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New Public Management and corporatization in the French public sector: a critical analysis

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Abstract

Purpose – This paper examines the trajectory and consequences of New Public Management (NPM) reforms in the wake of privatizations, target-based controls, and public sector corporatization and to explain why outcomes are not consistent across sectors, particularly in healthcare.

Design/methodology/approach – A theory-driven framework, the Reform-Cycle & Sector-Mechanism Fit (RCSMF) model links sector conditions to the performance of NPM instruments. A structured synthesis (1990-2024) with replicable coding scheme is applied to peer-reviewed studies and official reports to highlight patterns of adoption, recalibration, and reversal.

Findings – Service delivery improved in some domains (e.g. airports, telecoms), but NPM-driven corporatization increased operational costs, inequity, and declining quality in healthcare, water management, highways, and education. Performance metrics were often manipulated, and market tools widened urban-rural gaps. Furthermore, quick-fix NPM practices often failed and were subsequently reversed. Overall, French reforms followed a hybrid path of selective NPM adoption with strong state oversight, yielding differentiated outcomes across sectors rather than a uniform marketization shift.

Originality/value – This study highlights the unintended outcomes of market-based reforms on equity, access, and professional autonomy. It introduces a reproduceable framework that explains why and when NPM instruments succeed or fail and offers guidance for the next reform.

Keywords New Public Management, Corporatization, Public sector, Reform reversals, PPPs, Hybridization, Healthcare, France

Paper type Research article

Introduction

France has undergone a substantial transformation of its public sector since the 1980s, which began with a series of privatizations and subsequently adopted the principles of New Public Management (NPM). The aim was to modernize public administration by adopting private sector practices (e.g., competition, management by objectives). Corporatization, which involved the restructuring of state-owned entities and public services to operate like private entities, was an initial but important element of this transformation.

The paper analyzes France's reform narrative through a unique reproducible lens - the Reform Cycle and Sector-Mechanism Fit (RCSMF) model. Three parts compose the model: (1) Sector specificities (e.g., equity, access); (2) NPM instruments (e.g., targets, corporatization); and (3) Readjustments through recalibration and reversal (Hood *et al.*, 2004; Christensen and Lægreid, 2025; Elston, 2024).

The framework assumes that whenever outputs are standardized, quality is auditable. NPM tools can be used to increase efficiency. The same tools induce gaming in services such as healthcare, where quality and access vary. In such a context, reform cycles often follow hybrid

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initiatives characterized by re-centralization, heightened professional standards, and contestation, rather than a linear shift towards delegation or the splitting of large public organizations into smaller ones.

Several propositions are introduced in the paper: (1) Competition works better when services are easily accessible and performance is easy to measure; (2) Activity-based payment may reduce service quality if no safeguards are implemented (Kelman and Friedman, 2009); (3) Public-Private Partnerships (PPPs) struggle when quality is multidimensional and costs are high; (4) Negative outcomes and externalities increase the likelihood of cycle reversal or recalibration; (5) Reversals lead to recalibration and to hybrids; and (6) Systems with strong professional self-governance and transparency recalibrate NPM instruments. These propositions guide the paper's empirical framework and explain why French reforms yield inconsistent results, particularly in the healthcare sector.

The authors use peer-reviewed articles, official evaluations (e.g., Cour des Comptes, OECD/EU), and ministerial reports to draft a synthesis for the RCSMF framework. We code the sources on common dimensions (sector, instrument, period, and outcome signals). Outcome signals consist in: (+) improvement; (0) mixed-neutral; (-) deterioration. Triggers are reported to explain the signals with the resulting outcomes. We provide pilot coding and examples in Appendix A and a replicable template to expand the database.

Methodology and scope

The authors conducted a structured review by searching Scopus and Web of Science for 1990-2024 using combinations of terms (France AND public management OR corporatization OR privatization OR PPP OR DRG OR hospital financing) and analyzed government reports and EU/OECD publications. We prioritized peer-reviewed studies and official reports with sectorial evidence. To mitigate bias, we coded improvement (efficiency, access, quality) and dysfunction (gaming, trade-offs) and used counter-evidence for balance. We provide a qualitative analysis of this point by emphasizing triggers, mechanisms, and outcomes across sectors. We build on the work of Hood on control and cyclicality (Hood *et al.*, 2004), reform reversals (Christensen and Lægreid, 2025), and negativity-bias in reforms (Elston, 2024) to analyze French trajectories and cycles.

NPM evidence

It is acknowledged that examples where target-setting and competition resulted in measurable gains. Gaming and readjustment emerged in other cases when standardization is not always possible, and outcomes are difficult to predict, and when fairness and access are prominent public values, as in healthcare (Kelman and Friedman, 2009). In France, efficiency gains are stronger in public services with clear, observable outputs, well-defined expectations regarding service quality, and predictability. In other domains, such as healthcare, where there is no alignment of goals, compromises between the government, the public, and the profession are likely to prompt recalibration.

