

An Era of Governance through Performance Management – New Labour’s National Health Service from 1997 to 2010

Abstract

In 1997, the New Labour government inherited a ‘crisis’ in the UK National Health Service (NHS) from the outgoing Conservative government. To address this perceived crisis, New Labour offered investment and, contrary to expectations, further neo-liberal health service reforms. In particular, the government extended the scope of performance management beyond financial numbers to encompass all aspects of managerial and organisational performance. Drawing on an analytics of government framework, this paper will show how reforms were framed and given meaning through a framework of hierarchical accountability and centralised control. These panoptical arrangements relied on performance management technologies of targets and ratings, which were linked to patient choice and a prospective funding system called ‘Payment by Results’. In turn, these top down technologies disciplined knowledge, identity, and visibility and control of practice.

Key Words: Performance Management; Accounting History; Accountability; Governmentality; Healthcare; NHS

Introduction

Healthcare is a significant political issue. Specific challenges arise around costs, funding constraints, operational efficiency and effectiveness of care against the background of increasing demand for health services. The cost of healthcare accounts for 9.4% of GDP in developed countries (World Bank 2014). NHS expenditure for 2013/14 alone exceeded £120 billion, which was funded by general taxation to provide cover for a population of just over 60 million people (UK Public Spending 2014).

The media have repeatedly reported that the NHS is in crisis (Anonymous 2015; Boffey and Campbell 2014; BBC 2015; Colvile 2015). The NHS has experienced a significant rise in the demand for general practitioner and hospital services over the

last years. The supply of health services has not expanded at a similar rate, resulting in the breach of various waiting time targets set by the government. This mismatch between demand and supply of health services poses challenges regarding accountability and transparency (Commons Select Committee 2013), financial sustainability (National Audit Office 2014) and quality of care (Dixon et al. 2011). It also provokes more general questions regarding the design of public services (Richard 2011) and even the very survival of the NHS.

Against the background of suggestions that good overall performance ratings for public service organisations may not always translate into good performance (Eckersley et al. 2014; Ahrens and Ferry 2015; Ferry and Eckersley 2015; Ferry et al. 2015), the performance management arrangements of the NHS have, in particular, been called into question (Bevan and Hood 2006; Paterson et al. 2014; Chang 2015). The performance indicators used to assess NHS hospitals struggle to capture the complexity of quality of care in terms of effectiveness and impact, and may lead to gaming (Rowan et al. 2004; Bevan and Hood 2006). The Mid Staffordshire hospital scandal provides a stark illustration of this issue¹. The public enquiry held in the wake of the scandal concluded that the hospital had put ‘targets before care’. The hospital’s priorities were its finances and foundation status application rather than its patients (The Mid Staffordshire NHS Foundation Trust Public Enquiry 2013). Its performance was judged to be high according to the targets and parameters set by the performance framework, yet its operational activities were a danger to the health and in some unfortunate cases the lives of its patients. Despite these problems, performance management continues to be seen as a panacea to improve the NHS. Indeed a framework of centralised control and hierarchical accountability through financial audit and transparency remains in place, alongside performance audits and recently introduced checks to address quality concerns.

¹ Stafford hospital is a small district general hospital run by the Mid Staffordshire NHS hospital trust. The Trust became a foundation hospital in 2008. Between January 2005 and March 2009, an estimated 400-1,200 patients died as a result of poor care. Alerted by the unusually high mortality rates, the Healthcare Commission (the NHS care regulator at the time) investigated the matter and found that there were serious issues affecting patient safety. The public enquiry that followed highlighted that the cost-cutting exercises made as a result of the pursuit of foundation trust status were the key reason for poor care.

A gap exists in understanding how governance through performance management came about and expanded during the 13 years of the New Labour government from 1997 to 2010. To address this gap, the paper will consider how New Labour sought to address the perceived NHS crisis it inherited from the outgoing Conservative government in 1997. It will show that alongside significant investment in the NHS, New Labour stuck to the path of neo-liberal health service reforms set out by the Thatcher and Major governments. The hallmarks of new public management (NPM) - the widespread use of explicit and measurable standards of performance, the emphasis on outputs and results, cost containment and efficiency gains, the contract-based relationship between providers and commissioners and the intensification of the encroachment of private sector management practices (Gray and Jenkins 1995; Hood 1995; Lapsley 2008) - were deployed in order to address the perceived crisis.

The paper will employ an analytics of government approach (Dean 1999, 2010) to critically analyse how the New Labour government used technologies of performance management in a framework of centralised control and hierarchical accountability to frame reforms, operationalise them and legitimate investment. It will be shown how these technologies of performance management disciplined knowledge, identity, and visibility and control in NHS practices.

The paper will now set out a history of accounting and performance measurement in the NHS before the New Labour government through a review of the relevant literature. It will then outline the research methodology and methods, focussing on the analytics of government framework and how it was employed in this study. The analytics of government framework will then be applied to critically analyse the problematisation, modernisation and utopia in the NHS under the New Labour government. Finally, we discuss the conclusions and implications of the paper.

A History of Accounting and Performance Measurement in the NHS before New Labour

Accounting and accountability practices have been used for monitoring the performance of hospitals and doctors (Jackson et al. 2013) and as a technology of entitlement (Holden et al. 2009; Jackson 2012) long before the creation of the NHS.

Since its creation in 1948, the NHS has undergone numerous reforms (Ham 1997; Levitt et al. 1999). Subsequent UK governments have mobilised hospital accounting practices with the aim of fostering efficiency, cost awareness and cost containment.

