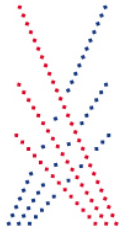

BRITISH ACADEMY
OF MANAGEMENT

BAM
CONFERENCE

3RD-5TH SEPTEMBER
ASTON UNIVERSITY BIRMINGHAM UNITED KINGDOM

This paper is from the BAM2019 Conference Proceedings

About BAM

The British Academy of Management (BAM) is the leading authority on the academic field of management in the UK, supporting and representing the community of scholars and engaging with international peers.

http://www.bam.ac.uk/

Post-New Public Management in Public Healthcare: Recycled, Hybridized, Paradigmatic?

Summary
New Public Management (NPM) is increasingly used pejoratively and claimed unfit for the complex challenges in contemporary societies, for example aging population structures and, as a result, increased number of cancer patients. Consequently, *post*-NPM gains increased attention. Drawing from a longitudinal case in Swedish cancer care, the present article seeks to pinpoint post-NPM in public healthcare practice. It is revealed that some post-NPM aspects are recycled by combining traditional public administration (pre-NPM) and NPM aspects: the former's re-professionalisation is combined with the latter's foci on performance measures, decentralisation, and accountability. Other post-NPM aspects are hybridizing typical NPM aspects with new (post-NPM) aspects: for instance, customer-focus is taken further to include the patient's active participation in co-designing services, and standardization is reinterpreted to concern meeting-places rather than efficiency. Yet other aspects are replacing NPM shortcomings: for instance, trust is replacing control, and a systems approach is replacing the intra-organisational focus.

Track: Public Management and Governance

Word count: 6 847 (excl. tables and references)

Erik Eriksson[1*], Andreas Hellström[1], Thomas Andersson[1,2], Christian Gadolin[2], Svante Lifvergren[1,3], Nils Conradi[4]

[1]Department of Technology Management and Economics/Centre for Healthcare Improvement, Chalmers University of Technology, Sweden
[2]Business Administration, University of Skövde, Sweden
[3]Skaraborg Hospital Group, Sweden
[4]Regional Cancer Centre West, Sweden

*Corresponding author
Department of Technology Management and Economics/
Centre for Health Care Improvement
Chalmers University of Technology, SE-412 96 Gothenburg, Sweden
erik.eriksson@chalmers.se

Introduction

"It was cancer. But it was not the tumor that took his life" (Dagens Nyheter, 2013). The quote opens a report series in a major Swedish newsarticle about the consequences of New Public Management (NPM) in public healthcare. Rather than the tumor, it was the NPM ideas that caused the death of the patient, it is argued. Already the founder of the concept, Christopher Hood (1991, 1995), emphasized that NPM should be understood as an ambiguous concept, varying based on sectorial and geographical context as well as theoretical anchorage (Gruening, 2011; Ohemeng, 2010; Simonet, 2015). Generally, it is argued that NPM ideas emerged on a broader scale in the end of the 1970s and early 1980s in a number of industrialized societies (Hood, 1991; Osborne, 2006). These ideas were adopted from private sector and therefore argued to be well-fit to tackle the scampering costs of public services caused by the traditional and bureaucratic organisation (Hood, 1991). Despite the lack of coherency, a common distinction separates between two aspects (Andersson and Liff, 2012; Karlsson, 2017): *managerialism*, in which the efficiency of public service organisations' (PSOs) production processes is at heart (Lindberg et al., 2015), and *marketization*, in which focus is put on competition among (private, public and non-profit) service providers and the free choice of the service user, or "customer" (Nordgren, 2009).

Despite recognition of increased efficiency and cost awareness among PSOs due to the application of NPM practices and tools (Dan and Pollitt, 2015; Hood and Peters, 2004), others have found little evidence for NPM's benefits, as the literature has presented "an ocean of studies of the application of NPM […] but only a modest sea of works that offer direct empirical analysis of outputs, and no more than a small pond that convincingly connect specific reforms to particular outcomes" (Pollitt and Dan, 2011, p. X). Hood and Peters (2004) found that not only did NPM have difficulties in achieving the intended results, but also caused unintended consequences. Lately, NPM is predominantly used pejoratively. Specifically, the critique addresses both managerial and marketization aspects of NPM, for example too much focus on supervision and control of process output at the expense of trust in the professionals (Quist and Fransson, 2014) and a too narrow focus on satisfying individual public service user's needs at the expense of societal needs (Eriksson and Nordgren, 2018; Stoker, 2006). Other critique addresses a higher level of abstraction, arguing NPM to be unfit for meeting the complex challenges in contemporary societies (Osborne, 2006).

Through globalization and digitalization, today's societies are more interconnected than before (Mintzberg, 2015). The nation state's borders are less distinct than before, and goods and people move with relative ease between geographical spaces and the premise of intangible human capital over tangible goods has entailed not only a blurring of space, but also the time aspect (Vargo and Lusch, 2008, 2016). In short, the developments have led to a change in where things can be done, when things can be done, and by and with whom things can be done (Normann, 2001). In addition, medical and technological advances impact today's societies. Today, it is possible to cure diseases that could not be cured before, or at least for people to live with diseases that were lethal before. Consequently, many industrialized societies face the challenge of an aging population structure and an increasing number of older citizens suffering from multiple and chronic diseases that put the welfare system under strain. The other side of the coin is that in many countries the working force decreases – particularly alarming for mainly tax-financed healthcare systems such as in the Scandinavian and British healthcare systems (Lifvergren, 2013). The aging population structure is also the main reason that cancer is increasing in many countries (Coleman et al., 2011). For example, in Sweden one in three people is expected to develop cancer during their lifetime (SOU, 2009). Due to medical progress, many of them will continue to live with cancer as a chronic disease. However, the

changed population structure and disease panorama also require welfare services to change – and in this sense, it is argued that NPM may cause more harm than good (Osborne, 2006). Consequently, increased attention is put on *post*-NPM ideas. However, just as with NPM, there is no shared of agreement of post-NPM and empirical examples are sparse.

The present article seeks to increase knowledge of post-NPM and how it is manifested in healthcare practice set in contemporary and complex society. By drawing empirical material from a longitudinal and collaborative research imitative with one of Sweden's six regional cancer centers, the article also addresses the called for need of empirical examples of how PSOs may be organised in a post-NPM era (Denhardt and Denhardt, 2015; Osborne, 2006). Just as when NPM emerged (Jun, 2009), post-NPM too is often described as new and paradigmatic (O'Flynn, 2007; Stoker 2006). Essentially, that is what the present article seeks to answer: Is post-NPM paradigmatic and new, or is it rather recycled and/or hybridized?

New Public Management and Public Administration

The foundations of NPM has briefly been accounted for in the introductory section. Here, the elaborations are deepened and put in relation of what preceded NPM – public administration – and still is present in PSOs. On an overarching level, NPM has been important in highlighted the poorly designed PSOs (Osborne et al., 2015; Radnor, 2010), that were large, inflexible and centralized in a Weberian hierarchical bureaucratic sense and that has led to inefficient PSOs (Lindberg et al., 2015).

