the practice of policy transfer among the states was accelerated through the establishment of the Single European Market in 1992 which further intensified interactions between the twelve member states of the European Community. Rose emphasised that the transfer of policies involves attracting appealing concepts and exercising political influence. Power imbalances between neighbouring states are common, as Rose (2008b) demonstrated through the study of George Hoberg's analysis of the American impact on Canadian environmental regulations.

Rose (2008b) highlights how policymakers can employ evidence from other countries to achieve various objectives. The approach involves highlighting a specific concern on the political agenda, mitigating political stress, acquiring understanding regarding various policy alternatives, or reinforcing established stances. However, Rose (2008b) warned that lesson drawing has a moral aspect, originating from disagreements surrounding political objectives. In such situations, Rose (2008b) recommends that references to external experience can be employed rhetorically in ideological discussions. The underlying presumption in this study is that different nations have similar challenges and objectives. The nations may thus learn from each other's successes and failures and get new perspectives. Policymakers may attempt to acquire insight by evaluating the outcomes of policies implemented in various settings. The strategy intends to enable them to make informed decisions more likely to have positive consequences for their nations. (Rose, 2008b)

Policy transfer has found extensive application in classifying and clarifying processes within and between various political contexts. Although it is undoubtedly linked to concepts such as policy diffusion, lesson drawing, and policy innovation, it is evident that policy transfer has become a unique field of study (Benson and Jordan, 2011). At present, three primary approaches to studying policy transfer can be identified. The researchers identified two interconnected mechanisms that support the evolution of the policy transfer concept. The initial mechanism involves ongoing development, broadening to incorporate other theoretical and empirical viewpoints. The concept also undergoes integration, engaging with other academic domains. In future, policy transfer research may continue to evolve, experience deeper integration, or enter a phase of declining conceptual significance.

Benson & Jordan (2011) provided an empirical investigation on the evolution of lesson drawing by studying the flow of public policy transfer in the European Union, interpreted through the lens of Dolowitz and Marsh (1996) which provided the seminal context. Benson & Jordan (2011) identified the key actors in the policy transfer process. The enablers of policy transfer included elected representatives, political factions, government administrators, advocacy organisations, policy innovators, and international organisations at a higher level. The researchers also recognised additional non-governmental actors involved in facilitating the transfer of policies across international boundaries. The actors included transnational advocacy networks, charitable organisations, research organisations, and groups with shared specialised knowledge, eg, epistemic communities. However, it is the impact of global organisations that have garnered the most attention, especially within the realm of the European Union. (Benson & Jordan, 2011)

Benson & Jordan (2011) revealed that the main reasons states engage in policy transfers were dissatisfaction among policymakers, public concerns, perceptions of policy failure, political competition, the need for legitimizing specific policy actions, and uncertainty. The researchers also highlighted the main components of a policy that are transferrable, including policy objectives, arrangement and substance, policy tools or managerial methods, establishments, belief systems, notions, perspectives, and negative lessons. Benson and Jordan (2011) determined that policy transfer can occur in various forms, including hybridisation and synthesis that denotes emulation, copying, and inspiration. Like Rose (1993), Benson & Jordan (2011) identified several barriers to policy transfer, which included intellectual hindrances during the pre-decision stage, contextual challenges during implementation, and local public sentiment. Benson & Jordan (2011) further showed that policy transfer has evolved, encompassing various theoretical and practical perspectives. Its integration with other literature and discussions may continue, potentially undergoing further integration.

2.3 Dolowitz and Marsh model

Along the same lines, Dolowitz and Marsh (2000) sought to demarcate the evolution of policy transfer. In 1996, the researchers conducted a systematic review of relevant scholarly articles in policy transfer. The authors attempted to highlight the cyclic progression, entailing the uptake of policies in various countries and subsequent adjustments within each nation, demonstrating the widespread occurrence of policy transfer. The study also highlighted the significance of specific

individuals and institutions within this process, along with the challenges linked to it. The study also indicated that policy transfer is driven by globalisation, communication advancements, and international organisations including the EU, IMF, and World Bank promoting and enforcing similar policies across diverse countries. Global economic influences and communication facilitate the exchange of ideas and knowledge, further accelerating the rate of policy transfer between countries.

Dolowitz & Marsh (2000) developed the archetypical model aimed at easy conceptualisation and study of policy transfer as centred around six components. The questions include what motivates individuals to partake in policy transfer. Who are the pivotal participants in the process of policy transfer? What exactly gets transferred? Where are the insights extracted from? What variations exist in the extent of transfer? What hinders or aids the policy transfer process? Similar to Benson & Jordan (2011), Dolowitz & Marsh (2000) reported that policy objectives, policy substance, policy tools, policy initiatives, establishments, belief systems, concepts and perspectives, and adverse experiences are the main transferable components of policy transfer. However, the researchers noted that not all policy transfers are successful. Uninformed transfer occurs when the recipient nation lacks information about the policy or institution in the source country. Incomplete transfer results in failure, while inappropriate transfer occurs when disparities between economic, social, political, and ideological contexts are not adequately considered. (Dolowitz & Marsh, 2000)

The researchers posited that it was more accurate to envision transfer as existing on a spectrum that extends from drawing lessons to directly imposing a programme, policy, or institutional structure onto a political system. The spectrum may be used as a tool to comprehend the operations more organised, and it is advantageous for two related factors. First, it establishes the categories researchers may use to arrange their empirical studies, which is important given the complexity of analyzing policy transmission. Second, many transfer cases have both voluntary and coercive elements, with the continuum helping in recognising this fact, and improving the understanding of the procedure.

In Dolowitz & Marsh's (1996) earlier study, the authors conducted a literature review to explain the dynamics and elements of policy transfer in England. The authors revealed two types of policy transfer: voluntary, where a country willingly adopts and implements policies, practices, or ideas from another nation because it sees value or benefit in doing so, and coercive policy transfers. Coercive policy transfers refer to when a country is compelled or pressured to adopt

certain policies, often by external factors such as international organisations, powerful states, or economic forces or, in some cases, internal factors. Like Dolowitz & Marsh (2000), Dolowitz & Marsh (1996) also established that elected representatives, political parties, government administrators, advocacy groups, policy experts, and international organisations are the main actors in transferring policies from one country to another.

The authors highlighted the global economy places constraints on governments, and economic pressures can prompt policy transfer. The integration of the global economy has led to the convergence of institutional structures and trading practices in the securities market and banking sector, for example. Countries heavily reliant on one another may feel compelled to adopt similar policies. Additionally, a country can be indirectly influenced toward policy transfer if its political actors perceive it as lagging behind neighbouring countries or competitors. Concerns about falling behind in a significant public issue can trigger attention, and the accumulation of actions elsewhere might create a sense of insecurity about being isolated. (Dolowitz & Marsh, 2000)

Dolowitz & Marsh (1996) also determined that policy objectives, policy design and substance, policy tools or managerial methods, establishments, belief systems, concepts, and adverse experiences are the main components of a policy that can be transferred. The researchers adopted Roses' (1991) five policy transfer types and models: copying, emulation, hybridisation, synthesis, and inspiration. Later, they adapted the five types to four by conflating hybridisation and synthesis as 'combination'. The researchers also identified constraints to successfully implementing policy transfer strategies, such as programmes with singular objectives which tend to be more transferable than those with multiple goals. Additionally, the likelihood of transfer increases with the problem's simplicity. When the problem is straightforward, the policy is likely to be adopted. In addition, programmes with fewer perceived side effects are more prone to transfer. The ease of transfer also depends on the extent of available information about how a programme functions in a different location. Lastly, transferring a programme tends to be simpler when outcomes can be easily predicted. (Dolowitz & Marsh, 1996) The Dolowitz & Marsh theoretical framework is discussed in greater detail in Chapter 3.e

Eckert and Borzel (2012), through a review of a study by Sabel & Zeitlin (2010), sought to explicate the concept of experimentalist governance advanced in the European Union by a majority of member states. The researchers reported that the expansion of regulatory measures is underpinned by an iterative process of constructing and refining framework regulations across

diverse levels and sectors. While broad goals are established at international organisations, lower-level governance actors possess a notable degree of autonomy in achieving the objectives. The dynamic framework relies on obligations to furnish progress reports, participate in peer assessments, and engage in deliberative processes that may foster policy transfer. The experimentalist governance framework carries democratic merits, similar to a directly deliberative polyarchy (Eckert & Borzel, 2012). As posited by Eckert & Borzel, a directly deliberative polyarchy embodies a context where established practices are challenged through debates grounded in immediate experiences, and this occurs in the absence of centralised control.

However, the researchers warned that experimental governance may affect the democratic process of EU member states. According to Eckert & Borzel (2012), experimental governance has the potential to make problems with democratic representation worse. The researchers revealed that democratic decision-making procedures would not be seen as important in experimental governance as they should be. The researchers also posited that post-national constitutionalism is offered as a theoretical framework that questions the easy applicability of current forms of representative democracy to transnational situations. The authors assert that attempting such a change, such as enforcing cross-border policy transfer, can have unforeseen repercussions, eg, prioritizing institutional self-interest above sincere attempts to increase input validity.

Eckert & Borzel (2012) discuss experimental governance as a departure from traditional hierarchical models, focusing on dynamic accountability. According to the researchers, experimental governance challenges the principal-agent approach by requiring principals to rely on agents' expertise rather than detailed instructions. The approach blurs the line between conception and execution in policymaking. However, experimental governance is not a clear extension of formal hierarchical decision-making but offers a networked, deliberative alternative (Eckert & Borzel, 2012). Experimental governance allows interactions between hierarchical and non-hierarchical approaches, using a penalty default mechanism to incentivise actors to participate in deliberation.

2.4 Policy transfers across boundaries

Policy transfers occur within different levels. While some policy transfers happen internationally, some occur at transnational levels. Evans (2009) reviewed the literature on the critical perspectives of policy transfers. In the review, the researcher evaluated the implications of political changes, changes in the structures of economic institutions, changes in global communication, and how nations and states have changed. The researcher also investigated policy transfers as an organisational learning process and how policy experts use it to effect policy changes. The overall conclusion drawn from the review was that effective policy transfers were informed by the movement of ideas and information through policy transfer networks and policy transfer agents. The policy transfer networks included the different forms of policy transfers that are in process: failed transfers, voluntary, and completed transfers. Thus, multilevel models of policy transfer analysis comprehensively explain policy changes in policy transfer networks.

An understanding of policy transfer and translation was also provided by Stone (2012), who acknowledged the extensive research on policy transfer and diffusion in the past two decades. Stone (2012) explored the trends regarding policy diffusion and the multidisciplinary social science literature on policy mobilities, learning, and translations in this review. The review also focused on the role of non-state actors and international organisations in the transnational transfer of ideas, and developing professional networks promoting policy coordination and harmonisation. The literature analysis for both aspects revealed that policy transfers occur at both international and local levels. Based on reviewed studies, while domestic policies promote diversity and state differences, important policy changes, reforms, and innovations are often influenced by external state factors to a great extent. With various local and international factors influencing policy changes, knowledge transfers are more extensive when compared to policy transfers in general. Translators must first identify the knowledge to be transferred and the surrounding uncertainties in policy transfers.

Marsh and Evans (2012) reviewed the literature to understand policy transfer from experience and published studies. This study focused on the main ideas McCann and Ward presented regarding policy transfer, criticisms of McCann and Ward, and the ontology and epistemology of policy transfers. A focus on McCann and Ward's critique of published literature revealed that most studies focused on the agents of policy transfers rather than the agency, the national scale of policy transfers, policy transfers as implicit literalism, and the rationality of the entire policy

transfer process. The ontology and epistemology of policy transfer is that it is not always a complex, power-laden process but also a straightforward a-to-b movement. Therefore, the simplicity or the complexity of policy transfers is influenced by the levels at which the transfers occur. Arguably, complex policy transfers occur at international levels, while straightforward a-to-b movement of ideas and policies occurs at local, eg, trust, levels. Although the literature on policy transfers has matured, researchers should embrace both sides of the policy transfer concept, the side with problems and the constructivist side, to develop a broadened understanding of the concept.

Evans et al. (2011) studied international policy transfers. The focus was on policy transfers between global and local jurisdictions, and global and sovereign policy transfers. The researcher extensively reviewed the literature on governance institutions and actors involved in policy transfers in different government and non-government sectors. The review of published literature focused on policy transfer as an organisational learning process and evaluation of policy transfers by policy scientists. When studying policy transfers, the researchers often focus on the different forms, including emulation, policy learning, convergence, band wagoning, social learning, and transnationalisation. As an organisational learning process, policy transfers at different jurisdictions result from new learning opportunities, the decline in institutional memory due to loss of material, failure to record data and decisions, and the emergence of new governance systems. International policy transfers and global policies may occur at broad levels when transferring ideals and goals, institutional transfers, ideological, personnel, and administrative transfers. Overall, policy transfers at different levels are influenced by the role of state and non-state actors, and institutions supporting policy transfers, eg, management consultancies or think tanks, resulting in complex globalisation.

2.5 Health policy ideas and policy transfers

Policy transfers have proved crucial in developing and acquiring new ideas aimed at fasttracking policy changes in healthcare systems and improving the quality of care available to patients. Mechanic (1995) investigated the Americanisation of the English National Health Services as a strategy to reform British healthcare systems. The focus of the reforms was to facilitate the independence of hospitals in terms of service and budget autonomy, creating an internal market that separates the provision of service from care financing and allowing general practitioners (GPs) to be fundholders in place of their patients. While the United Kingdom can borrow a lot

from the United States regarding easy access to health, universal coverage, controlled healthcare expenditure, and well-developed primary care services, the NHS has continued with many inefficiencies even with the new reforms. Mechanic argued that while fundholding and decentralisation of care improved the NHS services, much of the information borrowed from the United States was poorly used, thereby deeming the implementation of NHS reforms difficult.

Powell et al. (2018) extended the research conducted by Mechanic (1995) on the Americanisation of English National Health Service. Taking a typological approach, Powell et al. (2018) investigated the Americanisation of the NHS by first exploring the meaning of Americanisation, the development of the discourse about Americanisation, and a focus on other possible meanings of Americanisation. The analysis of the identified articles in this study revealed that most of the NHS changes were internal, focusing on individual system-level changes rather than the entire system change. The Americanisation of NHS occurred on policy learning levels, especially in transferring ideas, personnel, and institutions. Another important change was in public health care funding on private care delivery. Despite the typological approaches, the researcher established that a comprehensive comparative analysis would inform the potential Americanisation of the NHS through systematic studies on policy changes, and the meaning of Americanisation.

Ham (2005) compared the health system England and the U.S. concerning the types and levels of provision and finance. The researcher compared Kaiser Permanente in California and the British National Health Service (NHS). The literature comparing both health systems revealed that financing and providing care in both the US and England was difficult, given the limited learning opportunities and information on both systems. In recent studies, Ham (2005) established that many opportunities for learning and sharing between the two systems have helped NHS adapt to care management and the techniques that Kaiser Permanente uses. To ensure that England effectively adapts and implements the healthcare practices adapted from the US, Kaiser staff provided English experts with support and expertise on primary care trusts (PCTs) and nursing skills to reduce unplanned hospital visits. Although this is the case, Ham (2005) established that both countries need practitioners who understand the two health systems to ease the seamless adoption and implementation of practices from both cadres.

Shortell et al. (2014a) evaluated, tested, and reported on the reforms that worked to develop accountable care organisations (ACOs) in England and the United States. The high number of chronically ill patients and aged population informed an integrated, accountable, and quality

care in England and the United States. Shortell et al. (2014b) reviewed the literature on accountable care organisations, their evolution, use in improving healthcare quality, and adoption in England's NHS, rebranded as Integrated Care Systems (ICSs). In the United States, ACOs were developed to reduce the costs of accessing health care and improve the quality of care available to patients. This was accomplished by having practitioners take personal responsibility for their patient's health in a team concept. In the context of NHS, ICSs have informed budget development and aligned incentives to stimulate the delivery of quality services. Moreover, using technology and the team concept to share information and communicate with at-risk patients has fostered networking and commitment to quality healthcare.

In addition to the accountable care organisations (ACOs) informing healthcare reforms in the United States and England, Blumenthal and Dixon (2012) researched the key areas where both countries could learn from each other for potential further improvements. In the literature review, the researchers focused on organisation, financing and information technology as areas that England and the U.S. can mutually learn from each other. The review analysis revealed that the NHS had much to learn from the new payment systems developed for the U.S. healthcare systems. Pay for performance, bundled payments, and value-based purchasing encouraged efficient and high-quality care. The NHS will also draw valuable lessons from the national bodies, eg, NICE, developed to manage and scrutinise healthcare payments and test new interventions for efficient and improved care. Conversely, the US learned from the NHS's adoption of electronic health records for recordkeeping and efficient delivery healthcare services. The accountable care organisations and Clinical Commissioning Groups (CCGs) have much to learn from each other, hence the importance of policy transfers and policy diffusion.

Unlike Ham (2005), Vrangbaek and Christiansen (2005) investigated the development of healthcare policies in Denmark, focusing on the administrative health reforms of 1970. Using the theories of path dependency and institutional inertia to explain stability and structure, the theories of policy reforms and processes have influenced the development policies at the macroeconomic control of global budgets, the quality of services offered, and the use of technology. However, the policy responses aiding the decentralisation of healthcare were negatively influenced by a lack of autonomy, poor incentives, and unfavorable governance structures. Moreover, county and central government tension interferes with the provision of care. The new health policies are gradually shifting the governance structure in healthcare to a

more decentralised system favouring competition between different governance principles. The new systems also combine the provision of care with ownership and financing. The changes in health policies have attracted significant attention to healthcare, including the internationalisation of demand. Although policy reforms have been adopted, reports are unclear whether the reforms will yield the expected benefits and improve the current health system.

Greener (2002) reviewed the literature to understand reforms and analyse the health policy in England under the perspectives of path dependency, social learning, and policy transfer. The reforms in the National Health Service in the U.K. were informed by policy changes developed from policy transfers, social learning, and path dependence. In effecting policy change and transfers, the researchers established that social learning is crucial in indexing the extent of policy change and providing a framework for analyzing coherence in the present paradigm. Overall, the social learning approach to policy analysis focuses on the deliberate attempts by policymakers to adjust policy goals in line with new information or past responses. Path dependency is focused on continued policy changes that anchor health reforms.

French et al. (2014) also investigated policy transfers and reforms in healthcare in a systematic review of the literature and a case study of policy transfer in England. The studies reviewed in this literature were retrieved from ISI Web of Knowledge, Scopus, and Business Source Premier databases. The studies for review were not limited to a particular date, and the search was conducted using specific search terms. The researcher selected health policy journals. The analysis informed the case of academic health science centres (AHSCs) in England in policy documents published between 1996 and 2012. A total of 372 studies were reviewed. The review's outcome revealed that international academic health science centres are newly developing organisations. In addition to being new developments, elite networks are crucial in policy transfers, and future researchers should focus on the role of professional elites in facilitating policy transfer within AHSCs. Using these findings, it would be advisable for policymakers to reduce competing policy incentives for AHSCs, and encourage their international operations through increased public funding.

Unlike French et al. (2014), Tuohy (2017) analysed published articles on America's health reforms focusing on policy change as a political strategy. Tuohy's (2017) comparative perspective included reviewing studies on conditions likely to result in incremental or discontinuous healthcare reforms and policy changes. The reforms in American healthcare were informed by the rapid changes brought by the failures of 'big-bang' strategies and the success of

'mosaic' strategies. The researcher noted that policy changes in the U.S. are intermingled with politics, and policymakers will tend to effect changes that support their current and future positions. The American political institutions and their varied interests influence social policies and mobilise the necessary authority to overcome the progressive proliferation of social institutions. Despite the proliferation of institutions overcoming veto points, discontinuous change and windows of opportunity for social policy changes are still rare. When the windows of opportunity are open, combining the confluence factors with political actors creates a strong partisan incentive that proliferates social policy change in healthcare. (Kingdon, 1984)

The transformation of healthcare worldwide has gained significance with governments and healthcare stakeholders. With the need to provide quality healthcare, countries have begun paying their healthcare practitioners via the DRG system. Sheaff et al. (2020) investigated the use of DRG systems in three European countries: Germany, England and Italy. A qualitative research methodology was used. One hundred fifty-four participants were interviewed, and 111 policy documents were analysed. Besides interviews and policy documents, an action learning set from 2010-2012 continued to 2018-2019 to provide the researchers with additional data. The data analysis revealed that managers in all three countries contained healthcare costs by increasing hospital activities through weakened DRG incentives. The results showed that the managers collaboratively agreed to reduce DRG payments for care above the agreed case ceiling and when the activity reduced below the agreed volume. The concept of managerial workaround has proved crucial in transforming the healthcare system through balanced diagnostics. More empirical studies are needed on DRG systems and managerial workaround to inform the development of more transformational healthcare systems.

The research offers numerous reasons why health policy ideas have been prioritised among European and North American countries across the Atlantic Ocean to achieve universal healthcare. Sheaff et al. (2020) examined managerial workarounds in three European DRG systems. Qualitative tests of assumptions regarding the character, consequences, and antecedents of managerial workarounds were made from published health policy documents and interviews at relevant national levels, including England and Germany, as well as other regional bodies in Italy. The sampling strategy included selecting study sites by the standards of their respective healthcare systems and using similar data collection methods in each nation. Sheaff et al. (2020) conducted informant interviews with 20 in Germany, 24 in Italy, and 110 in England, who identified the policy and guidance documents that were most relevant. The

findings demonstrated health policy ideas such as financial incentives to hospitals to increase activity and even overtreatment. Hospitals can claim additional reimbursement by documenting extra nursing services. However, space limitations resulted in the researcher narrating rather than quoting the informant's data.

Studies indicate that health policy ideas often stem from government agencies, management or health care consultancy organisations, research institutions, and international organisations such as the World Health Organisation. Eckl and Hanrieder (2023) explored the political economy of consulting organisations during reform processes in a case study of world health organisations. The researcher analysed the experiences of the World Health Organisation and how it instituted new forms of consulting based on health policy ideas. The case study was conducted to discuss the consultant-mediated reforms of the World Health Organisation's Roll Back Malaria partnership in 2015 to ameliorate health policies across European countries. The study analysis was based on primary documents, interviews with key informants, informal discussions, and participant observation. The study review established that health policy ideas were created through consultancy from various health practitioners and organisations for a consolidated policy on malaria across Europe (Eckl & Hanrieder, 2023). However, the limitation was that privileges given to these health care stakeholders led to limited information gathered because some were unwilling to share ideas.

Health policy ideas can be strategically created by enhancing healthcare networks across the Atlantic. This can be achieved through professional awareness and proximity to the local communities to create links between formal and informal resources. Kingdon (1984) studied the agendas and alternatives in creating public health policies regarding pandemic containment measures. Kingdon (1984) proposed Community Action Programmes in which innovation is used at the local community level in Italy and other nations across Europe and North America to provide improvised solutions to disease outbreaks and containment measures. The researcher recommended transferring health policy ideas across nations to enhance a unified invention process. Kingdon's (1984) study indicates why some choices become prominent on the health policy agenda while others do not.

Developing health policy ideas requires various factors, including network governance through collaboration, cultural sensitivity, and adaptation. Research indicates policymakers need to be open to learning new health policy ideas from one another's experiences and should be willing to adapt new policies to align with their context in addressing healthcare challenges (Andresani

and Ferlie, 2006). Network governance has been a key strategy to create more health policy ideas among countries across the Atlantic. As Andresani & Ferlie (2006) stated, network governance structures and processes can promote health policy idea creation through effective stakeholder capitalism and sharing opinions and views based on experience and challenges encountered in different countries. Andresani & Ferlie (2006) suggested that developing a multiparadigmatic model of ethical and organisation theories as an alternative to network governance can be thinkable and institutionally practicable across the Atlantic.

2.6 Policy learning and networks

Learning about health policy ideas from different regions can provide an informed discussion and regional debates for policy transfer. Policymakers, experts, and researchers can evaluate and adapt successful health policies from one side of the Atlantic to suit the other side's needs. An article by Fossum (2012) highlights the need for policymakers to learn about health policies adopted in different nations across the Atlantic to get new concepts and ways of thinking used on the other side of the Atlantic. Fossum (2012) investigated the reflections on experimentalist governance and regulations of health policies and found that policymaking and implementation can be learned through collaborative governance, where ideas are learned from other nations across the Atlantic through democratic partnerships for improved health policymaking (Fossum, 2012). The researcher recommended learning health policy ideas on both sides of the Atlantic to enhance innovation and address similar health challenges in their regions.

While Fossum (2012) examined the reflections on experimentalist governance and health policy idea learning, Martinsen et al. (2021) articles analysed experimenting European health care forward and network interactions. Network interaction has been enhanced by experimentalist governance through the network formed by cross-border experts in healthcare. The articles used social network analysis based on data collected through surveys on the information exchange programmes and most effective known health care practices across the Atlantic in countries including Norway, the UK, and Iceland. Martinsen et al. (2021) established that network interaction as networked governance results in EU healthcare cooperation whilst domestic organisations can condition who interacts with whom and learn new ideas from. Unlike Fossum (2012), Martinsen et al. (2021) suggested that learning through network interaction can be enhanced by determining the extent to which domestic institutions can condition such interactions.

A research article published by Addicott and Ferlie (2007) highlighted that networks are emerging as new innovative institutional forms in the public health sector in the United Kingdom, further supporting the notion that access to larger health networks enhance the learning of health policy ideas from across the Atlantic. The article discussed five peer-reviewed studies of managed clinical networks (MCNs) for cancer conducted in London to understand power relationships in healthcare networks. The findings revealed that a model of abounded pluralism helps in understanding power relations with the MCNs in London. However, power over healthcare policy development is exerted in the top-down mechanisms of the government and its associated national institutions. The implications that the study support is the discussion that introducing collaboration to the management of public health services can be improved through learning health policy ideas from various nations. In the article by Addicott & Ferlie (2007), there was limited understanding of the nature of power in health policy network relations in the public sector.

Challenges faced in the health care system are generally similar among most European countries. These nations can learn from each other about the challenges and their solutions and share their strengths and innovations in the health care sector through sharing health policy ideas across the Atlantic. Walshe (2001) noted that the US healthcare system is chaotic, wasteful, and fragmented, and prevailing healthcare values differ from those in European nations such as the UK. As a result, the transfer of health policy ideas can only be enhanced by learning these ideas across borders. This will help integrate best health care practices and innovative health policy ideas into the US healthcare system. Despite the challenges faced by the US health care system, there are also many useful ideas and significant lessons to be learned from the US healthcare experience that can be seen by other countries across the Atlantic (Walshe, 2001). The researcher suggested that national solutions to the health care problem can be integrated with international health standards to achieve desired health policies.

Countries situated across the Atlantic Ocean may have different and more or less diverse health care policies, perhaps with similar or different sets of challenges. However, learning from another country's weaknesses and strengths in their healthcare systems can be helpful in assuring improvements in a country's own healthcare system. Boaz et al. (2000) stated that learning each nation's health policy ideas can provide ideas on best health care practices across the Atlantic, resulting creation of effective healthcare policies by the policymakers in the US and nations across the Atlantic region. Key thinkers, researchers, and healthcare experts

should examine each nation's health policies to make informed decisions regarding appropriate health policies for implementation. Boaz et al. (2000) conducted a sector-by-sector analysis of evidence with some cross-cutting themes regarding health policy idea sharing and transfer across borders. Boaz et al. (2000) recommended examining health policies across the Atlantic region to provide a contemporary review of the realities of evidence-informed policymaking and practices in the healthcare sector.

Transfer of health care policy ideas can also be enhanced through learning different health care practices and ideas to make conclusive and well-informed decisions on health policies. Shaw et al. (2014) conceptualised the shaping of critical health policies using the Think Tanks policy model, and Think Tanks works to influence health policy in the UK. The authors presented an interpretive health policy analysis of collected data from UK-based think tanks through informants who appeared to seek to neutralise the presentation through diverse discursive mechanisms. Data analysis established how a sample of healthcare think tanks positioned themselves publicly as independent institutions. The study was based on a proposal to reform the English National Health Service and extend market principles in the realm of health care. While Boaz et al. (2000) highlighted the use of examination of health policies across the Atlantic region, Shaw et al. (2014) suggested technocratic healthcare planning and expansion to assert different skill-related practices to allow feeding of emerging evidence into health policy to improve health service delivery.

Policy transfers are central for learning and transferring ideas to promote policy changes. Dolowitz & Marsh (1996) reviewed the literature on policy transfer, focusing on the lessons individuals, states, and countries have learned from policy transfers. The study focused on transferring policies based on strategic decisions made by key players. The review analysis identified six main actors involved in policy transfer: political parties, policy entrepreneurs/experts, elected officials, civil servants, pressure groups, and supra-national institutions. The researchers explained that groups such as policy experts, supra-national institutions, and elected officials facilitated policy transfers through their nationwide and international networks that acted as sources of new ideas for policies and programmes. Although policy transfers influence policy developments, the researchers identified factors such as structural and institutional constraints experienced by policy agents to impact policy transfers negatively. Another constraint was the political, economic, and bureaucratic resources needed to implement policy transfers, with transfers likely to follow the dominant political ideology of the

host country. The researchers have suggested a broadened view of policy transfers, focusing on policy transfer constraints.

Besides reviewing the literature on policy transfer, Dolowitz and Marsh (2000) investigated the role of policy transfers in contemporary policymaking. The researchers divided the article into four sections. The first section explored the extent of and reasons for the growth of policy transfers. The framework of analysis for policy transfer was the second section, and the third section explored literature distinguishing between the different types of policy transfers. The fourth section reviewed literature examining the relationship between policy failure and policy transfer. The overarching finding is that although policy transfers may influence policy changes, they may also lead to failures in policy implementation. The researchers emphasised the significance of overseeing each policy implementation to ensure that inappropriate, incomplete, and uninformed transfers did not result in policy failure.

Stone (2001) investigated the lessons learned and the international diffusion of ideas following policy transfers. The literature on policy transfers is focused on how institutions, policies, ideas, and administrative arrangements of one political setting, either present or past, are used to develop policies, institutions, and administrative arrangements in other political settings (Stone, 2001). The study was categorised into two sections. The first section provided a general overview of literature on policy transfers, especially diffusion, convergence, social learning, and policy networks. The second section focused on the non-government domain in policy transfer. The literature analysed that non-state actors, including policy experts, interacted with international and government organisations to facilitate the transfer and sharing of sharing. The transfer of ideas and policies is possible through the networks created by key players, and social learning provides a framework that tracks the effective transfer of ideas and information. Future researchers should pay significant attention to the coercive character of transfer and focus on global policy transfer rather than within the OECD.

Marsh and Sharman (2009) compared policy transfer and policy diffusion literature. The comparative literature identified the following differences: The first difference was that the literature on policy transfer was on agency, while policy diffusion focused on structure. The second difference is that literature on policy diffusion is focused on finding patterns, while transfer literature is based on process tracing. Policy diffusion and policy transfer are influenced by four mechanisms: competition, coercion, learning, and mimicry. Governments deliberately emulate foreign practices and institutions in learning to develop efficient and

effective policies. Conversely, competition is when governments borrow policies and practices to reduce inflation to remain competitive. The mechanisms of coercion and mimicry describe the influence of powerful nations and institutions, such as the World Bank, on a country's financial and budgetary policies. Although diffusion and transfer literature are common, their differences in structure and agency necessitate an increase in sample size and in-depth examination of processes that explain policy diffusion patterns.

Additional research on policy diffusion and policy transfer was presented by Obinger et al. (2012), who reviewed qualitative and quantitative studies to understand policy transfers in Comparative Welfare state research. The literature review was informed by the researcher's growing interest and questions on policy diffusion and interdependencies between countries. The theoretical perspectives of the literature revealed that competition, emulation, coercion, and learning were key mechanisms influencing policy diffusion and transfers. The mentioned mechanisms influenced transnational policy learning processes, ambitions to adopt and conform to the new policies by political actors, strategic government interactions to realise competitive advantage through policy transfer, and the role of donor countries enforcing policy changes through coercion. The researchers noted that the levels at which countries will interact, learn from, or compete with each other are significantly influenced by the nature and strength of bilateral relationships. Future researchers should conduct conceptual and theoretical research on policy diffusion and transfer based on the preceding findings.

Marsh & Evans (2012) researched policy transfer, focusing on lessons from the past and using the ideas to understand future policy transfers. The researchers studied policy transfer by discussing published studies on policy debates, policy transfer, policy success, lessons from the past, and new sources for policy learning. Exploring literature on policy transfers based on public policy debates revealed that policy transfers were influenced by governance and networks within a political system associated with issues of power. The success of policy transfer is influenced by the country's ability to learn from the past and a decline in institutional memory. A decline in institutional memory was associated with institutional restructuring, increased staff turnover, media changes, and growing popularity. Learning from the past informs the future of policy transfers focusing on the processes work and those that do not and the complexities of implementing policy changes. Overall, policy transfers across jurisdictions increase the opportunities to learn about new governance systems and the influences of communities on policy transfers.

The lessons learned from policy transfers and associated limitations were also studied by James and Lodge (2003). Understanding public policy in England, the concepts of policy transfers and learned lessons are crucial. James and Lodge (2003) based their study on three questions, all seeking to explore the lessons drawn from policy transfers. The review of published literature revealed that policy transfers influenced policymaking at cross-jurisdictional levels. The key lessons learned regarding the specification of mechanisms to improve learning and policy changes that influence policy success. The limitations of policy transfer success are often informed through uninformed transfers characterised by the borrowing country lacking enough context or information regarding the policies or institutions being transferred. Incomplete transfers of key elements as well as insufficient attention given to the political, economic, ideological, and social differences are some of the main reasons behind policy transfer failures.

Trouve et al. (2010) utilised a qualitatively methodology to investigate the role of path dependency theory in studying institutional integration in France. Semi-structured interviews were the primary sources of data. The participants were individuals involved in decision-making from different levels. Other data sources were analysis of administrative documents and observations of advisory board meetings. The results analysis of the data revealed that institutional integration was complex and highly fragmented. Using path dependency theory, the researcher established that the incomplete reforms of gerontological policies juxtaposed and generated the coexistence of institutional systems. Overall, no single organisation can build institutional integration and determine gerontology policies. As an analytical framework, path dependency has demonstrated the complexity of clinical and organisational integration. The researchers recommended further in-depth research on the various forms of coalition networks influencing the art of policy making.

Policy diffusion and transfer of health ideas across the Atlantic involves understanding diverse nations' unique health systems regulatory environment and the specific cultural context. Stone (2012) investigated the transfer and translation of health policy ideas by learning about different policies from diverse countries across the Atlantic region. The article reviewed some trends in political science diffusion, transfer of healthcare policies, and translation of such policies to fit into the local healthcare system. The articles highlighted the need for policymakers to understand health policies from different nations across the Atlantic to know how they operate and how they can be integrated into the health system (Stone, 2012). In this case, policy transfer and translation become a transnational process. As a result, the health policy transfer

framework can undermine the temptation of viewing the forces that can change the policy in a domestic context.

The soft transfer of information and health policy ideas via personal, professional, or electronic networks is frequent and fast. Stone (2010) explored private philanthropy or policy transfer and the transnational norms of the Open Society Institute for Enhanced Health Care. These articles were researched through various methods, including data from OSI's website and other policy publications participation through observations and interviews. The data collected confirmed that once a global civil society becomes attractive, it can be used to justify institutions of global governance by transferring health policy ideas across different jurisdictions in the Atlantic region. Through cross-national learning platforms, policymakers in nations in the regions, through diplomatic channels, can transfer healthcare knowledge and practices for policy formulation (Stone, 2010). In this regard, policymakers can learn from different nations about innovative health policy ideas.

Policy transfers from different regions tend to espouse informed governance decisions and can be enhanced through future governance program workshops on transferring health policies across the Atlantic region. Some studies examined how policies from exporter nations can be identified as worthy of being emulated and how to apply them (Page, 2000). Page (2000) indicated that through bilateral agreements between member states, nations can transfer policies across various sectors, including healthcare, for sharing health policy ideas and adoption. Foreign evidence can be a validating gesture to provide proposals for cross-national transfer of policy ideas, thus making it hard to determine if anything can be transferred and adopted as provided by health care practices observed from other states or localities within the region. This can aid in policymaking and implementing different ideas across the Atlantic through democratic partnerships for better health policy decision-making.

Transnational policy networks can also facilitate the transfer of health policy ideas across the Atlantic region. Similar to Shaw et al. (2014), Stone (2000) utilised a Think Tanks policy transfer model to examine independent policy institutes' strategies surrounding non-governmental policy transfers. Stone (2000) stated that the discussion regarding health policy transfers has often focused on the official actors and networks. However, non-governmental organisations also transfer policies via foundations, think tanks and non-governmental institutions. According to Stone (2000), the significance of think tanks during the policy transfer process is based on their capability to spread ideas through their advocacy of the idea movement and their involvement in

domestic and transnational policy networks, which further necessitates the need for transnational policy networks. This applies as well to management consultancies captured by the following vignette.

Vignette

Management consultancies

Some might argue that management consultancies (hereafter, MCs) serve to ‘frame’ issues for stakeholders. Indeed, but on the other hand, however, it can be argued that MCs proceed far beyond framing to the character of their advise, advocacy, and overt pushing of ideas and solutions with clients, both proprietary and otherwise. In this connection, they are also subject to acting as agents of policy transfer. Their influence is both broad and deep, some would say ‘insidious.’ Kirkpatrick et al (2016) provide an general overview of the sector. Alternatively, Skouteris et al (2019) delve into consultancies’ value for money, and their ostensible impact on improvement.

According to Eckl & Hanrieder (2023), existing research cite the rise of consulting firms in intergovernmental organisations (IGOs), as evidence of the global spread of managerialism. The literature also suggests this rise and growing relevance of managerial expertise are mutually reinforcing “since consultants’ prestige is rooted in managerialist world culture.” (Eckl & Hanreider, 2023) MCs were instrumental in the spread of private sector practices into public management, as formalised in England’s New Public Management (NPM) with mixed success but with visages still present.

Mazzucato and Collington (2023) assert the illusion that MCs are objective sources of expertise and capacity. Further, in the end, what they refer to as the “Big Con” weakens our businesses, infantilises our governments, and warps our economies, they argue. The authors describe the track record of MCs in, for example, successfully executing privatisation of railroads in the UK, banks in Mexico, and more. Certainly, privatisation is and has long been of paramount concern in the politics of the NHS. MCs have extensive expertise in privatisation, mergers and acquisitions, restructuring, increasing productivity, developing metrics, and much more. The increasing use of MCs tracks closely with changing business models. So, it can fairly be said the history of consultancies parallels the history of capitalism. (Mazzucato & Collington, 2023)

MCs are known for publishing books and reports describe processes which may ultimately become proprietary, and then become the foundation for future sale of services. It is not unreasonable that this might presage a 'one size fits all' approach across clients. As MCs serve clients around the globe, they undoubtedly acquire information and knowledge which subsequently may be transmitted, inculcated across clients in a perhaps more passive form of policy transfer.

In 1970, the English NHS was troubled with bad organization, bad decision making overcrowding in hospitals with patients, for example, the elderly, assigned to improper (and wasteful) levels of care. (Bogdanich and Forsythe, 2022)

Both Labour and Conservative parties recognised the problems but had no solutions. They turned to McKinsey & Co., the global consulting behemoth, as the management gurus who could find solutions. In 1972, McKinsey published the "Grey Book," which laid out a plan to integrate the three branches of health care – primary care, hospitals, community services. (Bogdanich & Forsythe, 2022)

The overhaul implemented in 1974 was largely ineffective. An incomprehensible mistake by McKinsey was to install management by consensus, or committee, among doctors, nurses, and administrators. The finger pointing started. Nevertheless, landing a big project with the world's largest employer jump started McKinsey's global expansion. At the same time, McKinsey managed to stay engaged in UK for the next 50 years, which speaks to the firm's ability to adjust to changing politics and views. (Bogdanic & Forsythe, 2022)

What is known is that, in the UK, use of MCs has become habitual while, at the same time, they have been shown to have a largely negative effect on efficiency. (Sturdy et al., 2022)

Additionally, four years of data from 120 NHS hospital trusts in England showed that spending on MCs was strongly related to 'prior use,' ie, habituation, and an inclination to outsource tough problems. A small minority of these trusts did experience improvements. They were clearly exceptions rather than the norm. Overall, a sceptical view of repeated external MC use was supported. During 2018-2019, estimates are that over 300 million GBPs was spent on hiring external consultants by NHS providers and commissioners. (Sturdy et al., 2022)

Anecdotally, it was announced in December 2022 NHS England hired two consultancy firms to fill the 'skills and resource' gaps in its work to help digitise trusts, a 2bn GBP project, according to Health Services Journal (HSJ). As of July 2023, the bulk of consultancy spending by the

government's new hospitals programme had gone to two firms, 20m GBR to each, HSJ reported.

The national procurement and logistics agency has signed a GBP 9m contract with Deloitte to replace the ageing, complex and inflexible systems trusts use to order products, according to HSJ. These are only three albeit large areas of expenditures for consultancies in the NHS. The trend is noticeably relentless.

Hanrieder and Eckl posited that:

Consultants have been described as “wizards,” superior analytical minds who can turn around businesses, but also as “pretenders” who sell management fads and quasi-academic insights to business and government. In our recent research on the World Health Organisation (WHO), one of our interviewees also described them as ‘priests’ – companies that are hired to transform the organization on the basis of the ‘bible,’ (organisation strategy) [of the consultancy]. Yet, this neutral, detached image as a technical servant to a public organisation, is misleading. Rather, as we describe in our study of consulting firm engagement at WHO, consultants act as discretionary curators of reform inputs. They filter the knowledge and voices that go into reform proposals, and they are often closely entangled with the interests of certain stakeholders and funders. (Hanreider & Eckl, 2017)

It was anticipated that study participants would be keenly aware of the extent of influence and impact of MCs in the English NHS. These non-state actors should not be overlooked in the policy process, and potential agents of policy transfer which, however passive, carry the same implications as other means.

Policy differentials regarding weaknesses and strengths can hinder the transfer of health policy ideas across the Atlantic region. Greer (2011) determined the weakness of strong health policies and weak health policies through experimentalist governance and supporting coalitions in European Union health care policy. The review of published policy documents and interviews of informants across Europe revealed that EU health care service policy experience indicates the importance of supporting collaborations or coalitions of policy transfer, which can qualify for the generalisation of quality. Based on the interview data, Greer's (2011) article indicates that the hard law of health services in Europe makes it difficult to transfer policies to be emulated with

another state or nation. However, such laws support coalitions that enhance the transfer of health policy ideas across different nations in Europe and the Atlantic region. Laws legislated domestically on the health policy transfer have been rebuffed, but it has not impeded the EU power's creation.

2.7 Experimentalist governance

Experimentalist governance has been suggested for promoting policy transfer across Europe, North America, and the Atlantic region. Consistent with the findings by Fossum (2012), Fierbeck, K. (2014) also explored the changing forms of experimentalist governance in European healthcare and its impact on policy transfer. Fierbeck, K. (2014) used published articles on healthcare across Europe. In Fierbeck's (2014) study, mechanisms of health policy coordination and transfer were highlighted by stating that coordination of health policy can effectively provide policy solutions compared to formal and rigid forms of legal synchronisation. The strategy can politically establish a normative perspective that unifies all actors across the Atlantic region to outperform the ideological force upon which EU policies are based. This strategy by Fierbeck, K. (2014) enhances learning health policy ideas across various nations to promote its transfer and emulation amongst these countries.

A discussion of the determinants of policy transfer, strategies and decision-making for policy adoption is presented in 2.10. Also, a more definitive discussion of the principles of EG follows in 3.11

2.8 Co-creation and policy transfer

Other than experimentalist governance to facilitate health policy idea transfer, multi-actor collaboration through the creation of innovative solutions among countries can also promote policy transfer. Different countries experience diverse policies and their interpretations. Torfing et al. (2021) study was based on a theoretical framework for studying the co-creation of inventive health solutions and public value for policy and politics in the transfer of critical ideas in Europe. In this study, network governance, collaborative governance among nations, and strategic management for public innovation contributed significantly to transferring health policy ideas across the Atlantic region (Torfing et al., 2021). Torfing et al. (2021) recommended digital platforms that support the transformation and synthesis of different bodies of theory when studying the complexity of co-creation processes. The articles discussed have demonstrated

that health policy transfer requires strict policies and strategies across the Atlantic region to successfully share different ideas in healthcare to provide effective and innovative solutions.

2.9 How policy transfer occurs

Dolowitz (2003) also determined that policy transfer occurs through diverse mechanisms, including formal channels involving international organisations such as the UN and the World Bank, informal networks among policymakers, practitioners, and experts, international conferences, and academic collaborations producing cross-border research and peer learning through interactions and study visits. The mechanisms collectively promote the exchange of ideas, experiences, and successful policies across jurisdictions, facilitating learning and adaptation to local contexts (Dolowitz, 2003). The researchers highlighted that policy transfer impacts governance and decision-making by promoting innovation and learning by adopting policies from other jurisdictions. Policy transfer aligns practices and standards across regions, allowing for knowledge exchange and collective problem-solving.

However, Dolowitz outlined that policy transfer faces challenges such as cultural disparities, jurisdictional differences in institutional frameworks, governance systems and administrative processes, political variances, and socioeconomic conditions (Dolowitz, 2003). These factors can hinder the adoption and implementation of transferred policies and obstruct the transfer process because of opposition or lack of political will. Adaptation involves tailoring policy design, implementation strategies, and principles to suit local conditions, requiring comprehensive comprehension and engagement with stakeholders (Dolowitz, 2003). Adequate resources, including financial and human assets, are essential for effective policy implementation, as insufficient capacity can impede success (Dolowitz, 2003). Resistance to change from governmental bodies, interest groups, and the public can also obstruct policy transfer, as unfamiliar policies may be met with skepticism. Overall, policy transfer requires careful adaptation and consideration of local contexts and factors to ensure successful policy implementation.