Concerns over the cost and performance of the NHS were raised as early as the 1950s (Levitt et al. 1999). In 1953, the Minister of Health appointed an independent Committee of Inquiry (generally known as the Guillebaud Committee) with the remit to review the cost (present and prospective) of the NHS and to advise on possible ways of ensuring the most effective and efficient use of funds (Chester 1956). The Guillebaud Committee found no evidence for vast increases in the cost of the NHS, and did not recommend wholesale changes to its funding or administration (Anonymous 1956). The Committee did however suggest that Burdett's uniform system of hospital accounts, which the NHS had adopted (with few alterations), ought to be supplemented with a departmental costing system, which was more suited to planning, control and performance measurement (Gebreiter 2015; Robson 2003). The Committee reassured the medical profession that these management accounting measures were to be regarded as means to ensure the best value for money rather than imposing restrictions on the Service (Anonymous 1956, 32).

Concerns about the efficiency of the service and the effectiveness of the tripartite² administrative arrangements re-emerged in the 1960s and culminated in the first major reorganisation of the NHS in 1974. In 1967, The Joint Working Party on the Organisation of Medical Work in Hospitals issued its first report (known as the Cogwheel report), which recommended the adoption of 'divisions' (i.e. a group of specialties providing a common service and with a call on the same resources (Ministry of Health 1967, 16)). The Joint Party believed that such arrangements would foster a better understanding of the health needs of the community and a more

² From 1948 until 1974 the health services were divided into three areas: family practitioner services, community services and hospital services. The family practitioner services were administered by 138 executive councils, which were funded directly by the Ministry of Health. Local health authorities administered Community services and the funding of these services was partly provided by central government grants and partly by local authorities. Regional Hospital Boards (RHBs - 14 in England and Wales) administered hospital services via Hospital Management Committees (HMCs - around 400 in total) and boards of governors. Teaching hospitals were organized under boards of governors who were directly responsible to the Ministry of Health. The Minister for Health appointed RHBs; RHBs appointed HMCs; the Ministry of Health funded the hospital service through RHBs and HMCs, and teaching hospitals directly (Levitt et al. 1999; Ham 2004).

efficient use of resources in meeting those needs (op. cit. 2). The report advised that each division was to have the responsibility to carry out constant appraisal of the services provided, deploying clinical resources as effectively as possible. Clinicians were to take an active part in the coordination and planning of services and liaise with community services outside the hospitals (op. cit. 16). The subsequent Cogwheel reports in 1972 and 1974 reiterated the perceived need to change the NHS administrative structure and to involve hospital doctors in management.

The 1974 reorganisation of the NHS brought together the health services under one authority. The new structure consisted of three bureaucratic layers: Regional Health Authorities (RHAs), Area Health Authorities (AHAs) and District Management Teams (DMT). The reorganisation aimed to achieve three goals: to unify the service, to improve the coordination between health authorities and related local government services, and to introduce better management (Ham 2004). RHAs had the responsibility for planning, financing and directing the AHAs, which in turn were responsible for planning the service and appointing district management teams. This was a highly bureaucratic and hierarchical system, a 'corporate pluralism' which was supposed to function through a continuing process of negotiation between national and local organisations (Pettigrew et al. 1992, 47). Performance evaluation was embedded in the system from the top down (Department of Health and Social Security 1972). The Secretary of State was accountable for the performance of the NHS and controlled the performance of the functions delegated to the RHAs. The RHAs controlled the performance of the AHAs and regional officers, ensuring that services were provided efficiently and economically. The AHAs controlled the performance of the DMTs, ensuring that services were provided in accordance with agreed objectives, targets and budgets, to guarantee efficiency and economy. This reorganisation prompted the implementation of financial control based on functional budgets (Perrin 1988, 51; Robson 2007). Up until the 1974 reform, budgeting were prepared according to 'subjective' analysis, identifying the resources consumed by hospitals per subjective categories like staff costs, supplies etc. This system, however, did not allow tracing how the resources were used and by whom within the functions performed by the hospital departments (Rigden 1983, 64). Thus, functional areas of management were identified (i.e. nursing, diagnostic departments, catering, estate and

finance) in order to establish managerial responsibilities and provide the relevant data for performance evaluations.

The elaborate structure introduced in 1974 created the potential for conflicts between the different levels of authorities. The Merrison Committee (1979), which engaged in the first wide-ranging review of the NHS since the Guillebaud Committee, criticised the system for being overly complicated and too slow in making decisions (Ham 2004). The Merrison Committee identified clinical decisions as key drivers of health expenditure and criticised that doctors were not accountable for the financial implications of their clinical decisions. The team that advised the Merrison Committee on financial management suggested introducing clinical budgeting as a mechanism to control expenditure and involve clinicians in management and financial control (Lapsley 2001).

The Griffiths Report (1983) criticised the NHS management for its lack of leadership and weak accountability systems, and recommended the introduction of clinical budgeting and the appointment of general managers in the NHS. More generally, the reforms introduced in the wake of the Griffiths Report emphasised private sector managerial practices, explicit and measurable standards of performance, and control according to pre-set output measures (Hood 1995). Effort was placed on increasing efficiency and effectiveness, raising clinicians' cost awareness and exercising pressure to involve medical and nursing professionals in the management of hospitals. Measures such as cost per case, length of stay and waiting lists as well as a range of performance indicators encompassing clinical services, finance, manpower and estate management were used to compare hospitals and districts (Ham 2004).

