Post-New Public Management (NPM) and the Reconfiguration of Health Services in England

Louise Dalingwater
Introduction

New Public Management (NPM) reforms were introduced in the 1980s as a reaction to Keynesianism, which had shown its limits in responding to stagflation (a combination of low growth, high inflation and long-term unemployment) and effective fiscal management. NPM was based on the premise that private-sector managerial techniques were immensely superior to cumbersome Public Administration (PA) principles. However, like PA principles, NPM techniques started to show their limits in an increasingly digitalized era and particularly from the late 1990s onwards. It has been argued that the ingredients of NPM, which were essentially disaggregation, competition and incentivisation, have been replaced by new forms of governance which espouse re-integration, needs-based holism and digitization changes. This paper will therefore examine whether there has been an overhaul of New Public Management since the late 1990s. It will begin by considering the origins and application of New Public Management and then go on to consider the post-NPM or New Public Governance reforms of the late 1990s onwards. In particular, it will consider how post-NPM reforms have transformed the workings of public health delivery in England.

New Public Management (NPM)

Origins and Application

New public management (NPM) developed as a reaction to post-war public administration principles. Towards the end of the 1960s, faced with fiscal crisis and economic stagnation,
academics began to call into question the post-war framework that had been set up. According to monetarists, the causes of unemployment were rigid labour markets dominated by union power, the immobility of labour and excessive state benefits and levels of taxation. Hayek and public choice theorists also underlined the dangers of the growth of the public sector at the expense of the private sector. Public choice theorists claimed that individuals and groups all had a vested interest in supporting the growth of public services, which lead to over-production and waste. According to the “crowding out” hypothesis, espoused by Bacon and Eltis, public sector expansion was detrimental to the economy. Indeed, the authors claimed that by allocating greater resources to public spending, private sector investment was crowded out. An unproductive sector was thus seen to be expanding at the expense of a productive one. Such theories were taken on by influential politicians of the New Right in the 1970s and led to the development of a New Public Management approach when Margaret Thatcher came to power in 1979. The assumption of this new form of governance was that private-sector managerial techniques were immensely superior to cumbersome Public Administration principles. The application of such techniques in the public sphere was thus assumed to improve efficiency and effectiveness.

New Public Management (NPM) is nevertheless a difficult concept to define, perhaps because it is a loose set of techniques and ideas rather than a firm paradigm. Indeed, it was only a decade after the implementation of NPM that it was mentioned as a concept. Christopher Hood was the first to define the nature and practice of New Public Management. Clark, who went on to develop Hood’s definition, posits that NPM consists of three main concepts: 1) Marketisation, which means introducing market competition into public services by separating the purchaser from the provider, creating “quasi-markets” within the public sector (notably in healthcare, education, social services and social housing), competitive tendering or outsourcing to the private sector; 2) Disaggregation, that is strengthening central strategic capacity by decoupling policy and executive functions: tighter central control over policy and frameworks, moving from concentrating on process to output in control and accountability mechanisms, and finally 3) Incentivisation, which means creating incentives to encourage greater entrepreneurialism, more results, overall greater efficiency: performance indicators, performance-linked pay to create incentives for public sector staff to be more efficient, human resource management strategies, deprivileging professionals and public sector workers. NPM might therefore be reduced to three Ms: Markets, Managers and Measurement. In practice, this led to the overhaul of one of the most important public services in England: the NHS.

The Introduction of NPM in the National Health Service

The National Health Service (NHS) is the largest employer in Europe, with over one million staff. This organization is considered essential because not only does it provide health services to the British population but it also aims to ensure social cohesion, a strong workforce and contributes to economic growth. It is also very costly to deliver and this has led to successive reforms, especially since the 1980s to try and improve services and make efficiency gains.

