DIMENSIONS OF ACCOUNTABILITY: VOICES FROM NEW ZEALAND
PRIMARY HEALTH ORGANISATIONS

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ABSTRACT

Cooperative activity necessitates participants acknowledging joint goals, often delegating resources, consequent performance, tailored accountability reporting and feedback (Levaggi, 1995). Thus, accountability is a process reflecting the interdependence of social relationships (Roberts, 1991). Such interdependence is evident in publicly funded health care systems where governments contract with autonomous providers, as occurs in the New Zealand primary health care system.

Primary health care (as patients' first point of contact with the health system) was reformed significantly with the launch of the *Primary Health Care Strategy* [(Minister of Health, 2001) effective from May, 2002]. Increased government funding became available to Primary Health Organisations (PHOs), new entities that were to act as intermediaries between the government on the one hand, and primary health care practitioners on the other. PHOs became responsible for designing and contracting for the delivery of primary health programmes so as to improve their communities' health (Minister of Health, 2001). Consequent upon increased public funding distributed through these organisations, the government requires all PHOs to be 'fully and openly accountable' for all public funds they receive. O'Dwyer and Unerman (2006) term this 'holistic' accountability. Further, PHOs must be private not-for-profit organisations, reducing the likelihood that public funds will be diverted to shareholder dividends paid out by profit-oriented providers (Minister of Health, 2001).

Despite the promise of accountability, the challenges of meeting the expectations of multiple stakeholders and choosing effective accountability mechanisms potentially mitigate against PHOs discharging accountability adequately. Accordingly, this research is an interpretive study into the understanding of PHOs and their stakeholders of 'to whom', 'for what', 'why' and 'how' accountability is discharged and how these challenges are managed. Four PHOs consented to be included as case studies during the 2006 and 2007 financial years. This ethnographic research collected financial and non-financial data, observed community meetings, interviewed key stakeholders and integrated research participants' feedback to reflect on current theory.

It was found that stakeholders expect PHOs to prioritise either community or their funding and service providers, giving rise to possible conflicting demands. PHOs appear to manage this conflict internally, although the manner in which they do so evokes particular external images. Some District Health Boards (DHBs), as PHOs' funders, seek to manage PHOs' prioritisation by positing themselves as the arbiters of community needs. Further, while the *Primary Health Care Strategy* appears to require accountability to counter-balance control of PHOs with enhancing trust in DHB/PHO relationships, in this research it was found that PHOs subjected to strong funder control experience reduced autonomy and, by extension, fewer opportunities to learn.

A further finding of this research was that 'mapping' the observations of stakeholders' expectations and the operation of control and/or trust against each other enables the identification of deficits in the process of holistic accountability. Accordingly, suggestions for mechanisms that will enable PHOs to balance multiple stakeholders and discharge holistic accountability are derived.

ACKNOWLEDGEMENTS

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GLOSSARY AND ABBREVIATIONS

ACC   Accident Compensation Corporation

AGM   Annual General Meeting

DHB   District Health Board (for geographical listing see Appendix 1)

hapū   Māori for a sub-tribe

hui   Māori gathering or meeting

IPA   Independent Practitioner Association

iwi   Māori for tribe

kaumātua   Māori elder (male) in the *iwi* or *hapū*

kuia   Māori female elder in the *iwi* or *hapū*

NHS   National Health Service (UK)

NPM   New Public Management

PCT   Primary Care Trust (UK)

PHO   Primary Health Organisation (for geographical listing see Appendix 1)

SIA   Services to Improve Access (PHO programmes funded by DHB)

SPARC   Sport and Recreation Council

WHO   World Health Organization

1. INTRODUCTION

1.1.   *Primary Health Care environment*

New Zealand's State health expenditure has escalated in recent years from $5,309 million in 1990 to $8,319 million in 2002 – a real annual growth in public expenditure of 3.8 percent and an increase of 3.2 per cent per capita each year (Ministry of Health, 2004a).[1] Expenditure increases have been most marked in the area of primary health care, reflecting New Zealand's commitment to implementing the World Health Organisation's (1978) Alma Ata Declaration recommendation that primary health care be the central focus of nations' health systems (Minister of Health, 2001). The Alma Ata Declaration also recommended that primary health care, as a patient's first point of contact with medical professionals, be delivered equitably (by being universally available and accessible to all citizens) and meet citizens' continuing health care needs.[2] The New Zealand Government introduced a *Primary Health Care Strategy* in 2001, emphasising its desire to improve primary health care accessibility; it also noted that improved citizens' health would be beneficial to the economy.

New Zealand is not alone in expending escalating amounts on its health care system. The United Kingdom (UK) and the Netherlands, for example, have both introduced health care reforms in the last thirty years as they have sought to improve performance in their State funded health care systems. However, public funding for health care is limited and, consequently, taxpaying citizens pressure governments to design solutions that will deliver improved health care services cost-effectively as well as equitably.

During the 1980s, many Western governments, including the UK, Australia and New Zealand, introduced new systems for managing public expenditure, termed New Public Management (Wallis & Dollery, 1999). The key principles of New Public Management were:

    (i) to reduce State involvement in activities that could be performed effectively by private businesses or communities by transferring such activities to market-

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[1]   This resulted in government expenditure on health rising from 3% of GDP to 5.74%. By comparison, government's total expenditure on education in the same period increased at a rate of 1% of GDP to total 5.15% in 2002. ('Total Investments in Education'. Downloaded from the internet 6th June 2008 from www.educationcounts.govt.nz/statistics/data_cubes/resources/3820.)

[2]   The definition of primary health care from the Alma Ata Declaration is presented in Chapter 2.

based mechanisms (examples in New Zealand include the privatisation of Telecom, State Insurance and the Tourist Hotel Corporation). Through this means, governments could transfer to private businesses and communities the risk of failing to deliver promised services at agreed rates (English, 2005);

(ii) to retain State involvement as the primary funder of activities for which the State needs assurance of continued supply, but requiring government Departments to reduce their involvement in these activities by contracting-out service delivery to private business and communities (examples in New Zealand include education and health). This was accompanied by regulation and monitoring of those involved in delivering these services by means of, *inter alia*, ombudsman systems, public forums, and citizens' juries, as described in detail in Chapter 2;

(iii) to retain State delivery of services that could not, or were unlikely to be, delivered effectively by private organisations, but demanding accountability from the relevant public sector entities for public goods outputs. The requirement for public entities to be accountable for outputs replaced the former requirement for Departments to be answerable for their expenditure management (Walker, 1996).[3] The new approach was underpinned by contractual arrangements between Ministers and the Chief Executives of Government Departments (examples in New Zealand include the Police and the Defence Force).

New Public Management spawned a new vocabulary and a clear separation of the roles of 'purchaser' and 'provider' in a range of areas including education and health (Walker, 1996). Within the New Zealand health care sector, New Public Management resulted in the Ministry of Health identifying itself as a 'purchaser' of health care services and the health professionals and agents, with whom it contracted, as 'providers', to signify its more dispassionate role in a system where the State funded public, private and community health providers.

Since its introduction in the 1980s, New Public Management means governments have increasingly become parties to contractual or partnering arrangements with not-for-profit organisations (Walker, 2004). Governments appear to believe that contracting with such organisations is advantageous as these organisations can carry out public policy at a local level and employ both remunerated and voluntary staff. Other potential

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[3] The distinction between accountability and answerability is discussed in Section 1.2 below.

benefits include lower transaction costs in the delivery of social services, growth in social capital and buy-in from communities for government-funded programmes (Kearns, 1994).[4] The effectiveness and flexibility of not-for-profit organisations in delivering social services such as health care have earned them the title of 'magic bullets' (Vivian, 1994). The word 'magic' also reflects the enthusiasm with which governments have implemented this option.

In New Zealand, prior to New Public Management arrangements in the primary health care arena, the Government subsidised primary health care by part-funding citizens' visits to General Practitioners (GPs). Under a 'fee-for-service' system, GPs were paid a fixed subsidy for each patient visit, with the patient paying the balance of the relevant GP's fee. This funding structure remained largely unchanged from 1941 until the introduction of the *Primary Health Care Strategy* in 2001, despite rapid change affecting the wider health sector (McAvoy & Coster, 2005).

The first New Public Management reforms in New Zealand's health system began with the Area Health Boards Act 1983. In accordance with the Act, 14 Area Health Boards were established progressively to reform public health and public hospital services. These reforms were introduced in an attempt to achieve cost efficiencies in public sector institutions and, through the State Sector Act 1988 and the Public Finance Act 1989, to make these institutions accountable to the Minister of Health for outputs achieved (Ashton, 2005). While Davies (1989, p.87) acknowledged efficiencies may ensue, she asserted that a second objective (improved responsiveness to communities) resulted in a "conflicting and confusing accountability structure."

A change of Government in 1990 (from Labour to National) resulted in a further series of reforms aimed at achieving efficiencies in the health sector. These were introduced through the Health and Disability Services Act 1993. The Area Health Boards were replaced with 23 Crown Health Enterprises. These were established as publicly owned companies and were required to operate competitively in providing secondary (hospital) health care. In addition, responsibility for the purchase of health care services was transferred from the Ministry of Health to four Regional Health Authorities. These new Authorities contracted with the Crown Health Enterprises for secondary health care; they also purchased primary health care services from local providers (including GPs)

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[4]   A more complete argument of the reasons for this strategy is provided in Chapter 2.

through subsidies paid by a central company, Health Benefits Ltd. Concurrently, these subsidies were reduced (Jacobs, 1998). As a response to these changes, many GPs formed, and/or joined, Primary Care Organisations, mainly in the form of Independent Practitioner Associations (IPAs).[5] Some of these IPAs became intermediaries between Health Benefits Ltd and GPs, by managing the processing of GP funding claims. A number of IPAs also became actively involved in presenting GPs' views to their Regional Health Authorities.

In 1996 when a National-led coalition government was formed, the four Regional Health Authorities were folded into a single Health Funding Authority and the emphasis on competition in health care delivery was removed. The Crown Health Enterprises were re-named Hospital and Health Services in 1997 and they continued to contract with the centralised Health Funding Authority.[6]

A further change of Government in 1999 (to a Labour-led coalition) reversed the policy of centralisation of health services and, in 2000, 21 District Health Boards (DHBs) with local representation were established to undertake local purchasing of health services (Ashton, 2005; McAvoy & Coster, 2005). This most recent re-organisation provided a foundation for new structures and funding programmes for primary health care to be established through the *Primary Health Care Strategy*, which became effective in May, 2002 (Minister of Health, 2001).[7]

A key outcome of this Strategy has been increased public funding chanelled through new organisations called Primary Health Organisations (PHOs). These are built on the IPA concept, in that PHOs act as intermediaries between the government on the one hand, and GPs and other primary health care providers on the other. However, their remit is broader than that of the IPAs as PHOs are required, under the Strategy, to design and fund delivery of primary health programmes so as to improve their communities' health (Minister of Health, 2001). PHOs have been progressively established around New Zealand so that by 2006 a total of 80 locally-based PHOs were

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[5] As noted in Chapter 3, 84% of GPs joined a Primary Care Organisation of some sort. Of those, 80% joined IPAs, 15% linked into loose (non-IPA) networks, 3% contracted separately with Health Benefits Ltd and 2% were connected to community-owned organisations.

[6] This was established in 1997 as the Transitional Health Authority and was re-named the Health Funding Authority in 1998.

[7] Details of this Strategy are provided in Chapter 3. Key elements of the new structure are depicted in Figure 1-1.

contracting with their local DHB to provide primary health care services.[8] The Primary Care Organisations[9] (in particular IPAs) have sponsored, and many have shareholdings in, these new organisations, as the IPAs continue to provide professional support for GPs. However, the relationships between IPAs and current PHOs are varied. For example, some PHOs:

- are owned as vehicles of IPAs and the IPA is the sole shareholder;
- have been formed through partnership between IPAs and/or other Primary Care Organisations;
- are owned jointly by an IPA and one or more community trusts;
- are managed by community-owned Primary Care Organisations.

The change to a multi-professional, community-inclusive approach is similar to that adopted in the UK for the delivery of primary health care (Hill, Fraser, & Cotton, 2001) except that, in New Zealand, the government requires PHOs to be private not-for-profit organisations rather than public sector organisations as they are in the UK.

From the 2002-3 financial year, the New Zealand Government committed new budget funds totalling $2,200 million to be spent over the following seven years, to cover the cost of establishing PHOs and to subsidise additional primary health care services. The 2005 budget voted an extra $196.4 million to fund additional subsidies aimed at lowering patients' primary health care charges.[10] As State spending on primary health care has increased, questions have been raised as to whether public health dollars are being spent to improve citizens' health, on administrative costs, or on further reforms in the primary health care sector (Barnett & Barnett, 2004a; Howell, 2005; Jacobs, 1993).

As shown in Figure 1-1 (and explained in detail in Chapter 3), the *Primary Health Care Strategy* involves a number of parties. Firstly, the Minister of Health is responsible for implementing the government strategy in respect of health care, allocating funding for health care derived from general taxes, monitoring the delivery of health care services, and planning and/or funding national services and projects.[11] The Minister accomplishes

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8   Primary Health Care professionals are free to decide whether or not they will contract (as providers) with PHOs. In 2006 a few GPs remained on the old (pre-2002) system. In excess of 95% of New Zealanders receive primary health care services from PHOs.

9   See note 5 for the form of these Primary Care Organisations.

10 Hon Pete Hodgson: 'Budget 2005 Health overview'. Downloaded from the internet 18th June 2006 from http://www.beehive.govt.nz/View Document.aspx?DocumentID=23144.

11 For example, services from the New Zealand Health Camps and Plunket. National projects include

this by entering into an annual output agreement with his Department, the Ministry of Health. The Ministry of Health is responsible for providing policy advice and information to the Minister and processing payments to the DHBs.

Figure 1-1: Role of the key actors in the New Zealand Health System
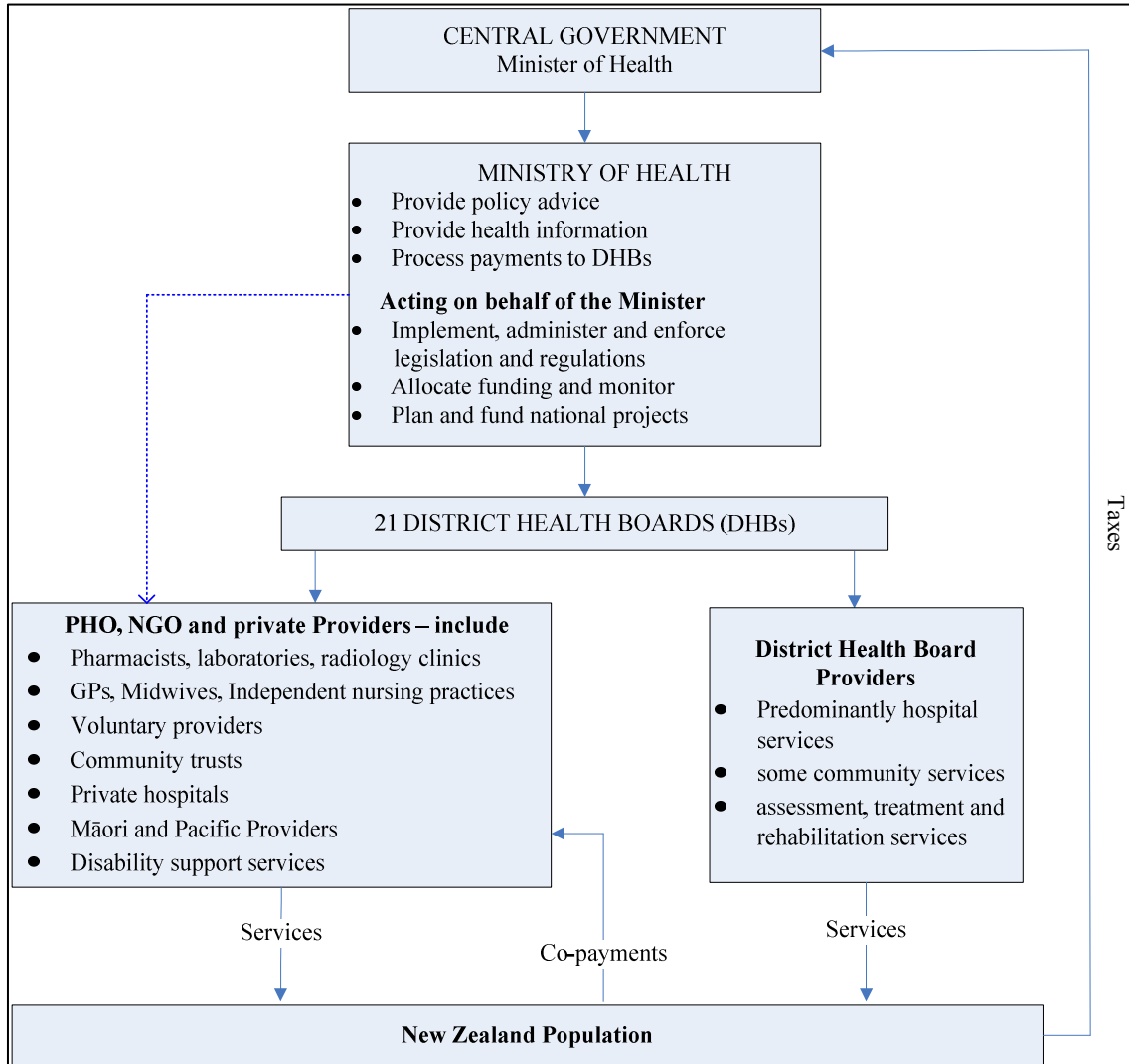
(adapted from Controller and Auditor-General, 2006)

The 21 DHBs are each responsible for a particular geographical area (as shown in Appendix 1). Through their 'provider arms', they deliver secondary health care services such as hospital services, community services and assessment, treatment and rehabilitation services. In addition, DHBs contract for health care services from private providers as well as non-governmental organisations (NGOs) who deliver services through: laboratories, radiology clinics, General Practice medical centres, midwives, private hospitals and Māori and Pacific Providers. Māori Development Organisations have particular responsibilities for achieving specified Māori health gain priorities, co-

the Meningitis B Immunisation Campaign.

ordinating service delivery, and working with both Mäori and mainstream providers to build their capacity to deliver comprehensive and responsive services to Mäori. Pacific Providers have similar responsibilities in respect of Pacific populations (Minister of Health, 2001). [12]

DHBs also administer the *Primary Health Care Strategy*, delegating responsibility for primary health care by contracting with (at present) 80 locally based PHOs. Each PHO contracts with appropriate health care providers (GPs, Nurses, and other Health Clinic professionals). Individual patients select a preferred health care provider who enrols them in the Ministry of Health-approved PHO with which they contract. Individuals may enrol with only one PHO, as the Ministry of Health has stated that it is not possible to manage its new population-based funding in respect of duplicate enrolments.

DHB contract payments are no longer tied to patient-GP visits on the former 'fee-for-service' basis. Instead, under the *Primary Health Care Strategy*, they are based on a population-based formula called 'capitation' (Minister of Health, 2001). Under this system, DHBs, funded from general taxes levied on all taxpayers, pay a fixed amount on an annualised basis for the PHO to supply primary health care services to its enrolled population. However, in general, this does not match the relevant health professional's fee per visit, therefore, patients are required to make co-payments when they visit their health service provider. Citizens who choose not to enrol in PHOs are unable to avail themselves of capitation-funded primary health care but may instead use the services of GPs who remain outside the capitation system or pay a higher fee than PHO members when they visit health professionals who are contracted to a PHO.

As may be seen from Figure 1-2, the characteristics of PHO membership vary quite markedly. Some of these variations affect the direct funding PHOs receive from the relevant DHB. Capitation funding is based primarily on the number of members (i.e. people enrolled) in a PHO and, in addition, each PHO receives an administration fee from the relevant DHB proportionate to its number of members. [13]

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[12]   Three Mäori Development Organisations have established distinct PHOs, (Hauora Hokianga, Ngati Porou Hauora and Taumata Hauora) whilst a number of other Mäori Development Organisations contract with existing PHOs to deliver services targeted to meet Mäori needs.

[13]   A detailed description of the PHO funding bases is provided in Chapter 3. The PHO capitation funding formulae is provided in Appendix 2.

Figure 1-2: Variations of some key PHO characteristics[14]

Factor	Minimum	Maximum
Number of members (Total enrolled = 3,909,791)	Whangaroa PHO - 3,133 members	Partnership Health Canterbury - 341,208 members
Capitation Funding per quarter (Total = $109,285,992)	Whangaroa PHO - $123,314	Partnership Health Canterbury - $8,599,391
Percentage of members in Quintile 5[15]	Whakatipu PHO - 0.07%	Hauora Hokianga Integrated PHO - 97.27%
Percentage of members in Quintile 1	Whangaroa PHO - 0.15%	Karori PHO - 58.1%
Percentage of members under 25 years of age	Taieri and Strath Taeiri PHO - 29.69%	Total Healthcare Otara - 50.92%

Another important determinant of capitation was the socio-economic rating of the geographic area in which a PHO's members live. PHOs with more members from areas with a lower socio-economic rating originally received funding at a higher rate per-member resulting in higher GP visit subsidies and lower patient contributions. This assisted these PHOs to fulfil the government's goal of increasing access to primary health care to those most in need, however since July 1st 2007, the core capitation funding between PHOs has not been differentiated in respect of socio-economic characteristics.[16] PHOs also vary in respect of factors such as age demographics and areas of habitation (whether PHO members are rural or urban dwellers or the composition is mixed).

Further, PHOs, as their name suggests, are corporate providers of primary health care, rather than specific individuals, but they may take one of a number of different legal forms. Although internationally, primary health care providers may be constituted in a variety of forms (they may, for example, be private profit-oriented entities, public sector organisations, private not-for-profit organisations involved in service provision in a philanthropic capacity, or health care funders themselves), the New Zealand *Primary Health Care Strategy* requires PHOs to be private not-for-profit organisations but they may, for example, be incorporated societies, trusts, or limited liability companies (Perera, McDonald, Cumming, & Goodhead, 2003).

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[14]   Extracted from data provided by the Ministry of Health as at 1st April, 2006.