The implementation of these reforms heightened the tension and conflict between the government on one hand and clinicians on the other, as the medical profession resisted engaging with budgetary information and processes (Bourn and Ezzamel 1987; Pollitt et al. 1988; Preston et al. 1992; Jones and Dewing 1997; Lapsley 2001). Thus, Mrs Thatcher, the then Prime Minister, set up a private review of the NHS which led to the introduction of the internal-market (The Secretary of State for Health 1989). Once again, the main concern of the reform was to strengthen management arrangements, whilst attempting to develop competition between providers of health

care with the separation of responsibilities between purchasers and providers and the establishment of self-governing NHS Trusts and GP (General Practice) fund-holders. The introduction of the internal market required providers to establish and publish prices for health services, so that they could be ‘bought’ by Health Authorities and GP fund-holders. The establishment of the prices was a crucial process, which would impact the performance of NHS Trusts. The Trusts were assessed in terms of their ability to meet a required financial return, achieve break-even on income and expenditure and remain within their external financial limits. The penalties for breaching these financial targets were heavy, thus unsurprisingly NHS Trust managers focused primarily on them. However, the shortcomings in costing and budgeting, which underpinned the system of performance evaluation, undermined the exercise and attracted heavy criticism, especially from medical professionals, whose performance scrutiny and requirement to occupy managerial roles had increased (Lapsley 1994; Jacobs 1995; Ham 2004). High cost variability, lack of robustness and comparability of costing data, the absence of integrated systems of cost and quality data, and the inability of the accounting system to capture the complexity of health services contributed to clinicians’ distrust of, and disengagement from, managerial reforms (Bourn and Ezzamel 1986; Jones 1999; Northcott and Llewellyn 2003; Llewellyn and Northcott 2005; Scarparo 2006; Kurunmäki and Miller 2008; Guven-Uslu and Conrad 2008, 2011; Chapman et al. 2014).

The introduction of management budgeting and market-driven incentives in the 1980s and 1990s aimed to create a system of performance management that would improve NHS productivity and reduce waiting times (Propper et al. 2008). However, it was New Labour’s NHS reform programme (Secretary of State for Health 1997, 1999) which instituted a much more aggressive target-driven policy (Propper et al. 2008) and greatly extended the era of governance through performance management inherited from the outgoing Conservative government. The 1997 White Paper claimed to envisage a shift towards a system of accountability centred primarily on quality rather than efficiency (Secretary of State for Health 1997). In England, the modernisation agenda of the New Labour reforms initially abandoned the market and shifted towards an integrated system of care, only to revert back to a system of competition with reforms that introduced ‘foundation trusts’, ‘payment by results’ and ‘performance ratings’.

The structural reforms by the New Labour government from 1997 to 2010 relied on a 'targets and terror' system of control and governance (Bevan and Hood 2006, 525), which was operationalised through a 'star rating' system from 2001 to 2005 (Department of Health 2001a), the 'Annual Health Check' from 2006 (Healthcare Commission 2006) and the 'NHS Performance Framework' implemented in 2008 (Department of Health 2008, 2008a, 2009). These multi-dimensional performance systems were designed to deliver specific national targets and standards for local NHS organisations. The achievement of a pre-determined threshold of performance (e.g. a three star rating) would have allowed NHS trusts greater managerial freedom from central control and the opportunity to become Foundation Trusts³. However, regional NHS Executive offices exercised an intense and tight level of scrutiny of health care managers (Hoque et al. 2004; Chang 2009) and the penalties for poor performance were high. Managers of NHS Trusts risked being fired and Trusts were publicly 'named and shamed' (Bevan and Hood 2006).

An extensive literature has examined the effects of implementing these performance measurement and management systems. For example, Hoque et al. (2004) analysed the Government's policy of granting more managerial freedom and autonomy to NHS Trusts' managers as a lever for improving performance. The authors discovered that NHS Trusts' managers did not perceive to have autonomy. The managers felt that the centre exercised a high degree of micro-management of the targets and firmly controlled the financial resources, thus limiting the possibility of exercising any strategic decision-making. Other studies of performance measurement and management in the NHS raised questions about whether it is largely for legitimisation, driven by political demands, or whether it improves efficiency and patient care (Chang 2006; Conrad and Guven-Uslu 2011, 2012). Chang (2006) investigated the responses of local healthcare managers to the implementation of the Star-rating

³ In England, hospitals are grouped into two main categories: Foundation Trusts and acute NHS Trusts. Foundation Trusts were introduced in 2004 with the aim to decentralise the management and provision of acute care, alongside the implementation of a number of changes that aimed to reinforce the market-style mechanisms in order to increase efficiency and effectiveness. Foundation Trusts are public benefit corporations, which are independent non-profit making entities owned by members from the local communities. They have been given much more financial and operational freedom than other NHS trusts, they are not under direct control of the Secretary of State for Health and no longer accountable to Strategic Health Authorities. But they must adhere to the arrangements made by an independent regulator (Monitor), who issues hospitals with a licence to operate.

system. He argued that local managers distorted clinical priorities and altered performance information as they sought legitimacy from central government. The managers did not consider the performance indicators and targets adequate to fit with the local management processes. Rather, the indicators were deemed too high level and top-down driven, unable to capture the dynamics of local performance. Further, Chang (2009) argued that political reforms might have introduced management control systems like the Star-rating system with the intent to serve as a coercive mechanism to 'advance political interests and power and to attract favourable attention from the public' (op. cit. 160) rather than improve performance. Managers' instrumental use of the performance measures alerts us to the consequences of an instrumental approach to setting targets based on 'formal rather than substantial rationality' (Conrad and Guven-Uslu 2012, 246).

The performance management literature provides a clear picture of the unintended consequences of 'targets' leading to 'terror' (Bevan and Hood 2006; Propper et al. 2008), showing how gaming and conflicting accountabilities affected the NHS. The discussion above sets the necessary historical background. The paper will now set out the analytics of government framework. We explain how this framework has been applied in this study in order to critically analyse the discourse about the implementation and use of performance measurement and management in the reforms implemented by New Labour from 1997 to 2010.

Research Methodology and Methods

The paper employs Dean's (1999, 2010) analytics of government framework to analyse how the New Labour government embarked on a programme of reforms and investment between 1997 and 2010. This covers the 'problematization' of an NHS in crisis, and the formulation of 'solutions' that increased the plethora of performance management arrangements through targets, ratings and regulations.