France has one of the largest public sectors among OECD countries. Public spending has been high over the past decade, ranging from 55 to 58 percent of GDP, highlighting the state's significant role in providing welfare, education, and healthcare. Moreover, more than 20 percent of the active workforce is also employed in the public sector. The current institutional setup has greatly contributed to rising financial pressures, leading to public debt exceeding 110 percent of GDP and raising concerns about the long-term sustainability of public services. This institutional background explains why NPM instruments initially appeared as promising reform options for a large, universal public sector in need of fiscal discipline. However, the French bureaucracy, based on principles of equity, solidarity, and administrative hierarchy, acted as a barrier to market mechanisms. Consequently, reforms involved a selective application of NPM tools and privatization. Overall, French reforms must be viewed within an institutional context that both prompted cost-cutting measures and restricted their implementation.

NPM works best in sectors where outputs are standardized, quality is assessable, and providers compete on equal terms. Healthcare does not meet these conditions, as needs are uncertain; quality is multidimensional and difficult to assess; and goals include trust, continuity, and equity. France is treated as a generalizable instance of NPM hybridization and controlled reversal with healthcare, showing the limits of market orientation.

Partial privatization, delegation, and the retreat of the public service sector

The privatization of major national companies, including firms like Elf-Aquitaine, Rhone-Poulenc, SEITA, Usinor-Sacilor, Compagnie Générale Maritime, Renault, and Pechiney, occurred across various sectors. This process also impacted significant banks, such as BNP and Crédit Lyonnais, as well as the airline industry (Air France) and the telecommunications sector (France Telecom). It began in 1986 and peaked under the socialist government of Lionel Jospin from 1997 to 2002.

In France, privatization was shaped by certain national idiosyncrasies, including a strong tradition of state-led economic development (*dirigisme*) and centralized decision-making. On top of that, there is the symbolic role of public enterprises as instruments of sovereignty in key areas (nuclear programs). However, the government retained a significant stake in key companies, such as Orange (the government owns 23 percent), EDF (84 percent) in the nuclear sector, Engie (24 percent) in gas and electricity production, Areva (now Orano), and the state-owned RATP that operates trams, buses, and the subway system in the Paris area. The French railway corporation, SNCF, remains partially state-owned. The French government retained its strategic influence over the energy, transportation, and communications sectors through instruments of state-led capitalism, including golden shares, regulatory oversight, and the presence of public servants on the companies' boards of directors. These tools allow the state to pursue national economic and security interests, particularly in aviation, defense, and space, while maintaining a balance between liberalization and sovereign control.

'Corporatization': a new approach to managing the public sector

The success of these privatizations paved the way for the 'corporatization' of the public sector, i.e., the adoption of management recipes by public organizations. These managerial approaches were promoted by the French programmatic elite and a cottage of foreign and local consulting firms, i.e., 'the consultocracy', that typically consists of graduates from the top French engineering and business schools. This led to a hybridization of the French elite (Gallardo *et al.*, 2024).

The public-private revolving door was in full swing at every level of government, including the municipal level, which was thought to be immune to reform by an international consulting elite. In theory, NPM reforms aim to improve the quality and efficiency of public services through benchmarking of care providers, via Diagnostic-Related Groups (Lapuente and Van de Walle, 2020), or the creation of hospital league tables, the stirring of yardstick competition between public hospitals, and management by objectives, as in the corporate sector. This was evident in healthcare, with the rise of hospital league tables and conditional funding for public hospitals. However, NPM-driven corporate values (e.g., management by objectives such as patient volume targets, physicians' premiums, quantification exemplified by activity-based costing, cost-benefit analysis, etc.) eventually replaced public values (e.g., equity, quality, access, solidarity) that had previously shaped the public sector.

Efficiency gained priority over equality and fairness, first and foremost in the US, as noted by Berman (2022), and later in France. Rooted in health economics, a discipline that has thrived since the 1990s, this new allocation model has set resource utilization, efficiency, and performance metrics as priorities. However, these do not always align with public interest, as evidenced by the closure of public hospitals in rural areas. Under the guise of liberal technocrats, it later expanded to transform the entire public sector, streamlining the delivery of health services and emphasizing individual choice, efficiency, and accountability. It

emphasized cost-benefit considerations in the design of public policies and internal competition through benchmarking public service providers (e.g., local governments, public utilities), productivity improvements, and market-oriented approaches such as outsourcing, delegation to private contractors, and competitive bidding. Its advocates, notably the French programmatic elite, frequently conflicted with the Left Wing, who called for greater workers' rights, improved working conditions, equality, and limits on corporate power. However, the French Left Wing could not halt the spread of NPM.