Traditional Public Administration in the NHS up until the 1980s had led to a split between political bureaucracy and the professions. It was a decentralized system with the
Department of Health maintaining a loose control and being accountable for resources, quality and the quantity of service provision. When the conservatives were elected into government in 1979, there were 14 Regional Health Authorities, 90 Area Health Authorities and 192 District Health Authorities. The Area Health Authorities were created according to local authority boundaries whereas District Health Authorities covered the catchment areas where district general hospitals were located. District Health Authorities received funds from the Department of Health according to the capitation formula and hospitals negotiated an operating budget. In addition, the Resource Allocation Working Group was set up in 1975, responsible for allocating resources for secondary care according to need. The district management team was directly responsible for managing and ensuring the high performance of hospitals in a kind of “command and control” fashion. However, in practice, the medical profession was organized in clans who controlled the delivery of health services and imposed their own mode of governance. Outwardly, the hospital reflected the model of the professional bureaucracy. Doctors were thought and assumed to act in the best interest of their patients and therefore they could enjoy autonomy and self-regulation. However, in the 1970s, this mode of governance became increasingly under fire because of the NHS’ lack of efficiency and poor performance. According to Lapsley and also Le Grand, waiting times for treatment and variable quality of care meant that the public became increasingly critical of the doctors’ and professionals’ capabilities to manage health care. Public choice theory claimed that clinicians were acting through self-interest rather than for the public good.

NPM management techniques were introduced in the NHS after the election of the Conservative government in 1979. The Griffiths Report of 1983 was instrumental in changing the way the NHS was governed. This report, published by Roy Griffiths, managing director of Sainsburys, claimed that “if Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge.” Griffiths thus recommended that NHS hospitals be run like private companies by strong management who would put quality and customer satisfaction first. Following the Griffiths’ Report of 1983, a series of political reforms were carried through to stimulate a more business-like organization. Professional regulation and management by District Health Authorities was replaced by Unit General Management, with managers appointed from both the public and private sectors to manage hospitals. The next step, outlined in the white paper “Working for Patients”, was to offer greater choice for patients. This report claimed that buying care outside the health service would relieve the NHS of pressure and enable greater provision of services and thus greater choice. Public services were likened to private services with emphasis on the quality of services and value for money.

The private sector was presented as having superior qualities to the public sector. District health authorities were thus instructed to purchase care from private hospitals through private tendering. Indeed, Compulsory Competitive Tendering, the outsourcing of non-core services such as catering and laundry, was seen to be the most effective way of involving the private sector in the provision of health services to make efficiency gains. In addition, in 1989, the internal market was introduced in the NHS. The internal market made a distinction between the purchaser and provider, namely through the setting up of NHS trusts. Moreover, the NHS and Community Care Act of 1990 confirmed the gradual takeover of quasi-market forms of governance, which were part and parcel of NPM. This involved contracting relationships and reinforced the separation of the
functions of the purchaser and the provider. The purchasers, who were the health authorities, had budgets allocated to them in which they had to buy health services from the providers. Providers were health authorities. In order to play the role of health providers, they had to become NHS trusts. In addition, GP fund holders were created who could purchase services directly from providers instead of going via the Health Authority. The intention was eventually that the GP fund holders would replace the commissioning carried out by the Health Authorities. In 1994, the NHS trusts were created to further extend the separation between the purchaser and provider. These were self-governing, non-profit provider organizations financed by public capital. There was also emphasis on outputs and outcomes and clear targets were introduced in the NHS. Thus, massification of services, cost effectiveness, customer choice, performance management and performance-related pay became the key features of the new NHS under NPM reforms.

However, a decade after its application NPM also came under fire for its lack of a real theoretical basis, for its questionable benefits and the practicality of applying private sector techniques to the public sphere and especially health services. Towards the end of the 1990s, it came to be seen as one-dimensional, failing to be effective in the management and governance of health services and leading to fragmentation in the delivery of public services.

**Going Beyond NPM and changing forms of public governance from the late 1990s**

**Post-NPM reforms**

Reform measures were taken in the late 1990s which altered the nature of NPM modes of governance. Towards the end of the 1990s, developed nations were said to have entered the digital era which led to a reintegration and digitization, and thus new forms of governance. In addition, devolution made it essential to bring about reforms to public management as the transfer of authority to local regulatory agencies meant that the fragmentation of service delivery, seen to be a result of NPM, had to be solved. Empowering the regions also gave politicians greater incentives to ensure that central control was not completely lost and accountability and capacity were ensured. The post-NPM reforms brought in when New Labour came to power in 1997 were also made in order to improve the horizontal and vertical coordination of governmental organization which had emerged out of NPM.