The analytics of government framework (Dean 1999, 2010) has its roots in Foucault's analysis of government and governmentality (e.g. Fleishmann and Radcliffe 2005; Foucault 1972, 1977; Kurunmäki and Miller 2006, 2008; Lega et al. 2010; Macintosh 2009; Rose and Miller 1992). Foucault's notion of government is intended as conduct

both in noun and verb forms. As a noun, conduct can mean behaviour and action. As a verb, conduct can signify to lead, to guide, to direct. Thus government assumes a broader significance as 'the deliberate shaping of the way we act' (Dean 2007, 82). Within this broad definition, the term governmentality carries a dual connotation (Dean 1999, 2010). First, it is connected with 'mentalities of government' (Miller and Rose 1990; Rose and Miller 1992), 'a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed) capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it is practised' (Burchell et al. 1991, 2). Second, governmentality is concerned with the relationship between government and other forms of power, specifically sovereignty and discipline.

Studies of governmentality have been concerned with 'regimes of practices', which encompass practices for the production of knowledge and truth engaging multiple forms of technical and calculative rationalities (Dean 2010, 28). These notions of governmentality engender an analytics of government 'which focuses on the rationalities and technologies of rule and the way a practice of government is invested with an *ethos* and seeks an end or goal, a *telos* (Dean 1999)' (Dean 2007, 82).

Dean's analytics of government describes regimes of practices as 'organised ways of doing things', through which rationalities, technologies, authorities and subjectivities are created and sustained (Dean 2010, 30-33). Thus the aim of the analytics of government is to provide a 'detailed description and analysis of the rationalities, techniques, goals and identities formed in the practices that seek to guide the conduct of oneself and others' (Dean 2007, 83). He considers the framework of analytics of government as a means to study 'the conditions under which regimes of practices come into being, are maintained and are transformed' (Dean 2010, 31). Furthermore, Dean (2007) argues that the analytics of government also engenders critical analysis, as it allows exposing the disconnection between the views purported by the 'programmer' (Dean 2007, 83), the logic of practices and their effects.

An analytics of government begins with 'problematization' whereby governing activities are scrutinised (Dean 2010, 38) and governmental failings, gaps and difficulties are identified, analysed and developed, in conjunction with the

identification of (utopian) solutions that will allow for the remedy of the identified problems (Rose and Miller 1992, 181-183).

Dean's framework of analysis of regimes of practices comprises four dimensions, which are separate yet interconnected: 1) fields of visibility; 2) technical aspects (techne); 3) forms of knowledge (episteme); and 4) identity formation. The first dimension, fields of visibility, is concerned with forms of visibility that make possible to identify the objects (who and what) of governance (Dean 2010, 41). The field of visibility analytic asks how and why some things are made visible. For example charts, tables, graphs, organisational charts and reporting arrangements constitute ways of visualising objects and subjects of governance. The fields of visibility analytic is also concerned with understanding the way in which relations of authority and obedience are formed and how different actors are connected to one another. The second dimension, techne, is concerned with the means, procedures, techniques, technologies and vocabularies engaged in accomplishing ends of government. More specifically, technologies of performance can impose limits over relevant expertise and constrain local action towards governmental programmes through targets, monitoring and audit processes. Similarly, technologies of agency can summon actors and their participation in processes of governing, and include different participation and partnership forms, as well as infrastructures and materials that create and sustain action (Dean 2010, 42). The third dimension concerns the values, expertise, language and forms of thought employed as knowledge and know-how in governing practices (Dean 2010, 42). The fourth dimension is concerned with understanding which forms of identity (individual and collective) programmes of government try to shape. This dimension explores what forms of conduct, behaviour and duties are expected of those who exercise authority and of those who are to be governed, and what capacities and attributes are to be promoted. This refers to people and groups taking on a particular role and characteristics associated with forms of identity through which governing operates. Regimes of practices stimulate, encourage and assign competences, qualities or other specific attributes of identity, rather than pre-ascribe identity (Dean 2010, 43). Government is characterised as facilitative and preventive rather than directive and distributive (Dean 2007, 84). Regimes of practices elicit identification as the individuals and groups form a sense of selves through such attributes.

In this paper, the analytics of government framework is applied to archival documentation relating to the 13-year period of the New Labour government in the UK (1997-2010). The documents examined for the purposes of this paper discussed management, accounting, accountability and reporting practices in the NHS. They were published by the Department of Health, various devolved governmental bodies like the Audit Commission, and independent organisations like the King's Fund⁴. The analysis examined these documents to determine the perceived problems, utopian solutions and technologies of performance management that characterised NHS discourses during the New Labour period. Finally, we corroborated our analysis with reference to the extant literature on accounting and accountability in the NHS.

The paper will now apply the analytics of government framework to critically analyse an era of governance through performance management in the NHS under the New Labour government from 1997 to 2010.

Problematisation, Modernisation and Utopia: The NHS under the New Labour Government

Problematisation - Inheriting a Crisis

In the run up to the 1997 general election in the UK, the opposition Labour Party rhetoric in their manifesto was of a NHS under threat that needed to be saved,

'Labour created the NHS 50 years ago. It is under threat from the Conservatives. We want to save and modernise the NHS.'

'Our fundamental purpose is simple but hugely important: to restore the NHS as a public service working co-operatively for patients, not a commercial business driven by competition.' (Labour Party Manifesto 1997)

Following election success in 1997, the New Labour government broadcasted a rhetoric that they had inherited a NHS in 'crisis' after 18 years of Conservative

⁴ The King's Fund is a think tank concerned with the health care system in England.

government. For example, New Labour Health Secretary Andy Burnham suggested that,

‘The change of government in 1997 brought a change of fortune for the NHS and broke a cycle of decline’, which reinforced their messages whilst in opposition that Bevan’s creation could lose public support and there were only, *‘Seven days left to save the NHS.’* (Campbell 2010)

The inherited challenges were not mere political rhetoric and blame games. The scandal relating to excess deaths at the children’s heart surgery unit at Bristol Royal Infirmary led to a public inquiry conducted between October 1998 and July 2001 by a panel chaired by Professor Ian Kennedy. Following an Interim Report in May 2000, the Bristol Royal Infirmary (BRI) Inquiry Report (also known as the Kennedy Report) in 2001 was wide ranging in the problems identified. The Department of Health (2002) noted that,

‘1. The BRI Inquiry Report provides us with a powerful analysis of the organisation and culture of the NHS in the years up to 1995. It highlights poor organisation, failure of communication, lack of leadership, paternalism and a ‘club culture’ and a failure to put patients at the centre of care. It draws attention to the lack of standards for evaluating performance in the NHS and for assessing the quality of care, and a lack of clarity about where the responsibility for such assessment lay, at both the local and national level (...).’

