Digital Era Governance in the NHS in England
(or Reconciling Paradigms)

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Introduction
For many years now, politicians have argued that a reactive, illness-oriented NHS
bureaucracy in England needs to be modernised, and replaced by a more proactive
system, focused on the health and wellbeing of the population and on improving the
quality of its services. It has, though, proved difficult to identify a coherent account of
government policies. What links giving GPs responsibility for commissioning services,
continuing concerns about the safety of hospital services, and efforts to tackle obesity and
other public health 'crises'? Does it make sense to talk about an NHS which is populated
with mutual organisations on the one hand, and is expected to rely on the expertise of
large US corporations on the other? And, why is there such concern to improve the co-
ordination of health and social care services right now, after decades of fraught
relationships between the two?

Current debates about the NHS in England are, understandably, dominated by the
Coalition's radical policies and the need to reduce expenditure by a total of £15bn.-
£20bn. in the next four financial years.[1] This is not the time to predict what the NHS will
look like in 2015. Sober analysts are expressing serious concerns, but the last time the
NHS was in a similar position, in 1994-95, the 'internal market' reforms were
substantially watered down and the NHS survived more or less intact.

Now *is* a good time, though, to discuss the strategic choices that are being made about the
NHS in England, about changing objectives and the institutions that will have to deliver
them. Whatever the outcome of the Coalition's proposals, they set a direction of travel
for the next few years. The choices are analysed in the context of the debate about the
current status of New Public Management (NPM) policies, and of new paradigms that
have – depending on whom you read – grown up alongside it or replaced it. The next
section reviews the Coalition's proposals. Then, three 'tests' are applied to the proposals,
as practical aids to understanding the strategic choices they embody. They reveal a
strong preference for NPM-style policies, but also set out a range of policies that promote
partnership and other non-market forms of co-ordination. The following section argues
that this apparent inconsistency can be resolved if one examines digital policies. It is
argued Coalition policies are based on parallel NPM and Digital Era Governance
policies, with digital patient records linking the two, as the source of data for both clinical

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[1] Secretary of State for Health (2010) Equity and Excellence: Liberating the NHS. Cm 7881. London, TSO.

and administrative functions. The implicit belief is that the two will be mutually reinforcing, but key ideas are untested, and the prospects for success difficult to evaluate.

The Coalition's Plans for the NHS
Over a long period, starting in 1989, successive governments have changed NHS structures, and gradually introduced incentives intended to improve the performance of managers and clinicians. The overall direction of travel has been away from a large, centrally directed bureaucracy and towards a 'mixed model', which retains the bureaucratic superstructure, but has a mainland European-style health insurance system operating within it. Throughout the period frustrations have been expressed with bureaucracies, but it has also been recognised – by most commentators – that privatization is not feasible, both because it would be very difficult politically, and also because health care markets are prone to failure.

In the period to 2010 the emerging system-within-a-system was essentially a regulated market. In theory, at least, a regulated market is attractive to policy makers, as they can design incentive mechanisms within a cash-limited system, and achieve both cost containment and efficiency objectives. Health insurance models involve market-type arrangements, with multiple purchasers and providers. A central body sets annual tariffs - centrally determined prices - for services.[2] Providers have incentives to match the tariff, or to provide a service below the tariff price, as they can keep the difference. If citizens are able to 'shop around' for their insurer and for their GP, then they can stimulate competition for both insurance and provision. Health insurance, when compared with a bureaucracy, offers mechanisms to encourage competition, and incentivises commissioners, providers and citizens. In short, it is an NPM strategy for the NHS.

In the course of the last ten years, however, there has also been clear evidence of a countervailing tendency. Concerns about the quality and safety of services have prompted examination of care pathways – the journeys that patients take through health care systems – and the ways in which the organisation of care can increase the likelihood of errors. There has also been a sea change in thinking about public health, with policy makers arriving at the view that the NHS in England has been too reactive, and must do more to promote health and prevent disease.[3] This means, *inter alia*, closer working relationships with local authorities and third sector organisations, because smoking, obesity and other current concerns are multi-agency problems.