Indeed, from a vertical standpoint, stronger central control was also brought in to play by increasing central resources. From a horizontal point of view, post-NPM reforms focused on empowering agencies and state-owned enterprises. It also entailed bridging the gap between governance and government, that is stronger links between the state, the private sector and civil society. New Labour discourse focused on “joined-up” government to mend the fragments that had been created by previous forms of governance, both Public Administration and NPM. The aim was also to form a more cohesive structure and create more loyalty among public sector workers. Partnerships were thus encouraged between the public and private spheres as a way of joining-up government or indeed to create “joined-up governance”. Multi-level governance was also introduced in the shape of networks and partnerships.
Despite these reforms, it can be argued that NPM forms of governance were still prevalent. New Labour presented post-NPM reforms as a modernization programme bringing a more collaborative approach, joint-up government, network arrangements, aimed at a lesser fragmented organization of public services. These were aided by advances in new technology. In reality, private sector techniques were prioritised. Under New Labour, there was still evidence of a drive for efficiency in public services as there had been during the Thatcher years. Emphasis on responsiveness to users and giving public choice were very much in line with NPM ideas. New Labour was still focused on quantifying and setting performance targets. Compulsive Competitive Tendering was replaced by Public Private Partnerships to outsource services to the private sector. The Prime Minister’s Delivery Unit was specifically set up to manage and enforce performance management, performance indicators and Public Service Agreements.

The post-crisis coalition government also shows signs of resuscitating NPM ideas. The current government claims to have scrapped performance targets and developed localism. In practice, there is no clear evidence that targets have disappeared. Moreover, by making cuts to local public services, local government is obliged to take on NPM-style techniques: that is find ways of making efficiency gains. In practice, it is clear to see how post-NPM modes of governance have built on NPM if we consider the reforms that have taken place in the NHS.

Deconstructing and Reconstructing NPM in Health Service Provision

A number of problems associated with the new NPM mode of governance in the NHS were raised by New Labour when they were elected into government in 1997, such as the absence of clear incentives to improve performance, the disempowerment of patients, a lack of national standards and variations in treatment. Moreover, the original intention of the internal market was to create competition between hospitals and thus make efficiency and quality gains. However, little investment was made to purchase quality hospital services or to develop costing systems, which undermined the whole working of the internal market.

It has been argued that the arrival of New Labour to government heralded a new, third way approach which removed the excesses of NPM by scrapping the internal market and performance management targets in public health. Indeed, the white paper *The New NHS: Modern, Dependable*, published in 1997, shortly after the change in government, stated the changes to be neither going back to the old bureaucratic PA system nor embracing NPM: “…neither the old centralised command and control system of the 1970s [nor] the divisive internal market of the 1990s”, but instead an approach based on partnership.” The internal market was thus replaced by commissioning and payment by results which involved a more joined-up or network-partnership approach.

However, this does not mean that NPM was scrapped altogether under New Labour. In reality, NPM techniques continued to be applied in health services in England. New Labour still emphasised the importance of efficiency and effectiveness. A key element which shows the continuation of NPM techniques was the focus on the benefits of choice under New Labour. This meant essentially upholding the purchaser-provider split. Special emphasis was still placed on the marketising of health services and running the NHS like a business. In 2003, under the Health and Social Care Act, New Labour set up Foundation...
Trusts which were NHS Trusts which had gained this status because they were considered to be high performers. It was heralded as a joined-up approach by transferring accountability from the state to the local community in order to meet the needs of the local population. In reality, these NHS trusts had to compete and were forced to respond to market forces in order to survive. The regional offices were replaced by Strategic Health Authorities responsible for ensuring the performance and management of local NHS bodies. However, the proliferation of managers received criticism because it was said to destroy the public ethos and result in inefficiencies. Managers continued to ensure service provision of both clinical and support services. Performance targets were also extended under New Labour and the results were used to portion out funding, resources and Foundation Status. Clinical audits are the perfect example of how New Labour kept the performance targets that it had promised to do away with at the beginning of its mandate. Indeed, performance indicators continued to be applied to such an extent that the Healthcare Commission reported in 2006 and 2007 that patient safety had been breached on a number of occasions because senior managers had put reaching government targets, financial controlling and reconfiguring services first.