Managerialism of NPM

Through NPM, PSOs gradually shifted focus from public administration's bureaucratic foci on *how* things are done, achieved by hierarchy and obedience of rules and regulation, and (Alford and Hughes, 2008). Rather than input focus (i.e. budgets and grants), NPM focused on results-based management and output (Alford and Hughes, 2008; Hood, 1995), the latter controlled through standardization and performance indicators (Dunleavy & Hood, 1994; Hood, 1995; Almqvist et al., 2011). Yet an important feature was the decentralization of responsibility for production and results to autonomous units that were also held financial accountable (Christensen, 2012).

Improving and standardizing processes (Christensen, 2012) has been important in creating predictability and thus a way to improve efficiency and quality (Hellström, Lifvergren and Quist, 2010). The focus on efficiency by formulating goals and measurements of output, often by using tools and techniques from the industry, have been claimed to have been a positive contribution to public sector (Osborne et al., 2015), ranging from improved participation in cancer prevention (Olsson et al. 2014) or reduced waiting lists before surgery (Plantin and Johansson, 2012).

Commonly, the output focus of NPM has been argued to have created too much evaluation and supervision of professional's abilities to achieve preset goals (Hood, 1995; Verbeeten, 2008). Moreover, lacking contextual understanding of NPM reforms have been highlighted (Pedersen and Löfgren, 2012). Moreover, the inward focus of NPM of improving PSOs internal processes has also been highlighted not fit in addressing facing many contemporary societies (Osborne, 2018). For example, Porter's (1985) value chain has been transferred to PSOs but has contributed to a focus of internal production processes at the expense of collaboration with others, including the service user – who is criticized to be relegated to a passive role as a receiver of value that is produced within a factory (or school, or hospital) (Osborne, 2018).

The decentralization of NPM has been criticized to lead to intra-organisational (or even on unit-level) focus at the expense of issues *between* organisational units (Eriksson et al., 2013). This intra-organisational focus of NPM is argued to have created externally ineffective public service organisations in an increasingly plural world (Osborne, 2006; Osborne et al., 2015). The need for collaborative arrangements may be particularly important in a healthcare context, argued by Mintzberg (2015, 2017) to often situate the most complex organisations, housing the different – sometimes conflicting – perspectives of management, nursing staff, physicians, and politicians. In addition to Mintzberg (2015, 2017, many issues in healthcare concern other players too (Eriksson, 2016). Thus, healthcare providers, just as other PSOs, do not have exclusive power of their own efficiency in the increasingly fragmented society, but rather they must realize they are part of complex public service delivery systems in which the relationships with a multiplicity of cross-sectorial actors are crucial (Osborne et al., 2015).

The standardization of processes has been criticized to create one-size-fits-all solutions (Berwick et al., 2002 Olsson and Lau, 2015). The accountability of "produced" output has also met critique, not least as exemplified in the introductory section in which this has affected staff to focus on "other things than curing patients". Moreover, NPM ideas are also claimed to have led to "depolitization" that has transformed citizenship and democracy (Malmberg and Urbas, 2017) and in which managers have been given more freedom in the quest to improve efficiency (Maor, 1999).

Marketization of NPM

The creation of markets and competition may be a reason that some PSOs have improved their service delivery (Osborne et al., 2015). Through contractualism, policy-making and service delivery bodies were separated into purchaser and provider (Alford and Hughes, 2008) which combined with privatization, private and third sector actors were to encourage competition and, consequently, increase efficiency (Eriksson *et al.,* 2013; Green-Pedersen, 2002).

These market-oriented elements of NPM have also implied that public service users have been seen as "customers" thus trying to address the poor user service of public administration (Alford and Hughes, 2008). In a healthcare context, one aspect of this is that focus is not only on medical quality, but also customer satisfaction and perceived quality of 'softer' issues such as interaction (Olsson, 2016). In running PSOs as businesses, awareness and consciousness of costs has been raised that, in turn, have driven rationalization and increased resource efficiency (Hood, 1995).

The market-oriented NPM ideas has also met resistance. For example, that the freedom to choose provider have mainly benefitted relatively healthy citizen of high socio-economic status (Swedish National Audit Office, 2014) – colliding with the principle of prioritizing those with the greatest needs, as stipulated in the Swedish Healthcare Act (2017:30). It is also suggested that there has been an over-belief in individuals' rationality and abilities to make informed choices (Nordgren, 2009). The potential risk of focusing too much on customer satisfaction has also been raised. For example, the risk for medical quality to be pushed aside.

Moreover, the lack of transparency of private actors has been highlighted (Lundquist, 2001). Paired with the NPM ideas of accountability for unit performance, the unexpected consequences of individualized concepts such as patient-centeredness may imply that certain patients become "risk objects" to staff and unit managers who try to send them elsewhere (Andersson and Liff, 2012). The emphasis on competition and the choice of individuals were claimed to have resulted in neither improved quality nor efficiency (Hartman, 2011) – indeed,

the efficiency of the healthcare market itself – referred to as a 'quasi market' – has also been questioned (Levin and Normann, 2001; Nordgren, 2009).

Post-NPM

As discontent with many of the NPM ideas has grown, a new public administration movement is emerging among scholars and practitioners (Bryson et al., 2014), labeled such as *New Public Service* (Denhardt and Denhardt, 2015), *Collaborative Public Management* (Agranoff and McGuire, 2004; Morse, 2011), *New Public Governance* (Osborne, 2006), *Public Value Management* (Stoker, 2006), *Joined-up Government* (Pollitt, 2003) or *Whole-of-government* (Christensen and Lægreid, 2007). An agreed upon definition is missing, but many of these concepts share commonalities. In the remainder of this article, these ideas are addressed simply as "post-NPM" (Christensen, 2012), and the aspects addressed herein include the networked nature, trust, and public values.

Networked Nature

Among the commonalities are that those post-NPM ideas often highlight the importance of networked governance, inter-organisational and intersectorial collaboration to achieve results (Alford and Hughes, 2008; Christensen and Lægreid, 2015; Ferlie, 2017; Ferlie et al. 2016). Not least are these collaborative programs, projects and bodies a reaction to – and a contribution of avoiding – the fragmented services or "pillarization" or "siloization" caused by NPM (Chrisensen, 2012; Chrisensen and Lægreid, 2011; Pollitt, 2003). What is commonly addressed to be an important contextual factor for the necessity of abandoning some of the NPM ideas are that the world today is increasingly "plural" or "complex". In such a world, problems that PSOs are to address are not easily understood, but rather to be "wicked" which require centralization and coordination (Chrisensen and Lægreid, 2011; Lodge and Gill 2011). These types of problems are societal matters of concern (terrorism, pandemics, refugees, poverty, climate change) rather than a "problem" for one organisation only, and include such as democratic values, sustainability, equality and policy areas that cut across boundaries (Christensen 2012). Whereas NPM to some extent could deliver efficiency at micro level, doing the same at macro level has proved difficult (Chrisensen and Lægreid, 2011). Addressing these "wicked problems" with NPM's intra-organisational focus is, of course, tricky. Rather, another approach is needed.

An pivotal actor in these network models are the service user and citizen – that is expected to shoulder an active role beyond NPM's role of making choices on a market (Anttiroiko and Valkama, 2015) and expressing (dis)satisfaction (Stoker, 2006). Thus, NPM's focus on customer satisfaction as in concepts such as service user quality (Ferlie et al. 2016) are strengthened in post-NPM. More importantly, the active customer notion also includes the service users' contribution in co-designing services or even co-innovating service systems (Osborne et al., 2016). Through digitalization, for example, contributing to other users' services or gaining information is easier than before.