The Coalition Government's plans for the NHS in England, published in *Liberating The NHS* in July 2010, have proved to be controversial.[4] Most of the commentaries to date have focused on three proposals, to make GP consortia the main commissioners of services, to 'open up' the NHS to private firms, and to abolish two 'administrative tiers', Primary Care Trusts and Strategic Health Authorities, with consequent job losses. But the proposals are part of a far broader prospectus, which include limiting the (currently very broad) powers of the Secretary of State, and the creation of economic and quality

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[2] http://data.gov.uk/dataset/payment-by-results-2010-11-national-tariff-information
[3] http://www.marmotreview.org/
[4] http://www.nejm.org/doi/pdf/10.1056/NEJMp1009188

regulators that will cover all health care providers in England, public, private and charitable. The current tariff system will be retained: there has been a debate about introducing price competition, but this seems less rather than more likely at the time of writing. Individual GP practices have to join consortia – many of these already exist – which will purchase services. Consortia will be able to keep any 'underspend', this being the difference between the Department of Health's budget allocation and their actual expenditure.

A number of policies are presented as 'putting patients and the public first', including the commitment that there should be more shared decision-making with health professionals (the slogan is 'no decision about me without me'). Some groups of patients will be given their own budgets, on the basis that they will be the best judges of their own health needs. Existing policies on choice of service, currently limited to elective hospital procedures, will be extended to cover choices about services for long-term conditions (eg diabetes, asthma, heart disease), maternity and end-of-life care. Presumably in recognition of possible equity risks in GP and patient decision-making, public health teams, based in local authorities, will be responsible for ensuring that population health and social care needs are met, and to encourage joint commissioning and delivery of health and social care services, and promoting health improvement in local populations.

These proposals have been published in a period of severe financial constraint. The NHS budget is being protected from the worst of the difficulties, but will nevertheless have to cope with real terms budget reductions in the next four years, and needs to reduce spending by a total of £15bn.-£20bn. in that period.

Supporters of the proposals point to evidence of declining NHS productivity. They believe that incentives to improve productivity are too weak, and need to be strengthened. They argue that GPs know what services their patients need and will make better commissioning decisions than Primary Care Trusts. Strategic Health Authorities are, they believe, superfluous. Critics argue, *inter alia*, that the NHS has improved its performance on a number of key measures in the last decade, suggesting that radical change is not necessary; the commissioning proposals are merely a smokescreen for the introduction of more private interests into the NHS, and presage its break-up; GPs face a serious conflict of interest, being both commissioners and providers of services; because GPs can retain 'underspends' they will have perverse incentives to minimise coverage and quality; and, accountability will be weakened, with the result that there will be insufficient oversight of GPs' decision-making.

Three Tests
This paper seeks to use established analytical frameworks to understand developments in the NHS, and conversely use developments in the NHS to shed light on those frameworks. There are always dangers in 'fitting' policy developments into a NPM or other framework, not least in biasing analysis: facts that fit the story are selected, and those that don't are quietly ignored. To guard against this, three tests are applied to the Coalition's policies:

1. Are the proposals internally coherent? (That is, do they make sense, or will they fall apart under the weight of their own contradictions?)
2. Do they help to explain how and why policy makers are responding to major policy drivers in health care?
3. Are they consistent with earlier policies? (Is there evidence of continuing focus on a policy, or are the proposals 'bright ideas' which have appeared for the first time, soon to disappear again?)

Between them, the tests should help to guard against overly deterministic assumptions about the origins or outcomes of policies.

First Test: Are the Coalition's Plans Coherent?
On the face of it the Coalition's plans have a strong NPM flavour, and we can test this point using two universal features of NPM policies, disaggregation and competition.

Disaggregation: The NHS has always contained a large number of organisations – including over 13000 general practices and several hundred hospitals – and was not included in the Next Steps or subsequent Agencification programmes of the 1980's and 1990's. The Coalition proposes to remove two 'tiers' of NHS organisations, Primary Care Trusts and Strategic Health Authorities, and to limit the powers of the Secretary of State to influence decision-making within the NHS. It is as if the NHS is undergoing Agencification very late, and with two effects. The first is to separate 'agencies' from the Centre, thus revealing the health insurance (market-like) structures within the current bureaucracy. This helps to make sense of earlier policies, such as the creation of NHS Foundation Trusts, which made little sense within a bureaucracy but makes much more sense within the Coalition's plans. The second is to reduce the numbers of organisations, as these are deemed to be too numerous, into consortia, most evident in the case of GP practices joining 500 or so consortia.