France has a long-established tradition of leveraging PPPs to privately finance public infrastructure projects (Abouzit, 2022). Nonetheless, this has not materialized in healthcare due to failed experiments, exemplified by the Evry Hospital scandal or the unsuccessful attempts by private operators to provide emergency services. Moreover, the intervention of private actors can negatively affect the quality of public services, particularly in labor-intensive sectors such as waste management and healthcare, due to employment cuts that lead to higher unemployment and reduced patient capacity (over 69,000 beds were suppressed in public hospitals between 2001 and 2017).

While the government has often celebrated its ability to attract private equity investments (Uri, 2019), these have been linked to job instability, lower pay, and limited investment in staff training. Staff reductions and increased workloads are aimed at cutting costs. However, these have negatively affected public perceptions of service quality. Due to political opportunism and higher transaction costs, PPPs cannot effectively transfer financial risks to the private sector, incorporate their expertise, and reduce local government debt, as observed in transitional economies. PPPs often involve too many complex factors that are difficult for bureaucrats to identify and comprehend. These factors include contractual terms, risk distribution, partner experience, and project features, which affect PPP performance. The high number of defects in newly built French public hospitals and the rent-seeking behavior of private operators (Rigamonti and Leroux, 2018), particularly in the management of prisons under PPP contracts spanning decades, is proof.

Mixed NPM outcomes across the public sector

Many issues in the public sector require a strong regulatory response. Quick market-based solutions do not suffice to address "wicked" problems – problems that are complex because they involve social, economic, and political factors (Gadson, 2024). The outcomes of NPM-driven corporatization have fallen below expectations in many areas. NPM rationing has weakened public services' ability to respond to citizens' needs, as exemplified by the closure of courts of justice, community pharmacies, regional train lines, bus services, and primary schools in rural areas due to budget constraints.

The NPM-driven reforms of postal services prompted public mail services to streamline operations, adopt labor-saving technologies, and digitalize simple processes, such as mail sorting, to cut costs. However, ensuring equal access to postal outlets remains a challenge, particularly in rural or underserved areas where many post offices have closed, and the elderly population faces mobility issues. Private operators are often contracted to deliver mail in areas that public postal employees consider unsafe, and they frequently employ undocumented immigrants for mail delivery. As for water treatment facilities, outcomes have been mixed. In Paris, the outsourcing of water services to private operators initially resulted in lower prices and improved service quality (Obeng-Odoom, 2018).

In other regions, however, privatization has led to higher prices for users, comparable or better water quality, and greater water losses due to insufficient maintenance of water pipelines (Porcher, 2017). The involvement of private operators in waste management has resulted in increased job losses, particularly in low-skilled positions, higher costs, uneven service quality in Paris, and more strikes over pay and working conditions in Marseille (Cutaya, 2017).

Given these limitations, several countries have seen a trend toward bringing water and urban waste management back under municipal ownership. For example, the cities of Paris

and Grenoble re-municipalized their water services. Evidence of the negative impact of corporatization can also be observed in the management of French forests. Since the 1980s, the resources allocated by state and local authorities to the National Forest Office (NFB) and the departmental fire and rescue services (SDIS) have decreased (Bontemps *et al.*, 2020).

Approximately 50 percent of the current NFB staff are contract workers rather than civil servants. Both the Ministry of Ecological Transition and the Ministry of Agriculture oversee the National Forestry Office, which has been significantly impacted by the state's neoliberal model, characterized by privatization and downsizing. In 1985, this Public Industrial and Commercial Establishment (EPIC) employed 15,000 individuals, which has since dropped to 8,200. Financial pressures prompt forests to be managed like for-profit farms, which grow the more profitable and fire-prone wood species, but incentivize public employees to spend less time on non-profitable but essential activities, such as fire prevention (Bernard, 2022).

Privatization has expanded to encompass the supplementary health insurance sector. It may also extend to the national lottery, the railway system, the management and maintenance of public housing, and the artist unemployment insurance fund. The adverse economic and social impacts are evident in sectors that have been partially privatized. French motorways are now the most expensive in Europe. Private schools in France have been linked to social segregation and economic disparities within the education system (Courtioux and Maury, 2019).

In contrast, NPM proved beneficial for airports, the cultural industry, and supplementary insurers. Aéroports de Paris (ADP), the operator of major airports such as Charles de Gaulle and Orly, was partially privatized, with the French state retaining a 51 percent stake in ownership. The Nice Côte d'Azur Airport and Lyon-Saint Exupéry Airport implemented performance indicators to enhance operational efficiency and invested in new passenger facilities, including self-service kiosks and automated baggage handling, following privatization.

Additionally, they expanded their aviation-related revenue sources beyond landing and passenger fees to include retail, real estate, and parking fees (Albalate and Bel, 2020). When competition is intense, jobs are clear-cut, and service quality is relatively easy to define and track, NPM appears to function effectively. The cultural sector underwent substantial reforms in response to the pandemic, aimed at improving its governance and instilling a more result-oriented culture. NPM promoted international cooperation, decentralization, and devolution to revitalize local cultural actors.