‘2. We accept that analysis (...).’

‘3. Our vision for the NHS was set out in The NHS Plan. We are pleased to see that the Kennedy Report recognises and acknowledges the significant contribution the Plan will make towards realising the recommendations of the Inquiry Report.’ (Department of Health 2002, 1)

The inherited challenges were also specifically acknowledged by the independent and highly influential King’s Fund in their detailed analysis of the NHS under New Labour (Dixon et al. 2011).

The Utopian Solution - Moving on through Investment and Reform

As a 'solution' to the perceived NHS crisis, the New Labour government promised much greater investment. But the investment was conditional on the implementation of fundamental reforms. This was expressed in the NHS Plan 2000,

'So urgent was the need for extra money for the NHS that many of the failures of the system were masked or considered secondary. In March we took a profound decision as a Government. We had sorted out public finances. (...) We decided to make an historic commitment to a sustained increase in NHS spending. Over five years it amounts to an increase of a third in real terms. Over time, we aim to bring it up to the EU average.'

'In doing so, we offered the nation and those in the NHS a deal. We would spend this money if, but only if, we also changed the chronic system failures of the NHS. Money had to be accompanied by modernisation; investment, by reform. For the first time in decades we had to stop debating resources; and start debating how we used them to best effect.' (Department of Health 2000, 8-9)

The New Labour government embarked upon a modernisation and performance improvement drive, including replacement of the Conservative government's internal market policy,

'Expanding and reforming the NHS takes time. (...) The process of modernisation is already underway. The internal market has gone and we have already started to build modern, responsive NHS services. The pace of improvement will now accelerate. Some improvements can be achieved quickly, others will take time.' (Department of Health 2000)

However, contrary to New Labour's pre-election rhetoric, the solution to the inherited problems was sought through the intensification of neo-liberalism and NPM mechanisms. After a brief move away from markets in the wake of the 1997 election, New Labour replaced the accounting-based performance indicators and internal market operated under the Conservative government with an even greater emphasis on marketisation, managerialism and performance measurement in the form of targets,

performance ratings and regulatory bodies. Together, these measures amounted to a highly aggressive system of governance through performance management.

Technologies of Performance Management

During New Labour's era of governance by performance management, the 'technologies' (Dean 2010, 42) employed in the hierarchical accountability arrangements for centralised control included the NHS Plan, targets, Performance Assessment Frameworks, performance ratings, league tables, Payment by Results (PbR) and regulation.

Initially, the NHS Plan (Department of Health 2000) laid down central government's medium term intentions through the prescription of a 10-year strategic planning system and a detailed reform programme. Additional funds were pledged to address geographical inequalities, improve standards, and increase patient choice. The programme included the establishment of an independent Commission for Health Improvement (CHI) to monitor the achievement of Department of Health set standards, the National Institute for Clinical Excellence (NICE) to support the modernisation agency for best practice, greater freedoms for local NHS organisations (subject to good performance), new care trusts to commission joined up social care and health service delivery, and an agreement to make further use of private providers as part of patient choice.

A 'golden thread' of performance management began to be established through the Department of Health (2000) NHS Plan,

'For the first time there will be a system of inspection and accountability for all parts of the NHS. The principle will be national standards combined with far greater local autonomy, with new money to reward good performance.'

(Department of Health 2000, 15)

The golden thread was built upon 'targets' and 'performance assessment frameworks' that became a measure of overall performance and, in effect, a proxy for measuring care,

'The NHS Plan highlighted the importance of 'Must do' targets, (...) 16.4 A key message arising from the consultation with the NHS in formulating this Plan was that it needs a small focused set of targets to drive change. Too many targets simply overwhelm the service. 16.5 This NHS Plan provides the clear, focused targets the Service has asked for. A small core of targets forms the Department of Health's Public Service Agreement with the Treasury. 16.6 The targets are for the NHS, in partnership with social services and for social services itself.' (Department of Health 2000)

The targets for the NHS included reducing waiting times, patients to receive treatment at a time that suits them, guaranteed access to a healthcare professional within 24 hours, patient satisfaction, reducing 'major killer' mortality rates and narrowing the health gap in childhood and throughout life for all socio-economic groups and geographic areas. As part of the reforms, these targets were measured and compared as visible and controllable benchmarks for the NHS.

The NHS Plan provided a basis for a golden thread of performance management, and this was supplemented with various initiatives including a new performance reporting system (Department of Health 2002a), payment by results (Department of Health 2004b), independent assessment by the Healthcare Commission (Healthcare Commission 2005), and new private sector partnerships (Department of Health 2005).

Of these supplementary initiatives, the Department of Health (2002c) Departmental Report provided an updated NHS Performance Assessment Framework (PAF) to arguably provide a more rounded view of performance,

'The NHS Performance Assessment Framework (PAF) (...) was published in April 1999, following a period of consultation, and is based on the balanced scorecard approach. The use of the balanced scorecard allows organisations to get a more rounded view of performance by identifying different key elements of performance and understanding how changes in them may have implications for others. The NHS Plan endorsed the PAF as a single system for measuring, assessing and rewarding NHS performance.' (Department of Health 2002c)

The Health Authority-based PAF highlighted six areas of performance which, taken together, arguably gave a balanced view of the performance of the NHS. These included health improvement, fair access, effectiveness in delivery of appropriate health care, efficiency, patient and carer experience, and health outcomes. The NHS Trust-based PAF was similar but included four areas: clinical effectiveness and health outcomes, patient and carer experience, efficiency, and capacity and capability.