[15]   A quintile is a statistical measure of socio-economic disadvantage presented as a deprivation index. New Zealand census data is analysed in meshblocks (small areas with a median of 90 people) against nine socio-economic variables. Meshblocks are grouped into quintiles with 1 representing the least deprived 20% and quintile 5, the most deprived (Controller and Auditor-General, 2002a; Salmond & Crampton, 2002). They are applied to PHOs in respect of the quintiles in which their members live.

[16]   Health Promotion funding remains differentiated in respect of PHOs' members' ethnicity and socio-economic status.

In addition to capitation, since January 1st, 2006, incentive payments have been available to PHOs that choose to enter a nationally-managed Performance Management Programme. The payments require PHOs to make improvements against national key performance indicators relating to:

   (i) the health of their enrolled members, and

  (ii) their performance in reducing inequalities in health outcomes.

Performance is assessed in three areas; that is, against indicators of:

      a) clinical best practice (especially amongst PHO members with high needs);

      b) administrative and processing capabilities: including the completeness of the PHO's members' register and the manner in which the PHO provides access for members with high needs;

      c) expenditure in pharmaceuticals and laboratory testing.

Aside from the voluntary Performance Management Programme, under the *Primary Health Care Strategy* and the Service Specifications (Minister of Health, 2001; Ministry of Health, 2002), all PHOs must meet certain requirements. More specifically, they:

- must provide or purchase (for example by contracting with GPs, medical centres and other primary carers such as nurses) primary health care services that are available 'around-the-clock';

- are responsible for improving their community's primary health status.[17] DHBs collect data on PHOs' activities to improve access, health promotion and quality improvement as well as activities to manage referred services;

- must comply with all the relevant legal, regulatory and contractual obligations to the DHB and other funders [including private health care insurers and the Accident Compensation Commission (ACC)];

- are responsible for their practitioners' and employees' adherence to the standards of the relevant professional bodies;

- must involve local communities in their governance structure and decision-making;

- are required to be fully and openly accountable for all public funds they receive.

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[17] In order to achieve this, they may also contract with other funders or obtain grants [for example, from their Local Authority, or Sport and Recreation New Zealand (SPARC)].

1.2. *Accountability*

The requirement for all PHOs to be 'fully and openly accountable' for all public funds they receive enables the Government to reduce the need for expensive regulatory and monitoring systems and this, in turn, leads to further cost savings for publicly funded health care (Brinkerhoff, 2004; Walker, 1996).

The imposition of an obligation on PHOs to be accountable suggests that the notion of 'accountability' is a commonly and well-understood concept. However, in practice, the term is ill-defined and is more readily identified when it is absent than when it is present (Zadek, 2003). Accountability arises from an underlying relationship in which one party (the acceptor) accepts delegated responsibilities from another (the delegator) (Mulgan, 1997). This gives rise to an obligation for the acceptor to perform, and to report on the discharge of, the responsibility. The delegator also has the right to receive such reports and to impose sanctions, or provide rewards, in respect of the performance of the delegated responsibility and the acceptor's report thereon (Birkett, 1988; Mulgan, 2003; Stewart, 1984). While answerability is a key component of accountability, accountability is distinguished from answerability by the right of the delegator to impose sanctions on, or provide rewards to, the acceptor (Harris & Spanier, 1976).

As a consequence of accepting delegated responsibilities (together with associated funding) for the delivery of primary health care services to their communities, PHOs are accountable for the discharge of those responsibilities and the appropriate use of the associated funding to at least the following stakeholders:

- the community at large, as a consequence of receiving taxpayer derived funding;
- the Government, through the Ministry of Health and the relevant DHB, as a consequence of public funding derived from the DHB;
- patients, for the primary health care delivered as well as for the funding derived from co-payments made by patients to the PHOs' contracted providers;
- contracted providers of health care services, in respect of the financial sustainability of the PHO, as a consequence of contractual arrangements with employees, practitioners, practices and health clinics;
- non-Ministry of Health funders, for patient services, as a result of receiving funding from the relevant funder (such as private insurers and the ACC);
- non-Ministry of Health funders, for grants received in respect of additional primary health care initiatives (for example, home insulation in Mangakino by

Lake Taupo PHO Ltd), or other special projects (for example, to SPARC for 'green prescriptions')[18] which are provided to patients by a number of PHOs (Ministry of Health, 2005a).

Faced by these multiple stakeholders, PHOs need to prioritise and reconcile their accountability obligations. Failure to do so may result in some stakeholder groups having their accountability obligations met, while other stakeholder groups' demands are discharged inadequately (Ospina, Diaz, & O'Sullivan, 2002). The difficulty of trying to satisfy conflicting needs and expectations of multiple stakeholders has been described by Bovens (2005b) as the problem of 'many eyes'.

In addition to performing their accepted responsibilities, PHOs must report on their performance: "effective accountability requires a statement of goals … transparency … honest reporting … an appraisal process and concrete mechanisms for holding to account" (Edwards & Hulme, 1996, p.5). The processes through which organisations may discharge this accountability obligation include:

   (i) formal reporting (financial and non-financial); and
   (ii) informal reports (such as ad hoc press releases and websites) (Bovens, 2005a).

1.2.1. *Formal mechanisms by which PHOs may discharge their reporting obligations*

PHOs are required to report on the performance of their accepted responsibilities through disclosures that will "allow the DHB and the public to fully understand the use of public funds and the quality and effectiveness of services [provided] in order to evaluate the results" (Minister of Health, 2003, p.4). The formal processes PHOs must adopt [as outlined in their agreement with their DHB (Ministry of Health, n.d.)] include:

* quarterly reporting to the DHB on non-ACC primary care services delivered to enrolled and casual persons;[19]

* publishing annual reports containing:

  o retrospective information on specified services provided, including the PHO's performance against its 'agreed services'. (The PHO consults

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[18]   A green prescription is a health professional's written advice to a patient to be physically active, as part of the patient's health management. (SPARC: 'Green prescriptions'. Downloaded from the internet 31st October 2006 from http://www.sparc.org.nz/getting-active/green-prescription/overview,)

[19]   Failure to provide these reports may affect the PHO's funding.

with the DHB regarding the composition of 'agreed services' prior to the start of a reporting process. These include continuously improving the PHO's providers' service quality, services to improve access to primary health care for high need PHO members and health promotion activities in the PHO's community); and

- o audited general purpose financial statements;
- developing Mäori Health Plans and Pacific Health Plans. Such plans must be developed within six months of a PHO's formation irrespective of a PHO's enrolled population ethnicity. Once developed, the PHO must provide evidence of health initiatives and health gains resulting from these plans;
- providing reports to other funders in respect of non-Ministry of Health funding received (e.g. the ACC, SPARC and private insurers).

A further formal accountability mechanism which the Ministry of Health expects each PHO to adopt (but does not mandate), is an Annual General Meeting (AGM) of its members.[20] In the UK, the public sector National Health Services (NHS) Trusts and Primary Care Trusts are required to hold AGMs as well as providing formal financial and non-financial reports, as a component of meeting their accountability obligations to the public. In 2003, Hodges, MacNiven and Mellet (2004) surveyed 225 NHS Trusts in the UK and attended AGMs of five of these Trusts to investigate the manner in which the AGMs facilitated the Trusts' discharge of accountability. They found that, despite the AGM being a mandatory requirement, there was ineffective discharge of accountability to public stakeholders, as the trustees failed to use the meetings to engender a feeling of community and did not seek, or obtain, constructive feedback on their performance as trustees. As a consequence, Hodges *et al.* (2004) concluded that these AGMs constituted a weak means of discharging accountability obligations.

Nevertheless, other commentators have noted that AGMs complement annual reports and provide an important feedback mechanism. For example, Catasus and Johed (2005) were part of a team of seven researchers who negotiated access to the AGMs of 36 companies listed on the Stockholm Stock Exchange. Although some have described the AGM as a ritual (for example, Apostolides & Boden, 2005; Spira, 2004), these

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[20] The Ministry of Health confirmed that PHOs are not required to hold AGMs but there is an expectation that they will, in order to comply with the Minimum Requirements for PHOs to involve their communities in their governing processes and demonstrate that they are responsive to their communities' priorities and needs (email, Ministry of Health, 17th November, 2005).

researchers found that the AGMs provided opportunities for participants to surprise governors and to intervene in a 'set piece', and they observed that this "is one reason why the AGM is a powerful setting" (Catasus & Johed, 2005, p.26). They concluded that AGMs are the "crown jewel of corporate governance" (p.25). This accords with the historically-accepted wisdom that AGMs enable people with a common interest to gather as a community to receive reports on the performance of those who have accepted delegated responsibilities and to question them on their past and/or future performance (Cordery, 2005b). The opportunity for stakeholders to appraise governors' performance makes these meetings one of Edwards and Hulme's (1996, p.5) "concrete mechanisms for holding to account."

1.2.2. Informal mechanisms by which PHOs may discharge their reporting obligations

In addition to the formal processes, PHOs may use informal mechanisms for discharging the reporting component of their accountability obligations. For example they may:

- provide information through regular PHO members' newsletters and notice-boards in health centres, GP practices and/or the community;

- hold open meetings with 'consumers', their communities, *iwi*,[21] or *hapū*[22] and *kaumātua*;[23]

- make use of local media to inform their communities of health promotion activities, especially media that enables a PHO to communicate in locally appropriate languages;

- maintain a web site to provide information and/or to obtain feedback on their plans and performance (Ministry of Health, 2005b).

In respect of formal and informal reporting, some commentators (for example, Cribb, 2005b; Milofsky & Blades, 1991; Najam, 1996) have expressed concern that, faced by multiple stakeholders, not-for-profit organisations such as PHOs, may privilege influential funders. Government and health professionals such as GPs may demand

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[21] This is Mäori for tribe.

[22] This is Mäori for a sub-tribe.

[23] In this case the Ministry of Health is using *kaumātua* as a general term to define a Mäori elder (male or female) in the *iwi* or *hapū*. These people are recognised for their wisdom and knowledge of Mäori language, history and customs. Mäori often use the term *kuia* for female elders.

preferential treatment and obtain reports that meet their specific information needs ahead of stakeholders who lack equivalent power, such as patients, the community, PHO employees and/or contracted providers.

In the UK, Hill *et al.* (2001) worked with one general health practice in Lanarkshire (in southern central Scotland) to develop a social audit as a mechanism to locate gaps in the discharge of this health practice's accountability to multiple stakeholder groups and, in particular, its patients. They found that requiring GPs to be accountable to an extended set of stakeholders was regarded by the GPs as threatening, or at least, "contentious as doctors regard the [medical] practice as very much 'their own business'" (p.460) and resented having wider reporting obligations. Following the launch of New Zealand's *Primary Health Care Strategy* and the establishment of PHOs, Matheson (2002) expressed concern that similar attitudes by New Zealand GPs may result in inadequate reporting, and thereby ineffective discharge of PHO accountability to the broad set of stakeholders envisaged by the *Primary Health Care Strategy*.

In addition to the contentiousness of requiring GPs to report to multiple stakeholders, Hill *et al*'s (2001) study ascertained that, despite patients' enthusiasm for health practices to accept obligations to a wide range of stakeholders, patients were unable to define accountability in concrete terms. As a consequence, accountability expectations could not be established and this potentially reduced the effectiveness of the discharge of the health practice's accountability obligations (Hill, Fraser, & Cotton, 1998; Hill *et al.*, 2001); it also highlights one of the challenges facing primary health care organisations (such as PHOs in New Zealand) seeking to be accountable to a wide set of stakeholders, including patients or members.

In Ireland, the government's programme of assistance to developing countries [through Development Cooperation Ireland (DCI)[24]] has recently required NGOs that deliver aid to demonstrate broader and more inclusive accountability than has been recognised by these organisations in the past. O'Dwyer and Unerman (2006) termed this 'holistic' accountability, examining relevant documents and interviewing twelve senior employees of a number of the NGOs, as well as the umbrella body for NGOs in Ireland (Dochas) and DCI, to ascertain why increased accountability demands have emerged and how those demands are met. They found that the organisations had institutionalised

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[24]   From 27th February, 2006 DCI was re-named Irish Aid.

narrow accountability mechanisms designed to ensure accountability was discharged primarily to funders. This meant these organisations were reticent to commit the resources required to forge meaningful relationships with beneficiaries and communities that were impacted by the organisations' aid and development activities. Further, a lack of comprehensive guidance on how to report to heterogeneous audiences meant managers were unclear as to how to include a wide set of stakeholders in their extant mechanisms. Historically, these organisations had been held in high regard by the public; consequently, the executives of the organisations exhibited considerable levels of complacency in their response to government demands for them to become more inclusive in the discharge of accountability (O'Dwyer & Unerman, 2006).

In a study investigating how not-for-profit organisations can execute their obligations to multiple stakeholders contemporaneously in a meaningful way, Ospina *et al*. (2002) interviewed over one hundred not-for-profit managers attending a series of leadership courses in the United States. The most effective of these managers noted that the key to broadening organisational accountability, and meeting multiple accountability demands effectively, demanded not complacency but actively identifying and listening to stakeholder groups.

Notwithstanding Ospina *et al's* (2002) study, research investigating effective means by which not-for-profit organisations in general, and primary health care providers in particular, discharge their accountability obligations is scarce. In New Zealand, Cumming, Raymount, Gribben, Horsburgh, Kent, McDonald, Mays and Smith (2005) conducted research on the PHO 'experience' during the first stage of the implementation of the *Primary Health Care Strategy*. Their initial report concluded that, whilst PHOs were discharging accountability obligations to DHBs (by providing formal reports in order to obtain their funding), processes to report to, and interact with, multiple stakeholder groups were less advanced and, in many cases, non-existent.

In her study of New Zealand voluntary agencies, all of which received funds from the government through contracting or tax relief, or both, Cribb (2005b) found that managers understood they were accountable to a select group of stakeholders and that resource constraints would limit the extension of their accountability obligations. While she interviewed managers and other employees of four voluntary organisations to discover which stakeholder groups they prioritised in discharging their accountability,

she noted: "to whom, for what and why the [not-for-profit] staff and board members are accountable has been given minimal attention, either in New Zealand or internationally, by researchers or policy makers. Indeed, several prominent voluntary sector researchers have identified this omission" (p.45).

Ebrahim (2003a) was one of these 'prominent voluntary sector researchers', known for his in-depth studies of NGOs that collect and co-ordinate government and other donors' aid funds in Western countries, and those delivering aid in Third World locations. In a theoretical article on the state of accountability in these not-for-profit organisations, he observed: "what is missing from much of the debate on accountability is an integrated look at how organisations deal with multiple and sometimes competing accountability demands" (p.814).

Ebrahim (2003a) questioned 'how', and Cribb (2005b) the 'to whom', 'for what' and 'why', accountability is discharged by not-for-profit organisations that contract with the Government to assist it with its policy delivery. PHOs established as a result of the *Primary Health Care Strategy* are not-for-profit organisations receiving an increasing supply of government funds. However, they also receive funds from other organisations such as private insurers and the ACC and their contracted providers receive co-payments from patients using their services. PHOs are required to be 'fully and openly accountable' for these funds (Minister of Health, 2001), to all their funders, and also for providing agreed services to their patients and communities. PHOs may be uncomfortable about the requirement for them to be accountable to these multiple stakeholder groups. Faced by the 'many eyes' of accountability (Bovens, 2005b), they may be challenged by the diverse expectations of their multiple stakeholders and also by powerful stakeholders who have the potential to capture the accountability process.

Further, the delivery of effective accountability involves various "concrete mechanisms for holding to account" (Edwards & Hulme, 1996, p.5). These include formal mechanisms – annual reports, plans and AGMs – as well as informal mechanisms such as newsletters, community meetings and media releases. However, PHOs may lack adequate guidance on the most effective mechanisms to employ given their limited resources. These two challenges: simultaneously meeting the expectations of multiple stakeholders and the choice of effective accountability mechanisms, potentially mitigate against PHOs attaining full and open public accountability as required by the Minister

of Health (2001; 2003). Accordingly, PHOs provide a rich field for investigating relevant and significant issues in the discharge of accountability by not-for-profit organisations.

1.3.   *Research aims and objectives*

Following from the above discussion, the aim of this research is 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. In order to achieve this aim, the research has the following objectives:

  (i) to define the concept of accountability and examine its key components within the context of not-for-profit organisations;

 (ii) to examine the nature, structure and responsibilities of PHOs;

(iii) to identify PHO stakeholders, and analyse their relative importance to PHOs and the manner in which they affect PHO accountability;

(iv) to identify and evaluate the various means by which PHOs may discharge their accountability for their financial and non-financial responsibilities;

 (v) to determine and evaluate the means PHOs currently employ to discharge their accountability obligations to their multiple stakeholders;

(vi) to identify the most effective means by which PHOs can discharge their accountability obligations to their multiple stakeholders

(vii) to make recommendations to relevant policy makers and key funders on effective means by which PHOs can discharge their accountability obligations.

This research seeks to synthesise the accountability frameworks of not-for-profit organisations against stakeholder models through an interpretive lens. Thus, the research seeks to deepen the understanding of the manner in which the PHOs currently manage their various stakeholder groups to discharge holistic accountability, in order to identify best practice.

1.4.   *Research methodology*

In order to achieve the research objectives, the following methods will be employed.

1.4.1.   *Literature review*

Relevant literature from the fields of accountability, public sector reforms (in particular primary health reforms), stakeholder salience, organisational sensemaking, and governance, will be reviewed. Databases, including Proquest, Web of Knowledge and EBSCOhost will be searched using key words such as 'accountability', 'community consultation', 'organisational sensemaking', 'not-for-profit governance', 'trust' and 'stakeholders', combined with 'primary health care', 'health reform', 'NHS Trusts' 'Primary Health Organisations' and variants. The literature accessed will include academic journal articles, books, monographs and conference papers. Relevant doctoral and masters degree theses will also be identified through the databases and accessed where possible. References listed in these theses and the other literature accessed will be reviewed to identify pertinent literature not sourced through the database searches.

The literature will be analysed and synthesised to identify relevant and topical information about the key components of the theory and practice of accountability, especially as it relates to not-for-profit organisations in the primary health care sector. A key objective is to identify the findings of prior research into how these organisations discharge their obligation to account for delegated responsibilities. The literature review is also designed to refine the theoretical framework adopted for this study (accountability) and, as case studies are to be used in this research, to review relevant case study research that has been conducted in the accounting discipline.

1.4.2.   *Document review*

A review of the *Primary Health Care Strategy* and other relevant documents published by the Ministry of Health will be undertaken to gain an overview of the nature, structure, responsibilities and mandatory requirements designed to secure the accountability of PHOs in New Zealand. The documentation for each of the four case study PHOs (see below), including PHO founding documents, annual reports and compliance reporting in respect of legal, regulatory and contractual obligations, will be

studied for the two financial years ending 30 June 2006 and 30 June 2007.

The document review will enable an initial impression to be formed of the expectations of PHO stakeholders (for example, the relevant DHB and PHO members) and identifying the mechanisms by which PHOs are discharging their accountability. It will also facilitate evaluating the role of formal and informal mechanisms as means of securing accountability to a wide range of stakeholders.

1.4.3. Case studies

There are currently 80 PHOs in New Zealand, so it is not feasible to study them all in detail within this research project. Four PHOs have been selected for in-depth study in a manner that ensures they represent the range of sizes, structures, geographical locations and enrolled populations of PHOs nationwide. Details of their selection are provided in Chapter 5, but in summary, the four case study PHOs are:

- PHO 1 – a large PHO that is constituted as a charitable trust. Its members are mainly city-based and enjoy higher than average socio-economic conditions;

- PHO 2 – a large, city-based PHO that is constituted as a limited liability company. It has a higher proportion of Mäori and Pacific Islanders than the national average, and the majority of its members experience lower than average socio-economic status and are younger than the national average;

- PHO 3 – a small, ethnically diverse, city-based PHO that is constituted as a charitable trust. Its members have incomes below the national average;

- PHO 4 – a small, rural PHO that is constituted as a charitable limited liability company. Its members enjoy higher than average socio-economic status and are older than the national average.

Case study research is context-dependent and therefore an observation-based ethnographic research method will be adopted to identify PHO stakeholders, their relative importance and the manner in which the PHOs discharge their accountability obligations to them. Key tools will include semi-structured interviews with salient stakeholders and observations of PHO public meetings as described below:

(i) Semi-structured interviews: key stakeholders in each PHO will be interviewed. These will include PHO staff, board members, DHB staff, and community members from groups representative of the PHO's stakeholders. The interviews

will be designed to gain insights into the means by which the PHOs seek to discharge their accountability to their multiple stakeholders, the problems they perceive in achieving this, and their level of success.

(ii) Observation of meetings: for each PHO studied, AGMs and community consultations will be observed to determine and evaluate the effectiveness of these accountability mechanisms in the discharging PHOs' accountability obligations.

1.4.4. Analysis of the empirical data

The data obtained from the document study, semi-structured interviews and observation of meetings will be collated and analysed. Analysis of stakeholders' accountability demands and the manner in which PHOs meet multiple demands through accountability mechanisms will include coding against themes derived from the data to build upon extant theory.

1.5. Contribution of the study

Ebrahim (2003a, p.814) challenged researchers to undertake an "integrated look at how organisations deal with multiple and sometimes competing accountability demands" from their stakeholders. The *Primary Health Care Strategy* requires PHOs to be 'fully and openly accountable' (Minister of Health, 2001) but does not prescribe concrete mechanisms by which PHOs should discharge this obligation.

Through the various means described, this research will identify how PHOs discharge their accountability obligations to multiple stakeholders. It will also identify effective mechanisms by which PHOs can achieve this goal and, in so doing, it will assist PHOs to design appropriate processes to fulfil their accountability obligations. Key findings of the research will enable practitioners involved with not-for-profit organisations in a professional capacity, specifically professional directors, members of the New Zealand Institute of Chartered Accountants, and advisors to not-for-profit organisations, to provide more targeted and informed advice.

As an outcome of the research, recommendations will be submitted to relevant policy makers (for example, the Ministry of Health) to enable policies to be developed that will assist PHOs to discharge their accountability obligations effectively to their multiple

stakeholders. This should result in more effective use of scarce health funding and contribute to the success of the primary health care reforms.

This study seeks to assess the discharge of accountability in practice against theoretical constructs, especially as they relate to the not-for-profit sector. These constructs in respect of not-for-profit organisations are relatively recent (Ebrahim, 2003b) and, therefore, are likely to be improved as a result of the findings of this research. In exploring the relationship between obligations to account and the discharge of these obligations, this research seeks to enhance academic understanding of accountability in practice and link that to accountability theory.