Trust

Yet a commonality of post-NPM is the emphasis on trust, both in co-workers within PSOs as well as in relation to other organisations in the network (Ferlie et al. 2016). The networked nature is argued to be a necessity also from staff's perspective because neither rules nor incentives – as in public administration and NPM, respectively – does suffice as a motivator for staff, but rather "their relationships with others formed in the context of mutual respect and shared learning" (Stoker, 2006, p. x). Thus, building successful relationships is the key to networked governance (Stoker 2006). To Pollitt (2003, p. 35) these collaborations are believed

to contribute to "achieve horizontally and vertically co-ordinated thinking and action". Horizonatal coordination between PSOs as well as between government and other actors have been central (Christensen, 2012), to avoid centralization to be vertical and hierarchial. "Post-NPM seems generally to be more about working together in a pragmatic and intelligent way than about formalized collaboration" (Christensen, 2012, p. 4).

Public Values

In addressing wicked problems, it is also claimed that focus on outputs of NPM is not enough for PSOs, but rather to focus on public values (Stoker, 2006; Meynhardt, 2009; O'Flynn, 2011). Thus, single individual's satisfaction or perceived value should be accompanied with a public level that address principles important for the collective citizenry (Alford 2016), including democratic values (Bryson et al., 2014), justice and equality (Arellano-Gault, 2010; Beck-Jörgensen and Bozeman). These collective norms are important in counter the fragmentation caused by NPM (Chrisensen and Lægreid, 2011; Ling, 2002). To Meynhardt (2009, p. 192) the collective dimension of public value is important because the public sector "cannot be reduced to individual cost-benefit analysis, customer orientation, or rational choice-models." Thus, public values are co-created in collaboration between the citizen, private, public and third sector actors (Moore, 1994).

Summary

Table 1 summarizes some of the key features of public administration, NPM and post-NPM as presented in the above and inspired by Benington (2007), Denhart and Denhart (2000) and Osborne (2006).

Table 1. Key features of three public management models

	Public Administration	**New Public Management**	**Post-New Public Management**
Theoretical foundation	Political science, public policy	Economic theory, management studies	Organisation theory, network theory, democratic theory
Focus	The policy system	Intra-organisational management	Inter-organisational collaboration
Emphasis	Policy implementation	Outputs	Processes and outcomes
Context	Stable	Competitive	Changing
Governance through	Hierarchy	Market	Trust, relationships
Organisational strucutre	Centralized, top-down authority	Decetralization of responsibilties	Collaborative strucures with shared leadership
Problems/needs	Defined by professionals	Wants, expressed through the market	Wicked, complex, volatile
Regulation by	Voice	Exit	Loyalty
Public interest	Expressed by politicians	Aggregation of individual interests	Dialogue about shared values
The public service user	Voter	Customer	Network actor

As seen in table 1, theoretically there are distinct features between the three public management models. However, what features are found in practice – and what typical post-NPM aspects may be found (and not) in the empirical material?

Methods

Setting

The Swedish national government initiated the inquiry *A National Cancer Strategy for the Future* (SOU, 2009). Central in the strategy were investments in cancer prevention; improved dissemination of knowledge; increased patient involvement; reduced disparities among population groups; and a need to develop the organisation of cancer care. The National Cancer Strategy also recommended the opening of regional cancer centers across Sweden with the purpose to, for example, provide research, transfer knowledge between research and care, to take responsibility for a more multidisciplinary approach in care and research, and to spread information across the various levels of care (SOU, 2009).

In 2011, as one of six, Regional Cancer Center West (RCCW) started. How the regional cancer centers were to organise their work was not regulated in the national cancer strategy (SOU, 2009). RCCW (2017) describes themselves as a knowledge organisation that collaborates with practitioners and other actors with the purpose to increase efficiency, patient-focus, and equality. Oftentimes, collaboration takes place with other actors from private, public and third sector. Statisticians, administrators, improvement facilitators and others are working at the RCCW office to support the regional cancer processes.

Participants

The regional so-called process-owners are responsible to develop and coordinate their respective cancer process together with a group consisting of specialists from different fields and hospitals as well as a responsible nurse. Many processes also have patient representatives. Other important tasks of the process-owners and their groups are to implement national guidelines and to make these more regionally relevant, work with quality registers, and to measure processes, logistics and production planning. The purpose is to offer patients care that takes the big picture in mind, to collect and spread knowledge. In total, there were twenty cancer processes, each headed by at least one process-owner. All process-owners are clinically active physicians and work at least 20 percent for the RCCW (2017).

Research Approach

The empirical material in this article draws from a longitudinal research initiative with the RCCW that started in 2011. The research approach has been highly collaborative in which the researchers have wanted to do research *with* management, practitioners and patients in order to improve cancer-related healthcare services (Coghlan and Brannick, 2014). In such an approach the researchers were not merely observing or relegated to analyzing events after the fact, but are directly involved in the field, processes or phenomena to be studied – and they sought to create knowledge in collaboration with those affected. Understanding these "softer" issues are important, not least in light of Jun (2009) arguing that the emerging post-NPM movement is grounded in positivism and functionalism and consequently it is assumed that people change behavior and actions due to structural and functional organisational change.

In this article, the first, second and fourth authors have been conducting research projects with RCCW. The fifth author worked as director of the center from its establishment in 2011 until 2017.

Collection and Analysis of Empirical Material

Empirical material also draws from the researchers experience in working in/with RCCW during 2011–2017. Material was also collected through official documents of RCCW. The

main source of the empirical material presented in the results section was collected through five focus group interviews with the process-owners. These took place during spring 2013 and between three to five process-owners participated in each focus group. In total, 18 process-owners participated in the semi-structured focus groups. All groups had mixed gender representation, in total 8 women and 10 men. The official documents were mainly used to triangulate and make sense of the interpretations of the focus groups (Jick 1979). Data from the focus groups were coded and categorized, inspired by the procedure by Graneheim and Lundman (2004) in which transcriptions are read multiple times and put into categories based on similarities. These categories were discussed among the researchers and adjusted accordingly.

Results

This section presents the categories from the focus groups.

Processes

The reason to introduce processes in cancer care was to improve the shortcomings of traditional healthcare organisation which was often based on the human anatomy and, consequently, medical specialization. Rather, the processes were conceived to run across these units. Similarly, some process-owners understood their role in relation to "traditional healthcare leadership" and management chain of command. In the latter, boundaries and mandate were clear. In the former, mandate was anything but clear and they perceived they did not have these "boundaries to work within […] we're boundless." Many of the participants in the focus groups were confused by the unclearness, for example: "… with what kind of right can I make demands and take action?" Another participant added that the reason for lacking mandate and boundaries was that the process-owners were responsible for neither staff nor economy. Maybe, argued a process-owner, they were responsible to offer support to the local clinicians only and that "at the end of the day, it is not really us who's in charge, even though that is not very clear." One participant in the focus groups thought that maybe there was a point in not having mandate as a process-owner: "It is not us that should decide […] 'you should do this and that,' but rather we're supposed to have a dialogue about it." Similarly, another process-owner thought that "the only tool one has, as I see it, is people's good will. And it's people that are supposed to do the work." To others, being a process-owner meant to "lend a helping hand" to the local hospitals, to "work together", and to have "a dialogue."

