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**UNDERSTANDING ACCOUNTABILITY IN AN EVER-  
CHANGING NEW ZEALAND HEALTH SYSTEM**

A thesis  
submitted in fulfilment  
of the requirements for the degree  
of  
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at  
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by  
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## ABSTRACT

The purpose of this research was to understand how the constant adoption of reforms affected accountability understanding and its practices in the New Zealand public health system.

This study adopted a qualitative methodology and took a critical hermeneutics approach in order to explore the reasons for, and formats of, public health reform, and the experience of health policy implementers in dealing with reforms, policy changes, and accountability. To develop new insights about accountability and its practices, this study reviewed a range of policy documents and relevant publications, and interviewed senior health managers who were experienced in dealing with reforms.

The research evidence is presented in line with Ricoeur's stages of understanding; these are: preunderstanding, understanding, and finally, comprehensive understanding. The preunderstanding was developed from study of secondary sources, while the understanding was achieved through interviews. A comprehensive understanding results from both review of and reflection on preunderstanding and understanding.

The findings are that reform can be described as a 'means without ends' because it was continually implemented in a political loop, in which, demand and supply for change were determined by the government's political interests. Postreform accountability was full of frustrations because of its complexity in practice. Surprisingly, despite that fact, the health managers still believe that accountability per se is essential. This study proposes that postreform accountability can be understood as two sides of the same coin: accountability means being accountable, in a normative sense, and not being able to be accountable, in practice.

The adoption of constant reforms has increased the level of organisational complexity. This has affected the notion of accountability and its practices because accountability rests in the organisational structures. This study suggests that accountability cannot be detached from its normative and mechanism perspectives. No matter how much the policy has changed or will change in the future, the possibility of policy implementers facing similar challenges and the same feelings is high because reform produces two identical outcomes for accountability: i.e., hopes and frustrations.

The study contributes in three ways to an understanding of accountability in the context of reform. First, it offers valuable insights into the ongoing developments in the public health system and the issues of accountability. Second, it contributes to the wider understanding of the effects reform have on the notion of accountability and its practices. Third, it advances understanding relating to recent discussions on postreform accountability.

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## GLOSSARY

|                   |   |
|-------------------|---|
| Acute activity    | Urgent condition requiring urgent treatment (with or without referral from a GP) soon after the need of care was identified |
| ACC               | Accident Compensation Corporation   |
| AHBs              | Area Health Boards  |
| BSMC              | Better Sooner More Convenient   |
| CEO               | Chief Executive Officer   |
| CHEs              | Crown Health Enterprises  |
| CSC               | Community Service Card  |
| DHBs              | District Health Boards  |
| DRG               | Diagnosis Related Group   |
| Elective activity | Non-urgent condition that not requiring immediate treatment   |
| ED                | Emergency Department  |
| ESPIs             | Elective Services Patients Flow Indicators  |
| EOI               | Expressions of Interest   |
| FMR               | Financial Management Reform   |
| GDP               | Growth Domestic Product   |
| GPs               | General Practitioners   |
| HBL               | Health Benefits Limited   |
| HFA               | Health Funding Authority  |
| HSS               | Hospital Health Service   |
| HUHC              | High Use Health Care Card   |
| HWNZ              | Health Workforce of New Zealand   |
| IPAs              | Independent Practitioners Associations  |
| MRG               | Ministerial Review Group  |
| NHB               | National Health Board   |
| NGO               | Nongovernmental Organisation  |
| NPM               | New Public Management   |
| NPS               | New Public Service  |
| NZPHDA            | New Zealand Public Health and Disability Act  |

|                |  |
|----------------|--|
| NZPHCS         | New Zealand Primary Health Care Strategy                                   |
| NZ             | New Zealand  |
| PHARMAC        | Pharmaceutical Management Agency   |
| PHOs           | Primary Health Organisations   |
| PMS            | Performance Management System  |
| Primary care   | The first point of contact for patients in getting health care services    |
| RHAs           | Regional Health Authorities  |
| Secondary care | Health care services provided by specialists upon referral by primary care |
| WHO            | World Health Organisation  |

# CHAPTER ONE

## OVERVIEW OF THE THESIS

### 1.1 Introduction

This study seeks to explore how constant changes in the public service through the implementation of continual public sector reform affect accountability understanding and praxis in public service delivery. This study aims to investigate the rationale for and the effects of reform on the meaning of accountability in the ever-changing New Zealand public health system by exploring the perceptions and lived experiences of a group of public health managers within that system. It is anticipated that the knowledge generated from this inquiry will afford new insights into accountability in the context of public sector reform.

To help readers understand my ideas and thoughts relating to the accountability issues in the context of public sector reform and how the investigation was carried out in the New Zealand health system, this chapter begins with the background of the research issue, followed by discussion of the research context and the research problem statement. The statements of purpose and research questions are then presented before discussing the research approach and the significance of this study. This chapter ends with the presentation of the thesis outline.

### 1.2 Background of the research issue

I was trained in the field of Public Administration both at undergraduate and graduate levels. I am neither a public manager nor a policy maker but I am a Public Administration educator who has a strong interest in the issue of accountability and public sector reform. My interest developed from the literature related to my subject area in public management and public policy. I encountered literature which convinced me of the importance of neoliberal

reforms to the public sector. Following the emergence of New Public Management (NPM) in the 1980s, I found that governments both in developed and developing countries enthusiastically supported the implementation of this reform as they believed that the neoliberal strategies would improve accountability, efficiency and performance of public organisations.

However, most of the literature related to accountability in the context of public sector reform concluded that accountability is an elusive concept; my teaching experience seemed to confirm the conclusion. For instance, my ten years' experience in teaching public management and policy studies led me to confusion around accountability concepts and practices. I found that accountability has changed throughout the years of reform; however, the changes appear to have had limited success in improving accountability (see Day & Klein, 1987; Dubnick, 2011; Mulgan, 2000). I noticed that I was struggling to explain to students the notions of accountability in the context of reform. While, in my experience, text books have offered a good definition for accountability they provide very little information on how accountability is practised in a specific public sector setting. I began to wonder whether the notion of accountability was idealistic and reforms were designed based on false premises.

Interestingly, despite such problems, accountability has remained an important indicator for public organisations. It has been used widely in governments' policy documents to impress the public that governments are practising a good accountability system. According to Dubnick (2011), ignoring accountability is impossible for governments because "it is cited as both the cause and cure for every ailment and imperfection in government" (p.707). On the other hand, it is also difficult for public organisations to detach themselves from reform because social and economic changes have pressured governments to implement change. Therefore, no matter how hard the change is, reform "does not seem to want to go away" (Lodge & Gill, 2011, p. 141). Considering the important roles of accountability, and the need for

public organisations to adopt continual reform, I was intrigued to find out how public managers are dealing and engaging with reforms, organisational changes and accountability.

Reviewing forms and trends of reform in New Zealand and internationally, enlightened me about the changes in the underpinning reform framework. The first neoliberal reform model, known as NPM, was introduced in the 1980s. However, in its later stage, the NPM model moved away from market mechanisms and managerial strategies towards social and democratic strategies, a model known as New Public Service (NPS). Although both these models are rooted in neoliberal reform, they are underpinned by different philosophies (see Blanchard, Hinnant, & Wong, 1998; Christensen & Laegreid, 2001; Denhardt & Denhardt, 2000; Goldfinch & Wallis, 2010; Larbi, 1999; Moynihan, 2009). In brief, NPM is characterised by market mechanisms and managerial principles. Its reform strategies are primarily influenced by accounting techniques, and accountability is narrowly defined in terms of financial efficiency and policy output. In contrast, NPS is underpinned by a combination of NPM and social democratic strategies. As the post-NPM model, NPS attempts to balance a strong focus of accounting and financial strategies with democratic principles, with the aim of increasing public sector performance (Denhardt & Denhardt, 2000). Under the NPS model, accountability is measured in terms of policy performance and outcome (Denhardt & Denhardt, 2000; Dubnick, 2011).

Major western countries including the UK, the US, Canada, Australia and New Zealand gradually changed their reform orientations from NPM to NPS when they found that NPM was unable to realise some of its promises due to its narrow focus on financial efficiency (see Christensen & Laegreid, 2011b; Denhardt & Denhardt, 2000; Norman, 2003). In response to the differences between NPM and NPS, governments have instigated major changes in their public sector management. For example, during the NPM era, the roles of the State as the central provider of public resources were transferred to the private sector under privatisation, contracting-out and deregulation policies

(Christensen & Laegreid, 2011b; Peters & Pierre, 1998). Under the NPS model, governments promote democratic values in managing public service through the adoption of collaborative strategies such as 'network government', 'joined-up government' and 'whole government' (Goldfinch & Wallis, 2010; Larner, 2000).

The NPM and NPS reforms have broadened the notion of accountability as they reinforce the need to harness managerial and professional accountability to political accountability (Day & Klein, 1987). Previous research in public sector reform has widely discussed the effects of NPM and NPS models on the structures and governance, but given little attention to how these changes have affected accountability (Aucoin, 1990; Barberis, 1998; Blanchard et al., 1998; Christensen & Laegreid, 2011a; Goldfinch & Wallis, 2010; Mongkol, 2011; Peters & Pierre, 1998; Rhodes, 1994). While some research has acknowledged the risks related to some reform strategies on accountability, very little is known about the types of risk or how they could affect accountability.

Simply defined, accountability refers to the expectation that those in the government sector should be held responsible for their actions (Day & Klein, 1987). However, as reforms have led to a fundamental change in the role of a bureaucratic State, the function of accountability has shifted beyond rendering an account of the resources used. Accountability is no longer about "who can call for an account, and who owes a duty of explanation" (Day & Klein, 1987, p. 5). The new accountability format requires managers to demonstrate the efficient use of resources, when following through effective policy decisions (Kluvers, 2003). The role of accountability, therefore, focuses on the performance of public agencies, where the agencies' achievements are measured on the basis of policy outputs and outcomes (Dubnick, 2005; Moynihan & Ingharam, 2003).

Despite the new concept of accountability providing a common background for account-giving and justification for acceptable performance (Messner,

2009), accountability remains a source of confusion among individuals, especially in public organisations (Koppell, 2005). Research into how accountability is practised concludes that the concept of accountability lacks clarity (Bovens, 2005, 2007), is ambiguous (Messner, 2009; Mordaunt, 2006; Ryan & Walsh, 2004) is multifaceted (Acar, 2001; Acar, Guo, & Yang, 2008) and, is multidimensional (Fimreite & Laegreid, 2009). Overall, the concept of accountability in the age of reform remains ill-defined and, therefore, the development of accountability theory is hindered; as a result, accountability remains ambiguous and elusive, in practice (Kim & Lee, 2010).

In terms of practices, several researchers have reported tensions between collaborative agencies over accountability and authority (see Flinders, 2001; Vangen & Huxham, 2010), and the requirement to adopt multiple identities in different contexts of accountability among public officials (see Newman, 2004). For these reasons, the proposition that accountability improved after the adoption of reforms has been called into question (see Atreya & Armstrong, 2002; Christensen & Laegreid, 2011a; Willems & Van Dooren, 2012). In the view of Jones and Kettl (2003) accountability “promised more than it delivered” (p. 3). Indeed, Dubnick (2011) refers the issue of accountability in the context of reform as a “reformist paradox”, where “efforts to improve accountability through reforms generates consequences that in fact alters and often undermines existing forms of accountability already in place” (p. 706). Hence, it would be interesting to understand the meaning that the term “accountability” has for policy actors who are directly involved in managing constant changes in delivering public services.

It must be noted that the public sector is not uniform in nature and each sector may utilise different reform strategies (Glynn & Murphy, 1996). For example, to meet various policy goals, a government may use the privatisation approach in the transportation services, employ concession contract for providing utilities such as water, and apply joint venture for education services. Thus, it is not possible to study the enormous variety of reform strategies adopted by various public services in one study. For these

reasons, this study intends to focus on one specific public sector that has experienced constant policy changes following the adoption of NPM and NPS reforms.

Globally, accountability is a major issue in public health services. Reforming health strategy under neoliberal reform principles is reported to have missed or be missing its targets due to the accountability problems in health governance (Gostin & Mok, 2009; Zadek & Radovich, 2006). Furthermore, there are other considerable concerns of accountability in health services. The concerns revolve around two major factors. First, health is a big business for government because it consumes a large amount of public money, so proper accounting for the use of these funds is essential (Brinkerhoff, 2004). Second, the way health policy is managed and implemented will significantly affect people's lives and well-being; politically speaking, therefore, delivery must be seen to be good (Brinkerhoff, 2004).

The New Zealand health service is no exception in this regard. Following the adoption of NPM reform, a number of researchers raised their concerns about accountability. For instance, Lawrence, Alam, Northcott, and Lowe (1994) revealed that the New Zealand health service has experienced several waves of reforms with demonstrable changes in accountability systems. Indeed, Davies (1990) claims that "proposed reforms within the public health sector in particular create an overloaded accountability structure with conflicting and enforceable accountability relationships" (p. 10). Over the last decades, accountability has remained an issue in the New Zealand public health system (Cordery, 2008; Gauld, 2012; Tenbensen, Mays, & Cumming, 2007). The information available on it, therefore, suggests that the New Zealand public health system is a useful context for studying the reforms on accountability issues.

However, the greatest challenge was that, prior to this research project, I had no experience of being involved with the New Zealand public health system. As I am not a New Zealander, I had limited knowledge and understanding of

the New Zealand public health system. Nevertheless, suggestions from Thomas (2011) made me believe that my lack of knowledge was not an obstacle to undertaking this project. According to Thomas (2011), having a local knowledge of the studied phenomenon is an advantage but it is not essential for researchers. For Thomas, studying a context without the local knowledge is still possible if the researcher chooses a classic or a good case in a particular research area.

To ensure the New Zealand public health system would fit this criterion, I conducted an extensive historical review of the health system at the beginning of this study. I found that the history of New Zealand's public health reform would provide unique and interesting insights, especially for researchers who are interested to learn about public sector reform and accountability. The uniqueness of the story of health service reform in New Zealand lies in its complexity and the mixed structure of public and private institutions which had developed long before the ideology of neoliberalism was introduced. The recognition of the private sector roles in delivering public health services led to the establishment of a dual system in health.

The dual system refers to two conditions: first, the application of a dual funding method and, second, the adoption of a dual accountability arrangement between primary and secondary care. The application of the dual system led to a fragmentation in the public health structure. Interestingly, the dual system has remained untouched, although the public health system has been in active transition for the last few decades. Reform has focused on the effort to improve the efficiency and effectiveness of the public health system through the adoption of various mechanisms such as, contracting-out, privatisation, and joined-up government. These mechanisms increased the level of complexity of the public health system because new organisational formats were implemented on top of the dualism structures. This scenario means that accountability is now applied to more complex structures and relationships; consequently, the New Zealand health system is

able to provide a good basis for studying accountability in the context of constant reform.

### **1.3 Context of research**

New Zealand's health services are a major government priority and concern. These services are largely tax-based with 78% of total health expenditure being financed from the public purse (Ashton, Mays, & Devlin, 2005; Jatrana & Crampton, 2009). Health is reported as the largest and fastest growing area of the government spending (Carville, 2014). For example, in the financial year 2001/02, the New Zealand government spent \$7.5 billion on health, and the expenditure is almost double in 2013/14 with a total spend of \$14.9 billion. It is anticipated that a similar trend will continue as the 2014 health expenditure is expected to increase to \$15.1 billion (The Treasury, 2014). These figures indicate that the economic performance of the health sector is of considerable importance in a small economy like New Zealand's. A good accountability system is, therefore, needed to build public confidence in the health system.

However, the ageing population, the growth in chronic diseases, and increasing public expectations have put considerable pressure on the public health system. In addition, there has been a great advance in the number of treatments for health conditions, which has resulted in the growing costs of health care. The ballooning health costs have become a major issue for the government because they grow faster than the economy, thus threatening the government's solvency (Ministerial Review Group, 2009). Due to these budgetary constraints, not all the health needs of the population can be met by a publicly funded system. Therefore, the government has developed filtering criteria to determine who should have access to certain health treatments (Broom et al., 2007). Ideally, the process of rationing is implemented through reforms which aim to improve the level of efficiency and effectiveness, as well as accountability, in the health services.

The New Zealand public health system has had four different health delivery frameworks as a result of the adoption of NPM and NPS reform models (will be discussed in Chapter Two). The ongoing changes driven by these reform models have brought adjustment in health service delivery methods, structures, and the types of people involved in health care services. Despite both NPM and NPS models offering some advantages, the adoption of these two models has added complexity to the management of health delivery because each model is driven by different policy approaches and methods of implementation.

From a critical perspective, Lawrence (2005) sees health policy reforms as the 'great experiment' because the introduction of reforms was implemented on the basis of political ideology rather than evidence-based analysis of what works and what does not. In Lawrence's view, the government interference has actually caused harm rather than improving the public health system. According to Lawrence (2005), the health sector at that time faced 'a crisis of legitimation' i.e., the government had introduced so many changes that no one could provide a rational explanation of what was happening and why. In terms of accountability, the concept has shifted away from the languages of professional autonomy and medicine toward the languages of finance and accounting (Lawrence, 2005).

Lawrence is not alone in his view. Over the last decades, the effects of each stage of health reform to the policy efficiency and effectiveness have been subject to debate (Ashton et al., 2005; Barnett et al., 2009; Gauld, 2008, 2012; Tenbenschel, Cumming, Ashton, & Barnett, 2008). The majority of researchers agree that reforms have largely failed to secure the expected gains in terms of improved policy efficiency and effectiveness (Ashton & Tenbenschel, 2012). However, little attention has been given to how the constant changes in the health structures affect accountability understanding and practices within the health delivery system. This study therefore, attempts to respond to the recent calls from the above researchers to investigate the issue of

accountability in the New Zealand public health system (see Dubnick, 2011; Greitens, 2012; Hodges, 2012).

#### **1.4 Research problem statement**

Reform usually comes hand in hand with new policy directions, which attempt to promote numerous benefits including improved accountability. While the effects of reform have been widely discussed, little attention has been given to how reforms affect the notion of accountability and its practices (Boston & Gill, 2011; Brandsma, 2007; Broadbent & Guthrie, 2008; Christensen & Laegreid, 2011a; Haque, 2000, 2007; Mulgan, 2000). It has been reported that the notions of accountability have changed in terms of: standards – the criteria by which public officials are held accountable; agents – to whom policy implementers are eventually accountable; and, means of accountability – how accountability is ensured by the government (Haque, 2000). However, because the goal of accountability has become complicated, how well accountability functions has also become problematic (Hodge & Greeve, 2007).

The existing studies identify the rise of accountability tensions in the structure of New Zealand health management following the adoption of a series of neoliberal reforms. However, the studies do not provide further information about the notion of accountability in the context of health service delivery, especially with regard to how the continuous reforms in the health sector affects the notion of accountability and how accountability has been defined in ever-changing, rationing processes (see Dowling, Sheaff, & Pickard, 2008; Mackie, 2010; Starke, 2010; Tenbensen et al., 2008; Tenbensen et al., 2007). Indeed, Hodge and Greeve (2007) also indicate a sense of anxiety toward accountability because so little is known on how accountability functions in the context of NPM and NPS. Van de Walle and Hammerschmid (2011) make a call for researchers engaged in public sector studies to provide more empirical evidence on the effects of reform on accountability.

On the basis of the above scenarios, there is a need to explore, in the context of reform, New Zealand health managers' understanding of accountability and its practices as they encounter constant changes in the public health system.

## **1.5 Statement of purpose and research questions**

The purpose of this research is to understand how the adoption of constant reform affects accountability understanding and its practices in the New Zealand public health system. The purpose of this study is guided by three considerations within the public health system.

Firstly, because the decisions about health reform were driven by different reform strategies over the past 30 years, it is important to identify the effects of reforms on the public health structures, governance and accountability. There must be a reason why the adoption of postreform accountability does not lead to the outcomes desired by the government and the people they represent. By analysing a series of reforms in the New Zealand public health system, this study will first, identify the formats of the reforms that have taken place and the rationale for adopting reforms in terms of accountability.

Secondly, since health service delivery involves various policy actors from the government and private sector, there is a need to consider the effect of constant reforms on the accountability arrangements within the mixed institutional arrangements of the health services. Therefore, experienced public health managers should be able to consider, if reform is continually adopted, what the effect on accountability is.

Thirdly, because health policy reforms in New Zealand move in different directions, it is interesting to identify the extent to which the continuing reforms have influenced the public health managers' understanding of accountability. If reforms have influenced the accountability understanding of public health officials, it is crucial to establish what the meaning of

“accountability” has been for public health officials in the context of ever-changing health reforms.

Based on the above arguments, the central research question set for this study is: what does “accountability” mean in the ever-changing New Zealand health system? To answer it, the following further research questions will be addressed:

1. What changes in the public health system have taken place over the last four stages of reform and what were the rationales for them in terms of accountability?
2. What are the challenges related to constant policy changes, and how do health managers feel about dealing with the changes in the public health system?
3. What are the public health managers’ conceptions of accountability after encountering the succession of organisational changes?

## **1.6 Research approach**

To develop new insights about accountability understanding and practices in the New Zealand public health system, this study adopted a qualitative methodology to illustrate the phenomenon under investigation. In particular, I employed critical hermeneutics and Ricoeur’s three stages of understanding as the methodological approach with the following research methods:

### **Documents review**

I examined a range of policy documents published by the Ministry of Health prior to the implementation of various reforms. These documents included discussion documents, ministerial statements, review documents and annual reports; and academic journals related to public sector reforms, public health studies, accountability and organisational changes. The aim of this method was develop my preunderstanding knowledge of the New Zealand public health reform. The process of analysing and interpreting documents involved a historical review and critique of the changing structures and accountability

arrangements in the New Zealand public health system. The analysis focused on the issues prior to the implementation of reform and the formats of reform.

### **Interview**

I conducted face-to-face interviews with a number of public health managers involved in managing the delivery of health services to the New Zealand public. This method was adopted with the aim of enhancing and validating the preunderstanding information gained from the policy documents and academic journals. I conducted interviews with 13 experienced public health managers from primary and secondary health organisations. The participants were purposefully selected using the snowballing technique. The participants were public health senior managers who had each worked in the health industry for more than 10 years.

The study adopted critical hermeneutics as the analytical framework for the process of analysing and interpreting data. In particular, this study employed Ricoeur's concepts of interpretation, namely: *historicity; autonomisation and distanciation*; and appropriation and engagement. The findings of this study are presented in three stages of hermeneutics understanding: namely, preunderstanding, understanding, and comprehensive understanding.

## **1.7 Significance of the study**

The rationale for this study derives from my desire to understand the implication of reforms on the meaning of accountability and its practices in public services. In particular, the findings are expected to enhance understanding of accountability in the context of a public sector organisation which has been subject to continuous reform. By exploring managers' experiences, this study has tried to understand accountability challenges and choices when reforms have moved in conflicting directions.

In addition, this study offers valuable insights into how the complex process of reform affects accountability arrangements in a public sector organisation. These findings attempt to illustrate how leaders in a particular type of public sector engage with constant policy changes. Specific descriptions of such scenarios are expected to describe the process of policy implementation and provide understanding of how best it might be managed.

It is important to understand the notion of accountability in the context of health services because dealing with people's lives and well-being requires policy makers to be fully accountable.

## **1.8 Thesis outline**

This thesis comprises seven chapters. A brief overview of the thesis chapters is provided below:

### **Chapter One: Overview of the thesis**

This chapter provides the overview of the thesis. It describes the background to the research issues, the research context, the research problem statement, the statement of purpose and research questions, and the significance of the study.

### **Chapter Two: Literature Review**

The aim of this chapter is to review literature related to accountability and public sector reform. This chapter describes the existing understanding of the notions of accountability and its practices in the context of neoliberal reform. To understand the changes of accountability in the context of reform, this chapter discusses the underpinning models of reform, i.e., NPM and NPS before highlighting the knowledge gaps in the existing literature.

### **Chapter Three: Methodology**

This chapter describes the research concepts that underpin the research process. I discuss the rationales of adopting qualitative methodology as the

research design and critical hermeneutics as the basis of research inquiry. This chapter also provides extended discussions of the hermeneutics approach and concepts which helps me to design the process of analysing and interpreting data.

#### **Chapter Four: Method**

This chapter explains the process of gathering, analysing and interpreting data for this study. It describes how the hermeneutics methodology was employed in the process of selecting participants, conducting the research process and making meaning of the texts. To establish the credibility of this study, I also include the discussion of the ethical consideration that guided the research process.

#### **Chapter Five: Preunderstanding**

Chapter Five provides my preunderstanding knowledge of the New Zealand public health system and the emergence of accountability issues. This preunderstanding knowledge was derived from the review of documents which I conducted prior to the fieldwork. I disclose my thinking about health service reform by discussing the types of reform and how changes in the policy direction have affected accountability. This chapter serves as the basis for further exploration at the next stage of understanding which is presented in Chapter Six.

#### **Chapter Six: Understanding**

This chapter represents the interview findings which reflected my understanding of the New Zealand public health reforms and the accountability issues associated with them. It provides a wide and varied range of the health managers' experiences – including a series of paradoxes, confusions and conflicts – in dealing with reforms, policy changes and accountability.

## **Chapter Seven: Conclusion**

By summarising the key findings of the study and the main issues of the investigated phenomenon, this chapter provides a comprehensive understanding of each area. It explains them in the wider context of the accountability and public sector reform literature. This chapter highlights the suggested contributions of this study and reveals the limitations that appeared in the research project. Then, recommendations for future research are offered before ending with final reflection of this study.

# **CHAPTER TWO**

## **LITERATURE REVIEW**

### **2.1 Introduction**

There is an extensive body of literature relating to the research topic (accountability) and context (public sector reform) of this study. The purpose of this chapter is to examine both topics, with the discussion being divided into three main sections. The first section considers the concept of accountability. It has been said that accountability is a vague and imprecise concept and so the review aims to understand the extant understandings in the literature from two perspectives: (i) normative accountability; and, (ii) mechanism accountability. The second section reviews the context of public sector reform, giving especial attention to the emerging models of NPM and NPS. Finally, in the third section, I discuss the knowledge gap in the area of reform and accountability, before ending the discussion with the chapter summary.

### **2.2 Defining accountability**

Although accountability has been widely used as a benchmark in assessing the standard and quality of organisations, defining accountability is challenging. The challenges arise because the 'chameleon-like' nature of accountability allows researchers to define and redefine it according to their beliefs, objectives and the time at which they conducted their research (Sinclair, 1995). Simultaneously, the setting in which accountability is practiced constantly changes in accordance with organisational motives. As a result, the discussions of accountability tend to go round in circles as many authors introduce their own definitions, concepts and frameworks for studying accountability (Bovens, 2010). However, these various definitions, concepts and frameworks are disconnected, and lack a consistent conceptual

framework. They, therefore, fail to provide conclusive findings to reduce the confusion (Bovens, 2010; Dubnick, 2005).

The objective of this section is to provide a fundamental understanding rather than offer a new definition of accountability. To avoid confusion in defining accountability, I follow Bovens (2010) who suggests that accountability should be viewed from two different perspectives, namely, accountability as a normative and accountability as a mechanism. Bovens (2010) argues that both accountability perspectives “address different sorts of issues and imply very different sorts of standards, framework, and analytical dimensions” (p.948). Therefore, looking at accountability from two different perspectives may help to solve at least some of the conceptual confusion, and may provide some foundation for comparative and cumulative analysis for the study of accountability. The next subsections discuss the concept of accountability from the perspectives suggested by Bovens (2010).

### **2.2.1 Accountability as a normative concept**

From the normative perspective, accountability is easily understood as a word which is synonymous with many other terms such as responsibility, responsiveness, integrity, transparency, democracy, equity, justice, honesty, and good governance (Bovaird, 2004; Bovens, 2010; Koppell, 2005). The various synonyms of accountability show that, over time, this word has been continuously reconstructed, and that developing processes have added more meanings and functions. For example, the definition of accountability has been elevated from its primary meaning – “responsibility” - to more challenging functions such as strengthening the process of governance (Day & Klein, 1987). Although accountability has many definitions, all of these definitions involve a common characteristic i.e., they convey an image of moral order with strong emphasis on trustworthiness and transparency.

The word accountability is often used in the policy context to indicate a desirable quality in an individual and desirable organisational behaviour

(Dubnick, 2005). Symbolically, when accountability is used in policy documents to signal organisational means and ends, it implies the positive quality of organisations. In other words, accountability is used with the aim of increasing organisations' charismatic images, because 'being accountable' is seen as a guarantee of implementing virtuous or normative actions (Bovens, 2010). This view is supported by Dubnick and Frederickson (2009) who regard accountability as a set of organisational promises made to shareholders and other stakeholders. They include the promise of control, the promise of integrity, the promise of ethical behaviour, the promise of democracy, the promise of performance, and the promise of justice or equity (Dubnick & Frederickson, 2009). For some people, organisational promises made to the public are almost always exaggerated; nevertheless, such promises increase the impression that an organisation has strong values. In the long run, the accountability promises will enhance organisational credibility as well as increasing public confidence in the organisation (DiTomaso, 1993).

Etzioni (1975) in his classic work on accountability has used such terms as "the symbolic uses of accountability" (p.279). Strategically, when the word accountability is employed as a policy or organisational benchmark, it describes the actual usage of accountability in specific ways in particular settings. For example, accountability is used as a standard for guaranteeing organisational and individual performance and also as an assessment of individual and organisational moral and ethical discipline (Kim & Lee, 2010). Accountability is often seen as providing solutions to a wide range of problems, and such accountability should result in greater organisational and policy achievements. For instance, governments have appeared to assume that accountability will be enhanced as a result of improved policy efficiency; as noted by Boston and Gill (2011), "a key premise on which the reform relied was that, with effective accountability systems in place, robust performance information would generate better performance" (pp. 224-225). This comment shows that as a word, 'accountability' appears to be a strong and popular rhetorical policy tool (Dubnick & Frederickson, 2009).

Although the meaning of accountability as a word sounds clear and understandable, Bovens (2010) claims that accountability in the sense of virtue or normative behaviour is hard to define substantively. For instance, Behn (2000) states, “sometimes we know exactly what these responsibilities, obligations, and duties are. Sometimes we have defined them very precisely. But too often we haven’t – or at least we aren’t all using the same definition” (p. 6). Difficulties in reaching a standard definition for accountability behaviour can be associated with its chameleon-like attribute: i.e., accountability is viewed and defined according to the perspective of participants (Sinclair, 1995). Hence, too often accountability carries and conveys different meaning for different people, organisations, eras, roles and political perspectives.

To date, accountability studies in normative perspectives have focused on the standard for accountability and the assessment of the behaviour of public organisations and public officials (Considine, 2002; Koppell, 2005), public sector performance (Dubnick, 2005; Dubnick & Frederickson, 2009) and individual accountability from ethical and moral perspective (McKernan, 2012; Messner, 2009). These studies have made contributions to explaining the usage of accountability, especially in public sector organisations.

### **2.2.2 Accountability as a mechanism (or social) concept**

Accountability can also be approached from the stand point of specific social relations or social practices. This approach is also referred to as ‘accountability mechanism’ because it links to the operation of accountability systems within organisations (Bovens, 2010; Roberts & Scapens, 1985). In simple terms, Roberts and Scapens (1985) define accountability as “the giving and demanding of reasons for conduct in which people are required to explain and take responsibility for their actions” (p. 447). This definition implies that the process of ‘being called to account’ involves regular face to face contact (Roberts & Scapens, 1985) between two parties known as the

'account giver' (accountor) and 'account receiver' (accountee) (Mulgan, 2000). The process of 'being called to account' has been accepted as a core definition for accountability by almost all scholars in the area of accountability (Mulgan, 2000). Definitions provided by these scholars indicate that the notion of a mechanistic accountability is established through the way in which accountability is experienced by participants in a particular social practice.

A number of scholars have agreed that the framework of accountability or the account-giving process was originally characterised by three core features (Bovens, 2010; De Vries, 2007; Haque, 2007). The first feature concerns the reporting function (Parker & Gould, 1999), while, the second feature relates to social relations and interactions (Mulgan, 2000), and the third feature is connected to the moral order and legitimacy structure which defines rights and obligations, including the rights to hold others to account (Conrad, 2005). Dubnick and Frederickson (2009) regard these three features as input, process and output. These features are interrelated as they portray three phases in the process of giving account, namely, the information phase, judgement phase and consequence phase. The process of giving account is implemented in a linear relationship with an emphasis on a systematic input-output process. Under this form of relationship, in the case of fraud, corruption or policy failure for instance, there will be a person who is held accountable and has to face the consequences of his or her action (Brandsma, 2007; Haque, 2007). Table 2.1 describes the features of accountability in the process of giving account in a particular social practice.

**Table 2:1 The features of accountability in the process of giving account**

| Features of accountability                                  | The process of giving account   |
|---|---|
| <p><b>Reporting function (Input)</b></p>                    | <p><i>Information phase.</i></p> <ul style="list-style-type: none"> <li>• At this stage the accountant is responsible to the accountee for accounting or answering for conduct or the discharge of a duty.</li> </ul>   |
| <p><b>Social interactions and relations (Process)</b></p>   | <p><i>Judgement phase</i></p> <ul style="list-style-type: none"> <li>• At this stage, the accountant has to meet certain levels of accountee's expectations, which have previously been agreed by both parties.</li> <li>• The accountee can pose questions to get more detailed information and the accountant has to provide justifications and explanations.</li> </ul>                      |
| <p><b>Moral order and legitimate structure (Output)</b></p> | <p><i>Consequences phase</i></p> <ul style="list-style-type: none"> <li>• At this stage the accountee evaluates the conduct of the accountant by referring to the accountee's justifications and explanations, and makes decisions regarding the sanctions or rewards to control the activities of the accountant.</li> <li>• The accountant has to accept the sanctions or rewards.</li> </ul> |

Drawn from (Bovens, 2010; Conrad, 2005; De Vries, 2007; Haque, 2007; Mulgan, 2000; Parker & Gould, 1999)

Similar features to those presented above have been used to model the process of giving account or show how accountability is practised in specific social contexts such as public organisations. The traditional structure of public organisation was developed from the bureaucratic model. This model is characterised by the principal-agent relationship, which one party (the principal) hires another (the agent) to undertake a particular task in accordance with the interest of the principal (Broadbent, Dietrich, & Laughlin, 1996). The principal-agent relationship typically involves the principal exerting strong control over its agents since the principal owns the legitimate power that allows it to manage the organisation's diverse expectations by controlling and coercing the agent's activities (Frink & Klimoski, 2004; Roberts & Scapens, 1985). In other words, the relationship between the principal and the agent should be characterised by responsibilities and goals that have been agreed upon by both parties (Cordery, 2008).

The relationship of mutual responsibility between the principal and the agent reflects the existing accountability relationships between them. For example, Day and Klein (1987) contended that “one cannot be accountable to anyone, unless one also has responsibility for doing something” (p. 5). Thus, from the perspective of accountability, the responsibility relationship between the principal and the agent also implies the accountability relationship between the accountor (the agent) and the accountee (the principle). Conventionally, accountability relationships between the principal and agent are known as hierarchical accountability. Under this form of accountability, the principal (the accountee) reserves the rights to call the accountee to account, including demanding answers and imposing sanctions.

However, the settings of any social practice are subject to change. For example, in the mid-20th century, the traditional features of public sector accountability came under pressure following rapid changes in public bureaucracy (Halligan, 2007a; Siddique, 2006). At this point in time, the growing division of labour expanded the role of the State in governing the system of government. Simultaneously, the number of professionals in the public sector grew, which then reinforced the need to harness managerialism to political accountability. To ensure the relevance of accountability in the context of organisational changes in specific social settings, accountability scholars (Romzek & Dubnick, 1987; Sinclair, 1995; Stone, 1995) agreed that there was a need to enhance the concept of accountability.

The process of giving account should be enhanced by acknowledging relationships, or the multiple ways in which accountability is experienced. Understanding accountability from the perspective of relationships helps to clarify the meaning of accountability because the forms of accountability usually change according to the social relationships context in which the policy actors are involved, and because, accountability is not only about formal requirements which involves top-down control but it is also about a matter of interpersonal relationships (Stone, 1995). Table 2.2 shows the framework of accountability relationships developed by accountability

scholars. It can be seen that the notions of accountability involves a wide range of relationship that increase according to the criteria of a particular the social practice.

**Table 2:2 The framework of accountability relationships**

| Researcher(s)  | Types of accountability relationships  |
|--|--|
| <p><b>Romzek and Dubnick (1987); Jonston and Romzek (1999)</b></p> | <p>Introduced four types of accountability:</p> <p><b><i>Hierarchical/bureaucratic accountability</i></b></p> <ul style="list-style-type: none"> <li>• Formal and hierarchical accountability relationship between a superior and a subordinate.</li> <li>• Systems of accountability are based on standard operating procedure or clearly stated rules and regulations.</li> <li>• Basis of relationship is supervision.</li> </ul> <p><b><i>Legal accountability</i></b></p> <ul style="list-style-type: none"> <li>• Formal and hierarchical accountability relationship between a controlling party inside (an organisation’s management) and outside the organisations (law maker).</li> <li>• Basis of relationship is fiduciary.</li> </ul> <p><b><i>Political accountability</i></b></p> <ul style="list-style-type: none"> <li>• Relationships between representatives and his or her constituencies. For example between elected official and citizen, agency head and general public or organisations and customers.</li> <li>• Basis of relationship is responsive to constituency.</li> </ul> <p><b><i>Professional accountability</i></b></p> <ul style="list-style-type: none"> <li>• The placement of control over organisational activities in the hands of expert employees. Basis of relationship is deference to expertise.</li> </ul> |

**Sinclair (1995)**

Introduced five forms of accountability relationships.

***Political accountability***

- A direct line or chain of accountability links the public servant with public manager, in turn accountable to the Minister, to the executive or Cabinet, to parliament and hence to the electors.
- The form of relationship is formal.

***Public accountability***

- Encompasses more informal but direct accountability to the public, interested community groups and individuals.
- Involves answering, through various mechanisms from newspaper reports to hearings.
- Is treated as complementary to public accountability.

***Managerial accountability***

- Is a formal and hierarchical relationship.
- A superior calls to account a subordinate for the performance of delegated duties.

***Professional accountability***

- This accountability invokes the sense of duty that one has as a member of a professional or expert group which, in turn, occupies a privileged and knowledgeable position in society.

***Personal accountability***

- This refers to basic value such as respect for human dignity and acting in a manner that accepts responsibility for affecting the lives of others.

Managing accountability relationships in specific organisational practices is challenging because the structures and types of relationships are different and subject to organisational change (Bovens, 2010). Often the criteria of mechanistic accountability which related to the questions: 'to whom is the accountability to be rendered' and 'what to render' are difficult to answer

(Bovens, 2010). As a result, the notion of postreform accountability has become increasingly ambiguous (Dubnick, 2005).

According to Bovens (2010), difficulties in managing different types of relationship will lead to problems in accountability practices, called 'accountability deficits' and 'accountability overloads'. From a normative perspective, accountability deficit refers to inappropriate behaviour or bad governance which results from the inability of public officials or public organisations to respond to the public demand (Bovens, 2010). Meanwhile, the mechanism accountability defines the deficit from the standpoint of loopholes that emerge in the web of control mechanisms (Bovens, 2010). From the accountability deficit perspective, the main concern is the growing accountability gaps between policy and practice due to the growth of formal power and the complexity of organisations (Bovens, 2010). Accountability overload is a term used by Bovens (2010) to denote the accountability problem that caused by overburdening accountability in terms of its obligations. This problem will result in a low return on accountability because overburdening accountability leads to the formation of various accountability problems, such as accountability dilemmas, paradoxes and traps. According to Bovens (2010), imposing evermore accountability arrangements, and being scrutinised more frequently and intensely do not necessarily produce better governance.

Dilemma and deficit in accountability are signs of danger for two reasons. First, dilemma never give the correct solutions (Poulsen, 2009), and second, deficits in accountability will increase oversight activities in organisations (Bovens, 2007; Halligan, 2007a). Furthermore, dilemmas and deficits will also create the opportunity for practitioners to manipulate confusing situations, and thus escape being held accountable (Jones & Stewart, 2009; Klijn & Teisman, 2005). Although, there have been a considerable number of studies on accountability mechanisms (Budding, 2004; Day & Klein, 1987; Newman, 2004; Romzek & Dubnick, 1987; Sinclair, 1995), insights into how dilemmas and deficits develop have not been sufficiently explained because

the effects of policy reforms on the notion of accountability and its practices have not received much attention. As a result, Pettersen and Nyland (2011) called for future researchers to study the key actors' interpretations in this context.

In summary, accountability can be understood from its two basic concepts: normative accountability and mechanism accountability. Normative accountability conveys the image of moral values while mechanism accountability is viewed as social relationship that can be utilised as an organisational instrument for achieving the objectives of accountable governance. Although these two concepts define accountability from different perspectives, they are complementary in practice, because accountability is about moral values and relationships (Bovens, 2010). However, mechanism accountability is more complex than normative accountability because it involves various types of relationships. The relationships of accountability are subject to organisational change, meaning that the types of relationships and the notion of account giver and account receiver will change according to changes in the organisational structures (Broadbent & Laughlin, 2002; Newman, 2004; Sinclair, 1995). Changes in accountability relationships have led to problems in accountability practices, known as accountability dilemmas and accountability deficits (Bovens, 2010).

It has become apparent to me that accountability is ideal in concept but complex in practices. To help understand the notion of accountability and its practices in the context of public sector reform, the next section discusses the underpinning models of reform and their effects on accountability.

## **2.3 Understanding public sector reforms and changes in accountability**

Delivering quality services for citizens is a core mandate of a government. Unfortunately, however, realising the mandate is not a straightforward task as governments are always under socioeconomic and political pressures. These pressures require governments to rationalise the forms of service delivery through reform because reform has been perceived as the only way to ensure governments succeed in carrying out their initial mandates (Aucoin, 1990; Pollitt & Bouckaert, 2004).

According to Pollitt and Bouckaert (2004) reform “consists of deliberate changes to the structures and processes of public sector organizations with the objective of getting them (in some sense) to run better” (p. 8). Such deliberate changes are informed by specific sets of ideas which characterised by ideologies, frameworks, or standard of actions. In the 1980s, a new set of reforms rooted in neoliberal ideology was introduced in the public sector. This new ideology promised to assist in:

1. making saving in the public expenditure
2. improving the quality of public service
3. making the operation of government more efficient
4. increasing the chances of improving the effectiveness of implementing policy
5. enhancing the governments’ accountability

(Pollitt & Bouckaert, 2004, p. 6).

Since its introduction in the 1980s neoliberal reform has become the most popular reform model in both developed and developing countries (De Vries & Nemec, 2013; Goldfinch & Wallis, 2010; Haque, 2007; Hong, 2013; Hood, 1991; Larbi, 1999; Mongkol, 2011; Sarker, 2006). For the purpose of this study, two models of neoliberal reform, i.e., NPM and NPS have been reviewed. In order to understand the rationales for reform, the transition from the bureaucratic model to NPM, and then from NPM to NPS is presented prior to the discussion of each model of reform. Subsequently, the

discussions on the reform models extend to the effects of reform on accountability.

### **2.3.1 From the Bureaucratic to NPM Model**

Before the 1980s, the framework of public service delivery was underpinned by the bureaucratic model. Under this model, a government carried out extensive roles and responsibilities from maintaining law and order to providing new social services such as education, health, housing, social security, and transport. The bureaucratic model, however, was regarded as economically inefficient because the size of the public sector grew and the administrative intervention appeared to be extensive. A large and growing government was seen as not conducive to better economic performance as it caused high government debts, stagflation and low levels of economic growth (Mitchell, 2005; Regan, Smith, & Love, 2009).

Prior to the neoliberal reform, most governments suffered from fiscal stress during the economic recession in the 1970s because the oil crisis hit different countries at different times and with different severity (Cendon, 2000; Loffler, 2003). During the recession, governments experienced declines in tax revenues and increases in public expenditure (Loffler, 2003). At the same time, governments were pressured by groups of the public who became better informed and began to raise concerns regarding the quality and efficiency of service delivery that was received. Such pressures led to the substantial criticisms of the bureaucratic model which was seen by the users as too slow, inefficient, and unresponsive because it was driven by regulation instead of performance (Larbi, 1999; McDonald, Checkland, & Harrison, 2009). These situations also led to public arguments and disenchantment, and pressured governments to find alternatives for providing public goods and services (Mascarenhas, 1993).

Therefore, governments both in developed and developing countries began to look for strategies, which would help them to improve the efficiency,

effectiveness and performance of public service delivery. Market and business principles were seen as appealing substitutes to the bureaucratic model, because the principles were developed based on the fundamental economic theorem, and they were believed to create a competitive environment for better government performance (Blanchard et al., 1998; Box, Marshall, Reed, & Reed, 2001; Christensen & Laegreid, 2011a). David and Gaebler (1992) rationalised the importance of adopting market-based reform as follows:

. . . the bureaucratic model developed in conditions very different from today. It developed in a slower-paced society, when change proceeded at a leisurely gait. It developed in an age of hierarchy, when only those at the top of pyramid had enough information to make informed decisions . . . . Today all that has been swept away. We live in an era of breathtaking change. We live in the global marketplace, which puts enormous pressures on our economic institutions. We live in an information society, in which people get access to information as fast as their leaders. We live in a market-based economy, in which educated workers bridle at commands and demand autonomy. We live in an age of niche markets, in which customers here become accustomed to high quality and extensive choice. (p.15)

In the view of David and Gaebler (1992), the bureaucratic model was no longer relevant for the public sector because the contemporary socioeconomic environment requires a different policy approach. Therefore, neoliberalism reform was seen as an attack on the bureaucratic model which operated in a closed system and centralised bureaucratic principles (Gauld, 2009; Osborne, 2009).

Furthermore, the resurgence of new-right politics in the US and the UK (during the era of Reganomics and Thatcherism) in the late 1970s and 1980s, and the growth of new information technologies, accelerated the adoption of market-based reform in the public sector (Larbi, 1999). New-right politics suggested that the market and private sector would be able to make the public sector leaner and more competitive, would make it more responsive to citizens' needs by offering value for money, choice, flexibility and

transparency (Loffler, 2003). The use of new information technology would speed up the achievement of the objectives of reform (Larbi, 1999).

The rise of the market and business model around the world was marked by a wide implementation of four administrative megatrends namely, reducing public spending and staffing, adopting privatisation and quasi-privatisation, utilising information technology, and developing an international agenda focused on general issues of public management (Hood, 1991). These megatrends were implemented for more than 15 years, before Hood (1991) coined the term NPM to describe these reforms. According to Rhodes (1994), the term NPM does not refer to any one idea but a collective of ideas which became a fashionable global trend after being introduced in the early 1980s.

NPM was seen by Van de Walle and Hammerschmid (2011) as a hybrid approach because it was derived from two different sets of ideas. The first set of ideas consists of the philosophy of neoliberalism, rooted in three major theories related to market mechanisms, namely, public choice theory, agency theory, and, transaction cost analysis theory (Cartner & Bollinger, 1997). The second set of ideas refers to the managerialist principles which focus on the need to establish the private managerial principles within the public sector (Aucoin, 1990). Due to its hybrid character, NPM was described as a marriage of opposites (Hood, 1991).

However, the NPM prescriptions for change were seen as offering a fresh approach to the public sector problems. NPM set three promising objectives that aimed to bring about this change. They were:

1. to improve public sector efficiency and the quality of services;
2. to reduce public expenditure; and,
3. to ensure the effectiveness of policy implementation.

(Hood, 1991; 1995)

The implementation of NPM largely emphasised an active and visible hands-on approach to professional management in the public sector with explicit

standards of performance, greater emphasis on output control, increased performance, contracts, devolution, disaggregation of units, cost-cutting, financial reporting and mimicking of private sector management practices such as the introduction of corporate plans, missions and statements, and the concept of citizens as customers (Blanchard et al., 1998; Christensen & Laegreid, 2001; Larbi, 1999; Moynihan, 2009). These strategies were expected to make public organisations more transparent and more easily accessible with regard to extensive evaluations (Nyland, Petterson, & Ostergren, 2009).

To support such developments, there has been a demand for accounting information to help public organisations deal with market and business principles. Broadbent and Laughlin (2005) define the usage of accounting information as “accounting logic” (p. 19). They argue that accounting information is a part of a steering mechanism and that applying the accounting logic in public organisations enhances the performance of the public sector. As a result of this change, the traditional values of public organisations such as equity, fairness and rule of law switched to managerial values adapted from the private sector, namely, effectiveness, efficiency, and analysis of costs and benefits (Norman, 2003).

NPM also redefined the role of governments in the context of service delivery. In order to improve the efficiency and accountability of public services, NPM required governments to change their role from ‘rowing to steering’ (Barlow & Rober, 1996; Rainnie, Firtzgerald, Gilchrist, & Morris, 2012). This concept was introduced by David and Gaebler (1992), based on their arguments that different sectors of economy i.e., public, private, and nongovernmental agencies should provide the goods and services in line with what each sector produces best separately or through collective efforts. Under this concept, governments were required to play the role of ‘facilitator’ as governments were best at steering policies directed to growth in the economy and which prevent discrimination in the social system.