1.6. *Limitations of the study*

All research is subject to inherent bias due to subjectivity in choice of data to collect, methodology and analysis. The challenge of ethnographic research (which is appropriate for this study) into socially constructed concepts such as accountability, is to grasp the meanings given them by the organisations researched. This was mitigated in this study by discussions and reports to the PHOs involved.

The findings of this research are also limited in terms of context and time period (Irvine & Gaffikin, 2006). The PHO reporting practices that will be examined constitute a small sample, will be contextually based and chronologically specific. The findings will apply to a greater or lesser extent to other PHOs and not-for-profit organisations, and/or at other points of a particular PHO's history. It is not the intention of this research to provide findings that are able to be generalised to the not-for-profit sector at large, or even to all PHOs. Attempts to do this may be invalid or constrained, particularly in relation to temporal and contextual matters.

1.7. *Outline of thesis*

This thesis is arranged in ten chapters as follows:

Chapter 1   *Introduction*: this chapter explains the context for the research and sets out its aims and objectives. It also outlines the research methods to be employed and notes the expected contributions and limitations of the study. It highlights, in particular, the need for, and paucity of, research

into the 'how', 'who, 'why' and 'what' of discharging accountability obligations to multiple stakeholders by not-for-profit organisations in general, and PHOs in particular.

Chapter 2   *Primary Health Care systems*: Chapter 2 presents the WHO definition of primary health care. It reviews literature in relation to three general systems. Specific regulatory and monitoring mechanisms to counter inadequacies in these systems are presented, including performance monitoring and citizen participation. Contracting with not-for-profit organisations and the emergence of 'Third Way' policies are also evaluated as a background to different national strategies.

Chapter 3   *The theory of Primary Health Care systems in practice*: through a literature review and document study, this chapter profiles the delivery of primary health care in four OECD countries to provide an understanding of New Zealand's *Primary Health Care Strategy*. Particularly, New Zealand has duplicated some UK systems in requiring PHOs to involve their communities and to collaborate in delivering effective primary health care. In New Zealand no additional regulation or competitive practices have been introduced (as they have been in the Netherlands), except for the requirement that PHOs be not-for-profit providers.

Chapter 4   *Accountability*: provides a definition of accountability, exploring the key concepts of accountability relationships and demands, beginning with the parties involved and presentation of the framework relevant to the New Zealand primary health care system. This chapter suggests possible reasons for not-for-profit organisations to be held accountable and for what, describes a process of accountability, and presents mechanisms currently employed in the sector. It canvasses the challenges PHOs may face, as expressed in current literature.

Chapter 5   *Research methodology*: describes and provides reasons for the particular choices made in this research project in respect of epistemology, methodology, the PHO case studies and the methods used.

Chapters 6-7   *Voices from key stakeholders* and *Voices from PHOs*: presents and analyses the views of PHO stakeholders (in Chapter 6) and PHOs (in Chapter 7). This leads to the development of a community-provider continuum and a control-trust continuum providing insights into similarities and differences as well as preferences as to whom, for what and why PHOs are accountable and mechanisms they may use to discharge these obligations.

Chapter 8   *Structural matters: addressing similarities and differences*: this chapter derives structural explanations for the similarities and differences observed in the case studies in Chapters 6 and 7. It analyses PHOs' implementation of the requirement to be not-for-profit organisations.

Chapter 9   *Dimensions of accountability*: reviews the observed experience of PHOs in respect of the community-provider continuum and 'identity', the control-trust continuum and 'contested space'. This chapter also makes suggestions as to how any deficits in PHOs' discharge of holistic accountability may be addressed.

Chapter 10   *Conclusion*: providing the key findings of the study, policy recommendations and opportunities for further research. This chapter highlights the contribution and acknowledges limitations, of the research.

1.8.   *Summary*

This introductory chapter has provided a context and justification for the research. It has outlined health sector reforms in New Zealand effected through the *Primary Health Care Strategy* (Minister of Health, 2001). This Strategy empowers the establishment of PHOs, not-for-profit organisational providers, to receive the greater portion of the Government's increased primary health care funding. These PHOs are required to be 'fully and openly accountable' for all funding received and will need to prioritise and reconcile multiple accountability obligations in order that these are discharged adequately to relevant stakeholders. Further, as not-for-profit providers likely to be constrained by resources, PHOs must also establish effective means for discharging these accountability obligations so that funds for health initiatives are used to the best

effect.

This chapter has also outlined the aims and objectives of the research and the methods used to achieve the research objectives. These are further described in this thesis.

In order to understand the structure of the *Primary Health Care Strategy* in context, typical policy solutions to primary health care delivery are described in the following chapter.

2. PRIMARY HEALTH CARE SYSTEMS

2.1.   *Introduction*

In this chapter, the definition of primary health care provided in the World Health Organisation's (WHO's) Alma Ata Declaration (WHO, 1978) is examined and three general systems for the delivery of primary health care are discussed. A discussion of the key regulation and monitoring tools that have been adopted to counter inadequate information about delivery quality and ideal levels of demand and supply, which pervades all primary health care systems, follows. The concluding section presents an evaluation of emerging primary health care policies adopted by various governments around the world, including contracting with not-for-profit organisations, networking and partnerships.

2.2.   *What is Primary Health Care?*

Primary health care may be defined as the services delivered at the first point of contact by a patient with a health care system, whether this be through General Practitioner (GP) services, pharmaceutical services or supporting nursing services. However, this definition does not embody the notion of the over-arching health delivery system, the funding regime, or the beneficial role of health intervention services to patients and communities. A more comprehensive definition was provided in the Alma Ata Declaration (WHO, 1978, Declaration VI). This defines primary health care as:

> *… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*

The WHO (1978, Declaration VII) explained that such health care systems would:

   (i) be culturally appropriate and respond to country-specific needs;

<ol type="i" start="2">
address the main health problems in the community;
include eight separate components -
<ol type="a">
education about prevailing health problems and methods of preventing and controlling them,
promotion of food supply and proper nutrition,
an adequate supply of safe water and basic sanitation,
maternal and child health care, including family planning,
immunisation against major infectious diseases,
prevention and control of locally endemic diseases,
appropriate treatment of common diseases and injuries, and
provision of essential drugs;

involve related sectors (e.g. housing, food, education) acting cooperatively;
promote self-reliance in communities and individuals, as well as participation in planning and control;
lead to comprehensive health care for all, through integrated support and referral systems;
rely on all health workers functioning as a health team responsive to community needs.

The Alma Ata Conference recommended that nations "launch and sustain primary health care as part of a comprehensive national health system" (WHO, 1978, Declaration VIII) and set the goal of "attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (WHO, 1978, Declaration V). The benefits to be derived from an effective primary health care system – sustained economic and social development – highlight the need for primary health care to be a prime consideration of nations' health systems.

The Alma Ata Declaration (WHO, 1978) identified three key principles as underpinning an effective primary health care system, namely:

<ol type="i">
equity, in terms of access and affordability;
promoting good health (health promotion); and

(iii) multisectoral cooperation.

The New Zealand Government endorsed the recommendations of the Alma Ata Declaration (WHO, 1978) in its release of the *Primary Health Care Strategy* (Minister of Health, 2001) and emphasised its desire to improve primary health care accessibility; it also noted that improved citizens' health would be beneficial to the economy and recognised the need to move towards multisectoral collaboration. The three principles are discussed below.

2.2.1. *Equity (access and affordability)*

McKee and Brand (2005) report that, between 1960 and 1990, advances in health care accounted for half of the improvement in life expectancy in Western Europe. However, not all citizens benefited to the same extent (McKee & Brand, 2005): some were marginalised through factors such as socio-economic status, ethnicity, belief, and being unable to express their need as a demand. The Alma Ata Declaration (WHO, 1978, Declaration II) condemned "the existing gross inequality" of different peoples' health statuses and called upon governments to reduce social inequality by increasing the affordability of primary health care, and providing universally accessible, quality primary health care "at a cost that the community and country can afford to maintain" (WHO, 1978, Declaration VIa). The continuing need to provide equitable access to quality primary health care was re-affirmed by the WHO on the twenty-fifth anniversary of Alma Ata (WHO, 2003).

2.2.2. *Health promotion*

This principle involves promoting health awareness and actions to improve health amongst citizens and communities so that they take increased control of their own health and health environments. Health promotion potentially develops individuals' skills, embraces community action, and fosters appropriate public policies and health care systems through means such as education, community development, legislation and regulation. For example, the WHO Europe (1998) recommendations include:

- education in respect of dangers of smoking, alcohol abuse and drug abuse;

- pre-school, primary and secondary school education to teach the basics of healthy lifestyles, including nutrition and accident prevention;
- educating adults about healthy eating and safe home environments.

2.2.3. *Multisectoral cooperation*

This key principle requires appropriate primary health care services to be delivered through the coordinated efforts of all sectors involved in national and community development, rather than being treated as a concern of the health sector alone. For example, the WHO Europe (1998) recommended the adoption of multisectoral strategies by member countries that include, *inter alia*:

- levying environmental taxes to reduce pollution, and encourage exercise;
- implementing trade and agricultural policies that promote health by increasing the availability and consumption of vegetables and fruit and reduce the risk of food contamination;
- increasing taxes on tobacco and alcohol products to reduce harmful consumption and its effects, and to prevent and treat drug use;
- undertaking urban planning to improve the healthiness of homes and work places;
- improving foreign aid policies to ensure they are not detrimental to the health of the citizens of other countries.

2.2.4. *Community involvement*

The WHO (1978) encouraged regions and nations to use these three key principles (equity, health promotion and multisectoral cooperation) to attain the year 2000 goal of all citizens enjoying a socially and economically productive life. In 1985, the WHO provided statistical measures to assist national governments gauge their nation's progress towards this goal. These included the following key performance indicators:

- at least 5% of gross national product spent on health care;

- ensuring the availability of safe water in citizens' homes or within 15 minutes' walking distance, and the availability of adequate sanitary facilities in citizens' homes or their immediate vicinity;
- all children immunised against diphtheria, polio, measles and tuberculosis;
- all children monitored for growth and development;
- access for all pregnant women to trained personnel during their pregnancy and childbirth;
- all citizens covered by primary health care services – including the treatment of common diseases and injuries, the provision of essential drugs and medications, and the control of locally endemic diseases (WHO, 1985).

The key to achieving these performance indicators identified by the WHO (1985, p.5) was: "a well informed, well motivated and active participating community." The concept of community is not defined by the WHO but can be described as "an aggregation of people by locality, ethnic, socioeconomic or political characteristics who have coherence as a unit and are able to operate together for shared purposes" (Crampton, 1999, p.5). These shared purposes include the design and delivery of communities' primary health care.

According to Flahault and Roemer (1986) and Hall and Taylor (2003), community involvement through citizen participation was instrumental to the success of experimental primary health care programmes that were developed in the twentieth century to improve public health and economic and social conditions, especially amongst lower socio-economic populations. The community-oriented primary health care movement, begun after World War II by Doctors Sidney and Emily Kark in South Africa (Kark, 1981), was the most successful of these programmes. Such community-oriented primary health care organisations have been established, for example, in some parts of the United States of America (USA), Russia (Rhyne & Hertzman, 2002), Wales and Israel (Gillam & Schamroth, 2002), Australia (Naccarella *et al.*, 2006) and New Zealand (Crampton, 1999; Matheson, 1992). Their key objectives are to identify the specific needs of the area served by a health centre and to tailor preventive and promotional services to meet those needs. These services may include a

number of non-GP front-line providers such as triage nurses,[25] as well as alternative delivery modes such as telephone help lines, to increase the community's access to primary health care. In order to ensure local health care needs are met, it is expected that the community will be involved in designing appropriate health programmes and promoting healthy lifestyles (Schoen *et al.*, 2004).

An example of an effective community-oriented primary health care group of centres is that of 'Parkland' in Dallas, Texas. It involves its communities by means of a leadership forum and community advisory boards (Pickens, Boumbulian, Anderson, Ross, & Phillips, 2002). The leadership forum prioritises community issues and develops medium term plans to address them. The community advisory boards provide input to decisions relating to the clinics' operational matters, assisting in the development of community collaboration. Pickens *et al.* (2002, p.1729) note: "[o]ccasionally conflicts arise on certain issues, but community residents have come to see Parkland as an advocate and a partner, not as an entity separate from the community." They also observe that harnessing conflict has strengthened primary health care delivery by creating an environment of coherence, trust and mutual support.

Despite endorsing the Alma Ata Declaration (WHO, 1978), signatory nations did not meet the WHO's goal for all peoples to attain adequate levels of health by the Year 2000.[26] Consequently, on the twenty-fifth anniversary of Alma Ata (in 2003), the WHO Secretariat called for nation states to renew their commitment to primary health care by adequately resourcing and involving their local communities and voluntary groups in primary health care programme design (WHO, 2003). The manner in which some of New Zealand's Primary Health Organisation (PHOs) do this, will be analysed in this research.

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[25] Triage nurses assess and assign degrees of urgency to patients to determine the order in which they will receive treatment. They may also provide medical care.

[26] While New Zealand met many of the bright line tests, issues in respect of equity, health promotion (to reduce endemic disease for example related to obesity) and multi-sectoral cooperation remained.

2.3. *Systems for delivering and funding Primary Health Care*

The WHO does not require its member states to provide (from the national purse) adequate primary health care for all their citizens. Some citizens may be able to afford to purchase health care as and when needed; others may rely on private insurance to cover possible future primary (and/or secondary) health care costs. However, market failure and access issues result in not all citizens being able to have their health care demands met by their private means or by private insurance (Wallis & Dollery, 1999). Also, patients may not find such insurance appropriate for low-cost primary health care interventions, when reimbursement administration costs added to premiums outweigh the original cost of care. Further, a primary health care system that is focused on equity of access, health promotion and multisectoral cooperation, has funding priorities that need to be addressed at a national, rather than individual level. Accordingly, since the end of World War II, governments have assumed increased responsibility for funding their citizen's health care (van Kemenade, 1997) as they have sought to promote healthier populations and to respond to citizens' demands for health care assistance.

As indicated in Chapter 1, under New Public Management, three general types of government funding and delivery systems can be identified along a continuum. These are depicted in Figure 2-1 in relation to primary health care, as follows:

  (i) (at one extreme) health care is delivered fully by the state in a monopolistic system funded by general or specific taxes;

 (ii) (at the other extreme) health care is privatised and delivered through free market mechanisms with funding from citizens direct to providers for services received or through contributions to insurers for potential services;

(iii) (in the mid-range) health care is funded by the state and citizens conjointly, with the devolution of health care services to private business and communities through a policy of 'contracting-out' (Robinson, Jakubowski, & Figueras, 2005). Citizens may pay the provider directly in full and be reimbursed (in full or in part) by an insurer or the government, or citizens may make co-payments to the primary health care

provider to augment the funding they receive from insurers or the government. It is likely that providers will compete for these contracts.

Each of these systems is discussed below, to provide a greater understanding of the implications for the structure of New Zealand's primary health care system on the case study PHOs in this research.

Figure 2- 1: Continuum of primary health care systems and funding flows
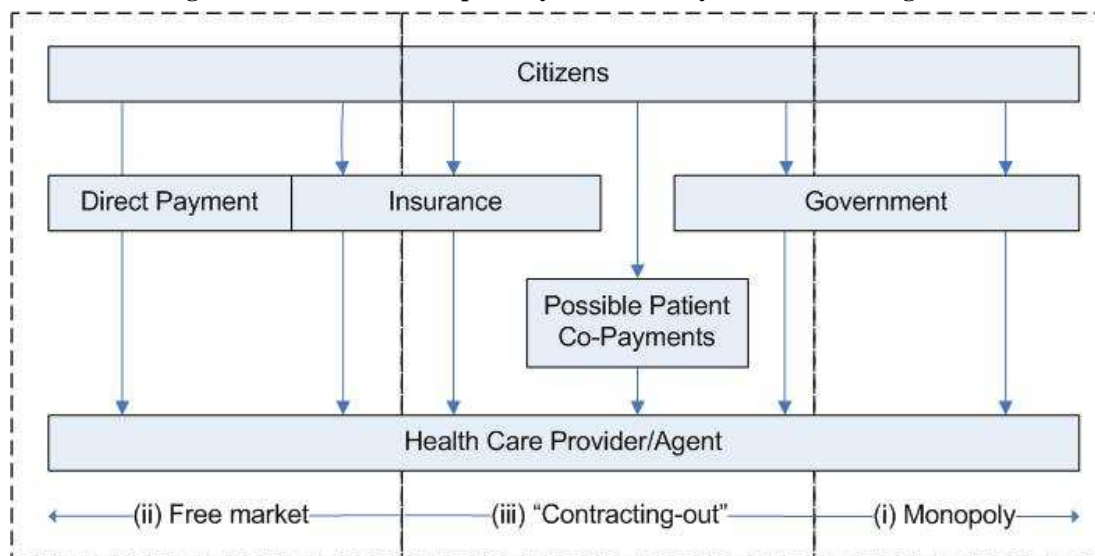
(adapted from van Kemenade, 1997)

2.3.1. *Monopoly health care systems*

A monopolistic health care system, delivered by the state or by a single private provider, tends to be hierarchical, centrally organised and delivers primary health care on a 'one size fits all' basis. The principal advantage of this system lies in the co-ordination of health care services that is made possible by a single funder directly contracting or employing primary health care professionals and administrators. The British National Health Service was formerly a monopoly and many low and middle-income countries such as Lithuania have also adopted this option (WHO, 2000).

However, these systems tend to be inefficient as providers have few incentives to deliver health care services cost-effectively (Robinson *et al.*, 2005), and patient over-demand may be encouraged. Further, when providers (or administrators) establish and negotiate charges, they

may capture the monopoly funder by skewing information in order to obtain more funding than is justified for the services provided (WHO, 2000). This potentially limits citizens' access due to the resulting resource scarcity. Monopolistic systems may also result in more primary health care services being provided than is necessary (over-supply). However, governments may try to counter the possible deficiencies of over-supply and/or over-demand by introducing expensive regulatory and monitoring systems – systems that also tend to reduce effectiveness in the provision of health services.

Homogeneous, monopolistic systems are unlikely to address community-specific primary health care problems as they lack the flexibility to promote and achieve community participation in the planning and control of primary health care delivery. Without this feature, the WHO's health promotion goal of having individuals take control of their health and health environment is unlikely to be achieved. Lithuania's health system provides an example of a monopoly that has become ineffective due to a lack of choice for patients (service homogenisation) and central control that stifles innovation and provider autonomy (Robinson *et al.*, 2005).

Further, inflexible systems may impede equity of access to primary health care if citizens cannot pay centrally determined costs or require other than the centrally determined services. Within-country regionally determined patient contribution rates and service provision (a 'spatial monopoly') may ameliorate this problem (Robinson *et al.*, 2005). Such a system edges towards the concept of 'contracting-out', at the margin of monopoly health care provision. Today, monopolistic systems, where the sole funder directly employs health care providers, are seldom used by Western governments.[27]

2.3.2. *Free market competition*

In contrast to a monopoly, free market competition delivers health care services aligned to

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[27] They may, however, be used by purchasers in particular circumstances. For example, in New Zealand, the West Coast District Health Board (DHB) employs a number of GPs directly in order to guarantee health care supply to their constituents in this rural area. GPs receive a competitive remuneration package and, compared to working in their own practice, enjoy a reduced administration workload and generous leave and study provisions.

consumer choice. When full information is available, providers streamline their organisational delivery so as to be competitive on both price and quality. Thus, free market competition encourages prices that reflect the patients' perceived quality of providers' services (Ouchi, 1980). When numerous providers enter a competitive market, the risk of purchaser capture by providers is reduced and this, as well as increased competition, may result in lower prices (Anderson & Blegvad, 2006). However, a purely competitive market is less likely to occur in primary health care than in other sectors, as information on the quality of the service provided is not readily available (Wallis & Dollery, 1999). Providers may skimp on quality if demand is not affected (Smith, Preker, Light, & Richard, 2005); they may also select patients according to their ability to pay, with the consequential risk that those who cannot afford quality care miss out.

Despite this disadvantage, the option of privatising health care services through free market policies has been advocated strongly by governments as they seek ways to secure effective funding and delivery of primary health care. In the last quarter of the twentieth century a number of European countries, for example, adopted policies designed to encourage free market solutions to health care provision (Bryce, 2005). For instance, in the Netherlands, the Government requires all citizens to purchase health insurance from the market-place, resolving the equity issue by subsidising those who cannot afford to buy insurance unaided. In the USA, in order to increase citizen's equity of access, the government provides health care insurance to a discrete range of citizens who are unable to access it for themselves (Smith *et al.*, 2005; Wallis & Dollery, 1999).

Views differ on the benefits to be derived from competition in health care provision and empirical evidence is inconclusive. Although increased competition has been shown to result in more cost-effective health care (Smith *et al.*, 2005), there is little support for the proposition that competitive contracting improves the standard of care. Smith *et al's* (2005, p.114) study of mental health care in the USA found that a competitive system resulted in providers engaging in a 'race to the bottom', thus reducing the quality of health care provided. Anderson and Blegvad's (2006) study of Danish dental care found that competition could not be viewed in isolation from state and professional regulation to restrict entry to the

dental profession and to monitor quality. These jointly reduced the effect of a fully competitive market-place, meaning that competition alone did not cause substantial increases in health sector efficiency or effectiveness. Such examples confirm the WHO's (2000, p.63) conclusion that: "markets work more poorly for health care" than in sectors where quality and pricing are more transparent.

2.3.3. 'Contracting-out'

Governments that are not prepared to expose their citizens to the full brunt of free market policies may develop policies that encourage competition, reduce barriers to entry and reduce state intervention, but retain centralised management techniques to define the use of the free market tools and to regulate and contain excesses (Considine & Lewis, 2003). Alternatively when governments seek to disband hierarchical monopolies, they may encourage entrepreneurship within monopolistic systems by moving to more horizontal styles of management. (This could be achieved, for example, by encouraging 'spatial monopolies' as suggested by Robinson *et al.*, 2005.) However, if governments wish to operate a system near the centre of the continuum, they may purchase primary health care on behalf of citizens through contractual arrangements with providers (i.e. 'contracting-out') (Considine & Lewis, 2003). Purchasing contracts may include performance targets, output goals and/or health outcomes that providers are required to meet.