Competition: The Coalition's plans are squarely based on the belief that competition will improve efficiency, the same belief that inspired the Conservatives' 'internal market' policies in the 1989-95 period. GP consortia will be able to commission in "the largest and most vibrant social enterprise sector in the world." [Liberating the NHS, para 4.21] Legally binding contracts, already in use between PCTs and Foundation Trusts, will be used more extensively between GP consortia and provider organisations. Choice was a key term during the New Labour period, and if anything will be pursued with even greater enthusiasm by the Coalition. As noted in the last section, patients will be able to make choices about more services, some will have their own budgets, and they will – it is hoped – be more active participants in their own care.
This said, there is also evidence of another market-style development, vertical integration of community and hospital services, which may limit competition in any one locality.

However one defines NPM, it is alive and well in the Coalition's plans. Reports of its death have been greatly exaggerated. As the observations about 'joining up' services above indicate, though, the Coalition's plans also include elements that are not obviously NPM-like. GPs will have to co-ordinate with one another in order to make effective

commissioning decisions. The public health function will be located in local authorities, the rationale being that population health improvements involve housing, social care and other non-NHS services, alongside NHS primary and community services. A third example is the safety of services, where startlingly high error rates, particularly in acute hospitals, have led to a greater focus on systems of care – on ensuring that the design of services, and hence co-ordination between professionals, helps to reduce the likelihood of errors.

Throughout the history of NPM authors have pointed out that it has co-existed with other styles of policy making, and the same seems to be true here. It is not immediately obvious how NPM and policies intended to promote non-market co-ordination might fit together – if they do so at all.

Second Test: Policy Drivers in Health Care
Much of the current commentary about the NHS focuses, understandably, on the controversial plans and on the financial pressures it is facing. But there have always been major forces at work inside and outside the NHS. There has been mounting concern about the performance of the NHS, reflected variously in concerns about steadily declining productivity, the quality and safety of services, and the mid-table placing in international 'league tables' of health outcomes for cancer and other major diseases. And, over the last ten years or so recognition has grown of a 'crisis' in public health, evident in media coverage of problems with our diets and lifestyles, with drug and alcohol misuse, and with the marked increases in the numbers of people with diabetes and other serious long-term conditions.

These developments do not appear to be fads. Indeed, it seems that the objectives of the NHS have changed. The foundational objectives such as universality and cost containment are still vital, but are now supplemented with new secondary objectives, notably maximising productivity and maximising the quality and safety of services. Thus the underlying logic might be that a combination of NPM and network-oriented (or post-NPM) policies are responses to a new, broader set of objectives than in earlier decades.

Responses to all of the drivers listed in the Table were evident in New Labour policies and are found in the Coalition's plans. One of the six chapters of *Liberating the NHS* focuses on the quality and safety of services. Innovation – which here means finding better ways of delivering services – receives strong endorsement, with a number of R&D programmes being preserved in spite of declining real budgets. There will be a new body to oversee the NHS workforce, as one element of plans to increase productivity.

Perhaps the most surprising items on the list are health promotion and prevention. The Conservative administrations of the 1980's and 1990's were always ambivalent about this sort of activity, in part it seems because it ran counter to the more libertarian, self-reliant, strand in their thinking. If people want to smoke, or abuse alcohol or eat the wrong food, that is essentially a matter for them. Today, though, prevention is a key policy area. And in practice, prevention requires inter-professional and inter-agency co-ordination (see the Box).

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Table
Main policy drivers in health care
(adapted from Wanless 2002, Table 1.1)[5]

Trend	Has led to policies focusing on ….
Increasing patient and public expectations	The quality and safety of services
Delivering high quality	
Changing health needs	The consequences of increasing life expectancy
	Health promotion and disease prevention
Technological innovation	Increasing the rate of uptake of best practices; eliminating ineffective practices
Use of the workforce and productivity	NHS productivity