Other process-owners said that it was important that the title emphasized that this particular person, or "owner," was supposed to be at heart of things. One process-owner believed that in one sense they were some kind of leaders, but "not very hierarchical." Another agreed and explained that their leadership was mainly about "leading the collection of hard data."

However, working together with the local clinicians was not a matter of course. One process-owner had noticed that it was rarely oncologists that they visited, but other specialists with "no clue of what we have been doing." A process-owner responsible for a generic, non-disease specific cancer process experienced that it had been hard to establish contact with others, that such things as pain relief or subsidies for relatives seemed trivial to many of them. Another process-owner agreed: "I have kind of the same problem, my patients are found almost everywhere, but nobody really wants to recognize that."

Another process-owner said that his boss as a clinician in the management chain of command had interfered with his regional role as a process-owner, dictating what he should and should not do as a process-owner.

Performance Measurements and Accountability

Ideally, the national quality registers enable evaluation of quality for specific diagnosis and on different levels of the Swedish healthcare system. These registers are operated by the professionals themselves who also decide what and how to measure. To many of the process-owners, to work with the registers – on both regional and national levels – took considerable amount of time. For some cancers there had been registers since the 1990s, while other process-owners had to develop their registers from scratch. Some process-owners expressed concern about the low reporting rates to the registers among the regional clinics and that they felt they were in no position to influence for things to improve.

However, it was clear that accountability to report these measurements was still important, but now the responsibility of the professionals themselves – through the process-owners – to collect. The number of registers and variables were seen as a problem, especially for the clinics under pressure. Even though new forms or variables could be important, there was an "outcry" when these were added to the registers. One process-owner mentioned that the registers were basically a good idea, for example by improving prompt treatment of patients, but that it took a lot of time for the clinicians and could risk taking focus off treatment: "… it is easy to measure, but it can be misused."

In visiting hospitals, the registers could be used to compare the hospital one was visiting with the region overall or national numbers. One process-owner had recent experience of using the registers to detect differences in survival rates among the regional clinics that could help the hospitals "worst off" to take action in detecting the causes thereof, because "you don't want to be the worst."

Trust and Profession-led Cancer Strategy

Despite that the NPM idea of performance measure was central, accountability as a NPM principle based on these measures was abandoned. Rather, an important and outspoken RCCW strategy was to try to decentralize and promote greater freedom for the healthcare professionals. Probably, the greatest shift towards this direction was the appointment of the process-owners, responsible for developing and disseminating knowledge about their particular field. All process-owners were clinically active physicians, but other than that the prerequisites of the process-owners varied. RCCW avoided to define how process-owners were to do their jobs. Instead, the process-owners were to decide how to do things, and how to define their own process-ownership. Each process-owner ran their own "process-team," often represented by various professions and different hospitals. Rather than the managerial and controlling function of NPM, the role of the RCCW office was to support the process-owners and their groups by, for example, providing statistics, education, and networking meetings, as well as covering traveling expenses and so forth.

Many of the process-owners had spent the first year as a process-owner to travel around the region to meet the local hospital representatives to "get an understanding" how they worked. Visiting the clinics was important in establishing dialogue with the local physicians and because "… dialogue is the only way to reach results." The process-owners believed it was essential that they themselves worked clinically, as it made them understand how "the work was done" at the local hospitals, "made dialogue easier," and created "trust among colleagues." Also, if one had "history in the field" and had "an established network" it helped in to gaining "authority" in contacts with the local hospital professionals. However, a few process-owners experienced that having a "history in the field" had resulted in that they had more "more

enemies than friends" among the local professionals. Moreover, working clinically at "the large hospital" was not necessarily a positive thing when visiting the smaller hospitals in the region, another process-owner experienced. While some process-owners thought that collaboration with the local hospital clinics was rather uncomplicated, others had had more difficulties. In the former, visits and contacts with the clinics were described in such terms as "good dialogue," "good reception when ones coming out in the region", or a feeling they did "something together." In the latter, when visiting local professionals, the process-owners felt that "… people don't say it, but I sense they wonder 'what is this good for?'"

One process-owner added that maybe it could be that the local clinics felt that "here they come to map our deficiencies." Because of this apparent risk, another process-owner said they were very careful not to be too demanding or controlling, but rather just to "present facts and let them draw their own conclusions." Another process-owner said that establishing trust and relationship had taken time, but once this was in place one could be more direct because "one has established trust making it possible both to give and take harsher comments."

A Systems View on Cancer Care

One way to handle the unit-focus of NPM was the sheer idea of working in processes, crossing the different units in traditional healthcare. One way to understand it, is that the process should be understood from the patient's journey through healthcare – a journey supported by the various actors in healthcare. In a similar way, a recurring metaphor of the organisation of cancer care in Western Sweden has been the aqueduct. The purpose of the metaphor is to visualize the cancer care *system*, in which various units and individuals are interconnected. The aqueduct tries to show that the patient's journey is carried by the water that runs in the upper furrow of the aqueduct, as interconnected. The water in the upper furrow is supported by the practitioners in the care team, or the upper vault. Each vault exists to support the level above. All parts or sections are included in the entirety.

All participating process-owners in the focus groups were familiar with the aqueduct metaphor, but opinions varied. Some interpreted the aqueduct to be "sympathetic" and "appealing," for example by making clear that "knowledge and interest derive from the floor" which is necessary in order to "make improvements more sustainable, or else they will be only temporary." Yet a process-owner interpreted the metaphor to highlight one's own responsibility as a process-owner. Others paid more attention to the clear and necessary "customer focus" of the metaphor: "… it has been useful for my own sake, I see things differently, that we are supposed to do things for the patient," or "… it highlights what we work for, not for our own sake but for things to be better for the patient […] sometimes we forget that." One process-owner thought the metaphor was useful in meeting clinicians at local hospitals, to show that things "hang together."

Others were more skeptical. While they thought it was a "nice picture," they had never used it or talked about it when visiting other healthcare professionals. Some thought it was "a little diffuse," or as elaborated by another process-owner: "… it is a little wishy-washy to travel around doing visits and to talk about aqueducts. We talk more concretely."

Despite the systems ambition, knowledge about the bottom vaults of the metaphor lacked among the participants in the focus groups. The organisational structure of the region was "confusing," "very hard to grasp," and some just did not "get it at all." Moreover, decisions at this level seemed to "pop out of nowhere", sometimes these decisions were crucial for the patient group – e.g. about new medication – but the process-owners had had no information of

neither its making nor their role in the continued process. Regional decisions of implementations of goals and performance measures caused even more confusion – not least because a national agency similarly defined such goals. Some process-owners had been involved in setting regional as well as national goals, but felt that because they experienced they "lacked mandate" or "had no contacts" these often political issue became more exhausting than rewarding: "I am a too small person in this hierarchal order."

Many of the process-owners sensed that a changed had come. For instance, "before each unit was a unit, now it feels like we're more of one big region." Another process-owner said that different specialist had now closer collaboration than before – important not least to avoid patients to fall between specialists but rather meet both at the same time.

The systems view also included the process-owner network. Meeting with the other process-owners were considered important by the participants in the focus groups. There was a sense of "connection" and "creating identity" in these meeting, that there were others doing the same thing. Moreover, the meetings were important to understand that some processes sometimes overlapped. Moreover, in meeting other process-owners one process-owner said it was important to have learned about the different "cultures" of surgeons and medicine specialists. The provided education was appreciated, but input concerning leadership and project management were missing, a number of owners argued, for example: "Generally speaking, physicians like us have very insufficient education in that [leadership]." Some asked for more education in "simple statistical stuff."