The governments of Western nations, in particular, are increasingly employing 'contracting-out' as an alternative to free market and monopoly systems for the financing and delivering of primary health care (Robinson *et al.*, 2005). Where governments opt for 'contracting-out', they typically nominate an agent[28] to manage the contractual relationships with providers and consumers in order to "link health needs, plans and priorities with the allocation of financial resources to different sectors and interventions within the health system" (Figueras, Robinson, & Jakubowski, 2005, p.48) thus retaining control of scarce resources, yet engaging flexibly with communities for equity of access. The purchaser is required to assess citizen's health needs, purchase appropriate services, and ensure choice of supply for individuals

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[28] This may be a Government Department or an external third party.

accessing the health system (Figueras *et al.*, 2005). Hence, Governments or their agents may purchase services from providers by means of:

  (i) fee-for-service funding; or

  (ii) capitation funding.

(i) Fee-for-service funding

With fee-for-service funding, patient visits to a health professional are subsidised by the purchaser making a fixed payment to the provider for each visit. The patient pays less than the true cost for the consultation and the GP (or other health professional) has guaranteed revenue in relation to that consultation. This funding solution was used in the past for patients' visits to their GP in Australia, England and New Zealand. The purchaser relies on health providers to deliver appropriate services on the appropriate number of occasions and not to stimulate over-demand in order to receive higher fee-for-service payments. Purchasers also rely on patients to demand an appropriate amount of health care, so that funding is minimised and the future supply of health care is not jeopardised.

(ii) Capitation funding

Capitation or population-based funding is the most commonly employed funding system for primary health care (van Kemenade, 1997). Under this system, purchasers pay the primary health care provider a fixed amount per patient on an annual (or other) basis, unrelated to patient visits. This amount is designed to fully or partially meet the cost of servicing each patient during that period. The provider may also require a co-payment from the patient (as shown in Figure 2-1) to reduce the possibility of provider-borne cost overruns. The purchaser establishes the demand level at which it is prepared to fund primary health care and potentially enjoys two benefits from employing capitation schemes, namely:

- it may quantify more precisely the costs of funding a primary health care system;
- its administration costs are reduced as regular payments are made to providers rather than fluctuating fee-for-service reimbursements.

Notwithstanding the advantages to be gained from capitation funding, this system potentially gives rise to reduced provider quality and 'cream skimming' (Howell, 2005). 'Cream skimming' may arise when a provider has incentives to attract patients for the funding they bring. Self-interested providers may target specific patients who are likely to be low users of their services – by, for example, marketing health check-ups to healthy, young individuals – thereby 'cream skimming' in order to reduce their own costs. 'Cream skimming' is particularly injurious to equity of access in primary health care systems since the opposite of targeting low users may occur when providers refuse to accept individuals who, from experience, or set demographic factors, have the potential to be high users and, therefore, be costly to service. In order to reduce the likelihood of 'cream skimming' and increase equity of access, government purchasers may require providers to enrol all patients within particular geographic boundaries. Alternatively, the purchaser may make extra payments to providers for patients who are likely to be high users of their services.[29]

While at a conceptual level 'contracting-out' seems to provide an effective and efficient means of delivering health care services to populations, irrespective of whether a fee-for-service or capitation funding system is adopted, government purchasing of primary health care services in the New Public Management era has been the subject of sustained criticism. For example, principal-agent contractual arrangements, binding 'caring' professionals (such as health care providers) to purchasers, is deemed by some (for example Broadbent, Dietrich, & Laughlin, 1996) to be inappropriate, as the strict specification of the types of care under 'contracting-out' may reduce professional freedom. In addition, the reasoning behind contracts may clash with professional values. Contracts are underpinned by an overriding economic rationale that assumes providers are self-interested rather than focused on the public interest and professional in their viewpoint (Broadbent *et al.*, 1996). Purchasers' measurement and management of outputs rather than outcomes[30] highlights the services provided to, rather than the impact of providing those services on, patients and communities

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[29] As described in Chapter 3, this occurs in the Netherlands' insurance-based system and the New Zealand capitation system where capitation is aligned to age and gender, shown to affect usage of health care services.

[30] Outputs are the goods and services produced by a provider whereas outcomes are the impacts on the community resulting from the actions (and outputs) of the provider.

(Jacobs, 1993; Olson, Humphrey, & Guthrie, 2001).

Other commentators, such as English (2005), have pointed out that when governments contract for health care services from private sector providers, they may also transfer the risk of incorrect assessment of a community's needs, or inadequate purchasing of services, to these providers. English (2005) reported that one Australian non-government health provider mismanaged this risk and was bankrupted, requiring the government to intercede and deliver contracted services in order to retain legitimacy with the voting public. This failure had a negative impact on the availability of funds for future service provision.

Other critics, for example Van Til and Ross (2001), note that governments use New Public Management policies to contract on a short term basis while seeking to achieve long term goals, thus freeing themselves from an obligation to create and fund long term institutions. Although this potentially creates flexibility in health care systems, allowing democratically elected governments to be responsive, the contracted primary health care providers are likely to be subjected to an uncertain future (Van Til & Ross, 2001). The Australian government has developed longer-term contracts through public-private partnerships in an attempt to negate this criticism. However, these contracts have merely extended the 'contracting-out' regime and may not represent a significant change from the New Public Management aims to devolve risk to third parties (English, 2005).

It is widely acknowledged that there is no 'one best way' to deliver cost-effective, and socially acceptable, primary health care that will satisfy the WHO's principles of equitable access to health care for all citizens (Robinson *et al.*, 2005) and health promotion.[31] Neither purchasers nor patients can measure objectively the quality of primary health care services provided or the appropriate level of demand for, or supply of, primary health care, especially in the short term. Complex primary health care systems cannot overcome resourcing challenges caused by incomplete information and, in an attempt to reduce the consequences of these difficulties, and to ensure that public funds yield the long-term benefits advocated by

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[31] The third WHO principle, multisectoral cooperation, is not addressed specifically by any particular health care delivery system. This principle is discussed in Section 2.5.

the WHO (1978) as effectively and efficiently as possible, governments have implemented regulatory and monitoring systems (Velasco-Garrido, Borowitz, & Busse, 2005; WHO, 2000). Possible means of mitigating the deficiencies attaching to each health care delivery system, including regulation and monitoring, are presented in Figure 2-2 and discussed below.

Figure 2- 2: Possible solutions to the deficiencies of primary health care systems

Primary health care delivery system:	Incomplete information regarding:	Possible solutions to consequences of incomplete information	Alma Ata (WHO, 1978) principles challenged by delivery system	Possible policy solutions to these challenges
Monopoly	• Ideal level of provider supply • Ideal level of patient demand • Quality of service provided to patients	• Regulate and monitor supply • Require patient co-payments • Establish and monitor key performance indicators; require accountability for outputs/ outcomes	• Health promotion • Equity of access	• Encourage monitoring by community participation • Allow regional price variations
'Contracting-out' through fee-for-service or capitation funding scenarios	• Ideal level of provider supply • Ideal level of patient demand • Quality of service provided to patients	• Fund through capitation • Require patient co-payments • Establish and monitor key performance indicators; require accountability for outputs/ outcomes	• Health promotion • Equity of access	• Encourage monitoring by community participation • Establish patient 'exit' and 'voice' mechanisms
Free market	• Quality of service provided to patients	• Establish and monitor key performance indicators	• Health promotion • Equity of access	• State provides health promotion or regulates to require market providers to supply • Subsidise or provide insurance for patients with minimal financial means

2.4.   *Mitigating deficiencies in health care delivery systems*

As may be seen from Figure 2-2, three challenges emerge as common themes in primary health care systems. Possible solutions to the deficiencies of over-supply, over-demand and a lack of quality information may be addressed by regulation and monitoring as described below. In addition, capitation funding and requiring patient co-payments may mitigate deficiencies (as already discussed). While New Zealand has moved to capitation combined with patient co-payments, monitoring and accountability may take many forms. Alma Ata Declaration (WHO, 1978) principles of health promotion may be effected and access to primary health care made more equitable (at least partially) through government intervention (regional price variations and subsidisation), as well as regulation and monitoring.

2.4.1. *Regulation and monitoring*

Regulation is defined in the Oxford Dictionary as: "prescribed rule, authoritative direction." Its purpose is to standardise behaviour and, in the context of primary health care, regulation seeks to protect consumers of primary health care services by, *inter alia*, establishing minimum quality levels. Whereas regulation is an *ex ante* action, monitoring by purchasers or citizens is designed to assess performance and to detect errors therein after an event (*ex post*), in order to prevent future errors and to ensure primary health care providers deliver services of an acceptable quality. Regulation and monitoring may take different forms:

   (i)   regulating through barriers to entry and professional self-regulation;

  (ii)   state/professional/insurers monitoring the quality of primary health care delivery;

 (iii)   community monitoring; and

 (iv)   patient monitoring through 'exit' and 'voice' mechanisms.

 (i) Regulating through barriers to entry and self-regulation

State practitioner registration requirements, combined with professional self-regulation, seek to ensure that only individuals who meet minimum educational and practical training requirements are registered and, once registered, practice in compliance with the 'rules' of the registering bodies. These 'rules' include technical, ethical and continuing professional

development requirements. Such qualification standards raise barriers to potential providers seeking to enter the primary health care system. In addition, governments may restrict providers by requiring them to practice only from accredited premises (Velasco-Garrido *et al.*, 2005).

Enacting, implementing and monitoring effective 'entry' regulation is costly for governments in terms of resources but, as the Sri Lankan experience demonstrates, the use of resources for this purpose is likely to be cost-effective (Figueras *et al.*, 2005; Mouritsen & Thrane, 2006). When Sri Lanka de-regulated its primary health care system there was no effective registration of private GPs. This resulted in a growing number of unlicensed GPs delivering services of varying quality and potentially increasing, to the patient's detriment, the likelihood of untreated (or inappropriately treated) ailments.[32] Unrestricted entry to practitioners who wished to deliver primary health care was exacerbated by the general absence of monitoring, as the Sri Lankan Ministry of Health lacked the authority and resources to take effective action.

(ii) Purchaser monitoring of primary health care quality

While professional bodies may use patient complaints to maintain quality checks on primary health care providers, purchasers may also monitor the performance of providers by requiring them to report their performance against key quality indicators. In identifying and rewarding primary health care providers who meet performance goals, purchasers can motivate providers towards performing at the desired levels (WHO, 2000).[33]

Requiring primary health care providers to report on their performance (i.e. their outputs and/or outcomes) necessitates their establishing appropriate data collection systems (Velasco-Garrido *et al.*, 2005). Output reports may include information on, for example, the opening hours of providers' premises, the availability of 'after hours' services, minimum

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[32]   In addition, the existence of untreated or poorly treated ailments potentially impacts adversely secondary health care services (hospitals).

[33]   The New Zealand voluntary incentive programme, available to PHOs since 1 January 2007, has been described in Chapter 1.

patient-professional consultation periods, and patients' immunisation statistics. Conversely, outcome reports may include information on, for example, patients' achievement of particular health targets, such as the WHO's (1985) child growth and development goals (Velasco-Garrido *et al.*, 2005).

However, health care providers may be unable to effect sufficient change to these outcomes unaided, even when their performance is targeted to do so, as multi-sectoral cooperation is frequently required. Further, measurement of some outcomes (for example, equity of access) can be complex but, it is nevertheless essential, if government funders are to assess the success of health programmes in improving citizens' health (Ebrahim, 2005).

New Zealand's voluntary performance management programme was received positively by a number of GPs when it was introduced in 2006, as the first set of outcomes was based on GPs attaining population-level screening measures that were within their control (for example, immunisation levels). While these initial measures may have been able to be achieved without multi-sectoral cooperation, it appears the second set of outcome measures will not. Hence, GPs expressed concern that such measures, that include individual patient disease management indicators ["which look better when sicker patients are excluded" (Cameron, 2006a, p.6)], may adversely affect patient access: they feared that some GPs would not receive incentives to service patients who were likely to remain unwell. GPs would therefore be less inclined to care for patients who may lead unhealthy lifestyles that exacerbated, rather than stabilised or improved, chronic conditions (Cameron, 2006c).

In other countries, for example England, primary health care provider 'league tables' (measuring *inter alia*: waiting time for an appointment, cleanliness of surgery and surgery opening hours) employ reputational effects to encourage GPs to improve service quality and as a means of enabling patients to choose between alternative providers. However, O'Neill (2002) argues that, despite the positive effects 'league tables' may have on GP practice quality, such measures are counter-productive as publishing 'league tables' aggravates already declining public trust in the performance of professionals.

Performance monitoring of primary health care in terms of outputs and outcomes has the

added difficulty that it may lead to a proliferation of performance indicators, generating three potential problems for providers. The providers may, for instance:

- not know which indicators are most important to the purchaser, so that the provider may waste resources assessing which indicators need to be met in order to avoid sanctions such as reduced funding (O'Dea, Sundakov, Allan, Cumming, & Congialose, 2001);

- find reporting on a range of indicators results in inadequate reporting of successes and failures when good performance in one area is outweighed by poor performance in another (or *vice versa*);

- resent using scarce resources to report on numerous measures when they do not perceive the exercise to be cost-beneficial for them as providers, or primary health care provision as a whole (Cameron, 2006c).

In addition to multiple indicator problems, diverse population bases – for example, those including significant minority groups and those encompassing disparate socioeconomic factors – have differing adoption and success rates for health interventions, and the impact of these factors needs to be taken into account when providers' performance is assessed.

Given these and similar pitfalls, it is clear that performance monitoring by purchasers requires careful management if its benefits in terms of improved quality of primary health care provision are to be realised. The Organization for Economic Co-operation and Development (OECD) is currently progressing a Healthcare Quality Indicator Project to develop a conceptual framework for health care outcomes indicators worldwide, including primary health care systems (Kelley & Hurst, 2006). The exposure draft outlines the dimensions of health care that should be measured and how, in principle, they should be measured (Kelley & Hurst, 2006); it concentrates on process indicators (or outputs)[34] and outcome indicators[35] rather than input (or structural) indicators *per se*.

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[34] These include, for example, whether at-risk patients' blood pressure has been checked by their GP.

[35] These represent health improvements (or deterioration) that can be attributed to medical care; an example is the relative number of hospital-acquired infections.

(iii)   Community monitoring

In addition to purchasers undertaking performance monitoring for themselves, in the last three decades governments have also encouraged citizen consumers to participate in monitoring the quality and quantity of local government-funded services (including health care). Sullivan (2002) and Newman, Barnes, Sullivan and Knops (2004) report on the UK government moves to promote citizen participation. Governments may encourage citizen participation in the monitoring of health care services for a number of reasons. As indicated in Figure 2-2 and expanded by Rowe and Sheppard (2002), these include:

- improving the quality of health care service provided and promoting public-professional dialogue on clinical governance[36] issues;
- enhancing citizen participation in health promotion; and
- achieving local accountability of providers for the quality and costs of their performance.

In addition, increasing citizens' influence over decisions in respect of the number and type of health care services available is more likely to result in local primary health care delivery that meets the needs of the local community (Mossialos & King, 1999) and may also reconcile citizens to the "unavoidable need for limits to what they can expect from health services" (Mays, 2000, p.125). Governments may require primary health care providers to seek community input into decision making on relevant matters through mechanisms such as focus groups and citizens' juries/panels. From 1996, the UK government introduced citizens' panels that were able to guide secondary health care providers' prioritisation of future health care services. However, Bovens (2005b) found that, as the providers were not obliged to report back on decisions reached after receiving input/guidance from these panels, citizens lacked the information needed to assess these providers' performance.

While citizen monitoring and participation in decision-making can play an important role in health promotion and establishing supply levels, Gustafsson and Driver (2005, p.533) found

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[36]   Clinical governance is the systematic approach to maintaining and improving the quality of health care. It requires providers to ensure that as professionals, they discharge high standards of care and constantly improve their performance against those standards.

that, in the UK: "[g]etting people involved is hard. Citizens aren't always active. They have little time …" Citizens may be apathetic, hoping others will participate and/or they may lack resources or the information required to be involved in monitoring and decision-making (Hirschman, 1980; Lee, 2004). Difficulties such as these present challenges for health sector policy-makers as they seek to identify the most effective monitoring roles for citizens to play.

(iv)   Patient monitoring through 'exit' and 'voice' mechanisms

As individuals, citizens who are dissatisfied patients may exhibit 'voice', seeking change by providing feedback to purchasers and providers in health care services (Hirschman, 1980). They may use a number of different mechanisms, for example:

- individual providers may offer 'suggestions' or 'complaints' boxes in their premises;
- health care professionals' associations may sponsor complaints systems for patients as part of a self-regulatory system;
- patients may also lobby for change through involvement with special interest advocacy groups; and
- governments may establish ombudsmen or other central systems for patients' complaints.

O'Connell's (2005) study of a social service transport system in the USA found that providers were less likely to capture the purchasers when users of the system had a complaints system available as a 'voice' mechanism. This monitoring system has been adopted by many government agencies in the USA.

Alternatively, patients who are dissatisfied with the health care they have received may choose to 'exit' one provider and seek another. 'Exit' assumes patients have choice and is recognised as a basic right in primary health care (WHO, 1986).[37] 'Exit' choices may proxy for competition and, when providers seek reputational benefits, 'exit' mechanisms positively affect quality (Meijer, 2005).

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[37]   The WHO Report "*Health Systems: Improving Performance*" (WHO, 2000) identified patient choice in respect of primary health care providers as an essential aspect of the responsiveness of health systems to meet people's legitimate non-health expectations about how the system will treat them.

Despite the benefits of 'exit' mechanisms, Meijer (2005) notes that patient choice may be constrained by:

- a shortage of health care professionals in a particular area (especially when communities have differing expectations and needs);

- loyalty of patients to particular health care professionals;

- the purchaser (state or insurer) reimbursing patient visits only to approved health care professionals. (This restriction may reduce patient choice to particular GPs, or motivate the patient to visit a GP when they would prefer to use alternative health care services, such as physiotherapy or homeopathic services).

2.4.2. *Cost-effectiveness and co-operation in primary health care*

Government regulation and monitoring, community monitoring and decision-making, and patient 'voice' and 'exit' mechanisms, have been used to address problems caused by incomplete information about ideal levels of provider supply and patient demand, the quality of service provided to patients and as a means of addressing the equity of access issues and improving the effectiveness of health promotion. While these mechanisms may partially address the deficiencies of primary health care systems on the monopoly-'contracting-out'-free market continuum as shown in Figure 2-2, two further aspects of primary health care have continued to concern governments, namely:

(i) cost-effectiveness in the use of public funds for primary health care;

(ii) reducing the negative effects of compartmentalisation in competitive and 'contracting-out' policies by finding effective ways to encourage multisectoral cooperation as recommended by the WHO Alma Ata Declaration (1978).

(i) Cost-effective spending of public funds for primary health care

Since the 1990s, in an attempt to ensure that public funds allocated to health care are used cost-effectively, governments have increasingly contracted with not-for-profit organisations for health care provision (Najam, 2000; Walker, 2004) and, today, in New Zealand all PHOs are required to be not-for-profit organisations. (This requirement is explained in Chapter 3.)

Not-for-profit organisations are distinguished from for-profit entities in that:

- typically they do not have ownership shares or shareholders;[38]
- equity is managed by organisational members who act as trustees for all members (mutual benefit);
- surplus funds cannot be distributed to organisational members (the non-distribution constraint) (Hayes, 1996).

The emergence of the not-for-profit sector has been described by Weisbrod (1988) as a manifestation of market failure, or failure of monopolistic systems, reflecting a demand-side theory. For example, not-for-profit organisations may deliver services differentiated from state supply to high-user patients or disadvantaged communities not covered by the standard (monopolistic) primary health care systems; or to whom profit-oriented organisations (in a free market) are not prepared to provide services. Thus, not-for-profit organisations address equity of access issues when they compensate for functions not fulfilled by other social structures. They may also provide a buffer zone, mitigating tension between state and society in politically sensitive areas such as the provision of abortions (Hayes, 1996).

It has been suggested by Hansmann (1987), Seibel and Anheier (1990) and more recently by Ben-Ner and Gui (2003), that members choose to form and control not-for-profit organisations providing public services, or 'trust' services, when information about the cost or quality of these services is inadequate. The combination of mutual benefit (that assumes members are prepared to fund services to an agreed quality) and the non-distribution constraint (signalling that service charges are not set to generate a surplus for members' individual use), ameliorate dissonance. For example, a beneficiary of dementia care or other elder care services may be unable to report on the quality of the institutional care they receive. Abusive carers may blame a beneficiary's bruises on the elderly person's failing health and lack of balance. In a not-for-profit service provider, the concept of mutual benefit suggests that members will trust the member managers to uphold service quality expectations (including staff education and staff:patient levels to prevent beneficiary abuse) that members

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[38]   Some not-for-profit organisations do, however, incorporate as limited liability companies in order to provide organisational members with financial protection. In this case, mutual benefit and the non-distributive constraint are the distinguishing features of the not-for-profit company.

simultaneously demand and manage.

The non-distribution constraint signifies organisational service charges that do not include a 'profit' element (Weisbrod, 1988) and this, together with these organisations' use of volunteers may result in lower charges at similar quality levels than that provided by profit-oriented providers. When governments contract with not-for-profit organisations they seek to incorporate the benefits of member management to reduce government regulation and monitoring costs, and to purchase cost-effective services at an acceptable quality.

Notwithstanding that altruists concerned with the public interest may establish not-for-profit organisations, shrewd entrepreneurs may also establish not-for-profit organisations in order to obtain a springboard from which to avail themselves of tax benefits and private donations (James, 2004; Weisbrod, 1988). Weisbrod (1988, p.11) terms organisations that abuse elements of the not-for-profit form, "for-profits in disguise." Along related lines, James (2004) raises concerns about 'sector-bending' when not-for-profit organisations contract essential service delivery from both not-for-profit and for-profit organisations. This may result in:

- value-convergence towards for-profit income growth and wealth accumulation;
- diversion of public resources to private gain; and
- misallocation of tax privileges (where they are granted).

Extrapolating her concerns to the primary health care sector would suggest that governments may experience reduced benefits (or they may not materialise) from contracting with not-for-profit organisations. Accordingly, governments may not be able to decrease regulation and monitoring, or improve equity of access through service differentiation to yield cost-effective primary health care systems.