2.10 Decision-making for policy adoption

Dolowitz (2003) proposed a list of guiding factors that influence a policymaker's decision to adopt a policy transfer through conducting a systematic review of the literature. The researchers

outlined that the motivation for policy transfer is to absorb knowledge from other jurisdictions' effective programmes. Adopting good policies from different settings helps policymakers avoid reinventing themselves and repeat successful results. The approach depends on the idea that a policy's chance of succeeding in one environment improves if it does so in another. The authors also reported that policy transfer is often driven by pressure to align with international norms and standards. International organisations, agreements, and standards-setting bodies can promote best practices and goals, influencing governments to adopt policies in areas including human rights, environmental protection, and trade regulations. Policy transfers also address shared global challenges including climate change, public health crises, and transnational crime by pooling knowledge and resources attained from successful policies promulgated in other jurisdictions.

In a previous study, Rose (1993) aimed to learn the intellectual aspect of public policy by establishing the determinants of public policy transfer and adoption by different countries. The study also addressed the protocols of public policy transfer by addressing the question of who searches for the policy. At what given time is the policy required? Moreover, how will it be implemented? Rose's (1993) study revealed how often the occurrence of international emulation, the process of drawing lessons, and the act of learning can be witnessed in other contexts. The author also highlighted the three most common barriers to a successful policy transfer: (1) the lack of distinctive components, (2) the flexibility to employ various types of institutions for programme implementation, and (3) the comparability of resources.

Rose (1993) also established four key focal points for comprehensive evaluations and considerations in the context of international emulation and lesson drawing. Firstly, evaluations should involve examining whether there exist clear and direct cause-and-effect relationships. Secondly, evaluations must also take into account the potential for relatively modest outcome changes. Thirdly, evaluations require recognising the established interdependence with other programmes such as adopting comprehensive policies to transition from a planned economy to a market economy. Lastly, evaluations should also take into account the importance of ensuring a harmony of values between the source and recipient contexts. A simple public policy transfer becomes complicated, requiring further thought and, at the very least, changes if any of the four criteria raises an unsafe signal. However, Rose (1993) reported that economists hold universal principles, but their policy recommendations are not always interchangeable. Comparative public policy specialists have divergent opinions, leading to disagreements and insightful

discussions that might hinder successful public policy transfer. The researcher offered a guide to a thorough structure that empowers policymakers to participate in lesson drawing skillfully. The structure involved taking into account historical, geographical, and contextual elements. The author also delivered practical advice to policymakers who seek to leverage the potential of learning from various periods and diverse contexts with this utilisation of cross-temporal and cross-contextual policy learning to amplify the quality of their policy choices.

Adopting a similar position, James & Lodge (2003), through a literature review, investigated the constraints of policy transfer and lesson drawing' in public policy research in England. The researchers highlighted that lesson drawing and policy transfer are influential in understanding public policy, especially in England. However, their proponents struggled with defining their distinctiveness, explaining their occurrence, and assessing their effects compared to other approaches. Lesson drawing resembles rational policymaking, while policy transfer blurs with various methods. The reasons for their occurrence and impact on policy outcomes remain unclear (James & Lodge, 2003). A major limitation of policy transfer research included failure to encompass the disparities between theories in which transfer is voluntary or coercive, signifying international treaties or external pressures do not mandate it, yet it remains confined because of bounded rationality constrained by organisational limitations (James & Lodge, 2003).

James & Lodge (2003) argued that lesson drawing mirrors traditional rational policymaking, where policy choices are guided by pursuing valued objectives through structured interventions by government bodies or agents. The choices involve a systematic search for means to attain goals, incorporating past experiences and available data for adjustments. The past analysis largely aligns with this established framework, aside from acknowledging practical constraints on policymakers. The absence of a clear distinction between lesson drawing and general rational policymaking complicates identifying lesson drawing evidence. The researchers also highlighted another limitation: the proponents' definition of policy transfer is even more complicated, making it challenging to distinguish from rational and various other policymaking concepts.

The researchers posited that accurate policy transfer measures are essential for assessing the effect of policy transfer on policy formation. The measurements can show if expertise from other places is used to create policies. A survey might examine how policies have changed during a specified period in a given industry or area. A measure should be developed to assess the relative significance of policy transfer compared to other policymaking processes. Because of

policy transfer's comprehensive character, however, different measurements cannot be drawn from it, making it challenging to disentangle from other policymaking processes (James & Lodge, 2003).

Similarly, through a systematic review, Benson and Jordan (2012) sought to highlight the future evolution and application of policy transfer strategies encompassing risk and opportunities. The researchers determined that the future of policy transfer was earlier favored to evolve rather than assimilate and decline. On the contrary, the authors also established that the future of policy transfer will adopt interdisciplinary assimilation and collaboration. The study revealed that political scholars have extensively investigated policy transfer using a rationalist perspective and have crafted diverse analytical techniques, particularly in the realm of international relations, to explore the socially constructed and situation-sensitive facets of policy creation across different tiers that can be applied in the future. The approach examines the impact of non-material factors like norms and concepts on shaping actors' identities, consequently molding their inclinations and strategies related to policy transfer. In addition, acknowledging the interconnected correlation between transferred policies, the participants in the transfer process, and the individuals molding those policies provides fresh research opportunities that align with the methodologies scholars embrace.

Benson and Jordan (2012) raise key questions to challenge the adoption of lesson drawings for the future evolution of policy transfer. Exploring the intricate pathways of policies and policy knowledge across various locations, observing their alterations during transit, and dissecting their integration into novel policy amalgamations presents an intricate challenge. The drawback poses substantial challenges for researchers concerning methodologies, data collection, and analysis. Such research might inherently rely on singular, non-accumulative, non-comparative case studies, given the distinctiveness of each assemblage process, which might be a challenge in future. However, the study is limited in its application since it depends on limited sources of data and information.

The study's primary goal was to use the viewpoint Dolowitz and Marsh (1996) developed as a framework to assess future studies. However, the findings by Dolowitz and Marsh (1996) failed to lay the intellectual foundations of the policy transfer approach. Second, depending heavily on their methodology imposed a restrictive definition of what constitutes policy transfer study. The researchers made recommendations that policy analysts should, as a result, take a more

flexible approach and offer illustrations of the kinds of issues that should now receive more emphasis in studies.

In a similar study, Dolowitz et al. (1999) reviewed the application of lesson drawing and policy transfer between the United States and the United Kingdom. For example, the researchers highlighted that Neil Kinnock received assistance from Democratic Party consultant Joe Napolitan for the 1987 election, but his impact was limited. The Democratic Party sought guidance from the Labour Party on its unsuccessful 1992 campaign, leading to the Labour Party adopting an electoral strategy from the Democrats. The scope of lesson drawing extended to the Labour Party's aim to secure election victories, resulting in new policies and electoral strategies from the Democrats. Dolowitz et al. (1999) also examined the factors that influence the policy transfer between the United States and England and found that international policy transfer involves interactions between politicians and bureaucrats, involving the study of policy documents and laws from foreign nations. While some officials are proficient in multiple languages, they often seek lessons from English-speaking countries to avoid translation challenges and facilitate smoother idea exchange. In addition, a common ideology exists.

The authors reported that the fact that both countries embraced ideas that served as the foundation for several policy reforms throughout the 1980s, the increase in transfers from the US to the UK can, in part, be attributed to shared ideologies. Personal connections also strongly impact policy transfers. Policymakers interacting on a personal level exchange ideas and experiences. Trust and collaboration grow, enhancing the likelihood of successful policy adoption elsewhere (Dolowitz et al., 1999). However, the researchers noted that most of the policy transfer has been one-way, with England doing most of the adoption. The phenomenon is because the United States was more advanced than the UK, and the United States reluctantly adopted any policies globally. The researchers also found that The United States is a source of inspiration for England, partly because of its federal system, and large scale, which offer a variety of models. The trend is further encouraged by the UK's conception of its worldwide position as a steadfast friend and supporter of the United States, especially during the 1980s.

Alluding to the previous findings, Sabel & Zeitlin (2010) suggested that the EU's regulatory achievements, both within its boundaries and beyond, are rooted in a recurring process of constructing and revising framework rules. The rules are formulated collaboratively by European and national actors across various policy domains. Within this framework, overarching objectives and the metrics to evaluate their attainment are established through joint efforts of EU

institutions and Member States. Subordinate entities possess the autonomy to pursue the objectives using their preferred methods. However, in exchange for this independence, the subordinate entities are obligated to provide regular progress reports and engage in peer assessments that compare their outcomes with those of others striving for similar goals using different approaches. The framework's objectives, performance criteria, and decision-making procedures are subject to periodic adjustments by various actors, including new participants whose viewpoints are crucial for comprehensive and impartial discussions.

Sabel & Zeitlin (2010) also evaluate the implementation of the revised architectural framework rules across several crucial policy realms. The sectors encompass data privacy, financial market oversight, energy, competition, food safety, GMOs, environmental safeguarding, antidiscrimination, fundamental rights, justice and home affairs, and external relations. The researchers' expert analyses showcase that contemporary advancements frequently embrace an experimentalist strategy. However, evolution also enhances the embracing of diverse and opposing viewpoints and the likelihood of reverting to more established modes of governance and policy transfer strategies. By examining the policy areas, the researchers contributed to a comprehensive understanding of the dynamics, challenges, and future possibilities within the EU experimental governance architectural framework.

In an earlier study, Sabel & Zeitlin (2008) established that the existing understanding of EU governance, depicted as multi-level and networked, neglects the evolving structure of public rulemaking within the Union. This structure's collaboration between EU institutions and Member States is instrumental in establishing overarching objectives and evaluation metrics. Subordinate entities, like national ministries and regulatory bodies, are granted the autonomy to pursue the goals using their preferred methods while maintaining accountability through regular progress reports and engagement in peer assessments. The objectives, performance criteria, and decision-making procedures undergo periodic reevaluation involving diverse actors, including new participants whose perspectives are crucial for comprehensive and unbiased deliberations. The architectural framework does not solely derive from EU treaties or institutional competencies but rather emerges and spreads across different policy domains. The framework includes telecommunications, energy, healthcare, employment, social inclusion, environment, and more, involving the exchange of policies and lessons between the domains.

According to the researchers, experimentalist governance should be interpreted through a functional perspective rather than focusing on its structure or institutions. The framework of

experimentalist architecture does not guarantee a direct match between governance functions and specific institutional mechanisms or policy instruments. A singular function, like monitoring and assessing implementation experiences, can be carried out using various institutional methods, individually or in combination. Conversely, a single institutional mechanism, such as a formal peer review process, can perform multiple distinct governance functions. The process encompasses evaluating the relative effectiveness of different national and subnational implementation approaches, empowering civil society to hold governments accountable on national and EU levels, identifying areas necessitating fresh forms of capacity building, and contributing to reshaping shared policy transfer goals.

Whilst there is much to unpack in the above, it was crucial to understand a priori the mechanism of policy transfer, and the seminal theoretical lenses of Dolowitz & Marsh, and Sabel & Zeitlin to explore it. Policy transfer is often messy, murky, and following no prescribed or smooth path, generally. Nevertheless, we know that it is occurring around the world and in a variety of sectors, including the UK and the conceptual tools assist to explore it.

Jones and Newburn (2006) asserted a very clear perception of the US as either a direct source, or at least inspiration, for a number of policy developments in the UK over the past 20 years. The list includes: welfare to work (Dolowitz, 1997; King and Wickham-Jones, 1999); the internal market in the NHS (Segall, 2018; Brereton and Vasoodaven, 2010); the child support agency (Dolowitz, 2000); adoption of Sure Start and related early childhood intervention models; reforms to higher education (Sawyer and Bagley, 2017); independence for the Bank of England, modeled after the US Federal Reserve; elected mayors; use of the language of the 'New Deal'; the earned income tax credit to eliminate family poverty. (Brown, 2017) Extensive UK crime control reform was heavily influenced by the US (Nellis, 2000; Wacquant, 1999) Many observers view the US as a significant influence on both the nature and trajectory of British social policy. Jock Young (2003), as an example, noted:

Via [John] Dilulo and James Q. Wilson Labour adopted the metaphor of the war against crime and against drugs, and incarceration as the key weapon in this war. From Wilson, it took the concept of zero-tolerance . . . I am not suggesting that either Tony Blair or the Home Secretary at the time, Jack Straw, have any direct acquaintance with these commentators. Merely that it is the ideas of such thinkers filtered through the lenses of policy advisers and speech-writers that have greatly influenced New Labour's policy on law and order. (Jones & Newburn, 2006)

This study is concerned, however, with health policy transfer. Is health care different from the other social policy domains? First, health care is demonstrably different in England because the NHS is cherished, revered almost as a religion. Second, it is well-organised, eg, BMA, and comprised of a dominant professional component, ie, clinicians, that strongly influences the direction of the medical profession, research, policy, and ethical standards. Evidence abounds for these transfers across macro, meso, and micro levels in the NHS, mostly meso and micro, at present.

Two observations are salient: first, peer-reviewed works reporting US health policy and programme actual transfers largely provide passing references to the US aspect (in part, this may be owing to concerns about US 'branding' after transfers are brought across); second, notably, there is no mention of whether the US is considered a privileged source of health policy and programme innovation, hence, there can be no opportunity to address the legitimate followup question -- 'if so, why.' Interestingly, think tanks were found to be guarded with their reports stemming from study tours, which often are preparatory to policy transfers. Also, studies of specific transfers generally do not give emphasis to a policy transfer in a policy transfer framework, and studies of policy transfer frameworks generally do not contain discussion of specific transfers, hence, something of a dichotomy. These issues contribute to gaps in the literature and raise potential research questions with the aim of resolving them.

The memoirs of the most recent past five PMs were reviewed to assess if literature gaps were addressed, the priority accorded NHS and health services issues, and, certainly, to determine if the US was mentioned prominently vis-a-vis the NHS. Indexes of the five memoirs were searched for National Health Service (NHS) and health. The results are in Table 1.

Table 1.

Prime Ministers' Memoirs on Health

Prime Minister	Index Entries	No. Pages
Thatcher	National Health Service	31
	Health	41
Major	National Health Service	16
	Health	9
Blair	National Health Service	42
	Health	0
Brown	National Health Service	68
	Health	0
Cameron	National Health Service	50
	Health	0

Margaret Thatcher, *The Downing Street Years*. New York: HarperCollins, 1993.

John Major, *The Autobiography*. New York: HarperCollins, 1999.

Tony Blair, *A Journey, My Political Life*. New York: Alfred A. Knopf, 2010.

Gordon Brown, *My Life, Our Times*. London: Vintage, 2017.

David Cameron, *For the Record*. New York: HarperCollins, 2019.

Suffice to say after reading each of the indexed pages in the table there was no mention of health policy transfer, a US to England transfer relationship or specific transfers completed, or the US as privileged or preferred source for health policy ideas, policies, programmes, or technology, etc. Indicative of a broader literature gap and lack of attention?

To be clear there is no shortage of literature criticising the US system, or non-system as it were, of health care, its absence of solidarity, equity, universality, and misaligned profit incentives. One of the most adroit warnings came from Kieran Walshe (2001) 'Don't try this at home': health policy lessons for the NHS from the United States. Significantly, there is persistent suspicion of the invisible hand of privatisation, which is subject to introduction via a 'Trojan horse,' and policy

transfers could be a prime suspect. Fears of a Trojan horse are real. However, on that score, there seems to be no reluctance to pursue policy transfers. This is a part, together with general criticism of US health care, of the counterintuitive nature of the US to England transfer relationship, which calls for further exploration.

In his memoirs, Prime Minister Brown (2017) summed up the privatisation question:

There were, and are, real limits to the capacity of markets to deliver public services like health care, and limits to the desirability of them doing so. The test had always to be the public interest. (Brown, 2017)

Friedson (2006) framed our understanding of the American medical profession and its professional dominance. However, Light (1991) refocused our understanding as professional dominance was replaced with the concept of countervailing power.

This is what the American medical profession has experienced over the past twenty years, as institutional purchasers became distressed at the unrestrained expenditure of their money by a profession that frustrated all early efforts at cooperative control.

We now have the interaction of countervailing powers, with organized buyers and sellers squaring off. The interaction differs from normal competition, and regulation does not work well. Public ownership is considered politically unacceptable. (Light, 1991)

The result in American health care has been “fragmentation, depersonalisation, dependency on capital, [and the rise of health care] corporatisation.” (Light, 1991)

Aspects of American exceptionalism in health policy in the literature call out the need to closely examine English health policy stakeholders, their perspectives, perceptions of the US, and over different periods of time.

In conclusion, the researcher turns to Klein for an apt overview, masterfully insightful, of US health policy exceptionalism, and English health policy transfer from the US. Drawing lessons for health care innovation or reform from the US requires:

. . . striking a difficult balance between historical determinism and free will, between cynical pessimism and naive optimism. The key to this puzzle may lie in a paradox: the United States is the most successful exporter of public health policy ideas and instruments yet has failed to build an effective health care system.

General ideas (like notions about the role of competition) and micro-instruments (like diagnosis-related groups) travel better than do health care systems. Ideas can be adapted to local circumstances, and instruments may easily fit into preexisting systems.

Importing systems from countries with different histories and institutions would require a tectonic shift in the American political landscape. (Klein, 2003)

2.11 Summation

Two seminal works were reviewed – Dolowitz & Marsh, Sabel & Zeitlin – to provide theoretical lenses to explore policy transfer. The progenitors of the D&M policy transfer concept were Rose (1991) for policy learning, and Bennett (1991) for policy convergence. There were discussions of the actors, processes, procedures, as well as specific transfers such as HRGs (DRGs) and ACOs (ICs). With an understanding of how policy transfer works and transfer examples, it will be possible to apply the selected theoretical lenses and methodology to explore research questions. Numerous actors outside of state or supra-national hierarchies involved in policy transfer play a huge role, notably including think tanks and management consultancies. Experimentalist governance has gained currency for certain efficiencies in policy development made possible by its agility for policy making outside of hierarchy.

CHAPTER 3 THEORETICAL FRAMEWORK

3.1 Introduction

Schwandt postulated that "Atheoretical research is impossible " (Schwandt, 1993), which is to say a theoretical framework underlies all research. Whilst important at the genesis of research to know the nature of knowledge and its construction (epistemology), and the "logical links to how you conduct research {methodology}," these elements do not comprise the theoretical framework. (Merriam, 2009) The theoretical framework is literally the frame or structure for a study. It is, as Maxwell posited, "the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs your research." (Maxwell, 2005)

Every study brings an orientation or stance, and that is where the theoretical framework is derived. Frameworks are rooted in many different disciplines and fields of study in the social and natural sciences. (Merriam, 2009) Researchers are socialised in a given discipline, which provides a lens through which they view the world. Hence, it is important to place a study in a broader context (Wolcott, 2005), and the theoretical framework is that broader context. All aspects of the study --problem statement, purpose, data collection, analysis, interpretation -- are influenced by it. (Merriam, 2009)

"Any research problem may be approached from more than one theoretical perspective ... The choice of a model/theoretical framework ... will guide the research process in terms of the identification of relevant concepts/constructs, definition of key variables, specific questions to be investigated, selection of a research design, choice of a sample and sampling procedures, data collection strategies ... data analysis techniques, and interpretation of findings. " (Schultz, 1988)

This study is situated in the discipline of political science, and the sub-field of social policy. Likewise, the researcher was socialised in the literature -- concepts, terms, definitions, models, structures, and theories -- of this disciplinary orientation. After a literature review, the salient framework for this study was judged to be a 'mainstream' political science policy transfer framework, which provided relevant variables and an organisation of their relationships to

answer the central research question. (Dolowitz & Marsh, 1996) In the end, this framework determined how the researcher perceived, made sense of, and interpreted data.

Before discussion of this framework, it is worth tracing its intellectual roots in 'lesson drawing' (Rose, 1991), because of the melding and overlap of the two concepts, which becomes manifest and aids understanding of theoretical development. A second theoretical framework, 'experimentalist governance' as formulated by Sabel and Zeitlin, will be discussed as an adjunct to the policy transfer framework to expand upon and fill any gaps in the exploration of some phenomenon. Finally, the even more recent development of a "fast policy" framework as posited by Peck and Theodore will be acknowledged. (Peck & Theodore, 2015)

3.2 Intellectual roots of lesson drawing

Rose pointed out that 'cross-national research' to improve national policy transcends the centuries. Aristotle sought ideas from across the Greek city-states to improve civic performance. Even the founders of America closely examined the English constitution with a view to improving upon it, or at least avoiding its flaws. Also, in the 18th century, de Tocqueville conducted his thorough-going examination of American democracy to " ... find there instruction by which we may ourselves profit," as he explained to his French readers. (Rose, 1991; de Tocqueville, 1954)

Rose's 'lesson drawing' provided the intellectual roots of the policy transfer framework. Indeed, Evans asserted that "Lesson drawing can be conceptualized as a form of policy transfer." (Evans, 2006) "Under what circumstances and to what extent can a programme that is effective in one place transfer to another." (Rose, 1991) Hence, lesson drawing is 'contingent,' ie, learning or 'borrowing' is not to be accomplished blindly - "success of a programme is affected by the specifics of context as well as general attributes," hence, the essential orientation is for the prospective potential for improving conditions. (Rose, 1991)

First, however, dissatisfaction with the status quo provides the stimulus to search for policy or programme solutions either across time or jurisdictions. With the rise of dissatisfaction, policymakers or programme managers are more likely to be pressured to accept the costs of uncertainty to answer the question of what might be a workable solution. This, in turn, produces policymaker emphasis upon 'experience', reflecting an obvious concern for 'feasibility.'

Policymakers and managers are action oriented, not social engineers. Rose was careful to point out that lesson drawing was defined as "an action oriented conclusion about a programme or programmes in operation elsewhere ... " (Rose, 1991) So, we again return to the crucial question of whether a "programme can be transferred from one place to another," implying 'successfully', ie, solving a problem. (Rose,1991) Importantly, Rose was clear in his assertion that lesson drawing extends well beyond post-hoc evaluation to prospective evaluation of this question.

Rose set out five steps in an ideal-type lesson drawing process:

1. Scanning programmes elsewhere to gain fresh ideas, with emphasis upon ' boundary- spanning' conclusions.
2. Producing a conceptual model of a programme, accurately described with only the basic programme elements.
3. Comparing models of an outside practice(s) with a model of the existing programme, which is the source of dissatisfaction at home.
4. Creating a new programme built upon empirical evidence of programmes in effect elsewhere, as a creative act, not only copying.
5. Prospective evaluation across time and space, with consideration that a programme in the 'present' elsewhere becomes the future at home. (Rose, 1991)

Not surprisingly, Rose posited that "evaluation and lesson drawing are inextricably linked." (Rose, 1991)

If a specific problem is being better managed in another jurisdiction there is a positive lesson; if not, the lesson learned is "what not to do." (Rose, 1991) Logically, the focus is on transposition of programmes already in place and in operation, not seeking a trade in ideas developed but never applied. (Page, 2000)

Evaluation of central variables, ie, comparison of conditions in 'importer' and 'exporter' jurisdictions, or 'borrower' and 'lender', if you like, and how differences might be either mitigated, circumvented, compensated for by adaptation, or deemed unresolvable, figures prominently in the selection of an approach to lesson-drawing. Rose encapsulated possible approaches in a

typology of lesson-drawing (through various evaluative processes) ranging from the simplest (1.) to most subtle (5.):

1. Copying: Adoption more or less intact of a programme already in effect in another jurisdiction.
2. Emulation: Adoption, with adjustment for different circumstances, of a programme already in effect in another jurisdiction.
3. Hybridisation: Combine elements of programmes from two different places.
4. Synthesis: Combine familiar elements from programmes in effect in three or more different places.
5. Inspiration: Programmes elsewhere used as intellectual stimulus for developing a novel programme without an analogue elsewhere. (Rose, 1991)

The emphasis in the lesson drawing literature (Rose, 1993) is "placed on understanding the conditions [emphasis added] under which policies or practices operate in exporter jurisdictions and whether and how the conditions which might make them work in a similar way can be created in importer jurisdictions." (Page, 2000) Here, one of the primary objectives becomes more clear, ie, using "cross-national experience as a source of policy advice." (Page, 2000) However, this pragmatic objective is augmented "by the academic-theoretical objective of understanding the distinctive political, administrative, social, economic or cultural conditions that sustain cross-national policy differences." (Page, 2000)

To understand conditions in both exporter and importer jurisdictions requires the examination of central variables and, as mentioned earlier, an understanding of what can and cannot be done to change conditions in the importer jurisdiction, as needed, to make the exporter's programme workable. In a review of lesson drawing, particularly in the context of Rose's body of work, Page described central variables as:

1. Objectives. The purposes of introducing a policy should be examined to possibly provide significant explanation of how it is operating.

Significance: a) performance criteria could have substantially changed from objectives upon which the policy was originally based; b) policy goals may be undesirable or

irrelevant to potential importers; c) acknowledgment of the divergent goals of one exporter might support more selective searches for others.

2. Program or policy design. To understand internal design of a policy or programme in an exporter jurisdiction will aid determination of whether these features exist in the importer jurisdiction, or whether they can be replicated, imitated, or substituted. Importance:

Features likely to be highly specific to the policy, programme, or practices under consideration and, Significantly, may include variables related to cross-national differences in:

a. Institutional structures of authority. Clearly, these structures differ between nations and must be taken into account, eg, differences in federal and unitary states (even within unitary states) and how they impact borrowing. Significance: strong central government authority might be crucial to operation of the policy or programme, or differences of authority structures or decentralization within unitary states might affect the scope for borrowing. (Rose, 1993)

b. Organisational characteristics. The unit of organization responsible for delivering a policy or program in one jurisdiction may not be replicated in another.

Significance: a clear understanding of institutional capabilities (including authority, skills, funding, time) to deliver policy or programme might affect decisions on assigning responsibility and accountability (including outsourcing to private sector), which could impede delivery either from the outset or over a longer term.

c. Mix of tools. Different governments use different tools to achieve results, which may not be similar. Rose cites tools of government to include "laws, money, advice." (Rose, 1993)

Significance: a specific mix of incentives, rules, and procedures which constitute policy and programmes might be difficult to replicate. Choice of incentives could impact the fundamental operation. (Page, 2000)

3. Wider societal variables. These are vast and highly diverse variables but refer to all the features of the environment in which a policy operates, whether political, societal,

economic, cultural, traditional practices, conditions of collaboration (eg, labour and unions), and even interaction with other policies.

Significance: presence or absence of features between exporter and importer jurisdictions might mean their functions must be fulfilled in a different way to optimise probability for success. (Rose, 1993; Page, 2000)

Finally, a distinction was drawn by Rose between the lesson drawing and policy diffusion literature. The latter concentrates upon "the attributes of those who adopt new measures sooner or later, and upon the pattern of diffusion." (Rose, 1991) Emphasis is on sequences of diffusion, rather than what is actually transferred or how. In this connection, diffusion studies tend to seek to identify "leaders and lagards in adopting programmes, and to account for the difference." (Rose, 1991) "Diffusion studies often presuppose a kind of 'technocratic determinism,' where lesson drawing tends to be voluntaristic. (Rose, 1991)

As discussed in the next section, the policy transfer literature (Dolowitz & Marsh, 1996) places emphasis on understanding the process (vice conditions) by which policies and practices are moved from exporter to importer (N.B. Terms interchangeable with lender/borrower, respectively) jurisdictions, with particular emphasis on the agents of policy transfer. The primary objective of policy transfer analysis is to illuminate decision making processes. This is precisely an objective of the present study as well. Potentially, the direct practical implications of understanding these processes are to identify that some methods of transferring policies and practices are better or worse than others. (Page, 2000)

3.3 The policy transfer framework

'Policy transfer' gradually emerged from the comparative politics literature. Most comparative studies before 1940 focused on formal institutions of government, thus were 'state centric,' and overwhelmingly descriptive. These studies lost favor during the 1940s as exploration of how civil society interacts with the state became the focus. By the 1960s, comparative policy analysis was the key focus. (Dolowitz & Marsh, 1996)

With the emergence of comparative policy analysis, a number of scholars, notably Walker, turned their research interest to a process called 'policy diffusion.' (Walker, 1969) Initially, these studies were not concerned with the specific content of policies transferred. Rather,

explanations of diffusion were based on "timing, propinquity and resource similarities; as such, they had a much narrower focus than later studies of policy transfer." (Dolowitz & Marsh, 1996)

Weaknesses in diffusion studies began to emerge. A major critical review in the 1980s argued: "(the) major problem of this research tradition is that it reveals nothing about the content of new policies. Its fascination is with process not substance." (Clark, 1985) The perceived need to answer questions ignored by diffusion studies led comparative policy analysts to initiate a discussion of lesson drawing and policy transfer. (Dolowitz & Marsh, 1996) It is fair to say, however, that 'lesson drawing', first posited by Rose, came first, and provided intellectual 'yeast' for the rise of policy transfer theory, an analogous concept. (Rose, 1991)

Policy transfer -- analogous to lesson drawing -- became an increasingly important concept in public policy analysis in the last three decades or so. Research in policy transfer experienced exponential growth in the late-1990s to the mid-2000s. (Benson & Jordan, 2011) As Rose argues, "policy transfer and lesson drawing is common" (Dolowitz & Marsh, 1996):

Every country has problems, and each think that its problems are unique. However, problems that are unique to one country are abnormal. Confronted with a common problem, policy makers in cities, regional governments and nations can learn from how their counterparts elsewhere responded. (Rose, 1991)

Indeed, they are both commonplace and common sense. As individuals, people are drawing lessons every day, whether consciously or unconsciously, and perhaps applying them as solutions.

There are numerous variations on the definition of policy transfer but it is generally acknowledged as "a process by which knowledge of policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of similar features in another," again, analogous to lesson drawing (Dolowitz & Marsh, 2000) Now, rather than a discrete area of research, policy transfer is employed in broader phenomena such as Europeanisation, globalisation, or policy innovation and, for example, is used to explain policy convergence (Holzinger & Knill, 2005) together with globalisation (Evans, 2009 ; Stone, 2004; 2010), and actions by non-state actors, particularly in the Europeanisation literature. "Similarly, policy transfer can both be caused by and be an outcome of policy innovation activities." (Jordan, et al., 2012) The term policy transfer may encompass a multiplicity of

possible diffusion activities -- sometimes confusing in the literature -- including policy knowledge-seeking (learning).

Dolowitz et al. posited that policy transfer is “. . . not concerned only with the transfer of policy programmes; in our view, ideological rhetoric, policy ideas, institutional structures, administrative arrangements, and . . . electoral strategies may also be transferred.” (Dolowitz, Greenwold & Marsh, 1999)

For purposes of this study, several definitions are noted. Health policy results from legislative, regulatory, or administrative actions which govern or direct the provision of health care services at multiple levels: 1) the national or strategic level, 2) regional or local level, or 3) programmatic or clinical level. At the programmatic or clinical level, policies, procedures, protocols, or processes are adopted for application in direct patient care, eg, remote patient monitoring, diabetes, chronic disease treatment programmes. Policy ideas are typically discrete ideas for innovation possibly not yet formalised in a coherent policy or programme in one setting yet of interest in another, where they might be adapted or more fully articulated. Policy learning is comprised of various policy knowledge-seeking initiatives and efforts, eg, conference calls, video teleconferences (VTC), study group or staff visits abroad, or documentary research.

Policy transfer was defined earlier.

Freeman suggested looking beyond macro level policy transfer to transfer at meso and micro levels to get the full picture of the possible locus of transfer. (Freeman, 1999) Hence, the researcher aimed to assess English interest in US health policy, optimising data collection by including the three levels of potential transfer as described above. In fact, the pilot study revealed the rich magnitude of micro level policy learning and transfer activity might be incalculable, and yet not easily discoverable by researchers. As an example, the chief executive of an NHS Trust in northwest England might unilaterally decide to send a multidisciplinary team to assess patient treatment programmes at selected US medical centers, which goes completely unheralded. This type of activity is important to note because it signals that policy transfer has a much bigger cast of stakeholders than just national actors.

Policy transfer can occur between countries with little in common but, typically, obstacles must be overcome. Indeed, at the outset, the researcher viewed health policy transfer from the US to the UK as counterintuitive, owing to the incommensurable systems of health care provision. So,

Bandelow posited that transfer at three policy levels must be distinguished: “1) deep normative core beliefs, 2) policy core beliefs, and 3) single instruments to solve specific problems.” (Bandelow, 2006) In Bandelow’s typology, the first two levels relate most closely to the national or public policy level where transfer might be least expected between diverse countries or systems. The third level comprises higher probability for health policy transfer involving, for example, elements like delivery improvement science, quality assurance, integration of services, role of GP’s, and budget setting.

Later, the focus of policy transfer research evolved from its state-centric conception to encompass a multiplicity of empirical contexts, other actors, and venues. (Benson & Jordan, 2011) This research has demonstrated that “transfer includes many actors including, inter alia, supranational organisations such as the EU (Bulmer et al, 2007); pressure groups, and transnational advocacy groups. (Stone, 2004; 2010) In their path-breaking work, Dolowitz and Marsh identified six actor types which could conceivably engage in transfer activities: “elected officials, political parties, bureaucrats/civil servants, pressure groups; policy entrepreneurs/experts; and supra-national organisations.” (Dolowitz & Marsh, 1996; see also Evans, 2009) At the same time, other non-state actors were identified by researchers, for example, transnational advocacy networks (Stone, 2010), think tanks (Stone, 2000), and epistemic communities (Dunlop, 2013). All of this work has demonstrated that “policy transfer involves many more actors than was originally thought.” (Benson & Jordan, 2011) It follows that these comprise variables of the policy transfer framework, which the researcher aimed to exploit to characterise the processes of UK health policy transfer.

It seems clear in the literature that health policy transfer can occur through diverse modalities, including institutional agents/networks, though not exclusively. The State might be involved but so might individual politicians, political advisors, academics, professional associations, foundations, policy institutes, consultancies, executives, managers, clinicians, and more. Policy transfer processes involve the “knowledge about how policies, administrative arrangements, institutions, and ideas in one political setting (past or present) are used in another political setting.” (Dolowitz & Marsh, 2000; Stone, 2001) Commonly, the unifying theme for those seeking policy solutions wherever they can be found is along the lines of ‘if it can work for them where they are, it can work for us here’, or simply ‘what works.’

As solutions to health care problems are evaluated within and between countries, whether at the national, regional, or programmatic levels, policy transfer can play a significant role in service

delivery improvement. To the extent they are interested in “what works” in other countries, policymakers in the US and England are primarily interested in each other. This has been called the “most different system comparison.” (Exworthy & Freeman, 2009) Largely at England’s initiative, however, knowledge interchange and policy transfer are sought almost exclusively from the US, ie, uni-directional. The UK “shows greater interest in learning from the US than vice versa.” (Ham, 2005) This is interesting for a number of reasons. The NHS performs better than the US on many objective indicators of population health status, clinical outcomes, and health care costs as a percentage of GDP (Ham, 2005), though still lags on outcomes compared to other OECD countries. The mechanisms of health care delivery in the English NHS and the US are essentially incommensurable from a ‘systems’ perspective. (Dolowitz & Marsh, 2000) Indeed, one could reasonably argue there is no US health care ‘system’ per se. Rather, it is a series of silos of excellence, driven largely by employer-based health insurance and with 25 million people completely uncovered. Whilst the NHS is taxfunded, universal in coverage, centrally planned and structured, and, by its essential nature, practicing ‘population health.’

Dolowitz, Greenwold, and Marsh posited that Thatcherism marked “a move towards neo-liberal or New Right policies to free the economy so that market forces can operate more effectively.” So, in the 1980’s, “there was a convergence between the economic policies of the Reagan and Thatcher governments around a New Right agenda.” (Dolowitz, Greenwold, & Marsh, 1999) This was a benchmark development because, since that time, the UK and US have had a common ideological position, neo-liberalism, possibly an energising factor in policy transfer from the US to UK.

Policy transfer is, at its core, a process of “learning from difference” (Dolowitz & Marsh, 2000; Stone, 2001), and identifying ‘what works.’ Within the policy transfer framework and in the English NHS context, this study aimed to understand if and why learning from one particular setting (US) might be privileged against others. The seminal book examining the connection of evidence to policy and practice was published in 2000. (Annette Boaz et al., 2000) Taking a fresh look in 2019, the authors posited:

There is an increased focus on understanding what research is available to policymakers and practitioners and ensuring that research is usable and used. We draw on Best and Holmes’ conceptualisation of the development of our understanding of evidence use. They identify three approaches to how evidence is used and shared

among policymakers and practitioners. (Annette Boaz et al., 2019; Best and Holmes, 2011)

1. The first approach focuses on dissemination, and how evidence is shared with the potential users, including how evidence can be made be more accessible, organized, and understandable.
2. The second approach focuses on relationships. This approach acknowledges the importance of connecting with others within research, policy, and practice when producing, using, and sharing evidence.
3. The third approach is focused on establishing evidence systems, and is not used as frequently. This approach requires leaders in public service to consider how systems and institutions support the use of evidence. (Annette Boaz et al., 2019; Best and Holmes, 2011)

The authors cite the US What Works Clearinghouse and recommendations or guidance provided by governments about how evidence can be used are examples of dissemination. The National Network for Education Research Practice Partnerships (NNERPP) in the US is a network that seeks to connect education agencies and research institutions, and an example of the relational approach. In the US, the William T. Grant Foundation, dedicating time and resources to studying the use of research-evidence in policy, is an example of systemic support of evidence use. Also, the Quality Enhancement Research Initiative (QUERI) at the US Department of Veteran Affairs, is an initiative that connects leaders in healthcare and Veteran Affairs to implement evidence-based programs and learn from those implementation efforts. (Annette Boaz et al., 2000; Best and Holmes, 2011)

These three approaches are encompassed, to lesser or greater degree, in the policy transfer process, depending on the approach. In fact, at this point, it is at least questionable 1) how much in-depth evidence and research might play a role in the process, and 2) whether those interested in a policy transfer might plug into a research network before initiating a search for transfer solutions . There is also application of these approaches across the two theoretical employed in this study. However, 'evidence to policy' is a substantial body of literature and debate unto itself, and its exploration would have to find its place in a separate thesis.

Research in policy transfer experienced exponential growth from the late-1990s to the mid-2000s. (Benson & Jordan, 2011) Dolowitz and Marsh built upon and expanded Rose's lesson drawing framework to a robust alternative framework articulated in two path-breaking papers (Dolowitz & Marsh, 1996; 2000), used as the foundation for data collection, categorising and distinguishing between different phenomena, data analysis and interpretation. This model will be further discussed next.

3.4 Dolowitz and Marsh model

Policy transfer is not at all or nothing process. While any particular case of transfer may involve a combination of processes and agents, Dolowitz & Marsh basically described four different gradations or degrees of transfer: (a) copying, which involves direct and complete transfer; (b) emulation, which involves transfer of the ideas behind, but not the details of, the policy or programme; (c) combinations, which involve mixtures of several different policies or programmes; and (d) inspiration, where policy in another jurisdiction may inspire a policy change, but where the final outcome bears relatively little relationship or similarity to the original. (Dolowitz & Marsh, 2000) As mentioned earlier, originally, D&M adopted Rose's five gradations but later conflated hybridisation and synthesis under the term 'combinations,' as above. (see also Rose, 1993) DiMaggio and Powell's isomorphism notes the imperative behind such similarities. Policy transfer would fall into their normative or mimetic forms, although international regulations might lead to some coercive forms. (DiMaggio & Powell, 1983; 2000)

"Initially transfer studies focused upon voluntary transfer," (Dolowitz & Marsh, 1996), a process in which policies implemented elsewhere were voluntarily examined by rational actors for potential utilization locally, but later began to address questions associated with 'coercive' transfer. (Dolowitz & Marsh, 1996)

Variables in the original framework (Dolowitz & Marsh, 1996) germane to the present study are related to the very basic questions of who, what, why, when, where, and how policy transfer occurs. Noted also, however, is the addition in 2000 of the 'policy success or policy failure' variables, though outside the scope of this study. (Dolowitz & Marsh, 2000)

To be clear, the scope of this study did not anticipate investigation of the broad sweep of all variables in the Dolowitz and Marsh framework. That said, the framework provided a logical, cogent, coherent, and useful plan for investigation and interpretation of data. Relevant variables

were explored to answer the central research question, and facilitated construction of additional research questions. Table 4 provides the entire framework, and is contained in Appendix A.

3.5 Who are key actors in policy transfer?

Nine actor types which could conceivably engage in transfer activities: elected officials (Heidenheimer et al., 1990); political parties (Hecl, 1974); bureaucrats/civil servants (Haas, 1980); pressure groups (Rose, 1991; see also McAdam & Rucht, 1993); policy entrepreneurs/experts; transnational corporations; think tanks (Stone, 2000; Shaw, 2014) supranational governmental and non-governmental organisations; and consultants. (Dolowitz & Marsh, 2000)

3.6 What is transferred?

Eight categories of the objects of transfer: policy goals; policy content; policy instruments; policy programmes; institutions; ideologies; ideas and attitudes; and negative lessons. Dolowitz et al. (1999) posited that policy transfer is " ... not concerned *only* [emphasis added] with the transfer of policy programmes; in our view, ideological rhetoric, policy ideas, institutional structures, administrative arrangements, and ... electoral strategies may also be transferred." (Dolowitz, Greenwold & Marsh, 1999) Early studies, however, largely focused on the 'hard' transfer of policy instruments, institutions and programmes between governments." (Benson & Jordan, 2011; Dolowitz & Marsh, 2003; Jones & Newburn, 2006)

Others (such as Stone, 2004), however, have been persistent in calling attention to the escalating importance of "the 'softer' transfer of ideas, ideologies, and concepts; elements of 'policy' that circulate freely among non-state actors under conditions of greater globalization." (Benson & Jordan, 2011) Stone argues that the 'soft' and 'hard' forms of transfer coexist well, and may complement each other. (Benson & Jordan, 2011; Stone, 2010)

3.7 Where are lessons drawn?

Three levels of classification for governance where transfer dialogue and activity may occur: 1) domestic: state governments, city governments, local authorities; 2) international: international organisations, regional, state, local governments; 3) national. (Dolowitz & Marsh, 2000)

Sub-national governments can draw or transfer directly from each other, eg, national governments can learn from lower levels, and lower levels from national. Transfers across nations can occur either at the national level, or involve interaction directly between sub-national units or governments of both nations. Lessons or transfers can also be drawn from or forced upon a political system from the international level. (Page, 2000)

3.8 When does transfer occur?

The model is largely silent on this variable, eg, not observable. The D&M model can be viewed at Appendix A. By way of explanation, however, it is clear that policy transfer may occur over varying extended periods of time and is the result of a single act such as a study tour or report of findings. For example, adoption of 'new public management' evolved over many years, not from a single act. (Wright, 1995)

That said, the central aspect of this variable is the 'period of transfer.' It is not to be undervalued as a variable because, over time, the number of people involved will likely increase (though might decrease) and, at any rate, the perspectives of those involved might change. As we know from the standard text in agenda setting, 'policy windows' open and close. (Kingdon, 1985) Equally, and again, over an extended period, the initial similarities between exporter and importer jurisdictions might either increase or diminish, thus impacting potential for transfer, whether positively or negatively. (Page, 2000)

3.9 Why transfer?

First dimension: a continuum from "want to have to," with "mixtures" in the middle. Perhaps the most common variable in the policy transfer literature. (Page, 2000) The category of mixtures reverberates in the economic literature with issues of 'conditionality.' An example would be countries, typically developing countries, being forced to adopt policies or practices as a condition of receiving loan or grant. (Hopkins et al, 1997) Conversely, at the other end of the

continuum, a country may act as a 'rational shopper,' searching widely until what is deemed the best example and fit of policy is found by the importer. (Bennett, 1991)

The fact of multiple dimensions involving a varying mixture of coercion and voluntary transfer may not be easily reducible to a single dimension. In one case, transfer may be ordered by higher level authorities but may not necessarily evoke a sense of coercion on the part of an importer, perhaps because there are sufficient incentives in place for transfer, or being subject to an international regime makes it fait accompli, for example. This could be an example of 'following suit before forced to.' In another case, pressure from the citizenry or clients may force change. In either circumstance, coercion in the traditional sense may not be emoted on the part of the importer, eg, recalcitrance may not play a role. At minimum, there are gradations of coercion. (Page, 2000)

Second dimension: the circumstances under which a country borrows from another is a significant dimension of the 'why' variable, likely more significant in incidences of voluntary transfer. These may include: a) characteristics of the borrower; b) sense of urgency of the borrower, c) characteristics of the policy (eg, fad or fashion); or d) characteristics of the exporter jurisdiction. (Page, 2000)

Third dimension: understanding the objective of the policy transfer. Are there intrinsic programmatic benefits? Will the imported policy provide support to an extant policy with which it has little or no direct relation? There are several possible reasons for governments using foreign examples: a) setting political agendas; b) satisfying domestic political pressure; c) legitimising decisions already made; d) searching for best demonstrated policy or practice; and e) emulating an exemplar. (Page, 2000)

Fourth dimension: the importer's choice to borrow from one country over others; related to the 'where' variable. A common explanation is "ideological proximity." (Page, 2000) This is particularly prominent in discussing imports into Britain by Conservative governments during 1979-1997. (Dolowitz & Marsh, 1997; Hall, 1981) It is known that during this period, for example, Prime Minister Thatcher had mutual admiration and a regular exchange of views with President Ronald Reagan, as the UK and US coincidentally pursued neo-liberalist policies and programmes. Dolowitz, Greenwold, Marsh posited that Thatcherism marked "a move towards neo-liberal or New Right policies to free the economy so that market forces can operate more effectively." (Dolowitz, Greenwold, & Marsh, 1999) So, in the 1980's, "there was a convergence

between the economic policies of the Reagan and Thatcher governments around a New Right agenda." (Dolowitz, Greenwold, & Marsh, 1999) This was a benchmark development because, since that time, the UK and US have had more common ideological positions, possibly a factor in policy transfer. Country selection could be more coincidence than design, or could, in fact, be considered more deliberately. 'There is also the possibility that selection could be constrained by previous selections in the same policy domain, or even previous selections in unrelated domains, ie, 'path dependency.'