Patient Involvement

That involvement of patients was pivotal was evident not only in the aqueduct metaphor, but also in the Swedish Cancer Strategy (SOU, 2009) as well as in regional documents of RCCW's. This involvement was beyond the patient as a choice maker on a market, that was primarily NPM's take on patient-focus.

Among the participants in the focus groups, bringing forth patient-focus in the routines were mainly positively received. One process-owner experienced "great win" by establishing dialogue with patients concerning how to improve services. By so doing, it had been obvious that they had previously "been focusing much more on medical lead-times, but now we're much more occupied with patient-reported lead-times." Some process-owners had taken patient involvement even further, by recruiting patient representatives. Those had been important in identify areas in need of improvement – from the patients' perspectives. By so doing, potential gaps between organisational units in which patients may "get stuck" could be identified, but also by suggesting improvements of invitations and pamphlets about disease and treatment. Yet other representatives had accompanied the process-owners in visiting other clinicians at hospitals. One process-owner agreed that having patient representatives was desirable, but difficult, because even though they got recruited "people have disappeared." Another participant agreed, having had "rewarding collaboration" with a representative from a patients' association, that had to be cancelled due to the representative's sickness. While having representatives was overall a positive thing, a "methodology" or "systematic way" for patient involvement was called for by two process-owners.

For others, the importance and benefit of patient involvement was not a matter of course. One process-owner was critical about measuring such as patient-reported data, arguing it was a "political thing" rather than based on medical evidence. Other process-owners agreed, emphasizing there was a risk to be taken "hostage by politicians," or as put by another process-

owner, it was "politically correct." Others said they would work more patient-focused, even though rather reluctantly.

Patient representation was also problematized. Not least because the fact that those willing to participate were "not exactly the weak patients," or that it "possibly is a certain type of patients that engage themselves." Another process-owner admitted it was almost impossible to deny patient associations representation when they asked for it. These people sometimes represented their own interests, rather than those of the association, as argued by another process-owner. Finding good participants seemed difficult.

Discussion

In this section, it is discussed whether the empirical case contains recycled NPM and/or public administration ideas of organising and managing PSOs, what may be considered hybridizations between NPM and post-NPM, and what could be considered to be new (post-NPM).

Recycled, hybridized or paradigmatic aspects?

Table 2. Aspects in the empirical case

	Aspect(s)	**Example**
Recycled (NPM and/or public administration)	Performance measures and reprofessionalisation	The focus on performance measures is a typical NPM feature (Ferlie et al., 2016). However, rather than managerial, the registers were operated by the profession themselves. Thus, in a sense the profession-led registers is a hybrid – but not between something old (NPM) and new (post-NPM) which is the focus of the next subsection, but rather as a hybrid between two "old" ways of working: the focus on performance measures of NPM and the professional's perspective in defining needs and problems of public administration or "reprofessionalisation" (Ferlie, 2017). Thus, it indicates a move back to knowledge of the professionals rather than management controlling them.
	Decentralization and reprofessionalisation	Also, the decentralization aspect of NPM was addressed, not least to promote greater freedom for professionals in healthcare. Here, the appointments of the process-owners themselves was important in that shift, as they were given mandate and responsibility to develop knowledge within their respective field of expertise.
	Accountability and reprofessionalisation	Accountability was also kept, but it was rather the professionals themselves that were responsible to require these from the local clinicians.
	Competition	Another aspect of NPM was the competitive aspect, in that positive competition was created among the clinicians, who learned from each other and avoided to be "the worst".

Hybridized (NPM and post-NPM)	Customer-focus 2.0	The customer-focus of NPM was evident in the healthcare-specific term patient-focus. Patient-focus was clearly stated in various guidelines and in routines. However, involving patients as co-designers of services and recruiting patient representatives was beyond patient-focus of NPM and rather a post-NPM (Osborne, 2018) feature broadening what the patient could do and changing the relationships between patient-staff. However, even in its most basic form, patient-focus was seen with skepticism by some process-owners, as a non-medical thing and something one had to do because it was politically correct. For others, patients were seen a problem-identifiers and co-producers who could develop services (Bryson et al., 2014; Denhardt and Denhardt, 2015).
	Sociological standardization	Also, NPM's standardization appeared in a hybridized form. Rather than standardizing efficiency and best practice, what was standardized in the case was to let people meet and thus best practice may emerge – and then create arenas that were facilitated by the process-owners. A standardization more similar to sociological standardization than NPM.
	Border-crossing processes	Also, the use of processes is a typical NPM aspect, but in the empirical case processes was used as a way to focus beyond unit-level – to overcome the shortcomings of bureaucracy and management chain of command by cutting across organisational units. As such, process-ownership helped to address the reality and issues of pressing concern that practitioners were facing (Bryson et al., 2014; Denhardt and Denhardt, 2015; Stoker, 2006). Travelling around to other healthcare providers was important in building trusting relationships and fruitful dialogue (Bryson et al., 2014; Morse, 2011) with other healthcare professionals.
Paradigmatic (or 'new') (post-NPM)	Trust and relationship	The overarching organisation, RCCW, did not define how the process-owners should do their jobs. Based on trust, the process-owners were to decide how to do things, and how to define their own process-ownership. RCCW had a supportive role rather than controlling role. The RCCW case shows similarities with the managed clinical networks in UK cancer care (Addicott et al., 2007). In a post-NPM fashion the professional collaboration are "managed" in both cases by the professionals themselves. However, in working successfully in these managed networks, trust was essential in the present case. The design of creating trust and relationships is at heart in Osborne's (2006) conceptualization of

		an emerging post-NPM administration. Rather than NPM leading to managers controlling services, managers ought to provide trust and dialogue in the professionals' expertize, and the professionals' ethos for action is likely to function as a motivator (Denhardt and Denhardt, 2015). Managers should also help to create and guide networks of inter-organisational and cross-sector relations and to enhance effectiveness, accountability, and capacity of the system overall (Bryson et al., 2014; Stoker, 2006). However, other than other healthcare providers few other sectors were mentioned so the networks could at the utmost be said to be of interorganisational nature, but not intersectorial.
	Systems approach	Even though the process-ownership itself emphasized processes, for many it was rather a networked logic rather than a sequential and linear process, as in many post-NPM concepts (e.g. Osborne, 2006). Thus, in a post-NPM fashion focus moved from efficiency within organisations and units to systems in which efficiency was rather understood as linking activities rather than single activity. This move away from intraorganisational to interorganisational focus was a new focus. Another aspect of a network logic was the importance of creating arenas for establishing and nurturing relationships. This was the case both for the process-owners themselves (in meeting each other and creating identity, identifying synergies etcetera) as well as creating arenas within their own processes (or networks) in order for professionals to to learn from each other. Thus, a coordinating role was important for the owners to keep the networks together and to fill them with purpose. Another aspect of the previous discussion of accountability was that in the present case it was not a distinction between accountability *or* trust. Rather, the case showed that it is about trust *and* accountability, using trust in creating accountable measures that is the responsibilities of process-owners to follow-up. In other ways, trusting accountability is based on a belief that professionals learn best from their peers. Similar to Addicott et al. (2007), overarching levels may interfere with target-setting and performance measures at the expense of the professionals' influence. For example, it was clear that the original healthcare organisation was not always in tandem with the process-ownership. For example, decisions appeared

		from nowhere from the overarching healthcare system and were decided top-down, concerning new drugs, performance measures etcetera. The hierarchy and political aspects of the overarching organisation was difficult and tiresome, some process-owners argued. As mentioned, working in processes itself was a way to cut across the division based on anatomy in traditional healthcare systems. However, working across established boundaries was not a matter of course and process-owners witnessed that non-oncologist specialist often had difficulties to understand them, especially non-medical issues like the situation for relatives.