The PAF was supported by a set of national headline NHS Performance Indicators that included interface indicators between health bodies and local authorities who increasingly jointly undertook social care, and intended to develop a full set of primary and community based indicators.

Importantly, the PAF was underpinned by benchmarking that would enable peer comparisons,

‘A bigger set of benchmarking performance indicators is also being developed to enable NHS organisations to analyse their performance against their peers, identify poor performance and make improvements.’ (Department of Health 2002c)

Identifying performance ratings for benchmarking, based on performance indicators, meant that league table rankings could be established in order to provide the public with performance information, which was another important part of the NHS Plan alongside modernisation and reform,

‘The Department also made a commitment to provide both patients and the general public with more comprehensive, easily understandable information on the performance of their local health services. In September 2001 all non-specialist acute NHS trusts were issued with performance ratings (stars), reflecting their performance during 2000-01.’

‘The star status assigned to organisations is based upon delivery of national targets and overall performance as measured against a balanced scorecard reflecting staff, patient and clinical focus. Trusts with the highest level of performance have been awarded a rating of three stars. Those that are performing well overall, but have not reached the same consistently high

standards, received two stars. Trusts giving some cause for concern were awarded only one star. Trusts that have shown the poorest levels of performance against key targets have received zero stars. A poor performance rating does not necessarily mean that trusts are failing to provide a good standard of care to their patients but that the overall patient experience is poor.'

'All zero rated trusts are required to produce a Performance Action Plan detailing specific action the trust will be taking to address its areas of poor performance. These plans are to be agreed with the Modernisation Agency and the trust's DH Regional Office.' (Department of Health 2002c)

The performance ratings and league tables (see examples in figures 1 and 2 in the Appendix) were visibly employed for distributing freedoms and punishments as a means of control that could be both coercive and enabling. For example performance ratings could lead to earned autonomy,

'Depending on a trusts performance rating they will expect to receive different levels of earned autonomy. The best performing trusts can expect: less frequent monitoring from the centre; fewer inspections by the Commission for Health Improvement; retention of more of the proceeds of local land sales for reinvestment in local services; extra resources for taking over and turning round persistently failing Trusts; be able to establish private companies; and, have the opportunity to shape national policy.' (Department of Health 2002c)

In addition, depending on the achievement of a set threshold of performance, NHS trusts could become Foundation Trusts, with greater governance powers and access to finance.

During New Labour's 13 years in office, the performance ratings went through several changes. In 2008 a new NHS Performance Regime was issued to:

'consolidate and build on our current strong performance, while giving us the tools to intervene early to tackle the relatively few incidents of poor performance when they occur. The regime brings together a range of

measures to safeguard minimum standards and to incentivise high performance in all parts of the NHS.’ (Department of Health 2008)

Furthermore, the attention began to focus on those deemed to be underperforming,

‘Based on the indicators underpinning the Performance Framework, organisations will be categorised as: Performing, Performance under review, or Underperforming. There are no positive designations of performance beyond Performing as the focus of this Framework is on unacceptable levels of performance.’ (Department of Health 2009)

The focus of assessment also changed for an overall performance categorisation,

‘Each organisation assessed by the Framework will be given two, equally weighted ratings using the performance categories (...): one rating for performance on Finance (Weighted across five sub-domains of Initial planning, year to date financial performance, forecast outturn, underlying financial position, and financial processes and balance sheet efficiency), and one for performance on Quality of Services (which is comprised of integrated performance measures, Care Quality Commission⁵ registration status and user experience).’ (Department of Health 2009)

Nevertheless, a frequent concern remained that the articulation and implementation of performance management frameworks were merely legitimacy exercises for high-level comparisons (Llewellyn and Northcott 2005). Indicators and targets were deemed to be too high-level and top-down driven, unable to represent the dynamics of local performance (Chang 2006). Sometimes operational readiness was more opaque. Indeed, it was argued that small changes to methodology could lead to very different ranking results (Chang 2006).

The concerns over performance ratings were not without foundation, as they formed part of the changes alongside PbR that informed the reform which linked investment to performance,

⁵ CQC subsumed the healthcare commission in 2009.

'PbR is the latest, and arguably the most significant, development in the financial flows in the secondary care sector since 1948.' (Appleby et al. 2012, 6)

The main stimulus for PbR reform in hospital services was the New Labour government 'reducing waiting times for planned operations' targets that needed increased activity levels. Delivering the NHS Plan (Department of Health 2002a) highlighted that block contracts based mainly on fixed total annual budget gave hospitals no incentive to attract additional patients by increasing activity above agreed contract levels. Following examination of other countries' payment systems, an activity-based payment system called PbR was phased in from 2003/4 to provide a closer link between the work hospitals performed and payments they received,

'...all providers will be contracted for a minimum volume of cases to achieve waiting time reductions; providers will lose money on a cost per case basis for failure to deliver; and providers will earn extra resources on a cost per case basis for additional patients that move to them.' (Department of Health 2002d, 20)

The initial implementation involved a small number of elective procedures, but was expanded to include almost all elective and emergency care. By 2010, it included about 60 per cent of the average hospital's activity depending on hospital type and activity mix and accounted for around one-third of total Primary Care Trust spending (Appleby et al. 2012, 9).