These transformations are consistent with broader global trends. As for the insurance sector, non-profit supplementary insurers have been consolidated into larger entities. These have subsequently adopted for-profit behaviors. They expanded their range of service offerings. They also sought efficiencies similar to those of for-profit insurers while maintaining their mutualist principles. This hybridization reflects the post-NPM evolution of public service organizations. Market and solidarity principles appear to coexist within new organizational forms, even though the latter has been weakened.

Manipulation of metrics

For public institutions, the Tyranny of Metrics (Muller, 2018) is fully in effect. The reliance on performance-based contracts (which condition the funding of care providers on achieving specific targets) for public hospitals, the NPM-driven 'yardstick competition' or benchmarking of care providers against sample hospitals, the rise of medical guidelines and incentives, such as premiums for physicians, and cost-benefit analysis for pharmaceutical drugs and new medical technologies illustrate this point (Vandy, 2023).

However, these metrics can be intentionally altered. Data can be distorted to achieve a desired outcome due to the principal-agent relationship. The government (i.e., the principal) seeks to contain healthcare expenditures. This goal depends on an agent (i.e., a healthcare professional), who may order more tests than necessary to generate a higher income or, in the

case of Academic Health Centers, to cover research and physician training costs (private hospitals do neither research nor training).

By law, public hospitals have a department dedicated to coding diseases and maintaining the patient's Electronic Health Records, and the higher health authorities routinely audit the hospitals' DRG coding to prevent fraudulent billing, particularly up-coding, which involves attributing a specific disease or surgical specialty to another DRG category that benefits from a higher compensation rate. Milcent (2021) observed that private for-profit hospitals have a higher propensity to upcode since the 2009 refinement of the DRG scale, which takes into account the severity of the disease. As a result, DRG upcoding has led to funding being reallocated from public to for-profit hospitals.

In theory, the benchmarking of public and private care providers against a single DRG (Diagnosis-Related Group) scale should equalize funding. In practice, however, it aligns public hospitals' resources with those of the private hospitals with the lowest cost structures, since DRGs were originally calculated based on a sample of private, rather than public, hospitals. This is concerning because service offerings and patient needs differ; public hospitals treat a disproportionately high number of more vulnerable or severely ill patients, often referred to as "case-mix complexity" (Grant *et al.*, 2021).

As a result, public hospitals receive less funding than private hospitals despite their greater needs. Furthermore, market-oriented approaches (e.g., focusing on simpler and more profitable treatments) may jeopardize the mission of public hospitals. The former often treat more complex and, therefore, more expensive cases. It may also undermine some of their traditional values, such as access, affordability, and availability of care. These remain core elements of a single-payer healthcare system.

Consequently, DRGs are gradually being phased out as the primary payment system for hospitals in many high-income countries, except in France, where higher health authorities (e.g., the Ministry of Health) use DRGs as a key mechanism to 'steer' the health system, reflecting a broader trend in the governance literature toward performance-based management and policy steering (Liverani *et al.*, 2018).

Discussion

NPM policy reversals and additional renunciations

There have been several policy reversals that contradict the original key principles of NPM. For instance, France abandoned the NPM principles of splitting large public organizations into smaller entities. For instance, the SNCF (French Railway System) was initially divided into smaller organizations to comply with EU anti-competitive regulations. It was subsequently reorganized into the SNCF Holding. The latter consists of three major divisions: SNCF Réseau / network (infrastructure), SNCF Mobilités / Mobility (passenger and freight services), and SNCF Logistics. The same strategy was replicated in other sectors such as employment and higher education.

In 2008, the ANPE (National Employment Agency) merged with the UNEDIC (Unemployment Insurance Fund) to form Pôle Emploi, which is now responsible for both employment services and unemployment benefits. As for university education, the impact of NPM was limited to the devolution of decision-making powers through the University Autonomy Law of 2007, and universities were incentivized to merge rather than to be split into smaller entities. For example, the University of Paris-Saclay results from the merger of the Université Paris-Sud with ENS Paris-Saclay, Télécom ParisTech, Télécom SudParis, AgroParisTech, and CentraleSupélec. This contrasts with Italian public universities, which opted for performance-based funding, new managerial governance, and increased autonomy rather than mergers to enhance their rankings. In Germany, too, the Performance-Based Resource Allocation scheme tied university funding to their research output.