Post-NPM: Is it paradigmatic?

From the above it is clear that recycled ways of working – that is public administration and/or NPM – was found in the case, for example the NPM principle of performance measurement was kept but developed by regaining the professional focus of public administration. Accountability was also kept, but again, it was rather the professionals themselves that were responsible to require these from the local clinicians. There were also competitive aspects. Hybridized ways of working – a mix between NPM and post-NPM – was found in the extension of the customer role and their relationships with the staff, standardization was made but with focus of how things were done – not based on efficiency. Also, the NPM-focus of processes was modified by post-NPM in which processes cut across organisational units. New ways of working – parallel to post-NPM – was most clearly found in trust in the professionals and the efforts to create a systems view.

Moreover, some things were not mentioned in the focus group interviews. For example, economic aspects and cost-effectiveness was not mentioned despite that the process-owners were responsible also for costs, maybe because it is not traditionally included the physician's role. Similarly, despite the RCCW emphasis on equality in cancer care, these and other public values were to great extend absent in the focus group discussions.

Just as NPM was a reaction to public administration, post-NPM is a reaction to what precedes it. Whereas some scholars argue that the emerging post-NPM is "paradigmatic" (O'Flynn, 2007; Stoker, 2006), others (Denhardt and Denhardt, 2015) claim that many of these post-NPM ideas are not particularly new, for example the active role of citizens in co-producing public services that has been around in public sector since the 1970s (e.g., Ostrom and Ostrom, 1977), and interorganisational ideas have been questioned to be a "back to the future" approach (Kavanagh and Richards, 2001, p. 14). The difference is, however, that these ideas has been complementary or optional rather than in the forefront – which is the case in many post-NPM concepts (Denhardt and Denhardt, 2015; Osborne and Strokosch, 2013).

In the above, parts or aspects of the case have been highlighted. But as a whole – is it paradigmatic? Maybe a similar conclusion as when NPM emerged can be drawn: it is the mix that is new – even though some parts are rather old (Gruening, 2001). A shift in paradigm, however, is not likely, simply because there is no consensus or accepted paradigm existing in the first place (Gruening, 2001). Moreover, key aspects of NPM is institutionalized in PSOs (Goldfinch and Wallis, 2010) and therefore cannot be changed or replaced rapidly (Christensen

and Lægreid, 2008; Lodge & Gill, 2011), which may be one reason that hybridization is a rather common aspect in this article's empirical material. In this sense, maybe post-NPM should be understood as a continuation of NPM in which some ideas are kept, others developed, and yet others abandoned (Osborne et al., 2015). For example, in UK it is argued that NPM's performance management were retained in post-NPM (Ferlie et al. 2016). It is also argued that post-NPM is also about a rediscovery of pre-NPM ideas, for example bureaucratic models, rule of law, and centralization (Christensen and Lægreid, 2007). Not least is this a result of the depolitization of NPM in which managers rather than politicians held power at the proposed expense for issues such as social equality (Malmberg and Urbas, 2017). It is argued that there has been no shift from NPM to post-NPM (Lodge and Gill, 2011) but rather that the administrative systems today are hybridized borrowing from all the previous modes of governance (Christensen, 2012; Howard, 2015, Simonet, 2015) thus contemporary public management is layered or hybridized including traditional bureaucracy, NPM, and post-NPM (Christensen & Lægreid, 2011; Liff and Andersson, 2012; Pollitt 2016). Others have argued that the emerging view is argued to move beyond both NPM:s competitive aspects as well as the bureaucracy preceding it (Morse, 1994). Naturally, just as NPM (Simonet, 2015), the ideas of post-NPM have been implemented variously between countries and thus post-NPM looks different between nations (Anttiroiko and Valkama, 2015). Alford and Hughes (2008, p. 138) argue that many post-NPM ideas suffer from the same problem as NPM and bureaucratic models before them, in that they often advocate "one-best-way thinking" that is claimed to be applicable to all PSOs, and that it is unclear at what levels the ideas apply; is it programs, organisations, or public sectors? Rather, a pragmatic approach is favored by Alford and Hughes (2008) in which the public value to be produced, context, level etc. decide which particular management approach to adopt.

In sum, NPM ideas of performance measures and accountability were kept but complemented with pre-NPM's professional focus. Customer-focus and processes of NPM was hybridized with post-NPM extending the patient's role even further and letting processes cut across units. Post-NPM aspects of trust and systems view through interorganisational were added.

Conclusion

This article illustrates how post-NPM may function in practice, providing a case from Swedish cancer care, which faces many problems caused by NPM. However, rather than being a departure from NPM this article suggests that while some NPM aspects are abandoned others are kept, sometimes combined with aspects typical of public administration (pre-NPM) or post-NPM. Some other post-NPM aspects are replacing shortcomings of NPM, for example, trust rather than control and inter-organisational collaboration rather than intra-organisational focus. In sum, aspects of post-NPM in healthcare practice entail recycled, hybridized and new aspects. Looking at post-NPM as a whole, the mix of public administration, NPM and post-NPM may be understood as new – maybe even paradigmatic. Another way to see it is that post-NPM is simply a continuation of NPM in which some aspects are kept while those aspects that proved unfit has been replaced by pre- and post-NPM aspects. Without any doubt, post-NPM can neither be understood nor defined without NPM.

Managers of PSOs should be careful not to jump on the latest bandwagon. While new concepts include good things, so does old concepts. In providing cohesive and user-centered public services, taking advantage of the expertise and networks of staff in the field may be pivotal. In developing strategy for complex PSOs, in addition to hard data, softer aspects may be important to highlight, not least relationships based on trust and dialogue.

References

Addicott, Rachael, Gerry McGivern, and Ewan Ferlie. 2007. The Distortion of a Managerial Technique? The Case of Clinical Networks in UK Health Care. *British Journal of Management* 18(1): 93–105.

Agranoff, R., & McGuire, M. (2004). Collaborative public management: New strategies for local governments. Georgetown University Press.

Alford, J. (2016). Co-production, interdependence and publicness: extending public service-dominant logic. Public Management Review, 18(5), 673-691.

Alford, John, and Owen Hughes. 2008. Public Value Pragmatism as the Next Phase of Public Management. *The American Review of Public Administration* 38(2): 130–148.

Almqvist, R., Catasús, B., & Skoog, M. (2011). Towards the next generation of public management: A study of management control and communication in the Swedish Armed Forces. International Journal of Public Sector Management, 24(2), 122-145.

Andersson, Thomas, and Roy Liff. 2012. Does Patient-centred Care Mean Risk Aversion and Risk Ignoring? Unintended Consequences of NPM Reforms. *International Journal of Public Sector Management* 25(4): 260–71.