Meanwhile, private sector and nongovernmental agencies are recommended to concentrate on rowing activities as these sectors are best at producing goods and services (David & Gaebler, 1992). Through these specialisation activities, governments are likely to be able to encourage a better quality of goods and services at lower costs. These concepts brought the idea of the purchaser-provider split into the public sector. The public sector led the planning and monitoring of services, while the responsibility for delivering services was contracted out to experts from private or voluntary organisations. As a result, the management of the public sector and service delivery became fragmented and increasingly governed by contractual relationships (Barlow & Rober, 1996).

In summary, public sector organisations during the reforms were reclassified as commercial businesses and citizens were redefined as customers (Parker & Guthrie, 1993). As public sector organisations came to be seen as commercial entities, the public managers were required to be more responsive to their customers through the recognition of private managerial principles. These principles advocate granting greater autonomy to managers, reducing regulation, and focusing on results (Cejudo, 2008). Consequently, there was a move from qualitative to quantitative thinking and acting (Parker & Guthrie, 1993). This move not only brought active and visible hands-on professional management into the public sector, but also put a greater emphasis on accounting calculation concerning explicit standards of performance, and output controls, including cost-cutting and public budgeting. Furthermore, various private sector managerial strategies which did not require structural changes were introduced into the public sector. These strategies included: quality innovation, performance management, corporate plans, missions and statements, and the concept of citizens as customers (Blanchard et al., 1998; Christensen & Laegreid, 2001; Larbi, 1999; Moynihan, 2009). Overall, the NPM strategies appeared to be promising and attractive solutions for governments to deal with the problems of inefficiency in the public sector.

### 2.3.2 A critique of NPM and the formation of New Public Service

Although NPM was expected to lead to better performance in the public sector, some evidence indicated that it was not always able to achieve the expected result. The implementation of NPM-related reforms resulted in reports of:

1. an increase in a 'democratic deficit', due to a serious loss in public accountability (Atreya & Amstrong, 2002);
2. the creation of difficulties in attaining social equilibrium among citizens or customers (Eagle, 2005);
3. the undermining of democratic and constitutional values such as fairness, justice, representation and participation because of a high emphasis on market and managerial value (Denhardt & Denhardt, 2000);
4. the fragmentation of service delivery because of distinct tasks, purposes and conditions within the public and private sectors

(Mongkol, 2011; Rhodes, 1994).

From a managerial perspective, the implementation of NPM was seen as a 'new red-tape' for output and outcome due to its highly centralised approach and highly specified controls through contracting-out, performance evaluation, and accountability mechanisms (Goldfinch & Wallis, 2010). Meanwhile, the objective of reducing the costs of public provision seemed to remain as difficult to achieve as previously, despite the refocus from service provision to control through accrual accounting, auditing and external evaluation (Olson, Humprey, & Guthrie, 2001).

De Vries and Nemec (2013) provide analyses of the trend of GDPs, revenues, and debts in developed countries between 2003 and 2015 (projection). They reveal that public deficits in almost all countries are high, with a fast growth in public debts. De Vries and Nemec (2013) conclude that:

The dramatic decline in GDP, public revenues and stabilization expenditure reveal the urgent problems that many countries face. It is in those circumstances that industry, banks but also common people turn to their governments and demand solutions, which cannot be provided for by the market nor by a minimalistic public sector. It is not sufficient just to increase taxes and to implement cross-sectoral general cuts. In such a severe situation it becomes obvious that the one-size-fits-all solution of minimizing the influence of government has serious drawbacks and that the ideology behind NPM has reached its limits (p. 8).

As the NPM-related reforms were perceived as reaching their limit, governments introduced more holistic strategies using a social democratic approach. This approach stresses both 'society' and 'democracy', requiring the State to develop a robust and caring society (Gauld, 2009). This idea became a backbone of public policies in many Western nations, including the US (under the leadership of Bill Clinton, 1993 - 2001) and the UK (under the leadership of Tony Blair, 1997 -2007). Under this approach, a government is responsible for ensuring that social services such as education, health and housing are freely and universally available to citizens. This approach to public policy encourages the development of the welfare state in accordance with interventionist Keynesian economics (Christensen & Laegreid, 2011a).

The social democratic strategies referred to 'networks', 'joined-up government' and 'whole-of-government'. These strategies were developed on the basis of public sector values and the assertion of central control over agencies (Goldfinch & Wallis, 2010; Larner, 2000). In particular, Lodge and Gill (2011) note that these strategies blend the previous principles of neo-Weberian and NPM features which aimed to overcome the perceived NPM-generated weaknesses produced by specialisation, fragmentation, and marketisation. Denhardt and Denhardt (2000) label these strategies as the New Public Service (NPS), while Goldfinch and Wallis (2010), term them in a number of different ways: the 'third way', 'new governance', 'public governance, 'new public governance', 'public value creation' and 'post-NPM'.

NPS is rooted in three main theories, including the theory of democratic citizenship, models of community and civil society, and organisational humanism and discourse theory (Denhardt & Denhardt, 2000). Halligan (2007b) states that NPS is driven by two main objectives: renewing the public sector to improve capacity; and, refocusing the core public services to increase performance. Interestingly, governments retain their roles as policy players, but they are no longer in charge of policy delivery. The responsibility for delivering public services is assumed by centralised collaboration and a network which consists of diverse actors, including the private sector (Denhardt & Denhardt, 2000). Digital technologies have been used as mechanisms to facilitate the reintegration and coordination of service delivery (Christensen & Laegreid, 2011b)

The collaboration between governments and their networks demonstrates that NPS has moved away from market values towards democratic values. The role of the State under NPS is more about serving than steering the citizens. Denhardt and Denhardt (2000) propose that “the primary role of the public servant is to help citizens articulate and meet their shared interests rather than attempt to control or steer society” (p.549). Following this argument, Denhardt and Denhardt (2000) claim that public servants are no longer responsive to constituents and clients (under the bureaucratic model) nor to customers (as under NPM) but to citizens.

The changes from the bureaucratic model to NPM, and more recently to NPS, have required developments in public sector management. The functions of the public sector have not changed, but, according to Broadbent and Guthrie (2008), the assumption that the public sector organisations involved in providing services to the public are publicly funded, owned and operated is no longer relevant. They further argue that the ‘public sector’ is best renamed as ‘public services’. Public services no longer require direct government ownership, although they often continue to receive some government funding. With regard to this development, public services

become a more complex service-providing and policy-developing institution (Gill, Pride, Gilbert, Norman, & Mladenovic, 2011; Raadschelders, 2011).

Both NPM and NPS models have generated significant effects on the governance and structures of the public sector. Although these models are rooted in neoliberal principles, they are driven by different names and strategies. The following section describes the implementation of neoliberal reforms in the context of public sector accountability.

### **2.3.3 The effects of NPM on accountability**

Accountability is a core value of public governance and management (Cendon, 2000; Day & Klein, 1987). It has long been seen as an essential key component for the proper functioning of a democratic political system (Glynn & Murphy, 1996) but one which is highly subject to political persuasion (Parker & Gould, 1999). The concept of accountability has a direct relationship with the framework of service delivery and the model of the State (Cendon, 2000). In the context of public sector or service delivery, the concept of accountability was characterised by matters of responsibility (Olson et al., 2001). Thus, as the structure of the public sector responsibility was enhanced, notions of accountability were altered. Before the discussion of the effects of NPM on accountability is presented, it is worth reviewing the notions of accountability from the former bureaucratic perspective, so that the changes in the accountability concept in the age of neoliberal reform can be better understood.

According to Day and Klein (1987), the notion of accountability under the bureaucratic model is simple as it refers to the expectation that those in government should be held responsible for carrying out tasks on behalf of their fellow citizens. Theoretically, traditional accountability involves a linear relationship between two parties: “who can call for an account, and who owes a duty of explanation” (Day & Klein, 1987, p. 5). The relationship

between these two parties is formal, where the accountor has the authority to assign or negotiate with the accountee regarding the expectations of responsibility and the standard of performance (Mulgan, 2000).

The accountor reserves the right to call for account, including demanding answers and imposing sanctions. Hence, in the case of fraud, corruption or policy failure, for instance, one person is held accountable and has to face the consequences of his or her action (Brandsma, 2007; Haque, 2007). According to Bovens (2007), the consequences can be highly formalised, such as fines, disciplinary actions and penal sanctions, or can also operate on unwritten rules, such as calling for the minister's or senior executive officers' resignation. The form of relationship indicates that traditional accountability was built on a hierarchical structure involving answerability and enforceability (Samaratunge, Alam, & Teicher, 2008).

The operation of the traditional public sector was designed along bureaucratic principles which ensured accountability but required excessive rules and precontrol (Denhardt & Denhardt, 2000). Consequently, the framework of public sector accountability was characterised by hierarchical relationship in which the measurement of accountability was based on a set of rules and regulations flowing from public law and the system of control was considered rational and legal (Pfiffner, 2004). Under the bureaucratic model, financial accountability became a measurement criterion for judging or justifying actions or decisions taken by the politicians or government servants responsible. However, Day and Klein (1987) stress that financial accountability is regarded as an independent form of accountability because it is only part of administrative law, regulation or agreement, and is highly concerned with the financial control. Due to its independency, financial accountability was institutionalised as an audit, using neutral expertise, which plays important roles in controlling the process of political accountability (Day & Klein, 1987).

However, hierarchical accountability is seen as too rigid when it comes to practice (De Vries, 2007). The problems of rigidity arise from the weaknesses of the principal-agent relationship which allows domination of power by the principal over the agent. Therefore, the rights to call for account, demand answers and impose sanctions are seen as a “product of authoritarian [ism]” (Parker & Gould, 1999, p. 116) that generates fear and destroys trust among individuals in organisations (Harber & Ball, 2003). Behn (2000) has equated this form of accountability with punishment. According to Behn (2000), “when people seek to hold someone accountable, they are usually planning some kind of punishment” (p.4).

However, with the adoption of NPM, the traditional concept of accountability was expanded and went beyond rendering an account of the resources used (Glynn & Murphy, 1996). Accounting has become a key element in this new conception of accountability (Hood, 1995). In particular, the adoption of accounting logic is expected to enhance the transparency of public organisations as it has the power to shift patterns of organisational visibility (Broadbent & Laughlin, 2005). For instance, budgeting and costing systems have created a form of visibility and transparency at the organisational level. With the enhancement in transparency, the new system of accountability is believed to increase public trust in governments (Jacobs, 2000). To match with managerial principles, market mechanisms, and the new system of accountability, NPM focuses primarily on “managerial and downward accountability and less on traditional political and upward accountability” (Opedal & Rommetvedt, 2010, p. 194).

Overall, the system of accountability has shifted from process accountability (based on input control responsibility, bureaucratic procedure, rules and standards) to accountability for results (with an emphasis on quantitative measures that can assess the efficiency and effectiveness of policy implementations) (Cendon, 2000; Mulgan, 2000). As the role of accountability in the context of NPM is to ensure the efficient use of resources and the effectiveness of policy decisions, the control system of accountability

has come to focus more on quality assurance and overall performance management rather than on the scrutinisation of individual actions (Kluvers, 2003).

In relation to the above changes, Mulgan (2000) concludes that the core of accountability, or the process of giving account, is contestable on the ground, and has increasingly been extended beyond the notion of “giving an account”. Simultaneously, NPM has led to the rise of horizontal accountability in the public sector. Horizontal accountability is a condition where agencies report to others who are not their principals, such as peers, clients and other stakeholders (Schillemans, 2010; Willems & Van Dooren, 2012). This type of accountability emerged because the framework of service delivery under NPM invited professionals and organisations outside the government to deliver public services. According to Schillemans (2008), horizontal accountability is not a replacement for hierarchical accountability but is rather an essential extension to hierarchical accountability. This structure allowed accountability to be demanded by a range of stakeholders from inside and outside the public sector, including politicians, public officials, citizens, and private partners.

In further arguments, Mulgan (2000) states that the traditional accountability feature “leads to questions about different channels of accountability and their relative merits, about the balance between accountability and efficiency, and about distinctions between political and managerial accountability” (p. 556). Previously, Sinclair (1995) too had already noted similar limitations in treating accountability as a fixed and objective feature of structures and positions. Hence, the core accountability features in the form of the principal-agent relationship are seen to be no longer relevant in the context of their practices (Dubnick, 2005; Dubnick & Frederickson, 2009; Mulgan, 2000; Sinclair, 1995). These scenarios indicated that changes in organisational structure and governance have significant effects on accountability.

### **2.3.4 The effects of NPS on accountability**

The emergence of NPS in the early 2000s bore witness to the changing values in the public services. As noted earlier, the market values of NPM resulted in specialisation and fragmentation in the public service. NPS attempts to correct such problems by promoting democratic values through networking and cooperation between political and managerial structures (Bourgon, 2008; Durose & Rummery, 2006). Networks are complex links between individuals and organisations, driven by the interests of parties and their recognition of the value of working together (Southon, Perkins, & Galler, 2005).

Under NPS, the government becomes a part of a network which is conceptualised as mutually dependent on other actors, although the government may have superior access to resources and other participants (Gill et al., 2011; Rhodes, 1994). The primary role of the government is to help citizens articulate and achieve their shared interests rather than attempt to control or steer society (Maesschalck, 2004). While entrepreneurialism and authority are the mechanisms applicable to NPM and traditional public administration, trust appears as the equivalent control mechanism for the network (Denhardt & Denhardt, 2000).

Collaboration and networking strategies have a major impact on accountability. New systems of accountability have been institutionalised through the use of performance indicators and performance management (Broadbent & Guthrie, 2008). Thereby, managers have a role in enhancing the legitimacy of the organisation and its outputs. Accountability is delivered managerially through performance and setting financial management objective targets through formal conventions of parliamentary accountability via ministerial responsibility (Gains & Stoker, 2009).

Denhardt and Denhardt (2000) claim that accountability under the NPS strategy is more complex than it was in the NPM era. Indeed, accountability

under NPS has been described as multifaceted. As NPS is built on democratic values, public services are not only accountable to the government and its private partners (the businesses and voluntary organisations) but also to statutory and constitutional law, community values, political norms, professional standards and citizens' interests (Denhardt & Denhardt, 2000). The accountability of politicians may become unclear and ambiguous in some senses (with the exception of their personal behaviour), and other forms of accountability relationships (i.e., those that are ministerial, parliamentary, managers/professional, financial, legal) are also ambiguous. For these reasons, "the lines of accountability remain blurred and now perhaps more uncertain and confusing to citizens than in the past" (Gains & Stoker, 2009, p. 446).

The above discussions highlight how changes in the framework of reform have led to a shift in the notion of public service delivery and the accountability approach. The summary of the relationship between these changes is reflected in Table 2.3

**Table 2:3 The frameworks of reform and the forms of accountability**

| The framework of reform | The framework of service delivery |                                  |   | Accountability approach  |
|-------------------------|-----------------------------------|----------------------------------|---|--|
|                         | <i>Responsive to</i>              | <i>Underpinning values</i>       | <i>Actor(s)</i>   |  |
| Bureaucratic            | Clients and constituents          | Controlling the use of resources | Government and public sector  | Hierarchical, highly focused on the principal-agent relationship   |
| NPM                     | Customers                         | Entrepreneurial; market; price   | Government and public sector, private sector, voluntary organisations | Mixture of hierarchical and horizontal accountability relationships; highly focused on legal and contractual relationships |
| NPS                     | Citizen                           | Social; democracy                | Government and public sector, private sector, voluntary organisations | Mixture of hierarchical and horizontal accountability relationship; high emphasis on collaboration and trust               |

## 2.4 Accountability and reform: The knowledge gap

This research was prompted by a desire to investigate accountability in the context of public sector reform. The adoption of NPM and NPS models of reform brought a new dimension to the role of the State and the framework of public service delivery. With the objective of improving efficiency in terms of cost and quality of public service delivery, private sector, and nongovernmental organisations (NGOs) have been invited to be the public partners in providing public goods and services. Following these changes, service delivery has evolved from a political activity to a technical issue, with greater emphasis placed on technical information such as accounting, budgeting, and performance measurement (Kluvers & Tippett, 2012). In relation to this development, the use of private institutions and management techniques was strongly promoted in the public sector.

Although these techniques have improved certain levels of efficiency, there are risks associated with these approaches, especially in relation to accountability (Aucoin, 1990; Barberis, 1998; Blanchard et al., 1998; Christensen & Laegreid, 2011a; Goldfinch & Wallis, 2010; Mongkol, 2011; Peters & Pierre, 1998; Rhodes, 1994). The existing research concludes that reforms appear to have only a limited ability to improve accountability (Dubnick, 2011) Indeed, in many instances, reforms have often been accompanied by declines in accountability (Jones & Kettl, 2003; Lodge & Gill, 2011; Peters & Pierre, 1998). Greitens (2012) associates limitations in improving accountability with the failure of policy actors to understand two important issues: first, the notions of accountability in terms of the context in which it has been practiced and; second the challenges of dealing with the complexity of multiple accountabilities in public organisations. Greitens (2012) concludes that accountability is strongly emphasised but rarely understood. Therefore, Greitens (2012) urges researchers in the area of accountability to question the meaning, purpose and value of accountability in the public sector because such questions are desperately needed to enable understanding of the failure of accountability.

Digging deeper into the existing literature related to public sector reform, accountability and the New Zealand public health system has led to a number of conclusions. The literature on accountability and reform has developed over many years through the work of scholars from various disciplines such as political science, public administration, management and accounting. This body of research seems to reflect the growing importance of the issues of accountability and reform in public sector. In this study, most of the literature stems from public administration, and accounting disciplines. However, those literatures are quite separate because the disciplines have concentrated on different research interests and have different focuses. From the public administration perspective, the existing studies have focused on the effects of reforms on mechanism accountability (see Lupson, 2007; Newman, 2004; Schillemans, 2010; Sinclair, 1995) and normative

accountability (see Considine, 2002; Dubnick, 2005; Dubnick & Frederickson, 2009; Koppell, 2005).

The extant research (as mentioned above) has explored accountability understanding among public managers and interviewed heads of public sector agencies which are responsible for varied functions and scope of services and examined the notion of accountability from a large public sector perspective. However, rather than concentrating on one specific State sector, the studies on mechanism accountability focused on various State sectors and regarded them as one large sector. Table 2.4 shows the summary of empirical research on accountability in the public sector. It also shows that the various public agencies from which the participants in the studies were recruited.

Previous research (as indicated in Table 2.4) has recognised the emergence of various accountability relationships in public organisations and the conflicts between them. In my opinion, the existing studies, however, have not offered much insight into how policy actors from a specific public sector understand accountability and how the level of understanding affects the accountability practices. As noted in Chapter One, public sector is not uniform in nature and each sector appears to adopt different reform strategies. Indeed, the existing literature has confirmed that accountability is a fluid concept as the meaning of accountability changes in line with changes in its environment, including types of organisation (Greitens, 2012; Newman, 2004; Sinclair, 1995). Therefore, I argue that the existing findings may be insufficient to explain the meaning of accountability for a specific public sector, for example, the public health service, education, or public utilities. For these reasons, this study suggests that there is a need to clarify the meaning of accountability in an explicit State sector.

**Table 2:4 The summary of accountability research in public sector**

| Author(s) (year)/Title  | Research Question(s)/Research Objective(s)/Participant(s)   |
|---|---|
| Sinclair, A. (1995)<br><i>The chameleon of accountability: forms and discourses</i>   | <p><b>Research Objective</b></p> <ol style="list-style-type: none"> <li>To investigate how CEOs establish their accountability to themselves and to others.</li> </ol> <p><b>Participants</b></p> <p>15 Chief of Executives of Australia public sector organisations.</p>   |
| Newman, J. (2004)<br><i>Constructing accountability: network governance and managerial agencies</i>                                     | <p><b>Research Objective</b></p> <ol style="list-style-type: none"> <li>To examine the implications of the New Public Management (NPM – the shift from bureaucratic ethos to managerial regime) for the concept of accountability.</li> </ol> <p><b>Participants</b></p> <p>35 senior staff from government office (various sector) who closely involved in implementing modernising reform.</p>  |
| Lupson, J. (2007)<br><i>A phenomenographic study of British Civil Servants' conception of accountability</i>                            | <p><b>Research Question</b></p> <ol style="list-style-type: none"> <li>What are individual Senior Responsible Owners' (SROs) subjective understandings of their accountabilities?</li> </ol> <p><b>Participants</b></p> <p>38 British civil servants.</p>   |
| Schillemans, T. (2008)<br><i>Accountability in the shadow of hierarchy: The horizontal of accountability agencies</i>                   | <p><b>Research Questions</b></p> <ol style="list-style-type: none"> <li>What forms of horizontal accountability are on rise?</li> <li>What are they actually contributed to the accountability of agencies?</li> <li>How are we to understand the role of new arrangement in the accountability regime of agencies?</li> </ol> <p><b>Participants</b></p> <p>70 respondents from 13 large Dutch agencies:</p> <ol style="list-style-type: none"> <li>Agencies manager and senior official,</li> <li>Members of Executive Boards,</li> <li>Clients,</li> <li>Other stakeholders, and</li> <li>Senior official from parents departments.</li> </ol>   |
| Schillemans, T. (2010)<br><i>Redundancy accountability: The impact of horizontal and vertical accountability on autonomous agencies</i> | <p><b>Research Questions</b></p> <ol style="list-style-type: none"> <li>Is accountability regime in practice redundant in the sense that agencies have to account for the same aspects of their behaviour towards vertical and horizontal accountability forum?</li> <li>If found to be the case, does redundant accountability then have advantages identified in the redundancy literature?</li> </ol> <p><b>Participants</b></p> <ol style="list-style-type: none"> <li>Executives and central staff,</li> <li>Members of boards, commissioners, and supportive staff,</li> <li>Members of evaluation committee and supportive staff, and</li> <li>Senior civil staff from parent department.</li> </ol> |

In contrast to the public administration perspective, the accounting discipline literature on public sector reform and accountability from has placed a greater focus on managerial or management accounting issues (see Broadbent et al., 1996; Broadbent & Guthrie, 2008; Broadbent & Laughlin, 2005; Hodges, 2012; Kelly, Doyle, & O'Donohoe, 2015; Olson et al., 2001; Roberts, 2010; Roberts & Scapens, 1985). Therefore, rather than examining the notion of accountability, accounting researchers tended to analyse how the accounting logic influences the level of public sector efficiency. This tendency arose because neoliberal reform is designed on the basis of accounting logic, and therefore, the notion of accountability is understood from an efficiency perspective. A similar pattern of emphasis can be identified in the context of the New Zealand public health system (see Cordery, 2008; Cordery, Baskerville, & Porter, 2010; France, 2001; Jacobs, 1997; Lawrence, 1999, 2005; Lawrence, Alam, Northcott, et al., 1994). The researchers in this area acknowledged the rise of accountability issues resulting from reforms but gave insufficient attention to the meaning of accountability in the context of reform.

There are strong disagreements from public administrative scholars concerning whether accountability is about efficiency. For instance, Christensen and Laegreid (2011a) argue that improved accountability and improved performance are two different things and do not necessarily pull in the same direction. Meanwhile, Jones and Kettl (2003) contend that reform per se is insufficient to ensure accountability, as reform is needed only to strengthen the governments' institutions and management. Consequently, the adoption of a new policy strategy with the objective of improving efficiency and accountability may not be achieved, as claimed by governments, because these two objectives are different.

At the same time, there is limited understanding of the challenges in practising postreform accountability. It has, however, been understood that the adoption of neoliberal reform has led to the formation of new forms of institutional arrangements for the public health system such as contracting-

out, joint commissioning, and centralised performance measurement. According to Hodges (2012) these new organisational arrangements require new interpretations for accountability because the traditional forms of health delivery and accountability have changed significantly.

Moreover, the existing research related to accountability generally, and in the context of New Zealand public health reform specifically, has focused on a specific stage of reform. For instance, Lawrence (1999, 2005) and France (2001) analysed the implementation of radical market-based reform between 1993 and 1999, whilst Cordery (2008) examined accountability relationships during the DHBs and PHOs system between 2000 and 2008. Although Gauld (2012) and Cumming (2011) studied post-2008 reform, their research did not include discussions of accountability. The research related to reform and accountability in the New Zealand public health system seems limited, and the question of how accountability is understood and practised within a health care system experiencing continuous reform, therefore, remains unanswered. Although Bovens (2010) suggests accountability should be defined from its normative and mechanistic concepts, the effects of reform on accountability meaning and practices in the context of reform remains unclear.

According to Du Gay (2000), understanding basic administrative concepts such as accountability is important for policy actors because that understanding will influence the actions of policy actors in organisations. Newman (2004) also suggests that the ability of policy actors to interpret and construct concepts of accountability will support achieving policy results. In relation to the gaps in our understanding of accountability, this study proposes to identify how accountability is understood and practised in the context of continual public health reforms. To address the knowledge gap, this study asks the following research question:

What does “accountability” mean in the ever-changing New Zealand health system?

## 2.5 Chapter summary

This chapter discussed how the idea of this research were generated and developed. The chapter began with a review of current understandings of accountability concepts and its practices. The meaning of accountability is underpinned by two basic concepts known as normative accountability and mechanism accountability. These concepts define accountability from different perspectives but they are complementary in practice. The problem of accountability is embedded in its underpinning concepts. For this reason, the notion of accountability is ideal in concept but complex in practice. The chapter then moved further to a discussion of the underpinning models of reform i.e., NPM and NPS. These models are rooted in the concept of neoliberal reforms, but are each driven by different strategies. The shift from NPM to NPS resulted in constant changes in the public sector and accountability. Studies related to accountability and public sector reform were discussed in terms of research interests and focus. Although Bovens (2010) defined accountability from normative and mechanistic perspectives, the existing studies are inadequate in explaining the notion of accountability in the context of public health reform.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

The purpose of this chapter is to discuss the research concepts that underpin the method employed in this study. In order to develop phenomenological insights about the meaning of accountability in the context of policy reform, this study adopts a qualitative methodology as the research design, and a critical hermeneutics approach as a strategy of inquiry. The discussion begins with a review of what we already appear to know about the accountability concept, and justifications for employing a qualitative methodology as the philosophical orientation for this study. The next section describes the rationales for adopting interpretive enquiry and a hermeneutic approach as a basis of research inquiry. I then provide some explanation of the hermeneutics approach, its concepts, and its application in this study before concluding the chapter with a brief summary.

#### **3.2 Knowledge claim**

Although there has been considerable research in the area of accountability, the meaning of accountability remains difficult to define. Chapter Two revealed that the implementation of active and diverse reform approaches has increased the degree of accountability complexity which, as a consequence, reduces the original functions and roles of accountability in organisations. However, the extent to which accountability is experienced, especially in any given State sector, seems difficult to explain. I argued, therefore, that the meaning of accountability in a particular State sector needs clarification because each sector has adopted different types of reform. Therefore, the meaning of accountability across State sectors may be different because as Sinclair (1995) claims the meaning of accountability will change according to “ideologies, motifs and language of our times” (p. 221).

Furthermore, there is a call to investigate accountability in the context of the New Zealand public health system further because the existing research has focused on a managerial accountability perspective rather than on how accountability is understood in the context of reforms (see Boston & Gill, 2011; Brandsma, 2007; Broadbent & Guthrie, 2008; Christensen & Laegreid, 2011a; Haque, 2000, 2007; Mulgan, 2000). The New Zealand public health system has experienced an ongoing series of policy changes since 1984, and these changes have had significant effects on accountability conceptions and practices (see Cordery, 2008; Cordery et al., 2010; France, 2001; Jacobs, 1997; Lawrence, 1999, 2005; Lawrence, Alam, Northcott, et al., 1994). This study aims to provide some understanding of how accountability is understood and practised in the context of the New Zealand public health reforms. As such, the central research question is: what does accountability mean in an ever-changing New Zealand health system.

According to Dew (2007), the research aims will determine the methodological approach to be taken and the forms of data collection and analysis to be deployed because research aims are influenced by particular ontologies and epistemologies. Ontology is a set of assumptions or beliefs about the existence of different worldviews regarding the phenomena under study (Chua, 1986; Morgan & Smircich, 1980). Cresswell (2003) describes epistemology as theory or knowledge embedded in the theoretical perspective that informs a researcher on ways of obtaining knowledge. To identify an appropriate methodological approach, I conducted an extensive literature review to understand the worldview and knowledge claim of accountability.

Much of the existing research reported that accountability is embedded in the area of subjective reality (Cordery, 2008; Messner, 2009; Mordaunt, 2006; Mulgan, 2000; Newman, 2004; Sinclair, 1995); that accountability is intangible, and its conception is continually constructed and is based on individual's subjective meanings of their own personal experiences (Cordery, 2008; Newman, 2004); and, that accountability evolves as an organisation or

a country moves forward (Kim, 2009; Sinclair, 1995). The ontological views on accountability indicate that the reality of accountability is subjective in nature because it can be viewed differently by different people and from different situational context. The subjective reality of accountability indicates that the epistemology of accountability is acquired and analysed through, for example, the experience of public health managers who are involved in dealing with reforms and policy changes. Therefore, based on these positions, a qualitative methodology was considered the most appropriate research design for this study.

A qualitative methodology was chosen because this methodology emphasises the collection of first-hand materials in a natural setting (Denzin & Lincoln, 2013; Llewellyn, 1993; Malterut, 2001; Silverman, 2005). It was seen as the most accessible mode of entry for a study searching for a holistic, rich, and contextualised understanding and critique of lived experiences, social settings, and behaviours from a “micro perspective” (Parker, 2012, p. 55). Furthermore, this methodology is characterised by its aims, which relate to understanding some aspect of social phenomena which can be expressed through a number of media such as conversations, and written texts; and in visual forms including images, videos, and music (Grossoehme, 2014; Patton & Cochran, 2002). Dobuzinskis (1997) claims that these advantages make a qualitative methodology one of the best ways to understand how individuals create meanings through their experiences.

However, qualitative-based research consists of a set of complex interpretive practices because it has no theory or paradigm that is distinctly its own (Denzin & Lincoln, 2013). According to Denzin and Lincoln (2013) the choice of research strategy and method “depends upon the questions that are asked, and questions depend on their contexts, what is available in the contexts and what the researcher can do in that setting” (p. 8). Based on the research gaps identified in Chapter Two, the main research question set for this study was: what does “accountability” mean in the ever-changing New Zealand health system? In particular, this study was interested to understand: first, how

reforms shaped the meaning of accountability and its practices in the contexts of reforms; and secondly, how the experience of dealing with reforms, policy changes, and accountability was understood by policy actors. In order to understand the experience of policy actors, a hermeneutics approach was adopted as the research inquiry strategy. Hermeneutics is designed for researchers who are interested in studying what an experience means to a particular group (Byrne, 2001; Rinnie, 2012). The following section discusses further the hermeneutics approach as the strategy of inquiry for this research.

### **3.3 Hermeneutics as the strategy of inquiry**

According to Denzin and Lincoln (2013), “all research is interpretive, guided by a set of beliefs and feelings about the world and how it should be understood and studied” (p. 29). Interpretative inquiry offers a major advantage when studying a complex phenomenon because it not only has the capacity to describe events but can also help the researcher to understand how and why the same events are interpreted differently by different stakeholders (Guba & Lincoln, 1994; Sofaer, 1999).

Interpretive inquiry differs from positivism which sees the researcher and research as an independent subject and object. Interpretive inquiry, by contrast, believes in a close relationship between researchers and their research. Closeness in the relationship between the researcher and researched is important because it contributes to intrinsically meaningful research (Guba & Lincoln, 1994). Indeed, having this type of relationship is an advantage as researchers will often attempt to address the connection between themselves and their research objects, and between meanings and practices (Llewellyn, 1993).

Interpretive inquiry allows researchers to learn about the reality of accountability from the experience of social actors who engage in a specific social context (Blaikie, 2007; Crotty, 1998). According to Blaikie (2007), this

strategy allows social reality to be discovered from the 'inside' rather than 'outside' as the meaning or the truth of social reality is developed and transmitted within an essentially social context. The challenge for interpretive researchers is to understand the meaning of texts rather than to measure, generalise and predict outcomes from the data (Walker, 1996).

Hermeneutics is one of the available strategies of inquiry for interpretive research. The history of hermeneutics began in Germany in the 17th century around the time of the Protestant Reformation in Europe (Prasad, 2002). Protestant scholars tried to identify the literal meanings of the Torah and so engaged in biblical exegesis in order to provide explanations that could address the theological controversies that were emerging at that time (Blaikie, 2007; Byrne, 2001). This approach came to be recognised as a method of [biblical] interpretation because it provides new information that 'enlightens' a person's rationality in a specific situation. According to Blaikie (2007), in its early development, hermeneutics aimed "to understand texts written in radically different times and situations" (p.117).

The tradition of hermeneutics is located under the overarching interpretative paradigm and is closely related to the qualitative methodology (Arunachalam, 2010; Gummesson, 2003; Laverty, 2003; Llewellyn, 1993; Patterson & Williams, 2002). The goal of hermeneutics is human understanding: i.e., understanding what people say and do, and why (Myers, 2013, p. 182). Hermeneutics is also seen as an attempt to discover meanings and to achieve understandings of a particular context, along with ways of being and practice in lived experience (Blaikie, 2007; Wilson & Hutchinson, 1991). As a theory of interpretation (Gummesson, 2003; Phillips & Brown, 1993), hermeneutics concentrates on the historical meanings and development of people's experience and texts, in addition to considering their effects on individuals in a specific social context (Laverty, 2003; Myers, 1994; Prasad, 2002).

In practice, hermeneutics provides systematic approaches which enable the researcher to investigate the multiple and complex meanings of texts by

extending the meaning of any human action, product of expression, or institution that can be treated as text (Balfour & Mesaros, 1994; Lejano & Leong, 2012). By analysing textual evidence such as policy documents, interview transcripts, and archival information, researchers are able to derive narrative interpretations and illuminate issues that better reflect “situated agencies” (Hay, 2011, p. 175). The process of analysing focuses on the author’s point of view regarding the texts and the context in which the texts were produced. Hermeneutic interpreters are guided by a dialectic process, called the hermeneutic circle which requires a constant dialectic between the understanding of the text as a whole and the interpretation of its parts. The aim of dialectic process is to make the studied object clearer and sensible (Myers, 2013), and the study is presented as “people’s detailed stories” (Wilson & Hutchinson, 1991, p. 25).

Hermeneutics has developed over time and changed from “recovery of meaning” to “interpretation of meaning” (Llewellyn, 1993, p. 235). These distinctions can be traced through the three-fold classification of hermeneutics, namely, classical hermeneutics, philosophical hermeneutics, and critical hermeneutics (Prasad, 2000). In the following subsections the three categories of hermeneutics methodology are discussed.

### **3.3.1 Classical hermeneutics**

The history of classical hermeneutics was influenced by the work of Friedrich Schleiermacher (1768-1834), the father of modern hermeneutics, who introduced hermeneutics as a general theory of interpretation (Prasad, 2002). According to Schleiermacher, “hermeneutics is a part of the art of thinking, and is therefore philosophical” (Osborne, 2011, p. 70). However, Schleiermacher’s theory of interpretation provided a set of tools and techniques for understanding parts or passages of a text that may be difficult to understand (Prasad, 2002).

For Schleiermacher, a text has fixed meanings, and, therefore the goal of classical hermeneutics is to recover the authors' original intended meaning by re-experiencing the author's original intention (Chenari, 2009; Prasad, 2002). In order to achieve that goal, the interpreter has to enter the world of the author (Osborne, 2011). In this sense, interpreters must put themselves both objectively and subjectively in the position of the author and reconstruct every part of the expression in a way that captures the author's perspective (Chenari, 2009). Sitting in the author's position allows the interpreter to understand the original meaning of the text and helps the interpreter to produce a better understanding of the original author (Osborne, 2011).

The process of interpretation involves two strategies which Schleiermacher called 'grammatical interpretation' and 'psychological interpretation'. The grammatical interpretation strategy draws upon the lexicon of the language, and seeks to root the text in a particular historical and cultural context (Mallery, Hurwitz, & Duffy, 1987). Specifically, Osborne (2011) explains this strategy as follows: " It gives primacy to the language of the original author and original audience . . . and, every word in a given location must be determined according to it being-together with those surrounding it" (p. 70). Schleiermacher believed that the interpretation using a language mechanism develops a rich understanding of a social phenomenon because the grammatical interpretation corresponds to the linguistic aspect of understanding (Thompson, 1981).

However, using the grammatical interpretation alone will lead to 'quantitative misunderstanding' especially when interpreters deal with poetry or allegory (Osborne, 2011). Therefore, Schleiermacher suggests the use of the psychological or technical interpretation strategy to support a grammatical interpretation technique. According to Schleiermacher, the personality behind the text or the style of the author is important in the process of interpreting because it helps the interpreters to understand the discourse according to the author's presentation of thoughts (Osborne, 2011;

Rinnie, 2012). In other words, this strategy requires the interpreter to seek out the personality of the author so as to enable the interpreter's better understanding of the text.

Schleiermacher stressed that the interpreter can never attained complete knowledge using either the grammatical or the psychological strategy alone as no rules specify how to do so. These two strategies must be employed together as they complement each other. Interpreters are advised to repeatedly consider and reconsider the relationship between the whole and its parts. This process is called the 'Schleiermacher circle' (Osborne, 2011). Schleiermacher stressed that in working through this circle, interpreters must employ 'divinatory knowledge' and 'comparative knowledge'. On the one hand, Schleiermacher regarded divinatory knowledge as 'feminine principles' since the process of understanding includes empathy (projective introspection) and intuitive linguistic analysis (Mallery et al., 1987). The practice of divinatory knowledge enables the interpreter to assimilate the mental universe of another person (the author) (Arunachalam, 2010; Osborne, 2011). On the other hand, comparative knowledge was known as 'masculine principles' because the process of understanding involves analysing and comparing the knowledge. According to Gadamer (2006), Schleiermacher's conception of hermeneutics establishes a foundation of hermeneutics at a deeper level than existed before. Schleiermacher transformed hermeneutics from a technique to a general theory for regulating the process of understanding and interpreting texts (Prasad, 2002).

The legacy of Schleiermacher's hermeneutics was then continued by Wilhelm Dilthey (1833-1911). Dilthey enhanced Schleiermacher's psychological strategy by introducing the concepts of 'human individual' and 'lived experience' (Osborne, 2011). Consequently, the concepts of human individual and lived experience became new grounds for a psychological strategy as they led to the distinction between expression and meaning. According to Dilthey, while natural science aims at explanation, human and social sciences

focus on understanding as all social phenomena arise from human externalisation or objectification of individuals' feelings and experiences (Prasad, 2002). Since experience can be seen in the historical context, Dilthey stressed that interpretation of historical documents needs to be done in the context of history (Tan, Wilson, & Olver, 2009).

Hence, in Dilthey's view, the task of interpretation was depicted as "an emphatic grasping, reconstructing, and re-experiencing by one human mind (namely, the interpreter's) of the mental objectifications (e.g., texts, legal structures, historical processes, etc.) produced by other human minds" (Prasad, 2002, p. 15). In his later work, Dilthey recognised five sources of understanding which are derived from the historical and social context of the authors, namely, language, literature, behavioural norms, art, and religion (Tan et al., 2009). With this recognition, Dilthey expanded the concept of hermeneutical interpretation for understanding ancient and biblical texts to encompass human's experiences and actions. However, he retained the objectivist approach in the process of understanding. Dilthey also extended the application of Schleiermacher's general theory of interpretation to other social studies, such as legal or economic systems and the like (Prasad, 2002). In relation to this development, hermeneutics was recognised as an interpretive art in the human sciences.

### **3.3.2 Philosophical Hermeneutics**

Philosophical hermeneutics is related to the work of Martin Heidegger (1889-1976) and Hans-Georg Gadamer (1900-2002). This hermeneutics category is not a continuity of classical hermeneutics, but rather a contrast as it emphasised a different concept and strategy (Mallery et al., 1987; Prasad, 2002). For instance, classical hermeneutics is concerned with creating perspective theories for regulating interpretive practice, whilst with philosophical hermeneutics the emphasis is more on the philosophical issues surrounding the interpretation (Prasad, 2002).

The history of philosophical hermeneutics started with Heidegger's definition of the concept of understanding. Heidegger was trained by Edmund Husserl (1859-1938), a philosopher, mathematician and founder of phenomenology in the area of phenomenological intentionality and reduction. Heidegger, however, disagreed with Husserl regarding the issue of exploring lived experiences. Consequently, Heidegger dissociated himself from Husserl's work and developed his own concept of understanding based on the interpretation of human lived experience (Gadamer, 2006; Lavery, 2003). In his work, Heidegger was more interested to identify "what kind of being is it whose being consists of understanding?" (Geanellos, 2000, p. 113)

Heidegger introduced the concept of 'dasein' which literally means 'being-in-the-world' (Mallery et al., 1987). Dasein is an ontological concept of hermeneutics which developed from the nature of human existence called 'the mode of being human' or 'the situated meaning of a human in the world' (Lavery, 2003; Prasad, 2002). For Heidegger, understanding is a basic form of human existence, and interpretation is significant to the process of understanding (Jahnke, 2012; Lavery, 2003). Heidegger argued that dasein consists of both historical and finite criteria because in one's real life, things are perceived according to individuals' experiences (Mallery et al., 1987; Thompson, 1981).

In explaining the ontology of dasein, Heidegger introduced the concept of 'understanding' (Prasad, 2002). For Heidegger, understanding is about "the way we are" and not about "the way we know the world" (Lavery, 2003, p. 24). Thereby, understanding can be reached through a repetitive interpretation process called the 'hermeneutics circle', (Koch, 1996). Heidegger's hermeneutic circle involves two main stages, namely preunderstanding and understanding (Dobrosavljev, 2002; Koch, 1996; Lavery, 2003). Heidegger argued that "any interpretation which is to contribute understanding, must already have understood what is to be interpreted" (Spanos, 1976, p. 462). Thus, understanding is considered as happening when there is a change in the mode of understanding i.e., from the

preunderstanding stage (a part of the experience) to the understanding stage (the whole part of the experience) (Dobrosavljev, 2002; Koch, 1996; Laverty, 2003).

For Heidegger, as a part of understanding, preunderstanding is critical because all interpretations are derived from this stage. However, the preunderstanding knowledge of interpreters differs as it is primarily influenced by the individual's own background, culture and experiences (Laverty, 2003). The application of Heidegger's hermeneutic circle in the process of interpreting meanings or understanding in a particular social phenomenon is largely influenced by the individual's history and experiences. Heidegger argued that without preunderstanding knowledge, it is difficult to form understanding (Tan et al., 2009).

Heidegger's conception of understanding changed the fundamental concept of hermeneutics from a theory of interpretation to a theory of existential understanding (Mallery et al., 1987). Heidegger's work was further extended by another philosopher, Hans-Georg Gadamer. Based on Heidegger's ontological structure of being human, a more systematic approach to hermeneutics was introduced by Gadamer (Schmidt, 2006). However, the work of Gadamer has centred mainly on epistemological understanding and is concerned with the experience of truth or how understanding happens (Chenari, 2009; Jahnke, 2012; Svenaeus, 2003).

Gadamer (1996) claimed that the task of hermeneutics is to clarify the interpretive conditions in which understanding takes place. However, a definitive interpretation according to Gadamer is difficult to reach as understanding and interpretation are bound together (Laverty, 2003). Understanding is more likely to happen if the process of interpretation involves participation or interaction between interpreters and their researched texts or objects. Gadamer regarded such a process as 'productive' for the interpretation in understanding texts (Chenari, 2009). The adoption of a productive interpretation process would result in the fabrication of new

meanings rather than reproduce the overall original intents (Arunachalam, 2010; Chenari, 2009; Jahnke, 2012).

Gadamer (1975) argued that interpretations can never reproduce the author's original meanings because by nature, interpreters have their own preunderstanding or prejudice knowledge which is formed within their own history and tradition. Consequently, interpreters always understand the 'same thing' differently. Gadamer (1975) defined prejudice as "a judgment that is given before all the elements that determine a situation have been finally examined" (p. 240). Gadamer (1975) does not conceive of prejudice as a negative or a false judgement. Rather, he proposes that it can be considered as a part of an idea that has both a positive and a negative value. Since prejudice is something that is unavoidable, Gadamer (1975) suggests that interpreters identify "true prejudices" through justification of rational knowledge (p. 242).

In principle, Gadamer agreed with Heidegger that the process of interpretation starts with a preunderstanding or prejudice. However, in a productive interpretation, dialogue is an essential process in coming to an understanding (Austgard, 2012). According to Gadamer (1975), an event or a truth occurs when interpreters understand the concept of the text. As understanding can be found only in its application, and not in any original meaning of the text, Gadamer introduced the concept of a 'fusion of horizons' which is also known as a dialectical interaction between the interpreter and the text (Chenari, 2009; Dobrosavljev, 2002; Gadamer, 2006; Kinsella, 2006). This concept was shaped by three factors, namely, the effect of history, the tradition of cultural practice and the language (Chenari, 2009; Gadamer, 1975).

For Gadamer, because interpreters are nurtured by their own experiences and traditions, they usually possess their own unique horizon of understanding (Chenari, 2009). Gadamer (1975) defined a horizon as "the range of vision that includes everything that can be seen from a particular

vantage point” (p.269). Interpreters usually speak in a narrow horizon, and therefore, horizons must be expanded by opening up new horizons through a continuous dialectical process among interpreters, and between interpreters and texts. Gadamer (1975) portrayed horizons as below:

The horizon is rather something into which we move and that moves with us. Horizons change for a person who is moving. Thus the horizon of the past, out of which all human life lives and which exists in the form of tradition, is always in motion. It is not historical consciousness that first sets the surrounding horizon in motion. But in it this motion becomes aware of itself (p. 271).

The process of expanding the horizon of understanding is also known as the hermeneutics circle. The circle involves a process which moves back and forth movement of the entire text, to its parts, and back to the entire text again. The back-and-forth movement in the dialectical process not only refers to the entire text and parts of the text but also involves communication between people and texts. For Gadamer, understandings can never be absolute knowledge nor ever be fully satisfied, as self-knowledge is subjected to “self-renewal and self-activation through the rediscovery and restoration of one’s relationship to tradition” (Colburn, 1986, p. 371). Therefore, the process of interpretation in the hermeneutic circle should be practised in a continually unfolding interaction or dialogue between the texts and traditions

Similar to Heidegger, Gadamer also was concerned about the importance of language, especially in the process of expanding the horizon of understanding. According to Chenari (2009), Gadamer believed that history and tradition are expressed within language as language is viewed as a fundamental medium through which we understand the world. Language not only refers to the texts in which knowledge is documented but also involves conversation because understanding comes to exist in dialogue. Therefore, the language in the context of hermeneutics acts not just a ‘fact’ but as a ‘principle in the process of interpretation because all human knowledge of the world is

linguistically mediated (Gadamer, 2006). While reading a text, an interpreter continues to read with the aim to understand the text. The process of reading also permits the interpreter to experience the text and to understand the language of the text in light of the prejudices brought by the interpreter into the text.

The work of Heidegger and Gadamer emphasised the subjective approach as they rejected the assumption of classical hermeneutics that texts have definite meanings. In order to produce a productive meaning, Heidegger and Gadamer offered a model of interpretation, called the hermeneutics circle, and provided explicit explanations about the concept and the process of understanding. Since the process of interpretation is believed to happen in the subjective world, distinctions between understanding and interpretation are no longer maintained under the philosophical hermeneutics and these concepts were used interchangeably (Prasad, 2002).

### **3.3.3 Critical Hermeneutics**

Despite the increasing use of critical hermeneutics in various disciplines, including education (Ghasemi, Taghinejad, Kabiri, & Imani, 2011), nursing (Geanellos, 2000; Koch, 1996), communications (Phillips & Brown, 1993), and, information systems (Myers, 1994), a systematic definition of critical hermeneutics remains difficult to unearth due to the dearth of studies on this concept (Roberge, 2011). Critical hermeneutics seeks to integrate explanation and understanding in a constructive dialectics which is noted in texts (Thompson, 1981). It has been recognised as an innovative strategy of enquiry resulted from the polemics between Hans-George Gadamer and Jurgen Habermas during the 1960s and 1970s (Myers, 1994; Roberge, 2011).

The criticism by Habermas of the work of Gadamer revolved around three major issues which related to the limitation of philosophical hermeneutics in the context of critical theory. First, philosophical hermeneutics was criticised because of a lack of critical values as it takes interpretation at a face value

(Myers, 1994). As discussed earlier, the original function of hermeneutics focused on describing the process of recovery of meanings. As hermeneutics developed, the original function of hermeneutics changed from recovery of meanings to the interpretation of meanings (Llewellyn, 1993). The changes, however, were concerned only with improving the process of understanding a text in terms of the text itself. For instance, the implementation of the hermeneutic circle, according to Colburn (1986), affords only the opportunity of self-renewal and self-activation through the recovery and restoration of one's relationship to traditions but is unable to produce any new meanings which may hide in the texts.