Although the NPM-driven delegation of power holds potential benefits, as countries with a higher level of decentralization report greater responsiveness to local public needs and higher

satisfaction levels (Durmuş, 2024), that delegation was reversed in the French healthcare system. This reversal reflects enduring French administrative idiosyncrasies, notably a strong centralist tradition. The Higher Health Authorities regained their decision-making power to ensure budget discipline. The Regional Health Agencies are now responsible for all health-related decisions, not just hospital decisions, as was the case with the previous Regional Hospital Agencies. In 2009, the HPST law also mandated that hospital directors and department heads be appointed by the Regional Health Agencies (RHAs), which are, in turn, overseen by the central health authorities.

This reflects the technocratic and hierarchical nature of the French state. Central control is and has always been seen as essential to the conduct of the country. This hierarchical structure establishes a clear vertical chain of command that runs from the Ministry of Health to the RHAs to the hospital level, with the High Authority on Health serving as the monitoring body. The objective is to balance the regionalization of health policies with central regulation. This re-centralization effort is also evident abroad. Regarding the British NHS Foundation Trusts, devolution was overturned. The argument was that it prevented the Labor administration from implementing redistributive policies (Johnson, 2024). In France, however, devolution remains highly controlled. It is confined to Health Contracts between local authorities and the Regional Health Authorities (RHAs). This illustrates French preference for negotiated contracts that emphasize devolution and local participation while preserving central authority.

The UK is widely recognized as the pioneer of NPM due to its early adoption of market mechanisms, performance targets, autonomy of public health organizations, and public-private partnerships (PPPs). In contrast, France can be described as a cautious follower whose reform approach reflects careful and selective learning from the British experience. Empirical evidence from the NHS showed that targets could reduce waiting times, but also encouraged data manipulation and gaming. French policymakers learned from these experiences and introduced benchmarking, activity-based payments, and performance indicators while maintaining strict administrative oversight. Additionally, PPPs and outsourcing in the UK and France faced criticism due to their high transaction costs, fiscal burdens, and declining service quality in labor-intensive sectors. Consequently, France subsequently limited PPPs in healthcare to contain costs. Failed or controversial experiences in the UK reinforced French doubts about market reforms in areas such as healthcare. Finally, the increasing backlash against NPM in the UK over the past decade, including calls for reintegration and recentralization, further influenced French reform strategies. While the UK shifted toward post-NPM arrangements with the adoption of Integrated Care Systems, France adjusted earlier reforms by strengthening hierarchical control, limiting the autonomy of care providers, and adopting hybrid governance systems that combine managerial tools with traditional administrative authority. British reforms, therefore, did not serve as a blueprint for convergence but as a reference point for French reforms.

A recent reversal in NPM policy pertains to the role of government agencies. In theory, these agencies are meant to be the primary implementers of NPM policies. However, there has been a movement in France to reduce reliance on these agencies, which are estimated to number around 1,500.

The concept of ‘de-agencification’ emerged as a response to the 2008 global financial crisis, which prompted the central government to suppress them to cut costs (Sześciło, 2022). Coordination and management issues among government agencies, along with the ambiguity surrounding their impact on the efficiency of public administration, accelerated their termination. The skepticism toward autonomous agencies also results from France’s earlier technocratic centralization. Citizens expect policymaking to remain a prerogative of the central state. It should not be dispersed across semi-independent bodies. For example, the Conseil de Modernisation des Politiques Publiques (CMPP) and the Révision Générale des Politiques Publiques (RGPP), which oversee public policy reforms, were suppressed in 2012.

The NPM-driven delegation of power to lower levels of government in France (e.g., regions, cities, communes) was also rejected, as it proved costly. This delegation was unable to

prevent cronyism and extravagant spending by locally elected officials. These outcomes highlight a deep tradition of local political patronage and the extreme fragmentation of the French territorial landscape, which comprises over 34,000 communes, the highest number in Europe. Administrative amalgamation or consolidation, modeled after the Scandinavian reforms (notably Finland in the 2000s and 2010s, and Denmark in 2007), aimed to mitigate these cost overruns by enhancing their bargaining power against suppliers and sharing existing facilities. However, communal identity, which remains politically sensitive, clashed with the top-down restructuring of local governance. Nonetheless, municipal mergers in France, as well as in Italy and Greece, failed to achieve savings due to a lack of economies of scale and the alignment of staff salaries with the highest of the merged jurisdictions.

Hybridization and differentiation among EU health systems

Recent years have been characterized by the hybridization of reforms. EU health systems have experienced differentiation rather than homogenization or unification. France has retained some of its traditional NPM non-market recipes. These include a quantification of health services, for instance, via activity-based accounting or the tracking of medical procedures; the adoption of patient protocols and medical guidelines at the national level; the setting of patient volume targets; and cost-benefit analyses for drugs and medical procedures. These reflect a longstanding French preference for a rule-bound administration and ministry-level technocratic planning, which, incidentally, is rooted in the legacy of health planning that began right after WWII. In Italy and Spain, in contrast, policymakers adopted a flexible 'shopping-basket' approach that applies more easily to the domestic context (Bel and Casula, 2024).