When governments seek to reduce monopolistic control, independent not-for-profit organisations with diverse community memberships may provide legitimacy for necessary health care resource allocation decisions within communities (Wilmot, 2004). The perception that not-for-profit providers' decisions possess increased legitimacy over a government provider's allocation, is particularly evident in low socio-economic communities that distrust

formal institutions (Pross & Webb, 2003; Simmons & Birchall, 2005; Taylor, 2004).

Interaction within communities to build social networks and trust has been described by Putnam (1995) as social capital, the 'glue' that holds communities together when common values that reduce social tension and lower transaction costs are generated. Social capital enhances economic and social welfare (Bryce, 2005) and intimate local knowledge may comprise a cognitive asset[39] that, when deployed by not-for-profit organisations to assess local needs, reduces the likelihood of services being over- or under-utilised (Weisbrod, 1988). A not-for-profit organisation's cognitive social capital and goodwill may result in these organisations delivering social programmes more effectively than a government, particularly if distrust of the latter exists. Social capital generated by not-for-profit organisations may also include physical[40] and intangible[41] assets, for which communities will request not-for-profit organisations to be accountable (Bryce, 2005). The salient characteristics of social capital (such as voluntary staff and networks to obtain intimate local knowledge and commitment) may not be present in all not-for-profit organisations. Some organisations rely on paid, professional staff or may not have regular membership meetings. In these scenarios, social capital may not develop (Smith, 2004) so that the social capital benefits of lower transaction costs (including cost-effective regulation and monitoring) and enhanced economic or social welfare, may not eventuate.

(ii)   Reducing compartmentalisation - multisectoral cooperation

In addition, the increased use of competitive 'contracting-out' by government purchasers may lead to the compartmentalising of health care services, encouraging specialisation of service providers and service fragmentation, instead of collaboration. It appears logical that systemic fragmentation mitigates achievement of multisectoral cooperation, a key Alma Ata

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[39]   Cognitive assets relate to the trustworthiness of a not-for-profit organisation that works for an identifiable public good.

[40]   Not-for-profit organisations accumulate these (for example a community health centre or gym) from the community's donations and tax concessions to provide long term benefits of economic value. The assets are owned by the community through their holding of residual equity.

[41]   Intangible assets or goodwill are related to a not-for-profit organisation's reputation over profit-oriented entities (extending from member management and the non-distribution constraint).

(WHO, 1978) principle to improve citizens' primary health care status. It has been suggested that New Public Management (NPM) policies have diminished interdependence and encouraged 'silo' planning and delivery of public services, including primary health care (Adams & Hess, 2001). Bhatta (2003) terms the current age a 'post-NPM environment' which seeks to remedy the negative impacts of vertical-silo policy making and service delivery.[42] Hence, policy makers and commentators are calling upon organisations to recognise their interdependencies with others, while retaining their own identity and continuing to employ a unique approach to meet social and business goals through networks and partnerships.[43]

Podolny and Page (1998) describe networks as collections of actors that have an enduring series of exchange relationships. 'Joined up solutions', and the breaking down of 'silo' distinctions between organisations through 'Third Way' (or 'post-NPM') networking strategies could encourage multisectoral cooperation if organisational members are prepared to subjugate their power in a (shared) relationship (Considine & Lewis, 2003). 'Third Way' policy rhetoric has emerged with the objective of instituting consumer trust, increasing government legitimacy and, through networking, encouraging wider collaboration than previously experienced (Giddens, 2000; Simmons & Birchall, 2005). This impacts primary health care policy in that governments are seeking to link health sector providers into networks or partnerships[44] and then to link these partnerships to other sectors[45] in order that health goals are addressed holistically.

'Third Way' political trends are evident in the UK, USA, Europe and New Zealand (Denhardt & Denhardt, 2000), but overarching policies remain undefined. Nevertheless, the characteristics of the 'Third Way' that are particularly relevant to this study include:

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[42] This can be evidenced in New Zealand where integration of central government decision-making is supported by the: Public Finance Amendment Act 2004, the State Sector Amendment Act 2004, the Crown Entities Act 2004 and a campaign to site similarly-focused Departments in conjoined campus-style buildings.

[43] The terms 'networking' and 'partnerships' are used interchangeably by policy makers and commentators.

[44] For instance in New Zealand GP practices are funded through PHOs – a network of primary health care providers (this is further described in Chapter 3).

[45] For example in the UK, Regional Health Authority meetings include high-level representatives from Primary Care Trusts and Local Authorities (as further described in Chapter 3).

a) the adoption of markets denominated by partnerships within communitarian ideals in preference to monopolistic delivery;

b) the community being perceived as the 'master-virtue', meaning effective policy delivery utilises social capital derived from the community (often through not-for-profit organisations);

c) accountability of recipients of public money as a 'Third Way' imperative (Callinicos, 2001; Powell, 2000).

Each of these characteristics is explained below.

a) Markets with communitarian ideals

The communitarian ideal embodies the notion that individuals will share their identities and have reciprocal (market) transfers within communities, rather than protecting and/or enhancing their own interests (as self-interested utility maximisers) (Adams & Hess, 2001). However, Dean (2003) considers that individuals are unable to completely subsume their own self-centredness. Goodin (2003) also warns against romanticising communitarian markets, noting that cliques may abuse public trust, capture public money and encourage opacity for incompetent handling of delegated funds.

However, 'Third Way' protagonists assume networks and partnerships will employ adequately regulated markets to check the abuse of power by government, the economy, and communities (Giddens, 2000). In addition, although the 'Third Way' prefers market mechanisms for regulation, Hudson and Henwood (2002) provide evidence that key players may hierarchically instigate controls. This occurred when the UK Government mandated further 'watchdog services' (for example, Children's Trusts for each local authority) rather than encouraging partnering through networks and communitarian monitoring. Such actions challenge the ideal that communitarian markets are preferable to monopolies.

b) Communities that grow social capital

'Third Way' politics emphasise long-term community interests and the building of social capital (Glaser, Denhardt, & Hamilton, 2002) through the encouragement of innovation and

learning (Giddens, 2000). However, citizens need to have equal opportunities and to be community-aware in order for social capital to be generated from networks between the state, not-for-profit and profit-oriented organisations. Increased trust increases social capital and breeds public confidence for responsive governments.

Notwithstanding the generation of social capital networks, Callinicos (2001) warns that 'Third Way' communities may not necessarily be the egalitarian groups envisaged by Giddens (2000). He suggests that strong community members may be intolerant and prejudiced, thus excluding and subordinating others, and advancing decisions that are counter-productive to community learning and growth.

The 'Third Way' imperative for community networking is understood by some to be but one more manifestation of governments' desires to reduce costs through extending NPM reforms (Brinkerhoff, 2003; Powell, 2000). Sceptical communities may reduce the benefits of 'Third Way' politics. In New Zealand, for example, efforts by the government to develop partnerships for citizen-focused, relationship based and collaborative social policies, have been perceived by affected communities to be 'time consuming' and 'unnecessarily complex' (Community-Government Relationship Steering Group, 2002). Accordingly, the Community-Government Relationship Steering Group (2002) suggested that trust between government and the non-governmental organisations delivering these programmes has been undermined, rather than increased.

c) Accountability as a 'Third Way' imperative

'Third Way' partnerships are underpinned by the notion that providers of public services (including primary health care) are accountable to a wide set of stakeholders (including the community). This accountability (broader than the NPM ethos) is assumed to be beneficial in that it encourages public service providers to increase their focus on the demands and needs of communities rather than bureaucrats (Meijer, 2005). While NPM devolved through 'contracting-out' policies that demanded efficiency and cost effectiveness; and monopolistic policies used accountability to control and command employees, the accountability of this 'Third Way' collaborative effort is expected to be lateral or communitarian. (This notion is

discussed in Chapter 4.) However, Sullivan (2002, p.365) notes that, for UK 'Third Way' policies: "despite the expressed commitment to restoring local accountability, the mechanisms that are being most rigorously developed are those which reinforce accountability upwards to central government."

Along with many of the broad concepts embodied in 'Third Way' rhetoric (such as trust, respect and influence), 'accountability', 'networking' and 'partnership' have subjective meanings and have been found to be difficult to frame practically. In this regard, Considine and Lewis (2003, p.132) note: "if they were found to exist in practice, any one of these new models or ideals of organisation would represent significant change to the architecture of governance." This lack of conceptual clarity leads to a plurality of 'third ways' without clearly defined policies[46] (Powell, 2000), indicating that 'Third Way' or 'post-NPM' environments may not be a panacea. This is confirmed by Goddard (2006) who understands that current 'Third Way' practice remains within the principal/agent paradigm where public services are planned and delivered in 'silos', rather than a communitarian paradigm, suggesting that multisectoral collaboration through policy changes may be difficult to achieve.

2.5.   *Summary*

In this chapter the definition of primary health care provided in the WHO's Alma Ata Declaration has been outlined and the WHO's three key principles for primary health care – equity of access, health promotion and multisectoral cooperation – have been explained. In order for primary health care to meet the WHO's principles, well informed, motivated communities, that are active in the design and delivery of primary health care, are necessary. These principles provide a background, not only to the New Zealand reforms, but also to the goals to which New Zealand's primary health care system and the case study PHOs aspire.

Governments around the world have employed different systems for delivering primary health care, ranging from monopolies through 'contracting-out' to free market competition.

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46   Giddens (2000) acknowledges that the 'Third Way' embodies a plethora of policy ideals within a pluralist structure.

Within these systems, different funding mechanisms have been adopted, including fee-for-service, and capitation schemes. Governments as purchasers may ameliorate systemic problems through their own and citizen's regulation and monitoring. Cost-effectiveness has been addressed when governments contract with not-for-profit organisations. 'Third Way' policies preferring networks and partnering for delivering primary health care services may encourage multisectoral collaboration. However, from relevant literature reviewed in this chapter, it appears that there is no one best way to design and fund primary health care delivery.

In the next chapter the primary health care systems of five countries are described in order to illustrate the policies reviewed in this chapter and to compare four representative countries against the New Zealand *Primary Health Care Strategy*.

3. THE THEORY OF PRIMARY HEALTH CARE SYSTEMS IN PRACTICE

3.1. *Introduction*

This chapter provides an overview of primary health care funding and delivery systems in five countries − Australia, the United Kingdom (UK), the Netherlands, United States of America (USA) and New Zealand. Examining the differing health care systems of the four overseas countries provides a context for understanding the New Zealand system and its accountability requirements.

Australia, the UK and the Netherlands, have been selected (along with New Zealand) by a number of writers (for example, Considine & Lewis, 2003), as representative of different approaches to public services reform − including primary health care. The USA has also been selected for this study as it provides minimal public funding for primary health care services.

The diverse approaches taken by these countries provide examples of health care systems on the continuum of primary health care policy solutions presented in Chapter 2. As indicated in Figure 3-1, the USA provides an example of a primary health care system delivered almost exclusively through free market mechanisms. The Netherlands has recently reformed its primary health care delivery to include free market competition augmented by 'contracting-out' mechanisms which are designed to ensure equity of access to citizens. The Australian primary health care system has eluded reform and employs 'contracting-out' with a strong monopolistic flavour, providing heavily subsidised primary health care to the majority of its citizens. The UK primary health care system has been reformed quite dramatically in recent years, from a monopoly to an internal market and, latterly, to a system based on 'Third Way' policies. The experiences of these four countries have influenced recent New Zealand reforms, embodied in the *Primary Health Care Strategy* (Minister of Health, 2001). The current New Zealand system is described in the final section of this chapter.

Figure 3-1: A continuum of Primary Health Care solutions

3.2. *Primary Health Care in the USA (an example of a free-market system)*

Health policy in the USA is dominated by the view that medical care is a free market commodity (Schlesinger, 2002); accordingly, the system is focused on private health insurance with 70% of adults under 65 accessing help with health care costs in this manner (National Center for Health Statistics, 2006). Notwithstanding the government's commitment to the World Health Organisation's (WHO) principles of equity, health promotion and multisectoral cooperation and, despite the highest health expenditure per capita in the world, it has been suggested that the USA's citizens face reducing access to a fragmented system beset by cost overruns (Oberlander, 2004). In addition, McDonald, Cumming, Harris, Davies and Burns (2006) suggest that the USA does not have a comprehensive primary health care system.

Individuals in the USA tend to access primary health care through employer-sponsored insurance cover, although a recent survey found that adults in the USA spend in excess of $1,000 per annum on health care (Schoen *et al.*, 2004) – more than citizens in the other referent countries (Australia, Canada, New Zealand and UK). This survey did not differentiate between primary and secondary health care but Oberlander (2004) notes that the high cost of medical care in the USA leads to fewer individuals accessing recommended primary care.[47] The Schoen *et al.* (2004) survey also found that, in the USA, at least 57% of adults with incomes below the national median chose to go without appropriate health care or did not uplift a prescription because of the cost.

Further, it has been suggested that primary health care delivery in the USA lacks a patient-centred or primary health care orientation (Schoen *et al.*, 2004). Structural differences in medical training and practice, combined with a shifting of the locus of

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[47] Access to health care is exacerbated by the fact that over 45 million Americans (approximately 17% of the population) are not insured and therefore may not be able to afford recommended care (National Center for Health Statistics, 2006; Oberlander, 2004).

patient care from GPs to hospitals, has led to fewer GPs and family medicine physicians (Grant, 1989; Starfield & Oliver, 1999).[48] In addition, as a consequence of insurers' purchasing preferences, and the discontinuous nature of employment-related insurance, few patients have a particular physician to whom they relate (Starfield & Oliver, 1999).[49] The consequent lack of choice for insured citizens, and the high per capita costs of health care for insured and uninsured citizens alike, signals a potentially inequitable system.

In 1965, in an attempt to reduce inequity which reflects affordability, the USA Government established Medicare and (State-run) Medicaid programmes under the Social Security Act 1965. This Act acknowledged the government's responsibility to provide some health care as a 'societal right' (Schlesinger, 2002), a concept underpinning the WHO (1978) principle of equity. Medicaid offers free (or subsidised) health coverage or direct medical services for children from low income families, pregnant women, medically-needy elderly and disabled individuals. However, Butler, Rissel and Kharvapour (1999) cite research which suggests that, due to exclusions, nationally only around 50% of the individuals meeting basic poverty criteria are covered.

Medicare is a Federal health insurance programme for qualifying disabled individuals and citizens aged over 65 years. The elderly typically access basic Medicare secondary care insurance premium-free due to Medicare taxes that were deducted when they were employed.[50] Limited primary care Medicare cover (as well as extended secondary care) is also available at a premium, based on the individual's income. As it provides access to health care insurance for individuals who are unable to purchase it from the free market due to cost considerations or their medical history (including pre-existing conditions), government's Medicare is an insurer of last resort.

Medicare and Medicaid plans are managed by the Health Care Financial Administration

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[48]   Starfield and Oliver (1999) report that, in 1995, 12% of physicians were family medicine oriented (or GPs) and a further 12-16% were general paediatricians or general internists. Even research from the 1970s showed that 20% of the population received 'general medical care' from specialists (Starfield & Oliver, 1999).

[49]   For example, Starfield (1996) reported that more than half of the individuals enrolled in insurance plans had changed their provider affiliation in the previous three years, and three quarters of these changes had been involuntary as they were due to employer decisions.

[50]   Employees and employers pay Medicare taxes (1.45% of earnings in 2006 and 2007). These also add towards qualifying credits for Social Security benefits.

(HCFA) which contracts with Health Maintenance Organisations (HMOs) on a capitation basis (O'Dea *et al.*, 2001).[51] A majority of these capitated HMOs purchase services from primary health care professionals on a fee-for-service basis (Starfield & Oliver, 1999). Insurers, including Medicare, use HMOs to contain costs, limit provider over-supply and patient over-demand, relying on primary health care professionals to be 'gatekeepers' to reduce referrals to costly secondary care. A likely outcome of cost containment is a reduction of GP consultation times, resulting in the reduced likelihood of preventative measures and health promotion messages being provided by these professionals. Accordingly, health promotion, a core Alma Ata principle (WHO, 1978), has historically been largely ignored in the USA (Starfield & Oliver, 1999).

The HCFA, as a primary health care funder, monitors HMOs' performances through measures developed by an independent organisation, the National Committee for Quality Assurance. The key performance indicators, termed HEDIS (Health Plan Employer Data and Information Sheet) measures, have varying foci. These include significant public health issues such as cancer, heart disease, smoking, asthma and diabetes as well as evaluating customer service and efficiency (O'Dea *et al.*, 2001). Schoen *et al.* (2004) note that private insurers have also begun to use HEDIS core indicators that relate to preventive care and this has resulted in non-Medicare/Medicaid insurers increasing health promotion activities.

As noted in Chapter 2, key performance indicators, such as HEDIS quality measures, supply information to purchasers about the quality of service provided to patients. In 19 States, HEDIS measures are made available to the public, while 23 States publish reports on health plan member satisfaction (Kingsley & Cryan, 2002). Therefore, if patients are in a position to choose their own health care professional, key performance indicators may be available to inform their choice. Further, the USA free market model means that the purchasers (primarily individuals and employers) who are dissatisfied with a provider can 'exit', although this negative voice will be constrained by the availability of an alternative supplier, purchaser loyalty and cost. As regards the operation of citizen 'voice', USA policy-makers have experimented with consumer participation in health planning through organisations such as Health System Agencies. However, these have

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[51] From 1 July 2001, the HCFA was re-named the Centers for Medicare and Medicaid Services, but the research cited pre-dates this change.

been limited to input on secondary health care issues and have not been taken up nationally (Grant, 1989). There is a paucity of research about other operations of citizen 'voice'. Except for a limited number of community-oriented primary care programmes (such as 'Parklands' described in Chapter 2), there appears to be little community involvement in the USA primary health care system.

Although delivery varies between States within the USA, the economic burden of the primary health care system is largely imposed directly on individuals. Currently, it is not compulsory for individuals to hold health insurance cover in any State and, accordingly, insurers may refuse to cover less healthy individuals or those less able to pay. Unless these individuals are eligible for the Medicaid or Medicare programmes, they will experience access inequities. The deficiencies of an insurance-based free market system (including inequity of access) are evident in the USA model. The Netherlands experience with insurance provides a perspective closer to the 'contracting-out' portion of the continuum as will now be discussed.

3.3.   *Primary Health Care in the Netherlands (an example of a free market system at the edge of contracting out)*

The Netherlands has a well-developed national primary health care system which is widely accessible. Independent primary health care providers include GPs, physiotherapists, dentists and midwives. In addition, community nurses are employed by a number of different health care organisations (van Kemenade, 1997). The Netherlands is one of a number of European countries that use health insurance as the key funding mechanism for primary health care.[52] Today, as a result of recent health funding reform, all citizens must hold health insurance in the Netherlands; previously, individuals may have held (optional) private insurance cover, paying for insurers to purchase specified primary health care services from providers on a fee-for-service basis. However, many citizens (approximately 60%) remained uninsured and had their primary health care needs met by the State through a social security system (Groenewegen, 1994). The State purchaser paid providers a fixed capitation in respect of those individuals.

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[52]   Others are Austria, Belgium, France, Germany, Greece, Luxembourg and Switzerland (van Kemenade, 1997) .

In the 1970s, policy changes were initiated to increase the focus on primary health care, but they were never fully implemented and, although the government sought to institute health insurance cover for all citizens by regulation, the introduction of a comprehensive social security system failed. During the 1980s, in line with New Public Management moves to reduce government involvement and introduce free market policies, an independent committee undertook a review of the health system. In 1987 it produced a report entitled the Dekker Plan (after the Chair). This recommended "ambitious and revolutionary" health system changes (Helderman, Schut, van der Grinten, & van de Ven Wynnand, 2005, p.197). The key element of this report was that a single basic insurance scheme should be scoped, to cover 85% of the total health care costs of the entire population. Competition between providers was recommended following the release of the Dekker Plan, but the benefits of this (in terms of cost reduction) were questionable (Groenewegen, 1994).

Following a change to a centre/left government in 1990, the Dekker Plan was accepted, the level of obligatory insurance cover was increased to 95% with the remaining 5% to be borne by patients. This compulsory health insurance was introduced incrementally (depending on the commitment of subsequent coalition governments) with a regulated market-based system becoming fully effective on 1 January 2006 (Naccarella *et al.*, 2006). This health insurance system introduced fee-for-service contractual arrangements between insurer purchasers and providers. It affects patients, insurers and the State in the following way:

- all Dutch adults must purchase health care for themselves and their dependants from private insurers to the value of €1,100 per amum[53] (the patient bears the cost of a small excess);

- the state refunds the costs of low income or unemployed individuals through the taxation and social welfare system;

- private insurers are obliged to offer a basic package to any individual seeking cover (regardless of pre-existing conditions);

- the state makes 'risk-adjusted payments' to the private insurers on the basis of their portfolio of citizens, although the insurers bear the greatest financial risk

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[53] Personal communication: Professor Tom Groot, Free University of Amsterdam, 15 March 2006.

(Helderman *et al.*, 2005). Risk-adjusted payments are made from a central fund, comprising an income-related premium[54] funded by employers.

Rico, Saltman and Boerma (2003) describe these Dutch arrangements as 'pioneering'. The Netherlands' system addresses the cost of care by using the private insurer purchasers to monitor and restrict providers over-supplying medical services to their patients. However, Rico *et al.* (2003) found that such actions were unpopular with patients and that wealthier citizens made arrangements to access desired levels of care directly, outside the social health insurance system. Yet, Tapay and Colombo (2004) found there is reduced potential for inequalities in access to occur, because public financing is not linked to public provision.

The presence of a number of health care insurance providers delivers 'exit' choices to consumers who play an important role in ensuring that provider quality is maintained and regulatory capture does not occur. Consequently, the government would expect to reduce regulatory mechanisms in the areas of quality controls, competition regulation, and price-fixing (Tapay & Colombo, 2004; van Kemenade, 1997). Further, as all insurers are required to provide cover for any applicant, irrespective of their health record or socio-economic group, free market competition provides patients equitable access to primary health care. However, the heterogeneous nature of consumers means that individuals can over-demand with impunity.

These incentives in the Netherlands' system address difficulties arising from inadequate information about demand and supply (identified in Chapter 2). In addition, as insurers define care in terms of services required by patients rather than professionals who provide the service, this may lead to competition [for example, between General Practitioners (GPs) and nurses]. Alternatively limited cooperation will ensue when, for example, secondary care providers contract with a private nursing organisation to provide outreach nursing, or dentists and GPs co-locate in a medical centre (Groenewegen, 1994).