Secondly, Habermas acknowledged the usefulness of Gadamer's methodological standpoint in the context of social sciences. However, Habermas argued that the functions of Gadamer's philosophical hermeneutics are limited within the framework of critical theory, especially when dealing with society's emancipatory, ideology and communication issues (Colburn, 1986; Roberge, 2011). For Habermas, interpretation should be implemented not only in the context of the history or tradition of the texts or participants but it should also be extended in the context of social structures which enables the formation of meaningful understanding (Myers, 1994). Habermas believed that the process of understanding would be more meaningful if interpreters were to critically evaluate the totality of understanding in a specific situation (Myers, 1994). Debates on this issue resulted in the insertion of emancipatory concept in the process of interpretation. Adapting this concept in critical hermeneutics enables researchers to make known the lived experience of a person.

Specifically, Habermas disagreed with Gadamer on the issues related to tradition and culture and the influence of these factors in the formation of prejudice (Prasad, 2002). For Habermas, tradition or culture is not something that is naturally created because Habermas believed that they are actively constructed by people through critical self-reflection (Mendelson, 1979; Prasad, 2002). Habermas agreed with Gadamer that prejudice is an

unavoidable factor in the process of interpretation. Yet, interpreters should not accept all prejudices as legitimate prejudices since the individual's self-reflection will filter and alter all the prejudices according to the interpreters' backgrounds and histories (Prasad, 2002). Critical hermeneutics research requires researchers to be familiar with the historical context of the text or phenomenon that being investigated. However, to generate independent and critical understanding, researchers must first differentiate between productive prejudice and unproductive prejudice using self-reflection (Davey, 2015).

Thirdly, Habermas recognised Gadamer's views on the importance of language in the process of interpretation. Habermas agreed with Gadamer that language plays a central role in the process of interpretation as it has the ability to connect all social institutions. However, Habermas believed that interpretation could be influenced by the forces of ideology because critical theorists view language as an "ideological infection" (Jacobs, 2014, p. 306). Habermas claimed that the language structures continually altered and inevitably became "a medium of domination, deception and social power" or "sedimented violence" due to the influence of an interpreter's ideology (Prasad, 2002, p. 22). For this reason, the results of the interpretation will not be genuine (Jacobs, 2014). To limit the influence of individual ideologies, Ricoeur introduced the concept of 'distanciation' (further discussion is offered in the next paragraph).

The Habermasian and Gadamerian debates lasted for nearly a decade. However, most scholars regarded this series of debates as 'a family quarrel' because the source of the tensions was apparently rooted in differences in the worldviews and knowledge claims of Habermas and Gadamer (see Prasad, 2002; Roberge, 2011). Under the influence of the insights of Habermas and Gadamer, Paul Ricoeur (1913-2005) formulated some propositions to address their debates. Ricoeur believed that critical theory and philosophical hermeneutics are mutually dependent. He argues that critical theory is

necessary as philosophical hermeneutics requires critical values to deepen the understanding (Mootz, 2006; Ricoeur, 1974; Roberge, 2011).

Ricoeur reconciled Habermasian and Gadamerian debates through propositions called the theory of interpretation. This theory has transformed hermeneutics from a narrowly defined method to a broad epistemology and philosophy of understanding (Prasad, 2002). Ricoeur believed that hermeneutics has to remain its focus on textual interpretation but the process of understanding should develop with explanation which takes into account the influence of language, reflection, understanding and the self (Geanellos, 2000; Thompson, 1981).

This new form of interpretation theory has been regarded as critical because the changes proposed by Ricoeur involve a number of radical moves. Firstly, Ricoeur removed the principle of *the authorial intent* – “the idea that the meaning of a text resides only with its author” (Geanellos, 2000, p. 113). According to Ricoeur, “a text takes on a life of its own” (Myers, 2013, p. 187), meaning that a text is autonomous, objective, and independent from its original author. This principle allows researchers to move from text rigidity and provide interpretation beyond the notion that only one understanding is meaningfully correct (Tan et al., 2009). To enable interpretation beyond one understanding to happen, Ricoeur acknowledged the concepts of textual plurality and multiplicity, and, therefore, he believes that texts have many meanings and that interpreters may interpret the same text differently (Myers, 1994).

Secondly, to support the autonomisation principle, Ricoeur emphasised the concept of *distanciation*: a process whereby the researcher objectifies the text by “freeing it from the author’s intentions and giving it a life of its own (Geanellos, 2000, p. 113). In other words, researchers are recommended to interpret historical data through their own lenses. The principle of *distanciation* is important as it is believed to increase researchers’ *appropriation* (Geanellos, 2000, p. 114). Philosophically, *appropriation* has

its foundation in Gadamer, where it refers to “the concept of making something one’s own” (Geanellos, 2000, p. 114). Ricoeur expands Gadamer’s concept of appropriation by defining it in this way: “the interpretation of text culminates in the self-interpretation of a subject, who thenceforth understands himself better, understands himself differently, or simply begins to understand himself” (Tan et al., 2009, p. 8). Thus, appropriation means that interpreters can only understand the meaning of texts which they are engaging or appropriating for themselves. Ricoeur believes the inclusion of the appropriation concept will possibly enhance one’s understanding of oneself.

Thirdly, to enable deeper understanding, Ricoeur extended the concept of the hermeneutics circle. For Ricoeur, the process of interpretation involves not only continual movement between the parts of and the whole understanding, but also includes interpretation of expressed and unexpressed information. Ricoeur’s idea related to his arguments that social actions and situations should be considered as texts which can be used for interpreting social meanings (Butler, 1998). However, spoken words are found to be inadequate for expressing meanings because the story tellers (interviewees) sometimes use inappropriate words to describe their experience (Eilifsen, 2011). In detail, Eilifsen (2011) states:

Words allow us to express our thoughts, meanings, feelings or dreams, so that other people can learn to know the truth about us. Words can also hide or express the wrong meanings and sometimes we do not have the right words in mind (p.1).

Therefore, interpretation of expressed and unexpressed information is believed to generate a deeper meaning (Myers, 2013). In this process, interpretive understanding is generated in a continual movement between the parts and the whole until a larger and deeper understanding is established (Geanellos, 2000). Combining the hermeneutics circle with interpretation of expressed and unexpressed information resulted in three

stages of understanding process, namely preunderstanding, understanding and comprehensive understanding.

Ricoeur's propositions contribute to the development of contemporary hermeneutics called critical hermeneutics. Although there is no definite definition for critical hermeneutics, it has been perceived as an integrative theoretical framework combining philosophical hermeneutics and critical theory (Myers, 1994). In other words, critical hermeneutics goes one step further than traditional hermeneutics and critical theory. However, the interpretive act for hermeneutics scholars is one that never reaches an end because there is always a possible alternative interpretation that could emerge during self-critical reflection (Davey, 2015; Myers, 2013).

### **3.3.4 Summary of hermeneutics approach**

Table 3.1 summaries the criteria for each hermeneutics classification: classical, philosophical and critical based on discussions of hermeneutics development in section 3.3. From the summary, it can be observed that the three-fold hermeneutics classification was underpinned by different interpretation goals, and methods but the process of interpreting and understanding the meaning of texts can employ the same hermeneutics concepts. For example, to understand the present situation of a research phenomenon, hermeneutics approach requires researchers to review the history of their research phenomenon. Reviewing historical facts of a research phenomenon is important because it helps researchers to build their preunderstanding knowledge that can be used to assist for the next level of understanding. However, classical hermeneutics reviews the history of a research phenomenon from the authors' points of view whilst philosophical and critical hermeneutics require researchers to understand the history through individuals prejudice (the influence of language, culture and experience). Nevertheless, because critical hermeneutics aims to generate independent and critical understanding, researchers are demanded to filter their prejudice between productive and unproductive ones. This is

because unproductive prejudice will not be able to enhance understanding (Prasad, 2002). It can be observed that the process of interpretation using different hermeneutic methods will generate different levels of understanding.

**Table 3:1 Summary of hermeneutics classifications and criteria**

| <b>Criteria</b>     | <b>Classical hermeneutics</b>  | <b>Philosophical hermeneutics</b>   | <b>Critical hermeneutics</b>  |
|---------------------|--|---|---|
| <b>Scholars</b>     | Friedrich Schleiermacher (1768-1834)<br><br>Wilhelm Dilthey (1833-1911)  | Martin Heidegger (1889-1976)<br><br>Hans-Georg Gadamer (1900-2002)  | Paul Ricoeur (1913-2005)  |
| <b>Goal</b>         | To recover the author's original meaning   | To understand something differently   | To integrate explanation and understanding  |
| <b>Techniques</b>   | Schleiermacher's circle of interpretation that based on: <ul style="list-style-type: none"> <li>• Grammatical</li> <li>• Psychological</li> <li>• emphasised on historical-based interpretation</li> </ul> | Hermeneutics circle based on: <ul style="list-style-type: none"> <li>• 'preunderstanding'</li> <li>• understanding</li> <li>• emphasised on the effects of prejudice, dialogue and fusion of horizon</li> </ul> | Interpretation is based on the three stages of understanding: <ul style="list-style-type: none"> <li>• Preunderstanding (emphasised on history but concerns only with valid/productive prejudice)</li> <li>• Understanding</li> <li>• Advanced understanding</li> </ul> |
| <b>Concept</b>      | Historicity<br><br>'Schleiermacher circle'   | Prejudice (history, experience, culture)<br><br>Hermeneutic circle (dialogue, fusion of horizon)  | Recognise all hermeneutics concepts: history, prejudice, hermeneutic circle; but link the process of interpretation with distanciation, and appropriation principles  |
| <b>Contribution</b> | Creating theories for regulating interpretation  | Identifying philosophical issues surrounding interpretation   | Introducing 'emancipatory' term – to make known the lived experiences and personal voices of the persons  |

As a guideline for interpretation process, Table 3.2 presents a general summary of all hermeneutics concepts and their criteria.

**Table 3:2 A Summary of hermeneutics concepts**

| Hermeneutics Concepts                   | Criteria  |
|---|---|
| <b>Historicity</b>                      | Understanding cannot be approached from a neutral position. It develops from the history of researchers' contexts of studies. History helps researchers to inform the present. As history evolves over times, it can never be correctly interpreted.  |
| <b>The hermeneutics circle</b>          | A constant interaction between researchers, and texts or their studied objects. The aim of the dialectic is to clarify understanding.   |
| <b>Prejudice</b>                        | Prejudice or preunderstanding is developed from prior knowledge that is established in the earlier process of understanding. Prejudice can be considered as an exploratory stage, where hermeneutics researchers attempt to understand the nature of their studied objects.   |
| <b>Autonomisation and distanciation</b> | In order to perceive a new meaning, researchers are suggested to distance themselves from their preunderstanding (including their own prejudices) and interpret the texts according to their own lenses. Therefore, researchers should make the text autonomous (by removing the authorial intent) and open to unlimited reading and understanding. |
| <b>Appropriation and engagement</b>     | The process of creating new meanings through autonomisation and distanciation will make researchers interact reflexively with the texts. Such interactions will take researchers to the next level of interpretation called appropriation and engagement and generate new meanings for the under study phenomenon.                                  |

In conclusion, the hermeneutics concepts and classifications will help researchers to understand a complex and contradictory phenomenon because the process of interpretation is perceived as being able to lead to in-depth analysis. However, in practice, it is not necessary for researchers to employ all the hermeneutics concepts because the possibility of using hermeneutics inappropriately and simplistically is relative high (Myers,

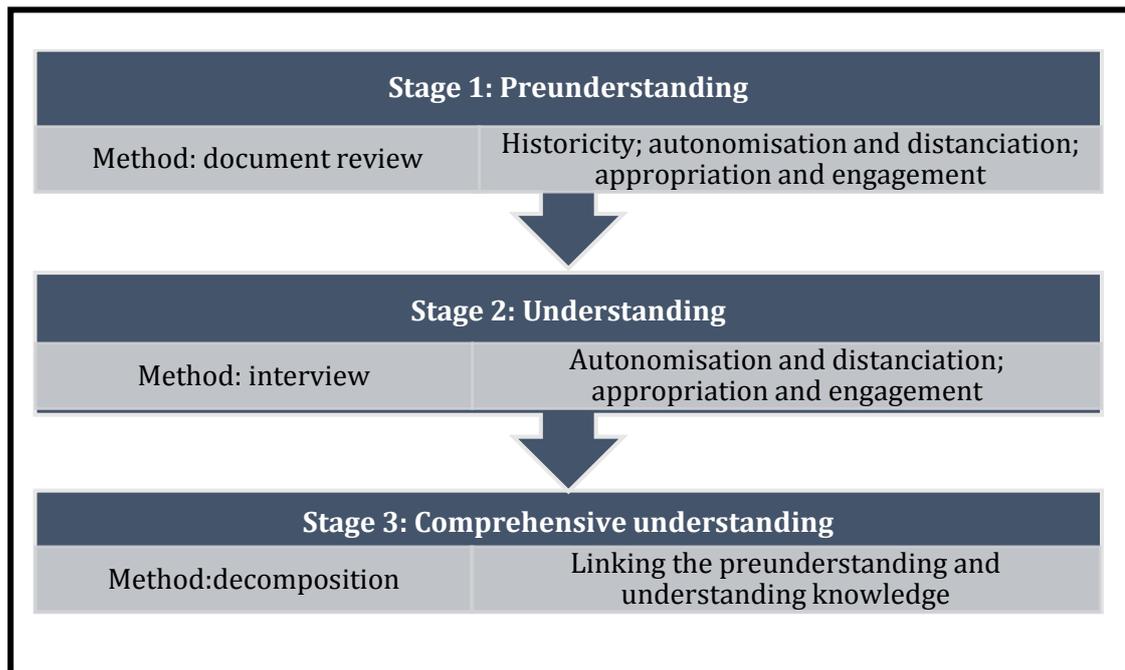
2013). Therefore, Myers (2013) suggests hermeneutics researchers match their research objectives with any hermeneutics classifications, and implement the process of interpretation using relevant hermeneutics concepts.

### **3.4 The application of critical hermeneutics in this study**

To answer the main research question in this study: what does accountability mean in an ever-changing New Zealand health policy, I adopted critical hermeneutics as a strategy of inquiry. Critical hermeneutics was chosen because the method offered by this approach was seen as appropriate for this study enquiry into how public health managers understand the notion of accountability and its practices in the context of constant policy changes.

The process of constructing knowledge in this study employed three concepts of hermeneutic, namely historicity, autonomisation and distanciation, and appropriation and engagement. These three concepts were chosen because they call for both active engagement and critical reflection during the process of understanding meanings. The three hermeneutics concept were implemented within Ricoeur's three stages of understanding: preunderstanding, understanding and advanced understanding. Each stage of understanding was driven by different research questions and complemented by different methods, namely document review and interview. Figure 3.1 shows the ways in which hermeneutics concepts were applied in developing my understanding about accountability in the context of public sector reform.

**Figure 3.1 The application of hermeneutics concepts**



Stage 1 aimed to answer the first research question: what changes in the public health system have taken place over the last four stages of reform and what were the rationales for them in terms of accountability? In particular, this stage was set to develop my preunderstanding knowledge about the New Zealand public health system and reforms. However, since I had a limited understanding of the New Zealand public health system at the beginning of this research project, my prejudice or judgement of public health reform in New Zealand was pretty much influenced by the information that I found during the research process. This study began with a review of the New Zealand public health reform history. The historical search was guided by the first research question, and therefore, this stage focused on collecting evidence related to the reasons for and formats of reform. I employed the concept of historicity in reviewing relevant documents with the aim to familiarise myself with the historical context of the New Zealand public health system.

The critical hermeneutics approach however, requires hermeneutics researchers to identify only valid (productive) prejudices in developing their understanding by distancing between researchers and their own prejudices.

Therefore, throughout the research process, I positioned myself as an outsider, and employed the concept of autonomisation and distancing; and, appropriation and engagement in the process of examining the historical background of New Zealand health. These concepts enabled me to understand fundamental issues, such as factors that shaped the public health system, reasons for implementing reform, and formats of reform through my own lens. However, the knowledge gathered at this stage provided only partial understanding of the whole. This knowledge was then used as a basis for further exploration in the second stage of understanding.

Stage 2 was designed to enhance my preunderstanding knowledge. This stage aimed to answer the second research question: what are challenges related to constant policy changes, and how do health managers feel about dealing with the changes in the public health system?; and the third research question: what are the public health managers' conceptions of accountability after encountering the succession of organisational changes? In particular, this stage was designed to uncover the participants' experiences of and beliefs about public health reform and their experiences in dealing with accountability requirements in the context of frequent policy change. This stage also attempted to provide some understanding of how accountability is understood and practised in the context of New Zealand public health reform. The hermeneutics concepts of autonomisation and distancing; and, appropriation and engagement were applied when analysing interviews.

Knowledge generated from preunderstanding and understanding however, contributes only to the construction of knowledge from the contexts of text and interpreter because such knowledge is based on apparent meanings. To construct deeper meanings, researchers must adopt the third stage of interpretation, called decomposition (this concept is discussed in Chapter Four). In particular, the third stage aimed to address the main research question: what does accountability mean in an ever-changing the New Zealand public health system. Combining information gathered from both

preunderstanding and understanding stages was expected to establish deeper understanding of health service reform and accountability.

### **3.5 Chapter summary**

This chapter presents a detailed description of the research orientation that underpinned this study. Since the subject of accountability was viewed as intangible and embedded in a subjective reality, this study took an interpretative paradigm and qualitative methodology as its research approach. In particular, the hermeneutics approach was used to address the objective of this study: to understand accountability meanings and practices in the context of constant policy changes. The data were analysed using the critical hermeneutics approach. My use of the hermeneutics approach in collecting, analysing and interpreting data recognises the stages of preunderstanding, understanding, and comprehensive understanding.

# **CHAPTER FOUR**

## **RESEARCH METHOD**

### **4.1 Introduction**

This chapter presents the methods used for gathering, analysing and interpreting the research evidence. As noted in Chapter Three, this study adopts a hermeneutics approach and employs the critical hermeneutics concepts of historicity, autonomisation and distanciation, and appropriation and engagement when analysing data. The discussions of this chapter are arranged as follows. In the first section, I describe the process of gathering and interpreting data using document review; in the second section, I discuss the process of collecting and analysing data through interview. Next, to establish the validity and reliability of the research process, I describe the data gathering and interpreting processes in detail.

### **4.2 Document review**

According to Merriam (2009), documents are a ready-made source of data which involve a wide range of written, visual, digital and physical material relevant to the researcher's area of investigation. Documents are held to be evidence for past and current realities, as well as for future plans. Documents take a variety of forms, including advertisements, agendas, attendance registers, minutes of meetings, manuals, background papers, books, and various public records (Bowen, 2009; Gray, 2009). Document review was identified as an appropriate method for this study because it helps to develop the researcher's preunderstanding of the New Zealand public health system.

This method proved helpful in gaining historical insights into past events and policies in the New Zealand public health system. Furthermore, it also provided not only a useful way of tracking changes and developments in the public health system, but also a means of obtaining a clear understanding of

how New Zealand health services have progressed over time. Compared to other qualitative methods, documents analysis can be considered as an efficient method because it is less time-consuming and requires only data selection, instead of data collection (Bowen, 2009). Most of the documents used in this study were retrieved through online searches of the University of Waikato Library, the Ministry of Health Library, websites and the New Zealand government's official website, known as [beehive.govt.nz](http://beehive.govt.nz). In order to ensure the efficiency of future tracking, the relevant documents were classified and recorded according to their historical background and stages of reform.

While historical information is believed to inform the present, adopting the document review method was challenging. In my experience, due to my limited understanding, reviewing New Zealand public health history and reform was frustrating initially. I could not understand the meaning of those documents and why the information in written policy documents focused on particular issues, such as distribution of health care, the State's role in health care, efficiency and effectiveness of health delivery. Indeed, I did not really understand why the private sector, especially general practitioners, appeared to be so influential in health policy decisions (see section 5.2 for further information). Moreover, in the early stages, I could not understand the political perspectives of and the ideological competition between the Labour and National Parties in public health policy documents. Everything appeared unclear, mixed and complicated to me as I come from a different country that practices a different political and public health system. Therefore, the possibility of arriving at inaccurate interpretations was high.

Nevertheless, this method had several other advantages which helped me to limit the possibility of producing inaccurate interpretation. First, documents in many instances are not affected by a research process due to the special nature of their being: stability, exactness, and coverage or what Cresswell (2003) terms unobtrusive or nonreactive. Hence, written documentation has a high level of stability because the researchers' presence does not alter what

is being studied, which makes them suitable for repeated reviews (Bowen, 2009). In this study, all relevant documents were reviewed several times so as to ensure the accuracy of the discussions. Secondly, the documents used for this study, included policy documents and academic journals, sources which are known to have a high exactness value because of the way in which these documents are published, which guarantees the accuracy of the information they contain (Bowen, 2009). Therefore, the authenticity and credibility of documents used for this study were reasonably high.

Gray (2009), however, warns that researchers who use this method will often find that vital data are missing. This situation arises because documents may sometimes be irretrievable or be difficult to retrieve. The possibility to face such difficulties in this research was high because historical reviews required me to investigate the New Zealand public health reform for the last 30 years, and therefore, I had to ensure that I could get access to all relevant documents that covered the period of analysis (details of this process were discussed in section 4.2.2). The following subsections discuss the process of selecting and analysing documents.

#### **4.2.1 Selecting documents**

Management of data sourced from documents began with the selection process. For the purpose of this research, documents used were academic journal articles in the area of New Zealand public health development, reform, and policy; government publications, including green and white papers; commission reports, both printed and electronic; annual reports of public health agencies; newsletters; Parliamentary Hansards; and, websites of the Ministry of Health and other public health bodies.

The process of selecting documents was guided by the objective of identifying the changes in the New Zealand public health system since the 1984 reform, and their effects on the accountability arrangements. However, in order to improve my understanding, I found that I had to read literature

beyond the scope of this research on, for example, the New Zealand political and governmental system, the history of the New Zealand public sector reform, and specific health programme research on area such as rheumatic fever, the breastfeeding programme, and health targets.

The selected documents were recorded in two ways. First, documents were categorised into three classifications, namely material from academic journals, policy documents (including all related government publications), and websites (including the Ministry of Health and relevant public health institutions and agencies). Secondly, in order to assist the process of developing a preunderstanding narrative, the documents in every category were arranged in line with the stages of reform to which they related.

#### **4.2.2 Analysing documents**

Mining data from documents has a long tradition in qualitative research (Cortazzi, 2002). Similar to other analytical methods in qualitative research, document analysis requires data to be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge. According to Silverman (2005), the process of analysing documents is more concerned with whether texts depict 'reality' rather than whether texts contain true or false statements because in many instances, documents are produced and used for a variety of organisational purposes (Gray, 2009).

In analysing documents, this study drew upon the three hermeneutics concepts of historicity, autonomisation and distanciation, and appropriation and engagement. As a means of establishing my preunderstanding, the process of analysing the data commenced with a review of the historical background of the New Zealand public health system. According to Kelly and Maynard-Moody (1993):

We can only understand the actions of others if we understand this conception of narratives and their historical, embedded character. We can only make sense of what we

attempt to study – be it the effects of particular public policies or the specific actions of members of an organizational unit, or anything else – if we explore the history of our subject (p.137).

To assist the next level of analysis, I adopted the concepts of autonomisation and distanciation. These concepts allow researchers to free themselves from the principle of authorial intent. Thus they help to limit the influence of the original author in the process of interpretation, while enabling researchers to engage with and make appropriate meanings from the text. In my experience, adopting these hermeneutics concepts granted me the freedom to determine the direction and formation of the preunderstanding knowledge. I developed the preunderstanding knowledge by reviewing the historicity of New Zealand public health reform from its early setting to the present day. The stages of reform were identified through the Parliamentary Library Research Paper (2009) which briefly describes the stages of reform in the New Zealand public health system between 1938 and 2000. The paper summarises the significant policy changes and lists the significant policy documents which relate to the implementation of health policy reforms at each stage of reform.

My understanding, at this stage, was enhanced by reading relevant policy documents. At the beginning, these documents were difficult to understand as I was not familiar with the context of reform. To overcome this problem, I read relevant academic journals and books. Again, the application of these hermeneutics concepts was helpful. The iterative process of reading, thinking and writing, as suggested by the hermeneutics approach, enabled me to develop my interpretive preunderstanding knowledge. Employing the three hermeneutics concepts in analysing these documents helped to establish rich and deep insights into the history of public health reform in New Zealand. During this process, the research question was kept in mind in terms of the changes that had taken place in the public health system over the last two decades, and how those changes had affected accountability. The material was organised in line with these key areas in order to ensure the formation of preunderstanding knowledge. I found that my understanding level improved

as I extended and repeated the process of reading, writing and thinking several times.

However, discussions of reform covered by the Parliamentary Library Research Paper (2009) focused only on the early stages of reform i.e., those that took between 1984 and 2000. Therefore, to enhance my understanding and extend the discussion, I supplemented this information with recent material published in academic journals. Gauld (2012) and Cumming (2011) were the main authors who wrote on post-2008 health reform in New Zealand. Gauld (2012) provided an overview of the post-2008 period by discussing the establishment of new health institutions in the public health system. Following the establishment of new health organisations such as the National Health Board (NHB), the National Health IT Board, and Health Workforce New Zealand, and also the announcement of initial plans to reduce the number of PHOs, Gauld (2012) expected that the public health system would become more complex in the future. Meanwhile, Cumming (2011) discussed the potential of New Zealand to have an integrated health system after the 2008 reform.

However, because the papers were written during the early phase of the 2008 reform, the discussions appeared to be limited as reform was still in the planning stage. In my opinion, the implementation of reform became more aggressive after the National Party gained another mandate to lead the government in the 2011 election. A number of changes were introduced to support the initial reform plan introduced in 2008. Charting the progress of the plan allowed me to create an extensive discussion of the post-2008 reform that encompassed all the changes in the public health system (including both changes in primary and secondary care) between 2008 and 2013. Thus, this process of exploring and establishing an understanding of the public health reform through the concept of historicity helped in the engagement in and appropriation of the data.

To ensure the quality of my interpretations, a peer debriefing technique was employed in the process of analysing and interpreting documents. Peer debriefing refers to “someone who is familiar with the phenomenon being explored” (Creswell & Miller, 2000, p. 129). One of the members of my supervisory panel has had research experience in the field of the New Zealand public health system and thus was able to provide not only support in terms of knowledge related to my topic but also as a reviewer of the study process and the congruency of emerging findings and interpretations (Merriam, 2009).

### **4.3 Interview**

The interview is the most commonly employed method in qualitative research (Britten, 2006; Bryman & Bell, 2007). Maykut and Morehouse (1994) define an interview as a conversation with a purpose, while Kvale (1996) describes an interview as a “construction site of knowledge”(p.42) which must be understood in terms of five features of information. These have been categorised as conversation, narrative, language, context, and, the inter-relationship between interviewer and interviewee. Britten (2006) views an interview as a collaborative enterprise, where both interviewer and interviewee are engaged in the business of constructing meaning. Thus, Rubin and Rubin (2005) suggest that interviewees in qualitative research should be regarded as partners in the research enterprise rather than as subjects to be tested or examined.

Since this study was also aiming to capture perceptual information related to the effects of public health reform on accountability, the interview was seen as a valuable method to adopt. The document review method was efficacious in tracking changes and development of reforms in the New Zealand public health system. However, data derived from this method are unable to provide detailed information, such as understanding people’s behaviour and feelings and interpreting people’s worlds in relation to specific subjects (Merriam, 2009). Interviews not only enable immediate follow-up and

clarification, but are also helpful in forming understanding of the meaning of the daily routines of selected participants (Marshall & Rossman, 2006; Rubin & Rubin, 2005). I found that interviews provided opportunities for health managers to voice their life situations in their own words, a possibility mentioned by Kvale (1996). Data derived from this method also helped me to understand how health managers perceived public health reform and accountability practices in the health services.

The interview provides at least three options for researchers in gathering perceptual information (Britten, 2006; Merriam, 2009). The options are structured, semistructured and unstructured interviews. However, in this study, the structured interview was dismissed as an option due to its standardised and rigid criteria. The development of a structured interview begins with a list of themes, issues, problems and questions to be covered (Qu & Dumay, 2011). The lists are derived from a review of the literature and thoughts of the experts. Then, the standardised questions are formulated in such a way as to generate the conditions for generalisation across populations (Barbour & Schostak, 2011; Saunders, Lewis, & Thornhill, 2003). The problem of using highly structured interviews in qualitative research is that rigid adherence to predetermined questions may not allow qualitative researchers to access participants' perspectives and understandings of the world (Merriam, 2009).

Although both unstructured and semistructured interviews enable researchers to access participants' views, I opted for semistructured interviews in collecting perceptual information for this study. The semistructured interview was chosen because this type of interview provides some structure through a list of issues to be investigated. In other words, it allows researchers to use a general research framework for preformulating interview questions, while permitting researchers to pursue any new lines of inquiry that might emerge during the course of the interview (Myers, 2009). This flexibility enables interviewers to capture unexpected issues and information which may arise during the data collection process.

According to Merriam (2009), the unstructured interview is open in nature because it aims to help researchers who have limited information about their research phenomenon to ask relevant questions. Researchers usually have no prior list of interview questions as the questions will emerge during the interview sessions because an unstructured interview is grounded in the views the participants offer in response to each question. It would, therefore, have been not only difficult but also inappropriate to apply unstructured interviews in hermeneutics research because the hermeneutics approach requires researchers to develop their preunderstanding knowledge before forming their understanding knowledge. In my experience, preunderstanding knowledge significantly influenced my views on New Zealand's public health reform which later led to the formation of interview questions.

#### **4.3.1 The process of selecting participants**

The process of selecting suitable participants for this study was determined through the application of hermeneutics principles. According to Laverly (2003), hermeneutics researchers should aim to select participants "who have lived experience in the context of study's focus, who are willing to talk about their experience, and who are diverse enough from one to another to enhance possibilities of rich and unique stories of a particular experience" (p. 29). For the purpose of this study, I set the following criteria as the basis for selecting participants. The participants should have:

1. knowledge about the New Zealand health policy reform
2. experience in managing change at different levels of health delivery
3. the willingness and ability to serve as a key informant for this study.

The above criteria indicated that a key set of relevant actors for this study should be selected on the basis of their work positions and experiences. According to Christensen and Laegreid (2007), reform efforts are primarily undertaken by people who are in leadership positions. Hence, in this study, I aimed to interview participants who were in senior positions and had experience in dealing with health policy changes resulting from the adoption

of reforms. In my opinion, this group of people could be considered as experts because they had detailed and up-to-date knowledge on reform and policy changes. I also believed that only those who had gone through different stages of reform could share their views, experiences and opinions about the need for reform and the challenges in dealing with constant reforms in the public health system.

Although the positional and seniority criteria provided a clear guideline for recruiting participants, I nevertheless found the process of recruiting participants itself was a challenge. Reaching a sufficiently large group of potential participants who met the positional criteria of the study proved difficult because no background and work experience of health managers is made publicly available. Therefore, I decided to employ a snowball technique or participant-driven sample, in this study. This technique enables researchers to use participants to contact other respondents (Heckathorn, 1997; Streeton, Cooke, & Campbell, 2004). The process of selecting participants started with identifying a 'champion' or a key informant for this study. The champion is someone who is capable of gaining access to 'hidden' or 'hard-to-reach' populations (Streeton et al., 2004).

A member of the Department of Accounting helped me to identify a potential champion. I sent an email to this contact, a senior manager of a DHB, whom I named Manager One. In the email, I briefly introduced myself and my research. I asked Manager One to suggest someone from his organisation who might be able to help with my research. Manager One was able to introduce me to another senior manager from the Planning and Funding division. I named this manager Manager Two. According to Manager One, Manager Two has reasonable experience in public health planning and funding and also has a good relationship with other managers at the primary health level. For these reasons, I decided to appoint Manager Two as a champion for my sampling purposes. I approached Manager Two by providing details of my research and specifying my research requests.

Manager Two took several weeks before agreeing to become a champion for this study.

Once agreement was obtained from Manager Two, I invited her to an initial meeting. This meeting was used as a platform to brief Manager Two about the research project and to highlight the research needs and expectations. Manager Two then named several potential participants, and provided their contact details. Manager Two also allowed me to use her name when approaching possible participants. Manager Two held the champion position only at the beginning of research access. As interviews progressed, the number of referred participants increased and some of them became new champions. The new champions then referred me to their contacts by introducing me and my research. This snowballing or participant-driven sampling technique was not only convenient but also helped in reaching the targeted participants through the process of referral from one participant to the next. I was introduced to at least 20 potential participants who had reasonable experience in dealing with policy changes and reforms in the New Zealand public health system.

Nevertheless, the process of recruiting participants in this study was still very challenging for several reasons. First, the New Zealand public health system itself was experiencing a major reform during the period of data collection for this study. After the 2011 election, one of the reform strategies set by the National Government was to reduce the number of PHOs from 82 to 32, so as to encourage regional and national collaboration through the establishment of new regional and national health boards. This reform strategy significantly changed the roles and positions of the existing health managers and these changes affected my research study as they led to the withdrawal and rejection of some of the targeted participants.

Secondly, the targeted participants in this study included top managers, most of whom had a hectic work schedule following the adoption of new reform strategies. Although agreements to participate in this research project had

been obtained, in theory, at an early stage, the scheduling of the actual interview sessions with participants remained unconfirmed, in practice, and was, therefore, still uncertain. A number of follow-up contacts, both through emails and phone calls, had to be made and it was hard to obtain immediate responses from participants. In fact, I had to wait an average of about 2 to 4 months before an interview took place. There were cases where my requests for interview were put off for several months just because managers could not decide a date for an interview. Although frequent follow-up was made, some interviews were cancelled because managers suddenly decided to leave their organisations. Some managers who got promoted to other positions later changed their minds and decided to withdraw from this study because their new positions were no longer relevant to the interests of the study. The following are examples of withdrawal and rejection emails from those approached in relation to the above issues:

Dear Azizah,  
Apologies for not responding earlier. Unfortunately, I am not in a position to now participate in or organise (the name of the PHO) participation in your current research.

The level of activity across the organisation has significantly increased with a number of key personnel fully committed to those activities and would not be available for interview in regard to your research.

Again, my apologies that we are not able to assist any further.

(Personal communication, June 15, 2012)

Kia ora Azizah,

Thank you for your invitation to participate in your research. Unfortunately this primary health organization will be disestablished at the end of the year as we have joined with other coalitions. All the best for your research.

(Personal communication, October 3, 2011)

Despite such setbacks, I managed to conduct 15 interviews with 13 participants between April 2012 and November 2013.

I was aware that the snowball sampling technique would lead to a potentially collective view of the phenomenon under investigation because a sample derived from this technique includes members of a specific network as a result of the tendency of participants to suggest others with whom they share similar characteristics. To compensate for this possibility, I had to ensure that the participants in this study were recruited from diverse positions and organisations. Each time I was introduced to new potential participants by the champion, I asked the champion for some brief information on the potential participant with regard to their experience and to the organisations for which they worked to ensure their backgrounds were related to my research needs. Although such information was limited in identifying what types of stories I might get from the referred participants, I found it was useful, especially in ensuring the voice of participants covered both primary and secondary care.

Table 4.1 summaries the summary of the participants' positions, work organisations and total work experience in the public health system. In total, 13 participants from both primary and secondary care, who had more than 10 years' work experience in managing public health services, were interviewed. All participants were in leadership positions and had different management and clinical backgrounds; 4 had started their careers as clinicians before taking on management responsibilities, while the remaining 9 participants had top level management backgrounds in various fields, including finance, communication and aviation. Hermeneutics values the

various participants' backgrounds and experiences as unique in their time, place and personal history (Walker, 1996). The advantage of interviewing experienced participants lay in their ability to present their lived experiences of dealing with reforms, experiences which allowed them to provide more insights into the implementation of reform.

Of the 13 participants, 8 were managers of PHOs, and 5 were managers of DHBs. Only 3 female managers participated in this study while the remaining 10 were male. In order to ensure the participants' anonymity, pseudonyms, such as P01 and P02 were used for the participants when reporting the findings. The length of their service in the health sector ranged from 10 to 31 years. Overall, the participants in this study had considerable experience in the New Zealand health service reforms (see Appendix 1, p.278 for details).

**Table 4:1 The summary of participants' positions, work organisations and total work experience**

| Position  | PHOs<br>(years of service)                         | DHBs<br>(years of service)        | Regional DHBs<br>(years of service) |
|---|--|-----------------------------------|-------------------------------------|
| <b>Board member</b>                               | P02 (26 years)                                     | P13 (12 years)                    |                                     |
| <b>CEO</b>  | P01 (15 years)<br>P03 (22 years)<br>P06 (18 years) |                                   |                                     |
| <b>Senior Manager<br/>(management experience)</b> | P04 (31 years)<br>P05 (27 years)                   | P09 (25 years)<br>P012 (21 years) |                                     |
| <b>Senior Manager<br/>(clinical experience)</b>   | P07 (16 years)<br>P11 (13 years)                   | P08 (16 years)                    | P10 (10 years)                      |
| <b>Total (13)</b>                                 | <b>8</b>   | <b>4</b>                          | <b>1</b>                            |

### 4.3.2 Conducting interviews

The process of conducting interviews followed the ethical guidelines for the study which had been approved by the Ethics Committees of the Waikato Management School. Since the list of targeted participants was based on the snowball technique, the process of approaching participants started soon after I was introduced by the champions to potential participants or after receiving participants' contact details from the champions.

The initial communications between me and targeted participants began through email. In the introductory emails to targeted participants, I attached three documents, namely, a participant information sheet, an interview protocol and an informed consent form. These documents were used to facilitate the participants' full understanding about the research area and how they could contribute to my study. In the participant information sheet (see Appendix 2, p. 281), I introduced myself and my study by informing participants about the objectives of the study, the expected outcomes and the benefits of this study to the research area. Before issuing an invitation to participants, I highlighted how their experience and knowledge are valuable for this study. I also assured participants about the level of confidentiality by explaining how the participants' identities would be protected and how the output from the participants would be used and disseminated.

In the interview protocol (see Appendix 3, p. 282), I provided an opening statement by thanking the participants for their willingness to take part in my study. In order to make participants feel comfortable with the interview process, I repeated my assurance on confidentiality. A list of possible questions to be asked during the interview was also provided. In sending the interview protocol I wished to signal to the participants that they were expected to familiarise themselves with and prepare themselves for the interview questions. I also used the consent form to inform them about their rights during and after interviews (see Appendix 4, p. 285). In that form, I stated the right to ask any questions, the right not to answer any interview

questions and the right to withdraw from the study. The participants who signed the consent form were treated as having provided their consent to take part in this study.

According to Laverly (2003), the interview process in the hermeneutics tradition should take place in a safe and trusting environment. Laverly (2003) defines such an environment as a situation in which an interview is conducted within the context of a relationship. The formation of preunderstanding knowledge using the document review method reduced the distance between me and the research field. Despite struggling at the beginning, I slowly developed my understanding about the New Zealand public health system.

Nevertheless, the interview process was still demanding as I had to manage the distance between me and the participants. In order to minimise this gulf, after being granted access, I made initial visits to the organisations and talked to the potential participants. During the visits, I explained my study and what was expected from participants. I also informed the potential participants that I might be asking naïve questions due to my limited understanding about the New Zealand health sector. Being concerned about my familiarity with the knowledge, one of the participants gave a presentation about the Maori culture and general health setting in New Zealand. The presentation was very useful as I learned new things which helped me to understand why the New Zealand public health system was designed in the way that it was. In addition, I was invited by another participant to sit in on a PHO weekly executive meeting. That was a valuable opportunity for me because I was introduced to other managers, which later enhanced my contacts. Although I had been granted access since January 2012, the first interview took place only in April 2012.

However, due to the hectic work schedules of some managers, initial visits were made only with eight participants. I communicated with the remaining five participants via emails prior to their interviews, informing them about

my research with and my expectations. While this technique broke the ice between me and the participants because it made the interview process go smoothly, at this stage, it was hard to establish a clear understanding of the participants' knowledge and their interests in the study. In my opinion, the snowball sampling technique provides limited opportunities for researchers to appraise the level of knowledge, experience, and interests of a wider group of participants. As samples are referred by champions, researchers tend to accept these referrals without much questioning of whether or not the proposed participants have the ability to provide required information. As a result, some participants provided limited information during interviews because their experience, knowledge, and interests provided only a limited fit with this study.

All interviews were conducted in an informal manner in the participants' workplaces. The interviews lasted from 45 to 90 minutes and were digitally recorded. Before starting the interview, I read the opening statement to the participants to acknowledge their participation and to remind them of their rights in terms of confidentiality and their participation in this study. Participants were informed that my interest was in their experience of managing health. After reading the opening statement for themselves, participants were given a consent form to sign. I began the interview by gathering background information on the participants such as the title of their position (designation), their roles and responsibilities, and the number of years they had worked in the health context. Identifying the participants' background helped me to ask relevant questions related to their organisational and situational contexts.

Since I was adopting a semi-structured interview approach, I already had a list of preplanned questions covering the participants' views on reforms and accountability. However, this list of questions was used only as a guideline. In some circumstances, I dropped or added new questions if I found the participants were telling a really interesting story which was relevant to my research. Furthermore, if I found any of the participants struggling to

respond to my questions (due to different terminology or understanding), I immediately reframed the question to make it more relevant to the participants' context. I also kept the conversation between me and the participants as open as I could to enable the participants' experiences speak to me. Although the interviews were digitally recorded, I made brief notes on a separate form which I named as 'Interview Guide with Field Notes' (see Appendix 5, p. 286). In this form, I wrote the key points or drew simple diagrams to help me during the transcription and writing up of the findings.

I transcribed the interviews as soon as I finished each interview session. I adopted a denaturalised method in preparing the transcript. According to Mero-Jaffe (2011) the denaturalised method enables researchers to prepare interview transcripts free from noises such as coughing, moans, stutters, involuntary sounds, pauses in speech, grammatical errors, body language, and so on. I chose this method because all the interview transcripts were sent back to the participants for their feedback. If the interviews had been transcribed using a naturalised method, the participants might well have felt embarrassed as this method retains all recorded interview details, including interview noises. According to Mero-Jaffe (2011), naturalised transcripts can leave interviewees feeling their speeches were unrefined.

Hagens, Dobrow, and Chafe (2009) warn that the sending back of interview transcripts to the participants has certain risks, although the technique has been approved as useful in helping researchers to validate their data. The risks according to Hagens et al. (2009) are related to the issue of bias and the possibility of losing some valuable data because some participants may ask for the deletion of or a change to certain information. In this study, I decided to send the interview transcripts back to the participants. Here, my concern was not only to improve the quality of the transcripts but also to help in clarifying certain information about which I was unsure.

I was aware that all participants had a busy work schedule. In order to help the participants deal with the transcripts, I provided several supporting documents along with the original transcript. The documents were:

1. A summary of the interview transcript

This summary comprised two sections. In the first section, I presented a summary of the participants' background information by highlighting their pseudonymous identities, their positions and a summary of their roles, responsibilities and experiences. I asked participants to pay attention to this section because that was how I was going to present them in my research. If participants were unhappy with the way in which I had presented their background, I encouraged them to provide further suggestions to me. In the event, all the participants accepted the way in which I presented their background information as no one came back and asked for changes. A sample of the summary is attached in Appendix 6 (p. 289).

In the second section, I provided a summary of the interviews by highlighting the important points that I had learned from the participants during the interviews. I informed the participants that the key-point summaries included only the important points derived from the interview data. I also advised them that those key points should be seen as raw data only, as the process of interpretation had not yet started.

2. Table of clarification

A table of clarification was developed with the purpose of helping me and the participants to track previous conversations which needed further clarification. The interview transcripts produced in this study were between 12 and 34 pages in length. It might have been difficult for some participants to read all the recorded conversation as they were busy professionals. In order to help the participants and me to track a specific conversation that was required for further clarification, I provided a table of clarification. The table made the revision process easier for both

parties. Under the “what to clarify” column, I included any interview extracts which required further clarification from participants and linked these to specific questions for the participants. The table allowed the participants to refresh their memories of the overall content of the conversations, and they could easily track the full conversation by returning to the transcript at the pages indicated in the table. The participants could provide the specific clarification by writing it under the “clarified” column. Table 4.2 shows an example of the table of clarification used in this study.

**Table 4:2 Table of clarification**

| Page No | What to clarify?  | Clarified (Responded by P09)  |
|---------|---|---|
| 12      | <p><b>Extract from the interview</b></p> <p>“What is the problem with that is primary sector is an aging workforce. Rural populations find that hard to get GPs, this DHBs certainly has that problem in Tokoroa and Taumarunui”.</p> <p><b>My question(s):</b><br/> <b>Could you please explain about:</b></p> <p><b>a. Why the primary care was considered as an aging workforce?</b></p> <p><b>b. Why people in rural areas find that is hard to see a GP?</b></p> | <p>Rural populations are finding it harder to get GPs to work and live in their communities. Remote and rural GPs have demands upon them greater than urban GPs and it’s harder for rural GP practices to work collectively (time and distance issue) so attracting GPs to rural towns is quite difficult. As a consequence the workforce in these rural areas is aging as younger professionals prefer the urban lifestyle or make choices not to work rurally while they are bringing up young families – i.e., they make choices about better schools, more exposure to sports and alternative activities etc. (less available in rural towns). As a consequence of GPs becoming harder to recruit and retain in rural settings GPs are closing off their enrolments making access difficult for populations to see GPs. This in turn places demand on smaller rural hospitals, or people wait longer to see the GP.</p> |

(Personal Communication, October 30, 2013)

Although not all participants' responded to my requests, I found the clarification process was helpful for those managers who did want to raise concerns as well as state opinions. In fact, clarification was useful for me as it improved the quality of transcripts and created ongoing cooperation between the participants and me. In terms of data management, I found this approach provided an easy way of tracking and managing data for this study. The examples below illustrate some of the feedback received from the participants:

Hi Azizah,

I have made several changes/edits to this as my thick Scottish accent must have been difficult to tune into.

Thanks for the opportunity – I really enjoyed talking with you and I hope your studies go well and you are very successful. We need your type of thinking in our system.

(Personal communication, July 23, 2013)

Hello Azizah,

Sorry for the delay. I have been on the road for a few weeks and got back from Christchurch yesterday so I have been catching up on everything.

A few requested alterations in relation to your key points' document:

Yes I did work in both public hospitals and primary care. For point 1 -views on accountability I would add that a point to the end around additional administration to meet the targets (as you could always discharge and readmit a patient to make it look like they meet the indicators).

A point to the second document:

Question 2 - medically veins are called vascular

I hope I have been helpful and again sorry for the delay. If you have any other questions please feel free to get in touch.

(Personal communication, November 14, 2013)

### **4.3.3 Analysing interview**

Data analysis proceeded by way of a long process of writing and descriptive analysis. I started the process of analysing data by examining the interview transcripts and field notes. The transcripts and field notes were analysed as progressively. I began my analysis by reading and rereading the transcripts to get a general sense of the participants' recalled experience and summarised my initial understanding in a standardised format, known as 'A Summary of Interview' as discussed in Section 4.4.2.

Then, I extracted the data by coding them manually with coloured pens. The coding process helps researchers to reduce or deconstruct data through the process of grouping and subgrouping all the relevant codes. According to Tan et al. (2009), the process of coding and grouping relevant codes is a mechanical process which does not involve any interpretative activities. The process of interpretation begins only after researchers have created linkages between deconstructed lived experience and activities within the context in which the activities took place. According to Van Maanen (1990), the process of interpretation in hermeneutic research involves a consistent process of thinking, writing, rethinking, and rewriting.

The initial coding and the process of thinking, writing, rethinking and rewriting did not work well at the beginning of my analysis. I found the stories provided by participants were fragmented, and themes were unlikely to emerge due to significant differences in their responsibilities, work experiences, and work organisations. My experience was reflected in the work of Wilson and Hutchinson (1991), who reported that data collected from hermeneutics approach cannot be broken into small units because in doing so, researchers will lose important aspects or meanings. To deal with such issues, I followed Patterson and Williams (2002), whose advice to hermeneutic interpreters to provide a holistic and insightful interpretation and not simply to identify themes. They advise this course of action because

the objective of hermeneutics is to understand and explain the interrelationship among themes.

In order to produce a holistic and insightful interpretation, I adjusted the process of analysis for this study by rearranging the analysis process. I made this decision because Anfara, Brown, and Mangione (2002) state that there is no right way to analyse qualitative data, as the aim of the analysing process is only to make sense of the qualitative information. Based on earlier interview summaries, I adjusted the process slightly by grouping the participants' responses around two main issues: first, the views and experiences of public health managers on reform; and secondly, the views and experiences of public health managers on accountability. I also linked the participants' responses with their roles and responsibilities, work experiences, and work organisations. At this stage of analysis, the findings attempt to explain the research evidence of what, why and how certain events happened. I, therefore, started to engage and familiarise myself with the texts. However, these findings provided only parts of the whole understanding, as the stories in these categories were not integrated and reflected a wide variety of participants' experiences.