Anttiroiko, Ari-Veikko, and Pekka Valkama. 2016. Post-NPM-style Service Integration: Partnership-based Brokerage in Elderly Care. *International Journal of Public Sector Management* 29(7): 675–89.

Arellano-Gault, David. 2010. Economic-NPM and the Need to Bring Justice and Equity Back to the Debate on Public Organisations. *Administration & Society* 42(5): 591–612.

Beck Jørgensen, T. B., & Bozeman, B. (2007). Public values: An inventory. Administration & Society, 39(3), 354-381.

Bejerot, Eva, and Hans Hasselbladh. 2013. Forms of Intervention in Public Sector Organisations: Generic Traits in Public Sector Reforms. *Organisation Studies* 34(9): 1357–380.

Benington, J. (Ed.). (2007). Reforming public services: 21st century public services, putting people first. The Stationery Office.

Berwick, D. M., Godfrey, B. A., & Roessner, J. (1991). Curing health care: new strategies for quality improvement. Journal for Healthcare Quality, 13(5), 65-66.

Bryson, John, Barbara Crosby, and Laura Bloomberg. 2014. Public Value Governance: Moving Beyond Traditional Public Administration and the New Public Management. *Public Administration Review* 74(4): 445–56.

Christensen, Tom. 2012. Post-NPM and Changing Public Governance. *Meiji Journal of Political Science and Economics* 1(1): 1–11.

Christensen, T., & Lægreid, P. (2007). The whole-of-government approach to public sector reform. Public administration review, 67(6), 1059-1066.

Christensen, T., Lie, A., & Lægreid, P. (2008). Beyond new public management: agencification and regulatory reform in Norway. Financial Accountability & Management, 24(1), 15-30.

Christensen, Tom, and Per Lægreid. 2011. Democracy and Administrative Policy: Contrasting Elements of New Public Management (NPM) and Post-NPM. *European Political Science Review* 3(1): 125–46.

Christensen, Tom, and Per Lægreid. 2015. Performance and Accountability: A Theoretical Discussion and an Empirical Assessment. *Public Organisation Review* 15(2): 207– 25.

Coghlan, D., & Brannick, T. (2014). Doing action research in your own organization. Sage.

Coleman, M. P., Forman, D., Bryant, H., Butler, J., Rachet, B., Maringe, C., ... & McGahan, C. E. (2011). Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. *The Lancet*, *377*(9760), 127-138.

Dagens Nyheter. 2013. Vad Var Det Som Dödade Herr B? https://www.dn.se/kultur-noje/vad-var-det-som-dodade-herr-b/ [accessed April 2, 2018].

Dan, S., & Pollitt, C. (2015). NPM Can Work: An optimistic review of the impact of New Public Management reforms in central and eastern Europe. Public Management Review, 17(9), 1305-1332.

Denhardt, Janet V., and Robert B. Denhardt. 2015. The New Public Service Revisited. *Public Administration Review* 75(5): 664–72.

Dunleavy, P., & Hood, C. (1994). From old public administration to new public management. *Public money & management*, *14*(3), 9-16.

Eriksson, E. M., & Nordgren, L. (2018). From one-sized to over-individualized? Service logic's value creation. *Journal of health organization and management*, *32*(4), 572-586.

Eriksson, Nomie, Kajsa-Mia Holgers, and Tomas Müllern. *Att utveckla vården: erfarenheter av kvalitet, verksamhetsutveckling och förbättringsarbete*. 2013.

Ferlie, Ewan. 2017. Exploring 30 Years of UK Public Services Management Reform: The Case of Health Care. International Journal of Public Sector Management 30(6-7): 615-25.

Ferlie, Ewan, Jean Ledger, Sue Dopson, Michael D. Fischer, Louise Fitzgerald, Gerry McGivern, and Chris Bennett. 2016. The Political Economy of Management Knowledge: Management Texts in English Healthcare Organisations. *Public Administration* 94(1): 185–2 03.

Frandsen, Ann-Christine. 2010. The Role of Disciplining/Translating Accounting Practices in Patient-centred Care. *International Journal of Public Sector Management*, 23(4): 381–91.

Goldfinch, S., & Wallis, J. (2010). Two myths of convergence in public management reform. *Public Administration*, *88*(4), 1099-1115.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today*, *24*(2), 105-112.

Green-Pedersen, C. (2002). New public management reforms of the Danish and Swedish welfare states: The role of different social democratic responses. *Governance*, *15*(2), 271-294.

Gruening, G. (2001). Origin and theoretical basis of New Public Management. *International public management journal*, *4*(1), 1-25.

Hellström, Andreas, Svante Lifvergren, and Johan Quist. 2010. Process Management in Healthcare: Investigating Why it's Easier Said than Done. *Journal of Manufacturing Technology Management*, 21(4): 499–511.

Hobbs, Jennifer Lynn. 2009. A Dimensional Analysis of Patient-centered Care. *Nursing Research* 58(1): 52–62.

Hood, Christopher. 1991. A Public Management for all Seasons? *Public Administration* 69(1): 3–19.

Hood, Christopher. 1995. The "New Public Management" in the 1980s: Variations on a Theme. *Accounting, Organisations and Society* 20(2–3): 93–109.

Hood, C., & Peters, G. (2004). The middle aging of new public management: into the age of paradox?. *Journal of public administration research and theory*, *14*(3), 267-282.

Howard, Cosmo. 2015. Rethinking Post-NPM Governance: The Bureaucratic Struggle to Implement One-stop-shopping for Government Services in Alberta. *Public Organisation Review* 15(2): 237–54.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative science quarterly*, *24*(4), 602-611.

Jun, Jong S. 2009. The Limits of Post-New Public Management and Beyond. *Public Administration Review* 69(1): 161–65.

Karlsson, T. S. (2017). *New Public Management: ett nyliberalt 90-talsfenomen?*. Studentlitteratur.

Kavanagh, D. and D.Richards (2001). Departmentalism and Joined-Up Government: Back to the Future? Parliamentary Affairs, 54 (1): 1–18.

Kerosuo, Hannele. 2010. Lost in Translation: A Patient-centred Experience of Unintegrated Care. *International Journal of Public Sector Management* 23(4): 372–80.

Levin, B., & Normann, R. (2000). *Vårdens chans: en modell för morgondagens vård och äldreomsorg*. Ekerlid.

Lifvergren, S. (2013). *Quality Improvement in Healthcare*. Chalmers University of Technology.

Lindberg, Kajsa, Barbara Czarniawska, Rolf Solli. 2015. After NPM? *Scandinavian Journal of Public Administration* 19(2): 3–6.

Ling, Tom. 2002. Delivering Joined–up Government in the UK: Dimensions, Issues and Problems. *Public Administration* 80(4): 615–642.

Lodge, Martin, and Derek Gill. 2011. Toward a New Era of Administrative Reform? The Myth of Post-NPM in New Zealand. *Governance* 24(1): 141–66.

Lundquist, L. (2001). *Medborgardemokratin och eliterna*. Studentlitteratur AB.

Malmberg, C., & Urbas, A. (2017). Health education and citizenship: From democratic politics to individual responsibility?. In *12th Conference of the European Science Education Research Association (ESERA)*, Dublin, Ireland, 21st–25th August.

Maor, Moshe. 1999. The Paradox of Managerialism. *Public Administration Review* 5–18.

Mead, Nicola, and Peter Bower. 2000. Patient-centredness: A Conceptual Framework and Review of the Empirical Literature. *Social Science & Medicine* 51(7): 1087–110.