It is unclear, however, how the WHO's Alma Ata primary health care principles of health promotion and multisectoral cooperation are met in this system, as insurers do not currently have incentives to meet these principles. Naccarella *et al.* (2006) confirm that

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[54]   This has been set at 6.5% of wages paid in 2006.

the main aims of the reforms were limited to providing universal access and improved performance to the primary health care system. The government relies on the market for private insurance and health care delivery to be self-regulating and, through market 'exit' choices, expects patients to locate and purchase insurance from providers who will meet their needs. The Netherlands is markedly different from the Australian social insurance system which is discussed below.

3.4. *Primary Health Care in Australia (an example of a 'contracting–out' system with strong monopolistic components)*

Australia's health system relies predominantly on government management and funding and, as in the USA, it does not have a primary care focus (Starfield, 1996; Weller & Veale, 1999). Although various delivery and funding models exist, Butler, Rissel and Khavapour (1999) note that Australians have traditionally expected the government to deliver services and, since the early colonial days, have encouraged active government intervention, pre-empting community participation in secondary and public[55] health care services.

In contrast to secondary and public health care, primary health care was initially delivered through individually funded patient-GP consultations. However, by the 1950s, private health insurance schemes had developed to assist individuals to prepay primary health care and benefit from pooling arrangements. In 1975, the Australian government created Medibank, a mandatory, universal public health insurance scheme, provided primarily through the Health Insurance Commission and funded by general taxes rather than by citizen's contributions. Medibank was replaced in 1984 by Medicare, an insurance scheme which is funded through a levy on personal taxable income,[56] effectively making the cost of the scheme more transparent. Figure 3-2 depicts the manner in which the Australian health care system is financed.

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[55]   Public health care refers to population interventions (for example, education and immunisation) to prevent disease and prolong lives. It also includes responsibility for environmental factors such as water quality and behavioural factors (such as reducing family violence) (Minister of Health, 2000).

[56]   In 2006 this stood at 1.5 percent.

Figure 3-2: Australian Primary Health Care funding
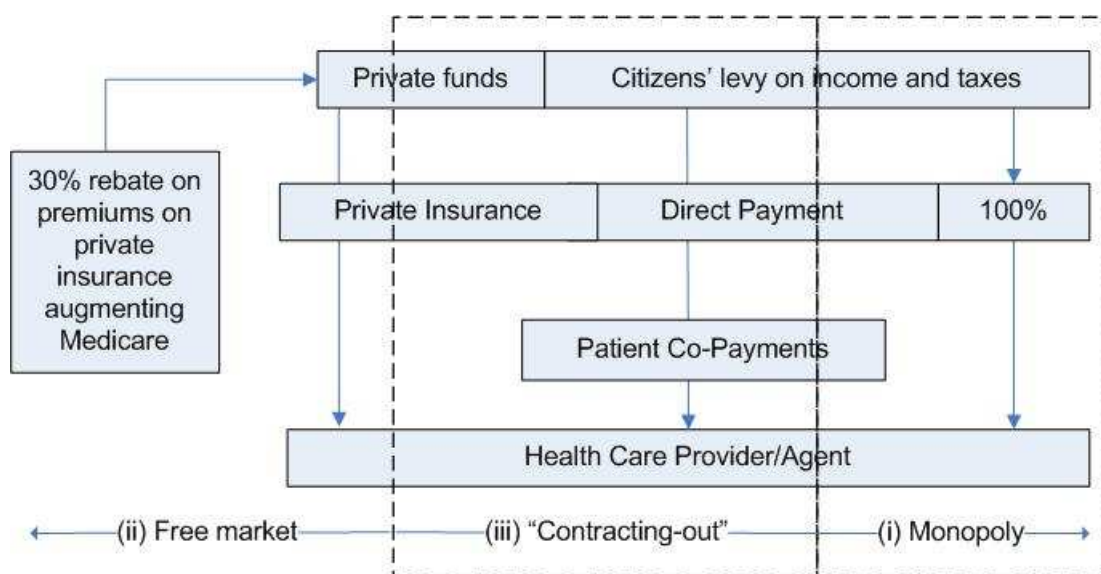
(Bloom, 2000; van Kemenade, 1997)

In order to ensure that citizens receive primary health care, the compulsory health insurance levy on individual income, together with general taxation, is used by the Commonwealth Government to fund the public Medicare scheme. Medicare subsidises patients' GP visits and prescription medications to the extent of 85% of total incurred costs, with patients meeting the remaining 15% (Bloom, 2000). As can be seen in Figure 3-2, Individuals may also voluntarily purchase private insurance and those who do so can claim a 30% rebate on their private insurance premiums through the tax system.

The fee-for-service funding from Medicare (at 85% of consultation cost) is paid to medical practitioners by the government via patients. The patient either pays the GP directly for their consultation and claims the government subsidy independently or the GP bills Medicare for the subsidy. In the latter case, the payment is sent to the patient who must deliver the cheque to the GP. Since the 1980s, in an attempt to introduce efficiencies to the Medicare primary health care system, GPs have been encouraged to bulk bill their primary health care reimbursement claims. Under this scheme, now adopted by around 70% of medical professionals, GPs accept the Medicare rebate as their full payment and do not charge patients a co-payment (Podger & Hagan, 2000). Further incentives and payment options have arisen as part of a 2003 review titled *Changes to Medicare (A Fairer Medicare Package)* (Naccarella *et al.*, 2006).

In addition to GP visits, Medicare also covers pharmaceuticals and certain practice nurse consultations. Initiatives such as incentive payments to increase bulk-billing have reduced administration costs, however Weller and Vale (1999, p.327) note: "Australian general practice lacks a history of experimentation with alternative organisational systems in contrast to the UK experience with GP fundholding." Although New Public Management style decentralisation has been adopted by most Australian States, there have been few modifications in contractual arrangements to devolve the risks of patient over-demand.

Recognising the need for cooperation and collaboration between primary health care providers, Primary Care Partnerships were introduced in the State of Victoria in 2000 but they currently receive only a small budget (McDonald *et al.*, 2006). Community Health Services have also emerged in this State, based on the community-oriented primary health care movement (Naccarella *et al.*, 2006). Across Australia, GPs have been encouraged to affiliate into geographically based Divisions of General Practice so that they may access continuing professional development and, through networking, improve service quality (National Health Committee, 2000; Podger & Hagan, 2000). While these may act as a broker for allied health services, Divisions of General Practice do not contract with GPs. However, Naccarella *et al.* (2006) suggest that these organisations potentially provide a basis for lobbying and GP management, as the Independent Practitioner Associations do in New Zealand.[57] With the election of a Labor Government in 2007, and the promise of $220 million to strengthen primary care and establish GP Super Clinics in local communities, the future role of Divisions of General Practice may also include owning and running these General Practices (Rudd & Roxon, 2007).

Despite these limited reforms, there have been few regulatory or monitoring mechanisms to counter potential GP over-supply in the Australian primary health care system. However, in July 2008, the Australian Government released 40 performance benchmarks to hold States accountable for the quality of their health services, and it is likely these will affect primary health care in the future.[58] Against this, the UK (specifically England) provides an example of a primary health care system that has been subject to numerous reforms, as different governments attempt to meet the challenges of inadequate

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[57]   As described in Section 3.6.

[58]   "Forty Health Performance Indicators, Australia" downloaded from the internet 4th October, 2008 from http://www.medicalnewstoday.com/articles/116243.php.

information about the quality and supply of, demand for, and effective allocation of funding for, primary health care.

3.5. *Primary Health Care in the UK (specifically England) – (an example of system reform to 'contracting-out' from monopoly through free market policies)*

The major changes in the English primary health care system since 1948 are shown in Figure 3-3 and described below. From 1911, when Lloyd George introduced the National Health Service Act, the UK Government provided social health care insurance to citizens who were employed (Dowell & Neal, 2000). In 1948, the UK Government introduced the National Health Service (NHS) with the aim of ensuring that all citizens would receive free primary (and secondary) health care. This system was funded entirely from taxes (van Kemenade, 1997). The resulting health care system [described by the WHO (2000) as a monopoly] was more centralised than in most other countries (O'Dea *et al.*, 2001). However, primary health care continued to be organised at the monopolistic edge of a 'contracting-out' system; GPs were retained as independent contractors (paid mainly by capitation) and, as such, were separate from other NHS services (Heywood, 2000).

Figure 3-3: Major English Health Care system changes
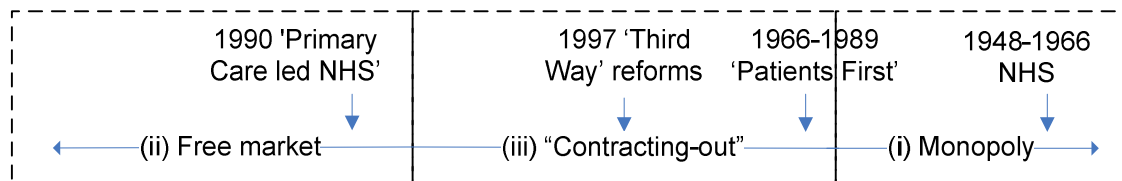
The establishment of the NHS in 1948 provided a structure through which, theoretically, GPs became directly accountable to central government (Day & Klein, 1987) but there were few mechanisms by which to address inadequate information regarding service quality, supply, or demand. Dowell and Neal (2000) described the GP from 1948 until the mid 1960s in the following terms:

> *The stereotype from this era, the sometimes gruff, cuddly, avuncular and largely unaccountable male GP has persisted, at least in the minds of cartoonists. Patient expectations were low, despite the 'liberation' of the free NHS, and GPs seemed to retain the universal respect and affection of their patients. (p.13)*

In 1966, in order to encourage GPs to work in partnerships and promote primary health care provision in needy areas, the NHS Charter introduced marked changes, re-structuring GP remuneration to include basic practice allowances and fees for specific tasks (such as

immunisation) (Heywood, 2000). The new funding regime also covered 70% of the costs of nurses and ancillary staff, and schemes were introduced to reimburse premises costs. The quality of care was addressed by a growing research base, rising societal expectations and, from 1979 an emphasis on *Patients First* (the title of the consultative paper published by the Department of Health and Social Security that year) (Peckham, Exworthy, Greener, & Powell, 2005). *Patients First* generated reforms to strengthen management at the local level of the NHS, by establishing district health authorities and dismantling area health authorities.

In 1986 a Green Paper (*Primary health care: an agenda for discussion)* discussed ways to reduce NHS primary health care cost overruns. This was followed in 1987 by a White Paper (*Promoting better health: the Government's programme for improving primary health care)*. However, by the late 1980s, these discussions with GPs were overtaken by the New Public Management perception of health care as a commodity that could be purchased from a market. The difference between this market mindset, and that of the USA and the Netherlands, was a requirement for increased monitoring and GP accountability for funding. New financial structures, purchasers, provider responsibilities and market terminology were introduced as the NHS purchaser attempted to match supply and demand, and to devolve further the planning and service provision of primary (and secondary) health care to communities (Dowell & Neal, 2000; Hudson & Henwood, 2002; van Kemenade, 1997).[59] In principle, primary health care remained free of charge to patients. However, for those receiving eye care and visual aids, dental care and prescription medicines, co-payments were introduced to address a scarcity of resources and to check patient over-demand.

In order to encourage high clinical standards and value for money contracting, the 1990 GP contracts (which were underpinned by the National Health Services and Community Care Act 1990) treated GPs as business entrepreneurs. GPs had argued for the emphasis on health promotion and disease prevention, and key performance indicators linked to financial rewards, that were introduced by the 1990 Act, but they believed that the accountability demands reduced their professional autonomy (due to 'excessive monitoring' by family health service authorities and the strict definition of core services

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[59]   In 1987, the government stated its intention to "give patients the widest range of choice in obtaining high quality primary care services" (Heywood, 2000, p.28).

each GP was paid to provide) (Broadbent & Laughlin, 1998; Lewis, 1997).

These New Public Management reforms, promoted as a 'Primary care led NHS', relied on a pseudo free-market, capitation funding by medical practice (rather than individual GP) and competition between medical practices (Mackintosh, 1993). The reforms relied on patient choice and exit mechanisms, as the policies for a largely internal market included the NHS Fundholding[60] scheme: GP practices with more than 11,000 enrolled patients could register as NHS Fundholders and could offer patients preferential secondary health care access (as explained below). These medical practices were attractive to patients who sought a quality 'one stop shop' including managed referrals to higher levels of care.[61] NHS Fundholders were allocated a portion of the local hospital budget for tests, certain community nursing services and non-urgent admissions for their enrolled patients – services that had previously been rationed through NHS-managed waiting lists. Further, GPs became privy to detailed costing data and could use this to effect practice efficiencies. Medical practices that applied these cost savings to improved primary health care services became even more attractive for patients seeking a single provider for their needs (Llewellyn, 1997). The Fundholding system made GPs more aware of their usage of secondary health care services and encouraged GPs to become active purchasers of these services (Heywood, 2000; van Kemenade, 1997). In addition, as up to one quarter of the secondary health care expenditure was managed by GP Fundholders, hospitals competed for GP practices to fill their patient-beds. Despite this, when Llewellyn (1997) interviewed GP Fundholders, one respondent argued that a free-market did not exist in primary health care; GP's incomes were not affected by the reforms and practices did not receive direct financial rewards as the cost-savings they achieved could be used only for the provision of extra services.

The NHS progressively employed the Fundholder regime to curb over-supply and, through promotion of cost savings at medical practice level, over-demand. However, Lapsley (1994) argued that the 'internal market' potentially reduced the UK's ability to meet the WHO (1978) principle of equity of access as GP Fundholders may:

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[60] Fundholding was introduced in England, Wales and Scotland from 1990 and in Northern Ireland from 1993.

[61] The threshold for eligibility based on patients enrolled was reduced from 11,000 in 1990 to 9,000 in 1992, 7,000 in 1993 and 4,000 in 1995, to encourage more medical practices to take up Fundholding.

- 'cream-skim', that is, turn patients away who have an adverse medical history;
- obtain preferential secondary treatment for their patients over non-Fundholder GPs' patients; and/or
- manipulate their budgets.

Conversely, in a later study that involved in-depth interviews with affected GPs, Lapsley, Llewellyn and Grant (1997) concluded that Scottish Fundholders (with a similar scheme) were generally not motivated by private gains but by a desire to improve the quality of health care delivery for patients of both Fundholding and non-Fundholding practices.

By 1997, around 70% of England's GPs (19,100) were associated with GP Fundholding schemes but, due to disquiet in respect of bureaucracy and conflicts of interest, 7,000 GPs formed Commissioning Groups as an alternative to Fundholding. Commissioning Groups and health authorities jointly purchased secondary care to promote equity of access (Broadbent, Jacobs, & Laughlin, 2001).

To address quality as well as cost in the centrally funded 'Primary Care led NHS', the NHS introduced a Purchaser Efficiency Index. This national quality indicator was complex and was subject to the criticisms of performance monitoring outlined in Chapter 2. Concern was expressed that inappropriate GP outputs were measured and that an 'evaluatory trap' was being encouraged by the NHS funder, with more time being spent on measuring and reporting than actually carrying out responsibilities (Olson *et al.*, 2001).

In addition to the Purchaser Efficiency Index, patients were invited to provide feedback on the quality of services received by the introduction of 'voice' choices. From 1991, a Patient Charter set out ten rights to which every patient was entitled (Green, Ross, & Mirzoev, 2007) and patients were invited to evaluate their local health services through forums and feedback against this Charter. NHS contracts required medical practices to introduce compensation schemes for patients when specific rights were not honoured (Mackintosh, 1993). This was followed, in 1992, by a 'Local Voices' reform which was designed to encourage citizens to report any complaints to the relevant NHS purchaser. Despite this, Levaggi (1995) maintained that accountability discharge by GP Fundholders was unaffected.

In 1997, the pendulum swung against the free market approach and (as indicated in Figure 3-3) the new Labour Government introduced 'Third Way' reforms, outlining an integrated care model in a White Paper: *The New NHS: Modern – Dependable* (NHS Executive, 1997). This constituted a 'marked change' in the focus of English primary health care (Dowell & Neal, 2000), and 'rapid reform' was instigated (Hill *et al.*, 2001); the White Paper also conveyed an understanding that free market polices had failed to address the issues of equity and multi-sectoral cooperation (Hudson & Henwood, 2002). Announcing: "[t]here will be a 'third way' of running the NHS – a system based on partnership and driven by performance … a new model for a new century" (NHS Executive, 1997, s2.2 and 2.3), the UK Government referred to longer term contracts, collaboration and the end of fragmentation – indicative of the 'Third Way'. Further, rather than requiring citizens to pay for health care directly, as was the practice elsewhere in Western Europe (for example the Netherlands), the Government reiterated its commitment to general taxation funding primary health care as the means of both improving health care and reducing inequity of access.

To facilitate 'Third Way' reforms, the White Paper, responding to GP lobbying, extended the Commissioning Group concept, with the Health Act 1997 requiring the establishment of Primary Care Groups as commissioning agents for all local community primary health care.[62] These Groups were governed by Boards comprising health professionals, health authority staff and local government representatives (NHS Executive, 1997, s.5.11). By including all of the GPs and community nurses in a local community, Primary Care Groups aimed to streamline accountability and financing arrangements (NHS Executive, 1997). However as they represented an NHS attempt to accommodate both Commissioning Groups and the disbanded Fundholder Groups, the introduction of Primary Care Groups was not without conflict (Broadbent *et al.*, 2001).

By 2002, the original 481 Primary Care Groups merged, developing into 300 free-standing Primary Care Trusts (PCTs) that are accountable to their local health authority. The PCT Boards comprise mainly lay members and the PCT is expected to engage in wide public consultation.[63] The NHS requires PCTs, secondary care (NHS Trusts) and

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[62]   In Scotland, the similar 1997 White Paper was called *Designed to Care – Renewing the National Health Service in Scotland* and Primary Care Groups were called Local Health Care Cooperatives.

[63]   By 2006, 151 NHS PCTs controlled 80 percent of the NHS budget ("Primary Care Trusts" downloaded

Local Authorities to work together to improve the status of communities' primary health, to generate and deliver Health Improvement Programmes and to develop partnerships addressing community needs. This task requires a delicate balancing of the demands of local community needs and powerful NHS directives in respect of nationally generated goals (Hudson & Henwood, 2002; Newman *et al.*, 2004). With the establishment of PCTs, the NHS in England recognises a broader primary health care model than that adopted in most other countries.

Potentially, the reformed system has a number of benefits corresponding to the WHO key principles. Firstly, the local nature of the contracting institutes a community basis that encourages health promotion. Secondly, by partnering with Local Authorities, the reform arrangements promote inter-organizational collaboration across sectors, as recommended by the Alma Ata Declaration (WHO, 1978). Thirdly, the requirement that PCTs must deliver comprehensive care to the whole community free of charge or at a low cost, reduces the likelihood that providers will 'cream-skim' in the selection of patients; it therefore assists the NHS to achieve equity of access.

The NHS perceives community accountability of PCTs as integral to the primary health care arrangements and it requires PCTs to engage with citizens (Department of Health, 2003). More specifically, it requires PCTs to:

- have community members participating in organisational governance;
- participate in Regional Health Authority meetings along with Local Authorities' Chief Executives, to encourage multi-sectoral cooperation;
- publish an annual report of services provided, patients' views and their responses, and compare the PCT performance with other PCTs nationally;
- have "clear arrangements for public involvement including open meetings" and public Annual General Meetings;
- involve citizens in health planning and governance through Patient and Public Involvement Forums (independent statutory bodies established under the Health and Social Care Act 2001)[64] (Milewa, 2004; NHS Executive, 1997, s.5.15).

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from the internet 27th December 2006 from: http://www.nhs.uk/England/AuthoritiesTrusts/Pct/Default.aspx).

[64] Some Regional Health Authorities used citizens' juries in the past and these are also recommended by the Department of Health, especially for secondary care services (Department of Health, 2003).

The Patient and Public Involvement Forums are largely advisory but they may also hold PCTs accountable in respect of their service planning and delivery. Local Authorities may also call PCTs to account separately through an Overview and Scrutiny Committee for Health (this responsibility covers secondary and community services in addition to primary health care). Practically, Jarrold (2005), Chief Executive of a Regional Health Authority,[65] suggests that health partnering and networking is experiencing some success, although media reports of poor financial health in many PCTs, and the costs of delivering wide patient choice, indicates potential difficulties with sustainability. Further, despite calls for community engagement to improve cost-effectiveness, commentators such as Dean (2003) and Green *et al.* (2007) suggest that, paradoxically, the 'Third Way' reforms in the UK have restricted community interest, as a result of a significant gap between policy and practice. An assessment by Milewa (2004) suggested that the structures may be assembled to exclude public decision-making and, as such, encourage opacity and inconsistent practice between powerful health service decision-makers and citizens. This gives weight to the calls by Cotton, Fraser and Hill (2000) for social audits to assess the extent to which stakeholder dialogue actually leads to accountability being discharged by medical practices.[66]

The PCTs' governance structures have been designed to ensure the PCTs are not dominated by GPs; they are led jointly by a Professional Executive Committee comprising a professional (GP) Executive Committee Chair, the Chief Executive and a lay Trust Chair (Johnston, 2005). However, Peckham *et al.* (2005) note that prior attempts at community consultation have been described as "tokenistic" and they are concerned that the PCTs may be unresponsive to citizens at a local level. Their concern is supported by the manner in which collaboration on such issues as health promotion has been rather slow to eventuate, reflecting the strong position that GPs have traditionally held in the primary health care culture, the PCTs' heavy work agenda and a lack of expertise in citizen participation (Currie & Suhomlinova, 2006; Rowe & Shepherd, 2002).

The most recent reforms have been described by Lapsley (2001) as 'command and

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[65] From 2002 these were termed Strategic Health Authorities (SHAs). The 28 SHAs were further amalgamated in 2006 and the number reduced to ten. (About the NHS. Downloaded from the internet 27th July 2007 from: http://www.nhs.uk/aboutnhs/howthenhsworks/authoritiesandtrusts/Pages/Authoritiesandtrusts.aspx.)