Unlike France, Italy decentralized its healthcare system. It granted significant autonomy to the Regional Health Authorities (ASL – 'Aziende Sanitarie Locali') and Local Health Units (USL – 'Unità Sanitarie Locali'). Spain pursued a similar strategy. It created autonomous communities ('Comunidad Autónoma') and local health management agencies ('Entidades Gestoras'). Both Spain and Italy adopted pay-for-performance contracts, patient choice (empowerment), and public-private partnerships (PPPs) in the delivery of public services, while France rejected the latter. This divergence reflects French skepticism toward PPPs and market mechanisms. It is also tied to its values of universality, and the state's moral responsibility in guaranteeing access to essential services such as health services.

Compared to France and Spain, Italian and British hospitals were granted more autonomy. That is the case of the NHS Foundation Trusts. The Italian Ministerial Decree No. 77/2022 also encouraged a shift away from large, centralized hospitals to smaller health centers, similar to the NPM approach. In contrast, France merged major hospitals, including Saint-Louis Hospital with Lariboisière Hospital in Paris, as well as several hospitals in the Loire Valley and Emergency Departments (EDs) in city centers, despite opposition from emergency physicians.

Top-down reformism appeared to be disconnected from grassroots medical and territorial realities, as well as health professionals. It implemented post-NPM policies that emphasize coordination between primary care providers (GPs) and secondary care providers, as exemplified by the establishment of Health Cooperation Groups and Territorial Health Communities, similar to the British Integrated Care Systems. France also promotes greater public participation, as seen in the rise of a 'Patient Democracy' and the reintegration of patient representatives and physicians into the hospital board of directors, akin to the British Foundation Trusts and their governors, who represent staff, patients, and the public. Like France, Germany opted for performance-based contracts and invested in Electronic Health Records and Telemedicine to improve access in rural areas. It also adopted diagnosis-related groups (DRGs), known as 'Fallpauschalen'.

Unlike Italy and Spain, Germany emphasized competition among sickness funds rather than hospitals. French healthcare agencies reported less bureaucratic and professional discretion than their German counterparts (Bach and Jann, 2010). This difference arises

because French agencies tend to rely heavily on accounting techniques (e.g., activity-based accounting), national medical guidelines and regulations, and quantifiable objectives such as medical outputs (e.g., the counting of DRGs that depend on the type of procedures performed, not the medical diagnosis), in their decision-making processes. This reflects the more rigid bureaucratic culture of the French state. Standardization and rules take precedence over Anglo-Saxon managerial flexibility.

Competition developed differently across health systems. In France, there are too few care providers for competition to thrive in rural areas (Chevreul *et al.*, 2021). In contrast, British hospitals compete for patients in an internal quasi-market known as the provider-commissioner split (Mason and Araujo, 2021). Clinical Commissioning Groups (CCGs) purchase health services from NHS hospitals, independent care providers, and NHS Foundation Trusts, competing against one another to secure better deals. The NHS compiles performance metrics, including clinical outcomes (such as readmission rates, infection rates, and complication rates), service efficiency (measured by waiting times and length of stay), and patient satisfaction scores, to create hospital leagues that patients can use to choose a care provider.

In contrast, French health organizations do not collect such statistics, except for those related to nosocomial infections. This reflects a more cautious approach to public reporting. It is also in line with the French preference for professional discretion and the protection of patient medical records' confidentiality. Both the French Ministry of Health and the British National Health Service (NHS) have promoted entrepreneurship. In France, private clinics (over 10,000 in 2022) emerged long before the COVID-19 pandemic to address the waiting lists in public hospitals. Hence, the rise of a French model's dual public-private nature, in which private providers coexist alongside a strong public hospital system, is made possible by a complex regulatory environment that limits full market competition. British patients can also opt for a private provider to avoid long waiting lists in NHS hospitals. These income-generating efforts, often established to support or enhance existing NHS services, have become more prevalent in cities following the pandemic (Exworthy *et al.*, 2024).

NPM exacerbated disparities. It gave larger hospitals an advantage in securing funds compared to smaller hospitals. Firstly, DRGs incentivize hospitals to prioritize standard, high-volume, more profitable treatments over complex, less lucrative procedures. Secondly, NPM encourages the specialization of care providers. Hospitals are incentivized to become centers of excellence in certain medical fields or types of care. Thirdly, performance-based funding models reward larger hospitals with greater economies of scale, resulting in lower costs and leaving behind those unable to meet these efficiency targets.