To reconstruct the research findings into a more holistic understanding, this study adopted a second level of analysis in critical hermeneutics called 'decomposition'. Decomposition also represents the third stage of understanding (or Stage 3, see Figure 3.1, p. 72). In particular, the term decomposition was introduced by Phillips and Brown (1993), and it refers to the process of interpreting and the reinterpreting parts of the understanding as a means of integrating them into the whole understanding. At this level of analysis, decomposition requires researchers to creatively combine parts of the understanding of the historical context with interview analysis, and to continually revise the interpretation of these parts (by contrasting the data with issues raised by relevant literature) before producing an interpretation for the whole text (Myers, 1994; Patterson & Williams, 2002; Phillips & Brown, 1993).

Additionally, decomposition requires researchers to interpret the expressed and unexpressed information. According to Geanellos (2000), the interpretation of these types of information will allow understanding to be enlarged and deepened. Therefore, in an attempt to tease out the deepest levels of meaning from my data, I made not only a comparison of the document and interview data but also contextualised them with the theory of reform and the concept of accountability (see Chapter Two).

In order to make sense of preunderstanding and understanding findings, I compare the historical background of the public health system with the participants' lived experiences within the neoliberal reform frameworks: NPM and NPS, and with accountability typology and relationships (Romzek & Dubnick, 1987; Sinclair, 1995). At this stage, I noticed that differences in participants' background such as their work training and experience had influenced their views on reforms and accountability. For instance:

As a person who was in DHB and with a public administration background, I did a lot of looking at public accountability, particularly around government accountability . . . – (P01, a CEO of a PHO)

I can tell you, I have been working in the commercial side of health now since August 1998 . . . – (P08, a senior manager of a DHB)

These examples show that the participants established their credibility as informants by highlighting their experiences before sharing their views or making claims on a particular issue.

## **4.4 Chapter summary**

In summary, this chapter sets out the detailed process for collecting, analysing and interpreting research evidence followed in this study. The hermeneutics approach was employed to illustrate the meanings of accountability in the context of constant public health reforms. The methods of collecting data involved reviewing documents and conducting interviews. The data were analysed using critical hermeneutics to enable independent interpretation. The validity and reliability of this study were assured throughout each of the steps in the process of research.

The study's findings, which were generated from document review and interviews are presented in the next two chapters: Chapter Five and Chapter Six. Chapter Five presents the historical background of the public health system. It provides the basis for my preunderstanding of the New Zealand health systems. In Chapter Six the health managers' experiences in dealing with reforms, policy changes and accountability are described. These lived experiences helped me to develop a fuller understanding of accountability in the context of reform.

# **CHAPTER FIVE**

## **PREUNDERSTANDING THE NEW ZEALAND HEALTH REFORMS AND THE EMERGENCE OF ACCOUNTABILITY ISSUES**

### **5.1 Introduction**

The objective of this chapter is to demonstrate my initial knowledge or preunderstanding of health service reform and the emergence of accountability issues in the New Zealand public health system. This initial knowledge represents the first stage of understanding (or Stage 1, see Figure 3.1, p. 72) of the research issue. The knowledge is demonstrated through the narrative of health service reform which was developed using a review of documents collected from various academic journals, the government's websites, policy documents and reports. My aim in this preunderstanding chapter is to disclose my thinking about health service reform. Specifically, this preunderstanding stage addresses the first research question: what changes in the public health system have taken place over the last four stages of reform and what were the rationales for them in terms of accountability?

In this study, my preunderstanding of health service reform in New Zealand serves as the basis for the next stage of understanding, which is presented in Chapter Six. The narrative of my preunderstanding knowledge is divided into two main sections. In the first section, I discuss the background of the New Zealand health system, and the pressure factors for reforms. The discussion covers the initial setting-up of a nation-wide New Zealand health system from the 1930s and concludes with the recent stage of reform in 2014. In this section, I identify two important pieces of information: firstly, the drivers of reform and formats for reform, which describe the important changes made at every stage of reform. Secondly, I reveal the emergence of accountability issues in the public health system

## **5.2 The initial setting-up of the New Zealand public health system**

In the late 1930s, the Labour government proposed and then implemented the Social Security Act 1938 with the aim of protecting the New Zealand public from the economic hazards resulting from the Great Depression of the early 1930s. Social security strategies proposed to support this act was to provide a universal health care system that would be free at the point of use to all New Zealander (Ashton, 2005; Morgan & Simmons, 2009). The government of the day believed that health was a fundamental right for every citizen and, therefore, services should be universally available regardless of individuals' ability to pay (The Government White Paper, 1974).

However, the proposal to provide free, universal health care for all New Zealander was never completed because it was strongly opposed by local GPs who were members of the New Zealand branch of the British Medical Association (Jacobs, 1997). GPs regarded a fully-funded health system as a threat to their individual business interests. GPs rejected the idea of being employed as part of the government's health workforce. They asked the government to respect their rights as private medical professionals, especially in the determining of fees to be paid to a doctor (Gauld, 2008; Jacobs, 1997; Mays & Devlin, 2005; Starke, 2010). After a three-year debate with GPs, the government finally agreed to subsidise GPs by reimbursing the full cost of their fee per consultation, while permitting GPs to levy patients for copayments (Ashton, 2005; Gauld, 2008). The government's consent was seen as a turning point in the history of the New Zealand health sector as it created institutional arrangements that persist to this day (Gauld, 2001).

As a result of the government consent in 1941, a 'dual system' of funding emerged in the New Zealand public health system under which two contrasting allocation methods between primary and secondary health care were applied (Barnett & Barnett, 1997; Barnett & Barnett, 2004; Starke, 2010). A nationalised or fully-funding system in the New Zealand health

system was genuinely applied for secondary care, whilst partial subsidy was applied for primary care and medication prescription (Ashton et al., 2005; Howell, 2005). This dual funding system has enabled the government to have full control over secondary care but a limited influence in primary care (Morgan & Simmons, 2009).

The dual funding method had a profound impact on the New Zealand public health system. This method separated the health care system into different sectors with clear distinctions between public and private, and primary and secondary care (Ashton, 2005; Cumming, 2011; Gauld, 2001). The distinction not only created the problem of separation between primary and secondary care but also influenced the allocation of public funding for the development of health care. For instance, because the government funded, owned, and operated public hospitals, most of the public funding went to secondary care. As a result, public hospitals were equipped with the latest technology and facilities and the standard of hospital care has continued to be high (Gauld, 2001). Meanwhile, as primary care was privately owned by GPs, its development remained limited until the late 1990s (Starke, 2010).

Under the partial subsidy system, GPs were granted the right to maintain their status as independent private practitioners, which gave them a higher level of autonomy and greater control over primary care than the government had. For example, GPs were allowed to determine the location they would use to provide services and the price they would charge to their patients. Consequently, a doctor could charge the patient over and above the subsidy if he or she felt the service warranted doing so (Richards, 1981). At the same time, GPs could claim the subsidy from the government that covered about two-thirds or 66% of their total consultation fees (Cumming, Stillman, & Poland, 2009).

The partial subsidy was seen as an open-ended budget system because the government did not put a limit on what could be claimed. Basically, the government paid GPs on a claim basis according to the number of patients a

GP saw and drugs they prescribed (Jacobs, 1997). Since the level of government control over primary care was limited, the rate of copayment was fully determined by GPs. During the tough economic times, most of the GPs tended to increase the patients' copayment rate in order to sustain their businesses. For instance, as a result of the oil crisis in the 1970s, the rate of copayment reached almost one-third of total GP fee-for-service charges and many patients expressed their dissatisfaction with the doctors' fees (Barnett & Barnett, 2004).

The increase in copayment charges caused patients with financial difficulties to delay seeking care and obtaining medication (Barnett & Barnett, 2004). Without consistent health care treatment at the primary care level, the chances of the public getting further treatment at the secondary care level decreased slightly because GPs were gatekeepers to secondary care. The prerequisite to getting treatment at the secondary care level is that patients must obtain a referral letter from a GP (Jacobs, 1997; Mays & Devlin, 2005). In other words, patients with a limited opportunity to see a GP because of financial difficulties would be automatically denied access to secondary care. Consequently, the problem of health disparities in New Zealand grew (Barnett & Barnett, 2004).

In summary, the foundations of the New Zealand public health system were laid through the Social Security Act of 1938. However, the initial aim of the Act was never fully realised. Due to the strong opposition from the GPs, the Act enabled New Zealand to adopt a dualism structure in its public health system. Although this system of dualism was formed by accident, and resulted in a fragmentation, the Act continues to underpin the present public health system and has remained unchanged since first being introduced.

### **5.2.1 The call to reform the health sector**

The world economic recession in the mid-1970s, which was caused by the oil crisis, put considerable pressure on governments around the world to change

the way in which they managed the State sector, primarily because governments were experiencing declines in tax collection and increases in public expenditure (Loffler, 2003). As a result, most governments suffered from fiscal stress during the recession, as the oil crisis hit different countries at different times and with different severity (Cendon, 2000; Loffler, 2003). New Zealand also faced strong economic pressures caused by massive public sector deficits, external trade imbalances and high overseas borrowing during the 1970s' economic recession (Grafton, Hazledine, & Buchardt, 1997). For instance, during the oil crisis, New Zealand trade fell by nearly half in a year; and this resulted in a steady rise in the inflation and unemployment rates. As a result, in 1984, the annual budget deficit was \$3 billion and the public overseas debt was above \$4 billion (State Services Commission, 1998).

Prior to the 1980s reform, the way in which the New Zealand public sector operated was seen as a major source of financial inefficiency; and New Zealand health services were identified as being amongst the least efficient parts of the State sector (McKinlay, 2000; Prince, Kearns, & Graig, 2006). For example, the practice of cash accounting in the government financial management system became an issue because nobody knew the true cost of public sector activities. Department budgets were constructed on the basis of inputs (the cost of production), rather than outputs (the quality or value of the product) (McKinlay, 2000). Furthermore, the central control of inputs substantially limited to the capacity of public sector managers to manage. As a result, the New Zealand public sector was perceived as inefficient (Hughes & Smart, 2012).

In relation to the situation outlined above, in the 1970s and 1980s there were debates about the need for cost containment, for better access to services, and for better coordination of different areas in health care (Starke, 2010). According to Fougere (1994) the situation had forced the government to rationalise the health care system so that it could deliver more with the same input of resources. As a result, the government began looking for a system that would help to improve the efficiency, effectiveness, and performance of

the health services. The history of reform began when the Labour government proposed a grand design for health administration through its White Paper: A Health Service for New Zealand 1974 (Martin & Salmond, 2001). This proposal aimed at improving efficiency and effectiveness in health care delivery.

Although the Labour government was defeated in the 1975 election, some of Labour’s proposals were later implemented by the National government. For instance, the National government enacted the Area Health Boards Act 1983 and decided to pilot the AHBs system, that had been designed by Labour, in the Northland and Wellington regions before proceeding with the full plan (Gauld, 2001). A new health funding system, called population-based funding was also introduced in 1983.

Labour was back in office after the 1984 election and decided to implement the full AHBs system throughout the country. Commencing from 1984 onwards, the New Zealand public health system has experienced at least four stages of reforms, including minor and radical changes under both left- and right-wing governments. Table 5.1 shows the timelines of major reform in the New Zealand public health system from 1984 to the present.

**Table 5:1 The timelines for the stages of reform in the New Zealand public health system from 1984 to the present**

| <b>Year(s)</b>         | <b>Stages and Types of reform</b>   |
|------------------------|---|
| <b>1984 - 1992</b>     | The beginning of reform<br>The Area Health Boards (AHBs) system   |
| <b>1993 -1999</b>      | Radical market-based reform<br>1993 – The Regional Health Authorities (RHAs) and Crown Health Enterprises (CHEs) system<br>1997 – The Health Funding Authority (HFA) and Hospital Health Services (HHSs) system |
| <b>1999 - 2008</b>     | More planned and community-oriented reform<br>The District Health Boards (DHBs) system  |
| <b>2008 to present</b> | Moves towards a unified model of care (post-2008 reform)<br>The Integrated DHBs (National Health Board, Regional Health Board and District Health Boards) and Primary Care Network                              |

Source: (Gauld, 2003b, 2012; NZ Parliamentary Library, 2009)

The following sections discuss the stages and types of reform in the New Zealand public health system from 1984 to the present day.

### **5.3 The beginning of reform: The AHBs system (1984-1992)**

#### **5.3.1 Issues prior to reform**

Following the 1938 legislation and the adoption of the dual funding method, the public health system became increasingly complex (Gauld, 2003b). According to the government, in the 1970s, the failure to coordinate health services between primary and secondary care affected the ability of the system to provide an efficient and cost-effective health service delivery, and established the problem of equity in terms of access to services for all New Zealanders (The Government White Paper, 1974). In practice, operating the dual health system significantly increased the government expenditure. Gauld (2001) notes that “over the period 1935-1945, the state’s contributions virtually doubled, from 39 percent of the total health expenditure to 73 percent and by 1980 stabilised around 80 percent of the total” (p. 23). Due to the ever-increasing growth in health expenditure, the capacity of the government to sustain this upward trend in health expenditure came into question (Martin & Salmond, 2001). The situation became critical when the first oil crisis began to hit the New Zealand’s economy in 1973/74. In response to the situation, the government decided to adopt some new managerial strategies in the public health system.

#### **5.3.2 The formats of reform and their challenges**

Based on Labour’s proposal, the National government introduced a modest health restructuring through the passage of the Area Health Boards Accountability Act 1983 and the establishment of the AHBs system in Northland and Wellington regions as a pilot study (Ashton, 2005). When Labour returned to office in 1984, the original plan of the AHBs system was implemented: 30 local Hospital Boards and Health Development Units were

gradually restructured into 14 Area Health Boards (AHBs). The AHBs system was fully realised in 1989. Similar to the older hospital board system, AHBs were responsible for secondary and tertiary care in their area with the coverage populations for each AHB varying according to geographical locations: the smallest covered 35,000 people in total, while the largest catered for 900,00 people (Starke, 2010). Under the AHBs system, board members were elected; they appointed their own chief executives. This practice showed that the communities were given important roles in managing health services.

AHBs received budgets from the government on the basis of population criteria (principally, on the basis of the patients' ages). Starke (2010) revealed that the population-based funding marked the introduction of a new emphasis on cost containment in providing health services. The government introduced a moderate NPM reform through the implementation of systematic planning and result-oriented reporting, finite budgets and informal contracts between AHBs and the Minister of Health (Barnett & Barnett, 1997). Each AHB was required to sign a performance-oriented accountability agreement with the Minister of Health based on the health goals and targets described by the New Zealand Health Charter 1989 (NZ Parliamentary Library, 2009). According to Barnett and Barnett (2003), the introduction of contractual relationships between the Ministry of Health and AHBs involved business principles and a management approach that included accountability and performance monitoring. These changes reflected the adoption of NPM strategies in health services.

Unlike secondary care, the primary care services continued to be separately funded and provided (Ashton & Tenbenschel, 2010; Gauld, 1999, 2003a). However, the primary care subsidy continued to grow at around 6% per annum and patients' copayment also increased, in process becoming amongst the highest in developed countries (Starke, 2010). High copayment charges created barriers to regular preventive care. As a result, there was a

growing inequality in access, especially in isolated areas where people could not normally afford the GPs' service fee (Barnett & Barnett, 2003).

In the early 1990s, further dissatisfaction with New Zealand's health care system arose. Despite evidence of positive improvement shown by the AHBs system, such as declining average length of stay in hospitals and little growth in the health spending as a percent of GDP between 1980-1990, the system was found to be inadequate to resolve the problems of financial accountability (Barnett & Barnett, 2003; Starke, 2010). Fragmentation of services between primary, secondary and tertiary care, along with different funding and accountability arrangements, led to costs shifting and tensions in health delivery management (Ashton et al., 2005; Barnett & Barnett, 2003). The AHBs system was reported to be inefficient and poorly managed, exceeding its budget and severely eroding assets in public hospitals (Mays & Devlin, 2005).

According to Maani, Yeoh, and Wallence (1998), the AHBs' problems arose due to several factors such as: lack of incentives for efficiency on the part of AHBs; inadequate monitoring by the government; and the dual accountability of AHBs to their elected representatives (to their community that elected them) and to the government that provided the funding (Ashton et al., 2005; Cumming & Mays, 2002). Moreover, Cumming and Mays (2002) suggest that the funding system for health populations was criticised for being unrelated to local population needs; making it difficult for the central government to contain costs; and for fragmenting health care services. Consequently, the waiting lists in public hospitals continued to grow whilst public confidence in the health system started to decline (Morgan & Simmons, 2009). These perceived problems pressured the government to look for other forms of reform.

## **5.4 Radical market-oriented reform: The RHAs and CHEs system (1993-1999)**

### **5.4.1 Issues prior to reform**

Following the election of the National government in October 1990, a number of radical changes in the delivery of social services, including health, were announced. The changes in health were announced through the passing of the Health and Disability Services Act 1993. This Act was guided by a quasi-market approach and rooted in neoliberal ideology. Hence, the Act was highly concerned with the principles of “fairness, self-reliance, greater personal choice, and efficiency” (Gauld, 1999, p. 56).

Health changes were led by the Treasury which itself was already being influenced by the idea of market mechanisms and competition. Barnett and Barnett (2003) names three reports which influenced the Treasury decisions in directing new reforms. They were:

1. Alain Enthoven’s works: Enthoven is an American professor who introduced the idea of an internal market in health care through a concept called ‘managed care–managed competition’. His publications on this area, especially around 1970s and 1980s inspired the British health care reform in the late 1980s. Since New Zealand has a close relationship with Britain, the adoption of reform in Britain significantly influenced the direction of reform in New Zealand
2. The CS First Boston Company report: The CS First Boston was commissioned by the New Zealand Business Roundtable to provide a report on delivering and financing health care in New Zealand. The report published in 1991, was authored by Patricia Danzon, a visiting American Professor for the CS First Boston, a company that provided consultation to the National Party.
3. The Gibbs Report: This was a review of hospitals and related services provided by a government-appointed taskforce. The taskforce was led

by Alan Gibbs, a New Zealand prominent businessman who strongly supported free-market views. This report was published in 1988.

According to Treasury, the level of health service efficiency could be improved if the health sector opened a way for private sector involvement (Ashton et al., 2005; Starke, 2010). The Treasury believed that resources could be better used through a system of managed competition (Alam & Lawrence, 1994). The decision to adopt the quasi market reform in health services was made by the National government in 1991 (Gibbs, Scott, & Fraser, 1988). The announcement surprised the New Zealand public because the adoption of that model demanded a 'big bang' implementation process, and subsequently reconfigured the whole New Zealand public health system.

This reform decision was widely criticised because it was made on the basis of how the government perceived health services rather than on the basis of a systematic evaluation of the health system (Lawrence, 2005). The announcement of health reform was seen as an abrupt decision from the top aimed at reducing government expenses. Even more surprisingly, there were no discussions or requests for submissions from interested parties prior to the introduction of legislation to implement this approach to reform. Some critics claimed that the government had shown its authoritative voice with regards to the reform decisions (Ashton, 1995), while Alam and Lawrence (1994) claimed that "the Government's 'real' motive was to reduce health spending either by reducing the cost or shifting some of the burden to users" (p. 42).

#### **5.4.2 The formats of reform and their challenges**

Through the quasi market-based reform, the government aimed to achieve two main objectives: "to focus public funding on the most important treatments and the neediest patients; and to improve the efficiency of hospital systems" (Morgan & Simmons, 2009, p. 31). In order to achieve those objectives, the government abolished AHBs and elected representation,

and introduced separate organisations which would be responsible for purchasing and provisioning health services (Ashton et al., 2005; Thompson & Gauld, 2001). Four new purchasing agents, called Regional Health Authorities (RHAs), were established as purchasers for their populations. The role of RHAs was to assess the health service requirements of their populations and to purchase services as necessary from the most cost-effective providers (Ashton, 1995).

Meanwhile, the service delivery arms of AHBs were transformed into 23 local Crown Health Enterprises (CHEs). As publicly owned, limited liability companies, CHEs were to be run on a commercial basis by making them – including private hospitals – compete against each other for a contract with RHAs (NZ Parliamentary Library, 2009; Starke, 2010). The government appeared to assume that the competition would force CHEs to improve the quality of their services and to reduce the costs of health provision by between 24% and 32% (Gibbs et al., 1988; Morgan & Simmons, 2009). Therefore, public hospitals were required to be run as efficient businesses with the aim of earning high investment returns for the government.

Running public hospitals as business entities, however, appeared to be difficult for several reasons. First, the injection of competing values into hospitals eroded the spirit of cooperation which, in turn, undermined the potential for New Zealand to have a ‘national health system’. Morgan and Simmons (2009) reported that the conceiving of public hospitals as business entities discouraged CHEs from sharing health innovations and information. Health innovations and new health information were regarded as strategic business tools by each CHE and these business tools were treated as CHEs’ confidential documents. In principle, CHEs had the right to keep their strategic tools confidential since they were protected by the Commerce Act 1986. However, from the public perspective, such protection denied the wider public its right to benefit from any innovations developed by any individual hospital.

Second, the introduction of Financial Management Reform (FMR) with the objective of improving economic efficiency and accountability, eroded the quality of health services (Lawrence, 2005; Mays & Devlin, 2005). FMR was a part of the New Zealand public sector reform, and was backed by three legislative changes: The State Owned Enterprise Act 1986, The State Sector Act 1988, and the Public Finance Act 1989 (Lawrence, Alam, & Lowe, 1994). The implementation of FMR was driven by three main objectives: efficiency, effectiveness, and value for money, which led to major changes in public sector accounting, including the health sector. In order to achieve those objectives, costs were used by health providers as the basis of health service provisions. This approach meant that providers would provide health services only if the services achieved the required efficiency level. Efficiency was described in the following terms:

1. the overall health expenditure gets maximum benefit from the resources used.
2. choices of expenditure are the best that could be made and no change in priorities among categories of public or private spending would improve overall welfare.

(Scott, Fougere, & Marwick, 1986, p. 11).

Although the concept of health efficiency was clearly defined, Scott et al., (1986) argued that the concept of efficiency is hard to apply, especially in a narrower context such as identifying the most efficient way of giving health treatment, because individual health conditions differ. Furthermore, measuring curative services is tricky because a cause and effect relationship between spending additional money and gaining further improvement in health status is hard to identify.

The search for efficiency in health through market-based reform led to a major transformation in the New Zealand public health system. According to Lawrence, Alam and Lowe (1994), “the recent reforms in NZ are intended to be sweeping and to change the culture of health care providers by increasingly infusing management with the conceptual language of business,

economics and of accounting rather than medical services” (p. 69). This intention can be seen through the breaking down of an integrated hospital into a number of ‘profit centres’, in which each centre is urged to use accounting information in controlling clinical costs and allocating resources (Lawrence, 2005).

To support the operation of profit centres, public hospitals were required to link the service output with funding. Furthermore, to realise this requirement, public hospitals were encouraged to adopt a more commercial approach in managing health care provision (Lowe, 2001). In relation to this, public hospitals developed a casemix system and institutionalized Diagnosis Related Group (DRG) framework. The casemix and DRG framework “is an attempt to manage and regulate medical practice in relation to the consumption of resource” (Lowe, 2001, p. 85). This framework, which is rooted in accounting information technology, is used as the basis of managing clinical activities by linking patients’ information (diagnosis, age and treatment) with resource allocation. The use of this framework was expected to enhance efficiency and effectiveness, as well as accountability in public hospitals because information generated from the DRG system will facilitate clinicians to limit unnecessary procedures and improve treatment protocols (Lowe, 2001).

However, being overly concerned about cost efficiency as well as value for money in measuring health efficiency resulted in difficulties for patients in receiving health treatment. For example, Lawrence (2005) contends that the patients’ illnesses were no longer treated by a single centre but by a number of related centres. The breaking down of an integrated centre into small and independent profit centres created difficulties for patients in obtaining health treatment. In many instances, patients were moved backwards and forwards from one centre to another just to meet the centres’ costing procedure. Such processes were seen as potentially affecting the quality of health services adversely. Similar results were identified in the casemix and DRG framework. The work of Lowe (2001) revealed that the case mix and DRG coding system

had, in practice, proved to be rather difficult due to inability of the health actors to commit with the system.

Furthermore, being overly concern about the costs and value for money issues has negative implications on patients. For instance, the rights of the public to receive health treatments were denied, especially when the cost of treatments was high. The case of Rau Williams, who was denied health treatments because of their high estimated cost, was a classic example (Lawrence, 2005; Manning & Paterson, 2005; Morgan & Simmons, 2009). Williams, a 63 years old man with diabetes was in the end-stage of renal failure. Northland Health refused his admittance to the End Stage Renal Failure programme (Feek et al., 1999). The decision was made on the basis of the access guidelines for entry into end-stage renal failure programmes. Three criteria were used as the indicators: age of the patient must be below 75 years old, patients must have no other serious diseases, and the cost of services must fall within a capped budget. Feek et al. (1999) argued that these guidelines were based on resource issues because patients with end-stage renal failure will often die if they do not receive renal replacement. Consequently, another renal treatment will not improve renal patients' health status. In other words, investment in renal treatment will not provide a good return in terms of health status.

In relation to the above case, the media reported the public health system as "the hapless, faithfully taxpaying Kiwi condemned to die by heartless bureaucrats because the lifesaving treatment she or he needs is deemed too expensive" (Morgan & Simmons, 2009, p. 32). Hospital management's lack of sensitivity to the needs of patients, compared to the costs of treatment, also increased the length of waiting lists. Within the first 3 years of the implementation of the quasi market-based reform strategy, the waiting lists continued to grow, increasing numerically from 64,000 in 1993 to over 94,000 in 1996 (Morgan & Simmons, 2009).

Third, public health is a public good and, therefore, commercialising the public good is challenging (Barker, 1996). In fact, in most cases, commercialising the public good with the aim of improving efficiency always ends in disappointments (Gilson, Doherty, Loewenson, & Francis, 2007). This failure to improve efficiency can be seen from the growing cost borne by governments and patients as a result of unexpected market conditions. For instance, CHEs were established with the objective of improving efficiency and effectiveness in health delivery. However, the reality indicated that CHEs inherited and continued to post deficits, and none returned any profits to the Crown (Mays & Devlin, 2005). For instance, by the end of the 1996/7 financial year, the 23 CHEs were carrying debts of NZ\$219.3 million, representing a negative return on equity of close to 12% and the predictions of financial improvement for 1997/8 were not achieved (Gauld, 1999).

The above situations show that the result of quasi market-based reform in public health appeared to produce the reverse of the government's earlier objectives. Rather than decreasing, health expenditure grew significantly following the implementation of the market-based strategy. According to Easton (2002), the reform was expensive, with total estimated costs ranging from 2% to 10% of the total annual health budget. The cost increased because the government had to bail out hospitals which overspent their budget (Fougere, 2001). In relation to such situations, Lawrence (2005) described the quasi market-based reform in the New Zealand public health system as a case of "iatrogenic disorder" (p. 4) that is, the remedy prescribed by the government for the treatment of public illness turned out to be more harmful than the illness itself.

Public health is not like other sectors, in which efficiency can be measured through the 'input and output process'. In health services, the quality of services is much more important than efficiency (Lawrence, 2005). Although economic efficiency may be achieved, it might not appear to be something that patients need the most. For these reasons, the quasi market-based

reform in the public health system was sharply criticised, in particular by providers and health care workers (Lawrence, 2005).

In response to such situations, the next coalition Government, which was established in 1996, decided to reduce the market element by introducing more centralised control (Starke, 2010). The four RHAs were combined into a single national government purchasing agency, called the Health Funding Authority (HFA), which was responsible for the purchase of all public health and social care services in all regions, whilst CHEs were reconfigured as not-for-profit Crown-owned companies called Hospital and Health Services (HHSs) (Ashton et al., 2005). Despite the fact that the for-profit objective of health provision was removed, providers were still required to operate in a business-like manner (Gauld, 1999).

Meanwhile, unlike reform at the secondary care level, the implementation of health service reform at the primary care level was limited to management of the funding system. For example, in 1991, the government revised the primary health funding system and replaced the universal funding formula with a system targeted according to patients' income and level of use of the service (Mays & Devlin, 2005). The government believed that by targeting subsidies to lower income groups, it would improve the access of these groups to health services. To reduce the financial barriers, the Community Service Card (CSC) and High Use Health Care Card (HUHC) were introduced to the targeted populations (Cumming et al., 2009). The CSC card was made available for low-income households, whilst HUHC was designed for those who regularly used a primary health service (Cumming et al., 2009). According to Starke (2010), the changes in subsidy criteria marked a new emphasis on cost containment in New Zealand public health.

As a result of the above changes, health services continued to be a national issue during the 1999 election campaign. The introduction of a new booking system which replaced the waiting list system was found to be unreliable (Morgan & Simmons, 2009). Under the new booking system, a patient who

was on the waiting list could be entered into the booking system if he or she could be given a date for surgery within the coming 6 months. If patients failed to obtain a date within that period, their name would not be recorded officially and would automatically drop off the waiting list (Lawrence, 2005; Morgan & Simmons, 2009).

Meanwhile, it was found that the targeted subsidy system introduced in primary care struggled to achieve its initial objectives. Mays and Devlin (2005) point out that under the targeted subsidy system, the GPs' consultation fees increased for lower income adults but decreased for higher income adults. In addition, while the quality of New Zealand primary health care services was rated well against international comparisons, studies on the accessibility of primary care showed the reverse (Mays & Devlin, 2005).

The Labour Party criticised the government "for its narrow focus on the production of services rather than the improvement of health, for having fragmented a public service, for fostering commercial behaviour, for increasing transaction costs, and for lacking local democratic input" (Starke, 2010, p. 501). The market-based approach in health was seen as having failed to convince the New Zealand public and this failure helped to bring Labour back into office, after the 1999 general election. The new Labour government introduced a new approach in the public health system with the aim of balancing the previous health policy objectives of efficiency, effectiveness and economy with equity, which is a traditional value of the welfare state (Lawrence, 2005). The adoption of equity value indicated the government reform strategy in the New Zealand public health system moved from NPM to NPS framework.

## **5.5 More planned and community-oriented reform (1999 - 2008): The DHBs system**

### **5.5.1 Issues prior to reform**

The quasi market-based reform in New Zealand health services in the 1990s cost the government around \$270 million (Morgan & Simmons, 2009). The government spent the money on reorganising health services through the establishment of new agencies and also through paying the government-appointed health consultants. The newly established health agencies were required to operate in a competitive business model with a strong emphasis on contracts and tenders, and price and quality (Gauld, 2005).

The introduction of market-based reform replaced the triumvirate system, an old management system that based on consensus between three main three executives, namely a doctor, a nurse, and an administrator with a new system that separated the management from professional operations (Gibbs et al., 1988). In other words, the old triumvirate system was divided into two divisions, namely health services and health management. According to Matheson (2013a), under the separation system “a doctor’s got to do what a doctor’s got to do. Money was passed over for the provision of General Medical Services”(p.4). Matheson’s statements indicate that health services were led by the health professionals, whilst health management was directed by professional managers who were accorded a distinct and relatively high status.

The market-based reform can be viewed as marking a tragic moment in the history of health service reform in New Zealand. The market model was criticised as unhealthy because the competitive tendering led to fragmented services, and lacked democratic values without accountability both to the government and local communities (Ashton et al., 2005; Gauld, 2005). Labour was trying to overhaul the system by reversing the market-based

strategies to community-based approaches. This new approach brought health services into yet another round of change.

### **5.5.2 The formats of reform and their challenges**

In 2000, once again, a new sketch of New Zealand health care system was being drawn following the introduction of a new policy direction by the Labour-led coalition government. In this round of restructuring, the policy direction contrasted with the previous policy path as it fostered cooperative rather than competitive models of service provision (Barnett & Barnett, 2004; Starke, 2010). Changes were implemented through the passing of The New Zealand Public Health and Disability Act (NZPHDA) of 2000. The aims of this Act were to improve the health of the population, to reduce health disparities, and to ensure access to quality services by providing greater public input into health decision making (Barnett et al., 2009).

In order to achieve the aims of the new Act, the government focused on two main strategies: re-reforming the key organisations of the health sector, and strengthening primary health care, including the subsidy system (Starke, 2010). The Ministry of Health then became the principal agency responsible for policy advice, funding and monitoring of the health and disability sector (NZ Parliamentary Library, 2009). The single health funder, the HFA, was abolished and its functions were transferred to the newly restructured Ministry (Ashton et al., 2005). The government reintroduced 21 regional health funding agencies called District Health Boards (DHBs) to replace HHSs. DHBs took responsibility for the purchase and provision of health services in their districts, including contracting with communities and primary care providers (Manning & Paterson, 2005; Morgan & Simmons, 2009; NZ Parliamentary Library, 2009; Starke, 2010). DHBs are governed by 11 board members, 7 of which are locally elected while the remaining 4 are ministerially appointed.

The implementation of the NZPHDA very much resembled the AHB system which had been legislated in the 1980s and scrapped in 1993; however, the main difference lies in the fact that the 2000 Act recognises DHBs as Crown entities whose boards, both elected and appointed, are responsible to the Minister of Health (Ministry of Health, 2010). In recognition of the Crown's relationship with Maori, each board has to include at least two Maori members to ensure a minimum level of Maori representation on boards (Cumming & Mays, 2002). Unlike the AHBs system, DHBs are the principal providers of primary, secondary and tertiary care (Ashton, 2005; Ministry of Health, 2010).

This arrangement shows that DHBs are responsible for developing local health services that integrate all levels of health care. Simultaneously, the introduction of elected board member system reflects the effort of the government to democratise the health care governance by increasing public participation in health care planning and the decision making process (Gauld, 2005). Nevertheless, although DHBs do not have a role in formulating policy, they do have important roles in implementing policy. Specifically, DHBs are responsible for planning, prioritising, and purchasing from an appropriate range of providers for their population (Gauld, 2005).

The most interesting aspect of this stage of reform is that the NZPHDA recognised the role of primary care in improving the health status and reducing health disparities among New Zealand's populations. After being separated for nearly 60 years, primary care was finally being included as a part of the national reform strategy under the NZPHDA. The government showed its efforts to strengthen primary health care through the passing of the New Zealand Primary Health Care Strategy (NZPHCS) in 2002. Uniquely, rather than providing a detailed implementation plan for the primary care system and overall health sector, the NZPHCS is full of new visions for developing the primary care system. This point is clearly made in the NZPHCS document which states:

The Strategy [NZPHCS] outlines a new vision for primary health care. It does not contain details of implementation, which will involve evolutionary change to protect the gains already made. Involvement and collaboration with the primary health care sector will be a key feature of the implementation process in the coming months and years. This is crucial to ensure that all issues are considered in developing the new arrangements.

(Ministry of Health, 2001, p. ix).

Under the NZPHCS, the government aims to create a strong primary care-focused health system aligned with the principles of the Alma-Ata Declaration of the World Health Organisation (WHO), which New Zealand signed in 1978 (OECD, 2009). Specifically, the primary care reform created two main instruments: a new primary health model, which involves community participation in improving the health of people; and, an alteration in the method of paying primary care subsidies (OECD, 2009). Howell (2005) considers that “the primary care reform under the NZPHCS fundamentally rewrites the ‘social contract’ between taxpayers, the government and general practitioners, with consequent changes in responsibilities and cash flows in the sector” (p. 6).

Through the NZPHCS, the government introduced a new form of primary care called Primary Health Organisations (PHOs). Basically, PHOs consist of “networks of different health care providers – and not just, as IPAs usually were, a GP network – and are supposed to be community owned and governed” (Starke, 2010, p. 503). Under this model, the PHOs are recognised as the DHBs’ vehicles with responsibility for providing essential primary health care services to their enrolled populations. The following are the criteria of a newly formed PHO as outlined by the government:

1. PHO will be funded by DHBs for the provision of a set of essential primary health care services to those people who are enrolled.
2. At a minimum, these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people’s health when they are unwell.

3. PHOs will be expected to involve their communities in their governing process.
4. All providers and practitioners must be involved in the organisation's decision-making, rather than one group being dominant.
5. PHOs will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
6. While primary care practitioners will be encouraged to join PHOs, membership will be voluntary.

(Ministry of Health, 2001, p. 5)

The formation of the PHO model was also seen as an effort on the part of the government to downplay the role of GPs in primary care (Barnett & Barnett, 2004). The previous health reform (1993-1999), which focused on the competition among CHEs for RHAs contracts, led to the establishment of Independent Practitioner Associations (IPAs) (Starke, 2010). IPAs were comprised of GPs and other health providers, both large and small, with the main aim of this amalgamation being to give the GPs a better position from which to negotiate contracts with the purchasing bodies in the quasi market system (Gauld, 2008; Starke, 2010). For example, Barnett and Barnett (1997) stated that "IPAs were viewed as vehicles for protecting the status of general practice in the face of considerable uncertainty in GP relations with RHAs" (p.56). As a new organisational model, IPAs spread very quickly in the 1990s and by 1999 over 80% of GPs belonged to an IPA (Starke, 2010).

The dominant position of IPAs in primary care indicated that they had a strong influence in controlling the rate of copayments. Too frequently, the rate of copayments was increased by the IPAs-GPs without concern for the ability of the vulnerable groups to pay (Starke, 2010). As a result, the problem of health disparities widened among these groups due to the issues of limitation of access. In response to such a problem, the government tried to minimise the role of IPAs in health service delivery by increasing community involvement as proposed through the new PHO model. Howell (2006) regards the new PHO model as the intention of government to replace the "old isolated ways of working" with a "new collaborative model" (p. 3).

To improve the format of health service delivery, the government also introduced a new funding system called capitation. The capitation system was seen as an effort to reduce the cost barrier which deterred some people from seeking care (Ashton, 2005). Through this system, the government aimed to reduce copayments for all populations by providing extra funding in order to ensure a reduction of out-of-pocket expenditure for the most vulnerable groups (Cumming & Mays, 2002; Starke, 2010). Specifically, the vulnerable groups were determined according to geographical location, age, ethnicity and chronic health condition. The identified vulnerable groups will receive the higher funding rate (Starke, 2010).

The bulk government payment to PHOs was determined by two alternative capitation formulas, namely, the access formula and the interim formula (Ashton, 2005). According to Ashton (2005), the access formula applied only for PHOs in which 50% of their enrolled populations were either Maori or Pacific, or living in a deprived area. Meanwhile, the interim formula applied to all other PHOs whose populations had light and moderate primary care requirements and who reside in nondeprived areas (Cordery, 2008). In order to reduce the level of copayments for primary care, the government has increased the higher subsidy rate to include all age groups starting from July 2007 onwards (Jatrana & Crampton, 2009).

The initial implementation of the 2000 reforms was reported as proceeding relatively smoothly (Ashton, 2005). Cumming (2011) claims that evaluations of the new health care system revealed some important achievements and improvements in health care services, including statistically significant improvement in health disparities and in health outcomes. For example, the Ministry of Health reported that infant mortality was dropping for both Maori and the total population, with the rate declining from 11.5 deaths per 1,000 live births in 1996 to 6.6 per 1,000 in 2005 (45%). Meanwhile, in relation to life expectancy, the statistics showed an increase of 3.5 years for males and 2.2 years for females over the period 1998-2007 (Smith, 2009).

Cumming (2011) claimed that, on the surface level, the 2000 reforms appeared to improve the health system, at both the primary and secondary care levels. However, in-depth analysis of the 2000 reform strategies indicated some problematic mismatches between the management of health care and the health delivery frameworks and the initial reform objectives (Ashton, 2005; Cumming & Mays, 2002). For instance, DHBs were facing several challenges in their roles as purchasers and providers in delivering health care services. Although DHBs were given authority to manage their funding according to local needs, DHBs continued to face difficulties in planning for their populations. The difficulties arose because of inaccurate information about the districts' populations as a result of rapid internal migration (Ashton, 2005).

Similarly, Ashton, Tenbenschel, Cumming, and Barnett (2008) revealed that the DHBs' chief executives and chairpersons claimed that the government used outdated population statistics in calculating health funding and sometimes gave incorrect domicile information for patients. In many instances, DHBs were subjected to the requirements of the Ministry of Health, which retained control over discretionary spending. For example, this was the case when new money which was transferred to DHBs had already tagged for spending on specific services such as primary care and mental health service (Ashton et al., 2008). For these reasons, it was sometimes difficult for DHBs to redistribute funds on the basis of local needs.

Furthermore, DHBs were also struggling with financial difficulties. Most DHBs had inherited a deficit from the previous CHEs structure (Ashton, et al., 2008). From the beginning of their establishment, DHBs were strongly encouraged by the government to reduce their deficits by 2005 and to work within their budget means. By 2005, all DHBs had succeeded in reducing their deficits by reducing costs within their own hospitals and through the injection of additional funds from the government. The combined DHB deficits in 2001/2002 fell from \$287 million to \$15 million in 2004/2005. However, this trend did not last because the health expenses increased from

time to time. Again, by 2008/2009, DHBs were running a combined deficit of about \$150 million and had made unfunded capital requests for between \$436 and \$636 million in the same period (Ministerial Review Group, 2009).

Meanwhile, primary health care was also facing a number of serious challenges in delivering health care services to the public. According to the OECD (2009) analysis, the result of the first 6 years of the NZPHCS had been mixed, and was mostly disappointing. Of the total of 82 PHOs, half were categorised as small, with fewer than 20,000 enrolled in total (Gauld & Mays, 2006). According to the OECD (2009) report, these small PHOs tend to be “community based, intrinsically motivated and receptive to community needs, and they have achieved some encouraging local successes, especially in deprived, poorly served areas with obviously high needs”(p. 126). However, in terms of management efficiency, the small PHOs were found to be less efficient due to their newly-formed status, restricted capacity and limited funding. For instance, the management cost for a small PHO accounted for up to 21% of the total budget and subsequently the government increased management funding (Gauld & Mays, 2006).

The other issue related to the PHOs model was the domination of the IPA-formed PHOs in the primary care sector. In the early implementation of the PHO model, the government announced that the capitation funding for primary care could flow only through membership with PHOs (Ministry of Health, 2001). Following the announcement, some of the IPAs-aligned GPs took the lead in forming new IPAs provider-driven PHOs (Gauld, 2008; Howell, 2006). Following this new formation of PHOs, the IPAs focused on other functions such as management services, clinical support services and advocacy, while the GPs continue to control patients charges (Gauld, 2008). Analysis of PHOs’ formation and enrolment patterns confirms that over 90% of individuals were registered with PHOs formed around IPAs (Howell, 2006). As a result, PHOs formed by IPAs simply became larger PHOs in their geographical areas. The OECD (2009) analysis indicated that the larger PHOs “may be geographically scattered with little local loyalty and often appear to

be mostly business propositions to capture and channel public money” (p.126).

As well as all the issues highlighted above, overall operations in the New Zealand health system were expected to become more pressing in the future due to a shortage of health workers. For example, the Association of Salaried Medical Specialist (ASMS – the hospital doctors' union) revealed that New Zealand is facing a serious shortage of specialist doctors (Powel, 2011). OECD data released in 2009 show that New Zealand was positioned at the bottom of the OECD table in terms of the number of practising specialists, with 0.8 specialists per 1,000 population (Association Salaried Medical Specialist, 2010). Thus, New Zealand falls well short of its international counterparts in having less than half of the OECD average 1.8 per 1,000. By contrast, Australia, which is also experiencing health workforce shortages and also fell short of the OECD average, still managed to have 1.4 specialists per 1,000 population (Association Salaried Medical Specialist, 2010). Meanwhile, the New Zealand Nurses Organisation reported a shortage of 2,000 nurses (Powel, 2011). The Executive Director of ASMS claimed that the shortage of senior hospital specialists and nurses was causing DHBs to fail to meet the government health care targets.

In addition, the National Party raised concerns about the growing percentage spent on health. Since 2000, the DHBs system was seen as consuming a large amount of the public budget, i.e., \$5 billion or 9% of GDP. However, the budget increment was not followed by a growth in the quality of health care delivery as waiting times were growing (Ryall, 2007). The National Party Leader, John Key, argued that while too much taxpayer money was being wasted, too few improvements were being made (Ryall, 2007). As a result, several questions pertaining to the performance and sustainability of the New Zealand health system emerged. In response to them, National proposed a better health performance through smarter use of resources. The following subsection discusses the post-2008 health reform.

## **5.6 Towards a unified model of care (post-2008 reform)**

### **5.6.1 Issues prior to reform**

Prior to the 2008 election, the National Party published a series of policy announcements for health. Perhaps, because the government noticed that previous arguments had been inadequate to persuade people to concur with more reforms, arguments for reform in recent reviews of health services have changed slightly. The arguments have shifted from the impact of macro issues (economy and social factors) to the micro or internal issues in health services (health sector performance). For instance, in 2009, the Ministerial Review Group (MRG) rationalised the needs for reform from sustainability perspectives. According to the report, the future of New Zealand public health system is under serious threat because of several challenges such as ageing population, health workforce shortages, poor quality of services and unsustainable health funding due to raising costs in health services.

The National Party believed that the existing public health system, which operated in a fragmented structure, was seen as unable to face such challenges. The fragmented health structure had resulted in administrative and service duplications which led to variations in quality of care, unacceptable waiting times, and unequal access to health services (Ryall, 2007). Gauld (2012) describes the scenario of the public health system as follows:

For a small country of 4.3 million, 21 DHBs and 81 PHOs seemed excessive, with high transaction costs, considerable duplication of planning, purchasing and administrative activities and wide-ranging concerns about variation in size, efficiency and service access. Clinical staff, meantime, had become increasingly alienated from management and policy makers. (p. 111)

Therefore, from the National party perspective, reform was needed in order to ensure the future sustainability of the health sector. In the BSMC paper, the National party highlighted its proposals for improving the overall

performance of health services (Ryall, 2007). According to National, the outlined proposals not only react to today's problems but also prepare health services for future challenges. The concept of BSMC demonstrated the NPS' intention to deliver better, timelier, and more convenient health care for all New Zealanders. According to Ryall (2007), objectives of the BSMC policy are:

1. to reduce waiting times
2. to improve quality and performance of health care
3. to create a more conducive health care for better individual patient and family experience
4. to provide a more trusted and motivated health workforce.

In its publication, "Health policy: funding and framework", National announced its funding intention and specific BSMC strategies (National Party, 2008). At the same time, National promised not to restructure but, rather, to focus on strengthening the health system by improving its performance (Gauld, 2012). Soon after the election of National in 2008, the MRG was commissioned to review the health system and its performance (Gauld, 2012). The commission was chaired by Dr Murray Horn, a former Treasury Secretary and a private sector banker; the group also included leading clinicians and managers in the health sector (Gauld, 2012; Ryall, 2009).

In the MRG's report, "Meeting The Challenge", the Commission revealed that the New Zealand public health and disability system was under serious threat due to excessive bureaucracy, lack of integrated care, low focus on patients' safety and quality, and lack of financial sustainability (Ministerial Review Group, 2009). The Commission presented 170 recommendations on how to reduce bureaucracy, improve frontline health services, and improve value in the public health and disability sector through structural changes at the national, regional, and local levels.

However, in a Parliamentary statement, the Minister of Health asserted that the government had no obligation to accept all the MRG's recommendations. The government was concerned only with recommendations which would

help to reduce the problems of bureaucracy and inefficiency in health service delivery. In the same statement, the government promised to ensure minimal disruptions in the wider health sector while implementing the process of reforms (Ryall, 2009).

### **5.6.2 The formats of reform and their challenges**

In 2009, the government officially introduced BSMC initiatives as a “new model of care”. This model focuses on patients rather than institutions as a core principle of service delivery (Cumming, 2011). The aim of this model is to improve the efficiency and quality of care by reducing unnecessary bureaucracy and waste, and by moving resources to the front-line services (Gauld, 2012). By focusing on quality improvement, the health system aims to deliver better patient outcomes and ensure better access to health services through smarter planning on resource allocations (Ministerial Review Group, 2009).

The government then formulated three main strategies to facilitate the achievement of these aims. The strategies are: shifting responsibilities away from the district level at the regional and national levels by implementing several structural changes at the national, regional, and district levels; adopting the development of information technology (IT), both in purchasing and in providing services; and, addressing the problem of health workforce shortages (Ministerial Review Group, 2009). These strategies signalled that health services would enter into another round of change. This new strategy for change conflicted with the government’s earlier promise that reform would be implemented without changing the existing health frameworks and structures (Ministerial Review Group, 2009).

As with previous cycles reform, changes in health during this round of reform were also driven by the issues of financial efficiency and sustainability. Having 20 DHBs to deliver the same services in different districts was seen by the commission as a duplication of administrative tasks which led to a

waste of public resources. Therefore, the government redesigned the existing structure of health service delivery. The structural changes began in 2009 at the central government level with the establishment of independent business units under the Ministry of Health, such as the NHB, the IT Health Board, Capital Investment Committee, and the HWNZ.

Made up of a ministerially appointed board, the NHB is a Crown Health Funding Agency that reports directly to both the Minister and the Director General of Health (Gauld, 2012). The NHB was set up to play crucial roles in creating more integrated health and disability support system at the national level. The NHB has developed a long-term policy plan with the objective of providing a high level of direction for the health sector. This 20-year plan describes the likely challenges, solutions and implications for the health system in the future. The plan also provides guidance for future decisions regarding service configuration and investment at all levels of the health (national, regional and district) and disability support system (National Health Board, 2010).