[66] The social audit function is further described in Chapter 4.

control' reflecting the fact that the Department of Health has continued to develop and manage performance measures designed to achieve cost-effectiveness; these include a number of different centrally managed mechanisms and accounting information (O'Dea *et al.*, 2001). For example:

- the National Institute of Health and Clinical Excellence provides guidelines for technology transfers;

- the Healthcare Commission assesses clinical quality and effectiveness (including those of PCTs and independent providers). They register independent providers and continually assess practices' clinical facilities, practice management, patient experience, additional services, and breadth of care. The Healthcare Commission also handles patient complaints;[67]

- PCT budgets and reports must demonstrate how the PCT will achieve financial balance by the end of each financial year (as required by the Department of Health). Further, PCTs are ranked nationally on their surplus/deficit and the change from the prior year.[68] Mooney (2007) suggests highly ranked PCTs also deserve 'Earned Autonomy' (currently operating in secondary care); including financial expenditure freedoms and freedom to enter into joint ventures with local authorities without requiring central permission each time.[69]

Notwithstanding the notion that national performance assessments provide a measure of control, health professionals believe they are more likely to respond to the needs of the local health community than to high level national performance measures set by central government (Chang, 2006; Johnston, 2005). The NHS publishes indicator data on GP practices, noting that a reputation effect will result in the public holding poor performers to account or utilising 'exit' mechanisms to reduce those performers' capitation incomes. The control devolved to the 'customer' seems consistent with what Starfield (1996) terms a 'marketing approach to accountability' where 'customer' satisfaction alone, rather than indicators such as clinical quality, equity of access and multi-sectoral collaboration are

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[67] 'About us' downloaded from the internet 4th October 2008 from http://www.healthcarecommission.org.uk.

[68] NHS 1.1 Finance – PCTs Q2 2006/7 downloaded from the internet 1st July 2007 from http://www.productivity.nhs.uk/Form_PCT_1.1_IncomeAndExpenditure.aspx?period=2006-2&report=p11&orgCode=5NC &email=.

[69] Mannion, Goddard and Bate (2007) found, however, that Earned Autonomy provided only a low powered incentive to improve the performance of NHS Trusts, and that there were practical and structural obstacles to greater freedom for NHS Trust managers.

used to assess GP's effectiveness in meeting communities' health needs (Johnston, 2005).

In summary, in the UK, ongoing reform has made primary health care foundational to the state funded system. The UK Government has signalled that it wishes to move away from the language of competition and purchasing to 'Third Way' policies for primary health care delivery through networking and partnerships. It continues to use 'contracting-out' as the basis of NHS management, and specific changes in primary health care systems have been underpinned by regulation and monitoring systems enforced by the government. New Zealand has employed similar reforms to those in the UK but, as will be seen below, there are significant differences.

3.6. *Primary Health Care in New Zealand*

Primary health care in New Zealand is a unique mix of public and private funding (Kininmonth, 2005). It remains distinctly separate from the secondary health care system but, as in the UK, primary care has progressively assumed many public health responsibilities. Significant New Public Management reforms largely bypassed primary health care until the relatively recent swing to a system focused on Alma Ata (WHO, 1978) ideals and the promotion of wellness rather than the treatment of illness. The salient features of New Zealand's primary health care system are depicted in Figure 3-4.

Figure 3-4: Major NZ Primary Health Care system changes

3.6.1. *Background*

(i) *Establishing a funding regime: 1938-1990*

Subsequent to the Labour Party's 1935 election promise to fund medical care so that it was free to patients and, in the lead up to the Social Security Act 1938, the Labour Government considered a number of schemes for the funding and delivery of primary health care. The New Zealand branch of the British Medical Association, on behalf of

GPs, recommended a state medical service comprising a national insurance scheme. However, an alternative comprehensive social security scheme received strong public support, and when the Social Security Act 1938 was passed, GPs remained independent of the State system. The manner in which they were to be paid was not resolved immediately and the GPs strongly resisted capitation, calling on the British Medical Association to assist them in their fight (Hay, 1989). When the government instigated its policy of free GP services in 1941, GPs were offered four different funding options:

- salaried positions;
- a capitation-based funding agreement;
- either one of two fee-for-service arrangements (a lower payment was offered to GPs who charged patient co-payments and a higher payment for those who forewent patient co-payments).

Most GPs accepted the government fee-for-service funding that enabled them to charge patients a 'top-up' co-payment[70] and this system remained in place until the *Primary Health Care Strategy* (Minister of Health, 2001).[71] From 1941 the great majority of primary health care expenditure was paid for by the government through non-discriminatory taxes. However, the government did not increase the fee-for-service payments until 1972, resulting in steady increases in patient's co-payments. Perhaps unsurprisingly, an increasing number of individuals purchased private health care insurance from the 1970s onwards.[72]

In 1975, *The White Paper: A Health Service for New Zealand* (McGuigan, 1975) advocated sweeping policy reforms including the then contentious recommendation that the fee-for-service subsidy on patients' visits to GPs be replaced with capitation. By

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[70] Accordingly, the state paid 7s 6d of a typical 10s 6d fee (Hay, 1989, p.121). By 2002 when the Primary Health Care Strategy capitation replaced fee-for-service, the fee-for-service subsidies were as follows: a) High Users and beneficiaries: $35.00 for under six year olds, $20 for children and $15 for patients over 18. b) For other patients: $35 for under six year olds, $15 for children and no subsidy for those over 18 ('GP visits' downloaded from the internet 8th June, 2006 from: http://www.moh.govt.nz/ moh.nsf/wpg_Index/ About-GP+ visits).

[71] 51 GPs (with a total of 80,000 patients) opted for capitation, but this had dropped to 18 GPs by 1949 (Crampton, Sutton, & Foley, 2002). From 1979 renewed interest in capitation began in the Union Health Centres (Malcolm, 2000; Matheson, 1992).

[72] From 1973, insurers included the Accident Compensation Commission which was established to cover the costs of people injured in accidents. This insurance is available to all people in New Zealand (including non-residents and visitors) and is funded mainly by levies on employers, deductions from employees' wages, motor vehicle registrations and a levy on petrol and diesel products.

antagonising key actors in the medical profession, *The White Paper* was a 'political disaster' (Lockett-Kay, 2005) and failed. In 1983 the government increased the subsidy for children, and, although in 1991 fee-for-service subsidies to high income adults were stopped, in 1997 the subsidy for under-sixes was again increased to reduce the co-payments demanded by GPs. Capitation funding remained on the agenda and was taken up by a small number of GP practices.[73] Further, Hospital Boards (progressively replaced by Area Health Boards) were funded by capitation for their public health and secondary services responsibilities from 1983 onwards. However, as per-capita health care expenditure varied greatly, especially between populations at opposite ends of the socio-economic deciles, formulating ideal capitation values was challenging at primary health care level (Matheson, 1992).

In 1987, the government paper *Incentives and Constraints in Primary Health Care in New Zealand* outlined a new strategy to prioritise primary health care (New Zealand Board of Health, 1987). This was to be achieved by changing the regulatory and reward structures for primary health care professionals to increase their accountability and to control costs through capitation. In addition, funding for health promotion and prevention was strongly supported by well-reasoned recommendations (New Zealand Board of Health, 1987).

 (ii)   Structural reform: 1990-2000

Health reforms gathered momentum in 1990 when the incoming National Government established four Regional Health Authorities (RHAs) (Northern, Midland, Central and Southern) to purchase and monitor health care services by collaborating and contracting with locally appropriate health care providers (Barnett & Barnett, 2004a). This strategy followed the market-based reform models (already discussed) in the UK and the Netherlands (Ashton, 1999). The RHAs instigated pilot primary health care projects

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[73]   Capitation funding was negotiated by Otumoetai (in the Bay of Plenty), progressively adopted by Union Health Centres through the 1980s and also by Karori Medical Centre in 1984 (Personal communication: Dr Jeff Lowe, Karori Medical Centre 29th August 2006). [A number of Union Health Centres exist and many are now part of a Primary Health Organisation (PHO), for example Otara Union Health Centre is part of Tamaki Healthcare PHO in Auckland and Newtown Union Health Service is part of SECPHO in Wellington. Seven Union Health Centres belong to Health Care Aotearoa as community-oriented, not-for-profit organisations ('HCA Member Organisations November 2002' downloaded from the internet 31st December, 2006 from: http://www.hca.org.nz/hca. htm).]

based on the UK's Fundholding approach, offering GPs incentives to reduce the RHA's costs in pharmaceuticals and diagnostic services (Malcolm, 2000). Fundholding structural change was not nationally driven as it had been in the UK, consequently its implementation varied regionally (Controller and Auditor-General, 2002a; WHO, 2004).[74] However, where it occurred, GP providers formed umbrella groups, known as Primary Care Organisations (as depicted in Figure 3-5), to negotiate and manage RHA contracts. RHAs included a management services component in these contracts to recognise their reduced workload when they could bulk fund large GP collectives (Central Regional Health Authority, 1996). Primary Care Organisations assumed four broad guises as shown in Figure 3-5, although within similarly labelled organisations heterogeneity existed.

The four broad organisational forms were as follows:
- Independent Practitioner Associations (IPAs), established as limited liability companies or trusts run by GPs; they generally offered an extensive range of services and had professional managers (Barnett & Barnett, 2004b);
- Contracting parties, generally GP-owned medical practices, run as small trusts, or limited liability companies;
- Loose networks that provided an umbrella for GPs to negotiate collective provider agreements with the Regional Health Authority purchaser. The GPs undertook their own management and, therefore, these GPs were not encumbered with the management costs inherent in the above two options;
- Community-owned organisations, including those established as non-government, not-for-profit organisations, to service disadvantaged people with high health needs (Controller and Auditor-General, 2002a).[75]

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[74] By 1997, 15.1% of GPs were on capitation funding. Regionally rates varied from 4.8% to 45% of GPs using capitation funding. By the end of 2001, it was estimated that nationally 22% of GPs were on capitation funding (Crampton *et al.*, 2002).

[75] While a number of IPAs joined the Independent Practitioners Association Council of New Zealand from 2001 for mutual support, Health Care Aotearoa was formed to support community-owned primary health care organisations.

Figure 3-5: GP membership of Primary Care Organisations by November 1999

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                        ┌─────────────────────┐
                        │     Total GPs       │
                        ├─────────────────────┤
                        │      3,159          │
                        └─────────────────────┘
                 ┌──────────────┴──────────────┐
    ┌──────────────────────┐         ┌──────────────────────┐
    │   Primary Care       │         │  Sole Practitioners  │
    │   Organisations      │         ├──────────────────────┤
    ├──────────────────────┤         │     501 (16%)        │
    │    2,658 (84%)       │         └──────────────────────┘
    └──────────────────────┘
 ┌──────┬─────────┬─────────┬─────────┐
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IPAs	Contracting Parties	Loose Networks	Community-owned Organisations
2,123 (67%)	86 (3%)	389 (12%)	60 (2%)
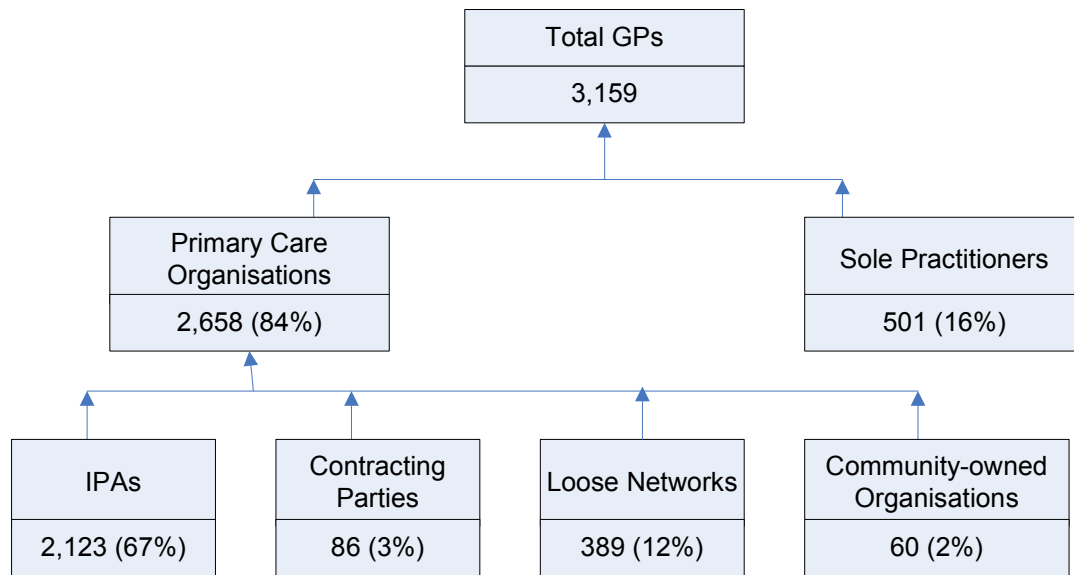
(extracted from Controller and Auditor-General, 2002a)

The RHAs utilised the central funder, Health Benefits Ltd, to process subsidy payments to primary health care providers, requiring computerisation and technological changes in Primary Care Organisations. High-level patient data (relating to gender, age, costs and conditions) could be analysed and was useful for practitioners, the Primary Care Organisations and the RHAs (Malcolm, 2000). Such data provided a basis for GPs to compare and modify their performance around regional norms; an effect magnified with the appointment (under the Health and Disabilities Commissioner Act 1994) of a Commissioner to whom GP's patients could make clinical complaints.[76] Further, when the IPAs collated GP data, IPAs could employ it to co-ordinate continuing education for member GPs, to seek funding for programmes to meet local health needs that may have traditionally been the domain of secondary or specialist care, and to develop GP cooperation, rather than competition on quality and price (Barnett & Barnett, 2004a).

As noted in Chapter 1, a further change of Government in 1999 reversed the policy of centralisation of health services and, in December 2000, the Labour Government launched the *New Zealand Health Strategy* (*Health Strategy)* (Minister of Health, 2000)

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[76] The Health and Disabilities Commissioner's Code is similar to the 1992 UK Local Voices reform as complaints are judged against a Code of ten rights of consumers of health and disability services. The Commission does not make judgements on funding or consumer entitlement. (Information about this independent but government funded organisation, was downloaded from the internet 15th July 2007 from http://www.hdc.org.nz.)

as a new framework with fundamental principles, national health system goals and objectives. These were to underpin a reformed health system designed to reverse declining health care statistics (particularly in Mäori and Pacific peoples' communities) and to improve the health status of all New Zealanders. Twenty-one District Health Boards (DHBs) were created on 1 January 2001[77] under the New Zealand Public Health and Disability Act 2000 to purchase local services. These DHBs are accountable to the Minister of Health (not the public) but retain public elections for 7 of the 11 Board members. Each DHB must hold open board meetings and involve the community in DHB planning processes through consultation.

As underlying principles, enunciated in the *Health Strategy* by the Ministry of Health, the DHBs and service providers were to:

- acknowledge the special relationship between Mäori and the Crown under the Treaty of Waitangi;
- promote good health and wellbeing for all New Zealanders throughout their lives;
- improve the health status of those currently disadvantaged;
- ensure collaborative health promotion, and disease and injury prevention, by all sectors;
- provide timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of their ability to pay;
- develop a high-performing system in which people have confidence;
- ensure active involvement of consumers and communities at all levels (Minister of Health, 2000).

To improve health outcomes, the *Health Strategy* outlined ten overriding goals and 61 population health objectives (these are outlined in Appendix 3). Thirteen of these 61 were defined as prime objectives for short to medium term implementation. In respect of meeting these objectives, the Government identified five service priority areas that DHB purchasers were to take into account for any new funding that became available, namely:

- public health (including health promotion and education);
- primary health care;

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[77] Their geographical distribution is shown in Appendix 1.

- reducing waiting times for public hospital elective services (to a maximum of six months) to increase equity;

- improving the responsiveness of mental health services (through collaboration);

- providing accessible and appropriate services for people living in rural areas (Minister of Health, 2000).

Despite free-market terminology permeating primary health care, expenditure figures from the year ended 30 June 2001 show government expenditure on GP services was 51%, exceeding that of individuals' co-payments and insurance premiums (at 49%) (Ministry of Health, 2004a).[78] However, Crampton *et al.* (2005) suggested that this level of funding is unusually low for a liberal democratic welfare state such as New Zealand and compared it unfavourably to that in the UK where comparable services are 100% government funded, and Australia where government subsidises 85% or 100% of the GP fee.

(iii) Changing the focus of the primary health care system - 2000 onwards

In 2000, *Improving Health for New Zealanders by investing in Primary Health Care* (National Health Committee, 2000) recommended that the government re-orientate the health care system in line with the Alma Ata Declaration (WHO, 1978) and capitalise on the extant Primary Care Organisations already contracting with the DHBs. The subsequent release of the *Primary Health Care Strategy* in 2001 (Minister of Health, 2001) adopted these recommendations, seeking to improve citizens' health and reduce inequalities by:

- introducing capitation across all primary health care;

- involving communities in projects that would benefit local populations (addressing both equity of access and health promotion); and

- encouraging multisectoral collaboration in disease prevention and management.

Forerunner Primary Care Organisations have formed not-for-profit PHOs to contract with DHBs on a capitation basis to provide health care for enrolled New Zealanders.[79] In turn,

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[78] It was more recently assessed that the average expenditure by government was 70% and patient co-payments at 30% (Ministry of Health, 2006a).

[79] PHOs' structures vary widely and include collaborations of a number of Primary Care Organisations,

PHOs contract with health providers (primarily, but not restricted to GPs), similar to the development of NHS PCTs in the UK but without the formal engagement of Local Authorities (Crampton *et al.*, 2005). This 'contracting-out' system is funded partly by patient co-payments but predominantly by general taxes through increased government funding. A visualization of the change from an illness focus to community health responsibilities is shown in Figure 3-6 where PHOs' responsibilities are labelled 'primary health care'.

Figure 3-6: PHOs' responsibilities under the *Primary Health Care Strategy*[80]
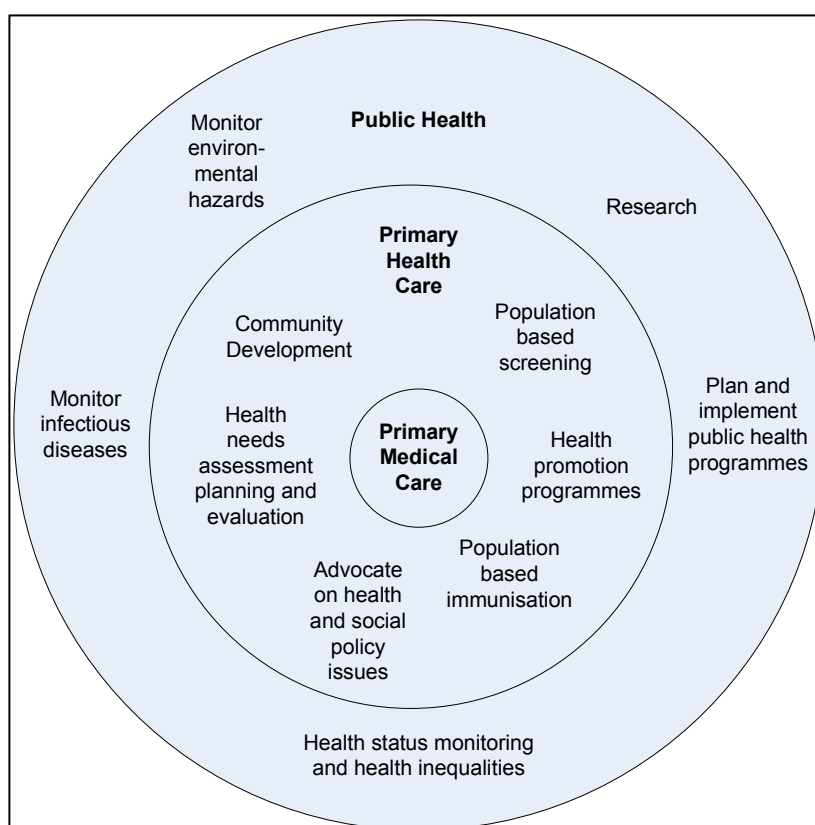
Patients may enrol with only one General Practice at a time and are encouraged to obtain all primary health care needs from that Practice. Although no regulatory mechanisms in respect of patient 'voice' are specifically provided for in the *Primary Health Care Strategy*, patient's clinical complaints may be heard by the Health and Disabilities

owned by a single IPA or GP Practice (as described in Chapter 1). GPs separately retain their membership in IPAs in order to be represented in industrial advocacy, be supported in education, improve the quality of professional practice and to undertake project management to produce better health outcomes (Fountain, 2006). In addition, the Independent Practitioners' Association Council of New Zealand has provided a single voice for organised General Practice since its inception in 2001.

[80] Extracted from presentation by Dr Peter Crampton "Population health and primary care" at the Primary Health Care Development Programme: Health Services Research Centre, Wellington, October 2007.

Commissioner, and the existence of numerous PHOs with General Practices contracted to them potentially promotes competition and provides patient 'exit' models.[81] Further, as the government requires PHOs to be not-for-profit organisations, it assumes that the benefits of cost efficiencies and higher quality as well as increased social capital (as outlined in Chapter 2) will at least partially remedy the effects of inadequate information.

3.6.2. *Primary Health Care Strategy funding*

The 21 DHBs – Crown Entities[82] – are responsible for funding and coordinating services to meet their community's health needs.[83] Two capitation schemes originally introduced under the Primary Health Organisation Agreement (Version 17) (Ministry of Health, n.d.) – Interim and Access – were employed for funding first contact services delivered by PHOs between mid-2002 and mid-2007.[84] The dollar funding amounts are detailed in Appendix 2. The Interim capitation was designed to meet the needs of citizens who had light to moderate primary health care requirements and dwelt in non-deprived areas. The Government progressively increased Interim PHOs' funding, rolling out the increased funding for particular age demographics over the period from 1 October 2003 to 1 July 2007 (beginning with under 18s and over 65s in 2004, the 18-24 age group in 2005, 45-64 age group in 2006 and finally, the 25-44 age group in 2007) (Abel, Gibson, Ehau, & Tipene Leach, 2005).[85] Accordingly, from 1 July 2007, all PHOs are effectively Access-funded.

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[81]   The freedom of patients to 'exit' providers is not a new feature of the *Primary Health Care Strategy*. Further, in some geographical areas, there may be no choice over which PHO people belong to.