These reform tools, while grounded in managerial rationality, overlook long-standing issues, such as spatial inequality. Smaller rural hospitals are at a disadvantage compared to larger city-based hospitals or academic health centers. The former do not benefit from economies of scale. They struggle to attract medical staff (nurses and physicians) and acquire sophisticated medical equipment, such as Magnetic Resonance Imaging (MRI) machines. This centralizing dynamic conflicts with France's Republican ideal of égalité in the provision of public services. It exposes the limits of one-size-fits-all reforms. Patients residing in the French 'empty diagonal' (Oliveau and Doignon, 2019) face limited access to health services. Despite decades of reforms, the long-standing issue of medically underserved areas persists (Lucas-Gabrielli and Mangeney, 2019). This is compounded by staff shortage. Germany and Italy have 42-45 doctors per 10,000 people; in contrast, France has only 31-32 physicians per 10,000 population. These shortages are further aggravated by the rigidities of French medical training, workforce planning, and the limited attractiveness of practicing in rural areas.

European health reforms did not converge towards one unique NPM model. Hybrid models reflect national preferences. France's model prioritizes an overarching state control over competition. Future reforms should encourage competition where outputs are clearly measurable and comparable. It should encourage public participation whenever quality is multidimensional and access.

Conclusion

NPM-driven reforms aimed to enhance public service efficiency and performance. In practice, however, it emphasized corporate values at the expense of public welfare. Partial privatization led to a decline in the quality of public services. Public values shifted from equity to efficiency in a bid to achieve budget discipline. However, the French NPM experience has not followed a straightforward or unequivocally successful trajectory. Some sectors, such as telecommunications, benefited users. Other sectors, like healthcare, road transportation, and education, fare worse. Challenges include provider closures and reduced access to services.

Many of the reforms have yielded mixed results. Some sectors (e.g., water distribution, highways) are experiencing increased costs, service disruptions, and growing dissatisfaction among the public. Therefore, there is a need to balance efficiency with public interest, address disparities exacerbated by NPM reforms, and find a delicate equilibrium between corporatization and acting as a responsible stakeholder in society. It remains unclear whether performance-based funding has improved health outcomes. Evaluations have yet to be conducted. What is certain, however, is that the increasing reliance on metrics placed an excessive administrative burden on public servants. These individuals feel increasingly alienated and often resort to gaming strategies as a coping mechanism in front of adverse reforms. These raise critical questions about equity, accountability, and the public interest. Hence, the French experience follows a hybrid trajectory that focuses on selective adoption, recalibration, and recentralization. In response, policy design should be contingent on sector-specificities. Competition, the setting of targets, and other market-oriented instruments apply only when outputs are standardized and quality is observable. In sectors such as healthcare, other metrics based on public value goals (e.g., equity, safety, and continuity) should be paired with professional standards and patient-reported outcomes. Investments in professional capacity, transparency (open data, quality, and complaints), and equity safeguards (targeted subsidies to ensure universal access) should be used across reforms. These would favor hybrid governance and align France with more successful European reform trajectories.

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Supplementary material

The supplementary material for this article can be found online.

References

Abouzit, F. (2022), *Constructing Punishment within Walls: Architecture and Spatiality of New Prisons*, Presses Universitaires de Paris Nanterre, Paris.

Albalate, D. and Bel, G. (2020), *The Economics and Politics of Airport Privatization*, Cambridge University Press, Cambridge.

Bach, T. and Jann, W. (2010), "Animals in the administrative zoo: organizational change and agency autonomy in Germany", *International Review of Administrative Sciences*, Vol. 76 No. 3, pp. 443-468.

Bel, G. and Casula, M. (2024), "Re-organizing the service-delivery machine in a 'post-NPM' era: a shopping-basket approach?", *Public Management Review*, Vol. 26 No. 9, pp. 1-25.

Berman, E.P. (2022), *Thinking Like an Economist: How Efficiency Replaced Equality in US Public Policy*, Princeton University Press, Princeton, NJ.

Bernard, G. (2022), "Fires: the neoliberal management of firefighters and the National Forestry Office (ONF) called into question", *Politis*, 2 September, available at: https://rapportsdeforce.fr/pouvoir-et-contre-pouvoir/incendies-la-gestion-neoliberale-des-pompiers-et-de-lonf-mise-en-cause-090214368 (accessed 3 July 2025).

Bontemps, J., Denardou, A., Hervé, J., Bir, J. and Dupouey, J. (2020), "Unprecedented pluri-decennial increase in the growing stock of French forests is persistent and dominated by private broadleaved forests", *Annals of Forest Science*, Vol. 77 No. 4, pp. 1-20.

Chevreul, K., Berg Brigham, K., Durand-Zaleski, I. and Hernández-Quevedo, C. (2021), "France: health system review", *Health Systems in Transition*, Vol. 23 No. 3, pp. 1-276.

Christensen, T. and Lægreid, P. (2025), "Reversing government reforms: radical change or adaptive adjustments?", *Public Administration*, Vol. 103 No. 4, pp. 1218-1231.