3.10 How does policy transfer occur?

In a process of voluntary transfer involving the substantial exercise of discretion and choice by the importer, this question seeks to address the circumstances under which lessons were sought. The process could vary depending on whether it was a deliberate process, or more casual, less collectively organised emulation. This process can be diffuse, multifaceted and, perhaps surprisingly, virtually unconscious among those involved. Alternatively, if a coercive process, the question of 'how' could be intertwined with the question of 'why.' (Page, 2000; Lawton, 1999)

It is important to note that "it is possible for transfer to be a process involving many organizational levels at the same time." (Page, 2000) Extending and elaborating the model, Evans and Davies (2002) posited that the policy transfer process should be examined through a multi-level, structure and agency approach. Their three-dimensional model incorporated "global, international and transnational levels, the macro-level, and the interorganizational level." (Evans & Davies, 2002) In the model, a notional policy transfer network provides a middle-range level of analysis and "links policy transfer, micro decision-making in organisations, macrosystems and global, transnational and international systems." (Evans & Davies, 2002)

In this connection, it is also worth extracting for emphasis from the 'who' variable that singular individuals are agents of transfer, and have a role to play in 'how.' (Mintrom, 1997) Key actors can be categorised by specific type according to, for example, organisational affiliation. Page makes the crucial distinction between the true "policy entrepreneur" and the "policy salaried employee." (Page, 2000)

The difference in the two actually relates to the 'how' variable. For example, the entrepreneur identifies policies or practices to be transferred and generates support among others to do so. Hecló refers to these as "policy middle men, leading figure in mediating a market for ... policy ideas." (Hecló, 1974) The salaried employee is instructed to look outwardly for practices and make recommendations. (Page, 2000)

So then there is a continuum of agents - at one end, the individual discussed above, and at the other multi-level organisations - involved in policy transfer. International organisations, eg, OECD, World Bank, NATO, and the EU "take up models of 'good practice' and use them as models for other nations to adopt." (Stein, 2008) Also in the literature are concepts of 'policy networks,' usually informal groups of individuals from different organisations but with common policy interests or questions. (Page, 2000; see also Rhodes, 1990) Coleman and Perl (1999) described this as a "transnational expert community ... mediating between national and transnational communities." (Coleman and Perl, 1999). Evans and McComb described it as an "epistemic community who have similar professional beliefs and standard of judgement and share common policy concerns." (Evans & McComb, 1999) Finally, the role of think tanks, as part of the epistemic community, play a crucial role in both 'action' and 'rhetorical' framing of issues for policy stakeholders, and serving as interlocutors, as fully articulated by Stone and Shaw. (Stone, 2001; Shaw, 2014) "Action frames are those implicit in the content of policies while rhetorical frames are those that underlie the persuasive use of argument." (Jones & Exworthy, 2015)

In the researcher's judgment, the 'who' variable was best addressed by interviewing politicians, political advisers, academics, clinicians, and consultants, and the what, when, why, and how variables would be addressed as social constructions in conversations with them. Two examples are: a) the 'what' variable was explored by asking questions and being alert to cues from participants regarding not only specific policies and programmes (to implement policies), but also expressed interest in structures, administrative regimes, ideology, aspirations, or only ideas sought, and b) the 'where' variable was explored to determine both the origin and direction of travel of policy transfer, ie, from which level to which level on both exporter and importer sides. This variable might also shed light on whether or not transfer was voluntary or coercive, ie, traveling downward from the top of an organisation such as a hospital or NHS Trust, or directed by NHS central office, NHS England, or Department of Health and Social Care, for example.

The intricacies of interaction, both within and between organisations and human networks are complex, and generally highly nuanced. Perhaps this is why Dolowitz and Marsh asserted that "Most policy transfer studies have an inadequate conceptualisation of the role subjective perception and judgements play in the definition of problems and solutions." (Dolowitz & Marsh, 1996) They went on to say that "aspirations against which achievements are judged are not given, but a social construction." (Dolowitz & Marsh, 1996)

Dolowitz and Marsh critiqued the policy transfer literature as overly positivist. It seems too few scholars in the literature attempted to examine the social construction of either public policy problems or solutions, though Anderson and Wolman were among the earliest investigators of this research strand. (see Anderson; Wolman) This issue has also been considered in Europeanisation and globalisation studies (see Hay & Rosamond, 2002) but remains underresearched in constructivist terms There remains plenty of scope for scholars to study policy transfer in more constructivist terms. (Benson & Jordan, 2011)

Congruent with the Dolowitz and Marsh philosophy inured to their model, the researcher adopted a constructivist versus positivist lens, and a qualitative approach for explication of some of the many variables in the model particularly germane to aims of the present study (Dolowitz & Marsh, 1996) Further, the researcher took the position that no amount of quantification could answer the central research question of this particular study, without countenance of any intent to discount the value or utility of quantitative studies.

This theoretical framework provided an essential guide to data collection and analysis in the domain of health policy and programme transfer. It guided development of research questions, identification of classes of actors to interview, and processes to examine, all in a constructivist approach to develop rich data for analysis. At the same time, the researcher assessed that the Dolowitz and Marsh framework was too invested in an institutionalist foundation. Obviously, this was due in part to the passage of time since is construction, and changes occurring in communications and governance.

In sum, the researcher judged that a constructivist lens and qualitative approach optimised the opportunity to answer the research questions. A solid linkage of the literature to the theoretical framework to the research questions, and to the method of primary data collection was apparent.

However, a second, updated, and less static theoretical lens, experimentalist governance, offered a less institutionalist framework, with enhanced focus on concepts of non-state actors, multi-level analysis, and policy networks, was employed. This will be enhanced in the next section.

3.11 Experimentalist governance

Policy transfer research evolved from its state-centric conception to encompass a multiplicity of empirical contexts, other actors, and venues. (Benson & Jordan, 2011) This research demonstrated that "transfer includes many actors including, inter alia, supranational organisations such as the EU (Bulmer et al, 2007); pressure groups, and transnational advocacy groups. (Stone, 2004; 2010) At the same time, however, other non-state actors were identified by researchers, for example, transnational advocacy networks (Stone, 2010), think tanks and epistemic communities (Dunlop, 2013; Stone, 2000; Shaw, 2014).

Both within and beyond the nation-state, transformations in the nature of governance are underway, as volatility and uncertainty are overwhelming conventional hierarchical governance and "command and control" regulation in many settings. (Sabel & Zeitlin, 2010) Experimentalist governance, or "soft" governance, is a significant response to these trends. While the term actually encapsulates a huge variation of principles and processes, at its most basic the concept simply refers to approaches that are not reducible to hierarchical command-and-control models. (Fierlbeck, 2014) The following vignette attempts to capture the broad outlines of EG.

VIGNETTE

Experimentalist governance: policymaking in the shadow of hierarchy

Experimentalist governance (EG) evolved as a theory of 'policy learning' in the European Union's organisational complex. EG is distinguished by its core innovation of bargaining in the "shadow of traditional public hierarchy." (Sabel & Zeitlin, 2010) This is stepping away from the state-hierarchical model of governance.

The essence of EG is “to connect different actors in multi-level networks that monitor, diffuse information on policy performance, and generate feedback.” (Zahariadis, 2013) The “socialisation in multi-level networks creates opportunities for exchanging and adapting local solutions, found in one place, to another place” (Zahariadis, 2013) -- virtually the definition of policy transfer.

Whilst the public hierarchy may be constrained in its ability to achieve the outcomes it desires, in part due to path dependency, it enlists the aid of non-state actors, who are “acting in some sense as its authorised agents or deputies in reaching solutions not directly available to the authorities themselves.” (Sabel & Zeitlin, 2010) From organizational psychology, “. . . capacities of a rigid formal organization are rendered flexible by connecting it to an informal network over which the hierarchy maintains control.” (Christensen & Piattoni, 2003); Eberlein & Grande, 2005)

The key concepts of EG include: deliberation, multi-level networking, informality, open coordination, mutual learning, and regulatory transparency.

In sum, solutions are devised, or decisions reached outside the downward pressures of state hierarchy and, with respect to policy transfer in the NHS, across macro, meso, and micro levels.

Using the 'experimentalist governance' (EG) theoretical lens of Sabel and Zeitlin, the essence of their framework is, in their words, "to learn from difference." (Zahariadis, 2013) Sabel found that dense networks of interactions" are the essential element. (Zahariadis, 2013) A rich exchange of information and resource interdependency produce their own monitoring effects across the network." (Zahariadis, 2013) Transactions and exchanges record experience and information that is valuable. Next, they diffuse information and experience through a network. (Zahariadis, 2013)

Radaelli argued that "the EU has evolved into a 'massive transfer platform' for disseminating different aspects of policy among member states." (Radaelli, 2000) Policy transfer was demonstrated to occur "within horizontal and vertical actor networks extending across governance scales below the state, both within and across borders." (Betsill & Bulkeley, 2004; Sabel & Zeitlin, 2008; see also Zahariadis, 2013)

All of this work has demonstrated that "policy transfer involves many more actors than was originally thought." (Benson & Jordan, 2011) It seems clear that policy transfer can occur through diverse modalities, including but not exclusively institutional agents/networks. The State might be involved but, in the case of health services, so might politicians, political advisers, professional associations, policy institutes/think tanks, academics, executives, managers, and clinicians.

Rooted in 'policy learning' in the EU, EG is concerned with the exchange of best practices through informal networks, parallel with policy transfer, and offers several relevant concepts for explication of this study's research objectives: collaboration, a multi-level nature, informality, networking, open coordination, product/process improvement, and mutual learning. Essentially, EG embraces movement of what works in one setting to a different setting through informal networks. (Sabel & Zeitlin, 2010) Its essence is "to connect different actors in multi-level networks that monitor, diffuse information on policy performance, and generate feedback." (Zahariadis, 2013) "Socialisation in multi-level networks creates opportunities for exchanging and adapting local solutions, found in one place, to another place." (Zahariadis, 2013); virtually, the definition of policy transfer. (Dolowitz & Marsh, 2000)

The key innovation in EU governance brought by experimentalism is bargaining in the "'shadow' of traditional public hierarchy," (Sabel & Zeitlin, 2010), sometimes called simply 'policymaking in the shadow of hierarchy.' The EG perspective captures the nature of the EU as 'a unique set of multi-level, non-hierarchical and regulatory institutions, and a hybrid mix of state and non-state actors'." (Borzel, 2012; Hix, 1998) Whilst the public hierarchy may be constrained in its ability to achieve the outcomes it prefers, it enlists the aid of non-state actors, who are "acting in some sense as its authorised agents or deputies in reaching solutions not directly available to the authorities themselves." (Sabel & Zeitlin, 2010) From organisational psychology, "... capacities of a rigid formal organisation are rendered flexible by connecting it to an informal network over which the official hierarchy maintains control." (Christensen & Piattoni, 2003; Eberlein & Grande, 2005) A simple example might be: NHS clinicians in a regional hospital or trust, independent of NHS central office, informally network to find best practices elsewhere to improve a service, and present ideas, policies, or programmes, which may or may not be declined for implementation.

The concepts and variables inherent in this social science theory promise to guide the collection and interpretation of data because of the correspondence with policy learning and transfer, as

evinced across several policy domains of the EU, its qualitative nature of enquiry, and the multipolar features of the NHS, which are actually similar to the EU.

There is increasing scope and intensity for policy transfer and recognition of its relationship with the systemic forces of globalization. Evans argued "that the limits of policy transfer analysis as a descriptive, explanatory and prescriptive theory of policy change can be addressed through the development of a multi-level 'action based' approach to the study of policy transfer." (Evans, 2009) Here, EG makes significant contribution with its multi-level analysis.

Emphasising distinctive but not unique features of EU rulemaking (also identified by others), Sabel and Zeitlin connect them for the first time into a "novel whole." (Sabel & Zeitlin, 2010) "These distinctive features refer, first, to multi-level decision making structures in which private and public actors of the supranational, national, and subnational levels interact within highly complex networks to produce policy outcomes." (Borzel, 2012; Kohler-Koch & Eising, 1999) This "polyarchic distribution of power" (Sabel & Zeitlin, 2010) fosters deliberation when conflict among actors renders majority decisions impossible. (Borzel, 2012; Joerges & Neyer, 1997)

The EG framework has been applied in several policy domains including EU energy, environmental, food safety, and anti-discrimination regimes, among others. (Sabel & Zeitlin, 2010) EU Justice and Home Affairs (JHA) provided a particularly interesting application because of the complexity of fields that it covers. On the other hand, the theory has been criticised for its potential limitations resulting from the fundamental construction of the EU on treaty law. Also, the theory's governance architecture has been questioned because of its lack of focus on effectiveness problems both in its governance and participatory aspects. (de Burca, 2006)

Soft approaches to governance will continue to thrive because they fulfil two very significant purposes. The first is instrumental: new governance mechanisms are useful because, in many cases, they are simply a more effective way of getting things done. They facilitate policy development in ways that a strict imposition of legal harmonisation cannot. This is especially true in the field of health care, where rapid technological change, high complexity, the need for scale economies, the quest for best practices, the focus on patient-oriented care, and the need for inter-jurisdictional cooperation mean that the static, rigid, and homogeneous model and of traditional command-and-control systems is increasingly unable to accommodate an efficient and sustainable model of health care. (Fierlbeck, 2014)

There are four functional advantages to softer forms of governance over more traditional ones: they are better at gathering local clinical knowledge of information on patient's' cultural diversity; they are more efficient at transferring knowledge from the clinical setting to higher-level agencies; they are flexible enough to facilitate learning while encouraging further experimentation; and they are able to close the "regulatory gap" that exists when the lack of fit between goals and tools hinders optimal results. (Fierlbeck, 2014)

There is a noticeable trend to view the EU as a governance 'system,' ie, more than an international organisation of states (Borzel, 2012), and one in which more and more policymaking occurs in the shadow of hierarchy rather than in EU institutions themselves. This is also the locus of learning and sharing, and ultimately what constitutes policy transfer.

Administratively, soft governance plays a very specific and important role in facilitating the interoperationalisation of health policy upon which an effective and sustainable European network of health care systems depends. Politically, these modes of governance also create a broader discursive space in the health policy debate which allows a constellation of interests to present a coherent alternative to the development of health care at a European level. At times, these two functions overlap; at other times they do not. But there is little reason to believe that they are either irrelevant, or destined to disappear. (Fierlbeck, 2014)

3.12 Network governance

In England, as of 2021, Ferlie reprised changes in the health policy process at the macro level. Ferlie sees alternative frames of analysis lodged between narrowly entrenched processes – the Whitehall or Westminster model (hierarchical) – and more pluralistic or network-based processes. Ferlie has published extensively on network governance (NG) and concluded that, on balance, there is evidence of pluralisation, yet in a highly bounded and provisional manner. (Ferlie, 2021) The researcher is inclined to assess that the two models could also be seen as ideal types or heuristics to guide our thinking. If so, this could indicate a spectrum between the two types.

Earlier, in 2006, it was asserted that there were two grand narratives of public management reform – New Public Management (NPM) and Network Governance (NG), each implying a

specific type of steering. Furthermore, it was assessed that the strongest impact in terms of academic and policy influence in the UK was network governance. (Andresani & Ferlie, 2006)

The NPM narrative imports ideas and techniques derived from the private sector as well as drawing on the classical management/administration tradition (see Hood, 1995a, 1995b; Whittington, 2001) NPM ideas stress a combination of: (1) empowered and entrepreneurial management rather than traditionally autonomous public-sector professionals and administrators; (2) use of quasi-market forces rather than planning; (3) strong performance measurement, monitoring and management, with a growth of audit systems. NPM reforms are typically 'top-down' in nature, driven by 'reformist' central government trying to squeeze more value out of large operational agencies and functions. (Andresani & Ferlie, 2006)

More recently, there has been a strong interest in the emergent forms of 'governance' compared to traditional 'governing.' Public policy literature has, in fact, highlighted an alternative form of steering: the network governance model. (Rhodes, 1997a, 2002b)

"A greater range of actors and interactions emerges, and the central state plays less of a directing and more of an influencing role. In such systems, coordinating power is collectively share between major social actors, possibly at multiple levels of analysis." (Andresani & Ferlie, 2006)

The shift of emphasis is from NPM, standing alone, to NG, with elements of NPM retained, a key iteration or evolution of NPM, as it were. As NPM was unable to fully deliver on its promise, public sector organisations necessarily worked in cooperative, collaborative mode (eg, not poaching staff, aiding the flow of information from one to another). As asserted above by Andresani and Ferlie, a wider range of actors became involved in the organization and delivery of health services. This might include international actors such as management consultancies and think tanks, thereby opening organisations to more international influences. NG appealed as a means to explain this development. Management consultancies are discussed elsewhere in this chapter.

Historically, a 2007 paper reported that networks were emerging as a "new, innovative organisational form of governance in the UK public sector. At that time, network-based modes of organisation were apparent in many public services but particularly apparent in the health sector. (Addicott & Ferlie, 2007) However, in a case study, the dominant NPM model with its centralised administration proved a formidable obstacle for five managed clinical networks

(MCNs) for cancer in London to survive. “The strengthened vertical lines of the NPM model that developed during the internal market era made it more difficult for networks to develop.” (Addicott & Ferlie, 2007)

The MCN model, as developed with cancer services, has been defined as “linked group of health professionals and organisations from primary, secondary and tertiary care working together in a coordinated manner, unconstrained by existing professional (and organisational boundaries) to ensure equitable provision of high quality effective services.” (Edwards, 2002) These networks were developed initially as a means of streamlining patient care and fostering the flow of knowledge between professionals and organisations. (Addicott & Ferlie, 2007)

The difficulties with the MCNs centred around power relations among dominant medical elites and the plural-elites in London. Some groups demonstrated little interest in cooperating or achieving consensus with other groups, rather sought to dominant decision-making, and did. The plural-elite groups, however, “exerted power in a different way, through resisting the enactment of policy.” (Addicott & Ferlie, 2007) As a result, a model of “bounded pluralism” was posited.

There is close theoretical correspondence in EG and network governance, ie, EG is a form of network governance. Ferlie is a leading and prolific authority, and the size and scope of the network governance literature could serve as a thesis on its own, indeed, beyond the scope of this singular thesis.

Also in 2021, Ferlie et al argued for selectively integrating different theoretical strands, eg, cocreation, public value management, public innovation, collaborative governance, network governance, strategic management, and digital governance to develop a more comprehensive framework to study public value outcomes. (Ferlie et al, 2021)

In the post-war era, the public sector was perceived as an almighty ‘legal authority,’ solidly anchored in representative government and bureaucratic rule. In the 1980s, New Public Management (NPM) re-envisioned the public sector as an efficient ‘service provider’ operating in public-private service markets and subjecting its agencies to new forms of performance management. Today, the public sector is gradually being recast as an ‘arena for co-creation’ that invites elected politicians, relevant public agencies and private actors and affected citizens to contribute to public service production and societal problem solving. (Ansell and Torfing et al., 2019)

Notably, in the Handbook on Theories of Governance, Chapter 51, Experimentalist Governance, Rangoni discussed how EG has been attracting attention in both academic and policy communities for the last 15 years. (Rangoni, 2022) In a separate article with Mathieu, they acknowledged the common spread of experimentalism while suggesting “an analytical framework based on ‘ideal types’ offers the best route forward to develop comparative analysis of experimentalism and non-hierarchical forms of governance more broadly. (Mathieu & Rangoni, 2022)

Across the board, there is consensus that non-hierarchical governance has not replaced but rather coexists with preexisting hierarchical governance. (Mathieu & Rangoni, 2022)

The fact is that these forms of governance have been conceptualised in a variety of ways. EG, network governance, and co-creation are a few but they share common DNA. The researcher would underline that they are spreading, not fading away.

A Google Scholar search in June 2023, using matrixed search terms ‘experimentalist governance’ and ‘network governance,’ failed to reveal articles which forthrightly described in any detail of the ‘cross-over,’ or intersection, which exists between EG and network governance, only glancing references to some commonalities. around the world. Szyszczak had the most citations: a search on these citations revealed that “Ferlie” is not mentioned. Accordingly, it appears that the two proponents are not in observable dialogue with each other. There was no existing comprehensive theoretical comparison or integration of the two frameworks in the literature. This is perhaps not a surprising circumstance as stove-piping of disciplinary scholarship is widely known to occur in academic circles, whether across a country, within a discipline, a department, or across the world. Perhaps this study contributes value in this regard.

3.13 Open method of coordination

Of all forms of ‘soft governance,’ OMC has received the most attention. It was first introduced in 1997 to facilitate development of the European Employment Strategy, and was quickly expanded to other policy areas. (Fierbeck, 2014) OMC was, as another aspect of EG, which inherited some of its ‘genetic’ makeup. Similarly, network governance (see Ferlie, 2006; Ferlie et al., 2011), as an enduring feature of New Public Management in the UK, contains features essential to the operation of EG as well.

“The open method of coordination (OMC) was coined at the [EU] Lisbon Summit of March

2000.” (Szyszczak, 2006) It was then that an evolution of the EU began to take shape, including compromise between economic and social agenda, national sovereignty and a sense of direction. (Fierlbeck, 2014) OMC broadly is “the use of new methods of coordinating policy in the arena of economic and monetary union introduced in the Maastricht Treaty of 1991 . . . and later in the arena of employment policy” (Szyszczak, 2006)

. . . the theoretical development of “experimentalist governance,” (also known, *inter alia*, as “new governance,” “soft governance,” or “soft law”) . . . became particularly important in the field of health care within the European Union. (Fierlbeck, 2014)

Among national decision-makers in the EU, there has historically been a reluctance to cede, *ie*, delegate, health care competences to the supra-national level. (Martinsen et al., 2021)

To overcome this impasse, EU institutions and member states have agreed on middle ground compromises by means of experimentalist governance. In this paper, we examine a tool of experimentalist governance in the making, *ie*, the network formed by the cross-border healthcare expert group (CBHC) in the Patient Rights Directive. We ask whether iteration by means of transitive relations carrying trust, takes place and the extent to which domestic institutions, *ie*, health care models, condition such interaction and thus learning. (Martinsen et al., 2021)

The authors found that “this type of networked governance [CBHC] brings EU healthcare cooperation forward, while domestic institutions greatly condition who interacts with and learns from whom.” (Martinsen et al., 2021)

The OMC, like many political institutions, is not a single purpose instrument, and it can do many things that gain supporters. Some of its uses are clear. It is an opportunity for the relevant health ministry officials to learn from each other without the costs of organizing separate conferences. It might help socialize health ministry officials into a more “European” way of working. It is an agenda-setting mechanism (one of a great many) in that it draws attention to member states’ performance on specific indicators. It justifies applying for EU funds (European Social Fund) to remedy deficiencies. It probably strengthens some campaigns that were gaining attention anyway, such as Europe-wide interest in health inequalities. It might strengthen the EU’s social policy thinking and legitimate social democratic concerns in a political system with a strong neo-liberal bias and tight fiscal policies. Each of these uses could, potentially, contribute to a supporting coalition among health ministries and perhaps line health

concerned with health outcomes who find that the OMC is useful as a normative reference or as a guide. (Greer, 2011)

Experimentalist governance conducted as other than OMC is generally “more specific, better defined, connected with professional groups or interests, and found in relatively marginal areas that lack the high costs and high politics of health care services.” (Greer, 2011) There are a number of these initiatives (networks) which have developed in Europe to pursue goals, including for rare diseases, blood safety, cancer, organ donation, and communicable disease prevention. Supporting (and democratising) coalitions are more easily developed for these smaller groups to either produce or influence policy, as opposed to driving health policy at the supra-national level and relying solely on ‘hard’ law. (Greer, 2011)

3.14 Fast policy

The researcher acknowledges that, in view of an increasingly complex, pluralistic, deinstitutionalising, and globalising world (see Dwyer et al, 2009), Peck and Theodore put forth a theoretically innovative framework of 'fast policy.' It is essentially an open-ended, multi-sited ethnography on speed. As with the previous frameworks, the focus is on "ideas that work" but which now are not only able to present to a worldwide audience but with transnational salience faster than ever before. This is due in no small part to changes in global communications, the digital revolution, political and economic structures, and in nation states themselves. (Peck & Theodore, 2015)

In the framework, traditional centres of power and political authority are still recognized as the focus of modern policymaking. However, networks of "policy advocacy and activism" now exhibit a "precocious transnational reach; policy decisions made in one jurisdiction increasingly echo and influence those made elsewhere; and global policy 'models' often exert normative power across significant distances." (Peck & Theodore, 2015) Today, they assert, "sources, channels, and sites of policy advice" sprawl across every more diverse actors such as web sites, consultants, practitioner communities, conferences, think tanks, global policy institutes, blogs, and more, not to mention the extant influence of hierarchical multilateral agencies. (Peck & Theodore, 2015)

It should not be overlooked that policy transfer has been a matter for high-income (HIC) countries, so transfers have largely been HIC to HIC. The authors, however, take a decidedly rare focus on north-south (developed-developing country) transfer. There is a focus on what fast movement of

policy means for development interventions. For example, it is observed how policy can move so rapidly from a sophisticated international city like New York to activists in a developing country and how it might adapt or mutate in the process. Research questions include: a) how do policies change as they move across distance and countries? b) what are the implications of all this movement for effectiveness of development interventions? c) are policies successfully adapted to local conditions? d) what does the speed of policy transfer imply for actually addressing needs of the poor and marginalized?

Two development policies are considered: Conditional Cash Transfers (microcredit), cash transfers that reward according to individually targeted behaviors, and Participatory Budgeting, engaging citizens on budget setting and allocations. They then explore how these policies change from various inputs as they move rapidly through a fast policy cycle.

Fast policy does not suggest it portends a methodological revolution. It does highlight and emphasise both new geo-spatial and speed dimensions of policy transfer activity. This is characterised as 'policymaking at the speed of social media,' where policies move faster than ever, and might affect the social content and context of policymaking processes and practices. (Peck & Theodore, 2015) Traditional practices of policy transfer can be fraught enough but the addition of speed likely increases the need for caution and solid, reliable processes.

The fast policy framework may be, in the end, a significant contribution to policy transfer theory development. For now, it is not fully articulated, in the researcher's opinion. It is set opposite orthodox policy transfer literature, which largely assumes policymakers are rational actors who pick and choose from ideologically neutral practices. While it, indeed, offers potential for future development of transfer theory it is not be central to the findings of this study.

3.15 Path dependency

In the flow of data from interviews for this study, the researcher detected nuances of path dependency. Certainly, it would be a theoretical 'stretch' to rely on the path dependency analytical framework to explicate more than a fraction of policy transfer in depth. However, it has apparent utility to understand, for example, the broad longitudinal aspect, ie, persistence of policy transfer practices in the UK-US relationship, but not a detailed consideration of the internal logics of particular policies. "This might be termed a 'nested' explanatory model, with

macro-institutional features (political systems, financing systems) explaining the broad stabilities and constraints, while contingent and opportunistic behaviors explain 'punctuations' [breaks from the previous policy path]." (Pollitt, 2000)

This framework is rooted in the school of thought of historical institutionalism, "which considers institutions as structural variables from which stem arrangements of ideas, interests, and powers." (Trouve, 2010) As such, they are the focal point of public policy activities because institutions contribute to structuring them by encouraging or constraining institutions, actors, and thus their activities. (Trouve, 2010)

Path dependency theory starts from the premise that organisations and actors are part of institutions that structure and channel their behavioral standards and activities along established paths. (Trouve, 2010) Paths are composed of institutions, with their values, standards, rules, and public policies determined by previous choices "that impose constraints on institutional development processes." (18)

Thus, the notion of dependence in relation to the path taken highlights the historical dynamic that dictates once a path is chosen, it is difficult to change it because the processes become institutionalised, and are reinforced over time.

March and Olsen (1996), in fact, "stress the role of institutions and suggest that many social actions are guided by rules of thumb, habit, and tradition, rather than rational deliberation proposed by economic theory." There are several reasons for this, including the influence of existing power structures and the limited cognitive capacity of human actors. The result is a tendency to keep developments within the paths set out by historical choices, and the gradually developed social and cultural norms that are tied to the existing structures. (Vrangbaek & Christiansen, 2005)

This is posited in juxtaposition to Pierson (2000), who uses the economic theory of 'increasing returns' to explain path dependent processes. (March & Olsen, 1989; Pierson, 2000) However, both argue that "political institutions and political processes tend to reinforce path dependent developments." (Vrangbaek & Christensen, 2005)

Over time, it becomes increasingly difficult to reverse previous choices since not following the established rules and standards has various associated costs – investment, learning,

coordination, anticipation, etc. As a consequence, a less than optimally functioning organisation will generate inertia.

A strong interpretation of historical determinism would suggest that policymakers are prisoners of the past. From this perspective, the notion of path dependency not only explains past history but also predicts the future. The ideas, institutions, and interests inherited from the past shape, and constrain, what can be done in the present. (Paton, 2003)

In a critique of the framework, Kay noted it only explains stability, not change. Kay continued that:

. . . path dependency, despite being theoretically inchoate and difficult to operationalize empirically, is a valid and useful concept for policy studies. However, its proper application demands sensitivity from scholars to other temporal dynamics that may operate in policy development. (Kay, 2005)

To address the potential for policy change, the theoretical ideas of path dependency and institutional inertia should be supplemented with consideration of political change dynamics. (Vrangbaek & Christensen, 2005)

The more optimistic free-will approach would argue that systems do change, and not always in ways that can be predicted: social scientists are skilled in rationalising ex-post facto what has happened in terms of the specific institutional and cultural inheritance of individual countries, but accurate ex ante facto predictions based on these same factors are conspicuously rare. Windows of opportunity do open, as we know, do open, often unexpectedly [see Kingdon, 1995]. (Paton, 2003)

Vrangbaek and Christensen posited a different perspective:

However, path dependency theories do not predict completely static systems, but only that changes will tend to stay within certain paths until the system is shocked or something erodes or swamps the mechanisms of reproduction that generate continuity. (Vrangbaek & Christensen, 2005)

In her 2010 paper for the American Political Science Association, a leading health policy scholar, Carolyn Tuohy, Tuohy argued that four types of policy change are possible. Further, the

intersection of two dimensions – pace of enactment of a new health policy and scale of the change – determine strategies for Tuohy’s categories of policy change: “big bang, blueprint, mosaic, and (by default) incremental.” (Tuohy, 2010)

Large-scale and/or rapid changes in overall health care frameworks are rare, because they require extraordinarily favourable conjunctions of institutional and political conditions. A set of political actors must be able to mobilise sufficient authority to overcome the key veto points in the health system and the government structure, and must have the political will to take on health care (typically as part of a broader policy agenda). Health policy scholars (myself included) have argued that path-breaking change is possible only in such windows of opportunity. The implicit if not explicit assumption has been that these are moments of “big bang” change. (Tuohy, 2010)

We need to establish the baseline conditions for health policy change in “ordinary” times – that is the periods (usually lengthy periods) between major reform episodes. In ordinary times, health policy frameworks remain in place, relationships are governed by the logic of the established framework and policy makers cycle through the policy repertoire established by those respective frameworks to make incremental changes. (Tuohy, 2010) Good policy is not made during anomalous times.

The researcher judges that path dependency is a useful but not sufficient, ie, not overarching framework, to explicate the intricacies of policy transfer, and deserves acknowledgement and observation.

3.16 Summation

In 2000, Dolowitz & Marsh developed the archetypal framework for policy transfer. It was state-centric and hierarchical, though the researchers subsequently modified it to include more non-state actors in light of evolution in modes of governance. Sabel & Zeitlin developed experimentalist governance, which reached out to a new level of governance outside of hierarchy based on policy learning in the European Union. EG, network governance, and cocreation are different forms of soft governance but they share common DNA, and they are spreading, not fading away. Peck and Theodore put forth a theoretically innovative framework of 'fast policy.' It is essentially an open-ended, multi-sited ethnography based on speed. As with the previous frameworks, the focus is on ideas that work. Path dependency dictates a path

chosen is difficult to change because the processes involved become institutionalised and reinforced over time, which can find potential relevancy in the broad sweep of policy transfer.

CHAPTER 4 METHODOLOGY

4.1 Introduction

The purpose of this study was to explore, with a non-probabilistic, purposive sample of elite English health policy stakeholders, the central research question: how do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer? The researcher believed that exploring this question would aid in understanding 'why,' as well as assist to explicate the important implications of imported policy or programmes for efficiency, effectiveness, equity, quality, cost, and values underlying the English National Health Service (NHS), for both current and future system reforms. There was no attempt to explore the NHS of the other countries of the United Kingdom, ie, Northern Ireland, Scotland, and Wales. Hence, this study of 'policy transfer' aimed to characterise agents and processes for transfer in England, institutional and organisational tools, potentially beyond official actors and networks, and did not aim to count policies or programmes transferred, or success of their implementation. Answers to the central question were pursued principally through the use of three broad research questions posed to all study participants, which in essence were the research objectives of the study reformulated in question format. However, use of prompt, probe, and follow-up questions from the interview schedule (see Appendix C) varied. Variation in these questions was largely dependent on the specialisms and experience of the participants. In their 'comfort zones,' participant responses were clearly more fulsome and often contributed to broader discussions, prompting still more

questions from the researcher which were formulated in the moment, making the interview schedule less than fully inclusive. Nevertheless, all of the dialogue was, with permission, electronically recorded and transcribed.

Principal research questions were as follows:

1. Do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?
2. Were significant differences or variations noted in the degree or extent of influence of US-based ideas across the three key periods of health policy reform –the periods of Thatcher/Major, New Labour, and the Health and Social Care Act of 2012?

This chapter describes the study's research methodology, and provides discussions of its components:

1. rationale for research approach;
2. overview of information sought;
3. description of the research sample and population;
4. research design and methodology;
5. data collection methods;
6. data analysis and synthesis;
7. ethical considerations;
8. trustworthiness of the research;
9. limitations of the study.

A brief summary concludes the chapter. (Bloomberg & Volpe, 2008)

4.2 Rationale for research approach

There are important antecedents to the formulation of research questions, and collection and analysis of data, which are crucial to the development of a research approach, and a priori to the awareness and understanding of the researcher of the kind of knowledge to be obtained, and how. Justification of methodology and methods is rooted in assumptions about reality which a researcher brings to the work, and these assumptions, in turn, lead to questions of the researcher's theoretical perspective. (Crotty, 1998) In the end, establishment of these elements constitute what might be referred to as the pillars for an approach to this study: (a) epistemology or worldview (constructionism), (b) design (qualitative), (c) theoretical framework (policy transfer), and (d) methods (interviews, documentary analysis). (Creswell, 2014) Each of these elements are, in a sense, interactive, and inform one another.

In Durdella's conception, ". . . methodology is a model that guides what you do in an investigation." Methodology differs from methods in important ways. Whereas methodology functions as a lens to explore a phenomenon, methods are the overall approach that you use to do the exploring. In this way methodology directs methods: How you view and what you believe about inquiry informs what you do in the field to gather and understand information. (Durdella, 2019)

At the centre of methodology are what Denzin and Lincoln (2014) refer to as "strategies of inquiry" (Durdella, 2019) -- "a bundle of skills, assumptions, and practices that researchers employ as they move from their paradigm to the empirical world", and where paradigms are "a set of beliefs and feelings about the work and how it should be understood and studied." (Denzin & Lincoln, 2014). These beliefs are pivotal to understanding the central components of any study – the research problem, questions, and design --and, ultimately, making sense of its results and findings. (Durdella, 2019) Antecedent to the research paradigm for a study are philosophical questions which are a priori to how the researcher sees and understands the work. It is these questions that are linked to the researcher's personal beliefs and, in turn, inform the research. "They form the core of who you are as an individual and guide the academic and research roles that you assume in your scholarly work." (Durdella, 2019) The philosophical stance of this study is discussed in the next section.

4.3 Epistemology: constructionism

Epistemology concerns how we know what we know, ie, the nature, scope, and general basis of knowledge. An epistemological stance bears heavily on both the approach to research, and the representation of research findings. This study has adopted a philosophical foundation in constructionism. Constructionism is a worldview that:

. . . all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. (Crotty, 1998)

We do not create meaning but we construct meaning, working with the world and the objects in it. Hence, different people can clearly have different interpretations of reality, and therefore construct different meanings -- even concerning the same phenomenon. Subject and object converge as partners in the generation of meaning. (Crotty, 1998) “The conclusion, therefore, is that all objects are made and not found, and that they are made by the interpretive strategies we set in motion.” (Fish, 1990)

The alternative epistemology of pragmatism, derived from the work of Peirce, James, Mead, and Dewey (Cherryholmes, 1992), was considered for this study; however, since it emphasises the research problem rather than methods, ie, using all approaches available to understand the problem, was not found to be the best fit for the problem under study. Similarly, a mixed methods methodology was less than an ideal fit because of the lack of any significant contribution that quantification could make to this study.

Likewise, post-positivism, generally representing traditional research, reflects an aim to observe and measure “the objective reality that exists ‘out there’ in the world” (Creswell, 2014), which does not fit well with the objectives and questions to be answered in this study. Further, postpositivism is reductionist in that it seeks, for example, to reduce ideas into discrete, testable variables which typically comprise hypotheses. (Creswell, 2014)

In any case, epistemology, while operating in the background, performs the essential functions of (a) informing methodological decisions, and (b) linking research design, methodology, and methods. (Durdella, 2019) Table 2 provides a simple representation of those relationships in

this study drawn from a similar table in Durdella (2019), and leads the discussion from epistemology to research approach (design).

Table 2. Epistemology and research approach¹

Epistemology	Definition of constituent parts	Research approach	Definition of constituent parts
Constructionism	“A way of seeing the world-- related to beliefs, biases, and assumptions about ontology (nature of reality), epistemology (how we come to know reality), and methodology—is a theorized approach to investigating the social world.” ²	Basic qualitative study	“A specific approach to inquiry that directs how you gather information (sampling, participant recruitment, and data collection) and make sense of information (data analysis and interpretation – where applicable.” ³

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¹Adapted from Durdella, N., *Qualitative Dissertation Methodology: A Guide for Research Design and Methods*, 2019, p.93.

²Durdella, 2019, p. 93.

³Durdella, 2019, p. 93.

4.4 Design: basic qualitative study

Merriam posited that a central characteristic of qualitative research is that individuals construct reality in interaction with their social worlds. Hence, constructionism is the philosophical position which is, in fact, the epistemology typically associated with qualitative approaches. (Merriam, 2009) Qualitative research aims to both examine and understand the world in which others function and interact so as to “achieve a holistic rather than a reductionist understanding”. (Bloomberg & Volpe, 2008; Bogdan & Biklen 1998; Locke et al., 2002; Maxwell, 2005; Schwandt, 2000). Rather than counting or measuring a phenomenon, the basic qualitative methodology used here aims to understand if and why UK health policy stakeholders, from their own perspectives, have predominantly perceived, understood, and taken meaning from US health policy and programmes. In keeping with a constructivist approach, research questions

were formulated to allow optimal latitude for participants to craft their responses. The methodology in turn shapes the choice of methods appropriate to achieve this understanding.

Qualitative research is interested in how meaning is constructed and how people make sense of their lives and experiences, uncovering and interpreting it. (Merriam, 2009) Indeed, “this understanding characterises all of qualitative research”. (Merriam, 2009) There are, however, varied designs of qualitative enquiry, which comprise well-recognised research ‘traditions,’ and each offers an additional dimension, primarily in particulars of the social context examined. (Bloomberg & Volpe, 2008) That said, there is some academic controversy over what should be included as a research ‘tradition’ in qualitative research and, indeed, what is rightly classified as a tradition. Principally, however, there are five traditions, which are commonly recognised as a typology of qualitative research: (a) phenomenology; (b) ethnography; (c) grounded theory; (d) narrative; and (e) case study. Each of these was given consideration for suitability in this study. There are others, however, such as ‘participatory action’ research (Kemmis & McTaggart, 2014), and ‘discourse analysis’, which arguably comprise a tradition. (Cheek, 2004) It was the researcher’s judgment, however, that none of these traditions were as well-suited for this study as the ‘basic qualitative study’, identified as the most common across a number of fields. (Merriam, 2009) For clarity, it should be noted that Merriam had previously used multiple terms to describe what she settled on as a basic interpretive study. In later years, however, she chose to conflate three terms often used -- generic, basic, and interpretive studies -- under the single rubric of basic qualitative study. The rationale for this change in terminology was simply that, indeed, all qualitative research is interpretive. (Merriam, 2009)

Similarly, in one sense, it could reasonably be argued that all qualitative research is phenomenological. (Merriam, 2009) However, phenomenology can be confusing as it is both an established tradition of qualitative enquiry, and a school of philosophical thought that underpins all of qualitative research, arising from psychology and philosophy. In this tradition “the researcher describes the lived experiences of individuals about a phenomenon as described by participants. This description typically culminates in the essence of the experiences for several individuals who all experienced the phenomenon.” (Creswell, 2014; Giorgi, 2009) So, the researcher’s task then is to depict the ‘essence’ or basic structure of experience. This approach is best-suited for “studying affective, emotional, and often intense human experiences.” (Merriam, 2009; Creswell, 2014) In the end, consumers of phenomenological research should

be able to say they now understand what it is like to have experienced a particular phenomenon. (Merriam, 2009)

Philosophically, a basic qualitative study is derived from constructionism, phenomenology, and symbolic interaction, and used by researchers who are interested in “(1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences. The overall purpose is to understand how people make sense of their lives and their experiences.” (Merriam, 2009) The basic premise of this study’s design is that a common objective of qualitative research is to develop an in-depth understanding of ‘practice or process’ and contribute to improvement. (Merriam, 2009) A basic qualitative study can be used, for example, to uncover the strategies, techniques, and practices across any number of fields. By contrast, these insights are not possible with quantitative approaches. Likewise, this study focused on the intersection of individuals and institutions/policy . In consonance with the most fundamental aims of a basic qualitative study, this thesis attempted to uncover:

1. the participants’ experiences
2. the meaning constructed by the participant from the experiences
3. the processes involved

Certainly, the international transfer of health policy from one setting to another has major implications for systems improvement, cost, quality, access, values, and equity of health services. In this connection, the purpose of this study was not only to understand ‘if’ and ‘why’ such transfers ostensibly occur from a privileged source but also to inform the insights of English health policy stakeholders based on an improved understanding of the context, practice, process, and actors of policy transfer.

In common with other traditions of qualitative research, grounded theory employs the researcher as primary instrument for data collection and analysis, also using induction to derive meaning from data. (Merriam, 2009; Corbin, 2007; Strauss & Corbin, 1990) However, the end product of this type of study is theory -- ‘grounded’ in the data. Theories are developed as data are collected and analysed. Rich description is not the primary focus. Theory-building is what distinguishes this type of study from others in qualitative research. A study becomes a grounded theory study only when a theory results. Such theories are generally ‘substantive’ or middle-range, not grand theories. (Merriam, 2009) Theory development was outside the scope

of this study's purpose. Rather, the aim was to apply and elaborate two different theories, even stretching their application when possible. That said, data is inevitably shaped to some extent by the theory(ies) employed and the researcher's own pre-conceptions. Hence, this study is informed or based in theory, not one of grounded theory.

Narrative research is a design in which the researcher makes sense of experiences by asking one or more individuals to provide 'stories' about their lives. (Riessman, 2008; Creswell, 2014) The information gleaned by the researcher is often 'restored' into a narrative chronology. (Clendenin & Connelly, 2004; Creswell, 2014) This is the use of stories as data, specifically, "first person accounts of experience told in story form". (Merriam, 2009) The narrative 'text' of the stories is what is analysed by the researcher. It is not uncommon for views from the lives of the participants and the researcher to be combined, culminating in a "collaborative narrative." (Clendenin & Connelly, 2004) This study's aims and research questions were not congruent with the aims or use of a narrative design.

Based largely in sociology and anthropology, ethnography is a research design which is among the most familiar and has a focus on human society and culture. (Merriam, 2009) Typically, ethnography "studies the shared patterns of behaviors, language, and actions of an intact cultural group in a natural setting over a prolonged period of time. Logically, "data collection often involves observations and interviews," and implicit in the longer period is the repetitive collection of data. (Creswell, 2014; Del Rio-Roberts, 2010) The present study was not focused on either a society writ large or culture.