Box

> Vascular Risks
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> It is now clear that the risk factors for heart disease, stroke, renal disease and diabetes – all major disease groups – are very similar. The risks of all four are increased by smoking, poor diet, lack of exercise and other a number of other factors. If risks can be reduced, there will be benefits to individuals and families and – it is hoped – reduced demands on NHS services.
>
> In practice, many people at risk do not have much contact with health services. It is not clear how best to identify and advise people at risk, although there is evidence that community nurses have important roles to play. PCTs, and now increasingly local authorities and GP consortia, are thinking about effective ways of identifying and advising people at risk. This will, by its nature, involve a number of professionals and agencies. For example, poor oral health can be an important indicator of deeper health problems, so it may be desirable to encourage dentists to refer patients to – say – specialist community nurses for assessment and advice. The majority of dentistry is now provided outside the NHS, and are not used to referring patients, so joining-up dentistry with other services presents a challenge.
>
> Whatever the details of the services that are introduced, reducing vascular risks will involve significant cross-professional and – organisational co-ordination.

This gives us a clue about the underlying logic of the Coalition's thinking (and indeed the general direction of travel in policy making). Some policies *reconcile* NPM and network-oriented policies. In the case of health promotion and prevention, policy makers believe that better integrated services (networking)) are an important tool for demand management (NPM). In similar vein, improving quality and safety requires better co-

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[5]

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009293

ordination of services (networking), but this also help to standardise care processes – to commodify them - which makes costing and pricing of services easier (NPM).

Third Test: Continuity of Policy Focus
A third test of the Coalition's plans is continuity: are they bright ideas, designed to last a year or two and disappear, or do we have reason to believe that they tell us something important about the general direction of travel? The Coalition's plans are ambitious, but there are a number of similarities with New Labour, and with 1990's Conservative, policies. These are considered under four broad headings, namely regulated market, network governance, innovation, and public and patient involvement.

Regulated Market: The Conservative's 'internal market' reforms of the early 1990's introduced the separation of purchasers from providers within the NHS. From 2003 onwards New Labour introduced a number of policies that, together, pointed towards the creation of a regulated market – albeit within the existing NHS bureaucracy. The Coalition is retaining two regulators, Monitor and the Care Quality Commission, as economic and quality regulators respectively. It is continuing to use tariffs – centrally set prices – for services. And it is continuing, almost word for word, with policies on Foundation Trusts – all NHS providers should become Foundation Trusts within 3 years, and they may be given more powers, eg to borrow from commercial sources.

Network Governance: Under New Labour, a number of formal network governance arrangements were introduced, eg cancer and other disease networks for disseminating good practice, R&D networks for recruiting patients to clinical trials. Ideas about care pathways came to prominence. After slow starts, there was also increasing support for health promotion and prevention, and for more effective partnership working with local authorities. (Conversely, certain types of partnership working, notably between GPs and hospitals, were not encouraged – this was the province of patient choice, and hence a key area for competition.) The Coalition has, so far, retained these arrangements and will greatly extend the network-like arrangements between health care, social care and public health (for health improvement programmes).

Innovation: As noted above, New Labour became increasingly concerned about NHS productivity, and the Coalition shares this concern. Policies deemed to support productivity improvements will – at the time of writing – be protected as financial belts are tightened. There may be other straightforward political reasons for the concern about innovation, to do with ensuring that pharmaceutical firms continue to find England an attractive place to undertake R&D.

Public and Patient Involvement: The NHS has never had convincing representative structures for patients and the public to influence decision-making, whether on behalf of local populations or of individuals. New Labour abolished the long-standing Community Health Councils in 2003 and tinkered with complaints procedures. It had little appetite to replace CHCs with effective arrangements. The Coalition, similarly, is making relatively minor changes, and introducing new local bodies – HealthWatch – which look as if they will have limited capacity to challenge commissioners or providers. One bright

spot here is Foundation Trust Membership, set up under Labour and retained by the Coalition.

It seems reasonable to say, then, that there are important examples of continuity of policy thinking. On the other side of the equation, there is also discontinuity. The Coalition's plans are distinctive in abolishing PCTs and SHAs, in giving GP consortia the main responsibility for commissioning. As we will see below, the Coalition has published ideas about 'digital citizenship' in health and health care, which also seem to mark a break with Labour policies.

Digital Resolution?
There is a substantial literature on the demise of NPM, and on what is emerging in its wake. The arguments to this point suggest that NPM is not dead after all, and is making a comeback in a major public service in England. It is simply too early to know whether this is an important development or a 'Canute moment', with policies doomed to be overwhelmed by the internal contradictions of NPM and external forces driving non-market forms of co-ordination.