Following the creation of the NHB and long-term health plans, the roles of the Ministry of Health and DHBs were restructured to align with these plans. The Ministry of Health is now the government's principal advisor on health and is fully responsible for health policy developments, and regulatory functions. The Ministry's other responsibilities, such as a funder of health and disability services, and manager of national operations, have been transferred to the NHB. In order to reduce duplications of some of the roles played by the DHBs and the Ministry of Health, the NHB is fully responsible for planning and funding those health services that are truly national in scope (Ashton & Tenbenschel, 2012). For instance, the NHB took over some of the DHBs' responsibilities, for example, as funders of services for their district's population and as providers of health and disability services. Simultaneously, the NHB is also responsible for monitoring, funding and organising DHBs, including improving DHBs' performance, ensuring a national focus for DHBs, and reducing duplication and bureaucracy, especially around planning and

funding for primary care, maternity, mental health and some other services (Gauld, 2012).

The NHB is supported by two subcommittees, namely the Capital Investment Committee and the IT Health Boards Committee. The primary objective of the Capital Investment Committee is to ensure better investment decisions in the health system through a new, centrally-led process of national planning and prioritisation for capital funding and investment in the health sector, along with advising on investment and infrastructure matters to support the government's service planning direction (Ministry of Health, 2014). Meanwhile, the IT Health Board was established with the objectives of strengthening the leadership of health information technology in the context of improving the overall performance of the health system, and of ensuring the IT strategy is reflected in capital allocation (National Health Board, 2010). The vision of the IT Health Board is to achieve high quality care and to improve patients' safety. In this way, by 2014, member of the New Zealand public was expected to have a core set of personal health information available electronically to them and their providers, regardless of the setting, as they access health services (National Health Board, 2010).

The government also established the HWNZ, another independent agency under the Ministry of Health, which has overall responsibilities for the planning and development of the health workforce. The aim of the HWNZ is to ensure that New Zealand has a high quality, fit-for-purpose, and motivated health workforce by aligning staffing issues with planning for service delivery (Ministry of Health, 2014). The link between the NHB and the other three independent agencies – IT Health Board Committee, Capital Investment Committee and HWNZ – is that the chairpersons for these three agencies are members of the NHB's board. Therefore, the NHB is expected to ensure all the efforts and strategies in the health sector are closely coordinated. Strategically, these agencies are working together with the Ministry of Health to consolidate planning, funding, workforce planning and capital investment, in addition to monitoring public expenses for various health agencies,

including public hospitals, primary care and other health services (Ministry of Health, 2014).

In 2010, the government established a Crown-owned company called Health Benefits Limited (HBL). A nationally-shared services organisation, HBL is owned by The Ministry of Health and the Ministry of Finance with the objective of reducing costs and increasing savings through the effective and efficient delivery of administrative support, and procurement services for DHBs ([www.health.govt.nz](http://www.health.govt.nz)). According to Gauld (2012), the goal of HBL is to reduce funding for nonclinical services by \$700 million over 5 years through centralising DHB office functions. The government also formed another Crown agency called the Health Quality and Safety Commission. The objectives of this commission are to lead and coordinate work in the national health system for the purposes of monitoring and improving the quality and safety of health and disability support services (Health Quality & Safety Commission New Zealand, n.d.)

The establishment of the above key agencies at the national level is in line with one of the MRG's recommendations to adopt a centralised approach. The centralisation approach is seen by the government as a reliable strategy to correct the perceived fragmentation problem in health services as it is expected to reduce unnecessary bureaucracy, and to ensure rapid implementation of the government's national priorities. Meanwhile, at the regional and local levels, the BSMC initiatives aimed at making the current DHB- and PHO-based model work better within a more unified system. The MRG's report argued that having too many DHBs had caused problems of fragmentation in the New Zealand health care system, whilst large variations in PHOs failed to contribute to wider system efficiency (Ministerial Review Group, 2009). Therefore, a collaborative-based approach for DHBs and PHOs was seen as being required in order to make these agencies deliver their services efficiently.

The MRG also recommended greater regional collaboration between DHBs. Through regional collaboration, DHBs are expected to find optimum arrangement for the most effective and efficient ways in delivering health services (Ashton & Tenbenschel, 2012). The collaboration involves procurement of supplies, human resources and payroll, the management of financial planning and information system, and provider audits (Ashton & Tenbenschel, 2012). Collaboration is believed to reduce administrative duplication and to help DHBs meet the health and disability needs of their populations (Ministerial Review Group, 2009). To realise the regional collaboration, the government established four Regional DHBs in 2010. The governance of the Regional DHBs comprised all the DHBs' chairpersons and CEOs. The establishment of the Regional DHBs was expected to enable effective regional decision making on behalf of the constituent DHBs at a regional level. Table 5.2 shows the configuration of the Regional DHBs.

Each Regional DHB is required to produce regional service plans across a wide range of services. In preparing a regional service plan, each region needs to identify 3 to 5 key service areas it intends to address and to provide more detail on the actions it intends to take (Ministry of Health, 2011a). The Regional DHBs' governance has to ensure that the actions are linked to and supported by IT and workforce planning (Ministry of Health, 2011a). The NHB is expected to provide feedback for the regional DHBs before receiving the finalised Regional Service Plan. According to the Ministry of Health (2008), the implementation of these strategies shows that DHBs are working both for local populations and for the population of the country as a whole.

**Table 5:2 The configuration of the regional DHBs**

| Region(s)       | DHBs  |
|-----------------|---|
| <b>Northern</b> | Northland, Waitemata, Auckland, Counties Manukau                                |
| <b>Midland</b>  | Waikato, Bay of Plenty, Lakes, Tairāwhiti, Taranaki                             |
| <b>Central</b>  | Hawke's Bay, Mid Central, Whanganui, Wairarapa, Hutt Valley                     |
| <b>Southern</b> | Nelson, Marlborough, Canterbury, West Coast, South Canterbury, Otago, Southland |

Source: Ministry of Health, 2008

In order to improve efficiency and effectiveness of health services, the National government also extended the collaboration strategy to the primary care level. National argued that, although the NZPHCS had been effective in improving access to primary care services, it was not working in producing more comprehensive care provided by a wider range of health professionals (Ashton & Tenbenschel, 2012). Therefore, the government required DHBs to collaborate with other local health care agencies, including hospitals, PHOs, and community clinicians, and also with the patients. The aim of the collaboration is to develop a new model of care with patient-centric services delivered closer to home. This model is expected to promote integrated family health centres and clusters in order to provide more health care services outside of hospitals and shifting care closer to home by helping people to keep themselves well, reducing avoidable hospital admission and readmission, and reducing unnecessary prescribing, tests and referrals (Ashton & Tenbenschel, 2012; Cumming, 2011). In 2009, the government, through a request for Expressions of Interest (EOI), invited PHOs to develop a new model of care within the existing NZPHCS 2002 framework; however, the model of care that is proposed by PHOs had to employ the BSMC initiatives (Cumming, 2011). The BSMC initiatives for primary care are:

1. to provide services closer to home
2. to make New Zealanders healthier
3. to reduce pressure on hospitals

(<http://www.health.govt.nz/>)

In order to achieve the integrated model of care, the government also required PHOs to form a consortium or a collaborative group of primary care providers which would meet specific criteria. For example, the PHO consortia must have their own governance group and integrated operational management structure. In developing the EOI proposals, PHOs are also required to use contractual mechanisms to advance their proposals. The setting up of such contracts generally requires the disclosure of all information (including financial information), the objectives shared and the rewards distributed, based on actual outcomes. According to Gauld (2014), the alliance concept derives from the construction industry, where independent companies are suggested to collaborate rather than compete. This concept is believed to ensure large and complex projects can be delivered on time and within expected budget.

More than 70 EOI proposals were received in response to the government's EOI invitation, with 9 groups (which later became health alliances) selected to proceed with the implementation of their proposals; these alliances were called BSMC business cases. Table 5.3 shows the 9 recent health alliances approved by the government under its BSMC strategy. The health alliances involve participations of DHBs and PHOs members across regions. The alliances cover almost 60% of New Zealand's population, while the remainder of the population is covered by 43 local independent PHOs (<http://www.health.govt.nz/>).

**Table 5:3 List of Health Alliances and their memberships**

| No | Health Alliance  | DHB   | PHO   | Enrolled population |
|----|--|---|---|---------------------|
| 1. | Canterbury Clinical Network  | Canterbury DHB  | Rural Canterbury PHO<br>Christchurch PHO<br>Partnership Health PHO  | 380,000             |
| 2. | Greater Auckland Integrated Health Network (GAIHN)   | Auckland DHB<br>Waitemata DHB<br>Counties Manukau DHB                                       | East Health Trust PHO<br>Procure PHO<br>Total Healthcare PHO  | 1.1 million         |
| 3. | Health Alliance Plus PHO - A Pacific-led PHO   | Counties Manukau DHB<br>Auckland DHB  | AuckPAC<br>Tongan Health Society<br>TaPasefika PHOs   | 75,000              |
| 4. | Eastern Bay of Plenty PHO  | Bay of Plenty   | Eastern Bay of Plenty PHO<br>Kawerau PHO<br>Te Ao Hou PHO   | 51,130              |
| 5. | Mid Central PHO  | Mid Central DHB<br>Whanganui DHB  | Otaki PHO<br>Horowhenua PHO<br>Manawatu PHO<br>Taranua PHO  | 152,693             |
| 6. | Midland Health Network   | Lakes DHB<br>Tairawhiti DHB<br>Taranaki DHB<br>Waikato DHB                                  | Waihi Beach Medical Centre<br>Tokoroa Primary Care Medicentre and Caldwell & Simpson  | 500,000             |
| 7. | National Hauora Coalition PHO - A Maori-led PHO  | Auckland, Waitemata, Counties Manukau, Waikato, Taranaki, Whanganui Northland Bay of Plenty | Te Puna Hauora<br>Waiora Health Care<br>Tamaki Health Care<br>Te Kupenga o Hoturoa<br>Nga Mataapuna Oranga, Tauranga<br>North Waikato PHO<br>Toiora PHO<br>Te Ao Hou PHO<br>Ngati Porou Hauora, Ngati Porou, Tairawhiti<br>Te Tihi Hauora | 270,000             |
| 8. | Wairarapa Community PHO (In 2012, Wairarapa Community PHO merged with Compass Primary Health Care Network. The new health alliance is known as Compass Health) | Capital & Coast DHB<br>Wairarapa DHB  | Compass Primary Health Care Network<br>The Wairarapa Community PHO<br>MATPPO  | 286,669             |
| 9. | West Coast PHO   | West Coast DHB  | n.a   | 31,202              |

*Note:* This table was developed by this author based on the New Zealand Parliamentary Debates (Hansard), the PHOs websites, medical bulletins, and newspapers. Due to the merging and acquisition in the primary network, there were small changes to the identities of some primary networks.

The changes in the public health structure were complemented by the setting announcement of health targets. Health targets are a set of national performance measures which have been specifically designed to improve the performance of health services. The health targets not only signalled the government's priorities but also provided a focus activity for health services (Ministry of Health, 2013). The results of the health target are published through the media quarterly each year. Table 5.4 indicates the current New Zealand health targets set by the government.

**Table 5:4 National Health Targets**

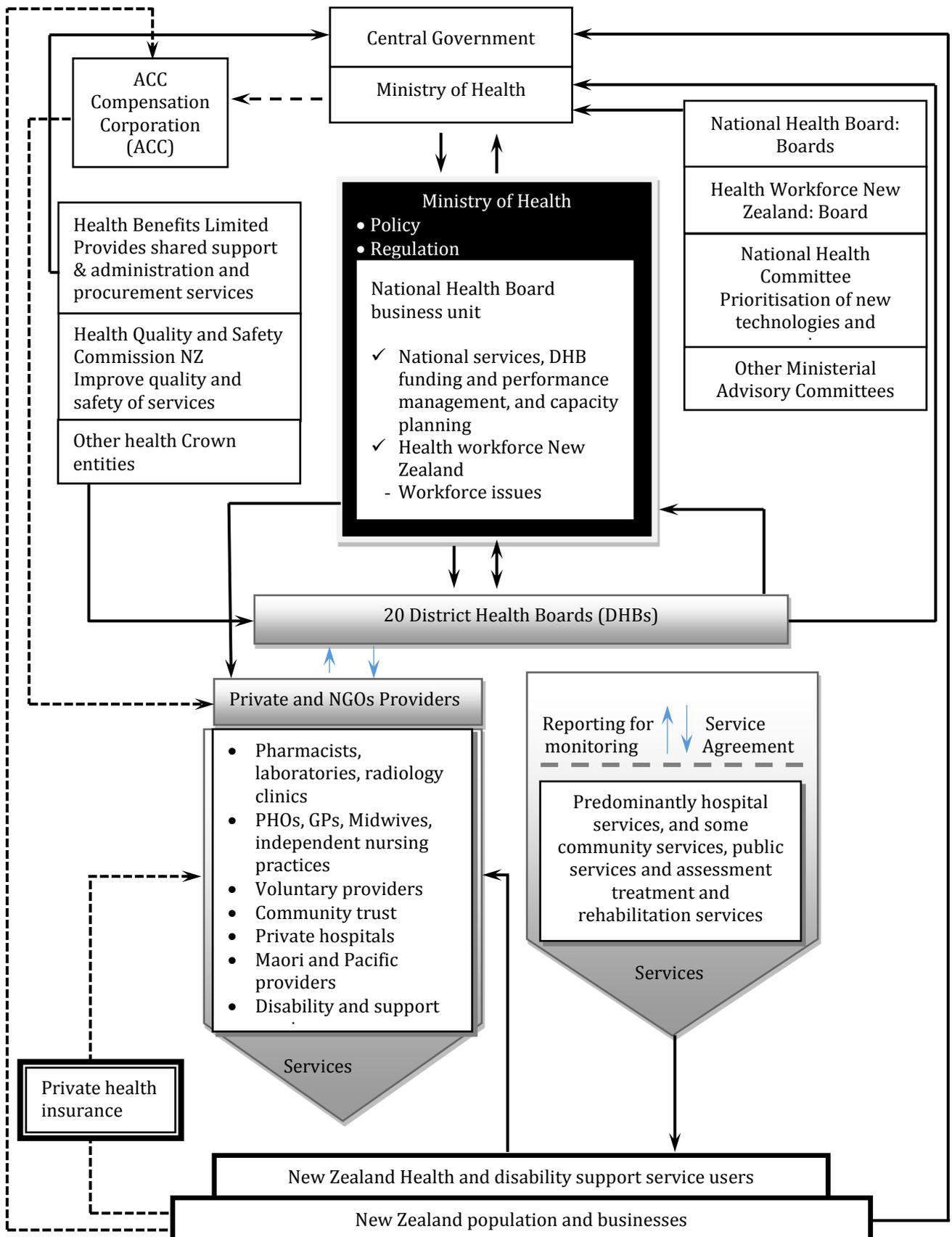
| Health Targets                                | Specifications  |
|---|---|
| <b>Shorter stays in emergency departments</b> | 95% of patients will be admitted, discharged or transferred from an emergency department within six hours.  |
| <b>Improve access to elective surgery</b>     | The volume of elective surgery will be increased by at least 4,000 discharges per year.   |
| <b>Shorter waits for cancer treatment</b>     | All patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.  |
| <b>Increased immunisation</b>                 | 90% of 8 month olds will have their primary course of immunisation (i.e., their 6 weeks, 3 months and 5 months immunisation events) on time by July 2014 and 95% by December 2014.  |
| <b>Better help for smokers to quit</b>        | 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90% of enrolled patients who smoke seen by a health practitioner in general practice are offered brief advice and support to quit smoking.<br><br>Within the target a specialised identified group will include progress towards 90% of pregnant women (who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer) are offered advice and support to quit. |
| <b>More heart and diabetes checks</b>         | 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.   |

Source: Adopted from the Ministry of Health (2011)

The post-2008 reforms have brought considerable changes in the health and disability system of New Zealand. To date, the implementation of post-2008 health reforms has achieved one of the government's objectives: to reduce

the number of PHOs. The establishment of health alliances had reduced the number of PHOs throughout the country from 82 in 2010 to 36 in July 2011 (Ministry of Health, 2011a). However, the establishment of key agencies at the national and regional levels has increased the level of complexity in the health structure. Instead of directly reporting to the Ministry of Health, DHBs now have another set of accountability relationships with new regional DHBs and the NHB. The web of relationships for health alliances has also expanded as DHB has to collaborate with other DHB partners and PHOs. Figure 5.1 shows the current structure of the New Zealand public health system.

**Figure 5.1 The Structure of the New Zealand Public Health System 2013**



Source: The Ministry of Health 2013

## 5.7 Understanding the patterns of change and the issue of accountability in the public health system

This section attempts to identify the changes that have taken place in the New Zealand public health system over the last three decades. Drawing on evidence collected from the document reviews, presented in the earlier narratives, I conclude that the New Zealand public health system has undergone a profound change in its governance and structures. Table 5.5 shows the summary of changes that have taken place in the health structures and governance over the last 30 years and the objectives behind the reform.

**Table 5:5 Summary of structural and governance changes in the New Zealand public health system from 1984 to the present**

| Year(s)/Stage(s) of reform                          | Structural and governance changes   | Objectives of reform   |
|---|---|--|
| 1984 -1992/<br>The beginning of market-based reform | 14 Area Health Boards   | To improve <i>efficiency</i> , effectiveness and performance of the health services and also to increase accountability.   |
| 1993-1999/<br>Radical market-based reform           | 23 Crown Health Enterprises (health service providers); 4 Regional Health Authority (health service purchasers) | To focus public funding on the most important treatments and the neediest patients; and to improve the <i>efficiency</i> of hospital systems.                              |
| 2000-2008   | 21 DHBs and 82 PHOs   | To improve the health of the population, reduce health disparities, and ensure access to quality of services by allowing greater public input into health decision making. |
| 2009-present<br>(as October 2014)                   | 1 NHB, 4 Regional DHB, 20 DHBs, 9 Health Alliances, 34 PHOs   | To improve the <i>efficiency</i> and quality of care by reducing unnecessary bureaucracy and waste, and by moving resources to the front-line services.                    |

Table 5.5 illustrates the changes that have taken place in the New Zealand public health system. It can be inferred that the patterns of change from one stage of reform to another were inconsistent and seemed to be contradictory. The patterns of change revolved around centralised and decentralised

strategies in the public health governance at the local and national levels. These findings were supported by previous scholars (see Ashton, 1995; Ashton et al., 2005; Cumming, 2011; Gauld, 2003a, 2012; Morgan & Simmons, 2009; Starke, 2010). For these reasons, it is difficult to suggest that any one of these structures produced any better results than the earlier one (Gauld, 2003b; Morgan & Simmons, 2009). Interestingly, what was noticeable about the pattern of reform was that, regardless of which model of reform was adopted, the objectives of reform remained aligned with the effort of improving efficiency and effectiveness of the public health system. In other words, the objectives of reform were repetitive and the repetition, therefore, indicates that the government had to remodel the previous reforms because the previous strategies were unsuccessful in achieving their initial objectives.

Previous studies (see Gauld, 2003b, 2012; Morgan & Simmons, 2009) claimed that the adoption of reform in the public health system was heavily influenced by the government's political ideology rather than the need to change. In detail, Gauld (2003b) noted that:

New Zealand has a single-chamber, cabinet dominated parliament that facilitates "fast law". The political culture is adversarial, and a 3-year electoral cycle impels hasty political change. This combination means policy is often driven by party ideology rather than evidence or demonstrated need and implemented in a relatively undiluted form, free of the checks and balances natural to their political systems. (p. 202).

In many instances, politicians appear to be primarily interested in retaining their governmental positions or being elected as the government. For this reason, they define the policy problem by looking at symptoms and choose the policy strategies which enable them to secure their positions. As a result of this practice, the policy strategies in the New Zealand public health system are fragmented and inconsistent because they are designed according to political rather than public needs.

Consequently, debates over the implementation of the New Zealand public health reform have raged for nearly three decades and are still ongoing. The public health system was criticised because it remained disconnected and the level of complexity and ambiguity in the existing dual health system increased significantly. For examples, in the 2000s, Easton (2002) regarded the New Zealand public health reform as 'unfinished business', because, despite the fact that the health sector has undergone several phases of reform, a number of issues still remained to be addressed. Around the same time, McKenna and Richardson (2003), described the situation of the New Zealand public health system as "... unknowable, there is no right answer and what they do often appears 'bitty' and unconnected to any bigger picture" (p. 81). In terms of efficiency, more recently, Morgan and Simmons (2009) revealed that the spending patterns in the public health system become costly due to the fat administrative structures and conflict of interests between politicians and DHBs. The scenarios in the health system were seen as undermining the potential of health institutions to deliver better services to the public due to fragmentation and inconsistency in health reform directions

Newman (2004) provides a new understanding about the effects of reform on the operations of public organisations. Newman claims that the implementation of market-based reform changed not only the structure and governance of public organisations but also influenced the thoughts of public senior managers. Public managers were depicted as having been captured by neoliberal ideologies that influenced managerial practices in public organisations. For instance, there was a significant shift from a traditionally bureaucratic function to a new managerial regime which produced a strong belief in competition and efficiency through the formation of new delivery techniques, known as contracted-out arrangements, privatisations, and partnerships. These situations raised a question regarding how the changes have affected the accountability arrangements in health services. The following subsection discusses the emergence of accountability issues in the public health system.

### **5.7.1 Reforms and the emergence of accountability issues**

The adoption of neoliberalism reform has challenged the meanings, mechanisms, and relationships of traditional accountability. Nevertheless, little is known about the effects of constant reforms on accountability in the context of a public health system. Studies on the New Zealand public health reforms have focused more on the effect of reforms on governance structures, service delivery frameworks, the health system in general (Ashton, 2005; Ashton et al., 2008; Barnett et al., 2009; Gauld, 2003b, 2008, 2012; Starke, 2010), and outcomes of the policy reform on the targeted populations rather than accountability (see Ashton et al., 2008; Barnett & Barnett, 2004; Smith, McDonald, & Cumming, 2008).

Some researchers acknowledge that the health reforms resulted in changes to the accountability systems (Lawrence, Alam, Northcott, et al., 1994; Mackie, 2010; Starke, 2010). Accountability arrangements in the public health system have been reported as complex, due to duplication of contracting accountability and accounting activities (Duncan & Chapman, 2010); and, ambiguous and conflicting due to the involvement of multifunders in delivering health services and diverse expectations of many stakeholders (Cordery, 2008). The blurred lines of accountability have had a serious impact on the public sector as they have created confusing situations, sometimes allowing participants to escape being held accountable. Mackie (2010) describes, “the blurring lines of accountability [as] allowing the Ministry to separate itself from poor DHBs performance, while taking credit for the good and leaving the DHBs to take the bad” (p.21).

Existing research reveals that the changes in the accountability systems have been identified as a source of tension in managing the health sector (Dowling et al., 2008; Mackie, 2010; Starke, 2010; Tenbensen et al., 2007). For example, the practice of dual accountability under the AHBs system resulted in conflicting goals and accountabilities between locally elected boards and central government. While the AHB system was scrapped and replaced by

other systems, accountability remained an issue in the subsequent stages of reform. For instance, Tenbenschel et al. (2007) examined the implementation of the NZPHDA 2000. Their study found that the new health system provided stronger local identity because it created more local venues for decision making by involving NGOs in health administration. However, the implementation of the new health system has affected the forms of accountability. In detail, Tenbenschel et al. (2007) report:

Accountability in New Zealand's publicly funded health sector since 2001 reforms have become more multi-faceted with a mix of hierarchical, network and market forms in play. As a result, governance is more complex and sometimes more opaque in comparison to the 1990s. (p. 23)

Investigating the issue further, Cordery (2008) undertook an ethnographic study on PHOs and their stakeholders in different regions of New Zealand. The aim of Cordery's study was to examine the accountability relationships of PHOs in New Zealand and to determine the mechanisms by which they might best discharge their accountability obligations to multiple stakeholders. The findings indicated that accountability arrangements in the new health policy structure had turned out to be complex, ambiguous, and conflicting as regards the different types of accountability faced by PHOs; this state of affairs resulted from the involvement of multiple institutions in delivering health services.

Although the studies mentioned above confirm that accountability remains an issue in the New Zealand public health system, they do not specifically discuss accountability in the context of reforms. Therefore, little is known about the effects of reforms on accountability. Too frequently, government has used the term "improving accountability" (see Table 5.5) as a reason to adopt new reform strategies, but little is known about the extent to which accountability has been improved and how it has been developed within the health sector. In my view, accountability has become enmeshed in fragile health structures that employed uncertainties in accountability practices. This situation raises a further question: what does accountability mean in the

context of constant reform? The existing documents and research provide limited answer to this question. Therefore, it is crucial to understand the impact of constant reforms on accountability provision and understanding more fully.

## **5.8 Chapter summary**

This preunderstanding chapter identified changes which have taken place in the public health system over the last three decades and the effects of the changes on accountability arrangements in the health system. On the basis of historical review and analysis of policy between 1930s and 2014, it can be concluded that New Zealand underwent four stages of reforms, which resulted in massive changes in the public health structure and governance. Analysis of the 4 structures of reform indicates that New Zealand has experienced successive and contradictory changes in the public health system for the last 30 years. Although reform was implemented with the aim of improving policy efficiency and effectiveness, the adoption of reforms has brought complexity in health structures, governance and accountability along with it. The next chapter will take us to Stage 2 in the application of hermeneutics, that is, the understanding stage which involved interviews with health managers.

# **CHAPTER SIX**

## **UNDERSTANDING**

### **THE EFFECTS OF REFORMS ON ACCOUNTABILITY: THE EXPERIENCE OF PUBLIC HEALTH MANAGERS**

#### **6.1 Introduction**

This study is concerned with the effects of constant health reforms on accountability provision and practices in the public health system. The preunderstanding narrative in Chapter Five (Stage 1) revealed that reforms have changed the structure and governance of the public health system, including its accountability arrangements. Although this series of reforms did achieve some advances, the direction of reform from one stage to another appeared to be fragmented and this fragmentation has led to inconsistent changes in the public health system. The preunderstanding narrative provided only a part of the whole understanding of accountability arrangements in the context of New Zealand public health reforms. However, this preunderstanding offered a sound basis for engaging with health professionals to learn from their experiences of reforms and new accountabilities.

To deepen my understanding of the research issue, this study adopted a naturalistic inquiry method to collect qualitative data. A series of semistructured interviews was conducted with 13 health managers with the aim of obtaining further insights on specific issues from their recalled experiences. I believe a better understanding of accountability in the context of reform can provide a new and insightful interpretation of the way in which accountability has affected and transformed the public health system. Starting from the premise that the health managers are experts in their own area of the health system, a hermeneutic approach was adopted for this study. I encouraged the health managers to share their views and lived experiences in dealing with reforms and accountability in their own words and based on

their own interpretation of their experiences. In order to understand and to make sense of the participants' experiences, the process of analysing data employed a critical perspective within the hermeneutics approach (Myers, 2013). A critical perspective was used because it enabled me to evaluate critically the totality of accountability understanding in the context of the public health reforms. My aim was not to present a theme, but rather to engage in thinking through what the texts (interview transcripts) reveal about how managers responded to the implementation of constant reform and changes in accountability.

This chapter represents the second stage (or Stage 2, see Figure 3.1, p. 72) of understanding about accountability conceptions and practices in the context of the New Zealand health reform. The findings are presented in two main sections. The first section is devoted to discussing the public health managers' experiences concerning the implementation of reforms. In particular, this section represents my understanding of health managers' experiences in valuing the rationales for implementing reforms and the responses of health institutions to organisational change, and the challenges of implementing reforms. The second section discusses the effects of reforms on accountability understanding and practices in the health services. Specifically, this section describes my understanding of the health managers' lived experiences in dealing with accountability issues.

## **6.2 Reforms, policy changes and responses to organisational change**

Dacin, Goodstein, and Scott (2002) explain that institutional change revolves around a dialectical interplay between actions, meanings, and actors. According to Dacin et al. (2002), as agents of change, actors have resources and power to initiate reform and shape the character of institutions through institutional change. Theoretically, actors will interpret pressures for reform (whether they are functional, political or social) and give meanings to them (rationalising the pressures) before responding to them. Putting this

theoretical view into the context of New Zealand health reform raised questions on how the health policy makers (the government bodies) interpret the pressures for reform, including the rationales for introducing the reforms, and how the policy implementers (the health managers) respond to frequent organisational changes in the public health system.

The preunderstanding chapter suggested that the government was pressured by functional and social factors to implement reforms. The government interpreted the pressures as threats to the health sector, and suggested that New Zealand had no choice but to change the way in which the health system was operating because the existing system was inefficient. The government then portrayed itself as being responsible for protecting the system and the people of New Zealand through the implementation of reforms.

Nevertheless, the public health system has been heavily criticised by the public for the failure of reforms to realise some of the government's objectives. The criticisms imply that there is a significant amount of anxiety related to reforms and accountability in the public health system. To examine this anxiety, the public health managers in this study were asked to share their experiences in dealing with reforms and policy changes. They were invited to explain the rationales for implementing frequent changes in the public health system from their own perspectives and experiences.

### **6.2.1 The rationales for implementing reforms**

I started the conversations with public health managers by asking them to provide their overall evaluations of the implementation of reforms. The public health managers related their diverse experiences, and provided mixed responses to my question. In general, I found that most of the public health managers, regardless of their experiences, positions and length of service, acknowledged the benefits of some of the reforms for the public health system. For example, one senior manager states:

I was around during all those transitions. When we developed the IT systems and accounting systems and we put in DRG systems, and we put in resource management systems, we got better understandings of what we were doing. The CHEs system was also useful at that time in regards to making the health system more accountable to New Zealanders and to the government. When we moved into the DHBs system, you know the concept of population health responsibility was a really useful thing. – (P05, a senior manager of a PHO)

P05 served the Ministry of Health and a number of DHBs in senior level positions, prior to her current appointment. In her 26 years' work experience, P05 experienced all four stages of reform (see Table 5.1, p. 105), and played critical roles either as a policy maker and/or policy implementer. Based on her experiences, P05 agreed that health reforms have produced some benefits for the public health system. According to P05, reforms made public institutions more accountable for the management of their resources.

P07, who was a clinician before going into management also states:

The outcomes of reform weren't all bad . . . the formation of DHBs . . . had some really worthwhile intent around 'capitation' based funding and the intention for DHBs to be accountable in terms of population health outcomes as well as individual patient outcomes. And it solved some of the primary sector issues in terms of a GPs model of care and business model. – (P07, a senior manager of a PHO).

The benefits of reform described by P07 related to the DHBs system (1999-2008). Despite all the controversies or criticisms, P07 suggested that the formation of the DHB system improved the level of health equality through the introduction of a new 'capitation' funding system and a new primary care model. The capitation system was introduced to replace the targeted funding scheme, and aimed to reduce copayments for all populations by providing extra funding to ensure a reduction in out-of-pocket expenditure for the most vulnerable groups. Meanwhile, with the introduction of the PHO model, the primary care service was no longer dominated by private GPs, who operated on the basis of a profit-business model rather than the needs of the public.

Under the new model, PHOs were recognised as the DHBs' vehicles for providing essential primary health care services to their enrolled populations.

P06, a CEO of a society-based PHO also revealed his positive views toward reforms despite the rapid changes in the health system.

There are many things in health policy that I completely agree with. I don't see that the direction of health is very different under different governments. I think the direction in health service development necessitates changes in policy and I'm very comfortable with that. – (P06, a CEO of a PHO)

P06, regardless of which political party has been in power, acknowledges the benefits of reform brought to the health sector. P06 provided some examples from his experience as a general manager in one of the RHAs in the late 1980s. He indicated that before the adoption of reforms, the government could not measure the quality of services provided by visiting anaesthetists in small rural hospitals due to a lack of procedures, regulations, and record systems. For instance, in June 2000, the New Zealand Nurses Organisation wrote to the Minister of Health and contacted the media about concerns over nurses employed at a small, provincial public hospital (Health & Disability Commissioner, 2009). The Nurses Organisation reported the admitted reuse of syringes by a visiting anaesthetist and the potential risk of disease transmission to 134 surgical patients (Health & Disability Commissioner, 2009). An investigation conducted by the Ministry of Health found that the breaches of duty of care by hospital providers were caused by the failure of health organisations to have adequate quality assurance and incident reporting systems in place. As a response, the Ministry of Health emphasised in its reform agenda the need to improve health delivery management by keeping documentation and quality manual up to date (Health & Disability Commissioner, 2009). According to P06, the reforms introduced by the Labour government improved not only work procedures and record systems but also created an effective work place and safety system in health services.

For P06, despite the National government sometimes being somewhat critical of the health sector, the policy changes introduced around Pharmaceutical Management Agency (PHARMAC) in the 1990s resulted in the best of innovations. PHARMAC was formed as a centralised bargaining agent for public pharmaceutical purchasing (Von Lanthén, 2004). PHARMAC introduced competitive purchasing tenders, at a time when a number of key pharmaceuticals were coming off patent. It has succeeded in bringing unit costs down over time (Von Lanthén, 2004). New Zealand is reported to have obtained the best deals in drug purchasing compared to other OECD countries (Matheson, 2009).

In my view, although P06 and P07 shared no common experiences, all the reform benefits described by them referred to improvements in financial management and resource usage, including some managerial procedures in the public health system. The improvements indicate that, in general, reforms have successfully achieved their initial objective: to increase efficiency and effectiveness in the public health system. It can be inferred that the participants, regardless of their backgrounds and experiences, principally agreed with the implementation of reform as they could see how reforms facilitated health institutions to respond to economic and social changes.

Nevertheless, the public health managers simultaneously raised criticisms of the same reform strategies. Despite all the improvements they cited, the majority of health managers felt that the reforms failed to realise all their objectives in the wider context of the public health system. For instance, P13, a DHB board member claims:

Health by its very nature keeps revolving; our ability to treat it keeps evolving. Annual plans, the government spending caps are very blunt. They are not refined mechanisms. They don't recognise, they don't evolve as the diseases develop. – (P13, a board member of a DHB)

According to P13, the biggest challenge in managing health care is that the trend for services demanded of this industry changes according to factors

beyond the health system's financial control; hence, the existing strategies are not seen as flexible enough to support the process of change. For P13, accounting tools and strategies which were introduced under market-based reform were tremendous mechanisms for business management but they did not work well for public services, especially in the public health system. According to P13, the public health system operates in a unique framework due to its structural components and social elements. Therefore, improving the public health system is not only about increasing the health status of households, but also concerns other issues related to the distribution of health resources and services among populations, the cost of financing the system, and diseases prevention. In the experience of P13, the new accounting tools were unable to support the overall change in the public health system because they focused on financial activities.

P13 claims that in reality, health care is not an economic commodity which can be controlled using a rigid throughput system. He argues that the public health system requires the government to introduce a distinct approach beyond financial boundaries because a rigid financial-based strategy reduces the ability of the health system to respond to change. According to P13 the failure of the government to recognise the limitation has affected the performance of the health system in general. He claims:

If you want to talk about reforms and efficiencies, we have not gone anywhere near far enough. – (P13, a board member of a DHB)

The excerpt shows that reforms produced limited improvements in terms of efficiency. P13 justifies the point saying:

I found that just amazing that in a country of our size, we don't have a national health computer system. I'm horrified with the fact that there are multiple purchasing departments in a country of 4.5 million people. Can't we just have one, very large, well-managed purchasing department? For example, let's buy 20 CT scanners at once, rather than 20

DHBs try[ing] to negotiate the best possible deal for one individual DHB. – (P13, a board member of a DHB)

Using the DHB system as an example, P13 explained how reforms have reduced rather than improved the level of efficiency in health services. The establishment of the DHB system with the aim to increase democratic values in health service governance has resulted in excessive bureaucracy and administrative overheads in the public health system. P13's reflections on reforms were supported by Rankin (2011), who reported that none of the reform introduced at that stage was able to restrain the rising cost of health care and that there was very little evidence that the rising costs had improved healthcare outcomes for New Zealanders.

The health managers' experiences can be explained in two ways. Firstly, the NPM and NPS styles of reform are more concerned with short-term economy and efficiency effects than with the long-term benefits for organisations and populations (Atreya & Amstron, 2002; Van de Walle & Hammerschmid, 2011). Secondly, the efficiency and resource-based contributions do not bring lasting achievements, due to uncertain economic performance, and changes in demands among health populations (Brunsson & Sahlin-Andersson, 2000). Another possible explanation for this may be that the NPM and NPS models are rather general and not related to problem solving activities (Christensen & Laegreid, 2011a; Jones & Kettl, 2003). For these reasons, existing solutions which were originally based on the short-term strategies may not be able to respond to such situations and so necessitate another round of restructuring.

The public health managers' stories describe that they have lived through two opposite experiences. On the one hand, the health managers appreciated reform strategies that improved financial and resource management, but on the other hand, they deprecated the same reform strategies due to the inability of the strategies to realise their objectives in the wider context of the public health system. Based on the health managers' initial responses as described above, it is possible to conclude that the operation of the public

health system is characterised by a series of paradoxes. In order to help me to understand why and how the paradoxes emerged in the public health system, the public managers were asked to explain the rationales for implementing a series of reforms in the public health system from the perspective of their personal experiences.

The interviews show that pressures for change came from the government which believed that the existing public health system was inefficient and ineffective. P09, a DHB senior manager says:

Reform is more about politics than policy . . . Reforms have been driven off by the issues that come from the politicians who have been abused [by a belief] that our health system is not working for the people. – (P09, a finance manager of a DHB)

P09 has worked for a DHB for 24 years. He has lived through almost all the stages of reform driven by the market-based model. As a certified accountant, he acknowledges the benefits of market-based reform to health management in terms of financial control and resource management. However, he also suggests that the implementation of reforms is sometimes an uncomfortable experience for him. In P09's view, decisions to implement reform came from the government because it believed the public health system was performing below par. In this sense, P09 talks explicitly about the government's decisions in implementing reform in the New Zealand public health system.

For P09, it was only the government that believed that the health system was problematic and delivered a poor quality of services. According to P09, the government's beliefs can be linked to the published reports which make the public health system look worse than it really is (see the government's report published prior to the implementation of reform, for instance, *Unshackling the hospitals* (1988), *Your health and the public health* (1991), *The Ministerial Review Group* (2009), etc.). The government has attempted to persuade the people to concur with its beliefs, in order to make the public agree with its prescriptions for reform.

P09 personally disagrees with the claims that health services in New Zealand are problematic. He states:

You might have some complaints, you can judge the food, you can like the nurses, and you can hate the doctors. But for whatever reasons, you can walk in here [hospital] with a reasonable confidence that you will get well treated. The stuff [the problem of efficiency and effectiveness] that we talked about is still embodied in [it] but the hospital services are functioning as they're supposed to. – (P09, a finance manager of a DHB)

P09's statements illustrate his views on the implementation of reforms in the New Zealand public health system. Despite all the controversies, he considers that the health service performance, especially at the individual level, is still good and reliable. For P09, although reforms brought considerable changes in the public health system, they did not substantially change the functioning of hospitals or medical centres.

In my view, P09's experience shows that the government has a strong political influence in New Zealand health reform decisions. Political influence refers to situations where "policy decisions are frequently made or altered not because someone has found the best way to do things but because certain people have a lot to say in the matter" (Barker, 1996, p. 21). P09's experience aligned with Gauld (2000), who claims that the existing governmental system permits the government to utilise power and authority for its own benefits. New Zealand follows the unicameral system, a Westminster-style system in which the decision making power is concentrated in the Cabinet. The unicameral system allows politicians to "push through new policies" without determining the viability of each policy (Gauld, 2000, p. 186). In this sense, it is possible to implement reforms as long as the government can justify the needs to implement reforms to the public.

P01, a CEO of a PHO also raised similar concerns related to political nature of policy decisions and implementation. He claims:

Overall, in my sense, things [policies and programmes] take too long to implement; innovation is very hard to implement in the New Zealand health system, and . . . the health system in New Zealand is very political. Sometimes, the government tends to be cautious around health care and there was political expedience rather than which is the right thing to be doing. – (P01, a CEO of a PHO)

P01 has 15 years' experience in the public health system. Prior to his current appointment, P01 served in senior executive and senior manager roles for the Ministry of Health and DHBs. P01 believes that reform decisions are driven by the government's political motives rather than contemplation of the right strategies for the health sector. P01 suggested that reforms, especially those related to policy innovation, are very hard to implement. P01 referred to the policy innovation linked to the implementation of the BSMC business case. As discussed in Chapter Four, the BSMC business case is a new health delivery strategy whose design was based on collaboration strategies. However, P01 has experienced several difficulties, especially at the beginning of the business case implementation, due to refusal of several health institutions, including Crown agencies, to give their cooperation (details of P01's experience are provided at 5.2.3.4).

Another participant, P04 also acknowledged the influence of a political motive in the process of implementing reform.

The government introduced change but because of political experience you see. They want to stand [up] for election. They try to show to the public they do this, they have done that, you see. But in reality they haven't done anything. – (P04, a senior manager and a board secretariat of a PHO)

P04's narrative describes reforms which were introduced because of the government's political requirements. He referred to this "political experience" because the government's private agenda that was "to stand [up] for election". According to P04, the government aimed to be on top of policy and to take credit for every potential benefit produced by reforms. By showing such achievements, the government hoped to please voters and win elections.

However, in P04's experience, implementing reform in the public health system is very challenging. The government not only has to deal with endless inefficiency issues, but also has to pay attention to any unexpected outcomes which emerge from the reform strategies. The unexpected occurred because, as the reforms were implemented, changes, both expected and unexpected, would appear. All the unexpected outcomes need solutions, otherwise they will exacerbate the problems of the health sector. Nevertheless, over the last 30 years, P04 believes that the government did not prepare itself to respond to those unexpected outcomes, and, therefore, the ability of health institutions to improve policy outcomes was always likely to be limited.

The participants' stories demonstrate that they believed that the rationales for implementing reform were driven by political motives rather than the needs of the public. Gauld (2003b) provides support for this finding when he says that “. . . changes were all imposed by politicians seeking to make an impression on the health sector” (p. 210)

In addition, the interviews reveal a significant clash in terms of the health managers' interpretations and the government's justifications with regard to the rationales for implementing reform. The preunderstanding chapter suggested that the government introduced reforms with the aim of protecting the public health system from functional and social pressures. However, in the experience of public health managers, reforms were introduced by the government for their own political ends rather than to meet the needs of the public. Indeed, the experience of the public health managers is reflected in Lawrence (1999), who claimed that health reform was not introduced to solve specific problems but to express politicians' ideological commitment.

## ***Summary***

This section explored the public health managers' subjective experiences in dealing with reforms in the context of the New Zealand public health system. In particular, this section attempted to identify the health managers' overall evaluations of the implementation of reforms, and to understand the rationales for implementing reforms from the health managers' perspectives. It revealed that the public health managers have lived through two opposite experiences as reforms produced diverse outcomes. Market-based reform apparently produced recognisable benefits for the public health system in terms of resource management and financial control. However, the reform benefits appeared to be limited in the larger health context of the public health system. Consequently, the public health managers experienced a significant disjoint between policy and practice. Indeed, their experience relating to the policy mismatch made the public health managers consider that the government had misrepresented the meanings and directions of reforms in the public health system.

In my opinion, the needs for reforms were justified by economic and functional factors, but the solutions or prescriptions were designed according to the government of the day's political interests. As a result, the course of reform in the public health system appears to have been uncertain and highly subject to political influences. Given these situations, it is my conclusion that the New Zealand public health system is trapped between two opposing requirements. The first is a requirement to meet policy objectives aimed to improve efficiency and effectiveness and to increase the quality of health services; the second is a requirement to meet the political agenda of the ruling government. For these reasons, rather than solving the problems, reform is seen as producing a continuing dissatisfaction. Interviews with the public health managers recorded a series of paradoxes in the health managers' recalled experiences with regard to this issue.

The following subsection tries to understand the responses of public health managers toward organisational change in the public health system.

### **6.2.2 Responses toward reforms and organisational changes**

Policy makers have the power to influence or determine policies and practices but they are not involved in the process of implementing policy. The process of implementing or executing policy relies on policy implementers. Sebele (2013) described policy implementers as a group of inductive thinkers who build on an operative theory of collaboration from the synthesis of their experiences. The roles of policy implementers are equally important as those of policy makers because the process of implementing policy often requires policy implementers to translate the intangible policy visions into tangible development (Sebele, 2013).

The health managers, who suggested that reform decisions were driven by political ideology, were asked to describe their personal responses to organisational changes in the public health system. According to all public health managers, decisions to reform apparently came from the top, and therefore, the implementation of reform was seen as compulsory for all health care agencies, including both publicly and privately owned entities. Throughout the interviews with the public health managers, it was apparent that the way of responding differed among health agencies and individual policy actors depending on the types of organisation within which they worked, and each individual's personal beliefs in reforms.

For instance, as one of the Crown entities (part of the government bodies), DHBs were obliged to adhere to all the reform requirements introduced by the government. However, in certain circumstances, it was difficult for DHBs to follow the government requirements as they were constrained by uncontrollable factors such as lack of resources and time. In response to such situations, some DHBs changed their patterns of working as well as their reporting. Drawing on an example from his DHB, P08 revealed how his DHB

redefined the way in which it managed its activities in order to meet the government's targets on elective activities. Under the national health targets, the government aimed to reduce the numbers on waiting lists for elective activities by increasing the volume of elective surgery by at least 4,000 discharges per year (Ministry of Health, 2013).

According to P08, managing elective services was challenging for every DHB because elective and acute activities were sharing the same hospital resources. For example, both acute and elective activities use the same hospital facilities and rely on the same health experts or specialists. P08 claimed that it was not easy for DHBs to plan their resources for managing both elective and acute activities because health is random by nature: management is unable to predict what will be happening in health industry in the future. According to P08, although DHBs are able to come up with a perfect plan, its implementation will be imperfect because people's health status and disease development are beyond the control of management.

P08 recognises the importance of hospitals giving elective activities the same priority as acute activities. However, in practice, due to their urgency, hospitals have to give priority to acute needs. As a result, the demands of elective patients are always deferred, and the numbers on the waiting lists for elective activities grows significantly as a result. To meet its elective activities as required by the government in the health targets policy, P08's DHB had to set up an internal policy that enabled the hospital to create a capacity and space for electives. The internal policy states:

For operating theatres we will do 80% of our acute demand within 24 hours and 100% within 48 hours. – (P08, a business support manager of a DHB)

According to P08, creating an internal policy such as the one outlined above enables the DHB to put in resources that allow the DHB to meet its acute and elective demands by managing this goal through recreating space and capacity to do the electives. However, in practice, the 20% allocation for

elective surgery was inadequate to reduce the existing waiting lists. As an alternative, his DHB outsourced some of its elective activities to private hospitals where doctors from public hospitals work. P08 discloses that his DHB spends about \$15 to \$18 million per year on such surgery. For P08, while such a technique may have helped the DHB to meet the government's current health target, it does not solve the actual problem around the elective activities. P08 confesses that contracting-out is not a sustainable mechanism in the long run because it does not help public hospitals to build or improve their capacity to provide elective activities. He also notes that the outsourcing strategy merely benefits the private providers in the long-term because they received a consistent supply of patients and money from public hospitals. However, according to P08, his DHB has a limited choice because all DHBs across the country must reduce the number on waiting lists in hospitals or face financial penalties.

P08's experience provides an impression that the process of implementing policy is constrained by the government's policy requirements. In other words, DHBs are given autonomy to determine the best way to implement policy decisions, but in practice, DHBs decisions on policy activities are subject to the government control which can be seen through a rigid policy requirement such as systematic reporting and tight budgeting (detail of the government control will be discussed in Section 6.2.3.1). DHBs have to work within their resource capacities and redesign the framework of policy implementation in accordance with the requirements outlined by the government. In this sense, it seems to me that DHBs are focused on meeting the government's policy requirements rather than the demands of their populations, as they might interpret them.

Similarly, primary care organisations have limited options in responding to reform. However, as primary care services are run by NGOs (community- and privately-own agencies), their degree or level of responding is seen as relatively steady compared to that of DHBs. The statement below describes how the PHO health manager, P03, responds to change.

I see myself as having a good understanding of the policy drivers and change and how we reposition our organisation to take advantage of these policy drivers. Perhaps we have been fortunate that this organisation is seen as one of the organisations that can respond to the change and move with required changes. If I could look back 21 years ago, the only thing that is unchanged is the name of this organisation. I would respectfully say that what we have today is certainly different from what we were 21 years ago. – (P03, a CEO of a PHO)

The above narrative reflects P03's experiences in responding to reforms and policy changes. P03 is a CEO and founder of a Maori-based PHO. He is proud of his achievements over the last 21 years. Although the government has been implementing different reform strategies for the last two decades, P03 believes that he has succeeded in managing the challenges of reform. Understanding the needs of reform has enabled him to protect the interests of Maori through his organisation. For P03, being a Maori means that he has a big responsibility to his people. Therefore, he continuously repositions himself and his organisation in order to secure the interests of Maori.

P03's experience evidences that primary care is more responsive than DHBs to the government reforms. Unlike DHBs, PHOs are not involved in translating health policy decisions. As contracted service providers, they are expected to deliver translated policy decisions to the public. In this sense, PHOs merely follow their contractual agreements in delivering health care services. Furthermore, the status of PHOs as NGOs, has allowed PHOs to easily align their organisational interests with the government policy changes.