Case studies are a commonly-used approach to enquiry in many fields (see Exworthy et al., 2011). As implied by its appellation, this research design involves in-depth analysis of a specific case, generally involving a process, programme, event, or activity, or perhaps one or more individuals.; By their nature, case studies are bounded by time and activity. This benefits researchers who are able to sustain data collection activity over a long period of time using a variety of data collection methods yielding very detailed information, which was not congruent with the parameters of the present study. (Creswell, 2014; Exworthy et. al, 2011)

The researcher determined not to pursue a singular focus on a specific policy case or cases, to include no singular focus only on policies actually implemented. First, to have this focus would limit an understanding of the extent and magnitude of English stakeholders' interest in and possible initiatives to obtain US policies at all levels. Second, despite expert interests and

advocacy, politics often impede policy implementation, notwithstanding the degree of interest, enthusiasm, or investment of effort to accomplish policy transfer. D&M's view of policy transfer is focused on process not outcomes. Third, lag periods most often ensue from acquisition of policy to transfer process to implementation, which would require a longitudinal study to capture. Finally, the origin or etiology of imported policies are not always acknowledged, making attribution difficult in some cases. In fact, 'branding' becomes an important issue in policy transfers and plays an important role in facilitation of successful transfers with relevant actors, eg, removing the American moniker from transferred policies or programmes prior to implementation. Nicola Burgess led a study of the five-year NHS-VMI partnership to transfer a quality and safety programme from the US where this phenomenon occurred (see Chapter 5, Findings I).

Adoption of a qualitative approach and basic qualitative study design was selected as the best course to pursue in-depth examination of subjective meanings, which study participants attach to what they encountered in their day-to-day professional lives. Qualitative research is largely inductive, ie, built from the 'bottom up' from individual perspectives of participants to broad patterns to broad understandings, or may be deductive as well. (Creswell & Clark, 2011)

In qualitative research, the 'researcher as instrument' provides a profound advantage for the collection and analysis of data. The researcher is capable of immediate reaction and adaptation, and is able to respond to not only verbal but non-verbal cues, thus offering expanded capability for the mediation of understanding. At the same time, the human as researcher has flaws and biases. Whilst they may not be eliminated, they can be recognised and monitored as to their influence on data collection or interpretation. (Merriam, 2009)

Peshkin observed that human subjectivity "can be seen as virtuous, for it is the basis of researchers making a distinctive contribution, one that results from the unique configuration of their personal qualities joined to the data they have collected." (Peshkin, 1988)

A qualitative approach is well-suited to the research objectives of this study because an indepth, richly descriptive product was the desired and expected end product. Measuring and counting in a quantitative approach (objectivist/positivist/post-positivist) have their distinct contribution. However, it is words -- descriptions of context, the participants involved, activities of interest -- which convey what the researcher learned about the phenomenon of interest in a qualitative study. Overall, qualitative research seeks to discover and interpret the meaning of experience. (Bloomberg & Volpe, 2008) This objective is contrasted with quantitative research which usually

attempts to test hypotheses, establish facts, distinguish relationships between variables, and produce generalisable outcomes. (Bloomberg & Volpe, 2008)

It was the researcher's contention that no amount of quantification could provide the rich data necessary to answer the questions posed in this study. As characterised by Dolowitz et al:

Here, however, we are concerned with voluntary transfer and, indeed, with one particular feature of contemporary lesson drawing by British governments, the propensity with which they 'borrow' from the United States. Of course, it is not possible to quantify the extent of this transfer. Governments do not provide convenient lists of what they borrow, or from where they borrow. (Dolowitz, Greenwold & Marsh, 1999).

Moreover, learning or borrowing may occur entirely outside of government channels at disparate and incalculable individual or institutional levels, which further complicates the prospect of collecting such data because of proprietary concerns, poor record-keeping, or simply no recordkeeping at all, among other associated issues.

It was the researcher's view the fundamental assumptions and key features that distinguish a qualitative approach fit well with this study, including : "(a) understanding the processes by which events and actions take place, (b) developing contextual understanding, (c) facilitating inter-activity between researcher and participants, (d) adopting an interpretive stance, and (e) maintaining design flexibility." (Bloomberg & Volpe, 2008) The researcher strived to maintain awareness of and be true to uphold each of these features throughout the study.

In sum, the present research fits well with Merriam's criteria for a basic qualitative study, among a number of different types, because it sought to improve understanding of the process, practice, and actors of health policy transfer from the rich experiences and diverse perspectives of elite UK health policy stakeholders. This type of qualitative study has the characteristics of (a) understanding how people make meaning of their experiences, (b) mediation by the researcher as instrument, (c) strategy is inductive, and (d) the outcome is descriptive. (Merriam, 2002a)

As a strategy for research, this methodology underlies the choice and use of particular methods, which are discussed in a later section. Clearly, methods are linked to desired outcomes.

Leading UK health stakeholders, with a focus on England, policy thinkers and entrepreneurs, politicians, political advisors, academics, managers, and executives, and clinicians were the

particular individuals whose understandings and experiences were sought as privileged sources to advance an understanding of English health policy transfer from the US. Data were collected through semi-structured interviews, and analysed inductively and comparatively to answer the central research question. (Merriam, 2009b)

4.5 Overview of information sought

This study focused on elite health policy stakeholders located in different organisations and regions in England. In seeking to understand both if and why English health policy stakeholders view the US as a privileged source of policy innovation and thus transfer, three principal research questions, with probe and follow-ups, were explored with participants to obtain needed information, as mentioned earlier.

In qualitative studies, typically, any of four general areas of information are needed in order to obtain the information necessary to illuminate the problem and answer the questions posed: (a) contextual, (b) perceptual, (c) demographic, and (d) theoretical. (Bloomberg & Volpe, 2008) The information needed to answer the research questions in this study was determined by the conceptual framework, and fit principally into two categories: (a) perceptual, and (b) theoretical. This information included:

- health policy stakeholders' descriptions and explanations of their experiences as related to the phenomenon under study
- an ongoing literature review providing the theoretical grounding for the study, support for the methodological approach, and support for the interpretation, analysis, synthesis, and conclusions of the researcher

Contextual information is particularly relevant when seeking to understand a sub-set of a population in a particular institution or organization. (Bloomberg & Volpe, 2008) It would typically include internal factors such as the background, history, and structure of the organisations where they reside, mission, vision, values, culture and leadership, as well as external factors such as political pressures, financial relationships, and public opinion. This information would portend greater meaning in a study where a single setting or site, culture, or environment was the focus, ie, a more static focus, such as in a case study. As already mentioned, the subjects were largely not bounded by one particular organization or setting. As

Lewin posited, behavior is a function of human interaction between the individual and the environment. (Lewin, 1935)

Typically, in qualitative research, interviews are the primary method of data collection. Hence, perceptual information was the most critical type of information for exploration of the central research question. The interviews provide a vehicle for uncovering a range of participants' descriptions of their experiences, influences on their decisions, their interpretations of events, and how any or all of these might have changed over time. That said, it should be remembered that perceptions are just that, ie, not facts but what people perceive as facts. "They are rooted in long-held assumptions and one's own view of the world or frame of reference. As such they are neither right nor wrong; they tell the story of what participants believe to be true." (Bloomberg & Volpe, 2008) Hence, perceptions are open to post-hoc rationalization or selfjustification.

Concerning demographic information, the researcher found that data elements such as age, gender, and ethnicity were dimensions that had not appeared in literature so that the researcher was not directed to them. Also, these dimensions were assessed to yield little additional information. In this regard, however, the researcher did typically prepare for interviews by familiarising with the interviewees' disciplines, various positions held, years of service, and specific areas of personal interest or specialism, all of which were available from the literature. Quite naturally, during the course of conversations with interviewees, there was mention of roles and responsibilities over the course of stakeholders' typically long careers, which served to provide confirmation of certain demographic information about which the researcher was already aware.

The researcher neither had interest in nor ever mentioned political party affiliations during interviews. Rather, an objectively neutral position was maintained in this regard. Being USborn and based, the researcher had virtually no specific knowledge and certainly no intuitive grasp of UK stakeholders' political affiliations prior to commencing field research, and scrupulously avoided taking notice of such during readings. Rather, the researcher questioned stakeholders during interviews to determine the 'where, what, how, and why' questions related to their thoughts and deeds with regard to health policy transfer from the US, without regard to political motivation, ie, there was no attempt whatsoever in this study to pursue explanation of their perceptions or actions with causal political connections. That said, the researcher was alert to

maintain critical analysis of participants' viewpoints and/or political orientations to assess possible bias, and to triangulate these with evidence in the relevant literature.

The researcher arrayed the alignment of information needed and methods employed, in relation to the research questions posed in this study, shown in Table 3. (Bloomberg & Volpe, 2008)

Table 3. Overview of information sought¹

Research questions	What the researcher requires	Method
1. Do contemporary English health policy stakeholders perceive, understand, and take meaning from the US as for health policy or ideas, learning, transfer?	Participant perceptions	Interview
2. Were significant differences or variations noted in the degree or extent of influence of US-based ideas across the three key periods of health policy reform – the periods of Thatcher/Major, New Labour, and the Health and Social Care Act of 2012.	Participant perceptions of substantive differences in each period	Interview Document review: peerreviewed literature, memoirs, speeches, grey literature

4.6 Research design overview

The following list comprises a high-level summary of the steps involved in carrying out this research. A more in-depth discussion of each step will follow in later sections.

1. Prior to defense of the research proposal and collection of data in the field, a review of the literature was conducted to glean and assess the contributions of other researchers in the areas of policy transfer theory, English NHS reform periods in the last three decades or so, elite stakeholders during each period, interest in and evidence of NHS policy and programme innovation, and various countries with specific policies and programmes of interest to stakeholders in England. The process was to start with the most generally relevant literature

¹ Adapted from Bloomberg, L.D., and Volpe, M.F. *Completing Your Qualitative Dissertation: A Roadmap from Beginning to End*, 2008

and winnow down to the most specifically applicable, in order to have a fully rounded understanding of the subjects, and is described more fully in Chapter 2, 2.1.

2. The proposal defense was conducted and approved in October 2015 at Keele University from which the researcher transferred. Following academic approval, the researcher submitted a detailed application for ethical approval of the study to the Ethical Review Panel (ERP) of Keele University, outlining all procedures and processes incorporated in the study to ensure adherence to standards for the study of human subjects, including university-required documentation for provision to interview candidates, confidentiality, data security, and informed consent. ERP370 was approved in April 2016 (see Appendix E). After transfer to University of Birmingham (UoB), Keele ethics application and approval documentation was reviewed and accepted, by reciprocity, and UoB assigned ERN_23-0704.
3. Upon approval of ERP370, elite stakeholders identified in the literature were categorised by reform period with which they were identified, ie, Thatcher/Major, New Labour, Health and Social Care Act Of 2012. Lists of stakeholders were vetted with three academic staff.
4. Extensive data mining was required in most cases to simply acquire contact information for the elites. As the researcher was US-based throughout the study, it was both cost-effective and efficient to contact potential interview participants by email. All university-required documentation, including formal letter of invitation on university letterhead, informed consent forms, and consent for quotations, were sent with the initial email (see Appendix D). Originally, attributed to Keele University, following the researcher's transfer to UoB, the documents were modified to identify UoB as the sponsoring institution, and used for the few remaining interviews.

In essence, the email served as a cover letter for the other documents. Once agreement to participate was obtained the researcher initiated negotiations for a specific date/time/location available on diaries for meetings.
5. Semi-structured, in-depth interviews were conducted with 31 health policy stakeholders who were geographically-dispersed in England, and represented multiple domains of English health services, including politicians, political advisers, academics, executives/managers, clinicians, and institutes/foundations or think tanks. The aim was to interview a sample of these stakeholders from the macro, meso, and micro levels discussed earlier.
6. Interview data were analysed individually and inductively across interviewees and compared.

4.7 Research sample

The sampling of study participants was purposive rather than random to ensure that participants had experienced or participated in the group or concepts under investigation in theoretically relevant ways. (Creswell & Clark, 2011) This required critical thinking about the parameters of the population under study. (Silverman, 2013) “Many qualitative researchers employ . . . purposive, and not random, sampling methods. They seek out groups, settings, and individuals where . . . the processes being studied are most likely to occur.” (Denzin & Lincoln, 1994) These were indeed the processes followed by the researcher.

As opposed to large samples of people or numbers of sites as might be appropriate for quantitative studies, the researcher recruited a relatively small number of participants who could provide in-depth if indeed not first-hand information about the central phenomenon under investigation. The researcher either contacted or attempted contact with 52 potential interview candidates. Of those, 31 accepted and completed interviews, while 21 either did not respond or declined. Hence, 60 percent of those contacted participated in interviews.

The response exceeded the researcher’s expectations. The researcher’s impression was that several factors were at play, which contributed to success in recruiting elite participants. First, the researcher was not only an American but based in the US as a part-time doctoral student, which appeared to appeal to a certain curiosity or oddity. Second, as alluded to in the initial email (cover letter for official documents), the researcher identified not only as a ‘mature’ student but one with a past full career in health care. Commenting on the exceptionally open and fluid conversations which ensued once ‘in the room,’ there appeared to be the ‘gray hair’ effect as the researcher’s maturity and experience was experienced first-hand, and seemed to put the participants at ease that they did not have to provide detailed explanations so that they were understood.

Unlike quantitative studies, the basic idea in qualitative research is not to produce generalisable findings or conclusions derived from the sample but to develop in-depth understanding from a few people, which can be abstracted to theory. (Mitchell, 1982) Hence, there is no calculable ‘n’ for a sample. The sample for this study included perspectives from each of the three levels -- macro, meso, micro – described earlier and further identified below. That said, also mentioned earlier, the multi-dimensional roles of participants at these various levels frequently enabled

exploration of research questions through the optics of multiple levels from a single individual. Sampling continued until the researcher determined a point of saturation or redundancy was reached, ie, when no new information was forthcoming.

Potential participants were identified in grey literature including government reports, peerreviewed academic, and health and medical care professional literature. The method employed was to identify elite health policy stakeholders who had long histories of extensive engagement with UK health policy or health services. Inclusion/exclusion was guided by current or former experience of participants as health policy stakeholders in England, specifically, in one of the following categories: (a) NHS executives or managers, including clinical managers, such as chief medical officers or chief nursing officers, (b) academics, (c) politicians, (d) political advisers, and (e) think tank officials. Further criteria for selection were: (a) national-level (macro) experience, (b) regional-level (meso) experience, eg, NHS trust or hospital, or (c) clinical- or programmatic-level (micro) experience, and (d) a minimum of 15 years of relevant experience.

Notably, only seven of the 31 study participants had *not* worked in more than one career field, whilst 24 had worked in 2-4 different careers roles, adding credence to the robust qualifications of participants, and their ability to contribute to this research, as shown in Table 4.

Table 4. Multiple career roles of participants

Number of categories (1-5) qualified for¹:

Career categories	1	2	3	4	5
	2	4	1	0	
Politician/Political Adviser	0	2	1	1	0
Clinical	0	5	2	1	0
Civil Servant	5	3	0	0	0
Think Tank	0	2	2	0	0
N=31	Tot. 7	16	6	2	0
Academic					0

¹ Based on biographical documentation.

Policy during three major reform periods – Thatcher/Major, New Labour, H&SC Act 2012 – was the focus. Hence, a list of participants meeting criteria above was compiled with each individual assigned to a heading for any of the three reform periods in which they were known health policy or programme actors. There was no purpose to be achieved by recruiting the participation of key informants who did not have expert-level qualifications, or who did not have experience in at least one of the reform periods, ideally in all three. Owing to their expert status and seniority, virtually all had experience working in all three. As a non-UK citizen or even parttime resident, at the outset, the researcher had little familiarity with and was not attuned to the political affiliations or characteristics of selected participants. For example, name identification of a potential participant would almost certainly not connect them to a particular government or political party in the mind of the researcher pending a Google check.

The researcher also employed ‘snowballing,’ the possibility of obtaining suitable referrals from participants themselves, which had occurred on several occasions during the pilot study. On some occasions, participants voluntarily offered a written list of recommendations for additional participants and, if no recommendations were proffered on the participants’ initiative, the researcher directly asked if there were such recommendations they wished to make.

As with the pilot, all interview participants were at the 'elite' or 'expert' levels in their professional status and experience in English health services. Dependent upon availability and time constraints, the researcher anticipated that interviews would be conducted at participants' own work sites. This plan allowed participants to remain on their own 'turf' to optimise their convenience, and also where their authority also resides. This plan was partially intended to 'level the playing field,' which was not a significant a factor in this study, as in studies more generally, because of the elite status of the participants. Interviews at work sites were largely the rule, though a small fraction of participants were retired or semi-retired, and no longer had office space. Hence, three interviews were conducted, respectively, at a hotel, a social club, a private residence, and one by telephone because of scheduling difficulties.

The seminal work of Dexter (1970; 2012) pioneered the concept of specialised interviewing for use as a tool in the social sciences, and its rigorously analytical guidance is still the gold standard. Dexter argued that interviewing people with specialized knowledge was qualitatively different from standardized interviews. In elite interviewing, the researcher must be able to adopt a posture which allows the interviewee to teach what the problem, question, or situation is. In other words, the researcher should be agile enough to allow wide berth for elite commentary. One purpose of this posture is leaving space between the researcher's frameworks and the interviewee's framework and vantage point "so that the researcher stays open to surprise and anomaly." (Hochschild, 2009)

The peer-reviewed literature on interviewing is relatively sparse, and the literature of specialised interviewing is even smaller. (Richards, 1996; Bogner et al., 2009) discussed the substantive convergence of literature in the German-speaking world regarding 'expert' interviews (Flick et al, 2003; Bogner et al., 2009) with the notion of the 'elite' interviews in the Anglo-American literature. (Gubrium & Holstein, 2002; Denzin & Lincoln, 2000) Between the traditions, the two interview forms are virtually mutually exclusive. However, upon close examination, Littig posited that, ". . . in many respects the content of publications on these two interview forms does not really differ fundamentally." (Bogner et al., 2009) "In fact, quite the opposite applies: central themes in both methodological traditions include the problems of gaining access to the elite or to experts (particularly at a high level) as well as the specifics of interaction and the actual interview process itself". (Bogner et al., 2009)

Although not identical, even the respective target group definitions (experts and the elite) for such interviews overlap. The focus of interest in both generally lies on the professional

(functional)elite and on professional experts. Indeed, it would seem that the differences between interviews with the elite and interviews with experts lie primarily in differing social and political sciences research traditions and interest. (Bogner et al., 2009)

As Dexter noted in his classic treatise, members of the elite and experts are “the influential, the prominent, and the well informed” (Dexter 2006/1969; Bogner et al., 2009), a definition that, in essence, has remained constant in methodological literature to this day. (Littig, 2009; Bogner et al., 2009) “Indeed, any search for a clear definition is usually in vain.” (Littig, 2009; Bogner et al., 2009); see, for example, Moyser and Wagstaffe, 1987, Seldon, 1996, Lilleker, 2003).

Hereafter, the researcher will conflate these terms and use ‘elite.’

Though there is no ‘one size fits all’ situation it is nevertheless clear from the literature (Harvey, 2011; Richards, 1996), and confirmed by the researcher’s personal experience, that several maxims for elite interviews should be observed: (a) persistence pays off when arranging a place on a diary, (b) be flexible for multiple cancellations/rescheduling, (c) build rapport and establish trust from the genesis of contact, (d) know your subject thoroughly and allow space for the elite interviewee to challenge or adjust your perceptions, (e) be aware of the temporal dimension of elite interviewing, eg, closeness to politically sensitive moments, which may either lead a priori to difficulty in access, either/or reluctance or ‘coloring’ of commentary, and (f) appropriate length of interviews, ie, not too long.

The researcher aimed for ‘maximal variation sampling,’ a commonly used strategy, in which diverse individuals are selected because they are expected to have different experiences, knowledge, or attitudes toward the central phenomenon. The criteria for selection were intended to encompass elite health care stakeholders and policy thinkers who often served individually in a cross-section of professional roles, and could provide those different perspectives. Additionally, the study design called for sampling at macro, meso, and micro levels: (a) strategic or national, (b) regional (trusts), and (c) clinical/programmatic (hospital). “The central idea is that if participants are purposefully chosen to be different in the first place, then their views will reflect this difference and provide a good qualitative study in which the intent is to provide a complex picture of the phenomenon.” (Creswell & Clark, 2011)

4.8 Data collection methods

As common in qualitative research, the primary method for data collection was the semistructured interview of key informants, who are generally regarded as elite UK health policy stakeholders in a variety of roles and domains. Other qualitative methods, eg, ethnography, focus group, or diaries, etc, were assessed as not applicable or unworkable. In a qualitative study design, however, it is desirable to pursue the search objectives with reflexivity. During the pilot study, for example, it was learnt the extent to which interviews might usefully be semistructured can vary with individual participants. Thus, the researcher used *a priori* a semistructured interview, with concomitant preparation to use 'prompt,' 'probe' or follow-up questions to facilitate or elicit, or expand responses from participants. That said, there was variation in the use of prompt or probe questions and, obviously, follow-up questions, on the interview schedule in accord with the general direction of the discussion, the effusiveness of participants, their particular expertise and reluctance to respond outside of it and, finally, simply the time available. These questions were documented on an interview schedule (Appendix C), originally submitted with the thesis proposal. Three principal research questions were uniformly posed to each participant, intentionally broad to permit wide latitude for responses, and provide the 'space' for elite participants as referenced in the previous section on the sample.

There was no difficulty encountered in obtaining fulsome responses from participants, albeit there were occasional indications that participants preferred reserving more extensive elaborations to their own specialisms, ie, 'comfort zones.' Arguably, this inclination may have enhanced the validity of the information provided in those matters, after taking into account possible biases. In fact, it is fair to state that questions were posed beyond (in the place of) the interview schedule, which was a natural evolution in the course of a highly interactive dialogue between two humans with extensive experience in the same field. For one thing, these elites had vast experiential expertise and, as a consequence, generally held well-curated views, which often led to voluminous commentary, and alerted the researcher to probe within the confines of expressed specialisms, in some cases.

Suffice to say, the traditional power imbalance between researcher and subject was weighted heavily towards the elite interviewee. Conversely, it was the researcher's sense that some participants, depending on their roles, eg, politicians or chief executives, were somewhat (but not overly) guarded in certain segments of their commentary, which led the researcher to 'work around' to probe through the lens of other areas of expertise and experience. Clearly, elite

interviewees were highly skilled in political astuteness; hence, able to adroitly deflect difficult or uncomfortable questions. This required agility on the part of the researcher to think and react in real time to changing behavioral or linguistic cues from the participants. Finally, because of the caliber of elites interviewed it was not uncommon for a single individual to have served in multiple roles, eg, any combination of politician, political adviser, cabinet secretary, chief executive, or academic, passing through a virtual 'revolving door' in career progression.

Of course, the researcher anticipated challenges in scheduling meetings with the class of study participants being recruited in accord with the protocol in the approved thesis proposal. However, invitation mechanism challenges were somewhat unpredictable and actually extended beyond expectations by requiring extensive data mining to obtain contact information, multiple attempts to establish contact, await responses, schedule and reschedule appointments. Most challenging of all was the level of effort required to coordinate a 'cluster' of appointments to (a) conserve time, and (b) enable international travel in an economical manner. Interactions to arrange meetings were only rarely with the principal, which lengthened the time to confirm details because the researcher was working through a personal assistant who had to pivot to the principal with every question before providing a response. Awaiting responses from invitees extended over as much as two months before sometimes ending in no agreement to participate. When positive, ie, agreement to meet, it was not unusual to have up to four diary changes over a two-month period. This created havoc with consolidating a block of diary appointments to justify travel, and in arranging conforming travel arrangements from the US. All said, delays became inherent to the process.

In any case, these elite professionals have limited diary availability. That said, the level of effort was entirely justified by the quality and value of data obtained for this study from key informants such as former chief executives of the English NHS, former secretaries of state for health, Peers, political advisors, and renowned senior academics in health policy and economics. It was clearly the case that arranging meetings with clinicians was the most difficult. Often, after going through several changes of date/time, meetings were ultimately canceled.

4.9 Pilot study

The common wisdom is that England predominantly looks to health policy (or programmes) developed and implemented in the US -- but then only among a handful of prominent health care actors. The reasons for this apparent central tendency have not been investigated or

reported in the literature. There are many factors which would intuitively militate against it, thus raising a number of interesting research questions.

In February 2015, a pilot study was conducted to explore the central research question: how do contemporary English health policy stakeholders perceive, understand, and take meaning from the US for health policy ideas, learning, or transfer? Using a qualitative methodology, the research method was the semi-structured interview, to produce in-depth data to answer the central question. Four study participants in England were interviewed: two senior English NHS managers, a senior UK health services researcher, and a former senior NHS nurse manager. Principal findings affirmed the predominant tendency for English health policy transfer from the US at the clinical/programmatic but not strategic level from among a small cluster of US providers, and the richness of data resources available to produce empirical evidence to explain this phenomenon in the main study.

The appropriate ethical controls were implemented before, during, and after the interviews. The letter of invitation, information sheet, and consent forms approved by the ethics review panel for both general participation and use of quotations, were emailed in advance. All documents were reviewed at the start of the in-person interviews for issues or questions. At the end of the interviews, there was a reminder about anonymity, ethical guidelines, data security, and how to register any concerns that might arise or withdraw from the research.

Two of four participants were surprised at how much they had to say on the topic, which demonstrated an ability to draw on their breadth and depth of experience and they seemed to enjoy. Even without conscious thought to the research questions in their day to day work they nevertheless provided thoroughly cogent responses. This revealed the value of the interviews not only to the researcher but also to the participants by unearthing previously hidden assumptions and perspectives held by the participants themselves. The researcher also had the impression that interviews could have extended many hours, with virtually unlimited data mining. Unfortunately, participants were busy professionals with limited time available. The data richness discovered in the pilot bodes well for future interviews, which will continue to include participants selected for expertise and knowledgeability. Additional questions were formulated to take a deeper dive into themes from the interviews.

There was no hint of unease or trust issues with the researcher, questions, or digital recordings for which permission was again confirmed. Likewise, there was no indication of any power or dominance issues arising between researcher and participants.

Participants were universally enthusiastic, and all opined that the research topic was an both interesting and worth pursuing. All indicated they would like to stay informed on the progress of the research, and volunteered to participate or assist further, if desired. Further, all stated or clearly insinuated the topic was worthy of their professional contribution.

The researcher self-transcribed the digital recordings of the interview. The researcher was completely comfortable with the operation of the digital recorder at the interview meetings. There was little to no setup time required. Microsoft Word transcript documents were filed in folders on a password protected personal computer, not in the Cloud. Participants were advised the source recordings were to be retained until the study is marked, and will then be deleted. The researcher learned much about the challenges of transcribing accurately -- listening to passages over and over again, and realising he did not necessarily hear correctly what he first thought he heard. A benefit of this process was to immerse and familiarise the researcher with the data and the themes that emerged from it. Due to time constraints, the researcher found that it was not only possible but necessary to conduct thematic analysis (Harding, 2013) in parallel with transcription.

The method of data collection proved a good fit with the guiding social science theory. The appropriateness of the categories of interview participants selected for the study – and anticipated for the main study -- was validated.

The existing literature served as an excellent launching platform to adopt a theoretical framework and to explore the research questions. Conversely, findings produced by the pilot were useful and contributed to the existing literature by explaining why English health policy transfer is predominantly from the US to England. They portend an original contribution to knowledge in the main study, and may contribute to key discussions and debate about the extent, utility, and appropriateness of this phenomenon.

The research objectives served well to elicit information consistent with the overarching research question. Data richness exceeded the expectations of the researcher, and was expected to be replicated in an expanded sample for the main thesis. Useful experience was gained in analysing qualitative data to identify themes and patterns within and between

interviews. Additional questions were formulated to explore themes emerging from the study in greater depth.

There was no difficulty encountered in obtaining fulsome responses from participants, albeit there were occasional indications that participants preferred reserving more extensive elaborations to their own specialisms, ie, 'comfort zones.' The researcher would argue, this inclination may have enhanced the validity of some of the information provided, after considering possible biases or rationalisations.

It is fair to state that questions were posed beyond (in the place of) the interview schedule, which evolved naturally in the course of a highly interactive dialogue between two humans. For one thing, these elites had vast experiential expertise and, as a consequence, generally held well-curated views, which often led to voluminous commentary, and alerted the researcher to probe within the confines of expressed specialisms, in some cases. Conversely, it was the researcher's sense that some participants, depending on their roles, eg, politicians or chief executives, were somewhat (but not overly) guarded in certain segments of their commentary, which led the researcher to 'work around' to probe from the perspective of other related areas of expertise and experience. This required agility on the part of the researcher to think and react in real time to changing behavioral or linguistic cues from the participants.

Finally, because of the caliber of elites interviewed it was not uncommon for a single individual to have served in multiple roles, eg, any combination of politician, political adviser, cabinet secretary, chief executive, or academic, passing through a virtual 'revolving door' in career progression (see Table 4). In fact, after the pilot study, the researcher did a 'coverage' or gap analysis to ensure the health care domains of interest were well-covered by interviews. The results showed that many participants had qualifications, expertise, or experience to justify their expert commentary in multiple domains or categories: (a) academic, (b) politician/political adviser, (c) clinical, (d) executive/managerial, or (e) foundation/think tank/consultancy. The purposes of this study were well-served by this circumstance.

During the course of the pilot study, the researcher gained confidence in interview technique, the validity and utility of the research objectives, and the robustness of data available for the main thesis project. That said, there were a number of useful lessons drawn for future consideration:

1. It is difficult to judge knowledgeability by participant position, ie, position may or may not predict familiarity with 'policy'. Hence, the degree of structure or prompting beyond the use of broad research objectives may vary to facilitate and optimise responses.
2. From the first interview, the researcher realised the necessity of clarifying and conflating strategic or national-level and clinical or programmatic-level 'policy transfer', ie, to make clear that policy transfer does not occur only at the national level, to avert participants' interpretations that might be too restrictive, and also to optimise data capture.
3. Similarly, it appeared helpful for the researcher to clarify and conflate the terminology of research aims to encompass policy learning, ideas, and lesson drawing, as well as policy transfer, and participants clearly had no difficulty in comprehending it.
4. The researcher was comfortable being actively engaged in a conversational style; however, after the first interview, the researcher assessed that actual dialogue should be attenuated, and the change in technique was apparent in transcriptions of the second and third interviews.
5. A brief introduction of the researcher's professional history was useful for participant's understanding of the 'level' at which the discussion could take place.
6. It was clear that there was no need to 'post' documents to participants in advance – internet email was completely acceptable and sufficient if not preferred -- particularly in light of the time/ distance, and expense involved for postal mail to England from a US-based researcher.
7. The researcher found it useful for discussion purposes to broaden the concept of policy to encompass programmes (eg, clinical practice guidelines, technology applications, etc). The purpose was to enable data capture of as much reaching out to the US, or 'transfer' activity involving the US and UK, as possible.

4.10 Data analysis and synthesis

In general, data analysis involves identifying recurring patterns that characterise the data. Findings are these recurring patterns or themes supported by the data from which they were derived. The overall interpretation [of findings] will be the researcher's understanding of the

participants' understanding of the phenomenon of interest. (Merriam, 2009) It was borne in mind by the researcher that identifying findings should be guided by the aims of thematic analysis, ie, "examining commonality, examining differences and examining relationships." (Gibson & Brown, 2009; Harding, 2013)

Collection of data and analysis should be a simultaneous process; otherwise, the potential efficacy of the study may be undermined, and/or reflexivity compromised.

The lens of two theoretical frameworks, used in complementary fashion in this study, guided the collection of data, and were triangulated with the existing literature and findings to assess their efficacy.

4.11 Theory core principles

1. Policy Transfer (Dolowitz & Marsh): state centric, hierarchical.
2. Experimentalist Governance (Sabel & Zeitlin): multi-level networking, deliberative, outside hierarchy.

4.12 Procedural steps

1. Segments of the data set responsive to research questions based on the existing literature were identified, ie, units of data potentially providing an answer or partial answer to research questions, and a record made of same.
2. Raw clusters of data were constructed and honed.
3. Clusters were organised into categories (themes), coded/titled, and tracked through all transcripts.
4. Data were continually added and/or eliminated from themes.
5. Data were continually identified for melding, resulting in elimination or melding of entire themes.
6. Sub-themes were identified and refined using Steps 1-5.
7. Themes and sub-themes were validated against data and re-titled, as necessary.

Identification of initial categories were primarily inductive based on repeated reading of full transcripts, which were, of course, later used to analyse and compare/contrast findings. The necessity for repetitive, careful, comprehensive reading of full transcripts cannot be overstated.

This research, like most, lies somewhere between an entirely inductive and entirely deductive approach. For example, an inductive identification of categories, and in a deductive approach, the starting point for this study was existing theory and literature, followed by data collection and analysis to answer a specific research question. (Harding, 2013)

As identified by Dolowitz & Marsh, categories could incorporate “policy goals, structure and content, policy instruments or administrative techniques, institutions, ideology, ideas, attitudes and concepts, and negative lessons,” as well as a transfer continuum (want to . . . have to?), whose involved and why, underlying values, degrees of transfer, constraints on transfer, demonstration of transfer, how transfer leads to policy success/failure. (Dolowitz & Marsh, 2000; 2011)

Codes assigned to categories have a substantial element of interpretation, and are subject to continual review and revision. (Harding, 2013) As the researcher searches for themes and findings in each category, it might be desirable to revise categories; for example, creating subcategories (sub-themes) to pool together all the examples from across a data set that can be categorized as “an example of x.” (Harding, 2013) A number of codes may be outside any category and may be discarded. Codes that do not apply to a sufficient percentage of respondents will also need to be discarded. Alertness to and identification of similarities and differences in the data from transcripts were the central objective. (Harding, 2013) In a constructivist approach, it was the researcher’s task to construct themes and sub-themes from the data.

4.13 Ethical considerations

Ethical issues are present and require careful consideration from selection of a research problem and extend through research questions, data collection, analysis, interpretation, writing up, and disseminating the research. (Creswell, 2009) Protection of human subjects is paramount. This means that an ethical research design is as important as an “intellectually coherent and compelling one.” (Bloomberg & Volpe, 2008) “Research does involve collecting information from people, about people.” (Creswell, 2009; Punch, 2005) Researchers need to

protect their research participants, develop a trust with them, promote the integrity of research, and guard against misconduct and impropriety that might reflect on their organizations or institutions. (Creswell, 2009; Israel & Hay, 2006)

The British Economic and Social Research Council (ESRC) established the gold standard for ethical research, which were implemented for this study by the researcher, as indicated below.

1. “Research staff and subjects must be informed fully about the purpose, methods, and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved.” In its essence, this standard underpins the principle of informed consent, which is central to social science research. (ESRC, 2005; Bloomberg & Volpe, 2008)
Researcher actions: All participants received a letter of invitation, information sheet, a general consent form, and a consent form for use of quotations, both prior to the interviews, and again at the interview meeting. Prior to starting each in-person interview, the researcher provided a brief overview of his background in health care, again briefed the aims of the research, and explained why the participant was chosen.

Consent forms were signed by both the participant and researcher, who offered to answer any remaining questions. Also, participants were reminded before, during and after interviews of the measures taken to ensure privacy, anonymity, confidentiality, and both the provision for withdrawal from the research as well as use of interview data in subsequent research, to minimise personal concerns.

2. “The confidentiality of information supplied by research subjects and the anonymity of respondents must be respected.” (ESRC, 2005)

Researcher actions: Uniform procedures were in place to securely handle sensitive or personal information, and to disclose the purposes of the research. (Creswell & Clark, 2011)
Participants were informed that anonymity was assured, all data were stored on a password protected computer, and that access was limited to the researcher and supervisor.

3. “Research participants must participate in a voluntary way, free from any coercion.” (ESRC, 2005)

Researcher actions: In all cases, participants were informed of their right to refuse to participate, or withdraw subsequent to participation, either for any reason whatever. This information was provided in writing.

4. “Harm to research participants must be avoided.” Social science research should minimise harm or risk to social groups or individuals. This includes damage to participants’ interest or well-being, including reputation, where sensitive material might be either sensitive or misunderstood, or used by a third party against the interests of participants. (ESRC, 2005; Silverman, 2013)

Researcher actions: The nature of the research objectives and conduct of interviews posed virtually no physical risk. Further, interviews were almost universally conducted in the work setting of the participants, ie, offices. That said, interview data was stored on a password protected computer and access limited to the researcher and the supervisor. Participants were advised of the option, without obligation, to agree to use of interview data in future research, and the plan and timing for destruction of interview data.

5. “The independence and impartiality of researchers must be clear, and any conflicts of interest or partiality must be explicit.” (ESRC, 2005)

Researcher actions: Were there any undeclared conflicts of interest – academic, personal, commercial – they were to be revealed to participants; however, there were none. Participants were advised in writing the researcher’s study was self-funded and, of course, names and contact information for the researcher’s supervisor and university research governance officer in the event questions or concerns might arise in future.

As noted above, the Ethical Review Panel (ERP) of Keele University approved this research as ERP370 (April 2016). After review and approval, by reciprocal agreement, the University of Birmingham assigned the new reference ERN_23-0704.

4.14 Trustworthiness of the research

Trustworthiness as opposed to, more commonly, ‘validity,’ was determined by the researcher a more fitting and encompassing concept for qualitative (versus quantitative) research, whilst still incorporating validity – accurately reflecting the world being described, and ensuring the integrity of conclusions reached. Guba and Lincoln (1994) posited that direct transference of validity and reliability concepts from quantitative to qualitative research was problematic in that it presupposes a single, absolute account or truth of social reality is feasible, and argued, rather, that there can possibly be one or more accounts. (Bryman, 2008)

4.15 Validity

“Validity differs in quantitative and qualitative research, but in both approaches it serves the purpose of checking on the quality of the data, the results, and the interpretation.” (Creswell & Clark, 2011) There is more emphasis on validity rather than reliability in qualitative research to assess whether the account given by both the researcher and the participants is accurate, can be trusted, and is credible. (Lincoln & Guba, 1985) In qualitative studies, validity comes from analysis of the researcher’s procedures based on information obtained from study participants, or from external reviewers. Basically, validity is established by assessing whether the qualitative data is accurate, and collected in accord with established procedures. The researcher followed to the extent possible, ie, time constraints and flow of conversation, the same procedure and interview schedule with each participant, including the targeted amount of time spent in the interview.

Multiple strategies of validation were used to assist in assessing the accuracy of findings.

1. Triangulation of different data sources, including both the substantial existing literature of policy transfer and its politics, and experimentalist governance, as well the memoirs of all five former PM’s (Thatcher, Major, Blair, Brown, Cameron) and selected MP’s during the reform periods,

grey literature, and findings. Themes were built from findings based upon converging sources of data or perspectives. (Creswell, 2009)

2. Bias of the researcher was clarified based on self-reflection. Reflexivity was identified as a core characteristic from the genesis of this study. As a consequence, the researcher explained, as appropriate, how culture, history, socioeconomic background, or national origin might affect interpretation of findings. (Creswell, 2009)

3. The researcher spent a prolonged period conducting field research. This produced a comprehensive understanding of the phenomenon under study, as well as enhanced understanding of people in their normal setting which enriched credibility of the narrative. (Creswell, 2009)

As a point of departure, the researcher used the method of carefully reading and repeatedly rereading interview transcripts, ultimately as many as eight times, before beginning analysis, increasing the likelihood that findings will reflect originally acquired data. From there, Lincoln and Guba (1985) provided alternative criteria to assess the trustworthiness of qualitative research: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability.

4.16 Credibility

Since we know that several different accounts of social reality are possible the credibility (or feasibility) of the account as told by the researcher is a determinant of its acceptance by others. (Bryman, 2008)

To support the credibility of this study, the researcher noted upfront his most prominent bias, namely, that the health services of the England were superior in many respects to health care in the US. By comparison, in the researcher's view, England's universality, access, equity, cost, and outcomes exceed the US, as supported by data. Put more bluntly, the US is falsely egalitarian with respect to the health care of its population. Hence, the answer to the central research question could be counterintuitive for the researcher. However, the researcher monitored and managed this bias by maintaining a neutral posture in the face of all participants. It was the researcher's intuition that, conversely, participants might harbor the assumption that the 'American' researcher was biased in favor of the US 'brand' of health care. Since, however, no comments or innuendo in this regard were ever forthcoming from participants this intuition was likely founded on something akin to 'guilty knowledge.' Subjective tendencies or biases were continually monitored and, if noted, were recorded in field notes for reflection.

The researcher was engaged in field research for a prolonged period, approximately four years on a part-time basis. During this period, there was repeated and substantive involvement with elite health policy stakeholders, which rapidly propelled the researcher across a substantial 'learning curve' for the phenomenon under study, and a diversity of perspectives concerning it. Encounters encompassed immersion in diverse settings and sites for interviews as well,

including Parliament, universities, hospitals, a social club, a private residence, and think tanks in England. Each of these represented its own unique challenges such as physical access, security, time available, interruptions, and background noise in varying venues. Likewise, there was no 'one size fits all' for developing rapport with participants, and the researcher placed a high value on rapport building from the point of initial written correspondence to meeting negotiations to face-to-face encounters so as to engender the atmospherics favorable to interview success. The researcher learned from and was enriched by each participant encounter, honed interview skills, and made adjustments along the way in presentation or explanation of various aspects of the research to enhance clarity of purpose for participants and improve efficiency of data collection. Time was always a valuable and scarce commodity with busy elite professionals.

Qualitative research tends to "view social life in terms of processes." (Bryman, 2008) Given the diversity of participant settings, their respective processes and interactions, there was a need to have a check on the researcher's interpretation of processes and interactions. Triangulation was used so that multiple sources of data were consulted. Triangulation thus provided a basis both for comparison and possible corroboration of the researcher's conclusions. As an example of its use, let us say a retired politician made a statement regarding positions previously taken on some aspect of health policy or programmes. The researcher could search peer-reviewed, grey, popular or professional literature, speeches, or memoirs to confirm the politician's stated position on that specific aspect at either a point in time or over time. Whether substantiated or not from the literature, triangulation as a tool provided a useful and informative cross-check on interview commentary, themes, and findings.

4.17 Transferability

Qualitative research tends toward depth, eg, intensive study of a small subset of individuals who share certain characteristics, rather than breadth, which is principally associated with quantitative research. Generally, this means that qualitative research findings are not expected to be generalizable to other settings. (Bryman, 2008) ". . . qualitative findings tend to be oriented to contextual uniqueness and significance of the aspect of the social world being studied". (Bryman, 2008) Lincoln and Guba (1985) argued that whether findings "hold in some

other context, or even in the same context at some other time, is an empirical issue.” (Bryman, 2008)

So, transferability of qualitative research does not concern whether there was a ‘representative sample.’ Instead, the research should provide what Geertz (1973) called “thick description”, ie, a rich account of details of the phenomenon under study. As a significant characteristic as well as contribution of qualitative research, Lincoln and Guba (1985) argued “that a thick description provides others with what they refer to as a database for making judgements about the possible transferability of findings to other milieu.” (Bryman, 2008) At bottom, transferability refers to whether a study provides sufficiently rich and robust detail for the reader to determine whether similar processes might also be at work in their settings, ie, the fit or match between the study’s research context and other contexts. Toward this end, “qualitative research is indeed characterised generally by ‘thick description’”. (Denzin, 1989; Bloomberg & Volpe, 2008) “Thick description” is a vehicle for communicating to the reader a holistic and realistic picture”. (Bloomberg & Volpe, 2008)

There was an impetus for thick description here. From its genesis, this study of policy transfer in the UK health sector aimed to characterise agents and processes of transfer (beyond official actors and networks), institutional and organisational tools, not simply count and describe policies transferred. The researcher understood that, with sufficiently thick description, these understandings could possibly extrapolate and contribute to understanding policy transfer processes in domains other than health care and in settings other than the UK, eg, environment, data privacy and security, justice, home affairs, and energy, to name only a few.

4.18 Dependability

Dependability parallels ‘reliability’ in quantitative research, though it is not assessed through statistical procedures. (Bloomberg & Volpe, 2008) Instead, as argued by Lincoln and Guba (1985), the merit of research (dependability) is established by adopting an ‘auditing’ approach. (Bryman, 2008) Hence, “dependability refers to whether one can track the processes and procedures used to collect and interpret the data.” (Bloomberg & Volpe, 2008)

In keeping with this approach, the researcher kept records of problem formulation, selection of participants, field notes, interview transcripts, data analysis decisions, etc, providing an ‘audit

trail.’ As noted in the findings chapter, these records were maintained in a secure but accessible manner, available for review by other researchers. For trustworthiness, the principal test used was triangulation, as discussed earlier.

Since “qualitative research frequently generates extremely large data sets” the auditing approach to dependability has not become a widely-used approach to validation. (Bryman, 2008)

4.19 Confirmability

Similar to dependability, confirmability corresponds to ‘objectivity’ in quantitative research. (Bloomberg & Volpe, 2008) In social research, “complete objectivity is impossible” (Bryman, 2008) , though “the researcher can be shown to have acted in good faith; in other words, it should be apparent that he or she has not overtly allowed personal values or theoretical inclinations manifestly to sway the conduct of the research and the findings deriving from it”. (Bryman, 2008)

In other words, this means that it must be assured that “findings are the result of the research, rather than an outcome of the biases and subjectivity of the researcher.” (Bloomberg & Volpe, 2008) To accomplish this objective, the ‘audit trail’ approach suggested by Lincoln and Guba (1985) in the dependability section above can play important role in confirmability. First, the decision trail for the study is identifiable for external reviewers. Second, though complete objectivity is unattainable, the researcher maintained reflexivity and an ability to trace data to its origins. Third, the audit trail approach was used to document ongoing reflection by either field journal notes, methodological memos, and interview transcripts, in order to provide the reader with a window to assess the findings of the study. (Bloomberg & Volpe, 2008)

4.20 Reflexivity

Reflexivity is a core characteristic of qualitative research closely linked to validity but also to quality. There are more than one meaning of reflexivity but here the salient connotation is “that social researchers should be reflective about the implications of their methods, values, biases, and decisions for the knowledge of the social world they generate.” (Bryman, 2008) Key decisions were documented as they were made. The methodological memo was used as a

vehicle for documenting decisions on 'mid-course corrections and the reasons for them, to provide an audit trail for reflexivity. For example, from the first pilot interview, the researcher realised the necessity of clarifying national-, regional-, and programmatic/clinical-level policy transfer to avert participants' (perhaps unspoken) interpretations that might be too restrictive, and to optimise data capture. Similarly, the utility of clarifying the relationship among the concepts of policy 'learning,' 'ideas,' and 'transfer' was noted and adjustments made, noting in particular, that they are analogous concepts and involve many of the same steps in a process. Finally, although interviews in a constructivism framework are typically quite conversational, the researcher learned in the pilot that his enthusiasm and resultant engagement in dialogue should be attenuated to conform to time constraints.