When the Lib-Con coalition government was formed in 2010, discourse seemed to suggest that they would make a clear break with NPM techniques. The 2010 white paper Liberating the NHS underlined how healthcare was still a public good and “free at the point of access”. The coalition government also announced that national targets, a key feature of the NHS in previous governments, would be abolished. They did, however, maintain certain targets that were part of the NHS Constitution, such as targets for access to hospital treatment, targets for access to cancer care and targets for waiting times. Other initiatives would also seem to counter NPM initiatives of disaggregation, competition and incentives and embrace governance of the new digital age, such as giving patients direct access online to their medical records and allowing patients to monitor their medical care. Indeed, the NHS website (NHS Choices) now enables patients to comment on the services they receive. The emphasis on choice is paramount with websites such as Patient Opinion and IWantGreatCare, showing how users can make choices about which provider to use. This does away with New Public Management agencies and in this case the citizen. These projects were, in fact, initially proposed or set up by New Labour and extended by the coalition government.

The White Paper Healthy Lives, Healthy People shows how the management of public health has been moved from the NHS to local government. This is still overseen by a new executive government agency, Public Health England. Health and wellbeing boards have been created to work with the clinical commissioning groups to establish health strategies for the population. The most significant reforms of the coalition government took place in 2012. The Health and Social Care Act of 2012 represented one of the most important structural changes to the NHS in its history. Under this act, primary care trusts and strategic health authorities were abolished. These were replaced by clinical commissioning groups, who were given budgets to buy care for local communities, and health and wellbeing boards. The clinical commissioning groups in essence meant creating a mix of directly elected individuals operating under an administrative body (chief executive and other officers) appointed directly by the Secretary of state.

However, if we look beyond the political discourse which heralds a more serious commitment to a holistic or joined-up/interconnected approach and emphasises local forms of governance, it is possible to see that the underlying themes of New Public...
Management are still clearly at the heart of NHS reforms under the coalition government. The emphasis on choice that we mentioned previously is actually a key feature of NPM because the focus is also on competition to provide greater choice. The White Paper Liberating the NHS states that “patients will be at the heart of everything we do. So they will have more choice and control.”¹⁹ In addition, although the government claimed they would scrap performance targets, there is no real evidence of this in reality. Indeed, the government has continued to set targets and use the data to report on health outcomes. Performance management of providers has also continued. Power has been given back to the professionals because they are seen to be the most knowledgeable about how innovative practices can be introduced into the health sector. In practice, however, this has simply meant switching accountability to the professionals who have become directly responsible for achieving the performance targets set out by the government and governmental agencies. Indeed a BMA survey carried out in 2013 found that 89.4% of GPs were under very high or high pressure at work. In addition, the survey showed that in practice, doctors were unable to push through changes to improve services because of lack of capacity (funding) and support.²⁰

Moreover, patient choice, professional power and localism would seem to hide the aims of trying to make the public sector more efficient. In practice, this has meant the quasi-privatisation of many services. The reforms that took place in 2012 were essentially made to cut costs since the primary care trusts were seen as more expensive to run than clinical commissioning groups. Priority is thus given to cutting costs and making efficiency gains, which are key aspects of NPM. Since March 2010, for example, the number of NHS managers has been reduced by 18% (-800). The 2010 Spending Review set forth zero growth in expenditure which means that the budget has been reduced in real terms because of ever increasing health costs. In addition, a Quality, Innovation Productivity and Prevention (QIPP) programme was enacted with a view to saving £20 billion by 2015. The current government has extended the use of Payment by Results (PbR) to promote quality and clinical effectiveness. Best-practice tariffs pay providers according to the actual cost of best clinical practice rather than the national average cost of care. These tariffs were introduced in 2010/11 for the treatment of cataracts, gallbladder removal, acute stroke care and fragility hip fracture.

In addition, the aim is to continue to contract out services to the private sector via the clinical commissioning groups. The latter are encouraged to put services out to tender, in order to encourage non-NHS providers to bid to take over the running of services in a particular area. Indeed, seven out of ten NHS contracts have been taken on by private companies or institutions. It would therefore seem that NPM techniques are still very much a feature of National Health Service provision in England.