The focus in this paper, though, is on the strategic choices that the Coalition is making. Is it possible to make sense of the separate strands of thinking in the Coalition's plans? (It has already been suggested that there may be a resolution of paradigms, but can this be right?) This section sets out a novel approach to the question, by using digital policies as a sort of 'lens' for understanding the wider policy landscape. It may not be immediately obvious why this might make sense. There are two reasons why it might. First, digital policies tend to exist in their own policy bubbles, being presented as ends in their own right – as self-evidently valuable – rather than as useful instruments for achieving other policy goals. Yet they still reflect strategic choices, and so offer a separate source of evidence about the Coalition's intentions. Second, and perhaps more compellingly, digital networks can in principle support both market and non-market transactions. Just as the Internet is a platform for both Amazon and Facebook, might digital networks support both market-like transactions and partnership working?

The Coalition published a consultation document, *Liberating the NHS: An Information Revolution*, in October 2010.[6] Some of the arguments are familiar to any observer of the NHS – data quality are poor and need to be improved, we have little data on health outcomes and need far more if we are to improve productivity, and we need better data and technical standards if we want semantically inter-operable systems that span professions and organisations. Some of the ideas are essentially developments of New Labour policies. New Labour had already made considerable progress introducing the elements of a health insurance system, notably with performance-related payments for GPs and tariffs for hospital treatment. And it had toyed with individual patient budgets. The Coalition will extend these developments:

> "… the NHS, with encouragement from the Department of Health, is already implementing patient-level information and costing systems (PLICS). The

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[6] http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/Informationrevolution/index.htm

implementation of PLICS is not mandatory but the Department of Health strongly supports the use of PLICS within the NHS. PLICS will provide organisations with the ability to understand their economic and financial drivers, benchmark their costs in detail against other providers and enable comparisons between different teams dealing with similar patients.

The implementation of PLICS will also help provide data for Service Line Management (SLM) - a combination of management and business planning techniques used by an increasing number of NHS foundation trusts. An SLM approach enables trusts to look at cost and profitability across a portfolio of services so that they can make informed decisions about how to manage existing services, prioritise new developments or plan investments. The robust reporting systems that underpin SLM give clinicians and managers the information they need to maximise resources and patient benefit." *(An Information Revolution, paras. 5.25-5.26)*

But much is novel. Three ideas stand out. First, there is a strong focus on the roles of patients, or at least on patient information. New Labour was always ambivalent about patients or citizens accessing their own data – over and above legal rights to see one's own records – and tied itself in knots over a number of policies, including access to Summary Care Records[7] and consent to use data for 'secondary purposes' such as clinical research.[8] The Consultation document represents a *volte face*. The mantra, "No decision about me without me", is taken to mean that patients need high quality information about treatment options, choices about where they are treated (via NHS Choices), and access to their records so that they can participate actively in treatment decisions.

Second, there will be a major push to measure the outcomes of treatment. There is a long-standing problem in health services, around the world, that few useful output and outcome measures are available. This will necessitate research and development to identify appropriate measures, as well as the creation of the necessary infrastructure to collect data, and link it to resource use data, so that the NHS can assess its productivity properly for the first time.

Third, there are ambitious plans to make NHS data widely available in an 'information economy'. The NHS Information Centre for Health and Social Care will have new powers to act as an honest broker, making datasets available to private and voluntary sector organisations, who will (presumably) use it to identify new services they might bid to provide themselves, or evaluate the quality of services being provided by GPs, hospitals and others in the new, plural environment. Local authorities, and new local public involvement bodies – HealthWatches – will use data to hold the NHS to account. This aspect of the proposals looks crucial to the Coalition's conception of accountability, given the stripping away of two tiers of NHS management and limits on the powers of the Secretary of State.