Courtioux, P. and Maury, T. (2019), "Private and public schools: a spatial analysis of social segregation in France", *Urban Studies*, Vol. 57 No. 4, pp. 865-882.

Cutaya, M. (2017), "Springtime in Marseille", *Circa*, 7 July, available at: https://circaartmagazine.net/springtime-in-marseille/ (accessed 3 July 2025).

Durmuş, V. (2024), "Does healthcare decentralization provide better public health security capacity and health services satisfaction? An analysis of OECD countries", *Journal of Health Organization and Management*, Vol. 38 No. 2, pp. 209-226.

Elston, T. (2024), *Understanding and Improving Public Management Reforms*, Policy Press, Bristol.

Exworthy, M., Lunt, N., Tuck, P. and Mistry, R. (2024), "From commodification to entrepreneurialism: how commercial income is transforming the English NHS", *Public Money & Management*, Vol. 44 No. 4, pp. 308-316.

Gadson, D. (2024), "Social equity and the responsible administrator: the challenge of equity in public policy initiatives", *Administration & Society*, Vol. 56 No. 6, pp. 786-800.

Gallardo, L., Gautier, L., Chabrol, F., Traverson, L., Oliveira, S. and Ridde, V. (2024), "Private consulting firms' intervention in public health policymaking: an exploratory review", *International Review of Administrative Sciences*, Vol. 90 No. 4, pp. 885-903.

Grant, M., Etkind, S., Gomes, B., Murtagh, F., Noguera, A., Pivodic, L., Bausewein, C., Antunes, B., Calanzani, N. and Higginson, I. (2021), "A systematic review of classification systems to determine complexity of patient care needs in palliative care", *Palliative Medicine*, Vol. 35 No. 1, pp. 3-23.

Hood, C., James, O., Peters, B.G. and Scott, C. (Eds) (2004), *Controlling Modern Government: Variety, Commonality and Change*, Edward Elgar, Cheltenham.

Johnson, R. (2024), "The limits of devolution for the left", *IPPR Progressive Review*, Vol. 31 No. 1, pp. 50-55.

Kelman, S. and Friedman, J.N. (2009), "Performance improvement and performance dysfunction: an empirical examination of distortionary impacts of the emergency room wait-time target in the English National Health Service", *Journal of Public Administration Research and Theory*, Vol. 19 No. 4, pp. 917-946.

Lapuente, V. and Van de Walle, S. (2020), "The effects of new public management on the quality of public services", *Governance*, Vol. 33 No. 3, pp. 461-475.

Liverani, M., Hawkins, B. and Parkhurst, J.O. (2018), "Political and institutional influences on the use of evidence in public health policy: a systematic review", *PLoS ONE*, Vol. 8 No. 10, pp. 1-9.

Lucas-Gabrielli, V. and Mangeney, C. (2019), "How can accessibility measures be improved to better target underserved areas?", *Journal of Epidemiology and Public Health*, Vol. 67 Suppl. 1, pp. S25-S32.

Mason, K. and Araujo, L. (2021), "Implementing marketization in public healthcare systems: performing reform in the English National Health Service", *British Journal of Management*, Vol. 32 No. 2, pp. 473-493.

Milcent, C. (2021), "From downcoding to upcoding: DRG-based payment in hospitals", *International Journal of Health Economics and Management*, Vol. 21 No. 1, pp. 1-26.

Muller, J. (2018), *The Tyranny of Metrics*, Princeton University Press, Princeton, NJ.

Obeng-Odoom, F. (2018), "Transnational corporations and urban development", *American Journal of Economics and Sociology*, Vol. 77 No. 2, pp. 447-510.

Oliveau, S. and Doignon, Y. (2019), "Is the French diagonal emptying? An exploratory spatial analysis of demographic decrease in France for the past 50 years", *Cybergeo: European Journal of Geography*, pp. 1-10, doi: 10.4000/cybergeo.31641 (accessed 3 July 2025).

Porcher, S. (2017), "The 'hidden costs' of water provision: new evidence from the relationship between contracting-out and price in French water public services", *Utilities Policy*, Vol. 48, pp. 166-175.

Rigamonti, É. and Leroux, I. (2018), "The inefficiency of public-private partnerships applied to French prisons", *Journal of Industrial Economics*, Vol. 162 No. 2, pp. 99-125.

Sześciło, D. (2022), "Agencification revisited: trends in consolidation of central government administration in Europe", *International Review of Administrative Sciences*, Vol. 88 No. 4, pp. 773-790.

Uri, J. (2019), "Foreign direct investment in France goes to both the most robust and the most fragile companies?", *Economics and Statistics*, Vol. 505-506-507, pp. 79-96.

Vandy, J. (2023), "The critical examination of the new public sector management in view of HRM – the critical success factors", *World Journal of Advanced Research and Reviews*, Vol. 18 No. 2, pp. 109-115.

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