**NPM and its Legacy : The Health Effects on the British Population**

²¹ In essence, despite some incremental changes in the post-NPM period, it is clear that there has been increased emphasis on market-based governance mechanisms and this had been upheld by successive governments since 1979: notably with the separation of purchasing and providing, contracting out and the emphasis on choice. The essential problem of building on NPM reforms is that health is being led by political aspirations rather than public good principles. Moreover, performance indicators are ill-adapted to
health. The diagnosis and treatment of health conditions and their outputs are complex and differ from one patient to the next, which makes measuring outputs and applying performance indicators tricky. Moreover, the continuation of NPM techniques which focus on private sector management practices has overturned the public service ethos. It has also weakened trade unions and collective bargaining because of contracting out, local employment contracts and individual performance-related pay.

In addition, it is not clear whether the quality of health services has actually gained from NPM and post-NPM governance. The OECD reports that the UK is very much middle-of-the-road for health outcomes. It may have an above average life expectancy rate, but primary prevention is often seen to be neglected because of the overriding emphasis on targets and the reliance on new providers from the private sector. In addition, recent reports from the Care Quality Commission and other sources (BBC, Patients Association...) have revealed problems in the care provided in hospital and long-stay hospital residence. Current pay freezes, axing jobs and limits to NHS funding will surely affect the quality of health services in the future, especially since the cost of providing health services is continually rising. It will become increasingly difficult to find staff ready to work when national pay is actually decreasing in real terms, which could lead to a decline in the quality of care. Additional cuts to local authorities means that although the government has given more power to the local government to manage health, they have not given the authorities the means to ensure high standards in health and social care.

**Conclusion**

It has been argued that we have entered a post-NPM era and that the emergence of a digital era has called into question NPM forms of governance. Devolution can be seen as the main reason for bringing about reforms to public management to avoid the deepening of fragmentation in governance. The post-NPM reforms of the late 1990s were also intended to improve the horizontal and vertical coordination of governmental organization which had emerged out of NPM. Nevertheless, it is fair to say that these were incremental changes in the post-NPM period since the market-based governance mechanisms, which are a legacy of NPM, are still firmly in place. Our study of the NHS and the post-NPM reforms is a clear illustration of this. As analysis of health services in the UK has shown, NPM still exists. It has just been repackaged into a more acceptable discourse: compulsive competitive tendering has become Public Private Partnerships, performance indicators were scrapped and replaced by other forms of efficiency-seeking methods. However, it seems questionable whether it is appropriate to export private sector management values and practices into the public domain. Devolution has shown that other approaches to public sector management are possible. Indeed Scotland and Wales have taken a more social democratic approach to public services, emphasizing collaboration and patterns of working rather than strictly adhering to the markets and targets of the English public sector. The Welsh first minister for example said “Greater consumer choice in public services does not fit in with Welsh values. What people want is a higher standard of community based public services all round.”
BIBLIOGRAPHY


1. In this article, governance is used in a very general sense to mean all processes of governing, that is systems of decision-making among actors, whether they be the government, civil society, a business entity...


7. This formula predicts future health costs for the districts of the UK. Funds are allocated according to this formula.

8. Whereas primary care refers to the work that is carried out by health professionals, whom patients must consult first (generally the General Practitioner - GP), secondary care refers to specialists (usually to whom the GP refers patients if they deem it necessary) and also acute care, provided by the hospital emergency department.


17. At the time of writing this system has still not been set up.


22. See note 8.

**ABSTRACTS**

The introduction of New Public Management (NPM) in the UK transformed the public sector in the 1980s, blurring the boundaries between the public and private spheres. However, from the late 1990s, it was clear that NPM techniques were showing some limits. Without retreating from governance back to government, some efforts were made to solve the problems that had arisen from greater vertical and horizontal specialization. The restructuring of the National Health Service (NHS) is the perfect illustration of how the role of the state in the world’s largest publicly-funded health service has been redefined by post-NPM reforms. The focus will be specifically on reforms in England because Scotland and Wales took quite different reform paths after devolution. This paper thus explores how modernist governance has transformed the organization and delivery of public health services in England. It will consider the limitations of reconfiguring the NHS to comply with a business-like and consumer-oriented model, with particular attention given to the post-New Public Management reform wave which began in the late 1990s.

**INDEX**

*Keywords*: New Public Management (NPM), post-New Public Management, National Health Service (NHS), governance, marketisation, disaggregation, incentivisation, England

**AUTHOR**

LOUISE DALINGWATER

Maître de conférences à l’Université Sorbonne Nouvelle Paris 3