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[7] http://www.computerweekly.com/blogs/public-sector/2010/06/trisha-greenhalgh-on-the-summa.html
[8] http://jme.bmj.com/content/34/1/37.short

Coinciding Logics
The Coalition's ideas suggest two useful lines of argument, one involving 'coinciding logics' and the other 'co-existence'. Taking the coinciding logics first, the central role of patients and their records is striking. Patients are no longer just patients. They are active participants in their own care, agreeing care plans with their GPs and other clinicians. For public health purposes they are citizens who may or may not be making sensible lifestyle choices. They are economic actors, deciding where they want to be treated (and, in time, who they want to treat them and where they wish to die). That is, patients provide a link between NPM and a partnership-based alternative – what some would label post-NPM thinking. Viewed in this way, electronic patient records are the cornerstone of the Coalition's policies. They will be the source of information for the day-to-day care of patients, and for recording agreed care plans.

A similar point can be made about outcome measures. At the moment most health systems generate a great deal of resource use and activity data but – to an outsider – surprisingly little outcome data. There are many reasons for this, some technical, some political – clinicians being reluctant to collect or to publish data. Many health problems do not have clear-cut outcomes, including many mental health problems, long-term conditions such as diabetes where the goal is successful maintenance rather than cure, and the often slow deterioration in health later in life. But much work is being undertaken on 'markers' of good quality care, and of successful maintenance of a decent quality of life for people who have a long-term condition. As already noted, policy makers want outcome data so that they can evaluate performance. Outcome data may also benefit patients, who could use it to monitor their own health or – at least in theory – challenge clinicians if outcomes are not satisfactory. Again, there may be a 'sweet spot' here, where a policy suits different interests.

The 'information economy' proposals are difficult to evaluate: we have not tried anything like this before. Insofar as it turns out to be practicable, it could be read as having both NPM and post-NPM elements. One reading is that the NHS Information Centre will publish data, available to all of us, that sharpens competition and contestability. The more that local authorities, and patient representative groups, know about services the more they can challenge local commissioners and service providers. Conversely, the same data might highlight weaknesses in the co-ordination of services between two provider organisations, leading to pressures on them to improve working relationships with one another.

Coexistence: Developments in Europe and the USA
The second line of argument suggests that NPM and post-NPM policies can co-exist. The ideas can be seen most clearly in European Union (EU) and federal US policies, so these are noted first, before returning to England.

In Europe and the USA, there appears to be convergence in policies on digital networks. In both jurisdictions there are two key elements, electronic patient records and large scale inter-operable networks. The EU has been promoting electronic records for several

years, and tracks progress towards implementation in member states. The Union also has a formal inter-operability strategy for health care, which envisages Union-wide exchange of individuals' health care information – my data being available to a Greek doctor, for example. The Union-wide networks will also be used to support the administration of health insurance. Health care is just one sector of the economy, where citizens can live anywhere, and hence may need treatment anywhere – so their records need to travel with them. Further, patients may choose to be treated a long way from their homes, possibly in another country. The networks will facilitate the administration of your treatment in Belgium or Poland.

There have been similar developments in the USA, which started in the later days of the George W Bush Administration, and been given strong impetus by the Obama Administration. Substantial funds have been made available as part of the economic stimulus package.[9] States are encouraged to create network infrastructure that will allow physicians to exchange data with one another – general physicians with hospitals, and hospitals with one another. The policies are also encouraging primary care physicians, many of whom still use paper records, to computerise their practices. The plan is that all health care organisations will have electronic records systems, and be able to exchange data with one another whenever necessary.

In both cases, then, the plan is to have two parallel networks, one for the exchange of patient data between professionals and the other for administration. The two can be managed separately, although they may use the same physical infrastructure within health care systems. In countries with social or private insurance systems, the main administrative task is to achieve digital insurance processing. But once administrative data are available they can be used for other purposes, including planning and commissioning (contracting for) services.

Once again, the electronic patient record is a key technology. It will be the source of administrative as well as clinical information. Returning to England, we can say that digital policies involve two parallel co-ordination strategies. One is an NPM-driven strategy, focused on providing the digital underpinning for market-like transactions (the rough equivalent of health insurance transactions in other EU member states). The other strategy is based on organisational co-ordination, on different styles of partnership working.

Digital Era Governance
Imagine, just for the next section, that you are responsible for the Coalition's digital policies and are thinking through their implications. A first task is to give the post-NPM developments a name: it has been suggested that they have network-encouraging characteristics, but no more so far. Most of the available candidates, for example in the network governance literature, have little to say about information systems and technologies, and it is difficult to know whether the analysis in the last section resonates with them: that would be a topic for another paper. One candidate that does look

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[9] One element of the American Recovery and Reinvestment Act 2009

promising, because it explicitly takes account of the rise of digital services, is Digital Era Governance.