In my opinion, the rapid and contradictory changes are not a major problem for NGOs such as PHOs because they rely on the government contracts as their source of income. Therefore, as long as the policy changes have allowed the flows of contract income to be maintained, changes in their delivery system have not been a major concern for PHOs. Throughout the interviews, it appeared that the majority of primary health managers choose to support the implementation of reform by accommodating themselves to changes in

order to ensure their PHOs remains as one of the players in the health industry.

Nevertheless, there were also unexpected responses from the people in the health system. For instance, P07 states:

We see a massive loss of health system intelligence leave health New Zealand as a result of BSMC. And in the last role that I had, over 40 people had resigned their space within a few months as an ongoing impact of change of that they don't believe in. And, when you talk around the health boards or the NGO-PHOs sector that was a very common story. – (P07, a senior manager of a PHO).

P07 talks about the response of health professionals or clinicians to the government's reforms. As a clinician who moved into management, she found that some of the managerial procedures or strategies which were produced with the aim of improving efficiency and effectiveness of health services worked against to the clinicians professional values (will discuss in detail in Section 6.2.3.4). In addition, some of the health workers simply lost their belief in the health system due to constant reforms, and decided to leave their work organisations: either moving overseas, joining private providers, or going into private practices. As a result, the New Zealand public health system is at present facing a serious loss in health professionals.

The above discussions indicate that the level of response to organisational change differ for health institutions and health actors. Most of the health institutions adhere to requirements of change and align their paths with the government reforms. However, some of the health actors, especially health professional, react differently, especially, when they find the policy requirements go against their professional values and practices.

In summary, this section described the health managers' experiences in responding to organisational changes in the public health system. It reveals that the responses of health institutions and individual policy actors to organisational changes differed significantly in terms of their level. As part of

the government agencies, DHBs find it difficult to play their roles as policy implementers because they have to ensure that they translate policy decisions in accordance with the government requirements. In this regard, DHBs seem not to act as they believe most appropriate for their populations but to perform in line with the measurable policies of government.

In contrast, PHOs as NGOs are in a better position because they are merely responsible for delivering translated policy decisions according to what has been agreed in their service contracts. To maintain the flows of the contract income, PHOs often change their strategic directions including organisational structures to accord with the ruling government's reform frameworks. In my view, PHOs have taken proactive actions in responding to reforms in order to retain their positions in the health industry.

It is my conclusion that health providers (both publicly and privately owned entities) cooperate with the government reforms. However, it is apparent that the government has difficulties in convincing health professionals to believe in reforms. To understand how health managers are coping with the impact of health reforms on their organisations and the health system as a whole, the public health managers were asked to describe their experiences in dealing with reform. Their reminiscences describe the challenges of dealing with reform. Details of the health managers' responses are presented in the following sections.

### 6.2.3 Challenges of dealing with reforms

The aim of this section is to understand how the health managers feel about dealing with frequent changes in the public health system. Specifically, I wanted to examine the experience of public health managers who operated in different systems, played different roles with different responsibilities and dealt with different policy approaches. The public health managers mostly confessed that being in such situations was not only demanding but also full of frustrations. The following comments from health managers clearly communicate this frustration:

It was a mixture of **frustration**. – (P01, a CEO of a PHO)

I think the people who work in the health care system are extraordinarily **frustrated** a lot of the time. – (P05, a senior manager of a PHO)

. . . that leads, from the governance point of view, to some **frustrations**. – (P13, a DHB board member)

It is very **frustrating**, yes . . . I think the greater increase in the frequency in change upsets and frustrates people . . . the implementation of reform **frustrates** me. – (P06, a CEO of a PHO)

In order to understand the health managers' frustrations, I asked them to elaborate on their experiences in relation to the challenges of implementing reform, and to explain how these challenges frustrated them. Throughout the interviews, it appears that frustrations among the participants, regardless of the institutions they represent, were caused by at least four issues, namely: political interference, lack of policy leadership and policy support, poor policy planning, and silo effects. The following subsections discuss these four issues.

### **6.2.3.1 Political interference**

The issue of political interference was captured during the conversations with the participants about the challenges in dealing with the implementation of reforms.

The people making decisions are often based in Wellington of course . . . local entities are not given the opportunity to make local solutions. So, it is very much top-down decision making. – (P06, a CEO of a PHO)

Ministers have the ability to build a political platform for how the future might be. – (P02, a board member of a PHO)

The government was never want [ing] to lose a desire to control. – (P13, a board member of a DHB)

The Ministry of Health still controls something. – (P05, a senior manager of a PHO)

The above extracts show that the government appears to retain its control over the health system. Indeed, some interviewees reported that it was unusual for them to make local decisions without political approval. In this context, the public health managers are aware of the political power that appears to control the directions of reform.

Reflecting on his role as a DHB board member, P13 indicates how the government imposed a control on the governance of DHBs:

I would say I would struggle to articulate more than four or five achievements in my 12 years on the health board because the plan is filled and the role has been so constructed by Wellington to ensure their vision is implemented. As an elected member, I can't directly influence the total direction of the ship but I can make the ship as a pleasant sailing, on its course. To change course is very hard. It's driven by Wellington and friends in management. And that is whether Labour's in power or National's in power, doesn't matter which political colour. – (P13, a board member of a DHB)

P13's narrative illustrates his belief that government exerted its control over his DHB. According to P13, the elected board system was introduced with the objective of fostering community participation in health improvement. However, in his experience, the elected board members had limited influence over health policy decisions because such activities were centralised at the government and bureaucrat levels. P13 comments further:

Although we implement the PHO policy locally, the [name of] DHB is actually a Wellington-driven strategy. And it goes to the point there's very little room for local innovation. Innovation in the [name of] DHB or any DHBs can't be mentioned in the same sentence. So, all [annual plans] are very prescriptive. We look at it and we can try to influence it but only within a very narrow prescriptive nature of the template and then, the draft goes to the Ministry of Health, who looks at annual plans and says, "Oh! It looks like it fits the criteria in the box, good annual plan! Wonderful annual plan Mr [name of] DHB! Good work!" – (P13, a board member of a DHB)

According to P13, the government introduced a ready-made annual plan template for all DHBs in New Zealand. From his perspective, the template was very prescriptive and narrow. For example, the government's recent annual plan template required DHBs to incorporate the national health targets in their annual plans. According to P13, the decision to implement the national health targets was made at the central government level without considering the local health agencies' views. P13 argued that DHBs struggled to implement innovations (outcome-based policy) in health delivery because their annual plans were highly prescribed and circumscribed by the government. To ensure DHBs follow the government's requirements, DHBs are required to file their annual plans with the Ministry.

In P13's experience, any attempt on the part of a DHB to resist the Ministry's requirements and implement its own visions would most probably result in conflict because, in reality, a DHB board is ruled by the government's vision. A DHB board comprises 7 elected and 5 non-elected members. Although the elected board members outnumber the nonelected, the chances of elected

board members influencing the policy decisions are very slim because DHBs' strategic directions are directed by nonelected members, and the chairpersons were 'handpicked' by the Ministry. According to P13, in many instances, the strategic directions of a DHB were controlled by the CEO and appointed board members:

So, in theory, elected members outnumber the appointed members. But think about politics, you are never ever able to get the 7 elected members to agree. So, with the 5 ministerial appointees plus with the very natural politics, the government is pretty safe. And, the chair is incredibly important; he chairs the meeting, controls the direction, and liaises with the chief executive. And this is why you always hear that the DHB board is simply being [the] rubberstamp person. – (P13, a board member of a DHB)

By referring to his own DHB, P13 demonstrated how a DHB board is controlled by the government. According to P13, the government masters a DHB board through its appointed board members. Appointed board members appear to be dominant as they have stronger voices and support. He also claimed that the government applied a double standard to its treatment of appointed and elected board members. For example, "in a 3-year term, occasionally, ministerial appointees will have conferences directly with the minister and we elected members aren't invited to that meeting". In terms of the domination of appointed board members in his DHB's governance, P13 sees this as "the tail is wagging the dog". For P13, such domination was seen as an effort to limit the voice of people in health.

P13's reflections give the impression that his experiences directly contradict what had been outlined in NPM and NPS reform principles: that control should be implemented through cooperation and collaboration. P13 acknowledged that the government transferred some of its responsibilities to the lower level health agencies like DHBs; however, instead of facilitating local decision making, the government appears to have taken control over the health system. This experience has frustrated P13.

In addition, the government's control can make the DHB boards appear to be incompetent:

They [the board members] represent themselves as something that they called governance, but if you make comparisons between the boards that you have in nearly all other DHBs' boards for that matter, and make comparison with the board of Fonterra, Mainfreight, New Zealand electricity, Air New Zealand, or anyone, you will find a very different level of confidence and capabilities. Our board does not do that . . . they have no influence. – (P08, a business support manager of a DHB)

P08 talks about DHB board member' lacking the qualities which were needed for effective actions. According to P08, a DHB board is supposed to operate as an independent board of directors which has the ability to assess overall directions and strategy of the DHB. However, looking at the way in which his own DHB board operates, and comparing the ability of his DHB with other companies' boards, he feels they lack such capabilities. Drawing on his experiences, P08 suggests that some of the board members exhibited a lack of knowledge and experience of the public health system. Therefore, they exert limited influence over policy decisions.

According to P08, while in theory a combination of elected and appointed board members in DHBs is a good idea, it provides a difficult working environment in practice. The board members elected by the public can be anyone from society regardless of their experience and knowledge. Meanwhile, appointed board members are selected by the government, and their appointments are based on their professional experience and they are, for example accountants or lawyers. At times, there is a gap between the appointed and elected board members in terms of their views and understanding because of their different backgrounds. Such situations are exacerbated when the government exercises its control via appointed board members. As a consequence, in P08's opinion, a DHB board was perceived as being unable to function as efficiently as other business boards in New Zealand such as those of Fonterra, Air New Zealand, or Mainfreight. It can

thus be supposed that the inability of DHBs' boards to make decisions about strategic directions diminished the overall performance of DHBs.

P08's experience demonstrates that many reforms are ideal in principle, but not so in practice. He suggests that the concepts of NPM and NPS such as 'steering', 'devolution and deconcentration' and 'public participations' are not fully adopted due to the exercise of overwhelming political control. However, despite its interference in reforms, the lower level health agencies such as PHOs continuously urge the government to include them in the reform processes:

The Ministry has a difficult task to do but often is out of touch. Sitting in Wellington, sitting in . . . dare I say, an ivory tower and only based on evidence-based research which is important of course but it's not always logical, doesn't always lead to good policy because human nature, culture, perceptions influence the implementation of a policy . . . They don't have the information. They could get it if they got out from the ivory towers and really engage with people like ourselves on the ground, intimately. – (P06, a CEO of a PHO)

P06 expresses his disagreement with the centralisation approach adopted by the government. He claims that the government lacks understanding of the needs of various health populations in different regions and districts. P06 believes that better policy solutions could be explored and achieved if the policy makers engaged local people in the reform process. P06 recalled his experience of being in a meeting with a group of high level policy makers. He revealed how they interpreted the information at hand due to lack of understanding of the health system:

And again, the Ministry will sit down and argue in Wellington: "Look! There are 3000 GPs in this country and it's more than enough". – (P06, a CEO of a PHO)

According to P06, such interpretations indicate that the policy makers are not au fait with the way the GPs system in this country works. In fact, they are

unaware of the existence of a 'hidden' workforce in the health system. In the experience of P06, not all of these 3,000 GPs are working full-time because some of them have opted to work on a part-time basis. Furthermore, not all registered GPs are resident in the country all the time. In reality, New Zealand relies on overseas doctors, and many GPs who remain on the list may have gone back home or to other countries such as Australia. P06 claims that such simple mistakes can lead to the wrong policy solutions and increase the level of complexity in the health system.

Another health manager, P07 raised her concern regarding the inability of the government policy leaders to make health policy decisions. From her position, the policy leaders had ignored the fact that New Zealand is a 'rugged and remote' country. She argues that New Zealand is different from other countries, and despite modernisation, New Zealand has remained isolated due to its colonisation history and geographic location. Therefore, in her opinion, imitating other countries' policies and blanketing the whole health system with one standard replicated policy in the hope of getting the same outcomes is ridiculous.

Both P06's and P07's experiences illustrate how the lower level health agencies recognised the importance of including their voices in influencing decisions on reforms. They believe a centralised strategy limits the benefits of reforms because the limited understanding of policy leaders about the health system and the various needs of health populations.

In summary, the political interference has caused the health managers to be concerned about the government's tendencies to control the process of reform. On the whole, it was the DHBs' public health managers who expressed their frustrations with the government control because such controls limit their ability to deliver good health services to the public. The PHOs' managers also indicated a sense of disappointment with the government due to its failure to include PHOs' views in reform decisions.

### **6.2.3.2 Lack of leadership and policy support**

Some participants associated the challenges of implementing reforms with a lack of leadership and policy support.

When it came down to the implementation, there wasn't enough leadership in the sector, or support from the government to really transform health service delivery to improve outcomes for health populations. – (P05, a senior manager of a PHO)

P05 reflected on her experience in implementing reforms and dealing with organisational changes. She found that the process of implementing reforms sometimes became difficult due to a lack of support from the policy leaders in terms of providing guidelines and information on how to implement the policy. Policy supports are important because they help to reduce the knowledge gap between policy leaders and policy implementers. If health policy implementers were clear about the systems and the implementation of policies, and the aim of those two, P05 believed they would be able to drive health institutions to a high level of performance.

Drawing on the example of the 1990s health reform, P05 described the confusion among health managers in dealing with reforms and policy changes. According to P05, because the 1990s reforms were driven by market strategies, the public health managers were requested to match up their investments with the operational units. Each unit manager was made accountable for the units' activities, which were measured in output terms. The policy leaders made the health managers believe that the strategy would enable the public health system to deliver the highest quality of care and achieve the best customer satisfaction. However, due to insufficient guidelines on how to implement the policy decision, the managers were simply 'breaking down' the hospital system into small departments or agencies with the aim of improving the efficiency and effectiveness of health services. The health managers then noticed that the strategy failed to achieve

its objectives. Instead, it resulted in complexity in health service delivery. For that reason, P05 states:

We don't do that well in the sector, we're very confused.  
– (P05, a senior manager of a PHO)

P05 says further:

The Ministry of Health has really struggled with the leadership for the last 7-8 years and got confused about its roles. And the District Health Boards have just been off doing their own thing and the performance of the system is highly variable depending on who's in charge. . . what we're seeing now is a declining performance of the system without that leadership. – (P05, a senior manager of a PHO)

As P05's sees it, the public health system has, since the 1980s reform, undergone rapid changes. These have resulted in changes in its structures and governance. Frequent changes in both public health structures and governance, however, have led to considerable confusion about roles and responsibilities on the part of public health actors. P05 had witnessed how the Ministry of Health and the DHB leaders struggled to realise the objective of reforms because of this confusion. As a result, the required changes failed to materialise at times because the Ministry and DHBs were unable to steer the requisite changes onto the correct path.

In her experience, P05 has found that reforms usually come with a large, but vague, framework. The process of implementing reform, including decisions on mapping the reform framework, is largely left to DHBs' own interpretations; thus P05 suggests that the effective change has depended heavily on who was in charge at the local level.

Our new policy setting for this government is potentially very useful. But it has the same risks as previous policies, as there isn't a leadership to affect it well, so, we will head out with the dog's breakfast. – (P05, a senior manager of a PHO)

P05 discloses that the policy makers may approve a good policy framework that potentially will benefit the public health system but, because there is a lack of leadership to support the implementation of reforms, a good policy framework often turns into a mess.

In contrast to P05, P08 defines a policy support as a clear policy framework which can be used for navigating the implementation of policy. He claims that without such support, it is hard for health managers to implement the policy.

Health policy is about what we are going to do, but never has context of how to do it, and how to operationalise it. That is a very significant problem in New Zealand. The government of the day will never come along and say to DHBs or the Ministry of Health – “this is what we want to buy, this is what we say that we are going to deliver and this is the way we want you to deliver it”. – (P08, a business support manager of a DHB)

According to P08, the problems of implementing health policy in New Zealand are rooted in the absence of a standard policy direction, such as ‘what is to be done’; ‘how it is to be done’; ‘why it has to be done’; and ‘what the accountabilities are for the delivery of it’. As a result, policy leaders tend to interpret policies in accordance with their own understandings. P08 illustrates his view using the following analogy:

Think about this [lack of leaderships and policy supports], it would be equivalent with the All Blacks coach being appointed. He would go to a tent meeting with the players and meet with the junior staff of the All Black side. He would say to them: “Guys, this is the direction that I want you to go in for the next 12 months; I’ll let you know if I’m coming to any of the games, other than that I want you to teach yourselves and train yourselves, I want you to look after your own logistics and supplies, and by the way, if anything goes wrong, don’t call me. – (P08, a business support manager of a DHB)

P08 interpreted his analogy as follows: first, all the public health managers are expected to perform according to a standard of performance which is set by the government. However, there is no proper training and clear

information given to the health managers. The public health managers feel that they are unlikely to perform well because of this failing. According to P08, reforms always come with new ideas and approaches, but policy implementers are often “clueless” especially at the beginning of reform implementation. For that reason, P08 believes that reforms need supports from the policy leaders, in the form of training and guidance. In other words, it is important that policy setters support policy implementers. However, in his experience, policy implementers are not given such support; the policy leaders themselves often have limited information or “know how” related to new reform programmes announced by the government. Second, P08 explained that the models of reform generally advocated that managers should be accountable for the result that they create. This reform component indicated, albeit indirectly, that the government should not be blamed if the policy went wrong because sound implementation is the managers’ responsibility. Another health manager, P09 also lived through a similar experience:

You will clearly see within DHBs a lot of money to create Maori health units under different names and types. So, there has been a lot of resource taken out from clinical and other areas to put into Maori health, attempting to improve their health status. But that policy was given to us without a framework. In response to that we created the Maori Health unit, with the aim of supporting the clinical unit. We changed the programme from time to time try to meet the objectives. And that is just how we responded. Have we achieved anything since 2011 back to 1993? Has it had an effect? I would say ‘no’. – (P09, a finance manager of a DHB)

P09 shares his observations of the implementation of Maori Health Policy. According to P09, over the last 20 years, DHBs have been required by the government to improve the health status of Maori people. Responding to this call, his DHB made a significant effort to meet the government’s requirement, including the establishment of a Maori Health Unit. However, because there were no clear guidelines from the beginning on how to implement the policy, and because the DHB policy leaders also had limited knowledge about Maori

health, and despite the programmes have undergone frequent changes, none of the objectives had been achieved.

Without leadership and policy support from the government, the process of implementing reforms leads to conflicts among policy implementers. Using the implementation of BSMC policy as an example, P07 shares her experience as follows:

Because we have 20 DHBs, we definitely have difficulties and tough dilemmas in dealing with DHBs. Although we have a national policy, called BSMC that clearly says about boundaries and borders between DHBs and PHOs, there were some DHBs which refused to recognise us as a partner in this health care system. For example, there was a local PHO from [name of the DHB], wanted to marry [to join] with our organisation, it will become our representative in that region, and hold the agreement on behalf of us. However, the DHB said that is not going to happen because they [the DHB] don't want to have PHOs outside of their districts. This was surprising because there were no such regulations stated in the BSMC policy framework. The Minister and the Ministry won't do anything about that because they don't want to hear any unsuccessful story about the BSMC policy.  
– (P07, a senior manager of a PHO)

The above narrative describes P07 experience in dealing with several DHBs when first establishing her health alliance. As the establishment of business cases and health alliances were approved by the Ministry of Health, P07 believed that all the policy actors such as the Minister, DHBs and PHOs would be aware of changes around the BSMC policy and would provide support to ensure the success of that policy. However, in the experience of P07, the reality differed from what had been agreed earlier. It seemed to her that the political and bureaucratic institutions were unwilling to support the implementation of the reform they themselves had introduced.

The health managers' experiences given above illustrate that implementing policy is challenging because those responsible for the process are often in situations where they are unsure what to do. Therefore, they frequently look

to policy leaders to support the procedural path they take to effect change. However, in my view, the participants' experiences demonstrate that the New Zealand public health system lacks support from its leaders. Those responsible for policy implementations claimed that policy leaders were unable to communicate the views, visions and objectives of policy reforms to them.

To understand the situations described by the participants, I asked the public health managers explain why they thought the situation outlined above had developed. The health managers offered the following responses:

One, they don't have that level of intelligence; second, they don't know the answers or the solutions to this either. – (P08, a business support manager of a DHB)

We don't have people who are willing to hold that conversation [about the implementation of reforms]. – (P05, a senior manager of a PHO)

The stronger the Minister, the more ideas he has himself and, therefore, quite often the influences are quite often from politicians down to the bureaucrats. Of course the implementation is from the Ministry through DHBs and PHOs. – (P06, a CEO of a PHO)

Sometimes, you may have a new minister that might have a very little health educational background. To understand the whole health system in short period of time is almost impossible. Even if you appointed a consultant from Auckland to advise the Minister of Health, he might not fully understand the complex environment in the public health system. – (P10, a project manager of a DHB shared service agency)

The above extracts show that the health managers believe that there is a lack of understanding and knowledge among policy leaders regarding the substance of the policy reforms. This deficiency may be because some of the policy leaders have been trained within different sectors and have limited knowledge of the health industry. For this reason, some policy leaders are

unable to communicate the detail of the policies to the public health managers. This finding echoes to Lawrence (2005), who concludes that “the public health system is under-resources for the work they do” (p.12). Barnett and Barnett (2003) reveal that many health managers came from outside the health sector. In my view, the experiences of public health managers in this study illustrate that there is a disparity between the current characteristics of health industry leaders, and what Stiller (2010) describes as the expected characteristics of policy leaders. According to Stiller (2010), policy leaders are expected to have strong understanding of cause and effect in the policy-making process and the ability to assist in the development of policy innovation.

In summary, a lack in policy leadership is affecting the process of implementing reform. In the experience of public health managers, this process is difficult because they are given inadequate support from policy leaders. This systemic defect has resulted in confusion among public health managers and prevented them from producing good policy outcomes.

### **6.2.3.3 *Poor policy planning***

Policy planning is about developing strategies to make policies materialise in practice and about considering what is needed in order to operationalise the policy strategies (Barker, 1996). However, in the experience of public health managers, health policy planning in New Zealand is poor. This issue was raised by almost all the participants. P09 states:

They [policy makers] have only ever kept the health bucket at the same level. So, they expect a policy change or a generation change to happen with the same money. They very seldom fund to pick it up at the start [sic], what they do, they tried to take up the same bucket. So, it’s never worked.  
– (P09, a finance manager of a DHB)

In P09’s view, the policy leaders often take reform planning for granted. The policy leaders simply assume that with the same amount of funding, their

new reforms will change the public health system in the ways they intend. According to P09, while planning for reform strategies, the policy leaders often identify solutions for the health problems at the point at which the problems appear; the policy leaders rarely consider the origin of the problems in order to produce solutions that address the fundamental issues in the public health system. As a result, although health services have undergone many stages of reform, they still face the same problems.

To understand the above claims, I asked the health managers to share their most challenging moments in implementing reform. Several participants identified their experiences in implementing the six hours health target. The six hours health target was introduced in 2009, after National's returned to office in 2008. Its objective was to improve the quality of Emergency Department (ED) services and hospital performance in general. The six hours target specifies that "95% of patients will be admitted, discharged or transferred from an ED within six hours" (Ministry of Health, 2011b). By implementing this policy, the government aimed to reduce overcrowding and obstructions to hospital access in order to improve both outcomes for patients and health service efficiency (Jones & Olsen, 2011). Overcrowding in ED is a problem because long waits are inconvenient and often uncomfortable. They may lead to poor outcomes for patients, and even mortality (Ministry of Health, 2011b).

In the experience of health managers meeting the six hours target is not easy. A senior manager of a DHB, P08 explains:

In terms of the six hours health target, we are the second lowest DHB in the country at the moment, and we are about to become the worst DHB in the country. – (P08, a senior manager of a DHB)

P08 describes the recent report of his DHB's achievement in relation to health targets. In speaking about this example, P08 implies the high possibility of his DHB being ranked lowest in a future report. According to

P08, ensuring that at least 95% of patients presenting to ED were either discharged from ED or admitted to hospitals within six hours of arrival is very challenging. He explains that the number of people across the country who come to ED is close to one million every year; in fact in his hospital, the number of ED attendees has increased by around 11% compared to figures for the previous 12 months. Public hospitals have a limited number of beds and that factor constrains hospitals' ability to support transfer of ED users to in-patient beds within the six hours' timeframe.

P08 describes the overcrowding problem in ED as follows:

At the moment, this hospital is full, absolutely packed. Tonight, the ED will not be able to locate any patient in-beds in this hospital. We have been like this for the last couple of weeks. We built a new ED, and everybody comes; so they are stuck in the ED and in in-patient beds. – (P08, a senior manager of a DHB).

This example shows the situation that P08's hospital ED faces at present. P08 repeated that the overcrowding problem in his hospital ED was critical, and at certain times, ED was unable to fulfil its fundamental role of providing care and treatment for those with serious illness or injuries 24 hours a day, 7 days a week.

As far as many public health managers are concerned, the imposition of the six hours target fails to help hospitals solve the problem of overcrowding in ED. Overcrowding in ED is not caused primarily by a limited number of beds in hospitals, but rather by a disintegrating structural division between primary and secondary care. Although the government invested billions of dollars to build new EDs and upgrade ED facilities, the overcrowding continues because the underlying structure of the public health system requires changes.

According to P13, the fragmentation of the health structure is a serious problem in the public health system, but nothing has been done by the

government to address the issue. P13 describes how, when the fragmented structure led to overcrowding issues in his ED, he made a complaint to the Ministry of Health:

Well Minister, the PHO model that you made us implement has created the mechanism where all local GPs joined together and they have become huge. And you Minister have advised them to register patients, as many as they want, but you forgot to ensure that actually they have enough doctors to manage the patients. So, there's no measurement in terms of patient versus doctor ratio. What is happening is – if patients can't be seen, patients don't want to go to other PHOs because they have to pay a higher copayment fee as casual patients. Patients then line up at the ED. So, our six hour target gets blown out. (P13 – a board member of a DHB)

According to P13, the implementation of reforms focuses on a narrow health perspective. In his experience, decisions about reform are often made without considering health services as a whole. P13 claims that when the government decided to introduce a new model of primary care, called PHO, in 2000, very little consideration was given on the effects of the PHO model on secondary care services. Despite the ability of the new PHO model to improve the level of access to primary care, the model has not eradicated the barriers to access which have their source in the costs of seeking treatment. He explains that patients with financial difficulties usually choose to delay or avoid seeking care from medical centres (primary care). Another health manager, P09, noted that if their health condition worsens, this group of patients will go to ED to get treatment because ED services cost them only time not money. The problem of overcrowding in ED continues because ED has been made the popular option for lower income groups. According to P09, hospitals are unable to redirect people to after-hours services in other medical centres, as doing so conflicted with their social responsibility.

The experience of public health managers in dealing with ED issues indicates that policy leaders may introduce reforms to deal with more superficial and malleable issues rather than address the more fundamental problems in the

health system. The criticisms of the implementation of the six hours health targets and national health targets, overall, provide evidence that the policy changes have been unable to solve the overcrowding problems in ED, or improve the outcomes of the health system in general.

It can, therefore, be inferred that the national health targets are not the best mechanisms for measuring health service performance. For example, P11, who is a clinical executive director of a PHO, claims that statistics are only raw data and that, in themselves, they have no inherent value in achieving targets. He argues his point further by saying that the health targets are designed to compel people in the health system to meet targets. This approach, however, runs counter to clinical principles which require health providers to perform their tasks that go beyond simple health targets and actually help patients to manage their health risks as well as possible. For P11, the ultimate objective of health policy and its reform agenda should be directed to improving outcomes for patients: he deems that objective the best way to achieve value for money. He stresses:

We should be doing things that improve outcomes for patients. It's pretty simple. We just need to produce a safe, good quality of care which has to be value for money – (P11, a clinical executive director of a PHO)

In addition, the public health managers associated the poor policy planning with the adoption of rapid change in health policy strategies. P01 states:

I think we have too much rapid change and I think sometimes we threw the baby out with the bath water – (P01, a CEO of a PHO)

According to P01, as reform is driven by political ends, the government tends to propose reform strategies which can bring a quick transformation in the health system, or at least apparent benefits before the next election cycle begins. The government hopes to show the public that it has succeeded in changing the way in which health agencies work. The government simply

drops or adds policies which it thinks will lead to this desired outcomes. In P01's experience, most of the reforms are implemented in haste and, as a result, the government is unable properly to obtain some of the benefits of these reforms.

Similarly, P04 claims the implementation of rapid reform has diminished the opportunity for the health sector to achieve some reform objectives. This failure arises because certain strategies and health issues require a period of time to pass before they deliver the planned outcomes. P04 explains that the failure of health policy makers to understand the health system and its fundamental needs, and criteria with regard to change, have led to huge disappointments among policy implementers. P04 shares his experience in dealing with the implementation of a rheumatic fever programme as an example. According to P04, New Zealand is still struggling to fight some third world diseases such as rheumatic fever.

Rheumatic fever is a problem in this country. Believe it or not, this first world country still has a problem with rheumatic fever. There are many ongoing rheumatic fever programmes, but the problem still cannot be wiped out. – (P04, a senior manager and a board secretariat of a PHO)

According to P04, the rheumatic fever programme was designed as a 10-year programme. However, the program was discontinued 3 to 4 years after its implementation because the newly elected government decided to implement another strategy. The progress of the programme fell below the expectation at this point because it had been designed as a 10-year programme. Rather than letting the programme run its full course, the incoming government took the decision to replace the programme with another approach. The result of such decisions is that they inhibit the potential outcomes of a programme from emerging fully. Rheumatic fever remains a serious New Zealand health issue to this day.

To understand the scenario, I reviewed the national programme for rheumatic fever. I found that the first national standard programme for

combating rheumatic fever was introduced in 2006, and was called the New Zealand Guidelines for Rheumatic Fever. These guidelines were in place for only 4 years. According to Hooker (2010), these guidelines were unsuccessful due to a lack of resources, support and leadership from DHBs and at the Ministerial levels. In 2011, under the National-led government, the New Zealand Health Foundation published a series of three clinical guidelines for the management, treatment and prevention of rheumatic fever to replace the earlier guidelines. The government was successful in changing the way in which the health agencies work, but not, however, in tackling the policy problems.

Another manager, P06 claims that it is not only policy decisions that are made in haste. Policy implementations and terminations are also often decided on an ad hoc basis. P06 states:

The implementation has been rushed and very vague. –  
(P06, a CEO of a PHO)

For P06, the process had been hampered by poor policy planning, as well as poor communication between the government and health providers. He drew on the example of the government's handling of the diabetes programme:

The Minister made an announcement last year that the diabetes programme was going to stop without saying what was going to replace it. And, of course, the number of diabetes reviews dropped off dramatically, understandably. And the Minister about three months ago asked, "what happened to diabetes reviews? They dropped off dramatically". Oh Minister! You made a policy announcement that they are going to stop funding these reviews and they will be replaced by a broader cardiovascular disease and diabetes management program but you made the announcement before you had the future programme in place. – (P06, a CEO of a PHO)

According to P06, despite the fact that changing a policy strategy is a major decision, in practice, such decisions are hastily decided. Consequently,

reform ends in confusion for policy actors and such confusion adversely affects efficiency and effectiveness in health service delivery levels.

In relation to the above situations, reforms were also seen to produce unwanted outcomes.

Health policy also has created a number of very-very [sic] difficult problems for us to overcome. It sounds remarkably good . . . it sounds fine, but practically, it is impossible. – (P08, a senior manager of a DHB)

According to P08, reforms often work well on paper but not in practice. He illustrates his claim by referring to the implementation of the BSMC policy strategy. Generally the BSMC strategy is intended to deliver health services to the place where people live, in a better format, and sooner. The key objectives are: to improve convenience for patients, reduce pressures on hospitals, and reposition the health system for its long-term sustainability. According to P08, the government intends to reduce the overhead costs of each DHB by pushing some services back onto primary care organisations. The government also believes that transferring some hospital services to primary care, or medical centres, will reduce pressures on hospitals.

A number of strategies designed to these ends have been implemented: for example, delivering more services from integrated medical centres, called BSMC business cases (see Section 5.6). Under this strategy, health consultations (as at public hospitals) will also be available in medical centres. Another approach is to introduce the concept of “tele-health”. This strategy allows medical centres and hospitals to provide more consultations via Skype, phone, and email.

Nonetheless, according to P08, the BSMC strategies are difficult to implement. Shifting health consultations from public hospitals to a primary care or medical centre has a major impact on hospital services. New Zealand is a small country and it has a limited number of health consultants. If these

consultants become primary care-based on a regular basis, the change will place more pressures on hospitals because hospitals will face a serious shortage of consultants, and may not, as a result, be able to meet the demands of hospital users.

The operational reality of life, as I explained to you – you can't put consultants or physicians at the GPs rooms [primary care] and still run the service here [hospital]. You can't have one person doing two jobs in two different places. It doesn't operate that way. It sounds fine, but practically, it is impossible. – (P08, a senior manager of a DHB)

For P08, transferring some hospital services to primary care is an ideal solution, but it is not practical because both primary and secondary care rely on the same human resources. P08 also raised his concerns on the implementation of tele-health. According to P08, tele-health is a good policy strategy but he is doubtful about the implementation of this strategy.

We have moved more and more into tele-health but it's still a long way to go and there is little in the way of the clinical professionals really trained in tele-health and developing disciplines around how to use it, i.e, policy, operational framework and such. – (P08, a senior manager of a DHB)

For P08, tele-health is a challenging strategy to implement. It requires not only comprehensive training for health professionals but also demands high commitment and passion for using technology in providing health consultations on their part. In his opinion, most clinicians are still not ready to adopt this new method. He has had several conversations with a number of clinicians: these exchanges indicated that health professionals have little interest in the tele-health strategy.

In summary, the public health managers expressed their frustrations toward health policy planning and implementation in New Zealand. In the experience of the health managers, health reforms are poorly planned. The government tends to produce policy outcomes that accord with its own interests rather than to create policy relevant to the fundamental needs of

health populations. The implementation of reform is seen as driven by short-term policy objectives and this approach results in greater conflict between efficiency and equity. According to Gauld (2006), reform decisions which are made in a hurry frequently lead to their failed implementations because they lack sufficient detail and allow inadequate time for management and clinicians to assess the procedures and finalised the reform strategies (Andrews & Boyne, 2010; Gauld, 2006). Consequently, reforms are unable to produce the desired improvement either in efficiency or patient care. This findings align with Lawrence (2005), who claims that “reforms are adding to the illness of the public health system (p.11)”.

#### **6.2.3.4 *Silo effects and competitive culture***

The aim of reforms meant to improve efficiency and effectiveness in health services has led to the creation of divisions and standardised work methods based on specialisations in functional areas. The specialisations, however, produce unintended outcomes in the health system, sometimes referred to as ‘organisational silos’. Organisational silos cause breakdowns in communications, cooperation and coordination among units in an organisation and with other stakeholders; they encourage fragmented behaviour (Fenwick, Seville, & Brunsdon, 2009).

In the experience of many public health managers, there are many silos within health institutions in New Zealand which flow from the establishment of functional specialisation areas. P08 illustrates this claim, saying:

When you look at this DHB, we give the impression of being coherent service. But in fact, we are a whole bunch of silos, all operating independently and there is constant friction between each silo. – (P08, a senior manager of a DHB)

At one hand we have surgery, medicine, haematology, oncology, radiology etc.; on the other, we have rural and community services which are made up of hospitals, family health teams, disability and our community supply. We run our community oral health services which is across the

schools and rural hospitals. None of those are joined-up, none of them. – (P08, a senior manager of a DHB)

P08's DHB is structured around three main functions namely, planning and funding, hospital and health services, and governance and corporate support. Each function is responsible for different areas covering both clinical and management of health services for the whole population in his health district area. To increase the reported efficiency of health services, each DHB function may be structured into a number of small units according to predefined specific roles and responsibilities. Over time, the units become 'silos' due to their functional specialisation and organisational barriers imposed between units. This arrangement damages communication and reduces opportunities for collaboration within the health agencies.

Silo structures create communication problems as constructed by P07:

Those people who are clinicians like myself who went into management, were completely devalued just because the managers don't understand the clinical services. The corporate managers, who were brought by the government in health management lacked contextual knowledge around health. They [corporate managers] tried to adopt commercial strategies which actually in my view weren't possible. So, we end up with dichotomy, which take many years to work through but I don't think it's finished. – (P07, a senior manager of a PHO).

P07 reflected on her experience of working in a DHB at the beginning of her career in health management. As a clinician who went into management, P07 experiences serious tensions between management and clinicians, when they are making decisions relating to policy planning and funding. According to P07, her DHB's planning and funding division was dominated by a group of professional managers who came from various industries. Although they were experienced managers, P07 claims that they lacked contextual understanding about the public health system. In many instances, those managers often perceived health services as the same as other businesses;

they believed the adoption of business commercial strategies would boost performance.

Considering such perceptions as inappropriate, P07 attempted to rationalise the professional managers' views by offering her experience and knowledge from a clinical perspective. She believes the professional managers should understand the implications of managerial decisions on patients, clinicians, clinical procedures, and health services in general. However, P07 has found that most of her suggestions were seen as irrelevant and considered as against health management objectives, which involved the improvement of efficiency and effectiveness of health services. According to P07, unwillingness of health management to accept clinicians' views in delivering health services resulted in two silos developing, and those two silos remain.

The management and clinicians rarely share their visions, roles and responsibilities which made the process of implementing reform difficult.

I have discussions with some departments across our regions. There somebody would say "what will happen to me if I don't deliver the Ministry targets? And I say "well the funding for the DHB is cut". They will reply "what's that problem for me? My [the] problem is with the patients. I treat them as they come through the door. I will accept them and treat them as I see them. That's the most important thing for my profession". And what can you say to that? – (P10, a project manager of a DHB shared service agency)

According to P10, that is the sort of dilemma faced by health management and health services in implementing reforms. Clinicians are important players in public health systems as they determine the ability of health institutions to offer health services. If clinicians refuse to be involved with the implementation of reforms, or decide to leave their positions, a hospital can no longer provide a service for a particular patient cohort; this is a bad outcome for patients. Furthermore, in performing their duties of care, clinicians often argue that they are supposed to be accountable for their patients' outcomes; not for meeting the health service management targets.

Silos also reduce the ability of management to control the behaviour and performance of individual practitioners. According to P09, in his DHB, there is a significant gulf between clinicians and health management due to the fact that “doctors and nurses don’t like being told how they will work”. In the experience of P09, some health professionals resist the adoption of new managerial practices in their clinical activities. He recalled an example where health management wished to introduce a scoring system to help clinicians determine waiting times for elective surgery. Patients were to be given scores according to two criteria: first, the length of time they have been on waiting list, and, second, those in most need. However, there were longstanding arguments concerning the management of waiting times around the criteria. According to P09, such arguments arose because the score for waiting time was subject to professional judgment, and some thought the system was open to abuse. Nevertheless, due to the existing silos, the management was unable to ensure clinicians followed the rules for the scoring system. The conflicts between health managers and clinicians resulted from a lack of agreed norms in professional and managerial values in the health system.

Some of the participants linked their frustrations with the level of cooperation provided by upper level government agencies. According to these public health managers, cooperation and coordination between health institutions is disappointing.

There is a situation where a DHB can say “well, the BSMC policy is all financed well, but we have already made a strategic investment plan and it [the investment plan] binds you for a 5-year strategic plan. The new government policy [BSMC] doesn’t really fit into it. And we are not really prepared to drop off our 5-year strategic plan in favour of the new policy”. So, it is a constant negotiation it would appear between the centre and a DHB as to what gets done and what gets through. – (P01, a CEO of a PHO)

P01 described his experience in dealing with the implementation of the BSMC business case. DHBs and health alliances had to demonstrate their

agreements on the implementation of the BSMC business case. Such agreement required:

1. primary and secondary clinical leadership at alliance decision making forums to jointly prioritise funding and service developments that best meet population health needs;
2. investment in primary and community based capacity (facility, workforce, information systems) through IFHC developments;
3. shifting of services where it makes sense to increase access for enrolled populations and their families;
4. real investment in the clinical pathways processes that support integrated care for patients.

(Ministry of Health, 2011a)

However, when it came to implementation, P01 was surprised, and frustrated by the responses of some DHBs to the business case being implemented in his organisation.

In [location of his PHO], we have approximately 60,000 enrolled people who cannot be serviced by us, because the DHB made a decision that they would not recognise us as a primary health organisation in [location of his PHO]. So you know, we have sought to resolve this with the DHB, but they have shown no interest or inclination to be prepared to change their view despite the provider and the wider communities being supportive of the direction that this organisation wants to take. – (P01, a CEO of a PHO)

According to P01, some DHBs refused to cooperate and recognised his health alliance without any reasonable motive for doing so. For P01, such a stance makes it difficult for his organisation to deliver services to the public.

I was told by the participants that the level of cooperation among DHBs varied because policy came with general statements, and DHBs were allowed to interpret and implement the policy according to their own understanding, and the availability of their resources. In another example, P11 said, in order for his PHO to deliver the Diabetes Get Checked Programme under the BSMC

business case, he has to deal with seven different strategies produced by seven DHBs within seven different contracts.

The situation became even more difficult when some DHBs attempted to differentiate themselves from other DHBs by implementing their own unique programme and being reluctant to share, or use, other existing programmes. For example, P07 states:

In here, we and our associated DHB run an intersector programme which is designed to tackle rheumatic fever disease. This programme had proven a good outcome and had been recognised as a good quality programme by the Director General of Health and Ministry of Health. But, because our associated DHB is using it, the other two DHBs won't, even though they also serve the same population. This is just because they want to have their own programme. – (P07, a senior manager of a PHO).

In the view of P07, the way in which DHBs play their roles in managing health services seems to be by competing with each other, and trying to be the national champion in health delivery. For that reason they refuse to collaborate with other DHBs and also PHOs. P07 complained:

I can't understand why they can't be treated under one system and under [an] integrity system. We've got about 17 different versions of software systems that collect data; we got five of six versions of PMS (performance management system) systems in the secondary care and primary care; we've got different patient management systems in the secondary care. But no one volunteers to collaborate or do it in one way. – (P07, a senior manager of a PHO).

In summary, the process of restructuring in the public health system has encouraged organisational silos within and between health agencies. Silos affect the level of communication between policy actors. They create confusion and unnecessary competition among health actors and institutions.

#### **6.2.4 Summary: Reforms, policy changes and responses to organisational changes**

It would appear that over the last decades, the New Zealand health reforms were implemented in a highly politicised and complex environment due to political competition among policy actors and health institutions. The public health managers expressed their frustrations in dealing with such situations. Health institutions were seen as incapable of being properly accountable because the implementation of reforms has been accompanied by political interference, poor policy planning, lack of leadership and damaging competition between health agencies. These factors reflect the challenges dealing with reforms embedded in the mire of political power and authority. Consequently, the public health managers have experienced a series of paradoxes or disjunctions between policy expectation and implementation.

The structure and governance of the health system is complex, and in the view of public health managers, the structures are “unmanageable”. According to the public health managers, the government is adding more administrative layers onto the structure and governance of the public health system through the creation of new agencies with responsibilities. As a result, the administrative size of the public health system is ‘getting fat at the wrong end’ because the additional administrative layers apparently create more duplication. The public health managers expressed fears that the government is risking the interests of the public and the tax payers’ money for political motives.

The complexity of the health structure and governance affect accountability arrangements in the public health system. For example, Gains and Stoker (2009) state “the lines of accountability remain blurred and now perhaps more uncertain and confusing to citizens than in the past” (p. 446). The constant reforms raise questions concerning their effects on accountability arrangements in the New Zealand health system. The next section explores the views of public health managers on accountability arrangements by

examining the challenges faced by public health managers in dealing with those arrangements.

### **6.3 The effects of reforms on accountability understanding and practices**

The aim of this section is to provide an understanding of the implications of constant reforms on accountability arrangements in the New Zealand public health system. Specifically, the section focuses on two main questions. The first, which draws on the public health managers' experiences, asks: what are their views on accountability provision and practices? The second, based on health managers' experiences dealing with various policy changes, asks: what does accountability mean to them? Answering these questions should help to provide some understanding of how individual health managers comprehend and manage accountability in the context of constant health reforms. The following subsections present the health managers' views and experiences of dealing with the constant changes in the health delivery framework and accountability.

#### **6.3.1 Dealing with organisational changes and accountability: The experiences of health managers**

This section seeks to answer the first question: what are the public health managers' views on accountability after encountering a series of organisational changes. The public health managers were encouraged to share their lived experiences in delivering health services around postreform accountability. Throughout the interviews, the public health managers acknowledged the importance of accountability in justifying their actions and results. The health managers' responses to the problem of implementing postreform accountability were categorised around two factors. The first factor concerns the problems of organisational complexity and multifaceted accountability relationships. The second factor relates to the conflicts concerning managerial accountability which emerged because of differences

in perceiving managerial values. These factors are discussed in the following subsections.

### ***6.3.1.1 The organisational complexity and multifaceted accountability relationships***

As noted in Chapter Five, the adoption of constant reform resulted in complexity of the public health structures and governance. Throughout the interviews, the public health managers revealed that the level of organisational complexity and responsibility increased over the years and affected the notions of accountability and its practices.

I think it is very hard to describe really, how much we've seen but also it is hard to describe how extensive the health service that we overview actually is. But, if you were going from top to bottom; and from bottom to top of the health system, you will understand the complexity. – (P09, a finance manager of a DHB)

P09's statements clearly evidence that the public health system is operating at a high level of complexity. In his experience, the level of complexity was so high and it was difficult for individuals to understand the complexity of the public health system unless they experienced it for themselves. Indeed, the Ministry of Health also describes the public health system as “a complex system working together” ([www.health.govt.nz](http://www.health.govt.nz)).

Conversation with the participants revealed that the complexity of the public health system had a noticeable influence on the implementation of postreform accountability, because, by its nature, accountability is implemented in accordance with lines of responsibility. In other words, the more complex the organisational structures and the more uncertain the lines of responsibility, the greater the problems that will develop in accountability. Using his DHB as an example, P08 briefly listed the roles and responsibilities of a management team at DHB level and explained how the complex lines of responsibility affected the implementation of accountability:

In terms of size and scale, I don't think many people understand just how big a DHB we really are and how much we spread our foot prints around New Zealand.

We procure locally for food, dairy products, groceries, milk [for hospital kitchen], building materials [for refurbishing and building], and providing health services. We are a large organisation with a large employed workforce in [name of the region], over 6000 employees. We operate 450 motor vehicles – made up of cars, trucks, vans, trailers, motor mowers, motorbikes, forklifts. We procure a large amount of information technology equipment each year – desktops, PCs, laptops, audio-visual gear. We run one of the largest information technology networks in New Zealand. We have nearly 3,000 desktops, devices distributed across the organisations. We are technologically connected to other organisations.

We are also the lead DHB in the regionalisation project that has been devolving under the current government's requirement since 2008. We are currently involved as one of the big five DHBs in the centralisation of shared services with Health Benefits Limited (HBL). HBL is the Crown entity, charged with centralising and creating a shared service agency, the first steps of finance, procurement and supply change, payroll and human resource and also information technology solutions. – (P08, a senior manager of a DHB)

P08's narrative indicates that the tasks and responsibilities of a DHB are broad, involving the operation of the public health system at different levels of administration across district, regional and national levels. A DHB maintains reciprocal relationships with: the Ministry of Health (national), DHBs (regional) and PHOs (district/local). The DHB's tasks and responsibilities are not limited to the provision of health services but also embrace the entire management of health services, including contract management, health education and information, financial and legal, and human resource services.

The lines of responsibility also demonstrate that DHBs are held accountable for the way in which they spend the funding and achieve the reform objectives. According to P08, all the tasks and responsibilities that were developed were meant to ensure that DHBs could create a supportive

environment for better health service performance in the New Zealand public health system. In practice, however, managing all the tasks was challenging because the lines of responsibility were highly complex. For P08, the level of complexity arises because different governments have introduced different incremental reforms to the existing health system. Each reform demanded that health institutions continually improved their efficiency, control and performance. In P08's experience, the process of meeting such a high demand requires health institutions to detail their tasks and responsibilities through the establishment of new processes, units, and agencies. For instance, the involvement of private providers through contracting-out and commercialising, and the creation of a market system in health service delivery, increased the level of complexity in public health governance and changed accountability relationships. As a result, the health managers were all working in multilayered structures and relationships within multiagencies with an extended accountability regime which was based on performance.

P08 explained that health policy actors must now recognise multiple stakeholders with different accountability bases. The public health managers were expected to respond to multiple demands from a variety of sources, inside and outside of the public health system, such as the Ministry of Health, DHBs, PHOs, and the Treasury. In addition, they were expected to operate with a strong focus on health performance and evaluation for the benefits of New Zealand health populations. Simultaneously, the present accountability system is making the public health managers accountable first, for their institutions' performance in delivering better health services to the health populations; and, second, for the performance of agencies which have been awarded contracts for delivering health services on their behalf. In P08's view, because reforms promised the public health system would perform better, the government has a strong confidence in this new accountability.