Throughout the study, in a constructivism worldview, self-reflection of the researcher was crucial to isolate and clarify any bias brought to the study, and adjust as appropriate. The intent was to be sensitive to political, social, and cultural contexts, and to create an open and honest narrative " . . . 'knowledge from a reflexive position is always a reflection of a researcher's location in time and social space.'" (Bryman, 2008; Pink, 2001)

4.21 Summation

This chapter provided a detailed description of the study's research methodology, or overall strategy, for the research. A basic qualitative study was employed to explore the question of whether English health policy stakeholders view the US as a privileged source of health policy and programme innovation and transfer. A literature review was conducted initially and was ongoing to first devise a conceptual framework for the design and analysis of the study, and to adopt a theoretical framework to answer research questions. In a qualitative approach with a constructivist world view, the primary data collection method was a semi-structured interview. The study sample was composed of 31 purposively selected individuals. Data which resulted led the way to construction of themes. Validity, credibility and dependability were established through various strategies, which included triangulation of findings, literature, and theory. The researcher determined that data analysis would be conducted manually. Comparing analysis of data from field research, ie, findings, with the literature, and theory, certain interpretations and conclusions were drawn. This study aims to provide insights for English health policy

stakeholders, including possible implications of health policy transfer for current and future health system reforms in the UK.

CHAPTER 5 FINDINGS I

5.1 Introduction

As described in the methodology chapter, responses of elite health policy stakeholders in England to research questions were obtained in face-to-face semi-structured interviews conducted by the researcher. Responses were collected from study participants from multiple operational levels – macro (national), meso (trust/hospital), micro (clinical/programmatic). Responses were also stratified by participant professional category, eg, academic, clinician, public servant, politician/political adviser, think tank. The researcher conducted manual analysis, repeatedly reading interview transcripts. Analysis of response content of 31 elite study participants yielded themes, which were correlated with selected direct quotations. As themes were constructed from the data, the researcher: (1) identified patterns within and between participant responses, (2) compared, contrasted, and, where appropriate, melded themes across participant categories, and (3) noted variances in ‘arguments’ attributable to different professions.

It is worth noting that only seven of the 31 participants fit exclusively in a single professional category, which is to say that nearly all had evolved through the proverbial ‘revolving door’ during long, successful careers. A crossover of study multiple participant career roles is

displayed in Table 4. A possible exemplar drawn from this table could be a clinician who, during different time periods, practised medicine, held an academic post, and became a government official or adviser. This phenomenon speaks to the robust qualifications of participants in this study to contribute answers to the research questions, and to the distinct richness of maximal variation sampling for the collected data. The findings are reported in this and the following chapter, organised by theme, sub-theme, and the associated research question. Here, the researcher will give voice directly to the study participants. Table 5 is a thematic map for this study and can be viewed at Appendix B.

5.2 THEME: US a privileged source

5.2.1 SUB-THEMES: US fraction versus other sources; limits to US primacy; policy pushing versus pulling.

5.2.2 RELEVANT RESEARCH QUESTION: Do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?

Participants had consensus that the US was a privileged source of health policy and programmes. However, participants provided their personal, interesting, and informative variations in the parsing of answers to this question and, in a few cases, the initial interpretation and reaction to it. Finally, there were some minor variations noted in the actual intensity of consensus of US status across governments, though the common thread, or ‘critical path,’ if you will, remained constant.

Chris, a politician and former minister during New Labour, provided commentary encapsulating how some variations have occurred in the interest of successive governments in learning from the US, collecting ideas, or transferring policy:

Because, particularly, for Labour politicians, the US is regarded as such an appalling healthcare system for reasons we were just touching on. And therefore, any suggestion that you might learn from the US is kind of regarded as treason. So, that's true in significant parts of the Labour Party, probably more so now, certainly much less in the New Labour days.

You also got the problem that within the NHS itself, there is still quite a culture. We are the envy of the world. We are the best health service in the world. And therefore the idea that anybody had anything to teach us, would it be insulting? This was more of the level of policy, how you run the thing. And I also thought it showed a degree of complacency because however good you are, there's always more to learn.

Conservatives in Parliament were exploring the potential of 'competition' and its several 'moving parts,' and it was natural to turn to the US for ideas.

And we certainly, at that point, were having some conversations with US health policy academics. And we were interested in the role of competition. And we were very interested in the purchaser-provider split that the conservatives were introducing into the NHS.

And when Labour was elected in '97, Frank Dobson became health secretary for the first couple of years. And he wasn't interested in any of this public service reform stuff. Alan Milburn came in at that point? I think he did. He and Tony Blair and some special advisors then sort of really got cracking on taking the parts of the provider split, relabeling it commissioner provider, whatever, setting up foundation trusts and really moving forward the idea of the internal market. But any use of that term 'market' in relation to the NHS just had Labour MPs, not just the hard left foot, some of the more moderate Labour MPs, and quite a lot of our members, and quite a lot of unions, and health service workers wary of privatisation. Even so, there is a considerable inclination in England to 'pilot' policy or programme bits to adapt them to local conditions, eg, customs, standards of care, and not directly copy from the US.

There are several salient points in this conversation. First, it was thought that US was the natural source for the internal market and competition concepts, which laid the foundation for the purchaser-provider split. Second, during New Labour, there was greater affinity for US health care than present day Labour. Third, there is a certain culture within the NHS which resists the idea of turning anywhere for health care ideas, owing to its status in the world. Fourth, there is a segment of stakeholders which harbors the virtually universal fear of privatisation, and the US is, again, the natural force for it.

As an element of the ever-present suspicion of 'privatisation' motives and the covert pursuit of it, New Labour was outsourcing to the private sector.

And the fear, I think, which is revived at the moment with sustainability and transformation partnerships (STPs) is that you would have commissioners who would end up turning the NHS into simply a glorified insurance scheme. And they would then buy all the healthcare from the private sector. And of course, it was a very important part of what New Labour was doing -- that we were bringing in private and not-for-profit sector players now to do particular bits of work, so cataract operations, orthopedic stuff, hips and knees, especially because that's where the waiting lists were longest. And waiting lists still, certainly by the time we were elected and many years after that, waiting lists was what the public was most concerned about. A&E as well, but waiting lists were really big. So, we brought in the private sector. We justified it publicly on the grounds that we needed additional capacity.

Sylvia, a senior clinician and academic across three reform periods, essentially added support to the above with the comment:

And, of course, where it [policy transfer] has happened most definitely is at the level of foundation trusts. So chief executives of foundation trusts play a role.

This was interpreted as an implicit rejection of policy transfer from the US at the national or macro level. Of course, it is at the trust/hospital level that problems (in search of a solution) are surfaced, external sources for solution consulted, commitments made to investigate and, if ultimately deemed suitable, resources for pilot testing and implementation are allocated for policy transfers.

Interestingly, Sylvia made additional points about the broader political landscape, and interrelated social factors impacting health policy, and how these might impact where policy transfers might be sought, eg, from the US:

Actually, all countries in Europe are opening up their healthcare systems to the market. The neo-liberal process is going on everywhere, it's just the rate and pace of it. That's the first thing. And the second thing is that the NHS is part of a bigger welfare state, which is also being marketised and opened up. So you can't really understand the 'why' unless you understand what's actually happening to all the other conditions, you know, the elements of housing, labour, education, and social care policy, etc. The answer must be yes.

It should be noted that there have been about 40 years of neo-liberal health care reform in the US, so the wholly capitalist approach to health care continues unabated and colours its policy and programme offerings for any which consult them.

John, a senior clinician, academic, public servant, and think tank official had a couple of initially surprising responses:

Is the US a privileged source of health policy innovation? No. Health policy transfer? No.

These terse and unhesitating responses conveyed in a somewhat unbending manner were interpreted by the researcher as either misunderstanding the question, or an attempt to emphasise a particular angle, which was, in fact, later confirmed. Importantly, the researcher immediately restated the question, and continued with exploration of the “no” responses which were, in turned out, aligned with all other interviewees, and remained consistent through the rest of the interview, ie, “no” meant no UK interest in the ‘underlying philosophy or organisation’ of US health care.

I think that there a lot of ideas that go backwards and forwards, but to a very large extent, I think on this side of the Atlantic, we look at specific examples of good things in America, and we also recognize the things which are not as good and which we wouldn't want to copy [see Bits]. A friend of mine who runs a very large [US] academic science center says that ... who I first met actually here at King's Fund, when he was on sabbatical between two big jobs. Of course, he said, "you do fairness, and we do freedom." And I think that is true ... we do fairness, and it is absolutely at the core of the British National Health Service. It is one of the cardinal values of this country, which came out of the Second World War and the early part of the 20th century. It is almost the state of a religion now, and it trumps absolutely everything else.

When I was talking about what I see to be the problems of the National Health Service, not least the quality of the outcomes in relation to other developed European economies, they are certainly better than the United States overall but they're much less good than say for example Holland or the Scandinavian countries. Holland probably has the best healthcare system in Europe. Both in real outcomes but also in value. My report is outcomes, not pounds or dollars spent. But I don't think we look to America for examples overall in the healthcare system other than the fact that we think it's bust.

What we do look to is specific examples in America that are really effective, like Kaiser or Intermountain Healthcare or University of Pennsylvania Medicine and Academic Health Science Centre, and the Mayo, for sure. But also Don Berwick of IHI has had a very significant influence, largely because he loves the National Health Service, and because he doesn't like the American healthcare system, so he contrasts them. So he's put in a huge amount of work over here, which is much appreciated. So the quality movement and the IHI [Institute for Health Improvement, Boston] have all been hugely helpful.

It is crucial to note, as described by John, a significant difference in values of the two countries with respect to provision of health care. Clearly, this difference is pivotal to sustaining a centralized, tax-supported, free at the point of service, national health service. At the same time, John highlighted better outcomes overall produced by this national health service in the UK versus US. Lastly, John set the stage for a later discussion of what the UK really seeks from the US – 'bits,' or specific tools and techniques – covered later in Theme 6.3.

Thomas, an academic, clinician, and former public servant reflected the position of the US vis-à-vis England in policy transfer. During the Thatcher years, the internal market was introduced based on a manuscript commissioned by Nuffield Trust and authored by American economist Alain Enthoven.

So, I suppose my first interest in my career in health policy was when I was in medical school in the early 1980s, and read an article on the internal market. A document [manuscript] got lost for a while, and then somehow or other Margaret Thatcher found it over a cup of coffee, and really liked it and brought it over [to UK], and there's the tale for you. Yeah, so even in my professional lifetime and before, the UK is often looked to as connected to the US. Why this is an interesting question.

The good US track record for innovation empowered by much larger R&D budgets in a much larger country, cultural and linguistic commonalities create an affinity between the two countries.

I guess partly, the US is a very innovative place. Almost the nature of your health system and the nature of your individualistic approach towards your culture means that you're an innovative place. That's always very exciting for a country that's relatively un-innovative, rather than just a health system that's relatively conservative. I guess it's partly about that. It's probably about a common language and history. We think we understand the US more than we understand the Germans or the Italians.

So inevitably, we look to you for ideas for that reason as well. I think we do so with our eyes open, in so much as we understand that the generation of new ideas in the US is a really good thing. The follow through and the formal evaluation of those new ideas is perhaps less good. So we like to pride ourselves on tempering. Stealing good ideas but then tempering them. Whether we actually do so is another question but we try to convince ourselves.

So, I think the US has been really important. It isn't the only place, for a number of reasons. Partly, whilst some politicians are not very enthused by what's going on in the US. There's quite a deep skepticism on the ground amongst clinicians, in particular. Mostly because of our difference in culture. We are very proud of the NHS, for all its flaws, and the perception is certainly, depending what administration is in power in the US, but the perception is the US doesn't get it or understand it.

In this response, there is likely a subtle insinuation of the (ever present) political aversion to privatisation schemes from the US making inroads in the UK. The assertion of pride in the NHS connects with uneasiness about a capitalist, market-oriented health care culture in the US, eg, individualism versus solidarity. There was a subtle reference to 'piloting' policy or programme transfers, and also to 'branding,' ie, 're-branding' those transfers. In other words, 'it must be built in UK!' The fact that there seems to be consensus that the US lacks either understanding of or serious interest in the NHS, and that there is little no policy transfer from UK to US, adds to that unease.

And therefore, frontline clinicians, particularly in my discipline of primary practice, it tends to operate in a left of center place because we operate close to the people. We tend to be a little bit skeptical. And therefore, policymakers' enthusiasm is likely to be tempered by the criticisms that they get from others. For that reason, over the years policymakers have tended to look at other examples. Not just English speaking ones. There's a lot of really good stuff going on in Spain, to a certain extent in Germany, quite a lot in Israel in my field in primary care the moment.

Where we've looked at and learned from the models, and probably found the models a bit more aligned to what we're trying to achieve in some of the models. Come from more collectivist positions ... more centrally organized, financed, managed systems.

And from cultures that are less technologically oriented. The big thing about the US is their love of and admiration for technology. And I can't call it a cultural trait because, of course, we're all about progression in some areas, but we have more of a skepticism of technology. So our job is to, in some ways, pursue technology in order to provide person-centered care.

5.2.3 Limits to US primacy

Edward, a former secretary of state for health responded to the first research question with a rather forthright dismissal of the notion that the US is a privileged source of health policy or programme ideas, learning, or policy transfer. This was followed by a rather tortured explication of how the UK has established relationships, experienced 'big influences' and outright borrowed ideas, policies, and programmes from the US, inexplicably falling back from moment to moment to dismiss the notion altogether. Participant quotations demonstrate this ambivalence. Variation from other participants involved several instances of 'parsing,' eg, US vs continental Europe influence.

Well, I think the answer is no, we don't in my opinion. And I say that because the UK like almost every other country tries to invent it itself, of course. But if I look at it, and I was thinking about your question, and if I go back, I mean you know, there have been some significant things that have come from the US.

If I roll it forward from there, the United States is more being held up as the bogey man not to learn from. That happens much more than it happens that we learn from it, but there are some discrete things [see Theme 5].

We're more inclined to listen to people outside the UK than you are, in my impression. And it's interesting when you look at research articles, and this is just a sort of indicator, two-thirds of articles in peer reviewed journals where there's a British first author, there is somebody from another country as a co-author. In America, this statistic is 25 percent. So you're much more self-contained in America. Only 25 percent have a foreign coauthor. Here it's 63 percent.

Now it's probably because we're small and you're big, and it's partly because we have the great diaspora of the Commonwealth. A fifth of the world are in a sort of, some kind of relationship with us. So, we're very, we're much more globally orientated.

However, he continued with some rationale for not first seeking US policy transfers, essentially based on different philosophies of health services:

So quite a rich interchange, but given that our systems are the opposite of each other, you know. Ours is about fairness and social solidarity. Yours is about everyone looking after themselves and competition [also see John's comments above].

In one segment of his commentary, he made an implicit reference to 'negative' policy learning, which still qualifies as seeking ideas and learning from external sources short of actual transfer, eg, perhaps predominantly turning to the US to learn 'how not to do something.'

In your country, there's a risk of people who've got the money of over-treatment. In our country, there's a risk of under-treatment. So there's an equal and opposite. So very often politicians have used the American system to try and scare voters, you know. 'Devil take the hindmost' sort of stuff. So it has been that way round.

And I think we've been inspired by numbers of great people. And we've got great links with [US] people.

So lots of discrete stuff. The biggest is internal market, although it wasn't an American invention, it was an American transfer. And the second biggest I guess is probably Don Berwick [safety and improvement technologies].

So do I characterize it as going and looking or do I characterize it as people cold selling? I think it's a bit of both actually. Bit of both. And at its sort of highest policy, I know it was in government, it hasn't been about the Americans. It's been about opening up to external parties with no particular move towards the Americans as opposed to anyone else. But towards the private sector. With the result, you know, if it looks like there's a market opening up for the private sector, well America can come visit.

Yeah, and we would be more inclined to get stuff from you that is more high tech, and get stuff from Europe that is more low tech and more population-based.

We don't learn that much from other people, but we've learned significantly from the Scandinavians on a series of different areas. As I say, some of the public health stuff goes back to Germany and to the continent more generally.

When pressed to characterise the largest fraction of policy transfers from all sources, he commented, "I think it would be America, unless I put the whole of Europe together. In which case it would be Europe, then America. But if it was America [versus any single country], then I think it would be America."

In another implicit reference to negative policy learning, he added:

Yeah, I mean I think that's got to be true, but it's not big. And there is also the negative of, you know, the American system has been held up as the thing to avoid. And there is more of that than learning from it. And some of that is political prejudice. Some of that is the Labour Party here wanting to be the government of the day and others saying you're just trying to turn us into an American system where the poor don't get any care.

Earlier, the observation was made that participants were 'parsing' their responses to the effect that the US was a privileged source of health policy and programmes but not at the national, system (macro) level of the NHS. Simply put, those participants saw US influence in the UK adoption of 'bits,' ie, specific tools and techniques to solve a problem or provide an enhancement.

In 2004, Simon Stevens, then a Downing Street health policy advisor to Prime Minister Tony Blair later becoming chief executive of the NHS, published a paper outlining a round of reforms of the NHS in light of anticipated large increases in its funding over the coming five years. Stevens presented three main reform strategies then underway, and three potentially competing assumptions which underpin them. First, improvement centered on an adequate supply of properly supported health professionals. Second, hierarchical control increased to counter selfinterested provider behavior. Third, implementation of an emphasis on local accountability and provision of incentives thereto. (Stevens, 2004)

By 2000, per capita total health spending was only \$1,813 in the United Kingdom, compared with \$2,387 in France, \$2,580 in Canada, \$2,780 in Germany, and \$4,540 in the United States. As a consequence, U.K. health infrastructure was outdated, with old buildings and inadequate equipment. (Stevens, 2004)

Moreover, there were 2.0 physicians per 1,000 population in the UK, compared to 2.8 in the US, and 3.3 in France and Germany. Media in the UK furthered the stereotype of the NHS (“good”) compared to the US (“bad”), and NHS (“bad”) compared to continental Europe (“good”). These polemics did not well serve to garner support for increased funding and modernisation of the NHS over years.

This was the backdrop for PM Blair’s decision in 1997 that a dramatic increase in NHS funding was imperative. Without it, he feared the NHS would wither, as a gap in system performance and public expectations would grow wider, and it would become a safety net of last resort.

So, in 2003, taxes were increased an average of 7.4 percent per year in real terms for the next five years. This effectively defused earlier claims that the public would resist properly and sustainably funding the NHS. That said, a gauntlet was laid down for increased funding to be met by an increasingly consumer-responsive health service. Policymakers then changed focus from financing to supply-side issues.

Three sets of reform strategies emerged: one-, two-, and three-dimensional, comprised of 12 overlapping strategies. One-dimensional reforms involve support for providers, and reflect the view that professionals traditionally “want to and will do the right thing if properly funded and free from external interference.” (Stevens, 2004) This is the policy orientation of the British state and medical profession extant for most of the post-war period. Accordingly, the strategies for reform in this set included: 1) increasing the supply of health professionals; 2) modernising infrastructure; and 3) supported learning and improvement. (Stevens, 2004)

One-dimensional reforms were necessary to build capacity and capability. However, twodimensional reforms sought to bring to heel health care provider self interest, inefficiency, variability in quality, and responsiveness to patient preferences. In England, events underscored this truth at Bristol Royal Infirmary, where cardiac surgeons exceeded their competence and children died, as a result, creating a public clamour for change to allow the incoming Labour government to act as a proxy for consumers, using four new hierarchical levers. These included: 1) national targets and standards; 2) inspection and regulation; 3) published performance information; and 4) direct intervention. (Stevens, 2004)

For three-dimensional reforms, “the localist challenge assumes that countervailing pressure on providers is indeed necessary but that it should wherever possible come not from line management, regulators, or government but instead from market incentives or local democratic

accountability. Strategies included: 1) active purchasing (1991 “internal market” reforms introduced the purchaser-provider split which persisted); 2) patient choice (moving toward ‘any willing provider’); 3) aligned provider incentives (five-year transition to DRG payment system); 4) new entrants and plural supply (mixed economy on supply side to expand capacity, eg, privately operated free-standing surgical centres under contract with the NHS, private diagnostics and primary care “out of hours’ services); and 5) local democratic accountability (in place of topdown control, foundation trusts accountable outward to their community).

The post-war health policy orientation in England has seen “an end to the bipartisan political consensus on the role of tax funding; a new bipartisan consensus on the value of a more mixed supply side; and increased challenge to the medical profession’s power . . . Health care improvement requires a source of tension to overcome the inertia inherent in all human systems . . . a relatively pragmatic phase compared with its more traditional ‘path dependency.’ Strategies associated with all three dimensions – one, two, and three – were running in parallel rather than sequentially. (Stevens, 2004)

“The risk of relying principally on hierarchical strategies is that they centralise blame, undermine intrinsic motivation, and produce a compliance culture in which only what gets measured gets done.” (Stevens, 2004)

. . . the history of NHS reform since 1991 has shown that a unidimensional reform model (be it cooperation, competition, or command and control) will not be sufficient to generate high performance in a sector as complex and varied as health care. Instead, a three-dimensional model is emerging, which corresponds to the triangular relationship between the British state, the medical profession, and the public . . . at least on the supply side, the era of English “exceptionalism” in health care is over. (Stevens, 2004)

In a variation on parsing, Archie, an academic and former public servant opined that, while the US was indeed a privileged source, it was at the level of ‘ideas,’ not transfer of specific policy or programmes, though examples of whole programmes were provided. In other words, the US was predominantly looked to for ideas, which were then worked out, or invented, if you like, in the UK. This is not the first or only time ‘it must be built in the UK’ was heard.

I think it is a privileged source of policy ideas, and there is a ready willingness to look to the United States. Clearly, one of the key drivers of that is we're meant to share a common language, although whether we do or not is a very moot point.

But it seems to me that many of our closer neighbors, and I'm thinking of places like Scandinavia, the Netherlands, to a lesser extent Germany, France, there really aren't linguistic barriers or boundaries between those, because the professional *lingua franca* is English.

But there seems to be a reticence about looking in that direction [Europe], and a greater willingness to look towards the United States, and to privilege the information that comes from the United States, which on the face of it is strange, because the context for that country is so different from something like a publicly-funded, publicly-provided service like the National Health Service, compared to the utterly fragmented non-system, in the United States, that has multi levels of diversity at state and federal level. So on the face of it, it's an odd place to look, but then, but I would agree, with your premise, that it is a place that is looked at as privileged as a source of ideas.

Archie, provided an elaboration if not similar view regarding the significance of language:

Why is it that there are similar systems that might be better, comparators to us, that we don't go looking for? If the question is in the language - can't speak Spanish, don't speak Russian, or whatever language - America is good. They have a good system. Well, that wouldn't rule out: why not Canada? Why not Australia? Why not New Zealand? To some extent we do do that and perhaps New Zealand is the closest, and in some ways it predates what happened to the U.S. because in the earlier 1990s the experiment, that we're still experimenting with, of markets and quasi-markets, we've actually borrowed a lot from New Zealand.

There might be a qualitative difference in the openness of the US to disseminating ideas to the outside world, which is well-perceived by potential 'idea seekers.' Indeed, this might be amplified by the numerous knowledge brokers in the US which has world-class status and global reach.

There are examples where we do - perhaps Holland - I think there are examples but it's as a whole-sale exercise gone back into compared to the U.S. I can only think that the U.S. marks it out from there is its willingness to promulgate, disseminate, supply its

ideas outside. Whether that's aided by global consultancies, starting back with McKinsey in 1970 but others since. KPMG, Price Waterhouse, many are involved not just in the technical programs, but at all levels.

The role and significance of management consultancies is certainly manifest in penetration of UK health care, and the US-UK nexus since so many of the largest, most influential firms are US-based. This subject is treated in Theme 3.0 Framers and Brokers.

In that sense I think that helps understand our interest in the U.S., the U.S.'s interest in us, but also perhaps why we don't go looking for other places as well. There's certainly many good ideas out there, but we don't always go looking with the same intensity I suppose. Maybe there is a social factor as well. Many people like going to the U.S. on holiday and a week in New York could be better than many other places I can think of.

But then why not Australia or why not Canada, for example? Equally, English is widely spoken in many other countries as not just the official language. It's the business language of other countries. There is an element of privileging the U.S. in that sense. For example, another country which is perhaps most similar to us which is Italy - a regionally based, tax funded system. European values, should I say - solidarity - that we would do well to learn from but we hardly ever look at.

Or San Francisco. Or anywhere else. Maybe there is a much more subtle issue at heart, rather than going around to some - I've got to be careful what I say about places - nondescript places in other countries. Some of the study tours, visits, et cetera, are quite a picnic! A study tour to Seattle, if you get the money obviously from your organization, could be a very nice thing thank you very much. Quite a basic thing, people have got an affinity for the U.S. Culturally, socially, familiarly, maybe there's a component there. Maybe that's just giving the edge to Italy - and distance obviously is a factor - but Australia and New Zealand are within reach these days compared to other countries. That's not the only factor, cost and time I suppose are a factor. That would be my rather long-winded way of saying why the U.S. is privileged.

Archie continued to demur on transfer of "whole programmes" but at times seemed, at least to the researcher, to conflate 'ideas' and 'programmes.' Intermixing perhaps could simply signal that transfers or programmes are not accepted wholesale, ie, do not occur without modifications to conform to the NHS system, as well as regional or local differences in standards of practice,

culture, customs, or other factors. This would be consistent with other participants who overtly referred to “piloting, tempering,” etc., and alluded to ‘branding,’ all of which play a significant role in the transfer and implementation of policy or programmes.

If I think about what gets transferred though, we can point to certain things, certain ideas, certain practices. Things like pay-per-performance, virtual integration, public reporting of quality data, some of the aspects of managed care, for example. Many of those things we see tried out and replicated, in the UK. But I see less transportation of kind of whole programs, and more the transportation of ideas, so ideas like competition and incentives, as a way of trying to improve quality and efficiency. Ideas like UserVoice, and the reputational adjustments that are made when there's public reporting information put in the public domain, performance reporting, put it in the public domain. So, the transfer seems to me often at a level of story and narrative, with embedded ideas, rather than the wholesale transfer of program ideas.

I suppose it depends for me on how broadly you define policy, as opposed to practice and individual initiatives. And I'm not sure that I've seen health policy in its broadest sense transferable but there will be component parts and perceptions of the systems that people might desire to duplicate.

A policy transfer decision typically starts processes involving ‘piloting’ and implementation, welldefined or otherwise. Once transferred, a policy or programme may or may not fail in piloting in the new environment. That said, success in a piloting phase may still ultimately result in a disappointing implementation phase, ie, producing less than the results anticipated when the transfer decision was made, or producing altogether different albeit beneficial results.

Evercare was a case management program of UnitedHealth, parent corporation of Evercare, for frail elderly of UnitedHealth in the United States, which was successful in reducing hospital admissions among nursing home residents. A 2003 study in the US by Kane et al. found that a control group of long-term nursing home residents had an incidence of hospital admissions twice as high as Evercare enrollees, also corresponding to both Evercare’s use of intensive care days, and preventable hospitalisations. The intervention (Evercare) also reduced length of stay in hospital by 57 percent, and emergency room visits by 48 to 55 percent. (Fraser et al, 2005) The multiple functions of advanced practice nurses used in primary care may have prevented

some hospitalisable events. Regardless, the authors concluded the major effect was to manage cases more cost-effectively.

UnitedHealth Europe, at the invitation of DoH, transferred the Evercare programme from the United States to nine trusts in the NHS, through pilot projects started in 2003. A study in England by Gravelle, co-authored by Sheaff et al, found, however, “the US version of Evercare was markedly different to the version in the United Kingdom as the former included intensive domiciliary nursing care of patients when they became ill.” (Gravelle et al, 2007)

Evercare pilots were the first widespread use of case management in the NHS. A principal focus and goal of Evercare in England was reduction of emergency admissions, emergency bed days, and mortality for a population of high risk cohorts, greater than 65 years of age.

Quantitatively, Evercare in England produced no significant effect on any of the metrics enumerated above. As in the US, advanced practice nurses in the England carried out multiple functions in primary care. Qualitatively, case management “added a frequency of contact, regular monitoring, psychosocial support, and a range of referral options that had not previously been provided to frail elderly people, and in some cases nurses reported that they had been able to intervene to avoid admission.” (Gravelle et al, 2007) The variance in quantitative analysis and the qualitative accounts of nurses might be “because Evercare led to increased case finding.” (Gravelle et al, 2007)

Two commentators on the Australian coordinated care trials suggested: “The possibility remains that the essential premise that better coordination reduces hospitalization . . . better care coordination [may] reveal unmet needs rather than resolving them. (Esterman & Ben-Tovim, 2002).

Finally, it is noteworthy that case management policy resulted in a national community matron (advanced nursing) policy. However, Gravelle et al. questioned whether even this feature of case management could succeed to reduce hospital admissions without a radical system redesign. (Gravelle et al, 2007)

Case management [Evercare] of frail elderly people introduced an additional range of services without an additional reduction in hospital admissions. (Gravelle et al, 2007)

In a subsequent paper, Sheaff et al. (2009) contributed the qualitative component to the earlier quantitative study. Case management for elderly people introduced an additional range of

services, eg, Community Matron programme using APNs, into primary care. Patients and caregivers highly valued case management, improved patient access, jthe broader health care system, as was hypothesised. Importantly, there was no associated reduction in hospital admissions, a central metric in the earlier study, and the avowed strength of Evercare. Without more radical system redesign this policy is unlikely to reduce hospital admissions as there is little difference in outcomes for Evercare and compared with other models.

Overall, there were lessons to be learned about the necessity and difficulty of ensuring a proper 'fit' of policies or programmes, even when piloted, upon moving from the 'lending' environment of operation to a 'borrowing' one.

In response to a follow-up question, Archie confirmed the belief that US programmes are not generally implemented without first tweaking or piloting to fit purpose.

Oh, absolutely programmes are modified or tweaked for UK implementation]. But you do see that, what you see attention being paid to are dominant ideas, so ideas of competition being one of the primary ones, or the whole discourse around safety, as opposed to quality, is another one, idea that jumped across the pond, very successfully, recognizing that hospitals are unsafe places, and that attention to patient safety was key to improving resource use, and improving overall quality. So that's, so I see the jump has been very much in a sort of conceptual ideas, or even ideological level, rather than the transplantation of specific programs of work.

How much buy-in of UK policy stakeholders for US solutions is a contingency for individual stakeholders and dependent on their roles, particularly with respect to underlying philosophy.

Many academics I think would pay a lot of attention to context, and would say the kind of policy options and the policy solutions that are applicable are very contextually contingent. That what works is not something that's an invariant that can be moved and transplanted, but what works is very heavily situated, and dependent upon the surrounding context, and so the simple transfer of policy ideas is a dangerous strategy, and so I think many academics of my acquaintance would be skeptical of policy transfer like that.

I think the extent to which you are, buy into the idea of picking up ideas and translating them and transplanting them into new settings, is a function of what you really want to do . . . if I think about some of the New Labour innovations around pay-for-performance for example, around the Quality Outcomes Framework in primary care, or introducing a stronger degree of competition between acute providers, and trying to get them to compete in a variety of different ways. I think there it was the, I don't think the ideas necessarily originated in the US, but I think there was a willingness to look there and use it as a buttress, kind of avenues that they wanted to explore anyway.

So, if you want to do that, if you're looking, if you've chosen to go down a particular policy route, and you're looking for some supportive evidence, or wraparound for that, then you're prepared to overlook some of those intercontextual differences [between US and UK]. But I think many academics would be wary of it.

Some people are wary, which is to say, openly hostile to the notion of privatisation of the NHS via the possibility of a US 'trojan horse' being introduced via policy and programme transfer.

Sylvia, the earlier clinician and academic, in particular, is notable for, from a decade or more ago, saying that this [infusion of US ideas] was a Trojan horse, this was about privatising the NHS, this was about breaking the NHS up into a series of businesses, that could then be taken over by organisations with committed to the profit motive, drawing on the big systems from the US, and has been deeply skeptical right from the very start about where this process was going. The researcher was impressed that not all academics have bought into that view, though this one is emblematic of a particular strand of thinking, shall we say.

Theodore, senior academic, continued with an example of the US being 'top of mind' involving UK academics conducting a study in improvement science.

... She [UK academic focused on improvement science] did some work with Peter Pronovost on the Michigan study. It was interesting, she didn't go to Milan or Berlin or Denmark. These are ideas that are coming from particular parts of the world that we don't necessarily always look for.

So, there are some smaller examples elsewhere but it's interesting, I struggle to go beyond those two if you're looking at New Zealand. I can speak of colleagues who have

been to Australia, are doing work there, we have a teaching program jointly but it's not on the same scale. It's not on the same types of issues, the same intensity, as the U.S. Just from being able to speak ... Being able to speak much longer about the U.S. experience, I've got a fairly wide knowledge. We don't generally have a strong engagement with Europe - it's going to be interesting after Brexit.

I went to a European Health Management Association meeting in Frankfurt for two days. We're well-regarded in what we do and I think our research is well-regarded and our practice is good, but we just don't engage as much with Europe and European debates. It tends to be a minority sport rather than a wholesale public participation. I'm not trying to overstate the U.S. either, but equally we've got to do that. Not saying there's zero happening in other countries, but if one had to weigh it out in terms of the activity it would be 75 U.S., 25 all others.

So, the question becomes whether or not the UK carries on a very deliberate or concerted exchange on health policy ideas and programmes. Is there an openness to influence from any other country?

Yeah. It's hard to answer that, and I'd answer it in two ways really. One is that I think throughout that period, when I think about the last 20, 25 years or so, I think the US has been privileged as a place as a set of ideas.

And there's been a greater willingness to go and explore there, and to have a degree of, to confer a degree of credibility on some of the policy solutions that've been developed in the US, and a less of a willingness to look at our continental neighbors, and almost no willingness to look at other countries such as Canada, Australia, New Zealand, for parallels, and I don't quite know why that should be. I don't know why one would privilege it in that way. But I think that is just kind of how I've seen it. But I wouldn't say it was concerted or systematic; I would say it was very ad hoc and idiosyncratic.

Very much more opportunistic than any kind of systematic process. And some of it I would call, what I would call 'policy grabbing.'

5.2.4 Issue of policy push vs. pull

Archie was queried whether he would characterise UK policy transfer as 'super market shopping'? You go in, and you look at what's on the shelves, and you say, "I'll have that, I'll have that, and I'll have this." Or, whether it is more economic interests in the US driving 'coldcalling,' or 'policy pushing;' bottom line, is it policy pushing from the US, or policy pulling from the UK? Archie answered:

Largely I would say it was, it's policy pull. I mean I don't see much in the way of policy push [from the US]. I mean there are exceptions to that, so, IHI is a proselytising organization. To put it mildly.

Yeah. And Don [Berwick] is its chief there. He's the chief shaman, so, yeah, and so I think that's an organisation that's done a lot of push.

But some of the other ideas, I think, if I look at US health policy academics, they've got their hands full trying to deal with federal and state agencies, and trying to get a strong hearing there. There are some organizations, RAND would be one, which I think does do a bit of export, and so, has a strong presence in the UK, in Europe . . . I would see it as more policy shopping is a good way of talking about it.

Theodore, an academic, provided supportive commentary:

I'm not too sure it's easy to say that in a Newtonian forces ... I don't know whether they're equivalent forces. I think there's both happening at the same time. Whether they're equal and covalent, whether they're the same parameters I'm not too sure. But it's interesting of the numbers of ideas that we might've exported to the U.S. compared the the numbers ... Our balance of trade in ideas, practices, techniques, might be - and I don't know about specific protocols or surgical techniques or whatever but more at a higher level - I imagine we are heavily in debt to the U.S. in terms of ideas.

Jack, an NHS public servant, provided an interesting and insightful parsing of push/pull that deserves noting:

Maybe the pull, maybe it's focused on different things. Pull comes from policy. So, for example, you mentioned some payment reform stuff. So policymakers have looked to the US for a lot of innovation around payment reform. Starting with DRG/HRG is now

looking at bundled payments and other things that we're starting to experiment with here, capitation in a more serious way. And so those things I think we certainly have looked to the US, where that is something where there has been a greater use of some of those policy financing innovations. Maybe some of the push is more on commodifiable stuff like technology, data.

John, provided an example of a transfer initiative directed from England:

For example, I was talking to Penn Medicine in Philadelphia, and of course they're leaders in proton beam therapy. So, I put the head of medicine at UCL in touch with him to chat because there must be opportunities for him to do research, and also for some learning that UCL can get from Penn. UCL is a leader in Europe, and so they can talk to folks at Penn.

He commented further on contributing factors for the privileged relationship:

You mentioned values. I think we do have the same Judeo-Christian value system, protecting life and health, the importance of justice and all that sort of stuff. All of that helps, which is not to say we're not the same with Europe, but there's an ease about the conversation [with the US]. At least I've found it so.

Is a common language important? Yes. Well, it is except to the extent that fortunately, and it's an accident of history which has hugely benefited both our countries, is that English is established as the language of science across the world, and aren't we lucky?

Darcie, a former academic now think tank official offered her view:

I think it's 50/50, but perhaps the UK is pulling a bit more. I wouldn't imagine that there's other parts of Europe, for instance, that would be trying to grab examples from the US or elsewhere in a way that the NHS does. I think there's a bit of an 'industry' here, in getting knowledge from other places. And it's a good thing as well as a bad thing, but I think yeah, it works both ways.

Alexander, a senior clinician and academic, noted:

So, I think there's two answers to that. Leaving the private sector aside, I think that there's been no push at all, it's entirely pull. It's entirely us looking around for ideas. It's seeing whether our systems fit and going out and finding them. I don't get the sense that

the political system, being a bit wider than the politicians, is evangelical in any way in terms of wanting to spread the word.

Joel, a senior trust level manager, provided comments on push/pull from his perspective of operations, and, interestingly, connected with several associated issues, not often referred to:

I think it is pulling from the UK. Although I think that partnership and alliance are what they seem to look at when they're over there [US]. A few photos on the council steps. People like it.

People do see it is a really good personal development opportunity. I've got people in this organisation invited to go in a few weeks time. They all care about it, think it's great, they can tell all their friends they're going. As I say, people see it as a bit of a perk, not saying its sort of a waste of time or a lazy thing. It's like a recognition thing that people are selected to go and talk to their peers in similar services or whatever they're doing, which is good. I think just a bit I might be missing and again it's just the policy bit as opposed to the shared learning about resolving particular clinical or business issues around the system, which is probably more where I've seen the only bits I've probably seen come back .

I would imagine for whatever reason we think we all learn from the US. Probably think the US doesn't think quite the same, it's a bit like you say, same as your pull and push thing to be a realist.

I don't think the appetite for learning I think that's probably where you're going. I don't think we use best practices in this country itself. [Yes, that's where I'm going. Why not look inside yourself?] I absolutely agree with you. But in the same way if people wanted to come on a study tour to Stoke it wouldn't float many people's boats. Let's be frank about it.

5.2.5 Summation

Across professional categories, ie, politicians and their advisers, clinicians, academics, managers, etc, there was consensus that the US is a privileged source of health policy and programme innovation and, hence, of policy transfer. Any resistance to this notion typically took

the form of aversion to the 'privatisation tag' which, in the UK, is justifiably lurking in the background of policy learning, ideas, and transfer associated with the US. Some participants initially resisted the notion on what appeared to be grounds for a more ecumenical, ie, less parochial view of US policy transfer, or to avoid appearing naïve; however, before those interviews ended each one who did so eventually circled around to confirm their assessment of the predominance of US policy transfer and that it, indeed, was the largest fraction (if not a large majority) of all health policy transfer into England. Participants had their own unique experiences, verbalising and 'colouring' their essentially common perspectives somewhat differently.

5.3 THEME: Differences across macro, meso, micro levels?

5.3.1 SUB-THEMES: no English interest at system-level; system-level benchmarks (internal market, competition, DRGs/HRGs, ACOs/ICs); trust/hospital level initiatives.

5.3.2 RELEVANT RESEARCH QUESTION: do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?

The researcher pondered whether NHS seeking policy, programmes, or ideas for transfer was more or less centrally directed, eg, by DHSC or NHS England? Or, alternatively, whether central authorities defer to NHS hospitals or Foundation Trusts to dispatch study groups or work teams to have a look at some policy, programme, protocol, or technology of interest? Or, whether central authorities play a significant role at all in reaching externally for innovative solutions?

Sylvia, elaborated (with a disapproving tone) the potential adverse impact of US influence, and delineated the meso -- not macro -- level as the focal point for transfer at this time.

Of course, where it has happened most definitely is at the level of Foundation Trusts.

So, chief executives of Foundation Trusts are key players.

Suffice to say notable exceptions are introduction of the internal market, competition, patient choice, which ushered in the genesis of US influence, ie, during the Thatcher government. DRGs/HRGs and ICs came more recently, and are discussed separately under Theme 5.0: Specific Tools/Techniques.

Turning back to the macro level, Sylvia added the perspective that:

We have a very neo-liberal privatising government and have done so since Thatcher. So, we've seen the mechanism, we've seen the tools for the market being brought in. I do know that the [UK] government uses [US-based] big management consultancies like McKinsey's and there must be policy transfer happening through these international consultants, McKinsey's and Price Waterhouse Cooper, which have a privatising mission and privatisation agenda because it also brings more money and more work for them. So, no doubt, there's a global transfer of ideas and you see that in the law, in the mechanisms, in the structures, in the systems that have been put in place.

Positing the implication of more or less across-the-board and continuous macro level US influence, albeit with disapproval and regret, was an outlier among participants.

In his memoirs, Kenneth Clarke recalled then Secretary of State for Health Keith Joseph engaged in an early attempt at NHS reform and was the first Conservative member to be accused by Labour of 'privatising the health service,' "an allegation leveled against every Conservative health minister thereafter throughout my career." (Clarke, 2016)

Keith was actually trying to introduce some modicum of business-like management into this chaotic, high-profile, and constantly crisis-ridden system. Unfortunately, he brought in the management consultants McKinsey to advise him. (Clarke, 2016)

At the time, in the early 1970s, McKinsey advocated a system called 'consensus management,' ie, running organisations by consensus among a team of executives with no one person being chief executive. Suffice to say, this ill-fated system of management shepherded into law by Clarke mainly served as the impetus for NHS reforms introduced by Clarke in the late 1980s, and complete abolition of the system as a failure, according to Clarke. (Clarke, 2016)

The important aspect of US influence involving think tanks and consultancies is further explicated under Theme 6.1 : Framers & Brokers.

Joel opined:

There has been a lot of looking at the States. If you look at where NHS managers and clinicians travel to, the States is the most common destination. So, I think it's fair to say, particularly with our chief executive, Simon Stevens, he would tend to look to the States.

Still intertwined, however, is the universal sentiment that policy at the macro (or national) level is neither transferable, desirable nor sought from the US because of the fundamental difference in basic philosophies of health care provision in England and the US.

James, a former secretary of state for health, asserted:

What we haven't done is apart from that one occasion of internal market is try to emulate your system such as it is. I don't think we have bothered anything on government-type approaches from you, that I can think of.

So, quite a rich interchange, but given that our systems are the opposite of each other, you know. Ours is about fairness and social solidarity. Yours is about everyone looking after themselves and competition.

In your country, there's a risk of people who've got the money of over-treatment. In our country, there's a risk of under-treatment. So there's an equal and opposite. So very often politicians have used the American system to try and scare voters, you know, 'devil-take-the hindmost' sort of stuff. So, it has been that way round.

According to Harold, an NHS senior manager at the meso or trust level described England's approach to transferring US innovations as searching for 'bits':

There's always something you can learn [from the US]. The cautionary note is it's not generic and transferable. There are real differences between the way that the American healthcare system works and the British healthcare system works. As a consequence, England's approach is generally to find the component parts, ie, the specific programmes, methods, or interventions, or the 'bits,' that are both attractive and offer potential for successful transfer to solve a problem or make an improvement.

Joel, another NHS senior manager, summarised his assessment succinctly:

So, I think we dabble with little bits of systems. But I don't think you can point to something that similar at the national level.

Trust level senior manager, George, described how bits might transition to national level policy:

What I don't think there has been in the UK is a systematic attempt to recreate that policy at a global level but more to say this bit works that bit works how do we fuse them

together into changing policy at this level and then how do we mix that with the wider determinants of health that aren't evident in the US model that we've cherry-picked.

Again, 'bits' like DRGs/HRGs and others are explored under Theme 6.3: Specific tools/Techniques.

Leo, a senior NHS trust level manager, expressed that policy transfer at the national level or Department of Health and Social Care (DHSC) was more conceptual, and insightfully parsed the diversity of care systems under the US umbrella, but all very different in structure, financing, and patient populations:

I think, for me, the headlines of the policy transfer at the super strategic level so up to the DoH has been more conceptual. So, I think there are people within the department probably over the last 20 years who've witnessed elements of the US system recognising there's multiple US systems because there are different mechanisms in the insurance sector, the Veterans sector, global health, ER, etc. concepts. So, when we say we transferred from the American 'health system' I think we've cherry-picked bits from lots of different US models, and different companies that we've worked with. So, I don't think it's as simple as saying it's a straight policy transfer. I think that's coming to UK design at a very high level strategic concept.