Underlying the performance changes in activity levels was the requirement for NHS hospitals to achieve a balanced budget, and New Labour saw PbR as a way to promote greater financial discipline and transparency of NHS organisations. This was because each hospital was paid the same amount for the same service volume, making it clearer when subsidies were necessary from central government to achieve a balanced budget. In addition, PbR formed part of a broader reform of budgeting technologies that included the introduction of 3-year budgeting to aid planning over the medium term. This would allow NHS organisations to better cope with volatility in budgets compared to traditional annualised financial years. This was important as the introduction of the whole of government accounts imposed new controls that

significantly increased volatility in budgets, although technically it had little impact as the NHS already practiced accruals (Department of Health 2001c).

The targets, performance ratings and budgeting changes were all subject to increased regulation, with accountability and reporting becoming broader than merely audited financial accounts by embracing performance management. For example, the NHS Plan 2000 established the independent CHI to regulate Department of Health standards and NICE to support modernisation. The NHS Plan also identified a need for visible targets. Over time these were supported by the National Clinical Assessment Authority to monitor performance (Department of Health 2001), quality standards for better health (Department of Health 2004a), and an accounting and control assurance framework (Healthcare Commission 2005). In addition, a plethora of inspection bodies covered a comprehensive range of areas. For instance, the Audit Commission was responsible for audit and review of financial system quality. The Healthcare Commission (2005) launched a new approach to measure, assess and report performance within a framework of national standards and targets set by government. The latter replaced CHI, the independent regulator of NHS performance until 2003/04, and the star ratings assessment system. Instead, the Healthcare Commission looked at broader issues than the targets used previously, and attempted to make better use of data, judgements and expertise of others to focus on measuring what matters to people who use and provide healthcare services. The overall aim of the new assessment of performance, and information gained through the process, was to promote improvements in healthcare by helping users make better informed decisions about their care, promote information sharing and give clearer expectations of performance standards. Monitor⁶ was also established as an independent corporate body regulating NHS Foundation Trusts. Furthermore, accountability was supported through transparency initiatives (Department of Health 2003a). This crowded regulatory landscape with its emphases on micromanaged targets and tight financial control stifled managerial autonomy (Hoque et al. 2004), despite the rhetoric of the benefits of a performance regime that would support front-line staff in managing the

⁶ Set up in 2004, Monitor is an independent regulator responsible for authorising, monitoring and regulating NHS foundation trusts. Its main duties consist of assessing NHS foundation trusts, ensuring that they have proper governance structures, are financially sustainable and deliver high standards of quality care.

delivery of healthcare to meet local communities' needs (Department of Health 2001b, 2008).

How Technologies of Performance Management Disciplined Knowledge, Identity, and Visibility and Control

The performance management technologies were employed in a framework of hierarchical accountability and centralised control, which in a 'panoptical' manner disciplined knowledge, identity, and visibility and control.

'Knowledge' (Dean 2010, 42) was affected by New Labour's NHS reforms. For example, the importance of patient choice meant customer service and consultation processes became more important as the 'market' let patients decide where to have healthcare,

'5.4 For the first time patients in the NHS will have a choice over when they are treated and where they are treated. The reforms we are making will mark an irreversible shift from the 1940s "take it or leave it" top down service. Hospitals will no longer choose patients. Patients will choose hospitals.' (Department of Health 2002d, 22)

Patient choice was important as it determined not only who would provide the care, but also which hospital would get the resources,

'5.7 Choice will be underpinned by new incentives. Those hospitals that have capacity to do so will earn more resources as the money follows the choice made by the patient. This is a sensible way of identifying and using spare capacity and, through the choices that patients make, providing new incentives for hospitals to treat more patients more quickly and to higher standards. In turn choice will create new incentives for hospitals not to build up long waiting times as they seek to expand activity.' (Department of Health 2002d, 23)

PbR meant this system extended across much of the NHS. As a result, doctors and administrators needed a better idea of the cost of certain medical procedures as each procedure only had a given amount of funding attached.

The importance of information flows in this performance management era around targets, performance ratings and local health services meant medical staff and administrators had to acquire new types of knowledge to understand the national and local health policy context,

‘5.8 Choice will also be underpinned by more information being provided to patients to help them make more informed choices. At a local level in each area the local PCT will provide independently-validated information to the public through its annual Patient Prospectus about the availability, the quality and the performance of local health services. (...) At a national level the new Commission for Healthcare Audit and Inspection will provide detailed information not just on comparative NHS performance but on the outcomes of care that are achieved by different health services in different areas. Starting with mortality rates following heart surgery, this will include published information about outcomes by individual consultant teams.’ (Department of Health 2002d, 23)

The hybridisation of staff skills was beginning to emerge as attempts were made to break down some of the demarcations of knowledge between medical professionals and managers so they could get a better understanding of their respective work roles in the name of improving patient care. Services were redesigned as organisational barriers were broken down,

‘Reforms are beginning to bite. Services are being redesigned as barriers between health and social care start to be broken down. Working practices are beginning to change as arbitrary demarcations between staff are eroded and more frontline staff are given greater authority.’ (Department of Health 2002d, 9)

‘1948 model - staff: rigid professional demarcation v New model - staff: Modernised flexible professions benefitting patients’ (Department of Health 2002d, 7)

In addition, the New Labour reforms coincided with the Kennedy Inquiry Report (2001) that expressed the need for managerial changes to provide expected standards

for guiding decisions, re-assuring the public of professional standards and accountability, and to reinforce the importance of good governance, leadership and management. As a result there were a series of changes to underlying knowledge including to Department of Health codes of conduct for NHS managers (2002b), the government of NHS boards (2003), codes of accountability (2004), and an integrated governance handbook (2006).