Meynhardt, T. (2009). Public value inside: What is public value creation?. *Intl Journal of Public Administration*, *32*(3-4), 192-219.

Mintzberg, H. (2015). *Rebalancing society: Radical renewal beyond left, right, and center*. Berrett-Koehler Publishers.

Mintzberg, H. (2017). *Managing the myths of health care: bridging the separations between care, cure, control, and community*. Berrett-Koehler Publishers.

Moore, Mark H. 1994. Public Value as the Focus of Strategy. *Australian Journal of Public Administration* 53(3): 296–303.

Morse, Ricardo S. 2011. The Practice of Collaborative Governance. *Public Administration Review* 71(6): 953–57.

Nordgren, L. (2009). Value creation in health care services–developing service productivity: Experiences from Sweden. *International Journal of Public Sector Management*, *22*(2), 114-127.

Normann, R. (2001). *Reframing business: When the map changes the landscape*. John Wiley & Sons.

O'Flynn, Janine. 2007. From New Public Management to Public Value: Paradigmatic Change and Managerial Implications. *Australian Journal of Public Administration* 66(3): 353–66.

Ohemeng, F. (2010). The dangers of internationalization and "one-size-fits-all" in public sector management: Lessons from performance management policies in Ontario and Ghana. *International Journal of Public Sector Management*, *23*(5), 456-478.

Olsson, E. M. (2016). Interpersonal complaints regarding cancer care through a gender lens. *International journal of health care quality assurance*, *29*(6), 687-702.

Olsson, E., Lau, M., Lifvergren, S., & Chakhunashvili, A. (2014). Community collaboration to increase foreign-born women´ s participation in a cervical cancer screening program in Sweden: a quality improvement project. *International journal for equity in health*, *13*(1), 62.

Olsson, E., Lau, M., Lifvergren, S., & Chakhunashvili, A. (2014). Community collaboration to increase foreign-born women´ s participation in a cervical cancer screening program in Sweden: a quality improvement project. *International journal for equity in health*, *13*(1), 62.

Osborne, S. P. (2006). The new public governance?

Osborne, S. P. (2018). From public service-dominant logic to public service logic: are public service organizations capable of co-production and value co-creation?.

Osborne, Stephen, Zoe Radnor, Tony Kinder, and Isabel Vidal. 2015. The SERVICE Framework: A Public Service-dominant Approach to Sustainable Public Services. *British Journal of Management*, 26: 424–38.

Osborne, S. P., Radnor, Z., & Strokosch, K. (2016). Co-production and the co-creation of value in public services: a suitable case for treatment?. Public Management Review, 18(5), 639-653.

Osborne, S. P., & Strokosch, K. (2013). It takes Two to Tango? Understanding the C o-production of Public Services by Integrating the Services Management and Public Administration Perspectives. *British Journal of Management*, *24*, S31-S47.

Ostrom, E., & Ostrom, V. (1977). Public economy organization and service delivery.

Pedersen, J. S., & Löfgren, K. (2012). Public sector reforms: New public management without marketization? The Danish case. *International Journal of Public Administration*, *35*(7), 435-447.

Plantin, Anders, and Mats Johansson. 2012. Implementing Production Planning Processes in Health Care: A Case Study of a Surgery Clinic. In Proceedings of PLAN Research and Application Conference, Lund, August.

Pollitt, Christopher. 2003. Joined-up Government: A Survey. *Political Studies Review* 1(1): 34–49.

Pollitt, Christopher. 2016. Managerialism redux? Financial Accountability & Management 32(4): 429-47.

Pollitt, C., & Dan, S. (2011). The impacts of the New Public Management in Europe: A meta-analysis. *COCOPS Deliverable*, *1*.

Porter, M. (1985). Competitive Advantage.

Quist, J., & Fransson, M. (2014). *Tjänstelogik för offentlig förvaltning: En bok för förnyelsebyråkrater*. Liber.

Radnor, Z. (2010). Review of Business Process Improvement Methodologies in Public Services. London: Advanced Institute of Management.

Ranerup, Agneta. 2010. Transforming Patients to Consumers: Evaluating National Healthcare Portals. *International Journal of Public Sector Management*, 23(4): 331–39.

Simonet, Daniel. 2015. Post-NPM Reforms or Administrative Hybridization in the French Health Care System? *International Journal of Public Administration* 38(9): 672–81.

Stoker, Gerry. 2006. Public Value Management: A New Narrative for Networked Governance? *American Review of Public Administration* 36(1): 41–57.

Swedish National Audit Office. 2014. Primärvårdens Styrning – Efter Behov eller Efterfrågan? https://www.riksrevisionen.se/rapporter/granskningsrapporter/2014/primarvardens-styrning---efter-behov-eller-efterfragan.html [accessed April 2, 2018].

Vargo, S. L., & Lusch, R. F. (2008). Service-dominant logic: continuing the evolution. *Journal of the Academy of marketing Science*, *36*(1), 1-10.

Vargo, Stephen L., and Robert F. Lusch. "Institutions and axioms: an extension and update of service-dominant logic." *Journal of the Academy of marketing Science* 44.1 (2016): 5-23.

Verbeeten, F. H. (2008). Performance management practices in public sector organizations: Impact on performance. *Accounting, Auditing & Accountability Journal*, *21*(3), 427-454.

Appendix A. Quotes from the focus groups

Categories	**Quote from focus group participant**
Processes	*… we work with very engaged people, who want to do their best, and therefore you don't need to force them to do things… if we can show and convince them that it is good for our patients, then we don't need any imposed regulation.*
	I don't have any money to solve things, neither am I wiser than anybody else. I don't own anything and if there's anyone who owns the process it is all those who is in the process together: patients, healthcare staff, politicians and others.
Performance Measurements and Accountability	*… her boss says that this [reporting to the register] is of low priority and then one starts to wonder what kind of mandate that one is having.*
	It is frightening to see how the management chain of command count numbers. It's the only thing they're interested in. Various parameters they come up with. We have patients that are easy, others that are complex… they can't be reduced to a number. I am afraid to be taken hostage in the process in which we have participated in developing a system that is then misused…
	We physicians are very competitive, we want to be the best in class, right? There's nothing wrong in being compared with others.
Trust and Profession-led Cancer Strategy	*… some think we are nagging […] they all have lots to do […] so when they don't manage to report [performance measures] it is because they don't have time for it.*
A Systems View on Cancer Care	*'[The aqueduct] turns everything upside-down, just as the process-ownership does, we're here to help, to support […] not to give directives and tell how to do things […] It is the local staff that knows best how to take care of their patients, we're only supposed to support them.'*
	… when talking to people one realizes that seeds have been sown and things start to happen […] people think more over organisational boarders now
Patient Involvement	*Well, we're a little bit tired. I am personally quite tired because we meet patients all day long, it's no news for us […] it is 'the thing' at the moment and for me it's not prioritized to put energy on it. That's how I feel.*
	I notice that it [patient involvement] is something that is coming now, which I should learn how to relate to, but it hasn't been part of my thinking thus far. I am not against patients, but I feel that it can be a little… it is not that easy for me.
	… we have some very active ones and I always get a little thoughtful about these people that always comes back, that always wants to participate […] those I call 'professional patients' that I am not too fond of. How do you find the 'right' persons?