The researcher would argue that whether 'bits' were picked from a series of different US models or only one the fact is that the UK transferred a policy or programme, in fact, a straight policy transfer did occur.

Leo opined on how he perceived the process works in actual practice, ie, from the 'bottom up.' In that connection, he actually posited the adage that 'all health care is local' so that piloting and tailoring is required for successful implementation:

What the NHS has then relied on is individual local planning organisations, be they commissioners or providers, actually going seeing what's happening in practice, bringing those ideas back and adapting them, piloting them in local studies, and then extrapolating that back off to a national policy concept. What I don't think there has been in the UK is a systematic attempt to recreate that policy at a global level but more to say this bit works, that bit works, how do we fuse them together into changing policy

at this level, and then how do we mix that with the wider determinants of health that aren't evident in the US model. That we've cherry-picked from other parts of the world.

Indeed, changing national policy has not occurred since the early genesis of policy transfer from the US. It has long been about acquiring 'bits.'

Further, Leo described how it is possible for 'pilots' to lead to broader development and diffusion of policy/programme:

What's happening in practice is bringing those ideas back and adapting them, piloting them in local studies and then extrapolating that back off to a national policy concept and a lot of UK policy and reorganisation has actually been a national attempt to mainstream something that's come from quite small scale pilots. And a lot of those small scale pilots have been driven I think in the early days predominantly through the Kaiser model, a lot of work with United Healthcare over the years, and we've had a long-term pilot with the VHA [Veterans Health Administration] and I think you can see elements of all those systems in what we're doing.

This was interpreted as implicit policy transfer from the US at the national or strategic level. Of course, it is indeed at the trust/hospital level that problems (in search of a solution) are regularly surfaced, external sources for solution identified, commitments made to investigate and, if ultimately deemed appropriate, resources allocated for pilot testing and implementation of policy transfers. Whether or not such solutions are adopted by NHS central authorities remains an open question.

A former secretary of state for health, Ethan, provided a more expansive view:

I don't believe there's anybody who, of any seriousness, has ever said we should adopt the US health system. There are bits of it.

It is interesting that we're obsessed with the U.S. but we don't, we really don't like your system at all. And I just think that you may be talking to conservatives, I don't know. I don't think you'd get them saying we'd like the U.S. system. It's interesting. To what do we look to the U.S. for? We'll mark the concept of market, obviously. We think the U.S. is the most market-oriented to that. But secondly, I'm sure it was the kind of the DRG system, which underpinned the payment system.

I think this, you could say this how Americans influenced, is that we developed the concept of independent sector treatment centers. And this was basically to give us an alternative source of provision in order to ensure that consultants did not screw us up on our waiting time initiative.

I think, if you wanted to sort of mount a case against the Americanisation of the NHS, I think you probably would say PFI, but I'm not completely convinced.

But translating [US] to the U.K. experience, I think, has always proved to be very difficult, in that sense. I can't, I'm struggling to give an answer on the period of time I was in government. I kind of, I was aware, of course, during that time that people were looking at HMOs. The Holy Grail is half in the U.S., we think that you found a way to control doctors more than we have here.

I guess, whether it's internal market, whether it's what we [Labour] do, whether it's what the Conservatives are doing. At heart, it's try and take our system and get the docs to be more corporate.

Arthur, a senior NHSE public servant, insightfully reflected to incorporate his first-hand experience being embedded in US health care:

The big movements in America, particularly with Obamacare about expanding coverage, that means nothing in the UK context. When I speak to people in England about it, they just don't understand why that's an issue. Nor should they.

At a macro level – federal level in the US – but a policy level, policy is not around the big issues that are the issues of debate in Congress, in the think tanks in Washington because they're just completely different issues. But the bit that I'm going to talk about . . . at the heart of the idea that struck me was in Britain, the quasi-market was a really, really important idea.

Can we get from the U.S. your ideas about how could we make our own system work better? We don't tend to look for, kind of, how is the U.S. system working. But we do because there was certainly a belief in part, of Labour, and certainly of Conservatives, that competition in markets is the best way to motivate. I think that clearly has a U.S. influence. You have so many experiments in the US that the innovation that happens at

a system and organisation level is of profound interest to the UK particularly because there's so many different versions from Medicaid, Veterans, state-oriented systems.

The official went on to describe the difference in approaches to 'population health' in the UK and US, taking the view that, in the broadest sense, this accounts for a lack of interest in US health care at its most strategic level:

There is a model of population health that is based upon actuarial work around insurance, which have some relevance and interest in the UK. There is another version, which is about the public health tradition of raising the health of the population, both the length of life and the quality of life within that. They are really quite different. They have overlap. The overlap space is a great place to be, and that's where we're [UK] going to in that, but they are two different things that happen to overlap. They're not the same thing which have different variants. That's really important.

The official made an interesting comment drawing out more differences that impact a lack of UK interest at the strategic level:

Just because we are the only really nationalised health service, apart from Cuba, we're not interested in what other countries can offer that are about that macro level. That's such a tenet of being British. You can't look at that. You can only ever be interested at levels below so it doesn't really matter that the American system is morally bankrupt and whatever because we're not interested in that. We're never going to go away from our National Health Service. We're interested in how you can amend the National Health Service. We're interested in America because America has so much variety in it. To talk about the US as a health care system is a complete misreading.

Oliver, a senior clinician, academic, and public servant differentiated UK interest in macro level US health care and 'bits' which can be cherry-picked from US policy and practice:

. . . but of course, we're interested in the United States and its ideas, but as I said right at the start when you asked me, I don't think we would copy your healthcare system. In fact, I'm sure we wouldn't copy your healthcare system. But that doesn't mean there aren't lots of useful things to learn from your healthcare system, because you don't actually have a system.

The 'bits' are further discussed under Theme 6.3: Specific Tools/Techniques.

A further comment addressed the (quasi-) market which, at the macro level, in fact found its way from America to England during the Thatcher years:

. . . has the market had a huge impact on the National Health Service? I doubt it. No, I don't think so. And certainly, I don't think there's been any wish to copy the United States' system, because the whole of Europe's based on some form of insurance. I have a slide which I show in America with some care. It says "life, liberty, healthcare and the pursuit of happiness."

Oliver cited an anecdote from an American colleague which put a fine point on the fundamental incongruence of US and British health care:

A friend of mine who runs a very large academic science center [in US] said to me "you do fairness, and we do freedom." And I think that is true ... we do fairness, and it is absolutely at the core of the British National Health Service. It's one of the cardinal values of this country which came out of the Second World War and the early part of the 20th century. It's almost the state of a religion now, and it trumps absolutely everything else.

With no connection to James, former secretary of state for health, Oliver's anecdote and commentary directly corresponds with James' comments above.

An NHSE public servant, Harry, described an interesting dichotomy of views of the US at a national level:

I think there is also a glitz and a glamour about the US health system which is a little bit almost unspoken. And actually, this cuts both ways. There's, on the one hand, a glitz and glamour, on the other a fear of the US health system. And that, I suppose, is something to do with a wider set of cultural, possibly political, assumptions made about the US. There are a certain group of people for whom anything at all from the US, must be from an urge to privatise, and to lose some of the core principles of the NHS, of equity. Yeah, it's a challenge to core values.

Grace, presently in a think tank but formerly an academic, and public servant as well, posited:

The predominant view, I think, amongst policy stakeholders in the UK is that the US system as a whole has profound flaws, that it doesn't provide universal coverage, it's got

significant economic spend, so it spends a very large amount of money to deliver relatively poor outcomes and doesn't achieve what would be an absolutely core and foundational goal for health policy in the UK of protection from catastrophic costs and an attempt to narrow inequalities.

So, systemically it's not looked to but despite that, I think it's clear that in aspects for service innovation parts of the US system are hugely admired. And so, obviously in present work on the foundation of the internal market is the thing that I think people would want to.

So, there is this polarity between, in one sense, huge respect for the academic and policy work that comes out of the US, the very thoughtful people who do that and that have been very influential in thinking and some of the paradigms. There is also an immense amount of 'antibody' to anything that is pushing the UK system to become like the US system.

Because I think we've fallen out of love with creating markets and competition, and we're moving decisively away from that in our policy. And so, the US provides little guide to non-market alternatives. And so, we're probably more interested now in... Well, if we don't have the market which we decided we definitely don't want, well, who is good at the alternatives? What is the alternative?

So, we're less and less, I think, in the market for the whole system, and more and more, I think, pick and mix where we're trying to say, "Okay, who's good in workforce? Who's good on transfer? Who's good on this? Who's good on social care?" Bricolage, indeed . So, we're probably a bit more into speed dating rather than the long-term monogamous relationship on health policy. I do think the fact that we spent 30 years trying to work out how to mimic the market, and competition.

Yes. I think it's fair to say that the consensus has been that they recognize the dichotomy, that they recognize the superior healthcare in the US at the individual patient level. But as far as the system itself And I even hesitate to call it a system because it's not a system. It's a system here [UK], not a system there. But anyway, for convenience sake, I'll use that and say, here there's revulsion to that. And when you talk about policy transfer, people are always very suspect of US because they don't want

anything to be a Trojan horse to introduce more privatisation, more market ... market is always below the surface concerns.

This last comment seems to substantially correspond with Harry's earlier statements describing a dichotomy of feelings about the US from "glitz and glamour" to fear of the motive to privatise. Grace went on to describe dichotomy at a different level:

And when you talk about policy terms, I think I would go to a very sharp distinction between macro policy and micro policy. And I think our macro policies have no [US] influence upon them whatsoever. You've got to look at the influence in micro policy. Yeah. And transfer tools.

A New Labour politician, Charlotte, opined on equating the US with the proverbial 'Trojan horse' for the purpose of introducing system-level privatisation in the UK:

Absolutely. And the fear, I think, which is revived at the moment with sustainability and transformation partnerships (STPs), is that you would have commissioners who would end up turning the NHS into simply a glorified insurance scheme. And they would then buy all the healthcare from the private sector.

Daniel, a clinician and academic, commented on questions continuing over the years about how to change the funding mechanism for the NHS, and how the US model (insurance) was never considered:

So, whilst I think the US has been really important, it isn't the only place for a number of reasons. Partly, whilst some politicians are not very enthused by what's going on in the US. There's quite a deep skepticism on the ground amongst clinicians, in particular. Mostly because of our difference in culture. We are very proud of the NHS, for all its flaws, and the perception is certainly depending on what administration is in power in the US, but the perception is the US doesn't 'get it' or understand it.

I think particularly of when they've [politicians] scratched their heads and thought, "There must be a better way of funding our system than what we're doing." Because the NHS exceeded its budget by 100% in the first two years and then by 1950, they were already panicking about the money. So, there have been repeated attempts to think, "There must be a better way of funding this," but, on the whole, have said there isn't.

But they have not looked to the US, so I don't think we've seen a US model as one to follow funding-wise, but in all other respects I think it has.

A clinician and academic, Henry, commented on seeking national or system level reform ideas from other than the US:

So, I think the US has been really important. It isn't the only place, for a number of reasons. Partly, whilst some politicians are not very enthused by what's going on in the US. There's quite a deep skepticism on the ground amongst clinicians, in particular. Mostly because of our difference in culture. We are very proud of the NHS, for all its flaws, and the perception is certainly, depending what administration is in power in the US, but the perception is the US doesn't get it or understand it.

And therefore, frontline clinicians, particularly in my discipline of primary practice, it tends to operate in a left of center place because we operate close to the people. We tend to be a little bit skeptical. And therefore, policymakers' enthusiasm is likely to be tempered by the criticisms that they get from others. For that reason, over the years policymakers have tended to look at other examples. Not just English speaking ones. There's a lot of really good stuff going on in Spain, to a certain extent in Germany, quite a lot in Israel in my field in primary care at the moment.

Where we've looked at and learned from the models, and probably found the models a bit more aligned to what we're trying to achieve in some of the models come from more collectivist positions ... more centrally organized, financed, managed systems.

And from cultures that are less technologically oriented. The big thing about the US is their love of and admiration for technology. And I can't call it a cultural trait because, of course, we're all about progression in some areas, but we have more of a skepticism of technology.

A majority of people practicing in the UK health care domain are wary, which is to say, sometimes hostile, regarding the notion of privatisation of the NHS via a US 'Trojan horse,' potentially introduced by a policy or programme transfer. A health services academic and former public servant, William, cited an example of this circumstance:

One academic in particular is notable for, from a decade or more ago, saying that this [infusion of US ideas] was a Trojan horse, this was about privatizing the NHS, this was about breaking the NHS up into a series of businesses, that could then be taken over by organisations with a full profit motive that would be drawing on the big systems from the US, and has been deeply skeptical right from the very start about where this process was going. I think not all academics have bought into that view, but I think this one was emblematic of a particular strand of thinking, shall we say.

How much buy-in of UK policy stakeholders for US solutions is a contingency for individual stakeholders and dependent on their roles, particularly with respect to underlying philosophy. One might say this view corresponds with Miles' Law, "where you stand depends on where you sit."

William amplified his earlier comment with the following:

Many academics I think would pay a lot of attention to context, and would say the kind of policy options and the policy solutions that are applicable are very contextually contingent. That what works is not something that's an invariant that can be moved and transplanted, but what works is very heavily situated, and dependent upon the surrounding context, and so the simple transfer of policy ideas is a dangerous strategy, and so I think many academics of my acquaintance would be skeptical of policy transfer like that.

John, opined on the common sense notion of transferring learning and ideas that work well in the US, and making them work in England:

I think it's important to measure value. I mean, how else do you decide what you can pay for and what you can't? So outcomes for pounds spent is my currency value. Outcomes for pounds spent. But the notion that there's a market that you then choose from that, I just don't think it's functional market. Even the private healthcare system... I'm a nonexecutive on something called the Private Health Information Network, which has been set up at a nonprofit organization through the Competition and Markets Authority to provide the consumer with the information they need to operate in the market, because how can you buy if you don't know the value of what you're buying?

So, we are now requiring the private healthcare industry in this country to publish outcome figures by doctor, for how many operations they do, what are their outcomes, what are their cross-infection rates, what are their functional outcomes? So, customers can make choices. We're a long way away from having a mature and sensible market. I suspect even the United States, from what I hear but I also I don't know much about that, I don't think it's been an important part of what we do at all, other than to the extent it's made us ask the question, "are we functioning as efficiently as we could?"

So, it is now a more managed system, and I think it's a fairly efficient system. People question that, but has the market had a huge impact on the National Health Service? I doubt it. No, I don't think so. And certainly, I don't think there's been any wish to copy the United States' system, because the whole of Europe's based on some form of insurance. Because I've worked in America, I'm a member of the National Academy of Medicine. I have some very good friends there. So, I've always been aware of what's going on in America. And I'm a huge Americanophile. I love the notion that, if you see somebody doing something well in America, you want to find out how did she do that, and how do I do it? Whereas there's a tendency sometimes in our country to discount and say, "Oh, it's bound to go wrong. We're not going to try that." So, I think that's nonsense.

The England-US connection has not escaped academic debate in prominent or peer-reviewed health care journals. Feachem et al. (2002) ignited a debate with Chris Ham et al. (2003) on which was the better performer – Kaiser Permanente in California or the NHS – on cost and performance. Kaiser, as it is commonly known, is a not-for-profit, health maintenance organisation (HMO), a version of managed care, with an integrated health plan (insurance), hospitals, and independent physician group practices. There was a sharp rise in debate participants after its publication including, for example, Allyson Pollock (2002), who claimed Feachem et al. used a flawed methodology (BMJ, 2002), and Himmelstein and Woolhandler (2004) asserted that Kaiser's actual costs were understated (BMJ, 2004). Following a peak in the debate, the article was extant as background for US-England discussions for much longer, particularly involving competition and market forces. It is fair to say this article was influential and helped established the contours of the debate on the US-England connection for years to come.

As Kaiser, a managed care organization, was highlighted by Feachem as a model of successful integrated, cost-effective care, one might extend across time a possible influence on UK health

planners leading to the policy transfer of Accountable Care Organisations (ACOs) from the US to England albeit renamed as Integrated Care Systems (ICSs). (Gleave, 2009)

At the time of the study, Kaiser had 6.1 million enrollees in California; however, Kaiser in total had another 2.1 million enrollees in Colorado, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington, and the District of Columbia. The California model was used for comparison in the study because it most closely corresponded with the NHS. (Feachem et al, 2002) In response to publication of the study, a flurry of 75 letters were received by BMJ, and a constructive if spirited debate had begun, according to BMJ. (BMJ, 2002) Seven of these were published and the rest summarized. (BMJ, 2002)

Forty six letters comprehensively dismantled the authors' analysis; the message implicit in many of these letters is that the authors and commentators had let their ideology cloud their judgment. Twenty seven supported the paper, offering the explanation that Kaiser's superiority was due to having more of everything: more beds, more doctors, more nurses, and better information technology. (BMJ, 2002)

In essence, the study compared the two systems with a focus on per capita costs and performance. Adjustments were made for "differences in benefits, special activities, population characteristics, and the cost environment." (Feachem et al, 2002) The study claimed that per capita costs were comparable within 10 percent. Of particular note, in Kaiser, rates of use of acute hospital services, adjusted for age, were one-third of the NHS. Of course, acute hospital services are where the largest cost centres are located compared to, say, surgeries (clinics).

The study concluded that the "widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment" (Feachem et al, 2002) were not substantiated by the study. Rather, Kaiser performed better at "roughly the same cost as the NHS." (Feachem et al, 2002) This goal was achieved on the front end by "prompt and appropriate diagnosis and treatment," (Feachem, 2002) by integration throughout a large system that benefits from a competitive environment, greater investment in IT, and, yes, more efficient management of hospital utilisation (acute bed days) – the largest cost centre. Prompt and appropriate diagnosis and treatment. (Feachem, 2002)

In September 2003, Chris Ham et al., then director of the strategy unit at Department of Health (DoH) published a paper in BMJ, which compared bed utilisation management in NHS hospitals with Kaiser. (Ham et al, 2003) This study covered two years of NHS inpatient admissions for 11

leading causes of acute bed admissions, lengths of stay, and bed days for patients over 65 years of age.

For the 11 causes selected for the study, total bed day use in the NHS is three and a half times that of Kaiser's standardised rate, almost twice that of the Medicare California standardised rate, and over 50% higher than the standardised rate in Medicare in the United States. Kaiser achieves these results through a combination of low admission rates and short lengths of stay in hospital. By contrast, Medicare has high admission rates and relatively short stays. The NHS has long stays and admission rates that tend to come between those of Medicare and Kaiser. (Ham et al, 2003)

Importantly, Ham et al. concluded that "The overall differences between the NHS and Kaiser for these 11 healthcare resource groups are consistent with the findings of Feachem et al for overall differences in bed day use than differences in admission rates." (Ham et al, 2003) The authors found that there is a so-called "California effect" in the way acute beds are utilised. This is likely explained by the fact that Kaiser is not only a major provider of health services but the insurer for its enrollees and, hence, contributes to significantly lower bed utilisation in Medicare in California than Medicare in the US. Ham asserts there is, therefore, a "Kaiser effect" as well. While largely confirming the Feachem findings, Ham's amplification came with an emphasis on length of stay, which is more assiduously managed by Kaiser and Medicare, as noted above. (Ham et al, 2003; Sklar, 2004)

Donald Berwick, widely-respected and heavily consulted in the UK, as head of the Institute for Healthcare Improvement (IHI) in Boston, asserted that "hospitals should regard an unneeded day of a hospital stay as a defect." (Ham et al, 2003) In accord with both the Berwick dictum and the Feachem findings, the Ham study concluded there is scope in the NHS for changing the methods of acute bed utilization.

Specifically, the NHS can learn from Kaiser's approach by developing closer integration between primary and secondary care, making use of intermediate care, focusing on chronic diseases and their effective management, and giving priority to self care and use of patients and families as co-providers. The NHS can also learn from Kaiser's experience of engaging doctors in developing and supporting an integrated model of care. (Ham et al, 2003)

There were voices and strong reactions on both sides of the questions. Many argued that the comparison was fatally flawed, ie, apples and oranges. Others attributed Kaiser's success, in

large part, to being a 'value driven organization,' and also to both doctors' and patients' commitment to a philosophy of egalitarianism, perhaps offering less choice but greater equity in services. (Abbasi, 2003)

The comparative costs of care in the NHS and Kaiser, and differences in population characteristics between the two studies lingered as a matter of debate.

In June, 2002, a paper published in BMJ by US professors Himmelstein and Himmelstein, argued that price adjustments used in the Feachem study falsified the comparison.

Feachem et al's price adjustment inflates NHS costs by 52%, assuming that the NHS plays no part in constraining drug prices, administrators' or specialists' incomes, etc. Conversely, the adjustment excuses the US system from responsibility for the world's highest drug costs and the billions wasted on healthcare executive and other hangers on. Feachem et al adjust away the price controls that are an important advantage of non-market systems. (Himmelstein & Himmelstein, 2003)

According to the authors, Feachem et al subtracted profits and excessive administrative costs from Kaiser, both integral to the competitive market environment in which it thrives. There is a coverage mismatch as Kaiser's coverage of nursing home care is negligible. Finally, the authors assert that Feachem overlooks more than 12% of Kaiser patients who receive care outside of Kaiser. Hence, Feachem et al. understated Kaiser's actual costs, according to the authors. (Himmelstein & Himmelstein, 2003)

'Not-for-profit' entities in the US are so designated by the Internal Revenue Service (IRS), the ultimate taxing authority, and thus obtain the valuable exemption from taxes on revenues. However, it is sometimes misunderstood this does not actually mean that no 'profit' is produced from an organisation's operations. Indeed, it is essential to do so in the US competitive environment. However, 'profit,' from a not-for-profit entity, is necessarily classified by another name on operating and income statements as 'excess of revenue over expenses.' True, payouts from these profits by another name are not made to shareholders but rather in theory reinvested in the organisation for benefits which inure to the community or society. Also, there is no prohibition on not-for-profits establishing separate, for-profit entities under their organizational umbrellas to generate additional revenues, which contribute to sustainment while paying taxes.

Interviewing elites is a specialised art, and interviewing politicians is a specialised subset. Typically, there are questions regarding issues which will be avoided, hedged, or only partially answered. Sometimes this may be the result of past legislative problems. The interviewer must be agile enough to remember, during the pressure of an ongoing interview with a powerful person, to remember which questions need to be rephrased or reframed or, if it is necessary to 'elicit' answers, ie, obtain answers without directly asking the question. Public servants tend to be less guarded and more straightforward with their answers.

5.3.3 Summation

Participants were unanimous in refuting or discrediting any implication that the UK had any interest in the underlying philosophy, organisation, or financing of US health care. In fact, a few 'recoiled' (a behavioral observation) when at first they misunderstood the researcher's question, thinking he merely implied UK interest in US macro- or strategic-level health care policy, until clarified. However, one outlier perceived central government or NHS authorities importing ideas, structures, programmes, techniques, and policies mostly from the US (and limited others) as the foundations for privatisation of the health service over time, and underlying neo-liberal, privatising trends which the participant explained was prevalent across UK government. Broadly, participants perceived policy transfer as a bottom-up enterprise, not originated or implemented at the macro or national level, with few exceptions.

Of paramount significance, however, was consensus recognition that the US is nevertheless far and away the leading source of policy and programme ideas albeit not at the macro, strategic, or national level. In this connection, both the significant roles of think tanks and consultancies, and cherry-picking 'bits' emerged to require further explication (see Theme 6.1, Framers & Brokers; and Theme 6.3, Specific Tools & Techniques).

CHAPTER 6 FINDINGS II

6.1 Theme: Framers and brokers

6.1.1 Sub-themes: think tanks, management consultancies, networks/personal relationships, fellowships.

6.1.2 Relevant research question: do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?

Sylvia, the senior academic and clinician heard from earlier, asserted:

I do know that the government uses big management consultancies like McKinsey's, and there must be policy transfer happening through these international consultants, which also peak McKinsey's and Price Waterhouse Cooper, which have a privatising mission and privatisation agenda because it also brings more money and more work for them.

She drew a comparison of academics with think tanks (epistemic communities) as important purveyors:

Academics are quite important for bringing ideas over, because we travel the globe. And pick up ideas and write about them.

Academics play an important role. So, if you look at ACOs, who would have introduced ACOs in the first place? Quite likely Chris Ham from The King's Fund. He certainly pushed integrated care long before our policy makers got it, and then the policy makers got it. And then ACOs became a way of implementing it.

Joel, a senior NHS manager in a Trust opined on study trips to the US arranged by a single coordinator who worked for him, noting a visit to a prominent US consulting firm:

I reckon she does 4-5 trips a year of 10 or so people. So over 500 people over all the years for programmes such as a smoking cessation programme ... certainly not directed from above ... we will set up a partnership, people building up relationships and running tours ... very intensive programs ... barely a minute free... to Boston, Louisville... another to Minnesota... went to very impressive organisations like Boston Consulting Group ... they did feel like quite glossy trips really.

Isaac, a senior academic and former political adviser, mentioned 'fellowships' as an important adjunct to establishment of US primacy in health policy:

There are, of course, a number of institutional links as well. I've been talking more about sort of more informal but you're right there are things like the Harkness Fellowship, of course. There used to be a system, a reverse system [US fellows to UK], I think it was called the Atlantic Fellows, but that stopped for some reason. And many Harkness Fellows have been very active in that [networking to propagate ideas] as well.

This is a good point to draw attention to, the fact that some of this policy transfer is actively promoted and facilitated by organisations like the Health Foundation and then the King's Fund, and the Nuffield Trust, and those, they act as brokers for some of these ideas.

Transatlantic dialogues are in a 'continuous loop' among knowledge brokers and their professional colleagues and contacts. Answers to vexing questions are sought by all sides and, at some point, an idea may emerge that is actually followed-up for transfer of a policy or programme solution in a particular context.

I do agree with that, and the Commonwealth Fund of New York has clearly been a very active. A catalyst for that kind of transfer, and has tended to see it as a good thing, the transfer of policies and policy ideas in different directions.

Theodore offered a different dimension, which spoke to the bi-directional nature of idea exchange.

. . . so regularly one hears of visitors to the King's Fund in London who are from the Mayo Clinic, who are from Geisinger, who are from Group Health, who are from Intermountain. Not just Kaiser anymore, but there is a regular flow of individuals, primarily to the King's Fund in London but not just there, who are purveyors - and I don't say that pejoratively - but they carry the baggage of U.S. health policy and ideas into the U.K., disseminate that through visits, through talks, through joint papers with the King's Fund.

This was a minority view in that few other comments were recorded indicating awareness of significant 'traffic' from the US to the UK.

The King's Fund is also instrumental going the other way, in terms of study tours, site visits, and others. If you add in, perhaps in a smaller way, the Harkness Fellowships, Chris Ham's work probably since the 2000s and ongoing, I think there's been a whole raft of activities which has tended to privilege the US health policy. That's fine in terms of supply and demand I think, but the question I always like asking from a public policy point of view is the 'dog that didn't bark in the night.' Why is it that there are similar systems that might be better, comparators to us, that we don't go looking for?

This was certainly the majority viewpoint – lots of traffic to the US.

Theodore added that a question was asked in a meeting with the Commonwealth Fund of New York:

What ideas have you taken [from UK]? There was a scratching of chins and puzzled looks. Gate-keeping was one of the ideas, and this was particularly from the 1980s and 1990s. Managed care, gate-keeping, but not in a way that would equate really to our GP service. To some extent that's 'by-the-by,' that's gone. That was a decade or so ago.

John weighed in:

But my suspicion would be that more of it goes to looking at the United States. You have study tours that have gone to the US from the King's Fund. Yes. The Nuffield likewise. Health Foundation likewise. But they also go to Europe, and they go to other places. But

I think probably more are going to the United States. It's a big place, and as I say, we have a common heritage and a common language.

So, I think there are lessons to be learned both ways, and I think it's a very productive conversation, but I would say but there are also lessons to be learned from looking across the rest of the world. Look at Australia, look at Canada, look at France.

Look at New Zealand. Look at, as I say, the best healthcare system, the Netherlands, in Europe. And see what you can learn from them, and see what you can transfer and what you can't transfer.

Charles, compared US entrepreneurship to that of other countries:

The US, partly because of its many entrepreneurial healthcare groups, spends quite a lot of money promoting their services in the NHS. So, a number of leading hospitals and leading advisory firms are entering the market in the NHS, mainly selling services to NHS commissioners and providers. And that isn't so much the case with the Swedish, or the Dutch, or other European healthcare systems. There's some elements of that, but the marketing, for want of a better word, of the US health system in the UK to the NHS audience, is, I think, greater than many other countries.

So, organisations like King's Fund, for example, will be very explicit about one of their roles being to share international good practice of what's going on. And they have one or two health systems a year that they work with, where they really build a relationship with that system. So, it's been at Christchurch or Wellington in New Zealand, they had it with Kaiser in the US.

Florence, a senior think tank official, opined on the value-added to policy learning by fellowship opportunities:

And so, quite interesting here we've put in place a fellowship program for Europe, which is joint with German foundation, and operated by a global conference. So, there's three countries in partnership, UK, Germany and Switzerland. They bring healthcare leaders from those three countries together. Yep, trying to do some of that sort of stuff, because it is networks and exchange of ideas and relationships. That, as you say, then spawns others.

Max, an academic and author, described in detail a unique perspective on framing and a style of analysis influenced by the US at a foundational level, largely promulgated in the discipline of political science.

Think of the big names [in US] – Aaron Wildavsky, etc. British political science was really not so very good, particularly on political theory but also tried to explain public policy and not as well as Americans in the field. So, you got this general intellectual atmosphere. Well, this is, I think, an academic point but it spreads. Don't forget the academics that taught in some extent, the NHS managers and others and politicians as well. If you're PPE [politics, philosophy, economics] at Oxford, you have politics in it again, you were exposed to this. So that's the general point I think for political science more generally. Well, really, this has been before we get to health policy. So, I think that's important.

What I'm getting at is the style of analysis. Whether it was health policy or other things it was strongly influenced by American ideas. One of my great friends and great influences and we've worked together [publishing] is Ted Marmor.

Yes. And we once were talking about who are the intellectual influences on us. And they were the same. And they were predominantly American ones. So, this is long before you start talking about health care policy. It's ways of thinking, I think.

That's one point. I think another point is the sheer attraction of the United States. The excitement of going to talk to these legendary figures. And then you've got the Harkness program. I think that explains an awful lot. I think of Simon Stevens, Jennifer Dixon at Health Foundation.

I think you can't overstate the importance, not of specific things about health policy, but a mindset where you go for intellectual ideas. So, America becomes a kind of intellectual Mecca. Every self-respecting academic wants to spend some time there.

I think it went both ways. Here was American ideas in a general way moving people. So, you had a lot of Americans ... Dave Mechanic, you reminded me there, did some distinguished work on [British] GPs, and so on. And so Enthoven was clearly a key character in all this ... Was part of a long line. Ted Marmor, again, one of his first projects involved the UK.

On the one hand, there's this general permeation of American, not health policy ideas, but ways of thinking. Let me put it that way. With an absolute visceral rejection of the American system. In a way, the American system allows the Britons to be even more proud of their NHS than they would otherwise be. You see what I'm driving at. It's this curious relationship with America.

It is indeed curious that the universal rejection -- certainly among the interviewees in this study - - of the US health care 'non-system' in the UK elevates even greater pride in the NHS. At the same time, the UK to seek 'bits' of excellence from the US for innovation or improvement in the NHS.

So, you actually got a real intellectual dynamic there. And I always think that anybody who understands American health policy and can make sense of it is already an advanced intellectual ... advanced intellectual achievement. When I listen to my American friends explaining what's happening, I think, God, could I cope with that? I probably couldn't, with the intricacies of American health per se. And I think it's precisely the fact that it's such a bloody mess that meeting and impressing lots of people has meant that intellectually, it's a ferment of ideas. And that I think is what impresses people here. It impressed me certainly.

And I think most of my intellectual influences were Americans. Who was there in this country where they're writing much about health policy in the '70s? Practically no one. I had an easier time achieving or getting a reputation because I didn't have any competition.

What I mean getting at is the scale of American problems met by the scale of American intellectual endeavor produce lots of interesting ideas. And I think it's that extra level of how do we solve the problems created by our system? That's what I would stress. But I think that's also what actually I think impressed people of the Harkness and otherwise, the sheer intellectual energy in the States, and ingenuity. And I think that's a great influence.

In the early 1980s, a collection of countries including the United States, Canada, New Zealand, and England elected to pursue an "ideology of market-managerialism" seeking to get more to

“get more from less” in public services. (Kitchener, 2022; Ferlie, 2005) This is the core of new public management (NPM), also linked to Osborne and Gaebler’s “re-inventing government.” (Osbourne & Gabler, 1992) Kitchener explored the rise of ‘market-managerialism,’ the core of New Public Management, through the lens of a failed US academic health centre merger. (Kitchener, 2002)

Fundamentally, Kitchener exploits “attempts to re-order the bases of legitimacy in fields of professional organizations,” to establish a model of the “antecedents, processes, and implication of this phenomenon,” using findings of a study of US academic health centre (AHC) mergers to illustrate each of its elements. (Kitchener, 2002)

This political agenda is pursued through loosely linked ‘new public management’ doctrines (Ferlie et al, 1996) that include contracting welfare states, a reliance on market forces, and the introduction into professional fields, of managerial innovations such as merger (Osbourne and Gaebler, 1992)

In the 1970s and 1980s, in both the US and England, there were social and political transformations occurring which established an ideological hegemony based on two main doctrines:

(1) the resurgent ideology of the market that proclaims that competition and efficiency are the major criteria that justify state expenditures, and (2) the ideologies of individualism, neoconservatism, and self-help that justify reductions in or the elimination of state expenditures altogether. (Estes and Alford, 1990)

In the US, this ideological perspective emerged in the context of health care costs seemingly out of control, an insurance company revolt, rising consumer dissatisfaction, and a political construction of fiscal crisis. US reformers proffered two main solutions:

First, health care was redefined from a ‘social good’ to an ‘economic good’ that required coordination through market disciplines. (Shortell, et al, 1985) Second, there were renewed calls for healthcare organisations to adopt ‘business-like’ structures and managerial practices. (Fennel and Alexander, 1987; Arndt and Bigelow, 2000; Kitchener, 2002))

The mobilization of these policies involved clear attempts to replace the prevailing professional logic and bases of legitimacy with a countervailing package of marketmanagerialism. (Kitchener, 2002)

A similar argument was made by Currie et al. in 2016, among others. (Currie et al, 2016)

As adoption of these doctrines spread, they acquired “the myth-like attributes of widespread and uncritical adoption that compel further adoption.” (Kitchener, 2002) This continued to compound into the phenomenon of a “merger mania.” (Kitchener, 2002) As of Kitchener’s study, scholars were yet to explore “dysfunctional outcomes,” which became a possibility with the “bandwagon” effect to adopt certain myths. (Staw and Epstein, 2000)

In Kitchener, the focal point case involving the academic medical centres (AMCs) of the University of California, San Francisco and Stanford University “explains why the intended outcomes of this innovation (merger) rarely emerge when it is ‘sedimented’ (Cooper et al, 1996) uncritically upon the enduring logic and structures of professionalism.” AHCs continue to exhibit the logic and structures of professionalism, while serving as an excellent exemplar of implications for changing the bases of legitimacy. (Kitchener, 2002)

In the UCSF/Stanford case, a critical examination of issues involving merger implementation would have surfaced research of problems associated with “(a) mergers in the business world, and (b) other attempts to sediment the myths of market-managerialism upon the enduring structures of countervailing professional logic,” (Kitchener, 2002), which hobbles attempts to integrate units effectively after mergers. (Friedson, 1970) This study was primarily concerned with the dominant professional group (AHC affiliated physicians) and their resistance to one managerial innovation/myth (merger). (Kitchener, 2002)

The Kitchener model may have applicability for AHC mergers in other western countries, and likely served to inform England. The boundaries of transferability are indicated by studies of ‘successful’ change initiatives in other fields. (Kitchener, 2002) At minimum, there is a cautionary tale for health policy transfer from the US to UK.

Ovseiko et al. acknowledge the rapid pace of AHSC development in the US, far outpacing England. At the same time, they suggest that the US might benefit from exploring the working’s in academic medicine in the universal health system in England. It is noted that Flexner studied medical education in England for insights to guide medical education reform in North America. (Ovseiko et al, 2010)

In a policy transfer of sorts, the authors compare and contrast organizational models adopted in two of the new AHSCs, with analysis using a framework obtained from US literature. (Ovseiko et al, 2010)

At the end, the paper offers the implication of opportunities for policy transfer. First, the authors advise that in both England and the US there is a trend toward “network” relationships in AHSCs. Second, both sides face financial challenges. The authors conclude with the following suggestion:

Therefore, policy makers in England and North America could benefit from future studies examining how their counterparts on the other side of the Atlantic respond to common challenges, as well as which health systems and policies provide better leverage for the tripartite Flexnerian mission of academic medicine. (Ovseiko et al, 2010)

In a later paper, Ovseiko et al. (2015) follow-up on AHSC mergers and evaluate a post-merger integration environment. Two legacy NHS trusts and a university were examined in the study. Many mergers fail to produce anticipated benefits. A successful post-merger integration is even harder to produce. The key to successful post-merger integration is a keen pre-merger understanding of the cultures of the specific institutions involved, and a near identically shared vision of the future culture of the conjoined organisations, academic and clinical. (Ovseiko et al, 2015)

England’s government have incentivised hospital mergers by creating more financially sustainable Foundation Trusts, NHS reconfiguration, and accelerated innovation. (Ovseiko et al, 2015) Similarly, in the US, the Affordable Care Act unleashed “a merger frenzy, with hospitals scrambling to shore up their market positions, improve operational efficiency, and create organisations capable of managing population health.” (Dafny, 2014) “Therefore, it is likely that in the coming years the trend for hospital mergers and integration will continue on both sides of the Atlantic.

In that spirit, the authors provide an empirical guide to assist academic and clinical leaders identify differences and similarities in culture across both academic and clinical enterprises, and to confront and resolve cultural issues early.

Darcie provided another think tank perspective:

I think my answer is very much a... a [think tank] answer, because I think we are in, again, a unique position in that we literally look at what works and translates, et cetera. So, I've probably got a slightly skewed idea already around assuming that everybody does it. I think already, I guess, there's a lot of people out in the sector that don't look anywhere beyond their own front door really, at the examples of how to do things or not to do things. And so, from the perspective of the [think tank], I think we have in the past looked predominantly to the US for examples of some of the, I guess, ways of dealing with the problems we've got here, or innovations and things like that. I suppose that started, or at least, it started in my awareness with quite a strong focus on what was happening at Kaiser. And I think that's been extended to other places, InterMountain [in Utah], a lot of what's happening elsewhere in California, et cetera. But places that really, I guess, in themselves resemble a closed system like we've got in the NHS.

Yeah, so when I did my Harkness, I mean, the purpose of the Harkness Fellowship is to go the US, pinch ideas, and take them back to your own country. So, the model's set up to find them.

As a specific example of the utility of the fellowship, US views were particularly useful for the transfer and implementation of the ACO [accountable care organisations], later Anglicised as ICS [integrated care system].

And before I went, there's a lot of tongue in cheek comments about, "What could you possibly learn from the US? Why would you want to go there? Their system's a massive, embarrassing failure." And not just from people here, from people in the US as well. I think it was a useful, amazing program. But I did go there specifically to look at what was happening around accountable care organizations (ACOs), how they were developing, and then it was at a time when there's a lot of talk here about integrated care but nothing formal, bringing anything together. I don't think people have really grasped the term or the concept yet. So, and then by the time I got back, it was the big topic.

And this morning in this conference, this is the word, it's all ACOs, ACOs, and I can see it evolving differently in the year that I've been away now. And we have, I think, rose back a little bit on some of the direct, I suppose, reproduction of what's been happening in the US, and trying to make it a bit more UK-focused. But [ACOs] definitely are a very clear

example of something that's been happening in the US, and stealing it, or adapting it to fit the context here, if not in the designs program and definitely in the name.

And I get it, I have that slightly artificial slant in that that's what we [think tank] do, so I see it more than others... I'm not sure if you asked a service manager up in Northumberland, or even a chief exec in Cornwall whether they're familiar with what's happening in Sweden, or even what's happening in the US, I'm not sure that they'd really have a clue. But for us, it's our bread and butter, to learn that, understand it, translate it, and spread it.

Yeah, I think it does go down to simple things like that. It's human nature. Yeah. And everything in the US looks new, and shiny, and more attractive in a simple way. And I think what I found being in the US on the Harkness Fellowship is that you'd go to, oh, what was it, Geisinger or somewhere like that. And you would have very attractive people wearing nice clothes, with slides straight out of their management consultancy, telling you how amazing everything was with lots of graphs going up or down, whichever was the right way.

This point at least begs the question of whether visitors are being provided the whole picture of policies, programmes, or technologies in the US. If not, it certainly raises the specter of making ill-informed decisions.

And one thing we did get to as was part of that programme was going to Canada, and when we went to Canada, we went to a homeless, alcoholic men's shelter in downtown Toronto, and saw how it really is. But we didn't see that in the US, and I don't think we'd get access to really, US life, I think we get these MBA students, these shiny presentations.

I think because the US, in many ways, shouts the loudest. That's not the best approach, but celebrates successes and is easily, you can graft something off the shelf, or from a journal, or people who come here in their suits and tell us things, or... it's easy to get access to, whereas I think the UK and other, probably the UK most, is a bit more modest with success. We don't shout about it.

6.1.3 Summation

Knowledge brokers of multiple kinds are pivotal in the framing and diffusion and, frankly, advocacy, of new ideas and innovation. The digital revolution has increased geometrically the speed of transmission of these activities, particularly in personal relationships and networks, for example, among academics who diffuse knowledge. Think tanks have a mission to make introductions of people, and to introduce and educate them to ideas and learning, with the capability to 'frame' them so as to focus targeting of clients, facilitate understanding, and receptivity. International management consultancies play a similar role. At the individual vice organisational level, fellowships and study tours historically have provided a unique immersion opportunity in the US compared to a 3-5 day seminar or conference either in the US or UK. US stakeholders, particularly management consultancies, apparently expend a greater magnitude of resources virtually incomparable with the UK in order to proselytize and market their intellectual property or hardware.

6.2 THEME: US influence across governments

6.2.1 Sub-themes: common thread, markets, competition

6.2.2 Relevant research question: Were there variations in the extent or degree of influence of US-based ideas over the periods of Thatcher/Major, New Labour, and Health and Social Care Act of 2012?

Participants were asked if they could characterise the extent or degree of US influence across the three reform periods framed in the study. The objective was to determine either significant variations in degree of US influence in different governments or, alternatively, an essential continuity of the thread.

Sylvia, a senior academic and clinician believes there is a common and seamless thread across governments with a singular mission:

No, I see these as arbitrary periods. What you've done is used administrative change in political parties, but there's been actually no distinction. We've had incrementally evolutionary change. And the Health and Social Care Act of 2012 wouldn't have been possible without the Thatcher changes and then the New Labour ones. But it's all been

incremental towards marketisation, underpinned by an ideological belief in markets, and that the public sector isn't useful. So, I don't see any, any variation. I just see it being a seamless transition. Seamless. From one to the other, punctuated by different administrations.

John commented questioned the virtue even workability of a sea change to competition:

As I say, I think dissecting off that bit of it, which is the occasional intervention in the otherwise healthy, to the extent the market enables us to think of healthcare like that, that was positive, and dealt with waiting lists in a way which is hugely effective and shouldn't be discounted. But I don't think the internal market in that sense, not least because we never got to the point where people were being paid in the same currency, because some hospitals cost more than others, and some populations seem to get more than others. So, we never actually managed to bottle it out in that sort of way.

Roger, a former secretary of state for health, opined:

That the Blair-Brown governments were obsessed with the U.S. is absolutely true. And that people, over the 30+ years [study framing period], they were in office and did go over to the U.S. a lot, yes. No doubt about that. As you can see, I'm struggling on the issue of the Labour government. I think my, I think techniques, yes, ideas, but I don't think philosophy. I don't think we were interested in that.”

Moving to the time period of the Health and Social Care Act of 2012, he posited that:

I, most of us are still puzzled by what it was all about. He has argued that we should not have been surprised he did what he did, because he'd been talking about it for years in opposition. But it was a surprise. And on the face of it, you know they inherited the NHS in a good condition. We had got waiting times down, and a big investment in the infrastructure. So why did he want to pull it up, pull the whole thing up by its roots? No one, I think, really knows. Lansley's wife's a GP in Cambridgeshire. And I imagine that he had thought a lot about Cambridgeshire, how it would work, and obviously HMOs to an extent, must have, he must have looked at HMOs [in US]. Because you could argue, couldn't you, that bringing GPs together into clinical commissioning groups, giving them the budget, the kind of discipline that HMOs exert in the system, you could envisage that, basically, that's what CCGs were there to do.

He (Lansley) must have looked to the HMO system [in the US] because, what came up was a bit different. Partly because HMOs are kind of independent bodies, aren't they, where CCGs are not. Therefore, the moment they came in, they found themselves being told what to do by the system, and secondly, they had no capacity. They didn't have enough good people to help the GPs make the right decisions. Very limited in the skills that they had. Then, third, it rests again on his absurd view that hospitals should compete with each other. In a situation where the clientele of those hospitals are mainly frail, older people. Why on earth would they want to go or be taken for care away from where they lived? You put the whole thing together and it was chaotic, it was expensive, chaotic.