It is important to stress that the term digital has two meanings here, one as a general term denoting a policy trend, and the other as a technological phenomenon. The policy trend first. Digital Era Governance comes in two forms, or waves. The first wave was made possible by the advent of large scale digital networks and advances in software engineering. It sought the implementation of electronic service delivery across government, so that citizens could pay taxes, renew driving licences and undertake myriad other activities online. It also sought to reverse or ameliorate some of the fragmentation associated with NPM reforms, and in doing so re-orient services around individual citizens – or customers – and break down barriers between existing organisational 'silos'. In the second wave of Digital Era Governance these trends are intensified, with further de-centralization and an increased emphasis on the central role of consumers, to the extent that the boundaries between services and citizens begin to blur.[10]

The Coalition's plans appear to fit both first and second wave Digital Era Governance thinking. In particular, they help to make sense of the various policies focused on individual patients/citizens in the 'information revolution' proposals, which might be viewed as second wave phenomena. This said, Digital Era Governance arguments assume that NPM is dead, or least severely wounded, and that is clearly not the case in the NHS in England at the moment. So, the Coalition's proposals implicitly suggest that large scale digital networks can support *both* market-like and Digital Era co-ordination. Or, perhaps more accurately, we might say that Digital Era Governance encourages us to think about a world where a number of co-ordination strategies are possible, including the use of legally binding contracts and other policies consistent with NPM.[11] The hypothesis here is that the Digital Era Governance *transforms* NPM, so that for example contracts can be negotiated and managed more flexibly than before, and contracts are part and parcel of close, long-running working relationships. Of course this sort of contract has existed for a long time, as Williamson and others have pointed out, but presumably the argument is that digital services make it easier to agree and maintain more flexible approaches to contracting.

The last comment prompts a further observation, which is that Digital Era Governance is not driven solely by technology. There may be two non-digital drivers. The first is exemplified by the use of contracts. Digital Era Governance makes sense when the tools and concepts of NPM are in place: it works because there is already experience of using the tools and concepts, and Digital Era Governance policies can re-shape and re-use them to re-integrate services. The second type of driver was discussed earlier. Even though the development of large scale digital networks in the NHS has been patchy to date, there is evidence that re-integrating, or more holistic, policies have been up and running for some time. Concerns about quality and safety, and about relationships with non-health agencies, are consistent with Digital Era Governance thinking even though they do not

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[10] The ideas are set out in more detail in the first paper in this panel by Dunleavy and Margetts.
[11] And consistent also with the New Public Contracting. See Vincent-Jones P (2006) The New Public Contracting. Oxford, Oxford University Press.

depend on digital networks, real or imagined.[12] Policy makers believe that digital networks will help to improve safety and quality, and to that extent mainstream and digital policies push in the same direction: but NHS staff are expected to improve quality and safety using any appropriate tool, and digital tools are just one option.

Final Comments
This paper has argued that NPM is alive and well in the NHS in England; that there are also substantive non-NPM policies, which emphasise non-market co-ordination of services; patients, or perhaps more to the point patient data, are central to current digital policies; reviewing the Coalition's digital policies suggests that NPM and Digital Era Governance policies may be able to co-exist with one another.

The arguments set out above suggest that, at least for the NHS in England, NPM and Digital Era Governance policies may be mutually reinforcing. Some of the points made here are necessarily somewhat speculative in nature, but it still seems reasonable to say that the 'coinciding logics' and 'co-existence' arguments suggest that the fit between the two strands may be rather better than one might expect, given the general thrust of the NPM/post-NPM debate. Of course, it is almost certain that there are flaws in the logic of Digital Era Governance which will become apparent over time, just as the flaws in NPM became apparent in the 1990's. And this paper has deliberately ducked empirical questions about the likelihood that any of the Coalition's ideas will actually work, particularly in a cash-strapped NHS. We might conclude that digital policies pass a 'basic coherence' test, but that the arguments here simply set out a framework for monitoring what actually happens over the next few years.

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[12] Indeed, systematic literature reviews show that there is little solid evidence that IT solutions improve patient safety.