Nevertheless, the implementation of postreform accountability appeared to be difficult, as is shown by the following:

I mean accountability to 11 PHO members is quite difficult to do. – (P02, a board member of a PHO)

We are having 20 DHBs in a country of 4.5 million people. This is not a good size of structure: 4.5 million [people] are a size of a city for other countries. We have ended up with 20 fragmentation versions or interpretations of what a policy is. Because of that we [PHOs] definitely have difficulties and tough dilemmas in dealing with DHBs. – (P07, a senior manager of a PHO)

For example, a consultant makes a decision: “I need to see this patient in 6 months”. The manager then argues “the policy says . . . no you have to see him within 4 months”. And the consultant will argue, “but the patient is well enough, I don’t need to see him until after 6 months”. The manager then says, “you have to because my KPI, my pay, my . . . everything is based on your meeting this target”. And this consultant will be saying “my duty of care is only with patients, I don’t care what your policy says!” So, you can see a very clear disconnect. – (P10, a project manager of a DHB shared service agency)

The above excerpts reflected the health managers’ views and experiences in dealing with policy changes in the complex public health structures and postreform accountability. These participants associated difficulties in implementing accountability with the complexity of public health structures and multifaceted accountability relationships.

In particular, both public health managers, P02 and P07 spoke about obstructions in dealing with accountability at the PHO and DHB levels. Meanwhile, P10 talked about the contradictory nature of accountability relationships between health management and clinicians. P02 described the difficulties his PHO faced in dealing with other 11 PHOs when first establishing a health alliance (see section 5.6.2). According to P02, these 11 PHOs were located across a large geographical area, across 9 DHBs. For P02, the transition from a PHO to a health alliance was challenging for all 11 PHOs because they had different management styles and clinical practices. The situation, has remained difficult and full of impediments even after the transition period because the new alliance still has to deal with 9 DHBs which

have different management and clinical practices. Indeed, a health alliance had to refer to each service agreement held by its alliance members (PHOs) before dealing with particular DHBs because the content of each service contract differs slightly across DHBs. For these reasons, P07 described her experience of dealing with various DHBs on behalf of a health alliance as tough and full of dilemmas.

Meanwhile, P10 explained how the contradictory nature of the accountability relationships led to difficulties and conflicts in the public health system. In P10's experience, the problems usually arise from disagreement between managers and clinicians on certain things. According to P10, management demands clinicians perform their tasks in accordance with standard administrative procedures or key performance indicators (KPIs), including health targets, because their performance is measured according to procedures and targets. However, clinicians are sometimes unwilling to commit themselves to these standards because some of the procedures and KPIs were developed in line with management perspectives and they sometimes go against the clinicians' standards of professional practice.

The experiences of these participants confirm the impression that postreform accountability is problematic because it was implemented in a complex public health structure and within multifaceted lines of responsibility. The multifaceted lines of responsibility led to increased demands for accountability. However, Messner (2009) cautions that in the case of ethical decisions or behaviours, more demands for accountability are undesirable because increasing demands for accountability are often translated into "a perceived need for tighter management control" within organisations (p. 919). Messner (2009) argues that in practice, tighter management controls are unable to ensure various accountability expectations can be fully met.

My observations suggest that the public health system is governed by a combination of various groups of actors and underpinned by several types of

accountability relationships. These encompass managerial, political and professional accountability. However, as the criteria for each type of relationships are different (see Romzek & Dubnick, 1987; Sinclair, 1995), the prospect of facing conflicts in accountability relationships is relatively high. For example, as policy implementers, DHBs hold not only managerial accountability but are also subject to political accountability from their constituents and policy leaders (the government, the Ministry of Health, and health Crown agencies). Simultaneously, DHBs also have horizontal accountability to clinicians who are bound by professional accountability. As compared to managerial and professional accountability, political accountability is relatively powerful, especially in influencing accountability arrangements in the public health organisations (Cordery et al., 2010). Political accountability is underpinned by hierarchical relationships, which enable the principal (the governments in the context of the New Zealand public health system) to coerce the agent (public health institutions such as DHBs and PHOs) to comply with the principal's demands for accountability. Even though, the health managers (DHBs) are given considerable freedom in making managerial decisions (in terms of financial and resource use), the opportunity of health managers to exercise their managerial autonomy appears to be limited because of the clashes which arise within and across these accountability relationships.

Furthermore, holding political accountability has granted the government full control over DHBs and PHOs, meaning that most of DHBs' decisions and PHOs' activities are subject to government approval. Throughout the interviews, the health managers revealed that the ability of DHBs to determine their strategic directions was constrained by the government requirements or sudden interventions created in response to political pressures. This situation indicates that the democratic criteria suggested by NPS have not been totally employed.

Simultaneously, interview data show that there were constant arguments between health management and clinicians relating to a mismatch on certain

managerial standards and clinical procedures between DHBs' management and clinicians due to lack of understanding between them. For example, clinicians saw health management as interested in financial matters rather than outcomes for the health populations; meanwhile, health management considered that clinicians, as a group of people, were difficult to work with because they do not like being told how they will work. Clashes between managers and clinicians have been regarded as conflicts between medical and accounting logics (see Lawrence, 2005).

The work of Parker and Gould (1999) may provide some further insights regarding the clashes in accountability relationships. Parker and Gould (1999) identify that the increasingly different forms of accountability emerging in the neoliberal reform era have resulted in different interpretations of accountability and tensions between the roles of different stakeholders. Such differences are likely to result in diverse and vague policy decisions and those impacts could lead to negative effects to public organisations including, negative behaviours (Budding, 2004). Thus, it is my conclusion that postreform accountability has become mired in the complex health structures resulting in difficulties in the implementation of post-reform accountability.

As noted earlier, in principle, the public health managers appreciated the implementation of reforms as they could see some of their valuable benefits for the management of public health organisations (see section 5.2.1). However, most of the public health managers expressed their disappointment with the implementation of reform because they felt that reform did not address changes in accountability:

Policy [reform] hasn't prepared this organisation for any of that [changes in accountability]. We operate in real uncertainty and lack of clarity. – (P08, a senior manager of a DHB)

There was no one trained for that and at end of the day, they [the government] expect that to happen. – (P09, a finance manager of a DHB)

The Ministry directions are too vague. They are not structured in a way that you should provide this in this way. It's very much like – please provide this – (P10, a project manager of a DHB shared service agency)

These managers' statements are typical of what the majority of the participants reported with regard to difficulties in dealing with postreform accountability. As policy implementers, these participants felt that DHBs were struggling in dealing with policy changes and accountability due to vague reform guidance.

Having received inadequate training to deal with reforms, P05 expressed her unpreparedness to work competently with organisational changes and accountability. P05 provides further explanation when she says:

We didn't build accountability system around that [the reform frameworks]. – (P05, a senior manager of a PHO)

To give an example, P05 explained that at every stage of health reform, the government endorsed a general guideline and planning for policy actors as their references. For instance, since the first market-based reform was introduced, the government has passed a number of guidelines and plans including the Area Health Boards Accountability Act 1983, the Health and Disability Services Act 1993, The New Zealand Public Health and Disability Act (NZPHDA) of 2000, and the New Zealand Primary Health Care Strategy (NZPHCS) in 2002. Even though, these guidelines did provide descriptions of health actors' roles and responsibilities in implementing reform, the guidelines were, nevertheless, all rather generalised. For P05, the frameworks did not provide further information about accountability provision and practices for health policy actors.

Based on the public health managers' responses, my conclusion is that organisational complexity has led to the development of multifaceted accountability relationships and that those multifaceted features have affected accountability arrangements in the public health system.

### ***6.3.1.2 The conflicts in accountability***

As noted earlier, postreform accountability has developed along the lines of managerial values, and emphasised performance, with a strong focus on efficiency, value for money, and customer satisfaction. This new accountability has been enforced through a web of actions and relationships involving the implementation of specific performance targets and the monitoring compliance through reports and audits. However, in terms of implementation, the participants disclosed that dealing with postreform accountability was perplexing because measuring performance in forms of results was complicated. The participants associated the problems with the conflicts in managerial values which underpinned postreform accountability, namely, efficiency and effectiveness, outputs and outcomes, and auditing and reporting. The conflicts emerged because of the different perceptions of policy leaders and policy implementers regarding those values.

#### ***6.3.1.2.1 Efficiency and effectiveness***

In order to sustain accountability for performance, neoliberal reformists emphasise the adoption of the concepts of efficiency and effectiveness in policy decisions. According to P08, health policy leaders appeared to have a strong belief in efficiency and effectiveness. They urged policy implementers to scrutinise the level of efficiency and effectiveness in the public health system, with the aims of improving accountability of health institutions and increasing the performance of health services. However, P08 reports a different experience:

There is a huge amount of issues with efficiency and effectiveness. If we want to deliver health services properly, they have to be efficient and effective. You cannot have one without the other. The efficiency has the implication of cost management, minimisation of waste. The effectiveness is about outcome. But my experience is often different. I can make things very efficient, but I may not make them effective.  
– (P08, a senior manager of a DHB)

The above narrative reflected P08's views on the concept of efficiency and effectiveness in health service delivery. According to P08, the government made policy actors believe that efficiency and effectiveness are mutually dependent, and therefore, adopting these two concepts in governing health services will improve the performance of health service delivery. However, in P08's experience, efficiency and effectiveness were two quite different concepts which have different policy implications. For P08, efficiency focuses more on finding the most efficient ways in managing cost, whilst effectiveness is concerned with the best ways of improving policy outcomes. P08 further comments:

Management is unable to grab the whole organisational problem and resolve it through efficiency and effectiveness strategies. They may lose attention to what it should be doing [because of differences in these concepts]. If management is pressured to focus on certain things, like financial performance for example, it will lose attention on another thing. – (P08, a senior manager of a DHB)

The excerpt illustrated P08's position on the adoption of efficiency and effectiveness concepts in postreform accountability. According to P08, due to a lack of resources (time, financial and experts), it was difficult for policy implementers like DHBs to adopt both efficiency and effectiveness concepts in delivering health policy. Indeed, P08 believed that these two concepts should not be linked together in the same context, arguing that when a manager focuses on efficiency, the goal of effectiveness can get lost, and vice versa. In my opinion, P08's statement reflected the point that efficiency and effectiveness are quite separate matters, and concentration on the success of

one does not guarantee, or automatically bring with it, success in the other sphere. P08 draws on an example when he says:

Our DHB is going to find savings this year of about \$44 million. We have spent so much time looking for savings, we will end up losing some of that money because we are looking at the savings but not worrying about how we are delivering the service. – (P08, a senior manager of a DHB)

P08's narrative described how his DHB lost its focus on policy outcomes (effectiveness) because of undue focus on efficiency. According to P08, his DHB was working hard to improve its financial efficiency by seeking savings of up to \$44 million. However, his DHB ended up losing some of the saving because, while focusing on increasing the saving, less attention was given to improving health services. Lack of effectiveness in delivering services increased the operation costs of the public health system and reduced the overall saving. Therefore, it is my conclusion that efficiency is an opportunity cost of effectiveness, and effectiveness often comes at the cost of efficiency.

#### **6.3.1.2.2 *Outputs and outcomes***

Both output and outcome are important concepts in postreform accountability. These concepts were introduced during the implementation of reform with the aim of ensuring the given course of actions or resource investments achieved their intended results (Day & Klein, 1987). Generally, the concept of output helps to answer 'what is being produced and how much it costs'. As output is easily measured and can be seen within a short period of time, it has been regarded as an appropriate performance measurement for public services (Norman, 2004). Meanwhile, the concept of outcome refers to broader changes or benefits created by policies, at certain times of their implementation (Norman, 2004).

Across the interviews, it was seen that the participants valued the importance of these concepts, especially in managing public funding and resources in health services. Indeed, some of them agreed that these concepts

are strongly linked when measuring the efficiency and effectiveness of the public health system.

When you spent your money on that particular client, will you get your outcome that you need? Because of that you need to measure the effectiveness of the service that you are delivering. Not just at the service level but individually down to the client level. – (P08, a senior manager of a DHB)

P08's comment underlines the importance of measuring health service performance. According to P08, postreform accountability has linked the concept of efficiency with output-based measurement. P08 explained that output-based measurement was introduced with the aim of ensuring DHBs and PHOs were accountable for delivering performance. However, health care services are subjective in nature, and therefore, measuring performance based on output has been considered as infeasible. According to P08, the government prompted a significant shift in measuring health performance by complementing output with outcome measurement. In relation to such changes, the participants reported that the government placed the emphasis on delivering outputs that contributed towards outcomes.

Nevertheless, the implementation of output- and outcome-based performance was reported as problematic. Throughout interviews, difficulties in measuring output and outcome appeared to be common issues among the public health managers:

They (outputs and outcomes) look similar to each other really . . . We can demonstrate how we have spent the money on programmes but we have no control on how the money will develop the outcomes. – (P02, a board member of a PHO)

I guessed the mental thought today is very much about outcomes. But we're not mature enough to understand outcomes. I would rather say it was a mismatch of performance measures. – (P03, a CEO of a PHO)

The above excerpts describe the problem faced by the public health managers in dealing with output- and outcome-based measurements. P02 spoke about difficulties in differentiating between these two concepts. In P02's experience, measuring efficiency based on policy output was easier than identifying outcomes. Meanwhile, P03 mentioned the inability of policy actors to understand the concept of outcomes in the context of health services. According P03, as a result of that lack of understanding, there was a large gap between health output and outcome, and he considered the gap as a mismatch of performance measurement.

Citing a specific example, P03 provided a detailed explanation of how the gap or mismatch occurs in a breastfeeding programme. According to P03, his PHO had to respond to assessment questions provided by the DHBs with regard to the breastfeeding programme carried out by his PHO. The assessment questions asked:

How many babies are fully breastfed? How many babies are exclusively breastfed? P03 argued strongly against the assessment questions, saying: I would say this is nonsense! What is the difference between fully breastfed and exclusively breastfed? What is the purpose of having this data? What are the outcomes that these measurements are trying to achieve? This is the sort of craziness that I talked about! – (P03, a CEO of a PHO)

In order to understand P03's complaint, I looked at the definition of breastfeeding used by the Ministry of Health for both breastfeeding concepts. The definition of exclusive breastfeeding is "infant has never had any water, infant formula, or other liquid or solid food, only breast milk and prescribed medicine have been given from birth" (Hungerford & Robertston, 2009, p. 11). Meanwhile, full breastfeeding is defined in this way: "within the past 48 hours, the infant has taken breast milk only and no other liquid or solids except a minimal amount of water and prescribed medicine" (Hungerford & Robertston, 2009, p. 11). In my opinion, the breastfeeding definitions provided by the Ministry of Health are complex and confusing, especially

when it comes to practice since the difference between these two concepts is too narrow.

Due to a lack of clarity in performance measurements and understanding of outcomes, policy implementers appeared to concentrate on policy outputs rather than outcomes:

The problem of DHBs is they concentrate more on outputs . . . so many outputs accountability. – (P04, a senior managers and a board secretariat of a PHO)

We avoid the whole question of accountability for outcomes. – (P02, a board member of a PHO)

I think people are just worried about accountability in terms of health dollars, and people are not worried about accountability for patients' outcomes. – (P07, a senior manager of a PHO)

Health targets are the examples of obsession of the [health] sector to the output-based performance. We measure particular, and very detail-specific clinical things. We think that if we measured those things the whole system will change, but it hasn't. – (P05, a senior manager of a PHO)

The experience illustrated above shows that some managers have found postreform policies place more emphasis on output than outcome. According to these participants, policy outcome is intangible in nature and it takes some time to produce. The government, however, often refused to wait a sufficient length of time for the desired outcomes to manifest themselves because the government itself was pressured by Treasury to show it had done something to improve the level of efficiency, and because the government needs to provide some reliable results to please the electorate. Consequently, all the efforts and resources were centred on the production of policy outputs and, as a consequence, the public health system appeared to be obsessed with output-based performance. Interviewees expressed criticism of the undue effort and focus on output-based performance. According to them, output-based performance neither reflects the actual performance nor does it help

the government to improve the outcomes of the system. In fact, simply meeting the health targets is not going to improve anybody's life.

The participants' experiences in dealing with output- and outcome-based performance provide an impression that the public health managers were confused with the measurement criteria used for monitoring accountability. It is apparent that the government itself was unable to provide a clear measurement for policy implementers. Haque (2000) sheds light on the issue of output- and outcome-based performance in this way:

The use of such performance measures is likely to encounter greater problems . . . where measurable performance criteria have hardly been a part of organizational culture in public governance. Many of the government's final outcomes are intangible and hard to define and translate into instrumental output measures. (p. 437)

#### **6.3.1.2.3 Auditing and reporting**

Across the interviews, auditing and reporting was identified as another critical issue that contributed to the conflict around postreform accountability in the public health system. Generally, auditing and systematic reporting was recognised as one of the control mechanisms for postreform accountability.

Overall, we believe in auditing and reporting, we believe in targets, we believe in publishing results. They are all good things. – (P07, a senior manager of a PHO)

We all engage with integrity with [the] DHBs, with [the] Ministry, who we are reporting to and we will deal with it. – (P11, a clinical executive director of a PHO)

Accountability is characterised by reporting. We have a delegation of authority, we have reporting lines, we have our annual account, and we have the statement of intents. We have to report all those things. – (P09, a finance manager of a DHB)

We will get audited by independent auditors from top to bottom as to make sure our management practices, clinical practices, quality systems, and governance are complying with the national service agreement. Yes, it is complex. – (P01, a CEO of a PHO)

The excerpts illustrated above show that many of the participants have recognised the importance of auditing and reporting in the public health system. These participants reported experiences of dealing with various types of audit and reporting to align the implementation of reforms with the intended results. Despite the complexity involved, these participants acknowledged the importance of auditing and reporting process in the public health system.

However, those who closely engaged with auditing and reporting process were unlikely to agree with the way in which the auditing and reporting process was implemented. P06 drew the example from his experience in dealing with audit and compliance issues. As someone who is responsible for organisational and staff performance, including clinical and audit compliance, financial risk management and clinical accountability of the PHO teams in meeting contractual obligations, P06 has experienced numerous challenges with those responsibilities. For instance, he commented on the challenges created with regard to the ambiguity caused by the lack of agreement between providers and auditors concerning performance targets.

It's very important to agree what is the appropriate level even if it is a simple measure. When I asked the auditors: "when was that agreed? When was that negotiated?" They got angry with me. – (P06, a CEO of a PHO)

P06's point was echoed by another health manager, P13:

But in the health context, I don't know if we all fully agree on what the expectation is. – (P13, a board member of a DHB)

The above excerpts pinpoint the main problem of control mechanisms in postreform accountability. According to these participants, there was a lack

of agreement between policy leaders and policy implementers about the measurement criteria in health services and, therefore, there was a serious flaw in auditing and reporting. For instance, P13 disclosed that decisions on health target criteria were made at the policy leaders' level without discussions with policy implementers.

Furthermore, audit practice, from P06's view has become worse as auditors come with vague targets and seek to impose penalties. P06 provides this example:

One of our auditors asked us to prove that our PHO has an appropriate level of service for our enrolled population. I said to the auditor, "please define what appropriate means?" He simply repeated, "prove that you have an appropriate level of service to your enrolled population". Then, I said, "so, now, how do I measure appropriate?" The auditor read the audit question to me again! – (P06, a CEO of a PHO)

He commented further:

You can't have auditors coming around with vague targets. Auditors must have specific criteria that were agreed, negotiated and signed off by all the parties. But, in actual fact, they [the auditors] were just asking questions and some questions are irrelevant. For example, they asked if we came out with a figure of 1 doctor for 5,000 people. Because I don't even know if anything would have happened, then, it would be like some little comment in my audit form. But, again why are they asking such question? If it's not important don't ask it. If you don't have an answer for me, don't ask the question, if you can't tell me what the right answer is, what is the target that I should be aiming for, don't ask the question. – (P06, a CEO of a PHO)

According to P06, because there was a lack of clarity between policy leaders and policy implementers on what was to be measured, auditors came with vague measurements. In his experience, auditors asked for irrelevant information which in his view was not useful for future improvement. From his point of view, the implementation of result-based accountability has increased the focus on targets and counting things, thereby increasing audit

and compliance pressure. He personally believes this undue scrutiny of details is unhelpful. P06 believed the audit and review process should be more helpful and bring about improvement. P06 felt that the auditors should come and say:

Hey! This is fantastic and here are a couple of suggestions for those areas where you are not performing so well, not read the questions 3 times! – (P06, a CEO of a PHO)

He also explained the link between funding, contracting and auditing. In order for PHOs to secure long-term contracts, they have to prove that they can be trusted. Trust between the government and PHOs is developed through the contracting and auditing process. However, according to P06, the process of auditing frustrates many PHOs. He provided the following example:

If they [PHOs] have 30 contracts, auditors will come this month and do [audit] four contracts, then, 3 months later, another one [auditor] comes and does 3 more contracts. Some of the information is generic but they ask the same questions . . . half of it maybe is generic like your business cases and overall financial budgets. But, they will ask again instead of sharing that information and having that information. They take an enormous amount of time to ask for the same information again and then another auditor will come in and will do 4 other contracts, but 1 of the 4 contracts includes a contract that was audited 6 months previously and then these 3 . . . So I think audits of entities rather than words on contracts would be very helpful. – (P06, a CEO of a PHO)

P06's narrative described his experience in dealing with auditing processes whereby he found that most of the audit processes involved were asking for the same questions for different contracts. He criticised the standard of auditing and the quality of auditors, commenting that "health auditing in New Zealand is really only in its infancy". P06 considered the auditing processes in the public health system to be ineffective. From P06's point of view, the audit process would be meaningful, if it could be regarded as a learning process for organisations. He believes organisations would be able to improve their performance if the audit processes were to encourage organisational learning.

In summary, this section explored the health managers' experiences in dealing with organisational changes and accountability. Specifically, this section attempted to understand the health managers' views and experiences on the implementation of postreform accountability. It revealed that the public health managers have acknowledged changes in the notion of accountability in terms of criteria and requirements. However, the implementation of postreform accountability was reported as problematic.

Postreform accountability was seen as too focused on the production of health service output and too rigid in its auditing processes due to confusion over the key concepts of efficiency and effectiveness. From the point of view of the health managers' experiences, the performance measurement results which report statistics do not reflect actual health performance. It appears that health policy leaders have not given the issue of accountability much attention as they have very little information on how to deal with postreform accountability. In addition, it can be seen that the structural and governance reforms in the health sector are becoming obscured and that the full benefits of policy implementations are not being realised.

### **6.3.2 Understanding the meaning of accountability in the context of public health reform**

In this section, the focus shifts to the second question: what does accountability mean to the public health managers? As discussed in the earlier sections, the adoption of reforms has had a profound effect on the public health structures and governance as well as accountability provision and practices. The public health managers saw the existing public health structures and governance as incompatible with supporting the multifaceted nature of postreform accountability. Indeed, the earlier sections demonstrated that the participants are working in a complex environment due to contradictions, conflicts, dilemmas, and frustrations in dealing with policy changes and postreform accountability. Hence, it is important to understand how these apparent situations influence the understanding of

accountability in the context of constant policy changes. The participants were requested to share their understanding of accountability through reflections on their experiences.

In analysing the participants' understanding, I looked closely at the context of participants' experiences and derived from them some common and uncommon accountability attributes to help me understand the pattern of the data. Across interviews, it was noted that the participants' personal values, beliefs and experiences shape the meaning of accountability. My interviewees all accepted that health service accountabilities sometimes do serve to motivate them to improve organisational performance. However, comments from my interviewees illustrate that sometimes the accountabilities imposed on them through the health service have actually made it more difficult for them to act to improve performance in the health system in ways they would like.

Therefore, it is my conclusion that the participants understood accountability as two sides of the same coin: ***accountability means being accountable; accountability means being not accountable.*** 'Accountability means being accountable' refers to the participants' beliefs that accountability functions as a mechanism for improving organisational performance. While, 'accountability means being not accountable' relates to participants' understandings that accountability has the ability to distance organisations from performance. The following sections provide evidence of both these states of affairs.

### ***6.3.2.1 Accountability means being accountable***

Generally, all interviewees agreed that reforms have extended the basic idea of accountability. The meanings of accountability were seen to centre on the main attributes of neoliberal reform principles such as: 'performance', 'performance measurement', 'outcomes', 'results' and 'contractual obligation'. The attributes the participants ascribed to accountability highlighted support

for the observations of Norman (2004): “Pre-1984, the emphasis was on ‘doing the job correctly and lawfully’. Between 1984 and 2000, the emphasis was on ‘doing the job efficiently’. Now the primary challenge is to get ‘better performance’ from the system”(p. 431). It can be inferred that the participants’ understandings of accountability have changed from its traditional concept, i.e., providing information or answering questions to a broader concept that includes performance management and evaluation.

In relation to the changes, most participants described the meaning of accountability as being accountable for organisational performance. Interestingly, although these participants did not agree about the nature of the difficulties involved in adopting performance-based accountability in the public health system (as discussed in Section 6.3), those arguments clearly shaped the managers’ understandings of accountability. Indeed, the participants believed that they are accountable for their organisational performance, and complying with attributes around performance such as obligation for contracts, meeting performance targets and measuring results.

It is about result-based accountability. It is also outcome-based accountability. Accountability for performance . . . I guess to me personally, I am accountable for running the organisation for success. – (P01, a CEO of a PHO)

P01’s interpretation of accountability was centred on result-based accountability. He believed that he is accountable for his board members’ ensuring that his PHO meets the performance standard set by the government and DHBs as written in their service contracts. The results of performance, measured in terms of output, were used for assessing individual and organisational accountability. P01 acknowledged that his conception of accountability was influenced by his personal background, values, and his work experiences in the public health system. According to P01, his public administration education has helped him to understand the structures and operations of the public health system. P01 emphasised that

his conception of accountability has developed around his experiences in dealing with various policy actors at different level of relationships.

On the contrary, P02 understands accountability thus:

It is about contractual obligation. Our accountability is based on outputs or outcomes. – (P02, a board member of a PHO)

P02's conception of accountability is focused narrowly on issues around contractual obligations. As a NGO, his PHO has formal contractual relationships with DHBs and the Ministry of Health, and therefore, the PHO is responsible for delivering health services in accordance with the contract specifications. To ensure the PHO was meeting the expected performance and accountability, the government and DHBs measured the PHO activities using output- and outcome-based results. For this reason, his understanding of accountability was established from this perspective.

Simultaneously, P02 acknowledged the complexity of the public health system and the issues around output- and outcome-based measurements, as well as the problems of multifaceted accountability relationships which resulted from reforms, but he preferred to view reforms and accountability in a positive way. P02 says:

I see change in a positive way. Often some people complain about change as sometimes being very disruptive and very uncomfortable. But, for me change is a useful tool which can be managed. – (P02, a board member of a PHO)

P02 believed that reforms would bring positive improvements if policy actors were able to manage reforms in appropriate ways. P02 comments further:

If you made mistakes in this game, someone dies. It's good to rationalise on how dollars are spent but it's not important. Our accountability is to the people of New Zealand. – (P02, a board member of a PHO)

The excerpt illustrates P02's conception of 'appropriate ways' as meaning being accountable for the New Zealand people. In other words, in order to achieve the intended performance, he believed that policy actors must be accountable not only to the government but also to the New Zealand public. For P02, health service industry is different from other services because it is about managing people's lives. Therefore, policy actors must be concerned about the implications of their decisions on the public because improving individual's health status is their real accountability.

To understand P02's conception of accountability, he was invited to share the factors that shaped his understanding of accountability:

I guess being a recipient of poor accountability often, and watching people do something that is not right are the possible factors. So, when you are given the opportunity to give something that may be useful to the community, you should be able to demonstrate that you are understood accountability: meaning that you have to do something that is right. – (P02, a board member of a PHO)

P02's elucidation illustrated that his understanding of accountability had developed around his personal experiences. In my view, P02's conception of accountability might be influenced by his experiences in the military before he joined the health sector in 1987. Although he has served the health sector for 26 years, his military values are still apparent. In our two conversations, he referred to his personal courage as a former military leader. He perceived reforms and changes as obligations to be fulfilled honourably; and he defined accountability as what is morally and legally right, which perhaps invokes a concept of military integrity. For that reason, he expressed no regret about the disestablishment of his own PHO that he had nurtured over the years when its dissolution was required to support the implementation of the BSMC health alliance.

In my opinion, P02's narrative indicates that he also understood accountability as being accountable for performance. However, his conception of performance-based accountability was centred on increasing

the public's satisfactions in health services. In other words, P02 measures accountable performance using citizens' satisfactions as outlined by the NPS model.

Meanwhile, the following three participants also expressed their beliefs in performance-based accountability but they focused specifically on measurement perspectives. P08, for example, acknowledged that his conceptions of accountability are influenced by his day-to-day job responsibilities.

I think working in different environments, and my personal day-to-day jobs have shaped my understanding in accountability . . . When we talk about accountability, you have fundamentally to come down to some frameworks by which you can measure things. We can measure nearly all things in health. – (P08, a senior manager of a DHB)

For P08, accountability in the public health system is about measuring health service activities. From his observations, the public health system is characterised by some measurement frameworks that are predicted on the beliefs that the measurement results would reflect the performance of the system. In his experience, some of the measurement frameworks, for example, the national health targets, have improved his DHB's throughput activities. For instance, over the last 5 years, P08's DHB has successfully reduced the elective surgery waiting lists by around 30% to 40%. In this sense, P08 indicated that his conception of postreform accountability was influenced by his responsibility in meeting output-based results set by the government.

As regards understanding how individual responsibilities influence accountability understandings, the work of Matheson (2013b) may provide some further insights on this issue. Matheson (2013b) conducted a study on how a leading DHB lost its ability to focus on equality of health services during a period of economic constraint. Matheson's study reported that in the year of 2008/2009, there were strong pressures from the government on

DHBs to increase their financial efficiency through the implementation of the national health targets. All DHBs shifted their strategic directions onto meeting the government health targets. Such changes in DHBs' strategic directions may have had an influence on P08's views on accountability because, since the implementation of the national health targets, DHBs' activities have been driven mainly by efficiency and measurement frameworks.

According to P08, despite all difficulties and criticisms, accountability survives successfully. P08 describes his views on accountability using this analogy:

This sounds flippant but actually I don't intend it to be . . . we are like mushrooms, we operate in the dark, we feed in an environment of food that sometimes is not really healthy, but at the end of it we turn ok as mushrooms. And mushroom is fundamentally a good thing. – (P08, a senior manager of a PHO)

According to P08, policy implementers described themselves as being trapped in a complex system full of conflicts between autonomy and policy. Nevertheless, in P08's experiences, the concept of accountability remained strong over time and had made people believe that accountability is one possible mechanism that could bring improvements to public services.

Both P05 and P07 also described their conceptions of postreform accountability on performance measurement, but they valued performance-based accountability from a normative perspective:

In my experience, accountability is about clarity and purpose – what we're here to achieve; and the measurement and reward system – how to contribute to that and the effects of one's actions. – (P05, a senior manager of a PHO)

Accountability is for what you do, how much that you do, how well you do it, and how well in terms of practice and who are better off as a results of it. Not supposed as how much and what. It is also about transparency, responsibility,

openness and contributions. – (P07, a senior manager of a PHO)

These extracts encapsulate the idea that both these participants linked the meaning of accountability with performance measurement and normative standards (internalised moral and ethical values). P05 believed that accountability is about clarity in its objectives, measurements, and reward systems, while P07 understood accountability as individual behavioural actions and implications for organisations. To get better accountability results, P07 preferred accountability to be measured in terms of outcomes rather than output. Similar to P05, P07 associated the success of accountability measurements with the inclusion of moral values such as transparency, responsibility, openness and making contributions. It is my view that the participants' understandings of accountability, arrived at through reflections of their experiences, indicate a sense of hope that postreform accountability will improve the performance of health services. In this sense, the participants hold the view that accountability will bring about improvements, if performance-based accountability is delivered with normative standards.

It is my conclusion that the meanings of accountability described by the participants give an impression that the conceptions of postreform accountability were influenced by the participants' personal values, beliefs, and work experiences. Regardless of the particular perspectives from which accountability is understood, the participants seem to believe that accountability means being accountable for the performance of their institutions. To achieve the intended performance, the participants also suggest that policy implementers should focus on citizens' satisfaction and employ normative values in the process of delivering health services.

#### **6.3.2.2 *Accountability means not being accountable***

The public health managers' conceptions of accountability changed slightly when they were asked about their confidence level in the new system of

accountability in terms of being accountable for performance. The public health managers reported that they still believe in accountability and endorse its strong fundamental purpose because accountability has the ability to transform the performance of organisations.

However, in terms of implementation, not all public health managers reported such positive outcomes. The health managers' responses drew my attention to some apparent inconsistencies and contradictions within and between the managers' experiences, as illustrated in the following comments:

The system of accountability in the New Zealand public health service is loose and weak. – (P03, a CEO of a PHO);

The notion of accountability is getting worse . . . accountability is problematic and [has] reduced the efficiency of the policy. – (P04, a senior manager and a board secretariat of a PHO)

The problem of accountability is . . . it is very murky . . . my personal experience tells [me the] accountability mechanism in New Zealand is being weakened. – (P01, a CEO of a PHO).

These statements are drawn from the stories of the participants' overall evaluation of the implementation of postreform accountability. In the experiences of many of public health managers, accountability is, in terms of its theory, an ideal concept but not such in its implementation.

The structure of accountability can be drawn on a piece of paper. But if you step back and look at our business and how hard it is to manage and deal with, I mean in terms of practice, you will get a true picture of it. – (P09, a finance manager of a DHB)

P09's comment illustrates that the implementation of postreform accountability is not as simple as it appears to be. Similarly, P08 says:

If you look at the health system now and make comparison to commercial entities such as Fonterra, Air New Zealand, or any other large entities whose basic underpinning is

customer service, and you take a view on what the health service looks like in New Zealand, you will certainly ask, “how can health service in New Zealand possibly operate like this?” – (P08, a senior manager of a PHO)

P08’s extract comes from the story of health managers in dealing with postreform accountability. In P08’s experiences, the notion of accountability in the public health system is complex if compared to other business entities. Accountability is underpinned by various relationships, including formal and informal ones; and it rests in several managerial values. As discussed in the earlier sections (section 6.3.1), varied relationships and contradictory values have led to difficulties in practising accountability caused by the blurring lines of responsibility.

For that reason, P08 felt that in practice, he could not exercise any real accountability. P08 states:

I think at the individual level, my job, personally day to day, I have virtually no accountability through anything that I’m doing. I have a lot of tasks that I simply have to do and I am accountable for doing these things. However, in terms of the performance of the enterprise though, I’m not accountable for anything. – (P08, a senior manager of a DHB)

P08’s statement implies that he understood his roles and responsibilities as well as his accountability, in terms of performance, those financial and throughput activities which related to his portfolio. However, in reality, P08 believed that he had no accountability over his organisation’s performance. According to P08, there were no policies or regulations saying that he is accountable for a particular performance. P08’s descriptions indicate that public health managers may account for their day-to-day work but not the overall performance of their organisations.

Listening to P08’s and P09’s experiences, it seemed to me that, rather than enforcing accountability, reforms have in effect opened up opportunities for confusing accountability. The study’s findings are aligned with Norman (2003)

who claimed that the blurred lines of accountability diffuse responsibility for management decisions and permit poor management. Indeed, Messner (2009) suggests that the adoption of reforms foster more distance in accountability.

Two particular examples support this point:

We have the policy that says 'every patient should be seen by a senior medical officer within 48 hours'. It doesn't happen. They [patients] might be seen with 8-10 hours, but if we discharged the patient within one day, they might not be seen by a senior medical officer. We have the policies that say 'we will structure the care plan, we might make them visible'. We don't do that. Sometimes, we don't even see the final results of diagnostic tests of the patient that has been discharged. – (P08, a senior manager of a DHB)

They are worsening the outcome for the patients actually. Because they are doing additional administrative work, and moving the patients around which they don't have to. Just simply to meet the Ministry's target. They meet the clinical time but they don't treat the patients equal to a lot of issues. They just build wards to place patients in. – (P10, a project manager of a DHB shared service agency)

These extracts were drawn from the story of the six hours health target policy. Both participants were clinicians before joining DHBs' management teams. These participants expressed a sense of dissatisfaction with the admission flow to ED. They claimed that the flow was created to meet the six hours health target but not to meet the clinical requirements. According to these participants, patients who come to ED will be seen by nurses to identify the acute types; then, the patients will be sent to the waiting room or short-stay wards for several hours before they are discharged (if patients have no serious acute condition) or transferred to a ward for further treatment. This admission flow has enabled DHBs to meet the Ministry's target, but it has not aligned with clinical guidelines, which require patients to be seen and treated by doctors before they are discharged or transferred from ED.

Due to such problems, P13 perceived accountability as:

A really blunt measure . . . are we delivering a world-class health system? And we measure that by: is the life expectancy of our citizens' improved? Is there deprivation or the occurrence of certain ethnic groups who have a higher density [sic] to have health issues: is that reducing? Are we meeting health targets? And if we not, then we have failed, that's the measure of our accountability. It's blunt, and it's not well articulated. That's the best that I can describe. – (P13, a board member of a DHB)

P13's narrative illustrates that his conception of accountability was established from his observations on the implementation of output- and outcome-based measurements in his DHB. He perceived the performance criteria used by the government to measure accountability and performance as “blunt” and “not well articulated”. P13 justifies his views, saying:

I would say the health targets, annual plan and the government spending cap are the best attempt. But, they are not a refined mechanism, they are blunt, and if you were over reliant on them, you would be unwise to do that. If we hold it [accountability] purely based on health targets, that would I say my 9 years were failed. I mean on some occasions we reach the targets but that's not even 1 year in any of my 9 years, where the board has achieved every one of the health targets. – (P13, a board member of a DHB)

P13 appreciated the government efforts for introducing the performance measurement in the public health system. However, in his experiences, most of the measurement criteria were unable to reflect actual performance of the public health system. P13 also expressed a feeling of disappointment for his DHB's populations due to his limited power to influence the government's crafting of better measurements (see discussions in 5.2.3.1). P13 comments further:

And, if I am going to be held accountable, then I would want more ability as a DHB member to change the strategic directions. – (P13, a board member of a DHB)

The excerpt illustrates P13's desires to have more authority in determining his DHB strategic directions. He believed that DHBs will be more accountable for the public if the government reduced the control on DHBs.

In summary, Section 6.3 provides a discussion of the effects of constant reforms on accountability arrangements in the public health system. Throughout the interviews, it was noticeable that the participants' understandings of accountability were influenced by their personal values, beliefs and experiences. As reforms were implemented under neoliberal principles, the health managers' conceptions of accountability were centred on performance and issues around managing performance. Nevertheless, working in the new accountability format within a complex public health structure was challenging for public health managers. The practice of accountability appears to be difficult due to its multifaceted relationships and conflicts in managerial values. Despite the difficulties, the public health managers still have a strong believe in accountability. Hence it can be deduced that the public health managers understood accountability as being two sides of the same coin: i.e., on one side, accountability means being accountable; while, on the other, accountability means not being accountable.

## **6.4 Chapter summary**

This chapter described the second stage of understanding of accountability in the context of reforms. In particular, this chapter described the public health managers' lived experiences of dealing with the implementation of reform and accountability in the public health system. I arranged the discussions according to two main issues: first, the government's rationale for implementing reforms and how the public health managers respond to organisational change; second, how the public health managers deal with reforms and changes in accountability.

The study's findings indicate that reform was implemented in a highly politicised and complex environment due to endless competition among

political institutions and health organisations. As a result, the public health system has undergone a series of changes in its governance and structures. However, due to political interference, lack of leadership, poor policy planning and the effects of silos, the reforms have hindered rather than improved the performance of the public health system. The public health managers have experienced a series of disparities between policy expectation and implementation. In other words, reforms failed to deliver the promised objectives to the public. This failure has led to the frustrations of public health managers.

As expected, the confusing situations in the public health system have had a profound impact on accountability provision and practices. The findings of this study suggest that reforms have changed the health managers' views on accountability. The public health managers' views on the concept of accountability have progressed from compliance (traditional accountability) to the adoption of a performance perspective. Accountability has become problematic due to the multiple accountability relationships that have evolved and the unclear criteria and values of accountability. The study's findings disclose a serious conflict concerning relationships, criteria and values of accountability. Nevertheless, the public health managers still believe that the implementation of proper accountability system could lead to improved performance. They believe that it is still possible if accountability systems are implemented in the right manner.

To comprehend why accountability in the context of reforms was understood from two opposite perspectives, the next chapter concludes the research issue by presenting a more holistic understanding using the second level of analysis, called decomposition approach. This stage is also known as the third stage (or Stage 3, see Figure 3.1, p. 72) of understanding.

# CHAPTER SEVEN

## CONCLUSION

### 7.1 Introduction

This chapter concludes the research project by providing the results of the research in terms of gaining a comprehensive understanding of the effects of continual public sector reform on accountability and its practices in the context of the New Zealand public health system. Through the adoption of the third stage (or Stage 3, see Figure 3.1, p. 72) of understanding, this chapter draws together empirical parts generated from the review of documents and interviews. Prior to the discussion of comprehensive understanding, a reflection on the major findings of the preunderstanding and understanding stages is presented. Subsequently, this chapter presents contributions, and limitations of the study, before ending the discussion with recommendations for future research and a final reflection.

### 7.2 Reflection on major findings: From preunderstanding to comprehensive understanding

I began this research by presenting my concerns related to the issues of accountability in the context of public sector reform. I argued that the notion of accountability has changed throughout the years of NPM and NPS reforms, but postreform accountability has brought little improvement in its practices. The irony of this situation is that governments have consistently offered the public their full commitment to improving accountability in the next round of reform. In many instances, governments have given their assurance that another round of reform would improve the performance of public organisations and enhance accountability. Dubnick (2011) refers to the above irony as the 'reformist paradox' because it has been proven that the implementation of new policy strategies often reduces rather than improves accountability. I argued that the government assurances on improving

accountability through the adoption of reforms reflecting the notion of accountability were idealistic, and that decisions for adopting reform were based on false premises. I was interested in understanding the experience of public managers in dealing with continual reforms, resultant changes in their governance and organisational structures, and the effects of changes on accountability.

The central research question of this study was: what does “accountability” mean in the ever-changing New Zealand public health service? This study set out to address the research question using a critical hermeneutics approach. The findings of this study were presented according to the hermeneutics stages of understanding, suggested by Myers (1994), and Phillips and Brown (1993). The stages of understanding are known as preunderstanding, understanding and comprehensive understanding. The preunderstanding stage was established through a review of policy documents and relevant literature related to the history of New Zealand public health reform. To understand the patterns of reform, the findings were arranged according to the rationales for and the formats of reform. The NPM and NPS models were used as the basis for examining the patterns of reform. Then, the next stage of understanding involved investigation of the health managers’ experiences in dealing with reforms and policy changes and their conceptions of accountability and its practices.

Preunderstanding and understanding stages were discussed in Chapter Five and Six respectively, whilst the third stage or comprehensive understanding will be offered in this chapter. The comprehensive understanding has been generated from the process of interpretation and reinterpretation of parts of understanding into the whole understanding. Prior to a discussion of comprehensive understanding, summaries of preunderstanding and understanding findings are presented.

### 7.2.1 Preunderstanding

Chapter Five presented the response of this study to the first research question: what changes in the public health system have taken place over the last four stages of reform and what were the rationales in terms of accountability?

Chapter Five reported that the New Zealand public health system has experienced different types of reform, including minor and radical changes under different ruling governments. A closer examination showed that in every new round of reform, the process of transformation was accompanied by changes in legal frameworks, administrative structures, and distribution of responsibilities. The changes were expected to help the government shift its role from funding organisations to funding performances (Norman, 2003). The above findings support previous research in this area (see Ashton, 1995; Ashton et al., 2005; Cumming, 2011; Gauld, 2003a, 2012; Morgan & Simmons, 2009; Starke, 2010).

An analysis of the strategies of reform indicates that the pattern of change was constant and revolved around centralised and decentralised strategies that reflected the influence of NPM and NPS models as discussed in Chapter Two. Regardless of which model of reform was adopted, the objective of reform remained aligned with the effort of improving policy efficiency and effectiveness. This finding also shows that the objectives of reform were repetitive; this repetition illustrates that the previous reform strategies were perceived as being unsuccessful in achieving their aims.

The findings move on to suggest that the government does not seem to accept that repeating the same reform objectives in each successive round of reforms is a sign of the failure of its former policies. Rather, the government chose to define the repetitive objectives as the consequences of the growing public expectations in health services. In its arguments, the government claimed that the growing expectations have created more pressures for the

public health system, and, therefore, that another set of reforms was needed to enable the public health system to respond well to such pressures.

To engender public support for another round of reform, the government rationalised its arguments using accounting technology and information to show the economic reality of the public health system. However, the most salient point underlying this fact was that the ruling governments tended to introduce distinctive policy strategies rather than consider the ability of the strategies to solve the existing problems. Brunsson and Sahlin-Andersson (2000) claimed that reforms were not aimed at improving the public services but rather attempted to change the modes of managing, controlling, and accounting for the services. This view suggests that reforms were introduced for the government's political survival rather than to address fundamental health problems.

As reveal in Chapter Five, the findings of his study support the work of Cumming (2011), Gauld (2012), and Ashton and Tenbenschel (2012) who caution that the government will face more challenges in the future because reforms have increased the complexity of the public health system. Indeed, the study's findings report that in the year after the 2011 election, we have witnessed more extensive change in the post-2008 reform. The government has established the NHB and the four regional DHBs on top of the existing 20 DHBs. It has introduced the concept of health alliance through the formation of the PHOs consortia. The establishment of these new agencies has increased the complexity of public health as it has added more administrative layers to the existing public health structures. The formation of new agencies is an apparent paradox because the strategies appear to run contrary to the initial objective of increasing efficiency by reducing administrative duplications and unnecessary bureaucratic procedures.

Reform has signalled a shift in the meaning of accountability and its practices. However, the document review provided limited insights into how accountability was structured and practised during the years of reform.

What is evident, however, is that the term accountability was consistently utilised by the government, especially in achieving public support for sustaining its reform agenda. As a return, the government, through its policy documents, promised the public that it would improve accountability and performance of the public health system. However, little information was provided by the government on how accountability for performance would be addressed within the public health system because most of the policy documents defined accountability from the policy actors' responsibilities.

At the end of the preunderstanding stage, I identified two main conclusions. Firstly, the implementation of reforms was constant, but the patterns of reform appeared to be inconsistent; they went in diverse directions. I concluded that the rationales for reform were justified from functional and social perspectives, but the strategies were designed in accordance with the government's political interests. Secondly, little was known about the notions of accountability in the years of reform. It was apparent that some definition for accountability was provided in some policy documents, but it was limited to the health actors' responsibilities. In my view, the normative values of accountability were utilised by policy makers to increase the public support for reforms. There was an expectation from policy makers that accountability would be enhanced and the performance of the organisations would be improved as the public health actors perform their responsibilities accordingly.

### **7.2.2 Understanding**

Chapter Six reported the results of interviews that investigated the health managers' subjective experiences in dealing with constant reforms, organisational changes, and the new notion of accountability. The summary of the findings were discussed in two main sections, i.e., reform, and accountability.

### **7.2.2.1 Reform: “is more about politics than policy”**

This section deals with the second research question: what are challenges related to constant policy changes, and how do health managers feel about dealing with the changes in the public health system?

One of the findings suggests that reforms made public institutions more accountable for managing their resources. This finding concurs with Gregory (2000), who reported that the greatest success of the New Zealand public sector early reform was a huge improvement in resource management and financial control. However, despite that benefit, the public health managers expressed their frustrations in dealing with reforms, and with policy changes. The public health managers believed that the health agencies had failed to deliver better services because neoliberal reforms focused more on the effort of improving resource management than on health services.

The interview findings confirm the preunderstanding conclusions that reforms were designed to tackle current issues rather than to address the fundamental problems in the public health system. In particular, the interview findings suggest that reform is more about politics than policy. The model for both NPM and NPS provide only general principles, which allow reformists to select only those principles which they wish to adopt and to interpret them according to the reformists' own contexts (Hood, 1991). In the context of this study, the government seemed to choose and interpret reforms in accordance with its political interests (Gauld, 2003b). These findings confirm that the models of reform are essentially rhetoric; i.e., their language suggests a sound basis for organisations to adopt change but provide little indication on how to operationalise the change (Christensen & Laegreid, 2007, 2011b; Hood, 1991, 1995; Lapsley, 2008; Van Dooren & Sterck, 2006).