In Roger's view then, patient choice coupled with competition among hospitals was not the ideal combination or panacea it was thought to be. As he notes, elderly patients (likely among others), were not favorably disposed to leaving their home area and to travel to a more distant hospital.

In just the U.S., I certainly think HMOs are based on the belief that competition is the best way to motivate people. I think those two things are still very strong in the Lansley model.

6.2.3 Summation

Participants were in consensus that they saw a continuous process, ie, a common thread present across the three reform periods framed by the study. Notwithstanding this perception, there was not consensus acceptance of the virtue or workability of that constant. It appeared that the original insertion of the US concepts of competition and market function during the Thatcher government was seen to have continued to this day, albeit with variations over successive governments, ie, differences in policy or programme emphasis. It was generally agreed that the Health and Social Care Act of 2012, with Lansley as architect, was intended to cement market principles modeled on the US.

6.3 THEME: Seeking selective tools and techniques

6.3.1 Sub-themes: public reporting, patient safety/quality management, clinical leadership, ACOs/ICSSs, pay for performance, care models

: Do contemporary English health policy. stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?

With the comment below, the researcher explained that, for the purpose of exploring this topic, policy was conflated with programme, so that policy is quite broadly defined so as to encompass as much England interaction with and hence influence of the US. This statement again confirms two salient points: 1) lack of England's interest in US ideas at the macro level, and 2) England's interest at selective tools and techniques.

Joel, a trust level senior manager, expressed this view as follows:

I suppose it depends for me on how broadly you define policy, as opposed to practice and individual initiatives. And I'm not sure that I've seen health policy in its broadest sense transferable but there will be component parts and perceptions of the systems that people might desire to duplicate.

As mentioned earlier, English health policy stakeholders have consistently kept to a narrative of interest in 'bits' from the US, ie, specific, targeted solutions, improvements, or innovations in delivery of health services. On this note, unanimity was found among participants in the interviews, as reflected in participant commentary below.

The observation was also made that participants were 'parsing' their responses to the effect that the US was a privileged source of health policy and programmes but not at the strategic, macro level of the NHS. Simply put, those same participants saw US influence in the UK adoption of 'bits,' ie, specific tools and techniques to solve a problem or provide an enhancement.

Peter, a former chief executive of the NHS was straightforward in his assessment:

Certainly, the USA is a rich source of health and medical innovation. And if a new neurosurgery technique works well in Houston it will work well in Manchester. I see no reason why we shouldn't reach out to the US to bring such innovations to England.

Thomas, a senior clinician, academic and former public servant summarised findings in this regard rather succinctly and well:

I think that there are a lot of ideas that go backwards and forwards, but to a very large extent, I think on this side of the Atlantic, we look at specific examples of good things in America, and we also recognise the things which are not as good and which we wouldn't want to copy.

John, a senior clinician, academic, public servant, and think tank leader contributed:

. . . but of course, we're interested in the United States and its ideas, but as I said right at the start when you asked me, I don't think we would copy your healthcare system. In fact, I'm sure we wouldn't copy your healthcare system. But that doesn't mean there aren't lots of useful things to learn from your healthcare system, because you don't actually have a system.

The DRGs came from there, and so the notion was, right, you can cost an episode of care and you can create a market, and we actually introduce more capacity into the market, which they did with independent sector treatment centers. But in fact, the very act of introducing them created the market competition. The NHS began to compete. And the private sector said, "Well, we'll do that," because it's a common price. Waiting lists disappeared to a large extent. So, we thought, well that's really good, and it was good. But then of course it doesn't work for people with chronic, complicated illnesses, and you can't apply the market to that.

He opined that, while the US is not a system but 'cylinders of excellence,' "What you [America] do have is some wonderful bits of it."

The views of two former secretaries of state for health were forthright and instructive:

James said:

What we haven't done is -- apart from that one occasion of internal market -- is try to emulate your system such as it is. I don't think we have bothered anything on government-type approaches from you, that I can think of.

Edward opined:

I don't believe there's anybody who, of any seriousness, who has ever said we should adopt the US health system. There are bits of it. People are still fascinated by the Veterans. Because it's kind of public service, large one, which is run by one organization. So inevitably, we think there must be some things in the way the Veterans run it. And we have a good opinion of the Veterans' services. And people have come over to tell us about it. But the other thing is, people are obsessed by HMOs. I'm not quite sure what the evidence is, but in theory, you can take an HMO, you can take a GP, and you can give them a budget, and you think you're all talking about the same thing.

Regarding another US health service in a single, large organisation and operating a large US HMO, Emily, a nursing leader opined:

God knows how many people have been over there (Kaiser) from here. How much money we spent. And I don't know what Kaiser thinks of it all. I do think they come to a view that, well, they all come over, but they [UK] never bloody won't do it (laughs). It is interesting that we're obsessed with the U.S. but we don't, we really don't like your system at all. And I just think that you may be talking to conservatives, I don't know. I don't think you'd get them saying we'd like the U.S. system. It's interesting. But they're going to Kaiser and others, perhaps they're taking the bits. They're just getting bits and implementing the bits all at the lower levels.

Indeed, and what I don't know about, because other people say, but look, basically Kaiser are very careful about who they let onto their, who come into Kaiser. I know, oh see, I don't know, and I don't so there are some negatives that people pick up, but the idea of an organization, which seems to have the incentives for prevention, for stopping people having to go for unnecessary treatments, that kind of fits, doesn't it, with the U.K. approach to health care?

To what do we look to the U.S. for? We'll mark the concept of market, obviously. We think the U.S. is the most market-oriented to that. But secondly, I'm sure it was the kind of the DRG system, which underpinned the payment system.

I think this, you could say this is how Americans influenced, is that we developed the concept of independent sector treatment centers. And this was basically to give us an alternative source of provision in order to ensure that consultants did not screw us up on our waiting time initiative.

I think, if you wanted to sort of mount a case against the Americanisation of the NHS, I think you probably would say PFI (UK Private Finance Initiative), but I'm not completely convinced.

But translating [US] to the U.K. experience, I think, has always proved to be very difficult, in that sense. I can't, I'm struggling to give an answer on the period of time I was in government. I kind of, I was aware, of course, during that time that people were looking at HMOs. The Holy Grail is half of it, in the U.S., we think that you found a way to control doctors more than we have here. I guess, whether it's internal market, whether it's what we do, whether it's what the conservatives are doing. At heart, it's try and take our system and get the docs to be more corporate.

The more I talk, I think the more I'm thinking that it's the techniques we want. That's what we want to get ahold of. Can we get from the U.S. your ideas about how could we make our own system work better? We don't tend to look for, kind of, how is the U.S. system working. But we do because there was certainly a belief in part, of Labour, and certainly of Conservatives, that competition in markets is the best way to motivate. I think that clearly has a U.S. influence.

In 1994, Thompson, a senior RN, toured four centres of clinical cardiac care and rehabilitation in the US. Organisation of services, specific interventions, and outcome and evaluation criteria were examined. US systems, compared to British counterparts are more structured in terms of organisation, coordination, and evaluation but also more geared towards cost containment, effectiveness, and efficiency. British systems are emulating the Americans more and more. (Thompson, 1994) A 2005 study tour funded by the Florence Nightingale Foundation Scholarship visited 16 universities across the United States, Canada, Ireland, and the UK. The need for this tour arose from nurses being increasingly required for history taking and physical assessment (HTPA). (Rusford, 2008) In 2010, participants on two study tours went to the US to visit evidence-based programmes using tried-and-true methods to improve child well-being. (Axford, 2010)

James, former secretary of state for health, was outspoken on the issue of clinicians in leadership position:

When I went to the US in 1980 that was what struck me is that docs ran hospitals. It just seemed to me it's a wonderful piece of work you're doing. Governments here have

made various efforts to get the clinicians to take on more serious roles. The docs are resistant, partly because of tribalism. If you join leadership you become 'tainted' and then there's an issue of security. If we were serious about getting more docs in leadership positions we'd have to find a way of giving them more security.

I'm glad to hear there are efforts to improve moving docs into leadership, training programmes, etc. We could do more to get more docs in leadership.

I think it's not just the docs, of course, but it can be nurses, but I do think how, in clinical leaders, in some of those very senior positions, is a good thing, in particular the chief executive level.

Addressing the Blair government years and cherry-picking bit, posited, "The main thing is IT during the Blair years." Discussion of the electronic health record suggests how policy or programme transfer can be parsed. In this case, according to the participant, the concept was born in the UK but the implementing technology was sought in the US.

No, I think we, the concept of electronic health record was, I think, dreamed here. I mean, I was involved in the early discussions here. I think that inevitably, in terms of the systems that could then bring it in, the U.S. is always looked to. Of course, the problem being in the US health IT systems are used for different purposes, aren't they?

A senior regional public servant, George, in management described a melding of US bits with bits from locations other than the US:

So, I think we have brought a lot of the US model and I think the Kaiser [planning] 'triangle' would now be known in every organisation in the UK as a fairly standard planning device but I think we've corrupted that model with bits that we've brought from elsewhere to try to make it work here.

'Blended' bits from other than the US:

There's a lot of work gone on with the NZ health system particularly around how primary care fits into the model because primary care is clearly well developed in the US system certainly in the concept of long term disease management, whereas in the NZ model the primary care sector is aligned to the commissioner rather than the 'acutes' as was pretty much done in this country.

George offered a resume of sweeping influences transferred from the US, which included the influence of Kaiser, the US insurance-based model, purchaser-provider split, cost control and accountability for providers, a market for planned care, competition between providers:

If you go back to the Thatcher era which was for us GP fundholding, and really bringing general practice, probably for the first time, as a driver in the system, the separation of commissioning and provision, I think that was hugely influenced by Kaiser. And the idea of separating out the fund from the deliverer of service and what led to our purchaser-provider split. And a sense from looking at the insurance-based model in the US, particularly of the need to control cost and actually having someone on cost control and design who could hold to account providers. The Thatcher reforms took that down to a very very local level so you were operating quite small populations, and on quite restricted range of care. So, fundholding only looked at planned care rather than emergency care and was trying to pick up on this idea of almost having office based consultants who would do an outpatient almost as a gatekeeper. And the first concept of developing a market for planned care and driving competition between providers -there's a huge Kaiser influence in that.

In this connection, the researcher asked George if there were initiatives taken to ensure the connectivity and hence continuity of care by introduction of health IT to, for example, transfer images and information between primary care providers and consultants.

I think in the early phases of this probably less so under Thatcher but more under New Labour we started to see the technological linking of hospitals to GP practices, our remote pathology services, and x-ray services. This idea of a single data base of patient obviously transferred itself into the sort of national IT project that we started in this country to put everyone on one system, which was probably our least successful import [from the US] because that didn't work on the scale it needed to.

Long term care management is, I think that's the biggest success, the biggest thing we've brought from the US. I think the other one is the use of remote technology and just bringing that technology concept and patient control in. So, within the last couple of years all of our community staff now walk round with handheld electronic devices that they can access clinical notes on. We're starting to develop patient-led portals where patients can pull up their own information. Now that is starting to challenge this concept

of paternalism (extant in UK) but is linked to the sort of growing consumerism of health, whereas these days a patient will turn up that will probably have researched their condition on the internet they know what the treatment options are and they will come with a plan.

Joel, a senior public servant in a foundation trust provided an example of the interest in bits in this way:

For me, when I've been to the States and I've experienced and witnessed stuff you can see pockets of absolute excellence, in terms of the ways in which the costing were done, ie, the fact that you can actually get a priced invoice and if that, by its nature, the cost base down to all the component parts. So, we dabble around what we call 'service line reporting' so we can actually understand the cost base for a certain service, and there the components parts are coming and going. It's like going into a shop and coming out with a receipt.

So, I think we dabble with little bits of systems. But I don't think you can point to something that similar at the national level. So, I think there is a lot of technology basically around that we can pick up and learn a lot from the States.

So, I've certainly seen things when I'm over there ... I've certainly seen the thinking and transference of bits of policy around. If we take an example, I think there is a real mindset in the NHS that prevention takes many years to deliver. I went over there [US] ... and saw somebody running the contribution schemes and systems for local health there. They were happy to invest in preventive systems for people because they saw the returns pretty immediately. If you are prepared to invest very tangibly in your risk pool and you're prepared to invest in preventative care then that is a big lesson I certainly brought back and into the NHS. So, Little bits like that.

Thomas, a senior clinician and academic discussed an example of 'cherry-picking' a programme and modifying it for implementation in UK.

A significant part of GP's income relates to 'pay for performance.' More ambitious than anything any of the Americans are trying. We took it [from US] and we expanded it.

The clinician opined that though there has been a single system in England since 1948, it has been very fragmented, particularly with regard to funding streams -- separate for sectors -- for primary care and community care, another big one for social care.

A solution was desperately needed to remove the 'silos.' And the ACO model, the integrated care model in which you bring organisations together through a governance arrangement and the funding system made sense. The big policy ideas from the States is around the integrated systems, accountable care organizations, accountable care systems.

VIGNETTE

From US ACOs to English ICSs

Accountable Care Organisations (ACOs) have changed the health care landscape in England. ACOs were developed in the US, with Elliott Fisher, M.D. of Dartmouth College, leading among other American colleagues. In the US, it is a formally organised and governmentally certified vehicle to deliver team care, each team being tailored to individual patient needs, eg, teams constituted differently for a broad spectrum of problems: physio, occupational health, diabetes, neurology, ob/gyn, pulmonology, cancer, etc., and also a different billing structure for charges. It is another means of bundling charges for clinical services. Like DRGs, there is a fixed payment but the payment is shared among team members and produces an incentive to hold down costs.

The King's Fund was prominent in efforts to connect US providers with English policy stakeholders interested in ACOs, and guiding the transfer process from the US to England as interlocuter. During implementation in England, the name was changed to Integrated Care Systems (ICSs) to remove US branding.

The salient observations for health policy transfers here are that: first, this is a programme transferred directly from the US and now spread across trusts in England; second, ICSs are now the law of the land and have changed the health care landscape in England; third, bringing ICSs to England involved the brokering and framing functions of health care think tanks in England; fourth, resistance to US branding led to the change of name.

On further reflection, the clinician continued:

So let me give you a recent one, and in some ways a rather micro-level one. So, I talked about what the Brits have learned from the US around report cards and publication of performance data. And that's been around for 20 years now we've been publishing data.

So, he [Secretary of State] is encouraging both specialist and generalists to publish their data at a level of individual clinicians, and that came about as a consequence of a visit that he did Virginia Mason where he was invited in to see the medical directors and the leaders of the organization.

We've been trying to bring in competition as a way to break up the improved quality and use data and other forces as a way to motivate people. Certainly, the public disclosure of data. Yes, absolutely but also the public in quality improvements, report cards, all of that stuff. That all started in the States as well.

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VIGNETTE

Transfer of a US quality and safety programme

In 2015, five trusts in England were selected in a competitive process to enter into a five-year partnership (2015-2021) with Virginia Mason Institute (VMI), part of Virginia Mason Franciscan Health in Seattle, Washington, to develop a localised version of the management system employed at Virginia Mason. VMI provided training and guidance for the transformation of quality and safety of service delivery. The partnership ended a year late due to the Covid-19 pandemic. Goals were to develop a sustainable culture of continuous improvement, and to compile improvement lessons that could be disseminated across the entire NHS.

Hospitals in the trusts were Surrey and Sussex Healthcare, Leeds Teaching Hospitals, University Hospitals Coventry and Warwickshire, Shrewsbury and Telford Hospital, and Barking, Havering, and Redbridge University Hospitals. All five trusts had received ratings of “Requires Improvement” or below from the Care Quality Commission (CQC). In advance of the partnership, three of the five trusts did values-based culture work, developing their own

'valuestreams,' including metrics to assess transformation progress. In the end, those three trusts had improved their CQC ratings. (VMI, 2022)

In a 2022 article, Nicola Burgess and colleagues at Warwick Business School (WBS) reflected upon broader lessons and application of the then still ongoing NHS-VMI partnership to advocate for more collaborative relationships -- starting with regulators and providers -- to drive improvement. By contrast, hierarchical systems extant in the NHS rely upon power and leverage to drive change by positional authority. (Burgess et al, 2022)

It was argued that "regulation needs to shift towards a more relational form of governance in which informal social systems foster learning across systems." (Burgess et al, 2022) The authors drew upon their experience in analysing the major experiment in service transformation in five trusts of the NHS in partnership with Virginia Mason Institute (NHS-VMI) in the US. (Burgess et al, 2022).

Organisational learning describes the process of assimilation and embedding new knowledge in an organization underpinned by social interactions between individuals and groups. (Burgess et al, 2019) Now that interorganisational networks are expanding there is considerable potential for organisational learning. Interorganisational learning is best supported by networked forms of governance – that is, when governance is shared between a group of autonomous organisations – rather than by a hierarchical approach. (Burgess et al, 2022) Notably, this is a principal tenet of the experimentalist governance framework.

Where there is hierarchical accountability provider organisations (trusts) are naturally driven to ensure compliance. (Addicott et al, 2006; Burgess et al, 2022) Networked governance promotes motivation in autonomous organisations "to work together, learn together, and improve together" (Romzek, 2012) in a more fluid fashion.

"As with interorganizational learning, networked governance is relational [italics added] emerging from informal social systems characterised by solidarity among network members, a shared goal, and frequent knowledge exchange." (Jones et al, 1997; Romzek, 2012; Provan et al, 2008) Burgess and colleagues had concluded in 2019: "Our analysis suggests that network governance can be more effective at fostering collaboration for improvement, and that such governance occurs through development of relational authority." (Burgess, et al., 2022)

“. . . relational authority is earned over time.” (Burgess et al, 2019) On the other hand, management by executive fiat and top-down regulation is ‘fast-acting,’ but fraught. “A different process to governance is plausible, possible, and desirable.” (Burgess et al, 2019)

Although the NHS aspire to more collaborative approaches pervasive top-down regulation can siphon the energy of the workforce. “Policy emphasis on managing performance can mean that staff focus on meeting targets, reducing the energy for interorganizational learning.” (Burgess et al, 2022)

A 2022 WBS study of the NHS-VMI partnership, led by Nicola Burgess, after its five-year conclusion, noted that each trust in the partnership “took care not to link the [continuous improvement] methods to cost improvement. (Burgess et al, 2022) “They didn’t want discussions or goals related to money to distract from their focus on quality.” (VMI, 2022) WBS also noted that “regulatory requirements to improve led [two trusts] to ‘stand down’ on improvement activity and focus on compliance.” (Burgess et al, 2022)

While long-term improvement and short-term performance mandates may seem like conflicting priorities, alignment is possible. When [one trust] was in [regulator] ‘special measures,’ the CEO told his doctors to focus on values: patient experience, quality, patient safety, and outcomes. The doctors were surprised he wasn’t going to harp on wait times and other targets. “No, I’m not,” he’d say. “Because I know that if you focus on those four things, that’ll just happen.” (VMI, 2022)

Anecdotally, the often heard refrain in the NHS when confronting problems is ‘time to restructure the organisation – a plague of perennial structural change. England seems to default to structures. There have been so many NHS reorganisations over the years. No doubt there were those who thought integration would be possible if only the structure was changed. The answer might be – no -- it will make integration harder.

The researchers acknowledged, of course, that the partnership was only one example of networked governance and limited to five provider organisations. The ultimate challenge is to “replicate this approach across the broader system.” (Burgess et al, 2022)

There are, however, other examples outside England in the EU in several different domains, eg, energy, food safety, data privacy, justice and home affairs, and anti-discrimination regimes,

among others. These examples are encapsulated in the experimentalist governance theoretical framework, which was valuable in guiding the research for this thesis.

Finally, the 2022 WBS study concluded that crucial lessons learned in the partnership were: “1) how creating a new management system requires the whole organization to work together to enhance value from board to ward, 2) how leadership must focus on coaching, not control, 3) how setting targets require both learning and ‘unlearning,’ 4) how a Transformation Guiding Board provides a model for collaboration.” (Burgess et al, 2022; HSJ, 2022) Throughout the report trust chief executives commented on the “extent and importance of changes achieved by their organisations.” (VMI, 2022) In the succinct words of VMI assessing the partnership: “time and errors reduced, and improvement mindset embraced.” (VMI, 2022)

The positive experience of the NHS-VMI partnership suggests the potential for organisational improvement using a systems approach, not only across England but worldwide.

Emily,
a senior nurse and academic remarked on US influence on care models:

The whole approach to planning care, this is going back to the 70s and the 80s, the different ways of organizing nursing care have often had their inspiration in the US. I think we’ve brought across five different care models from the United States. Then there is something called primary nursing which also comes from the States.

This is the patient primary care nursing. A US nursing ‘guru,’ her idea was that nurses like patient allocation but it was taken a bit further. A single nurse was the point of continuity for a patient mentioned earlier, English health policy stakeholders have consistently kept to a narrative of interest in ‘bits’ from the US, ie, specific, targeted solutions, improvements, or innovations in delivery of health services. On this note, unanimity was found among participants in the interviews, as reflected in commentary below.

Earlier, the observation was made that participants were ‘parsing’ their responses to the effect that the US was a privileged source of health policy and programmes but not at the strategic, system level of the NHS. Simply put, those participants saw US influence in the UK adoption of ‘bits,’ ie, specific tools and techniques to solve a problem or provide an enhancement.

Thomas, a senior clinician, academic and former public servant summarised findings rather well:

I think that there a lot of ideas that go backwards and forwards, but to a very large extent, I think on this side of the Atlantic, we look at specific examples of good things in America, and we also recognise the things which are not as good and which we wouldn't want to copy.

Fund holding

If you go back to the Thatcher era which was for us GP fundholding, and really bringing general practice, probably for the first time, as a driver in the system, the separation of commissioning and provision, I think that was hugely influenced by Kaiser. And the idea of separating out the fund from the deliverer of service and what led to our purchaserprovider split. And a sense from looking at the insurance-based model in the US, particularly of the need to control cost and actually having someone on cost control and design who could hold to account providers. The Thatcher reforms took that down to a very local level so you were operating quite small populations, and on quite restricted range of care. So, fundholding only looked at planned care rather than emergency care and was trying to pick up on this idea of almost having office-based consultants who would do an outpatient almost as a gatekeeper. And the first concept of developing a market for planned care and driving competition between providers --there's a huge Kaiser influence in that.

On planning. We have brought a lot of the US model and I think Kaiser would now be known in every organisation in the UK as a fairly standard planning model but we've corrupted that model with bits that we've brought from elsewhere to try to make it work here.

From the American model came the idea of clinicians having a greater say in the running of organisations because in the US you see lot more medics in control of decision making at a sort of a Kaiser level, whereas previously in the NHS system it was very much a system led by managers most of whom weren't clinically trained, most of whom had a finance background. Most chief executives came from there. You started to see a movement of much more prominence of clinicians in the management hierarchy.

Moving care outside of hospital

I think the other thing you saw, initially under Thatcher government but then under New Labour was the concept of more care outside hospital and the idea of preventive care. Now I think that lends itself more away from the US sector because you don't see as much of that population-based care. So, I think that's where for the first time we started to blend the concepts of United Healthcare case management with patients more in control of their own care but bringing in the wider determinants of things like the public health agenda of housing, a focus on mental health, etc.

Competition

What never really happened under the Thatcher administration was getting that into a big enough population mass to get a large-scale benefit. And there was a lot of concern that the big difference we have in this country to the American model is you can have provider failure in the US model. So, you can drive competition to a point that you can drive weaker providers out of the market and actually drive innovation through competition, whereas we never had a true market that we brought that into because it was politically unacceptable for us to drive that competition to a point where a hospital would go bust or would close down. So, it was a very limited in its impact because the minute you really started to drive reform to the point you would threaten the sustainability of a hospital the political model wouldn't allow you to follow that reform through. So, we had to modify the model we brought over and transfer it into a whole health system rather than something that originally started driving a hospital cost. So, I think the Thatcher era started to change a few things it brought in the idea of competition it got into the concept of market-driven but had a huge political risk factor that no one quite knew what to do with the limited scope so I think we saw some benefit at the individual patient level, particularly in the older population and long-term condition management but it was never allowed to go into a mainstream programme.

Veterans Health Administration

Now we saw more of a benefit from that from the US Veterans than we did from the Kaiser and United Healthcare models because one of the challenges we started to get from the medics in this country was the minute you take it outside the hospital it is unsafe because you can't possibly deliver some of this complex care out in communities

it must be overseen by acute consultants who would drive care and still very much a paternalistic model within the NHS. What we started to see from within Veterans was because they had more of a global population because their vets were clearly from a much wider demographic than the insurance-based model we started seeing them deliver care in remote communities we started seeing remote clinicians going out we started to see the use of technology in the-delivery of care that the NHS hadn't picked up and we started to see it was safe to do that. And we started to see remote doctors who would be supervised by consultants or actually could operate independently so back in the early 90s to mid-90s we started to bring the physician assistant model out of the us to the UK started to work in general practice in A&E and this concept that you have this autonomous junior doctor out supporting in the community referring into acute consultants but the default being more in the community became more acceptable within the medical profession and I think we owe quite a lot of that to the US model in particular.

Kaiser and United Healthcare

I think there was but I think it was heavily dominated by Kaiser and United Healthcare. A very select group. It was a very targeted US import. We've seen something in those models that we like I think what we've seen under New Labour and more recently is much more realization that you can't import a Kaiser model because it doesn't fit there are elements that you can cherry-pick but actually the model doesn't translate and a much greater acceptance of the need to go and cherry-pick from lots of different bits like the Veterans and others and well take a bit from them and a bit from them and a bit from them and when you put it together we can turn it into something that works in the Thatcher reforms. What we found was a bit of what you find in the US model really for those patients who are in that system it worked so for the patients who were part of the national pilot they got a much better service

So, I think it goes back to what we imported from Kaiser and United Healthcare which was a view into how do we make a treatment service more efficient which I think as we moved into some of the later phases under New Labour we did get more into where does the NHS fit into a wider population model.

I think it has shifted the NHS to think about long term care management in a way that we didn't before. So, I think it's probably changed the structure of what we do into what's more the NHS is here to do. I think it's influenced policy significantly around older people and older people management. I don't think we've ever really implemented the American model because I don't think we've squared it with population management, and I think that's always going to be an issue for us.

So, I've certainly seen things when I'm over there ... I've certainly seen the thinking and transference of bits of policy around. If we take an example, I think there is a real mindset in the NHS that prevention takes many years to deliver. I went over there [US] ... and saw somebody running the contribution schemes and systems for local health there. They were happy to invest in preventive systems for people because they saw the returns pretty immediately. If you are prepared to invest very tangibly in your risk pool and you're prepared to invest in preventative care then that is a big lesson I certainly brought back and into the NHS. So, Little bits like that.

I suppose the concept that is not as policy but what people are looking at now in terms of the system is the flavor of the month is the issue of the prime provider model which sort of nicely takes on the old system. So, I don't know if that came out of Kaiser Permanente really or not but that's where people are dabbling now and I think sort of a managed care organization so that you take on the whole risk so when you're saying here's 30m pounds that we spend on these people get an organization that can come in and manage the whole system feels like that is probably the biggest bit of influence from the US system about managing the total care for a population.

Diagnosis Related Groups (DRGs), adapted to Health Resource Groups (HRGs) in England, and pay for performance under New Labour were both adaptations of US programmes.

VIGNETTE

American DRGs become English HRGs

In the early 1980s, in response to out of control rises in health care costs in the United States, the US private health insurance industry invested in the development of Diagnosis Related Groups (DRGs), under contract with researchers at Yale University. This tool comprised a

system of 467 codes which ‘bundled’ charges for hospital services determined reasonable and customary for all diagnoses, with the possibility of add-on charges for permutations care needed to treat associated complications.

Each of the DRG groups together clinical diagnoses (usually from the International Classifications of Diseases) on the basis of broad clinical specialty (‘Major Diagnostic Category’), then whether surgical or non-surgical treatment is usual and then by other characteristics, varying by country, which predict the total cost of care for the patients so diagnosed (eg length of stay). (Sheaff et al, 2019)

In 1983, the public Medicare programme in the US implemented DRGs to control unremitting health care cost inflation. For both private and public sectors, more hierarchical control was exerted over previously autonomous service providers, with respect to fees for services. (Hsiao, 1986; Fetter et al., 1980) In the 1990s, transformation of many European health systems was underway to be market-like “to make them more manageable, contain the growth of healthcare spending, promote competition and open health care provision to a wider range of providers (corporate, not-for-profit, owner-managed, etc). One consequence was to adopt DRGs as the main pricing unit for hospital services.” (Sheaff et al, 2019)

In 1992, the English NHS adopted an analogous version of US-based DRGs, referred to as Health Resource Groups (HRGs) in England. Like Italian DRGs, England HRGs followed the US model (but less closely). (Sheaff et al, 2019) Certainly, HRGs were modified for implementation in the English context. In the US, DRGs were principally an accounting control mechanism, ie, managing provider remuneration, and a tool to monitor if not exert some control over clinical performance. In England, however, the HRG incarnation became less an accounting tool and a more expansive tool to solve institutional problems like waiting lists. At bottom, the performance component of HRGs served as a vehicle for competition among NHS trusts/hospitals. Thus, it seems the US private, market-based system implemented DRGs to introduce more hierarchy in the system, whilst a state-led NHS implemented HRGs to introduce market principles.

The English Payment by Results (PBR) system uses Health Resource Groups (HRGs). CCGs, nominally controlled by GPs, were the main payers. HRGs were defined independently of the US prototype but with an essentially DRG-like design and policy rationales and the aim of

increasing provider activity so as to reduce hospital waiting lists, a politically sensitive issue in the United Kingdom. Our informants also reported that HRGs incentivized hospitals to treat more cases and more intensive treatments, although hospitals' rising marginal costs (eg, for opening operating theatres at week-ends) limited the expansion. Our commissioner informants claimed that treatment thresholds had fallen and up-coding had appeared. (Sheaff et al, 2019)

Up-coding was an early and widespread response of providers to DRGs in the United States, aided by the development of so-called 'code-finder' proprietary software. In the case of the US as anywhere else, the objective of up-coding is to maximise payments for cases, pushing the boundaries of payer tolerance for outlier patients. ". . . studies already report providers upcoding patients to more lucrative tariffs ('DRG' creep) and supernumerary negotiations about outlier patients (Cots et al, 2011). (Sheaff et al, 2019)

In a path-breaking 2019 study of DRGs by Sheaff et al., "managerial workarounds," which make DRGs work, were delineated for the first time in organisational and inter-organisational contexts, unlike clinical and IT workarounds. (Sheaff et al, 2019) "Workarounds are the ways in which individual workers and work groups informally by-pass or alter the ways in which a formalised work process is executed, so that they can fulfill its task in another way." (Sheaff et al, 2019; Halbeslebe et al, 2008)

Generally, workarounds are responses to organisational problems (Lalley and Malloch, 2010) (eg inter-professional or inter-departmental boundaries, role ambiguity), practical inadequacies of new technologies, overwork, inflexible rules or communication blockages. (Sheaff et al, 2019) Not altogether detrimental and, in fact, often "constructive deviance" (Sheaff et al, 2019) leading to formally improved procedures, workarounds bear watching to ensure the system is not undermined by them, or they are inducing unintended consequences. In this connection, Sheaff et al reported:. . . policymakers in several countries (eg, England, Germany, The Netherlands, Greece) have tried to design DRG systems to achieve two somewhat conflicting aims. One was to make the cost of health care to payers more predictable and manageable (Covaleski et al, 1993), make providers more accountable to payers and prevent over-charging (Polyzos et al, 2013) by setting tariff payments prospectively instead of instead of reimbursing providers' actual costs retrospectively. However, DRG systems also incentivised providers to increase the number of cases treated and treatment intensity. Evidence from Europe and Australia, but less so from the United States (where DRGs replaced fee-for-service payments

which were already an incentive to increase activity), tended to indicate increased hospital activity volumes and/or intensity following DRG introduction. (Krabbe-Alkemade et al., 2017). (Sheaff et al, 2019)

This represents one characteristic likely to produce the need for managerial workarounds. Sheaff et al describe four characteristics of workarounds, as well as four characteristics of DRG systems likely to make workarounds necessary (see Sheaff et. al, 2019).

Since their adoption across the world, much has been learned from research how DRGs/HRGs work. In the case of both, at bottom, it was demonstrated that they are a flexible instrument, which can be employed in different ways to serve different health policy objectives. The transfer of DRGs from the US to England (albeit with revised code definitions) was one of the few national-level transfers to occur in the past 40 years.

Darcie, former academic now associated with a think tank:

So, I think that that's where we were looking for examples, so I think it's true that we have looked a lot at the US . . . that that is appropriate and sometimes is not appropriate, perhaps there's a bit too much emphasis looking at the US, not enough emphasis on what's happening in Europe, other parts of the world, or even other parts of the UK itself. I think some of the integrated care stuff, I guess, has been really useful. I think in the time that I was in the US, and looked at some of what was happening within ACOs was really exciting. Less around funding models and organizational structures, which have to be locally rendered, but more about understanding patient mix, and use of sharing data, or working together on a day to day basis.

Yeah. Some of the tech stuff, I think. That's really exciting and interesting, and I suppose learning what the necessary components are in order to make this work, I think has been one of the positive consequences of that. We have the ability to go and learn about it, think it's exciting, come back here and spread it, but there's not a 100 percent take-up, obviously, of what we think is good.

But then on the negative side, I think there is a bit of fatigue that, oh, the US is amazing, all you hear is the US is amazing. I hear people say we're doing great things and everyone's come and talked to us, talking about Kaiser, and InterMountain, ignoring what's on our own doorstep. And I think because of that, as well as a generalised cynicism around the US, sometimes can right

there put people off listening to what's happening, good and bad as well. So, I think that there's been positive and negative consequences of US influence.

Yeah, I think it does go down to simple things like that. It's human nature. Yeah. And everything in the US looks new, and shiny, and more attractive in a simple way.

And it sounded amazing, and everywhere we went in the US sounded amazing, and this is great, why aren't we all doing this? And I don't think we had really accurate demonstrations of what's happening on the ground. And the kind, the type, that don't tell you that, outside of California, Kaiser failed here, there, and all these things. You just get the end product, and it sounds amazing. So, I think there's an element here of, you'd rather go to San Francisco, and then there's element of us being convinced by salespeople.

Because I sat in a conference here this morning with 200 people from the NHS listening to presentations from New Zealand, and then I think, why are you here? Why are all you people here? You probably spent 500 pounds to come here and listen to this, and you're going to take something back from this to your own organization, and I'm not hearing anything that if I was a provider I could directly use. There's ways of knowing things, and I don't think that this predigested, 'here you go,' way of knowing is real.

Max, an academic and author opined:

I think the crucial thing is what kind of policy, at what level you're talking about. I would say, enormously important in micro technical policymaking, but then as you go up the level decreasing. DRGs/HRGs are an example of this.

Darcie continued:

They're the things that I think you've probably been doing in a number of isolated areas for maybe a decade or more in the US just because it made economic sense. We're a little bit slower to pick it up. But I think there are a number of American companies that are setting up new initiatives, technology-aided initiatives in the UK. I guess if they can make it work in the UK, then they can really go for the big markets, which are China and India. The British middle classes are willing to pay for an international service.

John, opined on transfers from the US:

I think there are good ideas that have been generated within systems that operate in America which are transferrable and are helpful, and you can both relish and appreciate. I mean, I love being involved.

Are pilots the smart thing to do for policies and programmes transferred from the US? Yeah, yeah, you don't just plug it in. There are examples nationally of using STP areas to pilot some of this. The Vanguards, for instance, as early adopters. Let's test it out, then have some fast followers, etc, can pick it up afterwards.

But I think the other thing about the States which you get more of than you do here is 'personalisation.' Individual health care plans based on what a person needs, rather than, maybe, what a person wants. And the NHS tends to be a one-size-fits-all solution in a lot of areas, rather than looking at "What does the individual need?" So more targeted healthcare interventions, based on population data that says ... the actuarial approach. So, what do we think this person will need in five, ten, fifteen, twenty years' time?

Let's give them what they need now so that they can be healthier, longer, than they would if didn't get what they need now. So, we've done a lot of work with Milliman, for instance, who've done a lot of work in the States on the Oregon methodology, which is about, let's look at ... The state of Oregon in the 80s said, for Medicare, basically said, "Let's ask people how we should spend the money to deliver the best outcomes."

The NHS is huge, which is the other thing I just wanted to mention. Whilst I talked about fragmented care along the pathway, organizational fragmentation is much more in the States. There isn't a national health service. . . . what the NHS has then relied on is individual local planning organizations be they commissioners or providers actually going seeing what's happening in practice bringing those ideas back and adapting them by piloting them in local studies, and then extrapolating that back off to a national policy concept. A lot of UK policy and reorganisation has actually been a national attempt to mainstream something that's come from quite small-scale pilots. And a lot of those small-scale pilots have been driven I think in the early days predominantly through the Kaiser model, a lot of work with UnitedHealthcare over the years but we've had a long-term pilot with the VHA and I think you can see elements of all those systems in what we're doing.

Kaiser Permanente in California is the reputed 'first among equals' as a source of ideas, policy, and programme. Believed to be the first of its kind UK relationship with a major US health care

provider, King's Fund was instrumental in developing a close and enduring relationship with the NHS and other policy stakeholders and Kaiser. King's Fund is strongly linked to Kaiser.

John continued:

What I don't think there has been in the UK is a systematic attempt to recreate that policy at a global level but more to say this bit works, that bit works, how do we fuse them together into changing policy at this level and then how do we mix that with the wider determinants of health that aren't evident in the US model that we've cherry picked.

This statement encapsulates cherry-picking 'bits' – policies, programmes, technologies – and making adaptations to fit the population health model of the UK, as well as lack of interest in adopting national-level policy from the US.

The picture is mixed. I think there are some really good ideas. I think the US is still and will remain an important source of new ideas because of what we described. Because you are a more innovative country, given by a whole series of factors, cultural factors and economic factors. I just think we need to continue to be more critical of those ideas and which ones are the ones that will really fit our culture, and which ones need adapting and how. And I think our orientation towards evaluating innovations is a good one and we need to stick at it. By that I mean rigorous scientific evaluations as opposed to just economic evaluations. (See Charles, Emily, and Arthur, under this theme.)

6.3.3 Summation

There was universal agreement that "bits," ie, specific tools and techniques, are what is sought from the US, whether to fix a problem, make an incremental improvement, or introduce a major innovation. The US is looked to as a ferment of ideas and a vast R&D base that is uniquely suited to produce innovation on a broad scale, compared to either continental Europe or UK. Coupled with common language, values, politics and, frankly, attractiveness and ease of access make it a veritable irresistible source.

CHAPTER 7 DISCUSSION

UKSA! An obsession with America pollutes British politics Britain|Bagehot

“Arguments over public policy are complicated by comparisons with America. Debates about the future of the National Health Service are polluted by the extreme and weird example across the ocean. The plethora of publicly funded health-care options in Europe is largely ignored.”

-The Economist, May 20, 2022

7.1 Foreword

It is worth revisiting, in summary fashion, the scenario, as it was initially set out to explore the central research question with key informants, in advance of the discussion of actual data collected. This study aimed to answer the central research question: do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?

Toward the end of this study, the May 20, 2022, Bagehot opinion page (appearing in every issue of The Economist) contained the statement quoted above. Though brief, it would have well-served to motivate the researcher to pursue this study if it had appeared more than eight years ago, and yet, now as then it still resonates; hence, perhaps appropriate that it appears here. However, it was the literature review that steered development of the research questions and design, and the selection of two theoretical frameworks suitable for guiding data collection and explaining data.

Taking a constructivist stance in this study, “all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interactions between human beings and their world, and developed and transmitted within an essentially social context.” (Crotty, 1998) Researchers’ work is to understand the journey that people are on.

In the context of this study, those involved in seeking health policy ideas or learning, and transferring policy are employed in complex organisations (eg, the NHS), and interacting with relevant counterparts in other complex organisations to accomplish this mission. They must engage in sensemaking, a “process in which people work to understand issues or events that

are novel, ambiguous, confusing, or in some other way violate expectations.” (Maitlis & Christianson, 2014) Certainly, investigating policy or programme solutions in another country, negotiating through unfamiliar protocols, processes, culture, terminology, technology, and personalities to reach decisions on feasibility (of transfers) is a sensemaking challenge, as is how to successfully implement innovations if transferred to the home country.

Sensemaking is a considerable body of scholarly work unto itself (see Chapter 2, Theoretical Framework). There is considerable variation in how the term is used, posing definitional challenges. (Maitlis & Christianson, 2014) One among the many definitions speaks to constructivism: “Sensemaking has been defined as the discursive process of constructing and interpreting the social world.” (Gephart, 1993) The researcher was alert to participants clearly answering questions from their perspective of having worked through events and people to find complex solutions in health care, whether technological or otherwise, and to first determine exactly where they might be found.

7.2 The questions

First, let us refresh recollection of the principal research questions:

1. Do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?
2. Were significant differences or variations noted in the degree or extent of influence of USbased ideas across the three key periods of health policy reform – the periods of Thatcher/Major, New Labour, and the Health and Social Care Act of 2012?

7.3 The theoretical frameworks

The researcher chose to use the lens of two different theoretical frameworks – Dolowitz and Marsh policy transfer, and Sabel & Zeitlin experimental governance -- to guide data collection, organise and interpret the data afterward, ie, make sense of it.

As discussed in depth in the Theoretical Framework chapter, variables in the benchmark framework (Dolowitz & Marsh, 1996) germane to the present study are related to the very basic questions of who, what, why, when, where, and how policy transfer occurs. This theoretical framework provided an essential guide to data collection and analysis in the domain of health policy and programme transfer. It was instrumental in guiding development of research questions, identification of categories of actors to interview, and processes to examine, all in a constructivist approach to develop rich data from participant experiences for analysis. This is a state-centric model.

However, it became clear that policy transfer can occur through diverse modalities, including but not exclusively institutional agents/networks. State institutions might be involved but, in the case of health services, so might politicians, political advisers, professional associations, policy institutes/think tanks, academics, executives, managers, advocacy groups, epistemic communities, consultancies, external networks, and clinicians. Hence, policy transfer research evolved from its state-centric conception to encompass a multiplicity of empirical contexts, other actors, and venues. (Benson & Jordan, 2011) The essence of the Sabel and Zeitlin 'experimentalist governance' (EG) theoretical lens is, in their words, "to learn from difference." (Zahariadis, 2013)

EG is concerned with the exchange of best practices through informal networks, parallel with policy transfer, and offers several relevant concepts for explication of this study's research objectives: collaboration, a multi-level nature, informality, networking, open coordination, product/process improvement, and mutual learning. Essentially, EG embraces movement of what works in one setting to a different setting, the virtual definition of policy transfer (Dolowitz & Marsh, 2000), through informal networks. (Sabel & Zeitlin, 2010) Its essence is "to connect different actors in multi-level networks that monitor, diffuse information on policy performance, and generate feedback. " (Zahariadis, 2013) This is (non-hierarchical) 'policymaking in the shadow of hierarchy.' The EG perspective captures "the nature of the EU as 'a unique set of multi-level, non-hierarchical and regulatory institutions, and a hybrid mix of state and non-state

actors.” (Borzel, 2012; Hix, 1998) , making it useful in part as a template for policy transfer in the NHS. That part is the essentially non-hierarchical approach to transferring policy and programme.

The researcher found EG to provide a more dynamic model extendable to disparate actors and influences beyond the state centric paradigm which, in a sense, is more ‘static’ by comparison. EG was more amenable to changes in communications in the digital era. The perspectives offered by both models, however, were making different contributions, in the sense of ‘no one size fits all.’

7.4 The sample

A purposive, non-probabilistic, maximal variation sample was composed of elite participants. These were NHS executives or managers, politicians, political advisers, clinicians, academics, and think tank leaders. To encompass as much variation as feasible diversity in organization, geography, and profession were taken into account. Accordingly, interviews were conducted in various geographic areas of England and in various types of health care organisations. Also, recognizing the importance of context specific processes, an attempt was made to interview at three levels: 1) macro (national or strategic); meso (regional trust/hospital); micro (clinical/programmatic).

The relatively diminutive body of literature for elite interviewing was consulted, and assiduously followed. Indeed, elite interviewing is an art unto itself, clearly a subset of interviewing more broadly. The gold standard remains Dexter’s Elite and Specialised Interviewing (Dexter, 1969; 2012).

Elite interviewing is a specialised art, and Dexter’s 1970 (reprinted in 2012) treatise remains the gold standard in a literature that is still relatively small among academic resources for general interviewing.

Based on the experience of elite interviewing for this thesis, several recommendations emerge for updating Dexter’s methodology, which mostly relate to the many changes in communications both digital and otherwise. There might be an update to emphasise the importance of rapport building, which should begin with initial contact. In current times, contact by email message is more likely than a letter to gain immediate attention. Texting should never be used. It is unlikely

that initial contact will be with the potential elite interviewee. Hence, contact with a PA should be treated as equivalent to contact with the interviewee in terms of respect, ie, the PA is the principal at that point. So, rapport at that point is crucial; otherwise, a researcher might not get past the 'gatekeeper.' Once in the room, a researcher needs interpersonal skills to immediately begin to build rapport with the principal, and be capable of 'circling back' to questions which are avoided, hedged, or only partially answered by rephrasing or reframing questions or, if necessary to 'elicit' answers.