The ‘identity’ (Dean 2010, 43) of the NHS began to change as mixed provision between public and private sectors increased (Department of Health 2000, 2001b, 2002a). Indeed, contrary to Labour’s pre-1997 rhetoric, the NHS became ever more engaged with the private sector and its market ethos,

‘For the first time the NHS and the private sector will work more closely together not just to build new hospitals but to provide NHS patients with the operations they need.’ (Department of Health 2000, 15)

From 2002 onwards, New Labour introduced market mechanisms into the NHS with the stated aim to improve performance. The rhetoric of the reforms included patient choice of provider, stronger commissioning, greater provider diversity, more hospital autonomy, PbR, and regulatory framework changes. This was to make the NHS more patient-centred and self-improving with reference to the objectives of better care, patient experience and value for money (Department of Health 2005).

The New Labour reforms were similar to those of the Conservative government’s internal market between 1991 and 1997, but extended an internal market to a quasi-market. For instance, under the internal market system it was a third party commissioning organisation that decided in which hospital patients would receive elective care, whilst under New Labour individual patients were offered a choice of hospital for elective care and it was the patient’s decision that became the driver for resource allocation.

Through the reforms, the ‘visibility and control’ (Dean 2010, 41) of performance had moved from an internal market based upon competition and trading accounts to a market based upon patient choice.

A golden thread of performance management systems enabled performance ratings to be produced for hospitals that were subject to performance audits and published in publicly available league rankings in order to facilitate comparisons. This visibility attracted much media attention and scrutiny as shown in this paper with regards to star ratings, and began to influence or even control the choices of hospital managers (Llewellyn and Northcott 2005; Chang 2006).

The performance management arrangements also facilitated the PbR regime (Department of Health 2000, 2001a, 2001b, 2002a, 2002c, 2002d, 2005, 2009; Healthcare Commission 2005, 2006) with funding visibly linked to performance for different procedures. It therefore became much more visible when a hospital had to be bailed out by the government if it could not achieve a balanced budget (Department of Health 2001c).

At the same time, the codes of conduct, governance mechanisms and accountability arrangements had also been strengthened (Department for Health 2002b, 2003, 2004).

Together these changes to stewardship, performance and accountability arrangements heightened visibility through league tables, rankings and balanced budgets and led to more centralised control and discipline.

Discussion and Conclusions

This paper has examined the wide range of financial and operational performance measures adopted by the New Labour government between 1997 and 2010. Drawing on an analytics of government framework, the paper found that the problem of a crisis in funding and performance that the New Labour government inherited from its Conservative predecessors, and their search for a utopian solution through modernisation based on performance improvement, were addressed by framing reforms and giving them meaning through hierarchical accountability and centralised control arrangements.

The hierarchical accountability and centralised control arrangements relied on performance management technologies that disciplined the knowledge, identity, and

visibility and control of practice. For example, the paper illustrated that (a) ‘technologies’ (Dean 2010, 42) shifted from an internal market based on a purchaser and provider framework towards a 10 year NHS Plan with strategies and detailed lower level plans that aimed to form a golden thread throughout the entire healthcare system (Department of Health 2000; Micheli and Neely 2010). This was combined with an increased use of targets and standards (Department of Health 2000, 2001a, 2001b, 2002c, 2002d, 2008, 2008a; Healthcare Commission 2005, 2006). Under New Labour, these performance management measures came to be seen as a proxy for the overall performance of healthcare providers, and much emphasis was placed on high level comparisons of performance metrics, as conducted by regulatory bodies like the Audit Commission, the Healthcare Commission and Monitor. As a result, performance measures were susceptible to ‘game-playing’ and frequently decoupled from operational realities (Bevan and Hood 2006; Chang 2006).

The technologies disciplined (b) ‘knowledge’ (Dean 2010, 42). The manufactured market competition disciplined medical and administration knowledge, but this had to shift towards being disciplined by performance measurement, targets and amalgamated ratings used as representation of organisational success in making decisions. Also this was within a market of patient choice that had funding linked to patient decisions across a growing range of healthcare activities (Chang 2009). Greater management and financial skills were therefore required to support medical professionals, and commissioning of activities as they began to replace some direct service provision (Chang 2006). In addition, to re-assure patients, there was an increased focus on codes of conduct, especially after the Kennedy Inquiry Report (Department of Health 2002b, 2003a, 2003b, 2004).

The knowledge forged (c) ‘identity’ (Dean 2010, 43). The knowledge of healthcare professionals and administrators operating in the public sector began to require knowledge of mixed healthcare provision with the private sector, which shaped identity from being public sector to a more hybridised form of service provision. This involved competition, partnerships, joined up health and social services, and more localised healthcare with larger strategic centres (Department of Health 2000, 2001b). In addition, there was more hybridisation of staff with a greater cross fertilisation of

medical, financial and managerial knowledge (Department of Health 2001b; Kurunmaki and Miller 2006).

The identity affected (d) ‘visibility and control’ (Dean 2010, 41), which shifted from a focus on competition, trading accounts and accounting ratios to a golden thread of performance management through plans, targets, rankings and league tables (Department of Health 2000; Micheli and Neely 2010). These worked alongside budgets, cash controls and PbR (Department of Health 2000, 2001c, 2004b) to discipline staff into a culture of ‘targets’ (Bevan and Hood 2006) and, on occasions, ‘terror’ (Propper et al. 2008).

The framework of hierarchical accountability and centralised control that became New Labour’s ‘solution’ to the perceived NHS crisis had therefore extended neo-liberalism and New Public Management into an era of governance through performance management. With reference to New Labour’s health policy record between 1997 and 2010, the King’s Fund suggested that it included a mix of achievements and disappointments (Dixon et al. 2011). It highlighted both the increased investment in the NHS, but also the continuous upheaval and reforms the health service experienced during the New Labour years. This paper echoes these sentiments, and suggests that, although it enjoyed some successes, performance management cannot discipline and control health services to solve the myriad problems facing healthcare in the 21st century. As a result, the accountability and transparency arrangements of the NHS (Commons Select Committee 2013), its financial sustainability (National Audit Office 2014) and the design of public services more generally (Lord Bichard 2011) require further consideration.

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