Due to the rhetorical nature of the reforms, all the participants alluded to the tension in reform decisions and implementations. As discussed in Chapter Six,

the participants reported that reform decisions were centralised at the ministerial level; and the implementation of reform was hindered by political interference, poor policy planning, lack of leadership and policy support, and the issues of silo structures and unnecessary competition between health agencies. For example, the government often made ad hoc decisions, which were sometimes not rational, just to meet the efficiency objective, rather than consider the implication of its decisions on the public health sector. The participants also suggest that reforms have been directed to the formation of functional specialisation, which in turn led to the creation of silos and undesirable competition among health agencies. Therefore, the implementation of reform appears to be problematic for the participants because the government itself lacked knowledge on how to deliver the reforms being introduced. These findings differ from the work of Van Dooren and Sterck (2006), who suggest that political influence has substantial effects only on reform decisions and less on daily operations. The findings of this study, however, suggest that the political influence appears to be critical in both reform decisions and implementations.

The result also indicates that the government has adopted hierarchical relationships, which in turn give the government full control over the lower level health agencies (Harber & Ball, 2003; Sinclair, 1995). This finding does not fit with NPM and NPS principles which promote the ideas of decentralisation and democratic values in postreform governance. The government appears to influence DHBs board decisions through the appointed board members while it monitors the activities of PHOs through DHBs regulations and contracts. This finding aligned with Gregory (2000), who describes the political influences in New Zealand as an “. . . elective dictatorship . . .” (p. 115-156). Nevertheless, having full control over the health management does not mean the government has any real control over the outcomes of reform, because, in the context of health, the services require supports from health professionals in order to deliver health services.

This study has found that the government appears to have difficulties in controlling health professionals but not in controlling health management. Technically, health professionals are bounded by their professional and ethical guidelines. In this sense, they are independent and are not subject to the government policy requirements. They, therefore, have the options of either supporting or not supporting a reform. This choice is made possible because health professionals are accountable for the process of care rather than outcome of that process (Wallis, 2013). Nevertheless, by contrast, the managerial accountability does require health professionals to be accountable for policy outcome. For these reasons, support from health professionals toward reform is limited to only those strategies which aligned with their professional accountability. For these reasons, the government control over the public health system is effective only in the health management division. However, by controlling the operation of health management, the government had expected that it would, or could, control the overall health service outcomes.

The health managers have expressed their concerns about the level of government control over the health management division. They report that the government dominates, and often redirects during policy implementations. The government control was seen as going against the reform principle of 'let managers manage'. This principle was seen to offer the public health managers considerable freedom to use their discretionary power to translate all the reform strategies in accordance with their institutional capacities and interests (Gregory, 2000; Maesschalck, 2004). Nevertheless, with the government retaining its hierarchical control over the public health agencies, this discretionary power is limited in actual practice. Again, these findings disagree with those of Van Dooren and Sterck (2006), who view policy implementers ('street level' employees) as the main transformers of actions.

In summary, the empirical findings suggest that the challenges in dealing with constant reforms and policy changes is rooted in the problem that

'reform is more about politics than policy'. In other words, the challenges are about the difficulties that the policy implementers have in dealing with the government's political interests. The gap between reform decisions and implementations created by the government's political interests has distorted the potential benefits of reform. This state of affairs has led to frustrations among the public health managers because reforms have changed only the ways services are delivered without making them more effective. These findings have deepened my preunderstanding on why and how reforms appeared to be inconsistent and moved in different directions.

### **7.2.2.2 *Accountability is about hopes and frustrations***

This section attempts to address the third research question: what are the public health managers' conceptions of accountability after encountering the succession of organisational changes? This research question aimed to understand how the health managers comprehend and manage accountability practices in the context of constant health reforms.

The findings of this study indicate that the meaning of accountability has broadened during the years of reform. The process of giving an account has extended from justifying individual conducts to a broader concept that includes being answerable for organisational performance and evaluation. The changes in the meaning of accountability support previous research in this area, suggesting that accountability is no longer about scrutinising individual actions and decisions but is a matter of organisational performance (Dubnick, 2005; Dubnick & Frederickson, 2009; Mulgan, 2000; Sinclair, 1995; Thomas, 2003). One possible explanation for the changes may relate to the emerging reality of the public health system. Reforms have increased the level of complexity in public health organisations and changed the lines of responsibilities. As accountability is closely attached to organisational structures and the framework of governance, changes in the public health structures and governance were found to shift the notion of

accountability and its practices (Broadbent & Guthrie, 2008; Day & Klein, 1987; Newman, 2004; Sinclair, 1995).

Further, the result of health service performance on how health managers comprehend accountability after encountering a series of reform indicates that accountability is not as simple as it appears to be. Performance-based accountability seems to conflict with a normative standard of accountability (moral and ethical values). As discussed in Chapter Six, measuring health service performance in terms of the policy output only made the public health managers accountable for their daily tasks and responsibilities but not for those of other people. The result of health service performance recorded in the forms of statistics did not reflect the actual performance of public health organisations. Additionally, the public health managers have experienced a series of conflicts in accountability relationships involving political, managerial and professional accountability. For these reasons, the public health managers believed they had failed to deliver accountable performance and expressed their frustrations in dealing with this new accountability. Surprisingly, despite that fact, the public health managers still believe that accountability, of itself, is not problematic. Due to these findings, I propose that accountability in the context of reform can be understood as two sides of the same coin: accountability means being accountable; and being not accountable at the same time. The two diametrically opposed sides of accountability reflect the notion that accountability is full of paradoxes because it consists of both a sense of hopes and frustrations (see below).

**Accountability means being accountable** refers to the health managers' beliefs that they are accountable to the public for the performance of their organisations. This finding suggests that accountability is an appealing concept for the health managers. It is apparent that two factors influenced the health managers' perceptions of accountability. First, they were influenced by the internalised feelings (personal values and beliefs) where being accountable is seen as a moral obligation (Bovens, 2007, 2010). The influence of personal values and beliefs in valuing accountability indicates

the meaning of being accountable is defined from the normative perspective. Secondly, because reform was designed in accordance with neoliberal ideology, the meaning of being accountable for the health managers has included their ability to contribute to better performance.

The health managers agreed that postreform accountability is complex, and dealing with this accountability in the complex public health system is challenging and problematic. Nevertheless, they contended that the complexity was instigated by the reform activities and not caused by a deficiency in the accountability concept. The health managers' arguments indicate that their conceptions of accountability remained optimistic during the years of reform despite all the emergent difficulties, as discussed in Section 6.2.3. This conclusion implies that accountability is underpinned with feelings of hope because their normative values influence people beliefs in accountability.

**Accountability means being not accountable** is associated with difficulties in dealing with the role of accountability when it acts as a mechanism for practising good conduct and meeting the targeted performance. The public health managers expressed considerable concerns about their inability to follow the formal requirements of the new accountability. Dealing with post-reform accountability was perplexing because managing performance in the form of results was complicated. Measuring the performance of public health organisations using managerial concepts such as efficiency and effectiveness, and, output and outcome, was challenging in practice. As discussed in Section 6.3.2.2, the implementation of these managerial concepts as indicator for accountability resulted in accountability conflicts.

The public health managers reported that achieving the required levels of efficiency and effectiveness at one and the same time is almost impossible. In practice, rather than being complementary, these concepts appeared to be competing, indicating that only one concept could be achieved at any one time. The study's finding here reveals that efficiency could be an opportunity

cost of effectiveness and effectiveness often comes at the cost of efficiency. Similar difficulties were identified with the adoption of output- and outcome-based performance. Although these concepts are useful in measuring public funding and resources, they appeared to be problematic in terms of their actual application due to a lack of clarity over these concepts. As a result, the adoption of output- and outcome-based performance ended with confusion among policy leaders and policy implementers. These findings are supported by the work of McKinlay (2000) who claimed that the output- and outcome-based performance has been recorded as the least satisfactory part of the New Zealand reform because officials are required to focus on outputs and have no formal responsibility for the outcomes to which they contribute.

The process of measuring accountability has been criticised due to the adoption of auditing and reporting systems, which in the views of health managers were a burden and not useful for future improvement. The systems have been narrowly focused on scrutinising details, and scoring results within the budget allocated in a particular timeline. The health managers see this type of auditing as unnecessary. There is also a lack of agreement between the policy leaders and implementers on the measurement criteria, which, in turn, is a further flaw in the process of auditing and reporting. As a result, the process of auditing and reporting is done as a formality, not as an opportunity for learning and growth for health organisations (Harber & Ball, 2003). The public health managers expressed their dissatisfaction with the role of accountability as an organisational reporting mechanism, as they felt they lacked effective control. The reforms were regarded as failing to engage with policy actors and to prepare health organisations for dealing with the new emergent multifaceted accountability. The health managers' experiences indicate that dealing with accountability could also result in frustrations. A possible explanation for this situation is that there was a lack of knowledge among policy leaders on how to deliver accountable performance. Strangely, although NPM and NPS reforms have promised better performance and accountability, little information is available on how to structure and deliver this new accountability.

In summary, the empirical findings suggest that the implementation of policy reforms has affected the health managers' understanding of accountability and its practices. However, because the experience in dealing with reform is inconsistent (due to the success and failure stories in the implementation of reform), the notion of accountability appears fluctuate between one of hope and one of frustration. These findings have helped me to understand the notion of postreform accountability and its practices.

### **7.2.3 Comprehensive understanding: The effects of reform on accountability**

The empirical findings confirm that the implementation of NPM and NPS models of reform has changed the New Zealand public health structures and governance. Although the adoption of these models of reform was expected to improve health service performance and accountability, the findings indicate that reforms have never realised these expectations. What was apparent was that development in the public health system has gone beyond the principles outlined by the models of reform. The process of reorganising of the public health system using NPM and NPS models resulted in multilevel and complex governance structures. These structures appeared to be fragmented and coordination became the key problem in making the structures work (Van de Walle & Hammerschmid, 2011). Although NPM and NPS reforms offer a reasonable level of freedom for managers to implement reform, the health managers felt that their freedom was curtailed by the government's hierarchical control over the public health system. The experience of the public health managers indicates that there were significant gaps between policy and practice and these gaps led to frustrations among policy implementers (see Section 6.2.3.3).

It would seem that the implementation of reform failed to achieve the desired end. Rather than admitting the embedded problems as failures of reform, the government repeatedly offered new strategies for improving the results in the next round of reforms. It had also been difficult for the public health

system to discard reforms because the reforms were initiated by the government. To legitimate the proposal for reform, the government rationalised its decisions using accounting information and economic calculations to show the public the benefits to be gained. The findings indicated that the process of proposing and implementing reform appears to go round in circles. Following this line of argument, reform can be described as a 'means without ends', meaning that reform is continually implemented in a political loop in which demand and supply for change are determined by the government's political interests.

The adoption of continual reform has increased the level of complexity in the public health system. The complexity of public health governance and structures has affected the notion of accountability and its practices because accountability rests in the organisational structures. In this study, the meaning of accountability has extended from justifying individual conducts to answering for organisational performance. Taking together all the empirical findings and discussions, this study confirms the arguments of scholars such as Bovens (2005) and Day and Klein (1987) that the new accountability is a complex concept, and that defining it is even more difficult because the meaning of accountability differs from one context to another due to its 'chameleon-like' criteria (Sinclair, 1995). Indeed, this study agrees with Sinclair (1995) that the process of defining accountability is challenging because "the more definitive we attempt to render the concept, the more murky it becomes" (p. 221). Interestingly, despite that fact, the public health managers viewed accountability as an unproblematic concept (see Section 6.3.2.1). Therefore, this study suggests that the meaning of postreform accountability remains elusive but appealing at the same time. Based on the public health managers' experiences in dealing with reform and policy changes, the meaning of accountability in the context of reform can be viewed as symbolising both hope and frustration.

Day and Klein (1987) state that the concept of accountability consists of two different functions: accountability as a moral order (normative) and

accountability as a mechanism. As a moral order, accountability is closely related to the normative perspective, where being responsible is considered as a respect of human dignity, whilst accountability for mechanism is about establishing relationships within and between various forms and structures of accountability. According to Bovens (2010), despite the significant differences between accountability as a moral order and as a mechanism, these two concepts are complementary. Accountability as a mechanism is meaningless without virtue or moral values and vice versa.

Most studies in the area of accountability have focused either on accountability as a normative perspective or accountability as mechanism (see examples in Chapter Two). The study's findings extend the suggestion of Bovens (2010) by adding the idea that the two concepts of accountability are not only complementary but also confusing and conflicting at the same time. The results of this study show that under the influence of the new governance structures which emphasise accountability for performance, the public health managers understood postreform accountability as a mechanism. Based on this finding, I join Newman (2004) and Sinclair (1995) in concluding that the policy implementers' conceptions of accountability are influenced by the ideology of reform.

The public health managers showed their positive acceptance of this postreform accountability. They held the view that postreform accountability would bring about improvement in organisational performance if it was really delivered. The health managers' views demonstrated that they valued postreform accountability from the normative perspective: being accountable for performance is understood as an obligation to perform to a standard or desirable standard of behaviour required by the public health system. Based on these findings, this study confirms that both accountability concepts (mechanism and normative) complement each other. This study demonstrates that accountability provides hope for the public health system, and the New Zealand public.

Despite that fact, it is apparent that the concept of accountability for performance was loosely defined. The word accountability was used widely in the policy documents but it was accompanied by little discussion on how the performance-based accountability should be implemented. Without such information to support them, health managers seem to be struggling to deal with postreform accountability. The public health managers revealed that they were unable to follow the formal requirement of postreform accountability such as meeting the health targets, and improving the efficiency because they were not given any clear direction on how to deliver performance-based accountability. The findings show that the public health managers faced significant challenges in dealing with postreform accountability because the real focus of the existing system is on the managerial process not on achieving outcomes for the health population (see Section 6.3.2). The health managers felt that rather than enforcing relevant measures, the new accountability system proved confusing.

Nevertheless, rather than putting the blame on the new accountability system, the public health managers placed all their criticisms of accountability on the shoulders of policy leaders. In the view of health managers, their policy leaders failed to provide proper direction for accountability when drafting the reform strategies. The health managers' beliefs show that their views on accountability remained neutral and ideal. The health managers' responses indicated that the policy implementers understood the mechanistic role of accountability, but tended to value accountability more from a normative perspective. Perhaps, this was the point at which the fundamental paradox in accountability emerged. The public health managers had a strong belief in performance-based accountability but they considered themselves incapable of being properly accountable due to their inability to deliver the formal requirements of performance accountability. The gap between accountability understanding and its practices resulted in frustrations among policy implementers. This study, therefore, suggests that the problem in defining accountability is rooted in the conflicts between its two basic concepts: accountability as a

moral order and accountability as a mechanism or social practice versus technique.

In the light of the findings reported, it can be said that postreform accountability may be successful in changing the role of accountability as a mechanism but not in altering an individual's personal belief in accountability. This study suggests that the meaning of accountability should be understood in terms of its being two sides of one coin. One face [re]presents its social practice, while the other [re]presents its technical aspects. Even though reform has enhanced the focus and relationships in mechanism accountability, accountability cannot be uncoupled from its social or normative perspective. It can be said that no matter how much the policy has changed or will change in the future, the possibility of policy implementers facing similar challenges and the same feelings remains high because reform produces two identical outcomes for accountability: that is hopes and frustrations.

### **7.3 Contribution of the thesis**

The exploratory nature of the thesis makes a contribution to the understanding of accountability in the context of reform. This study aimed to provide an understanding of the effects of reform on the notions of accountability and its practices. In doing so, this study reviewed the history of the New Zealand public health reforms and explored the subjective experience of public health managers in dealing with reforms, policy changes, and accountability. The findings of this study make three contributions to an understanding of accountability.

- First, it offers valuable insights into the ongoing developments in the public health system and the issues of accountability.
- Second, it contributes to the wider understanding of the effects reform have on the notion of accountability and its practices.

- Third, it advances an understanding relating to recent discussions on postreform accountability.

In particular, the current findings provide additional evidence with respect to the findings of Lawrence (2005), who claims that the public health system has undergone so many changes that no one can explain what is happening and why. An analysis of the patterns and trends of reform together with the health managers' experiences, has led to my conclusion that reform is 'a means without ends'. This finding signals that neoliberal reform knows no bound because the demand and supply of reform are determined by the government on the basis of its political interests. If the theses of current scholars such as, "neoliberal reform is still alive" (De Vries & Nemec, 2013, p. 7); "neoliberal reform will never disappear"; (Hong, 2013, p. 312), and 'it will continue well in to the future' (Atreya & Amstrong, 2002, p. 14) are valid, reform in the public health system is likely to continue in the future.

However, the rationale for implementing reforms remains unclear because the decision to implement reform is subject to governmental justifications. Due to its chameleon criteria, accountability will be affected by changes in the public health system, and further problems will continue to arise in the future. However, the interview findings indicate that the public health managers still believe in reforms because they understand that organisations need to change in order to respond to environmental pressures. They would prefer to have a well-planned reform rather than a hastily implemented change. Perhaps, a long-term policy with a clear accountability arrangement should be considered for the public health system to provide continuity in reform directions. The findings of this thesis could thus be important for policy leaders, policy implementers and other health policy stakeholders.

The findings of this study have also responded to the calls of Hodge and Greeve (2007) and Van de Walle and Hammerschmid (2011), for research into how accountability functions in the context of reform. These researchers have expressed their anxieties on this particular issue because so little is

known about it. By exploring the health managers' lived experiences, this study has provided authentic empirical evidences on the effects of reform on accountability. It can be said that postreform accountability was challenging because health managers were all working in multilayered structures and relationships within multiagencies with different accountability bases. The stories of health managers reveal that they have been trapped by paradoxes that have evolved in the area of accountability due to the multifaceted relationships and conflicts in accountability that exist in the public health system. These findings could be useful for future researchers who are interested in analysing postreform accountability relationships.

The study's findings have advanced the understanding on accountability by defining it in the context of reform. This study has confirmed that accountability remains amorphous because the uniquely fluid nature of accountability which allows it to be defined from two distinct standpoints i.e., as a normative or social practice and technical perspective. This study suggests that the two faces of the accountability coin are not only complementary but also confusing and conflicting at the same time because accountability cannot be disengaged from its normative perspective. Therefore, the notion of accountability in the context of reform can be seen simultaneously as a symbol of hope on the one hand and frustration on the other. This finding will help in building a greater understanding of why accountability remains a desirable ideal despite being trapped in the complexity of reform which aims to achieve it.

## **7.4 Limitations of the study**

Every research project has its own constraints. According to Simon and Goes (2013), methodological selection and research design come with limitations over which researchers may have little control. This study adopted a qualitative methodology and employed a hermeneutics approach as the basis of research inquiry. The methodological selection was arrived at on the basis of ontological and epistemological views relating to the research questions. Limitations in qualitative studies occur because research is conducted in a natural setting where it is difficult for researchers to control the research process (Bryman, 2004; Simon & Goes, 2013). The findings of this study are subject to at least two limitations.

### **7.4.1 Focus**

The findings of this study were derived from a review of documents and interviews with the aim of understanding the effects of reform on the notion of accountability and its practices. This study seems to focus on a broad area of health reform in New Zealand. As noted in Chapter Four, I had difficulties in recruiting participants due to the major transition in the public health system in 2011. I was unable to proceed with my original plan which involved research into the use of public private partnerships (PPPs) in the health sector. The structure of the public health system was changing significantly, and, as a result, some participants decided to withdraw from the study.

To avoid taking on a research project which might have to be terminated because of a shortage of willing data providers, I decided to change the direction of my research project prior to the data collection stage. According to Smith (2004) "one cannot do a good qualitative research by following a cookbook . . . what determines the quality of the outcome is the personal analytic work done by each stage of the procedure" (p.40). The intention to investigate accountability in the New Zealand public health system remained

the plan, but the focus moved from PPPs to public health reform in general. The new research direction was determined after considering the interests of existing participants who remained in this research project and the potential of recruiting new participants in the future.

However, the issue of broad research focus might have been mitigated by the research process. In order to answer the research questions as outlined in Chapter One, I chose to examine the four stages of reform from a narrow perspective that includes the trend and pattern of reform and the emergence of accountability issues which resulted from the reforms. Those selected to take part in the research were senior managers from DHBs and PHOs who each had more than 10 years' work experience in the health sector. As reform was seen as a process of metamorphosis (Broadbent et al., 1996), that closely relates to individual personal experience, the goal of recognising the meaning of accountability from a study of health managers' lived experience was adopted. During the interviews, I posed few questions about accountability relationships between health managers and others but placed more focus on managers' personal experiences in dealing with accountability. There will be many issues that were not covered during the process of my data collection, for example, the issues of accountability relationships, Maori health and accountability, and leadership's accountability. I chose not to evaluate those areas because this study was not specifically designed to evaluate those issues.

#### **7.4.2 Idiosyncratic context**

The preunderstanding stage was developed based on analysis of various government documents. Reviewing government documents enabled me to understand the government's planning for the New Zealand public health system from the government's point of view. The content of government documents may represent political ideologies or political interests of the ruling government. Therefore, the context identified for this study implied the influences of the ruling government's political ideologies. It was not the

purpose of this thesis to critique such ideologies, but to recognise them as potential influences on participants' responses.

Using government documents was also challenging especially in analysing ongoing reform. For example, in the Post-2008 reform, the government enforced the changes soon after the announcement of reform. The implementation of the Post-2008 reform strategies involved significant changes in the existing public health structures and governance. Although most of the changes were reported by the government, it was hard to keep track of all the changes because some of the government reports lagged behind the actual events. For instance, based on the Ministry of Health publication in 2008, I reported that the government established a regional DHB for the Southern Region consisting of seven DHBs. However, due to the 2010 merging between Otago and Southland DHBs (this new entity known as Southland), the numbers and membership for Southern Region DHB changed after the government's publications. The Southern Region DHB now comprises five DHBs and they are Nelson, Marlborough, Canterbury, West Coast, South Canterbury, and Southland DHBs. Therefore, a limitation of this documents analysis results from this natural evolution of reforms through the government inspired changes impacting on accountability in the ever-changing structures of the New Zealand health system. The limitation being that the findings can become convoluted as they need to be interpreted to the relevant time frame in which the findings were discussed.

Interviews also led to a number of limitations. This study was conducted in a specific State sector with a small number of participants selected through the snowball technique or convenient sampling. This sampling technique was chosen because the health managers' backgrounds are not publicly available. In principle, all the participants selected for this study met the general criteria as outlined in Section 4.4.1. However, because convenient sampling is based on referral from other participants, the sample distribution is limited to a specific network. Furthermore, the research questions designed for this study focused on health managers' personal experiences in dealing with

reforms and accountability. Therefore, the findings generated from this study might not be able to answer a large number of other research issues. Nevertheless, the study's idiosyncrasies might have been reduced by monitoring the referral chain. In this study, the referred participants were filtered based on their background and work experience.

## **7.5 Recommendations for future research**

This study provided empirical insights into how postreform accountability was understood and practised in the context of the New Zealand public health system. A number of potential areas for extending studies in accountability and reform have emerged from this study. To assist the future researchers, two areas are identified:

### **7.5.1 Accountability in the context of public sector reform**

Although the concept of accountability remains elusive, the study of accountability should be continued in the future. As it is evident that reform is a means without an end, the public sector is likely to experience more changes in the future. Since accountability is likely to be subject to a never-ending cycle of change, changes in the public sector will continue to influence the notion of accountability and its practices. It would be worthwhile to carry out similar kinds of studies in different types of public services in other countries. For those who are interested in comparative studies, it would be beneficial to compare accountability systems across public services and countries, so that a more holistic view and understanding of accountability could be established.

### **7.5.2 Accountability in the New Zealand public health system**

I believe more studies are needed in the area of accountability in the New Zealand public health system. Despite considerable discussions in previous studies in this area, a number of issues remain unexplored. One of these potential studies could explore the notion of accountability among indigenous health providers. This issue was raised by a participant in this study, but I was not able to include it in this research because it was not covered in my objective. However, I believe it is worthwhile to study this area because Maori health is a significant issue in the New Zealand public health system. Issues, such as how accountability is experienced by indigenous providers, could potentially be valuable.

Second, as this research project focuses on managerial accountability, it would be interesting if future studies considered other accountability areas such as political, professional, and personal accountability. Studying a specific accountability area would provide in-depth understanding of a particular accountability as these types of accountability are underpinned by different criteria. Third, the sample of this study is limited to the policy implementers who work in DHBs and PHOs. It would be interesting to study a group of policy makers (policy leaders) in the health sector to understand the workings of accountability within the sector. So that the findings to compare their interpretations of accountability with the views expressed by my respondents.

### **7.6 Final reflection: What I have learned?**

As I come to the end of my thesis, I realise how the research process that I have gone through over the last 4 years has shaped my thinking and understanding in particular ways. Being trained in the field of public administration, and engaged closely in policy studies, I should confess that my understanding toward public policy was too idealistic and narrow. I was influenced by my preconceptions, beliefs and knowledge when I started this

research project. As I viewed public policy as a problem solving activity, I believed the problem in defining accountability was rooted in the process of policy making and reforms.

However, being engaged in critical hermeneutics has opened up my thinking in developing understanding. The three stages of hermeneutics understanding have taught me how to structure and develop understandings. The process of rereading, rethinking and rewriting not only made me reanalyse my thinking and understanding but also required me to limit the influence of my preconceptions, beliefs and knowledge.

Having completed this thesis, I now have better understanding about the notion of postreform accountability and its practices. Having said that, I believe that I have also learned other important lessons with regard to the investigated area which I think have certain implications for me and my profession. I think the following knowledge will shape my understanding and thinking in the future:

- Public policy is not ultimately about problem solving for governments and society. Rather than solving problems, public policy can only control the level of a society's problems, and the ability to control the level of problem is dependent on the ideology of the governing elite. Reform is a mechanism, is perhaps a license for the political elites to impose their new interests, values and preferences on a community.
- Accountability is a naïve concept by its nature. It can be used and reused to engender support for the new policies produced by the political elites. Despite all difficulties, failures and frustrations, the level of confidence in accountability endures. There is always hope that good outcomes for accountability might arise from well-designed reforms.

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# APPENDICES

## APPENDIX 1

### Summary of participants' backgrounds

| Participant (s) | Position                              | PHOs  |
|-----------------|---------------------------------------|---|
|                 |                                       | Responsibility / Experience   |
| P01             | CEO                                   | P01 has 15 years' working experience in the health sector. Prior to his current appointment, P01 served in senior executive and senior manager roles for the Ministry of Health and a number of DHBs as well as PHOs.   |
| P02             | Board member                          | P02 has worked in health services for 27 years. Before joining the health sector, P02 worked in the law enforcement and military departments. P02 served a number of PHOs as a Chief Executive. In his current appointment, P02 is a PHO board member and holds a senior management position in a PHO.  |
| P03             | CEO                                   | P03 is founder of a Maori PHO and has held the position as the CEO of that PHO for 22 years. P03 served on a number of boards including the HFA and DHBs, ACC and nursing. In total P03 has spent about 30 years working in the New Zealand health sector.  |
| P04             | Senior Manager, and Board Secretariat | P04 has worked in health services for 31 years. P04 was a former Executive Trustee and Chief Executive for a number of health trust agencies. P04 has also served a number of health boards in various roles. In his current position, P04 is responsible for managing the operations of PHO at the national level. At the same time, P04 also serves as the PHO board secretariat.   |
| P05             | Senior Manager                        | <p>P05 has been involved in New Zealand health service for 26 years. In her 26 years' experience, P05 has served the Ministry of Health in contracting and consulting works, including developing health policy plans and long term strategies. P05 also served a number of DHBs at a senior level position of similar responsibilities.</p> <p>In the current position, P05 holds the portfolio of strategy and performance for a PHO. P05 is responsible for the performance management system of PHO and also the performance of BSMC business case.</p> |
| P06             | CEO                                   | <p>P06 has been appointed as the CEO for the last 10 years. P06 is responsible for strategic development of the PHO, including staff issues and performance, clinical and audit compliance, financial risks management and clinical accountability of the PHO's practice teams.</p> <p>Prior to his current position, P06 was the General Manager for a RHA, responsible for communications and managing community relationships. Before joining the health sector in 1994, P06 was involved in corporate</p>   |

|                        |                          | communication overseas. His overall experience in a management position is 26 years.  |
|------------------------|--------------------------|---|
| P07                    | Senior Manager           | <p>P07 has 15 years' working experience in the health sector. P07 started her career in health as a clinician in New Zealand public hospitals before being appointed as a senior manager for the DHB's planning and funding arms.</p> <p>In her current position, P07 is responsible for integrating services and aligning funding for inter community and primary environments. P07 also responsible for monitoring the operation of the PHO under the requirement of the national agreement.</p>  |
| P11                    | Executive Director       | <p>P11 has been working in health services for 13 years. He started his career as a medical practitioner and worked in a hospital for a year before joining primary health care. Besides his roles as a clinician, P011 is also doing consulting work related to Maori health. According to P011, his management experience is developed alongside with his clinical roles.</p> <p>In his current position, P011 is responsible for two portfolios. These are clinical integration in primary health services and BSMC business case. His main responsibility is providing advice to the senior management and to the board on clinical safety and quality. P011 also contributes to the design and development of the integration of clinical services with BSMC business case.</p>  |
| <b>Participant (s)</b> | <b>Position</b>          | <b>DHBs/Regional DHBs Responsibility / Experience</b>   |
| P08                    | Business Support Manager | <p>P08 has 15 years' working experience in the health sector. P08 started his career in health as a clinician and served in a number of public hospitals around New Zealand, before being appointed as a senior manager in the DHB's Finance Section, under the Planning and Funding Division.</p> <p>In his current appointment, P08 plays his roles as an internal consultant and a business type advisor responsible for two main portfolios: mental health and addiction services, and rural and community services.</p> <p>As a clinician who went into management, P08 is also responsible for providing the DHB's management of clinician perspectives and activities. His roles and responsibilities require him to work within the DHB, outside DHBs, across the primary sector and other health agencies including, ACC, ambulance services and rest homes.</p> |
| P09                    | Finance Manager          | P09 has worked in health services for 24 years. He started his career in the health sector as a certified accountant in 1989. Prior to that P09 worked as an auditor in a professional service company.   |

|     |                                   |  |
|-----|-----------------------------------|--|
|     |                                   | <p>In his current appointment, P09 is responsible for supporting information services under management and financial accounting. In particular, P09 is providing internal support and advice analysis for contracts, commercial, legal and financial risks.</p>  |
| P10 | Project Manager of a regional DHB | <p>P10 works for a DHB shared service agency as a Project Manager of Elective Services. P10 is responsible for delivering the Ministry's contracts across a group of DHBs in one regional area. The main responsibility of P10 is to identify the best model of care that can be adopted as a standard clinical pathway at a national or regional level through auditing processes.</p> <p>P10 started his career as a clinician and worked in both public hospitals and primary care for four years before deciding to further his master degree in business administration. Prior to his first appointment, P10 worked in care facilities on a part time basis for several years.</p>  |
| P12 | Senior Manager                    | <p>P12 has 20 years' experience working in the clinical record department of a DHB. She held a number of management positions for eight years before joining the current DHB. As a manager of clinical record, P12 is responsible for managing the department in preparing clinical record for patients who came for treatments to the related parties according to the privacy act requirements.</p>  |
| P13 | Board Member                      | <p>P13 is an elected board member of a DHB, who has been served the DHB board for 10 years. In the meantime, P13 is also an elected member of a city council.</p> <p>Before joining the health sector, P13 was a volunteer ambulance officer. He also involved in a paramedic team while he was in the territorial army. His knowledge about health service and health industry was developed earlier as he was brought up by a family who has a strong health career background.</p> <p>P13 started his career as a pilot before moving into aviation based business and held senior position roles in a number of airlines. Due to his wide experience this area, P13 also used to lecture at a couple of universities on air transport, and aviation related matters.</p> |

## APPENDIX 2

### *Participant Information Sheet*

*Waikato Management School*

Te Raupapa



THE UNIVERSITY OF

**WAIKATO**

Te Whare Wānanga o Waikato

### **ACCOUNTABILITY IN THE CONTEXT OF AN EVER-CHANGING NEW ZEALAND PUBLIC HEALTH**

Dear Sir/Madam,

I am Azizah Abidin, a PhD candidate at the University of Waikato, New Zealand. I am conducting the above research as my PhD requirement under the supervision of Associate Professor Martin Kelly, Professor Stewart Lawrence and Dr. Mary Low. The objective of my research is to identify the effect of continuous policy reforms on accountability provision and understanding in the New Zealand public health system.

The outcomes of this research will provide valuable insights for government and public sector organisations to develop better strategies in managing accountability in public organisations such as those in the health sector. It could help to reduce the problems of discharging accountability in organisations by increasing understanding on how reforms affect the forms of accountability. It will also identify the current challenges faced by organisations in terms of dealing with accountability requirement.

The outcomes of this research cannot be produced without your participation. As a person involved directly in delivering a good health service to the people of New Zealand, your opinions and experiences are crucially important in this research. Therefore, I would like to invite you to participate in this research.

Pseudonyms will be used for participants when reporting the findings of this research. For example, participants will be treated as anonymous and coded as P1, P2, P3, etc. The inputs provided by participants are based on individual perception and experience and will not represent the stance of organisations that they are currently attached to. The interview recordings will be transcribed and only the researcher and her supervisors will be granted access to the data (listen to interview recordings and read all the transcribed data). All the hard copy data (transcribed interviews) will be kept in a locked place. The interview recordings will be stored electronically and securely with a password. The recording and the original transcribed data will be destroyed upon completion of the thesis and relevant research publications.

The participants in this research will be interviewed for about 45 to 60 minutes (approximately). You may refuse to answer any particular questions and to withdraw from the study at any time up until **TWO (2) weeks** after the interview session.

If you have any questions about this study, please do not hesitate to contact me at 022-1284174 or email me at [naz1@students.waikato.ac.nz](mailto:naz1@students.waikato.ac.nz) or my supervisor Martin Kelly at [kelly@waikato.ac.nz](mailto:kelly@waikato.ac.nz).

I am looking forward to seeing you participate in this study. Thank you.

Yours faithfully,

Azizah Abidin

## APPENDIX 3

### *Interview Protocol*

*Waikato Management School*

Te Raupapa



THE UNIVERSITY OF  
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*Te Whare Wānanga o Waikato*

### **Opening Statement to Interviewees**

Thank you for taking the time to meet with me. I am interested to learn about the effect of continuous reforms on the notion of accountability. It will identify the current challenges faced by organisations in terms of dealing with accountability requirements.

This interview will be conducted according to your time preferences. The interview session will take about 45 to 60 minutes and also will be audio recorded, to help me concentrate on the interview session. Please be informed that only my supervisors and I will have access to the interview recording and the transcript. The interview recording and transcript will be used solely for academic purposes. Any quotations from, or references to the interview will be completely anonymous. All the hard copy data (transcribed interviews) will be kept in a locked place. The interview recordings will be stored electronically and securely with a password. The interview recordings and the original transcribed data will be destroyed after completion of the thesis and relevant research publications.

The inputs provided by participants are based on individual perception and experience and will not represent the stance of organisations that they are currently attached to. During the interview session, I will start with some background information questions before moving to the primary questions about your understanding related to accountability and its practices. These questions will be open in nature and I will be asking you for examples or further clarifications, drawn from your experience, to illustrate the answers given. Since the implementation of health reforms has started since 1984, I provide the summary of reform in Table 1 as to refresh our memory with regard to this topic.

The questions to be asked during the interview are as follows:

### **Background information**

- What is the title of the position you currently hold? For how long have you been appointed into this position?
- Could you please tell me your roles and responsibility in this organisation?
- Who do you report to?
- How many years of professional working experience do you have?
- Which organisations/industries have you worked in before?

## **Primary Questions:**

### **A. VIEWS ON REFORM**

- Can you remember how many phases of reform have you experienced? Did the experience change over time?
- Overall, what do you think about the policy reforms in the NZ public health?
- Can you tell me the rationales for implementing reform in this sector?
- What is the impact of reform to the NZ public health system?
- How you and your organisation respond to the changes?
- What is the impact of those changes on your roles and responsibility?
- Did those changes help to better clarify the health provider's responsibility, and to whom are they responsible?
- How do you feel dealing with all these policy changes? Are these changes manageable?
- How would you describe the current condition of the New Zealand public health system?
- In your opinion, to where the New Zealand health policy is heading to for the next 5 to 10 years?

### **B. VIEWS ON ACCOUNTABILITY IN THE CONTEXT OF REFORM AND RELATED ISSUES**

- What do accountability means to you? Why do you say so?
- What makes you view accountability like what you said just now?
- What is your opinion of the system of accountability in the NZ public health system?
- Can you identify the impact of reform on the system of accountability?
- Can you identify the rationale of reform in terms of accountability?
- What major challenges or difficulties have you encountered while performing your accountability requirement?
- Overall, how would you define the system of accountability in the New Zealand public health system?

## **Follow-up Questions**

- Can you give me an example?
- What do you mean by that?
- Could you please explain that further?

**A summary of the stages, and objectives and focus of reform in the New Zealand public health service since 1984**

| <b>Stages of reform</b>                                | <b>Objective and focus of reform</b>  |
|--|---|
| Incremental reform (1984-1993)                         | <p><i>Objective:</i><br/>To improve efficiency and effectiveness of health policy and to improve accountability.</p> <p><i>Focus:</i><br/>The government introduced a structural reform through the establishment of Area Health Boards (AHBs), a community governed board.</p>   |
| Radical market-oriented reform (1993-1996)             | <p><i>Objective:</i><br/>To improve health efficiency in terms of services and financial management.</p> <p><i>Focus:</i><br/>The government changed overall policy directions to a quasi-market approach through structural and financial reforms.</p>   |
| More planned and community-oriented reform (1999-2008) | <p><i>Objective:</i><br/>To improve the health of the population by reducing health disparities and ensuring access to quality services</p> <p><i>Focus:</i><br/>The government reversed previous health policy, re-introduced community governed health board system for the primary and secondary health care levels.</p> |
| Towards a unified model of care (post 2008 reform)     | <p><i>Objective:</i><br/>To improve efficiency and quality of care</p> <p><i>Focus:</i><br/>The government implements several structural reforms at the national, regional and local health levels. The structural reforms are supported by information technology (IT) development and workforce health planning.</p>      |

## APPENDIX 4

### *Consent Form for Participants*

**Waikato Management School**  
Te Raupapa



THE UNIVERSITY OF  
**WAIKATO**  
*Te Whare Wānanga o Waikato*

### **ACCOUNTABILITY IN THE CONTEXT OF AN EVER-CHANGING NEW ZEALAND PUBLIC HEALTH**

Azizah Abidin, PhD Candidate, Waikato Management School  
Email: naz1@students.waikato.ac.nz

#### **Consent Form for Participants**

I have read the Information Sheet for Participants for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time up until TWO (2) weeks after the interview session, or to decline to answer any particular questions in the study.

I agree to participate in this study under the conditions set out in the Information Sheet form.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's name and contact information:

Azizah Abidin  
Department of Accounting  
Email: naz1@students.waikato.ac.nz  
Phone (Mobile): 022-128 4174

Supervisor's Name and contact information:

Assoc. Prof. Martin Kelly  
Department of Accounting  
Email: kelly@waikato.ac.nz  
Phone (Office): 07-856 2889 ext: 8653

# APPENDIX 5

## Interview Guide with Field Note

Title of the interview: Accountability in the context of New Zealand public health reform

Archival No:

Site:

Interviewer:

Interviewee:

Date:

Start:

End:

### Background information

- What is the title of the position you currently hold? For how long have you been appointed into this position?
- Could you please briefly describe your task and responsibility in this organisation so I can get some understanding a bit
- Who do you report to?
- How many years of professional working experience do you have?
- Which organisations/industries have you worked in before?

### Primary Questions:

1. In this \_\_\_\_ years of working experience, what do you think about the policy changes in the New Zealand public health?
2. From your point of view, why the government initiated changes in the health policy?
3. How you and your organisations respond to the changes?
4. What was the impact of those changes on your roles and responsibility?

5. Did those changes help to better clarify your responsibility, and to whom are you responsible?
6. How about your organisation? Did the policy changes help to better clarify your organisation responsibility and to whom are your organisation responsible?
7. In your opinion, was the New Zealand public health systems benefitted from the implementation of the health policy changes?
8. In your opinion, to where the New Zealand health policy is heading to for the next 5 to 10 years?
9. What words come to your mind when I mention the word “accountability”?
10. What makes you view accountability like what you said just now?
11. What major challenges or difficulties (if any) have you encountered while performing your accountability requirement?
12. What is your opinion of the system of accountability in the NZ public health system?
13. Drawing from your experience, how would you define the system of accountability in the New Zealand public health system?
14. Do you think the New Zealand health policy reforms changed the meaning or the form of accountability in the public health system? Could you please explain?

### Follow-up Questions

- Can you give me an example?
- What do you mean by that?
- Could you please explain that further?

## APPENDIX 6

### SUMMARY OF INTERVIEW

**Title of the interview:** Accountability in the ever-changing NZ health system

**Interviewee:** [REDACTED] (P010)

**Site:** Meeting room, Hamilton

**Date:** 25/9/2013 (Wednesday)

#### SUMMARY OF PARTICIPANTS' BACKGROUND INFORMATION:

| Participant pseudonyms | Position                          | Experience   |
|------------------------|-----------------------------------|--|
| P010                   | Project Manager of a regional DHB | <p>P010 works for a DHB shared service agency as a Project Manager of Elective Services. P010 is responsible for delivering the Ministry's contracts across a group of DHBs in one regional area. The main responsibility of P010 is to identify the best model of care that can be adopted as a standard clinical pathway at a national or regional level through auditing processes.</p> <p>P010 started his career as a clinician and worked in both public hospitals and primary care for four years before deciding to further his master degree in business administration. Prior to his first appointment, P010 worked in care facilities on a part time basis for several years.</p> |

#### A. WHAT HAS BEEN LEARNED FROM THE INTERVIEW

##### Views on reform

##### 1. *The public health system in general*

The public health system has two different focuses, but both are operating in the same clinical space. First, is the national health focus, which is concerned with people's health status under one health system. The national focus is designed according to the national health agenda, targets and performance.

Second, is the local focus, which is concerned with an individual health status in one area of health. The local focus is concerned with different individual health needs for example individual needs in aging care, mental health, maternity, etc. As focuses are operating in the same clinical space, there are using the same resources around additional administration to meet the target (as you could

always discharge and readmit a patient to make it look like they meet the indicators)

Reform is needed in the public health system as it helps to improve the system but constant reform is not needed.

## 2. *The effects of reform*

The implementation of reform has a large impact on the clinicians and health providers, and also the quality of health services.

### a. *Reforms resulted in policy confusions and a clash in accountability between managers and clinicians*

The implementation of reform in health services resulted in structural changes which sometimes led to confusion among policy actors, especially the clinicians. For example, under the current reform strategy, the government has established new Crown entities at the regional and national level, called regional district health boards (Northern, Midland, Central and Southern) and the National Health Board. These new Crown entities are expected to help the existing individual DHBs to reduce their administrative costs through shared service strategies. DHBs are required to plan services on a regional basis and the new Crown agencies will help to deliver the regional plan. The mix between new and old agencies has increased the complexity of the structure of NZ public health and confused a lot of people including those in the system, such as clinicians.

Most of the clinicians decided not to bother about reforms. From their point of view, reforms were designed for improving the management of health services and assumed that reforms would have less impact on clinicians. Furthermore, in performing their duties of care, clinicians are supposed to be accountable for their patients' outcomes; not the health service management.

Over time, the implementation of reform has widened the gap between managers and clinicians. Managers are accountable to the government, while clinicians are bound by their professional legislation, and they have to stand by that legislation. One of the challenges that has resulted from this gap is to get both clinicians and managers to share responsibility because they are bound by different types of accountability - the clash between managerial accountability and professional accountability.

### b. *Reforms have affected the quality of clinical services*

When the government decided to introduce reform, some existing health structures were seen as unable to support reforms. Therefore, in many

instances, the implementation of reforms is accompanied by a major restructuring in the health structural and governance. Such restructuring involved a large amount of money allocated for the health sector. The more the government strengthens the management, the more money goes to that area, and the less the money is available for clinical services. This has led to a tolerance in quality in some clinical services

For example: the shorter stay in emergency departments (EDs) health target. This national health target has been introduced from 1 July 2009. This national target stated that 95% will be admitted, discharged or transferred from an ED within 6 hours. The aim of this target is to eliminate waits, and delays in all parts of the hospital to improve acute patient flow. As a result of that target, most of DHBs decided to enhance the size of their EDs through the development of new ED wards and buildings. In order to meet the six hour target, the flow of admissions to an ED did not meet the clinical requirements. Patients who come to an ED will be seen by nurses to identify the acute type; then, the patients will be sent to the waiting room or short stay wards for several hours before they are discharged (if patients have no serious acute) or transferred to a ward for further treatment. The flow of admission has enabled DHBs to meet the Ministry's target, but clearly, the admission procedure did not follow clinical guidelines, which patients should be seen and treated by doctors before they being discharged or transferred from EDs, did not meet the clinical requirements.

*“They actually are worsening the outcome for the patients because they are doing additional administration or work, moving the patients around which they didn't use to have to. Just simply to meet the Ministry target. They meet the clinical time but they don't treat the patients equal to a lot of issues. They just build wards to place patients in” (P010)*

Reform does not focus on the fundamental problems in the public health system. For example, the issue of overcrowding and overstaying in EDs is linked to situations in which people who need medical assistance but do not afford to see GPs. These people choose to go to the ED because they know that they will get treatments at no costs.

*c. Reforms have increased additional tasks to other groups of people*

Some reform brought changes in clinical administration and affected the way in which clinicians performing their services. Some clinicians are not ready to change and feel uncomfortable with change. For example:

*If they don't want to do it, a lot of time they can decide not to. I have discussions with some of departments even across in our region, there is somebody would say "What will happen to me if I don't deliver the Ministry target?" And I say "Well the funding for the DHB is cut". They will reply "what's that problem for me? My problem is with the patients. If I treat them as they come through the door. I will accept them and treat them as I see them. That's the most important for my profession". And what can you say to that? (P010)*

This group of clinicians sometimes decided not to bother about change and keep doing work in their ways. In order to achieve the initial reform plan, the management has to take other initiatives such as providing administrative assistance to that particular group of clinicians. Although such initiatives helped the management to realise their planning, it has increased administrative burdens for another group of clinicians such as nurses.

*d. The implementation of reforms is limited by the willingness of health professionals to change*

Reforms brought changes in health structures and governance. Such changes have indirect impacts on the way in which health professionals performing their tasks. If health professionals felt changes required by the management disrupted their clinical work, they may decide to leave their positions. New Zealand is a small country and the healthcare workforce is limited a particular area as it is very small (only one or two consultants). If a health professional decided to leave it will result in a huge loss to the hospitals and a particular patient cohort. Therefore, the management have to ensure clinicians feel comfortable with health policy changes.

*3. Reform is a political decision, always comes from the top but lacks policy context*

Decisions to reform always come from the top [the government]. However, the government provides only a general reform framework and usually leaves it to DHBs to decide or to interpret the general framework.

*"Reforms always come from the top but they are not structured in a way that you should provide this by this date and this way. It's very much like – please provide this" (P010)*

*"The ministry direction is too vague" (P010)*

Decisions of the policy frameworks are regularly being made by the top without understanding what is happening under the ground. It is very challenging for DHBs as they need to decide the criteria of the policy context

and at the same time have to suit the policy context with the capacity and demographic criteria of their regional population.

In order to meet the policy objectives, some DHBs imposed ineffective decisions. For example, the government introduced capped budget on administration with the objective to limit administrative budget in public health. However, because decisions made at the ministerial level it created another issue. Some DHBs are small and they usually have inadequate clinical and administrative staffs. The chances to increase the number of staff are slim due to the budget cap. This ended up with clinicians are doing administrative tasks.

The government is interested only in the output of the policy so that it will have good news to show to the voters when the next election is held.

## **Views on accountability**

### **1. The notions of accountability**

There are two sets of accountability thought that underlie the public health system. These are: (1) clinical accountability – this is the most important part of the public health system. Public health must accountable to the patients; the system should pay attention to the needs of patients, i.e., patients at the centre of care must be treated first. (2) managerial accountability – this is concerned more with the performance of the public health system, i.e., KPI, national targets etc.

These accountability thoughts have led to the disconnection of relationships between clinical staff and management staff. For example, the government introduced a performance indicator for elective services called Elective Services Patients Flow Indicators (ESPIs). The objective of this indicator is to measure on how well DHBs managing the key steps in the elective patient journey. One of the indicators is patients should be reassessed within 5 months after their first treatment. However, there are some consultants who feel inappropriate to follow the policy guidelines. From their point of views, if the patient is well enough, there is no point for them to see the patient until after six months. Although clinicians may have a valid argument in such situation, it has a huge impact on health managers and health institutions. For example, the budget for DHBs may get cut, the managers' work performance will drop due to the failure to meet the national targets.

### **2. The challenges in performing accountability**

- a. To develop understanding between clinicians and managers

Relentless reform makes accountability keeps moving and makes it difficult for clinical staff and managerial staff to come to a clear decision and to stand together.

b. Uncertainty

Public health system in New Zealand is always being in uncertain situations because reform is implemented on a short time basis; and directions of change are depended on who is ruling the government. Frequent and contradictory changes made people in the system confused and unsure their responsibility and accountability lines.

c. Audit

Reform has increased the amount of audit but input from audits is not being so helpful to the system because it focus more on the output rather than outcome.