7.5 The literature

Documentation of policy and programme transfers in the literature evinces England's initiatives to acquire health policy or programme ideas, learning, and transfer, the question of whether the US is a privileged source of innovation in those areas remained unexplored in primary research. The Thatcher government's use of Stanford University economist Alain Enthoven's ideas to design an NHS 'internal market' (Dolowitz & Marsh, 2000; Enthoven, 1985), Tony Blair's new payment mechanism for hospitals drawn from the US prospective payment system (DRGs), and systems for management of chronic disease, are notable examples of transfer from the US. (Ham, 2005) The expansion of academic health science centres was a case of health policy transfer from the US to England. (French, 2014) 'Nudge' policies to reduce obesity originated in the US, and were transferred to the England. (Oliver & Ubel, 2014) A joint report from Nuffield Trust and King's Fund addressed the stress on primary care in England, and looked to new models in the US. (Smith, et al, 2014) The King's Fund produced a report on accountable care organisations (ACOs) in the US because of potential implications for development of integrated care in England. (Shortell et al, 2014) The arrival of Simon Stevens, a former NHS executive, Blairite special advisor, and top executive of the largest US health insurance company, as chief executive of the NHS, was perhaps cynically viewed by some as a direct transfer of competition policy in health services from the US. (Davies, 2013) The literature contains many more examples.

It is certainly worth noting that, despite available documentation of transfers, writings were not generally found which couched them firmly within a policy transfer framework. For the researcher, this indicated that implications of policy transfers, the process itself, and whether it could or should be improved, were not being explored, and may portend the value of this study. Conversely, in literature focused on policy transfer as theory or process, the mention of specific

cases of policy transfer was lacking. So, in sum, there appears to be little cross-walk between the two facets of the literature.

In 1996, Dolowitz & Marsh (D&M) published a stock-take of the policy transfer literature, which was largely based in lesson learning, comparative politics and policy, and diffusion studies at the time. D&M also developed a path-breaking policy transfer theoretical framework which contributed significantly to the identification of actors and processes in policy transfer. It remained largely a state-centric and hierarchical framework though was broader in scope than previous studies. In 2000, the authors published an updated and expanded framework with the essential addition of non-state actors, eg, consultancies, think tanks, supranational organisations (like the EU), in response to changes in forms or modes of governance. In other words, this was taking a short step away from a state-centric theory. They also added the implementation phase of policy transfer. This change was useful as it extended the sources of data to enhance understanding of the process from end-to-end. In a manner of thinking, it actually portended the development of experimentalist governance which took non-state actors to a new level in governance. Here, there was an intersection or perhaps overlap at the margins of the two theories. Sabel & Zeitlin's (S&Z) experimentalist governance not only robustly encapsulated non-state actors but took policy completely outside of hierarchy, referred to as 'policymaking in the shadow of hierarchy.'

D&M went a long way beyond any previous works to establish an understanding of policy transfer processes. However, the attraction of the S & Z framework was, first, its core principle of multi-level networking, and how it might overlay the NHS with respect to policy transfer. It was learned from participants that there are not directives from higher ups regarding policy transfer so that NHS meso and micro level actors are free to network horizontally with colleagues, or externally to contacts in other countries, or vertically within the Service if they choose. Hence, there is a lot of multi-level networking regarding the pursuit of policy or programme transfers. In this process, there is also mutual learning, which is another core principle of S&Z. Further conforming to S&Z principles, within the NHS, this process is seen as informal, collaborative, and open coordination. Essentially, S&Z embrace the movement of what works in one setting to another setting through informal networks. Though there is 'no one size fits all' for the exact procedure, this is also essentially what occurs in NHS policy transfers.

It should be noted that there is no official recording or tracking of policy transfers, and certainly no centralised records. It may be that this is an area for improvement. Recording/tracking

would facilitate monitoring of implementation and policy success/failure. Further, it would provide a means of diffusing information about transfers throughout the NHS. One participant suggested the need for a formalised policy transfer policy, which would benefit the entire NHS (see Findings, Charles)

Both theoretical frameworks served as significant guides for searching the literature. These also served as preparatory for launching the collection of data in the field, which went beyond the literature, hence, making an original contribution to knowledge.

7.6 The responses

The paramount finding of the study was that no participant thought the US was a 'system' to be copied or emulated. This was a singularly strong, vociferous universal rejection. In fact, the US was widely regarded only as a 'so-called' system to be avoided. Most participants, rightfully, did not actually view the US as having a health care 'system' at all but rather a series of 'siloed' providers albeit 'silos of excellence.'

While only the Veterans Health Administration (VHA) was accorded recognition as a true integrated system in the US, most like the NHS but, in fact, they are not, as only the financing of Medicare is centralised, not the provision of care as in the VHA. Similar but still different, Medicaid financing is not even centralised but shared between the federal government and each state by various formulae. Further, virtually every state has a different set of rules for eligibility and payment scheme for providers.

The whole of understanding this finding among participants is a complicated one, however. It cannot be overstated that there was a definitive rejection of any semblance of US health care per se at a national or system level (identified in Findings). Indeed, there was widespread and high sensitivity to the idea and potential of a US 'trojan horse,' which could facilitate a trend toward privatisation of the English NHS achieved through the introduction of US innovations. There was general recognition that continental European health systems were largely overlooked in England, most often in favor of the US. At the same time, there was one outlier response who advocated for looking to low-income countries for novel (and lower cost) solutions to health care policy and programmes.

The penultimate finding (and counterfactual) is that the US was unanimously viewed as a privileged source of health care policy and programme innovation despite some permutations. However, there was definitive parsing of the favorability and utility of searching out the 'bits' or specific techniques and technologies from the US for transfer to England on the one hand (Chapter 5, Findings I), and no interest at all from, as was said, the 'non-system' level of the US. This was acknowledgement of the silos, or pockets, of excellence in health and medical care spread throughout the US where solutions are most often sought.

Stakeholders manage a series of contradictions or paradoxes regarding health policy transfer. An apparent natural affinity for the US is accompanied by a healthy scepticism of it; hence, looking elsewhere for solutions and, demonstrably, not looking inward to exploit 'local' knowledge or cylinders of excellence.

In some ways surprising, there was widespread awareness that the English stakeholders consulted only a small cluster of providers and institutions in the US for health care ideas and innovation. In fact, most could provide specific names comprising this small cluster, eg, (first among equals) Kaiser Permanente (California), Geisinger Health System (Pennsylvania), Intermountain Health Care (Utah), University of Pennsylvania (Pennsylvania), Mayo Clinic (Minnesota), University of California, San Francisco (California), Institute for Health Care Improvement Massachusetts), and Virginia Mason Institute (Washington state). Honorable mentions also included University of Chicago Hospitals and New York Health and Hospitals Corporation (New York City).

Whilst widely acknowledged that the Alan Enthoven monograph of 1985, under the auspices of the Nuffield Trust arguing for an 'internal market' in the NHS, was the genesis and pivotal event for an opening up to US influence and introducing competition in the Service, it was generally agreed that few other national level or macro policies were transferred from the US.

There were, however, two notable though admittedly rare transfers in process of being implemented country wide: first, the NHS-Virginia Mason Institute (Washington state) partnership was a successful implementation of a highly innovative, US-based quality and safety program; second, Integrated Care Systems (ICS) were adopted directly from the US and have become the law of the land as of July 2022. Both of these programmes portend improvements in their respective areas right across England. However, it should be noted that

both of these were 'bottom-up' transfers, ie, not directed from above albeit these two were carefully watched and encouraged.

Indeed, the point should be made here that there was universal agreement among participants that policy and programme transfers are imagined, conceived, initiated, and directed from the meso (trust) and micro (clinical) levels. When pressed, no participant could think of a single incident of being 'ordered' by either NHS central or DHSC to pursue a transfer from anywhere, including the US.

The researcher was clearly aware that interest in policy transfer was not exclusively for the US. Several participants were knowledgeable of policy transfer attempts in countries other than the US, including Spain, Italy, Denmark, and New Zealand. However, there was no mention of any long-term relations to pursue an idea, policy, or programme for transfer. For example, there was no relationship for this purpose that approached the UK-Kaiser Permanente partnership engineered by a think tank in England. Of those mentioned, the highest interest and longest running relationship was with New Zealand, for example, learning about primary care systems.

The literature offered little discussion of 'branding,' or 'piloting' but these were a clear priority for participants. The same can be said for both D&M and S&Z theoretical frameworks. Piloting was universally understood to be important and mandatory. There was agreement that bringing across policy, programme, ideas, or technologies demanded evaluation for cost impact, local culture, standards of care, safety, efficacy, local conditions, and reliability, to mention a few factors. Then the essential contribution of piloting is to 'tweak' the transfer as needed for local conditions. There appeared to be an element of pride involved as well. The question begged was why not look inward because there are clearly silos of excellence in UK as well as the US. Participants were clear in describing a preference for travel to the US vice in-country or to Europe for that matter, the US is "new and shiny" and, frankly, management uses study trips as a means of recognition and reward.

There was universal and energetic concern for piloting and branding, which are somewhat interrelated. Perhaps in connection with pride, there was mention of the importance of 'branding,' ie, 're-branding once a transfer has occurred. It was generally agreed that removing the American moniker or branding helped to facilitate acceptance of the transfer among all parties, eg, clinicians, staff, patients.

For these and all other stakeholders, it might be worthwhile to recall that they comprise a relatively small interest group. There may be an 'echo chamber' effect at work. Another possibility that cannot be ruled out is that in this same small group there is 'circular reporting,' ie, an idea or suggestion or theory might be thought original or new but in fact has recirculated.

The impact could be that, in effect, there is unconscious 'group think,' rather than critically challenging assumptions or assertions, hence, not the best decision-making process.

The English approach to the US for policy transfer is understandable when examined closely. Critically, one could say that it appears a bit schizophrenic. The privileged position of the US for health policy, programmes, and ideas is juxtaposed with a general cynicism toward US health care for all the known reasons: marketisation, privatisation, both traditional bogey men in UK and, likely, also cultural differences. Culturally, resistance may be borne of the propensity of Americans for loud entrepreneurship, or simply bravado ("loud vs. proud"). Regardless, it may also be the case that this American trait accounts for more interest in US ideas being generated, as compared to the less entrepreneurial European. That said, there was consensus that the US is not viewed as a policy pusher.

In conclusion, the researcher turns to Klein for an apt overview, masterfully insightful, of US health policy exceptionalism, and English health policy transfer from the US. Drawing lessons for health care innovation or reform from the US requires:

. . . striking a difficult balance between historical determinism and free will, between cynical pessimism and naive optimism. The key to this puzzle may lie in a paradox: the United States is the most successful exporter of public health policy ideas and instruments yet has failed to build an effective health care system.

General ideas (like notions about the role of competition) and micro-instruments (like diagnosis-related groups) travel better than do health care systems. Ideas can be adapted to local circumstances, and instruments may easily fit into preexisting systems. Importing systems from countries with different histories and institutions would require a tectonic shift in the American political landscape. (Klein, 2003)

A difficulty with literature focused on policy transfer as either theory or process is that details of specific cases of policy transfer are lacking; hence, it is difficult to put cases through either theoretical framework for analysis. What is clear is that D&M's framework remained a largely state-centric and hierarchical framework though broader than in

previous studies even their own. That said, D&M must be credited with a major step forward and the addition of essential non-state actors, which actually resulted in an intersection or perhaps overlap the margins with experimentalist governance. However, EG not only robustly captured non-state actors but took policy-making completely out of hierarchy, closer to network governance than D&M. Moreover, EG incorporates multilevel networking in the pursuit of policy, which can be a template on top of multiple levels in the NHS. The findings from interviews for the thesis sustain the utility of fundamental principles of D&M's state-centric, hierarchical elements, but also demonstrate NHS participants are experiencing the freedom that meso and micro level actors have to network horizontally with colleagues, externally with contacts in other countries, or vertically within the Service if they choose. There is no 'one size fits all' in EG, which is how policy transfer occurs in the NHS. Whether or not it should be that way is another question.

Using the experimental governance lens, many more actors in policy transfer were identified, and a collaborative learning process between "expert" and "users," as a more suitable approach to building knowledge and consensus on policy transfers. The process becomes one of knowledge interfacing and sharing, and involves negotiation among partners. (Sabel and Zeitlin, 2010)

To the extent they are interested in "what works" in other countries, policymakers in the US and England are primarily interested in each other. This has been called the "most different system comparison." (Exworthy & Freeman, 2009) Largely at England's initiative, however, knowledge interchange and policy transfer are sought almost exclusively from the US not vice versa, ie, unidirectional. England "shows greater interest in learning from the US than vice versa." (Ham, 2005) This is interesting for a number of reasons. England's NHS performs better than the US on many objective indicators of population health status, clinical outcomes, and health care costs as a percentage of GDP (Ham, 2005), though still lags on outcomes compared to other OECD countries.

a) The term 'unidirectional' policy transfer may at first appear to suggest 'coercive' but is not necessarily true and, in fact, rarely is. It is, in fact, non-coercive when in its pathway to implementation is built upon consensus among policy actors in a process

particularly notable in the experimentalist governance framework, and not ordered or forced by one entity upon another. Hence, unidirectional and coercive should not be conflated. Using the D&M lens, supra-national organisations, eg, the EU, can directly coerce policy upon member states. In this sense, supra-national organisations, eg, also the IMF or World Bank, can coerce policy. However, some would argue that because of a priori voluntary membership in the organisations, this action should be described as 'obligated,' not coercive. (Benson and Jordan, 2014) Within the EU structure itself, policy transfers can be worked out in a unidirectional, non-coercive process.

Trans-national corporations can coerce governments into policy transfers by the threat of removing business interests. Indirect coercive transfer can occur because of interdependent relationships or externalities, which can push governments to work cooperatively to solve problems, resulting in policy transfers. Technology can force governments to change policies to keep up with its rapid development. Governments can be indirectly coerced into policy transfers by their elected officials because of the sensed need to 'keep up' with competitor countries or because of an embarrassment. Even the emergence of an international consensus on a policy can serve as a 'push' factor on governments. (Dolowitz and Marsh, 1996)

b) By re-branding, it is possible to effect a stealthy or covert transfer. At the same, by the very nature of such transfers, it is obviously more difficult to uncover or track such transfers than 'normally.' More likely, it is the case that re-branding is necessary to gain acceptance of the transfer in the 'borrowing' health care system. This was learned during the course of participant interviews for the thesis. A prime example is the Virginia Mason patient safety and quality programme transferred from the US. A successfully implemented programme in the English NHS, it necessarily required a change of name as part of acceptance. One of the few strategic-level transfers from the US – the Diagnostic Related Groups (DRG) payment system – was renamed Healthcare Resource Groups (HRGs), which are the 'currency' of Payment by Results (PbR) in the UK.

c) Cohen et al. theorised in a 1972 paper that "organized anarchies are organizations [considered "decision situations"] characterized by problematic preferences, unclear technology, and fluid participation." (Cohen et al, 1972) Further, a "garbage-can" model produces a decision as an outcome or interpretation of several

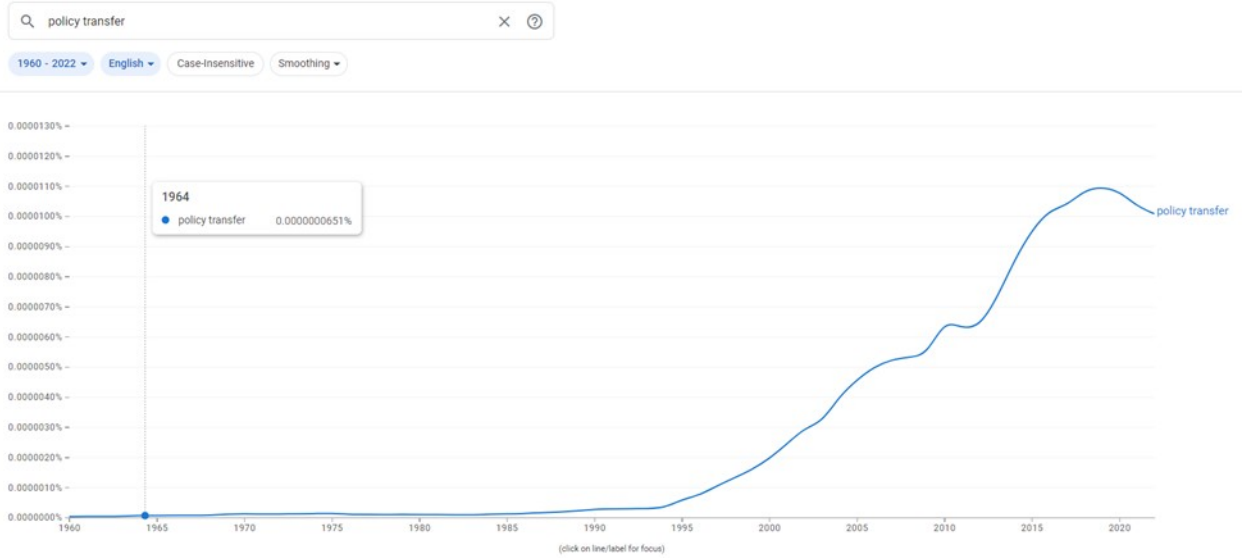
relatively independent streams: a) problems, b) solutions, c) participants, and d) choice opportunities. (Cohen, 1972)

So, originally a theory of decision-making (Cohen et al, 1972), the garbage-can theory evolved into a perspective on policy-making . It is notable that adaptations of the approach placed emphasis on the health sector. (Paton, 2013)

It is informative that Paton created a garbage-can framework to “explain each stage of the reform of the English National Health Service (NHS) over the last 25 years.” (Paton, 2013) With the garbage-can lens, Paton asserts that ideas and policies produced at each stage of reform have been arational if indeed not irrational. Paton believes the garbage-can alone is not enough to be sufficiently explanatory, which is to say arationality may rule in day-to-day policymaking (short-term) but ideological context, trend, or bias expressed through reforms are extant (longer-term). These two aspects in combination, however, do serve to explain “how policy over time is biased in a particular direction while seemingly arbitrary and directionless at each messy decision-point.” (Paton, 2013) The garbage-can model is being ‘re-discovered’ following ascendancy of evidence-based approaches (including decision-making and policy-making), whereby rational approaches were deemed to operate. Hence, the garbage-can model offers a useful counter-balance to that narrative.

In the early 1990s, scholarly exploration of a body of cross-national, cross-regional, cross-local, and cross-historical transfer of policy ideas, frameworks, programmes, and institutions began to accelerate in earnest. Its essence was the consulting of best practices and the inspiration drawn therefrom. Best known in the policy sciences is the concept of ‘policy transfer’ developed by Dolowitz and Marsh (D&M). (Dolowitz and Marsh, 1996; 2000; for critiques see James and Lodge, 2003; Evans, 2004; Marsh and Sharman; 2009) Policy transfer has been aided by the globalisation of policy networks enriched by international agencies, eg, OECD, management consultancies, and by IT.

The graph below shows very low publication content for policy transfer from 1960 to 1995, where there was a take-off point. Publishing in policy transfer massively increased and continued an upward trend from 1995 to near 2020, contributing to part of the context for it.



https://books.google.com/ngrams/graph?content=policy+transfer&year_start=1960&year_end=2022&corpus=en&smoothing=3&case_insensitive=falsens

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The garbage-can has particular relevance with respect to policy transfer because, as discussed earlier, it can be and most often is a messy, murky, non-linear, asynchronous process. For example, even in the terminologies of policy transfer a great variety has evolved, and hence contributed to fragmentation. (de Jong and Unalan, 2012)

Freeman’s application of “bricolage” to public health decision-making, aided by international networks illustrate this connection between garbage-can and policy transfer. (Freeman, 2007)

7.7 Limitations of the study

The researcher recognises that no study can fully escape limitations. That said, however, it is imperative is to recognize, acknowledge, and take measures to minimise limitations, whenever possible.

1. There was limited availability of actual appointment time with busy elites. The only measures that served to overcome this limitation were being completely reflexive in negotiating a place on diaries and, of course, the qualities of persistence and tenacity.
2. A considerable number of potential interview candidates contacted were not met. Some simply did not respond to repeated attempts at contact, whilst others responded but immediately declined, and still others went through an extended negotiation (across months, in some cases) before ultimately declining. Because of purposive interviewee selection those not met for various reasons would have been the equal in knowledge, experience, position, and status of those actually interviewed, and would have roughly doubled the sample.
3. The researcher considered an opinion of interviewees regarding the researcher's possible bias vis-à-vis US vs UK health care. This was the researcher's intuition, not in actual evidence. The question raised in the researcher's mind was whether or not interviewees' opinions in this regard may have influenced or shaped their responses. This is doubtful given the elite status of interviewees. The researcher did not betray that, in fact, his bias favored the UK system of health care.
4. The researcher did not try to assess outcomes of any policy transfer, ie, whether policy or programmes were actually implemented and, if so, whether they were successful; hence, not a longitudinal study of specific policy transfers.
5. The researcher did not compare one-to-one responses from each interviewee for validity. That said, themes which emerged from each interviewee were compared and compiled.
6. Time and distance: it is undeniable that the researcher's home base in the US presented its own special problems with respect to field work, which was

conducted entirely in the UK. Without question, there were cost and logistical considerations which came into play when arranging meetings with elite stakeholders in the UK. The researcher was required to be extraordinarily flexible to comply with diary availability of busy elites, which had both time and cost implications.

7. Civil service mentality: The British civil service is modeled on official neutrality. Additionally, there is often a 'silo' effect, ie, lack of interaction, coordination, or perspective outside one's own ministry. In effect, then, orthodoxies may be engendered which limit a fulsome view, opinion, or treatment of issues, and hence produce 'rote' responses, wherein path dependency may come into effect.
8. Clinical/programmatic level: Clinicians, medical directors, and nursing staff were the most difficult to meet. This represents the 'meso' level of investigation. Clearly, potential interviewees at this level were understandably extremely busy professionals, ie, directly involved in patient care. Many simply declined upfront to meet, whilst others agreed but subsequently rescheduled several times before ultimately declining. Despite indications of good intent, professional demands overwhelmed events
9. Specialisms may have limited commentary with respect to questions. Interviewees had a natural tendency to be more confident and fulsome with responses corresponding to their areas of expertise. The researcher had to be alert to mitigate these situations in order to conserve time to cover all issues of interest. This occurred in only a few interviews.
10. Rationalisation: Human subjects engaged in any endeavor have a natural tendency to 'rationalise,' eg, make sensible, what they have done, supported, or influenced over the course of a career. This tendency seems to increase in effect over time.
11. It is understood that elite actors engaged in English health care, ie, the NHS, comprise a relatively small circle. In 1996, Dolowitz & Marsh said that "policy transfer enhances the power of a relatively small circle of actors who consistently draw lessons from each other . . . instead of introducing new ideas, lesson drawing simply reinforces the existing system . . . thus maintaining the status

quo. (Dolowitz & Marsh, 1996) The challenge here may be an uncritical view taken by elite actors. This is indeed a limitation not readily subject to mitigation.

12. There was good access to interviews but, in the end, a partial sample.
13. Researcher in part-time PhD programme so able to have a longer period of field work and analysis than most but a limited window compared to the longer term trends discussed here.
14. Interviews were appropriate compared to other methods (eg, observation would have been difficult given the diffuse nature of the topic); however, a 'public account' might have been presented. This is despite the seniority of the interviewer, the ability to develop rapport as an experienced health leader, etc.
15. Mention of 'policy transfer,' eg, in introductory email to interviews might have introduced misplaced perceptions about the topic.

CHAPTER 8 Summation and Conclusions

Prior to this study, the question of the US as a privileged source of health policy ideas, learning, or transfer, and why, had never been explored in the literature. Hence, the findings herewith provide an original contribution to knowledge, with a view to expand understanding of the perspective of actors, processes, and implications involved for health policy stakeholders in England.

There was a need for rich context, detailed perspectives and understandings of study participants who had breadth and depth of experience in English health care, and in searching for solutions, and innovations. While there is considerable policy transfer literature, little of it is explicitly associated with health care, and simply no searchable literature was found to address in any detail the US as a privileged source of health policy innovation in England, only a few implications here and there. For example, an article might describe the transfer of say, a nursing care model or programme from the US, without placing it in the context of policy transfer.

Two different theoretical lenses were elucidated in the theory chapter – both proved useful to link with the literature, develop research questions, guide data extraction, and organise it – but the researcher found that S&Z's experimentalist governance (Sabel & Zeitlin, 2010) added a new, more dynamic dimension and explanatory power to D&M's more state-centric, hierarchical policy transfer framework (Dolowitz & Marsh, 1996; 2000).

The greatest strength of the study is the cohort of elite stakeholders who were not only generous with their time and participation but also seemingly eager to make a contribution to this particular subject, evinced from initial recruitment attempts. As described in an earlier chart, these elites had rich, broad and deep experience, and virtually all had careers in more than one sector of health care in England. The research was limited to England, not addressing the other three countries comprising the UK. It was not a longitudinal study and hence did not follow any specific transfer over time, or offer any assessment of the success or failure of implementation of transferred policies or programmes.

It should be stated early that an unexpected, extraordinary unanimity existed among participant views. There were no seriously conflicting views among participants. Of course, there was parsing at the margins, and differences in manner of explanation. However, all the main themes were strong in exposition and clarity. This was surprising given the seniority and depth of experience of the cohort, which would lead one to expect a greater divergence in responses.

Perhaps it might be expected in a study of this type that participants, say, of one category, could be set against those of another for comparative, analytical purposes. However, from the collected data, this was not possible to any significant effect, only perhaps at the margins. Perhaps this might beg a question regarding participant selection. However, the researcher remained confident that the selection and vetting procedure for participants (described in

Methodology) was sufficiently systematic to assure to the extent possible a broad and diverse representation of views.

It was emphatically demonstrated that study participants were opposed to considering adoption of any aspect of US health care from the system or national level. The universal opinion was that, in fact, health care in the US is delivered in a 'non-system;' rather, it is a series of silos albeit large ones. Conversely, it was unanimous that the US is a privileged source of health policy ideas, policies, and programmes. Lacking any system-level appeal, participants nevertheless thought the US has many 'silos' of excellence in health care, and agreed that the UK actively seeks out 'bits,' or specific techniques and tools from transfer to solve a problem. No participant thought the US was the recipient source of less than 50 percent of UK transfers sought, whether or not consummated, most estimates ranging from 60-70 percent or more. Despite the relatively high level of policy transfer activity with the US, it was learned that there is a relatively 'passive consciousness' of it, according to participants. There is clearly awareness of the activity, even acceptance, though somehow not a focus on the fact that a large aggregate of it concerns the US.

Why is this study important? Innovative health policy ideas, learning, and transfer have important implications for systems improvement, cost, quality, access, equity of health services, and values extant in the system. They can also incrementally change the fundamental nature of a system, particularly in systems of care which are wholly divergent in organisation, planning, financing, and provision. This is notably the case of England and the US, and there is a lot of health policy transfer occurring.

Transferring policies or programmes from a wholly different non-system can impact access, costs, and quality, known as Kissick's 'Iron Triangle.' The premise is that an improvement in one area will result in a decline in at least one of the others. In the researcher's estimation, the importance of these elements cannot be overstated. Needless to say, cost is a critical factor in the delivery of health services anywhere in the world. Cost can determine whether or not services are offered and where, which can drive quality. When and where services are available or not can also impact the equity of service delivery to populations. For example, transfer of a technology not readily available to a population or affordable can result in a twotiered system, leaving behind the less technologically literate. Access can be affected as transfers are implemented in one or another but perhaps not enough locations, owing to costs. Of course, in a vacuum, transfers can lead to system improvements. Values inherent in a system can also be

degraded, replaced over time, or changed more immediately, and this is a crucial point of consideration when seeking policy or programme transfers.

Whilst it is important to know that the US is a privileged source of health policy ideas, policies, and programmes, at the same time, it might serve to beg the question of whether other sources should be consulted more often, at least in selected situations, if nothing else.

Three important issues for the attention of health policy stakeholders in England emerged from this study:

1. There is a 'passive consciousness' (which could be read as acceptance) of the privileged status of the US for health policy ideas, policies, and programmes. This study indeed demonstrated a privileged status and a majority of policy transfers from the US. Greater awareness/focus of this fact might be called for to assess and/or alter, as appropriate, path dependencies, other aspects or conditions, as they might exist.
2. Elite stakeholders had consensus that a continuous, common thread of US influence exists across governments during the periods of reform. Thatcher opened the door to market forces. The Blair/Brown period saw assiduous pursuit of US ideas, policies, and programmes. Much later, the Lansley reforms in the Act of 2012 appeared to cement market principles modeled on the US. Of course, there were indeed variations in emphasis and policy content. Awareness that stakeholders had no corollary consensus on the advisability of continuing the trend might provide openings for initiatives that break the cycle.
3. Consideration might well be directed to formalising a policy transfer process across England's NHS. This might result in better coordination of transfer acquisitions upfront, and proper recording and efficient diffusing of transfer information across the Service on the backend.

Implications for future research

This study focused solely on the NHS in England. There was no pretense to generalise the findings to the NHS of other United Kingdom countries. There are many policy differences across the NHS's of Scotland, Northern Ireland, and Wales vis-à-vis England. Hence, research into policy transfer processes and practices in the other three countries is warranted, as well as *where* specifically external policy ideas, programmes, and learning are sought if they are,

toward an enhanced overall understanding in all four centralised, tax-supported national health services of the United Kingdom.

Future research should include a study of the ‘consequences’ of transfer of US health policy for England. One senior interviewee opined that England was pursuing “policy grabbing,” which may not have resulted in a coherent bundle of resources, implying that this was a negative consequence of policy transfer activity. This is a large, complex, and important topic which should be investigated for implications of impact on costs, quality, access, equity, and overall system improvement. A focus on consequences is likely to focus on the meso and micro levels vice macro since those are the levels where the impact of specific tools and techniques are most readily felt, and where most policy transfer activity. Studies could produce new insights into cases of ‘negative’ policy transfer wherein the focus of efforts is to reach out to learn ‘how not to do’ something.

Further, studies of specific transfers including longitudinal studies of transfers implemented in UK could be instructive for understanding the end-to-end process. Also, this study did not follow a specific policy or programme transfer from beginning to end. Such a study could help to identify deficiencies in the process, including potential obstacles of all kinds, and procedures for obviating problems.

Future studies could also examine implementation processes, which have a substantial separate literature. Likewise, there was no attempt to review the success/failure of implementation, which again has its own literature, and a future study of policy transfer failures could aim to improve efficiencies and effectiveness.

List of Abbreviations

A&E	Accident and Emergency
ACO	Accountable care organisation

AHSC	Academic health science centre
BMA	British Medical Association
CBHC	Cross-border healthcare expert group
CCG	Clinical Commissioning Group
CHS	Community health services
CMO	Chief Medical Officer
CQC	Care Quality Commission
DH / DoH / DHSC	Department of Health and Social Care
D&M	Dolowitz & Marsh
DRG	Diagnostic Related Group
EG	Experimentalist governance
ERN	Ethics review number
ERP	Ethics review panel
ERSC	Economic and Social Research Council
EU	European Union
FT	Foundation Trust
GP	General practitioner
HRG	Health Related Group
HSCA	Health and Social Care Act (2012)
ICS	Integrated care organisation
IHI	Institute for Healthcare Improvement Boston
ISTC	Independent sector treatment centre
IMF	International Monetary Fund

MCN	Managed clinical network
NHS	National Health Service
NHSE	National Health Service England
NHS-VMI	National Health Service-Virginia Mason Institute Partnership
NATO	North Atlantic Treaty Organisation
NG	Network governance
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
NNERPP	National Network for Education Research Practice Partnerships
NPM	New Public Management
HSJ	Health Service Journal
OECD	Organisation for Economic Cooperation and Development
OMC	Open method of coordination
PbR	Payment by results
PCN	Primary care network
PCT	Primary Care Trust
P4P	Pay for performance
PM	Prime Minister
PPS	Prospective Payment System

QUERI	Quality Enhancement Research Initiative
R&D	Research & development
SoS	Secretary of State
S&Z	Sabel & Zeitlin
UK	United Kingdom (used interchangeably with England)
US	United States of America
VA/VHA	Veterans Health Administration
VMI	Virginia Mason Institute

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Appendices

Appendix A

Dolowitz & Marsh model of policy transfer1

TABLE 1
A Policy Transfer Framework

Why Transfer? Continuum			Who Is Involved in Transfer?	What Is Transferred?	From Where			Degrees of Transfer	Constraints on Transfer	How To Demonstrate Policy Transfer	How Transfer leads to Policy Failure
Want To.....	Have To			Past	Within-a Nation	Cross- National				
Voluntary	Mixtures	Coercive	Elected Officials	Policies (Goals) (content) (instruments)	Internal	State Governments	International Organizations	Copying	Policy Complexity (Newspaper) (Magazine) (TV) (Radio)	Media Reports	Uniformed Transfer
Lesson Drawing (Perfect Rationality)	Lesson Drawing (Bounded Rationality)	Direct Imposition	Bureaucrats Civil Servants	Programs	Global	City Governments	Regional State Local Governments	Emulation	Past Policies	Reports	Incomplete Transfer
	International Pressures										
	(Image) (Consensus) (Perceptions) Externalities	Pressure Groups	Institutions			Local Authorities		Mixtures	Structural Institutional	Conferences Meetings/ Visits	(Commissioned) (uncommissioned) Inappropriate Transfer
	Conditionality (Loans) (Conditions Attached to Business Activity)	Political Parties	Ideologies					Inspiration	Feasibility (Ideology) (cultural proximity) (technology) (economic) (bureaucratic) Language		
	Obligations	Policy Entrepreneurs/ Experts	Attitudes/ Cultural Values	Negative Lessons			Past Relations			Statements (written) (verbal)	
			Consultants Think Tanks Transnational Corporations Supranational Institutions								

Downloaded from https://academic.oup.com/doi/10.1093/oxfordhb/9780199642882.013.0001 by University of Cambridge user on 12 May 2015

Source: 1 Dolowitz, D., and Marsh, D. (2000). Learning from abroad: the role of policy transfer in contemporary policy-making. *Governance* 13(1), 2000.

Appendix B

THEMATIC MAP

Solving the Puzzle

Themes (see chapters 5 & 6)

Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
Privileged Source	Macro vs meso vs micro	Framers & brokers	Influence across governments	Specific tools/ techniques	Consequences for England

Sub-themes

1	2	3	4	5	6
US % vs others	No system interest	Think tanks	Common thread	Public reporting	Trojan horse
Limits/resistance	System-level benchmarks	Networks	Markets	Safety/quality	Disruption of established order
Policy push/pull	Trust/hospital initiatives	Fellowships Management consultancies	Competition	Clinical leadership ACOs/ICs Care models	Piloting Failure to look inward

Appendix C

Interview Schedule

Principal research questions (posed to all participants):

1. Do contemporary English health policy stakeholders perceive, understand, and take meaning from the United States (US) for health policy and programme ideas, learning, or transfer?
 2. During each of three key periods of health policy reform in the English NHS of the last three decades or so -- the periods of Thatcher/Major, New Labour, Health and Social Care Act of 2012 – explore the degree or extent of influence of US-based ideas, and notable variations?
-

Prompt, follow-up, probe questions to be used as appropriate/necessary (not sequential):

How do you think English health policy stakeholders view US health care policy, in general?

Please provide an estimate of the percentage of health policy and programme transfers from the US, compared to other countries, by country or in total?

Which countries, other than the US, does England look to for ideas, learning, and possible health policy transfer?

What specific transfer activities with these countries?

For each country, what is a rough estimate of policy transfers to England as a percentage of the total from all countries, excluding the US?

Would you expect viable health policy transfer options from systems more comparable to England, eg, Denmark, Netherlands, or others?

Broadly, who are the key actors of policy transfers in England? Who are brokers?

Can you differentiate the roles of various actors involved in policy transfer activities in England?

What factors might create policy affinity between England and the US?

At what level do most health policy and programme transfers originate, eg, national, trust/hospital, clinical/programmatic?

Do you view the US and UK systems of health care as incommensurable?

Can you explain health policy and programme transfers from the US in light of obvious differences in the two systems?

Are US health policy or programme transfers concentrated in particular domains, eg, technology, finance and management, clinical medicine, etc?

Do English health policy stakeholders view the US as a privileged source of health policy and programme innovation?

Is health policy transfer from the US different from US policy transfers which have occurred in other social policy domains such as criminal justice, tax, welfare, and education? If so, how?

Appendix D

Letter of invitation, information sheet, consent forms

Invitee address

Dear _____:

I am a US-based doctoral candidate in health planning and management at Keele University -- now at thesis stage -- conducting field research for a study to explore English NHS reforms from the 'internal market' of the 1990s onwards, and the extent of influence from the US inter alia.

I write to solicit your participation in this study, as I am confident your contribution would provide crucial facts, insights, and balance. My request is for an interview of an hour or so maximum.

Study Title: Health policy shopping in the United Kingdom: a qualitative exploration of the US-UK nexus

Aims of the Research

This research aims to gain insights into United Kingdom motivations for reputedly turning predominantly to the United States for health policy ideas, learning, and transfer. The study seeks to obtain the views of NHS England executives/managers, politicians, political advisers, academics, and clinical managers.

There are three research objectives: 1.) to determine whether, in the view of contemporary UK health policy stakeholders, the US is a privileged source of health policy innovation and, hence, policy transfer; 2.) to compare and contrast three key periods of policy reform in the English NHS in the last 25 years as to the influence of US-based ideas; and 3.) to assess the consequences of health policy transfer for the NHS in England.

The research process will involve individual interviews, which are planned to last one hour or less. The interview will be scheduled during normal work hours within your place of work or another location if more convenient, and every attempt will be made to minimize disruption to your workday. All of the information obtained will be completely anonymised, and not attributable to you individually by name, title, position, or location.

This research is supervised by Professor Stephen Cropper, School of Social Science and Public Policy, Keele University.

With your agreement, I would hope to work with whomever you designate to arrange a meeting during the 17th to 27th April 2018. In the meantime, I am enclosing the University-required and -approved Information Sheet and two Consent Forms -- one general and one for use of quotes -- for your review prior to our meeting. The consent for use of quotes will be signed only after the interview, and you have had an opportunity to reflect on it. I will bring paper copies of the Consent Forms to our meeting.

Your willingness to consider participation in this research is greatly appreciated. I can be contacted for questions or more information at the email address below.

Yours sincerely,

//signed//

Anthony D. Stem

Email:



INFORMATION SHEET

(Version 3, March 19, 2016)

Study Title: Health policy shopping in the United Kingdom: a qualitative exploration of the US-UK nexus

Aims of the Research

The aims of this research are to conduct a study of the anecdotally reported tendency of UK health policy stakeholders to look predominantly to the US for health policy ideas, learning, or transfer.

You are being invited to consider taking part in the research study: Health policy shopping in the United Kingdom: a qualitative exploration of the US-UK nexus. The researcher for this study, Anthony D. Stem, is pursuing a Doctor of Business Administration degree in Health Planning and Management at Keele University, and is conducting this research for a doctoral thesis.

Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully, and discuss it with friends and relatives if you wish. Please ask if there is anything that is unclear or if you would like more information.

Why have I been chosen?

I am contacting policy makers, executives and managers, policy advisers, academics, and clinical managers, who have knowledge and/or experience in NHS England pertinent to activities and initiatives related to health policy development or transfer.

Do I have to take part?

You are free to decide whether you wish to take part or not. If you do decide to take part you will be asked to sign two consent forms, one copy is a general consent to participate, and the other is for your consent to use your quotes (not attributable to you individually), which will be signed only after your participation in an interview. You may retain copies of both of these forms. After an interview, you have the right to retrospectively withdraw any consent you have given at any time and for any reason without penalty. Upon withdrawal, any data relating to you will be destroyed. However, a request for withdrawal should be made within 120 days of the date of the signed consent form.

What will happen if I take part?

You will be invited to an interview during April 2018. The interview will last about an hour and will be held at a time and location convenient to you. During the interview, you will discuss your opinions of and attitudes towards the subject of health policy transfer in the UK. You may be prompted by questions from the researcher. Your discussions will be based on your understanding of health policy transfer to the UK in either your current or any previous positions in UK health services. **With your permission, the interview will be audio-recorded. The recording will be transcribed only by the researcher, securely stored, shared only with the researcher's supervisor, and destroyed after the research is submitted.**

If I take part, what do I have to do?

If you are willing to take part in an interview, you will need to be able to spare approximately one hour of your time. During the interview, you will be asked to talk about your views on UK health policy transfer, with particular focus on transfer from the US. The researcher will be present with you and may ask several prompt questions to initiate and guide the discussions.

What are the benefits (if any) of taking part?

The benefits of taking part are that you will be contributing to knowledge and understanding in this area. Health policy transfer is significant for the organisation, cost, quality, access, and equity of health services. The findings from this research may be of use to the NHS England, or community-based health services organisations in England and, therefore, you may well have a direct impact on future debates surrounding the subject of health policy transfer and its utility.

What are the risks (if any) of taking part?

The risks associated with this interview-based research are minimal to insignificant. If, at any time, you feel uncomfortable discussing your views you may so indicate and the interview will end. You may also advise if you experience any physical discomfort, which might or might not be related to a medical condition, and the interview can either be paused, or end, depending on circumstances and your wishes. There is no clinical testing, physical activity, or hazardous environment associated with this research.

How will information about me be used?

Participants will be identified in generic categories: managers, politicians, political advisers, or academics; not by true name or even specific title. With your permission, the interview discussion will be audio-recorded and transcribed. Transcriptions will be stored as a confidential file on an encrypted, password protected computer owned by the researcher, and recordings will be deleted after the study is finally submitted. The information collected will be retained for possible use by the researcher for no more than four years. Thus, participants consenting to this study are also consenting to use of the information in future studies conducted by the researcher but only within the next four years.

Who will have access to information about me?

The information collected will focus upon your opinions and experiences. All audio-recorded data and subsequent transcriptions will be kept securely by the researcher, Anthony Stem, on an encrypted and password protected computer. Pseudonyms will be assigned to participants in place of real names, and real names and pseudonyms will be stored separately in files but mapped to each other on the encrypted computer. These files will be available only to the researcher and supervisor. There will never be any reference to your specific position title, or location. Hence, there will be limited information about you available to anyone at any stage of the process.

Who is funding and organising the research?

The research is both self-funded and organised by the researcher.

What if there is a problem?

If you have a concern about any aspect of this study, you may wish to speak to the researcher who will do his best to answer your questions. You should contact Anthony Stem at [REDACTED]. Alternatively, if you do not wish to contact the researcher you may contact Professor Stephen Cropper at [REDACTED] who is the researcher's supervisor.

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study please write to Nicola Leighton, who is the University's contact for complaints regarding research, at the following address:

Nicola Leighton

Research Governance Officer

Research & Enterprise Services

Dorothy Hodgkin Building

Keele University

ST5 5BG

E-mail: [REDACTED]

Tel: [REDACTED]

Contact for further information:

Mr. Anthony D. Stem, [REDACTED]



CONSENT FORM

Title of Project: Health policy shopping in the United Kingdom: a qualitative exploration of the US-UK nexus

Name of Principal Investigator: Mr. Anthony D. Stem, Keele University, [REDACTED]

Please initial box if you agree with the statement:

1 I confirm that I have read and understand the information sheet dated March 19, 2016 (version 3) for the above study and have had the opportunity to ask questions.

2 I understand that my participation is voluntary and that I am free to withdraw at any time.

Note: Participants have the right to retrospectively withdraw any consent they have given at any time and for any reason without penalty. Upon withdrawal, any data relating to them will be destroyed. A request for withdrawal should be made within 120 days of the date of this signed consent form.

3 I agree to take part in this study.

4 I agree to allow the dataset collected to be used for future research projects.

5 I agree to be contacted about participation in future research projects.

Name of participant	Date	Signature
---------------------	------	-----------

Researcher	Date	Signature
------------	------	-----------



CONSENT FORM*

(for use of quotes)

*To be signed only after completion of the interview.

Title of Project: Health Policy Shopping in the United Kingdom: A Qualitative Exploration of the US-UK Nexus

Name of Principal Investigator: Mr. Anthony D. Stem, Keele University, [REDACTED]

Please initial box if you agree with the statement:

1 I agree for any quotes to be used.

2 I do not agree for any quotes to be used .

Name of participant	Date	Signature
---------------------	------	-----------

Researcher	Date	Signature
------------	------	-----------

Appendix E



Keele
University

Ref: ERP370

14th April 2016

Anthony Stem
3208 Bloomfield Ct.
Plano

Texas
75093 USA

Dear Anthony,

Re: Health policy shopping in the United Kingdom: A qualitative exploration of the US-UK nexus

Thank you for submitting your revised application for review.

I am pleased to inform you that your application has been approved by the Ethics Review Panel. The following documents have been reviewed and approved by the panel as follows:

Re: Health policy shopping in the United Kingdom: A qualitative exploration of the US-UK nexus

Thank you for submitting your revised application for review.

I am pleased to inform you that your application has been approved by the Ethics Review Panel. The following documents have been reviewed and approved by the panel as follows:

Document(s)	Version Number	Date
[REDACTED]		
Letter of Invitation	3	19-03-16
Information Sheet	3	19-03-16
Consent Form	3	19-03-16
Consent Form (for the use of quotes)		19-03-16
Interview Guide	3	19-03-16

If the fieldwork goes beyond the date stated in your application (30th November 2017), you must notify the Ethical Review Panel via the ERP administrator at research.erps@keele.ac.uk stating ERP3 in the subject line of the e-mail.

If there are any other amendments to your study you must submit an 'application to amend study' form to the ERP administrator stating ERP3 in the subject line of the e-mail. This form is available via <http://www.keele.ac.uk/researchsupport/researchethics/>.

[REDACTED]

Keele University, Staffordshire ST5 5BG, UK www.keele.ac.uk

[REDACTED]

If you have any queries, please do not hesitate to contact me via the ERP administrator on research.erps@keele.ac.uk stating ERP3 in the subject line of the e-mail.



Mrs Val Ball
Chair — Ethical Review Panel

cc RI Manager
Supervisor