[82]   Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister(s); their activities are included in the annual financial statements of the Government (Crown Entities Act 2004).

[83]   A DHB's governing Board must include up to seven local representatives (elected triennially) and up to four individuals appointed by the Minster of Health. DHBs are expected to undertake community consultation and, as purchasers of primary health care services, contract with PHOs to improve local health outcomes and reduce health inequalities.

[84]   GP services to patients who are not enrolled in a PHO (and are therefore defined as casual users) are still covered by fee-for-service funding (see footnote 70). Primary health care providers that are not PHOs may continue to claim the pre-PHO fee-for-service funding (Hefford, Crampton, & Foley, 2005).

[85]   Benefits paid to Interim PHOs for the Community Services Card users (low income earners and social security beneficiaries) enrolled with them was higher than for non-Community Services Card users. However, the government has signalled that this card will be phased out over the period from 2011 to 2013.

Initially, Access PHOs were defined as PHOs with enrolled patients dwelling in lower socio-economic areas[86] and, as a result, they received higher levels of funding to meet the primary goal of reducing health disparities so that patients paid no, or very low, co-payments for consultations. The understanding was that, as Interim PHOs received the higher capitation per enrolled member available to Access PHO members, their patients' co-payments would reduce.

In addition to funding for first contact services, which is typically passed on directly to the contracted providers, every PHO receives a number of other capitated funding streams as shown in Figure 3-7. These are: Services to Improve Access (SIA), Health Promotion and management fees. In addition, first contact services funding is increased for Care Plus,[87] Very Low Cost Funding[88] and Zero Fees for Under 6s.[89] Payments are also made to PHOs to cover delivery of immunisation services[90] and (from 2007) performance-based incentive funding.[91]

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[86]   As noted in Chapter 1, a deprivation index is used to measure relative social and economic disadvantage. Access PHO populations have concentrations of enrolled individuals living in NZ Deprivation Deciles 9 and 10.

[87]   'Care Plus' is a scheme for high users of health services; PHOs are provided with a higher level of capitation funding for patients who require 'intensive critical management' Funding is based on expected numbers of the PHO's 'Care Plus' patients and actual patients enrolled. For eligible PHOs, the funding is $199.51 per expected number of patients in an Access PHO and $211.75 for Interim PHOs (Ministry of Health, 2004c). Utilisation of this funding ranges between 40 percent of the eligible figure to over 100%.

[88]   'Very Low Lost Access Payments' comprises an individual practice and a PHO component when Practices maintain patient co-payments at or below the maximum levels set by the Ministry of Health (from 1 July 2008 these are $0 for under 6, $10.50 for patients aged 6-17 years and $16 for those aged 18 years and older). Payments range from $12.47 p.a. (male in 25-44 age group) to $79.48 (male child under 5).

[89]   'Zero Fees for Under 6s' is a payment for Practices belonging to a PHO participating in the Performance Management Programme who offer free standard consultations to under 6 year olds. The funding ranges from $1.67 p.a. (male 5 year old) to $59.61 p.a. (male under 5).

[90]   Specific public health immunisation services (for example Meningococcal B vaccine) are 100% government funded, i.e. PHOs are funded to deliver these to particular population free of charge.

[91]   Performance-based incentive funding is available to qualifying PHOs are at a rate of $2.67 per enrolled patient every six months (Douglas, 2006). Although the instigator, the Health Information Standards Organisation, became operational in December 2003, the performance management indicators were not developed for PHOs until 2006 (Controller and Auditor-General, 2006).

Type of funding	Explanation of funding type	% paid in this form	Basis of payment of capitation funding
To PHO			
First Contact services	To fund services based on socio-economic and age demography of enrolled patients	71%	Ranges from $52 p.a. (male in 25-44 age group) to $327 p.a. (male child under 5)
Services to Improve Access	To fund innovative ways to improve access to high need populations[93]	6%	PHOs devise and make application for projects
Health promotion	To develop health promotion activities within community	1.3%	Ranges from $1.85 to $2.89 per enrolled patient
Management fees	To recognise administrative costs of the PHO based on the number of enrolled patients	4.7%	For PHOs with up to 40,000 patients enrolled, $13.85 per patient up to 20,000 plus .80 thereafter. Larger PHOs, $4.60 up to 75,000 and tiered amounts above this
To DHB			
Pharmaceutical co-payments	Funding being phased in to reduce prescriptions co-payments	16.5%	$10 per pharmaceutical item (reduces patient co-payment from $15 to $5)
Laboratory payments	To reflect likely extra costs of laboratory services	0.5%	On application.

The Ministry of Health also provides supplementary rural funding to PHOs in rural districts to enhance these communities' medical services (a priority of the *Health Strategy*). Rural communities have diverse age and socio-economic populations that may suffer restricted access to primary health care as a consequence of a lack of transport and high costs; the costs may be monetary, or stem from the patient having to be absent from their employment for a long period to travel further than urban patients to visit the health professional (Panelli, Gallagher, & Kearns, 2006). Rural funding, which includes a rural bonus, rural workforce retention and a reasonable roster payment, seeks to subsidise primary health care provision to alleviate these communities' costs and assist rural PHOs

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[92] Capitation comprises 85% of the Government's primary health care funding in the 2006/7 year (Ministry of Health, 2006a).

[93] This funding is paid to PHOs for all Māori /Pacific enrolled and also for non Māori/Pacific enrollees whose demographics are Decile 9 and 10 (for rates see Appendix 2). The funding is for new services or to improve access. It has been used for a variety of projects, including the Whanganui Accident and Medical clinic, a collaborative effort to provide emergency care from 8am to 9pm daily (Yeats, 2006a), and interpreter services at a number of PHOs (for example Cameron, 2006b). DHBs approve SIA funding before PHOs spend it, but the Ministry of Health also demands that DHBs forward a summary of the proposal to them so that there is a consistent application of the conditions (Ministry of Health, n.d.). This lack of autonomy potentially reduces PHOs' legitimacy in their communities. This was illustrated in Nelson Bays where one GP described the PHO as a generator of local frustration because it was 'another layer of bureaucracy' with 'no independence' from the DHB (Mitchell, 2006).

attract and retain health professionals.[94] In addition, the Ministry of Health recruits overseas GPs, targets medical students and encourages locums in order to assist rural areas secure health professionals. It also encourages PHOs to increase opportunities for nurses in these areas (Ministry of Health, 2004c).

3.6.3.   Perceived difficulties with PHO funding

DHB contracts with PHOs for primary health care services include some unique features. Rather than contracts for service that focus on inputs and outputs, PHO funding is intended to improve outcomes and therefore extends beyond counts of service use as had occurred previously in fee-for-service reimbursement of GP consultations. In addition, contracts have an 'evergreen clause' with termination provisions rather than a requirement that the contract be re-negotiated and tendered for annually. DHBs are required to contract with PHOs for primary health care rather than to deliver the service themselves (Minister of Health, 2001). As this new style of contracting has developed, it has not been without its tensions, as described below.

(i)   Concerns of the Funder

Government spending on primary health care has accelerated since the *Primary Health Care Strategy* was implemented. Appropriate funding relies on knowing the 'true cost' of primary health care and, as previously noted, this calculation is complicated by socio-economic and quality considerations. Due to fears that health professionals and PHOs may overstate funding needs (Howell, 2005), the Ministry of Health instigated a review of fees to ensure that, as Interim funding was increased to Access funding levels, GP's co-payment charges were correspondingly reduced (Ministry of Health, 2004b). GPs have accused the government of 'price-fixing', and have also complained that PHOs were not arguing fiercely enough on their behalf, with some threatening to change their allegiance to another PHO more aligned to GP's requirements (Yeats, 2006b).

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[94]   The difficulties are such that the West Coast DHB has taken over the Reefton Medical Practice and employs GPs for that Practice and to service Franz Josef ("West Coast District Health Board" downloaded from the internet 22nd October, 2006 from www.southerndoctor.co.nz/view_rec_ad.cfm?empID= 50; "Rural board lures top doctors" downloaded from the internet 30th October, 2006 from http://tvnz.co.nz/view/page/862451). Hefford *et al.* (2005) suggest this should occur nationally.

The Controller and Auditor-General (2002a) identified potential problems in the DHB-PHO purchaser-provider relationship resulting from a lack of understanding of primary care at purchaser (DHB) level, combined with the DHBs' high staff turnover. These relational difficulties were confirmed in a recent study (Cumming *et al.*, 2005).

(ii)   Concerns of the PHOs as fundees

Understanding operational issues is integral to appropriate funding regimes. Initially the management fees paid to PHOs were insufficient to fully reimburse smaller PHOs which had relatively high fixed operational costs. For this reason, in late 2005, PHOs with less than 40,000 enrolled patients that could demonstrate efficiencies were eligible for a 'top-up' to their management fee. Reportedly, these PHOs considered the new amount was insufficient to make a significant difference to sustainability (Cameron, 2006c). However, in the absence of minimum size requirements for PHOs, and with the perception that decentralisation encourages community input, the way to address this issue is not clear (McCardle, Norgrove, Jordan, & Gouldstone, 2004).[95] Limited funding potentially stimulates ongoing tension between DHBs and PHOs that seek to develop appropriate services assigned to improve their community's health (Abel *et al.*, 2005; Crampton *et al.*, 2005; Hefford *et al.*, 2005).

3.6.4.   *Primary Health Organisations' structures*

(i)   Structured to achieve objectives

Structurally PHOs reflect the early collaborations - IPAs, Community-owned organisations, loose collaborations and other contractors - with the majority of PHOs incorporated as charitable trusts, or companies with a not-for-profit purpose and a small number being Incorporated Societies (Perera *et al.*, 2003). Core to their not-for-profit purpose, PHOs may not make distributions to their members or health care providers and must not be carried on for the purpose of profit or gain to an individual or organisation. However, Abel *et al.* (2005) suggest that when profit-oriented IPAs control limited

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[95]   A similar issue exists with DHBs which vary in population base (and therefore funding). Barnett and Clayden (2007) reported no support for forced or voluntary amalgamation, but that economies of scale may be achieved through strategic alliances.

liability PHOs, they are operating a private sector model.[96] DHBs tolerate a variety of PHO structural models (Abel *et al.*, 2005), although one community at least (Nelson) has stated its preference for a community trust rather than a 'business-focused' charitable company (Nichols, 2004). These tensions will be further explored in Chapter 8.

At a high level, the Greater Wellington Health Trust (2002) defined the three major functions of PHOs as:

- supporting and managing PHO functions, including the provision of:
    - administrative functions in relation to PHO members and funding;
    - support by education of front-line providers;
    - staff who could work over multiple clinics (if any) within the PHO;
- strategic governance, including collaborating with community and other stakeholders;[97]
- providing front-line services through clinics and other services.

The administrative functions of a PHO are frequently contracted out to management services organisations in respect of register and capitation management (McCardle *et al.*, 2004). PHOs may provide front line services by contracting or forming partnerships with service providers (e.g. GPs and nurses). These frontline providers may be incorporated as, *inter alia*, profit-oriented entities, sole providers or not-for-profit organisations.

In respect of governance, under the *New Zealand Primary Health Care Strategy* PHOs must demonstrate that PHO decision-making can be influenced by all providers (Minister of Health, 2001). Thus, nurses, other non-GP providers and community representatives potentially have a voice in a sector where GPs have traditionally held powerful positions. Matheson (2002) suggests that this should lead to comprehensive services that improve community health. Nevertheless, within some PHOs, the possibility of GP capture within the provider-PHO relationship makes meaningful participation of other representatives difficult (Abel *et al.*, 2005). However, GPs have also complained that their voice is being

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[96] The continued presence of IPAs in PHO's infrastructures surprises some commentators, especially as, notes Fountain (2006, p.1) "[t]he IPAs were written out of the Primary Health Care Strategy and told to go away."

[97] Governance of PHOs is undertaken by a Board of Directors (limited liability company), Trustees (charitable trust) or a Management Board (incorporated society). Unless a specific PHO with Trustees is discussed, both Boards and Trustees will be called "Boards" in this Chapter.

diluted (Topham-Kindley, 2005; Yeats, 2006b). As PHOs must operate a Mäori Health Plan, most PHO Boards have Mäori representation and those PHOs with Pacific enrolled populations also have a Pacific representative on the Board.[98]

As noted, community participation is foundational to achieving the cost-effectiveness sought when government contracts with not-for-profit organisations. Participation is most effective when Board members are representative of the community, knowledgeable about health care issues and, preferably, are elected by those communities (Church *et al.*, 2002; Lockett-Kay, 2005; Wilmot, 2004). Yet Lockett-Kay (2005) recognised that staff, providers and Board members undertake significant voluntary work for their PHOs and this may lead to under-performance if they lack the motivation or time to fulfil their obligations. There is a potential risk that government may under-fund not-for-profit organisations that rely on volunteers and philanthropy to subsidise social services delivery (Van Til & Ross, 2001).

 (ii)   Legal Concerns

The legal position of the *Primary Health Care Strategy* has been questioned by Wilson and Saunders (2005) who expressed concern that, without legislation, the creation and confines of PHOs can be engineered by the Ministry of Health without a Parliamentary Regulation Review Committee review. Despite legal advice to encourage the Ministry of Health to employ statutory instruments in respect of these primary health care arrangements (Buddle Findlay, 2002), this has not occurred.

Wilson and Saunders (2005) are also concerned that:
- preferential treatment to specific populations (Mäori and Pacific) through SIA funding may contravene the Human Rights Act 1993. However, to date, no PHO has had to face litigation in this respect.
- DHB−PHO contracts may contravene PHO obligations under the Commerce Act 1986 (Wilson & Saunders, 2005). Buddle Findlay (2002) recommended that PHOs carefully assess their business practices to ensure that they did not restrict

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[98]   The PHO Agreement and the *Mäori Health Strategy* (He Korowai Oranga) require PHOs to reduce Mäori Health inequities by being familiar with Mäori health needs in their area, and developing and fulfilling a Mäori Health Action Plan. These requirements may be more challenging for non- Mäori PHOs.

providers from contracting with other PHOs; or restrict individuals from becoming members for other than legitimate reasons.

3.6.5. *Challenges faced by Primary Health Organisations*

Three main challenges are faced in the PHO era. These are the:
   (i) change from an illness to a wellness focus;
  (ii) managing a short-term funding regime and government demands;
 (iii) balancing of stakeholders and community foci.

(i) Changing from an illness to a wellness focus

It is widely acknowledged that the extension of primary health care in line with the Alma Ata Declaration (WHO, 1978) is such a change in viewpoint that it is like 'mixing oil and water' (Meads, Killoran, Ashcroft, & Cornish, 1999). A change from an illness focus to a wellness focus with increasing responsibilities (as depicted in Figure 3-6) encourages PHOs to develop and expand services to compensate for a reducing DHB role in primary health care. In order to meet the requirement of the New Zealand *Primary Health Care Strategy* (Minister of Health, 2001) to improve community health, PHOs must confront social justice issues, balance competing demands and collaborate inter-sectorally, to encourage non-health sectors to identify and tackle health related issues (Auckland Regional Public Health Service, 2006). The National Health Committee (2000) suggested that disorders not amenable to medical intervention represented the areas of largest difference in national mortality rates, whilst the Minister of Health (2001) indicated that direct health services contribute merely 20 percent towards health improvement. To tackle wellness, may extend PHOs beyond traditional health tasks and involve them in advocating for appropriate government policies on education, income, occupation and the economy.

(ii) Managing a short-term funding regime and government demands

Abel *et al.* (2005) contend that a key challenge for achieving improved community health is establishing priorities for long-term population strategies over the immediate health needs of individuals. In addition to the barrier that short-term funding of long-term

programmes raises, disease-focused outcomes and clinical care outcomes measures need to be augmented by data collection on public health. Such data collection can be time consuming, difficult to analyse and may not fit neatly into a funding cycle.

In addition, PHOs need to be autonomous from government if they are to achieve long-term health goals. As they are funded by government, PHOs' independence may be reduced (Leslie, 2006). The document: *Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown* (The Treasury, 2003) recognises that PHOs' clinical and business decisions, and unique strategic and policy directions may differ from those held by the DHB. However, a PHO's ability to advocate for specific communities may be limited when it is required to comply with the Crown's strategic and policy directions and DHBs limit a PHO's ability to meet community needs.

Perera *et al.* (2003) found that PHOs that were able to use existing community involvement networks in their first year of operation were better able to argue a community position to their DHB. These PHOs were better placed to engage their communities and to be transparent in their decision-making.

(iii)   Balancing stakeholders and community foci

Craig (2003) understood that 'Third Way' policy borrowing is behind recent New Zealand health reforms to decentralise and move government closer to people, thus localising accountability. However Craig (2003) noted that New Zealand lags Britain in funding 'joined-up' approaches, although the raising of equity and access issues and talk of partnership is becoming increasingly common at policy level (Matheson, Howden-Chapman, & Dew, 2005).

Ensuring meaningful community participation is as a key issue for PHOs (Cumming *et al.*, 2005). The Health and Disability Sector NGO Working Group (2005) has noted a concern that some PHOs are not taking opportunities to work with other organisations in the community or to engage in cooperative relationships. Further, it has been reported that many community members do not know how to input to PHO decision-making and that PHOs have not yet been able to find the resources to be open to communities.

The obligation to consult with, and be accountable to, their community adds an additional layer of responsibility for PHOs (Ashton, Cumming, & McLean, 2004). The *Primary Health Care Strategy* states that quality primary health care will be "universally acceptable to people in their communities [and] involves community participation" (Minister of Health, 2001, p.1). The literature suggests that stakeholders should be a strong structural component of each PHO, and that consultation should be an important part of a PHO's accountability to its communities. However, the variety of PHO models and the challenges identified above will affect the nature of consultation and the extent of community participation in PHOs. Integration of accountability concepts with the PHO environment, is developed further in Chapter 4.

3.7.   *Summary*

This chapter has presented an overview of primary health care policies and practice in the USA, the Netherlands, Australia and the UK as well as detailing the New Zealand primary health care reforms. Free market models with minimal government involvement in the USA and the Netherlands are at one end of the policy continuum. The Australian government uses a 'contracting-out' system to provide social insurance. Although New Zealand's ACC system is similar (with wage-related premiums and cover for all citizens), the primary health care system in New Zealand more closely resembles the UK focus on primary health care and local participation. These were highlighted as 'Third Way' policies in Chapter 2.

It appears that by requiring accountability to the community, the *New Zealand Primary Health Care Strategy* (Minister of Health, 2001) seeks to build on and increase social capital. In addition, by choosing to contract only with not-for-profit PHOs, the government is likely to purchase cost-effective, quality primary health care from convergent expectations.

In the next chapter relevant accountability literature will be reviewed to build a model for this research. In addition, linkages will be made to accountability requirements imposed on PHOs by their stakeholders.

4. ACCOUNTABILITY

4.1. *Introduction*

In a functioning society, if activities are to achieve more than individuals can achieve alone, collaboration is required. Cooperative activity necessitates acknowledgement of joint goals, often delegating resources, consequent performance, tailored reporting and feedback (Levaggi, 1995). Accountability processes reflect interdependence within social relationships (Roberts, 1991).

Primary Health Organisations (PHOs) are required to be 'fully and openly accountable' for all public funds they receive and for the quality and effectiveness of the services they provide (Minister of Health, 2001). However, according to research conducted in the United Kingdom (UK) "there is a great deal of confusion about what the concept of accountability means" (Day & Klein, 1987, p.1); Penney (2002) who attempted to build a framework for accountability in the Canadian health system, concurred with Day and Klein's conclusion. Although Birkett (1988) argued that concepts of accountability are widely applicable to interdependent situations, more recent literature suggests accountability frameworks are historically and culturally distinct, rather than universal (Bovens, 2005a; Goddard, 2004). This distinctiveness derives from different paradigmatic framings and, as accountability is socially constructed (Dubnick, 2002; Sinclair, 1995), it is necessary to be specific about the meaning of 'accountability' in any given context.

This chapter defines accountability within the context of not-for-profit PHOs and posits a framework comprising the three components recommended by Dubnick and Justice (2004), namely:

- the social relationship (to whom accountability is owed and the role that accountability plays in that relationship);
- for what delegations accountability is demanded; and
- the processes and mechanisms by which accountability is discharged.

4.2. *Definition*

The Oxford English Dictionary defines the term accountability as: "a liability to give account of, and answer for, discharge of duties or conduct; responsibility, amenableness." This definition suggests an underlying relationship where one party (the acceptor) has accepted delegated responsibility from another (the delegator) and is answerable to that party for actions (or inactions) related to the discharge of the responsibility accepted (Lawry, 1995; Mulgan, 1997). The relationship between these parties is fundamental to accountability (Fry, 1995; Office of the Auditor-General of Canada, 2002). Responsibilities delegated and accepted have explicit and/or implicit terms and conditions attached and, in appropriate cases, are accompanied by the provision of resources to facilitate the discharge of the responsibility. In respect of the absence of demands or discharge of accountability, Appendix 4 suggests a number of risks that are developed through this chapter.

While acceptance of a responsibility connotes action, both Normanton (1971) and Bovens (2005b) suggest that accountability is the post-mortem of action. Accountability complements responsibility, as the discharge of accountability involves an account of the manner in which the responsibility has been discharged (Day & Klein, 1987; Jonsson, 1996; Roberts & Scapens, 1985). It should also be noted that there is a distinction between accountability and answerability. When the delegator has the authority to demand an account and impose sanctions, or give rewards to the acceptor, accountability subsumes answerability (Birkett, 1988; Harris & Spanier, 1976; Mulgan, 2003; Normanton, 1971; Stewart, 1984).

Primary health care purchasers, providers and recipients enter multiple, interdependent social relationships that include the acceptance of delegated responsibilities and require acceptors to account, as the post-mortem of action, on the quality and effectiveness of the discharge of the responsibilities accepted. In the context of primary health care, external evidence of the acceptance of responsibility includes, *inter alia*: a contractual relationship between a not-for-profit organisation such as a PHO and its District Health Board (DHB) under which the PHO accepts responsibility for providing defined primary health care services to PHO members (including patients), a contractual relationship between a health provider and the

relevant PHO, an individual confirming their nomination for a position on a governing board, or accepting employment from such a board or a PHO. Figure 4-1 shows some of the parties with whom a PHO may enter accountability relationships.

Figure 4-1: PHOs' relationships of accountability under the Primary Health Care Strategy
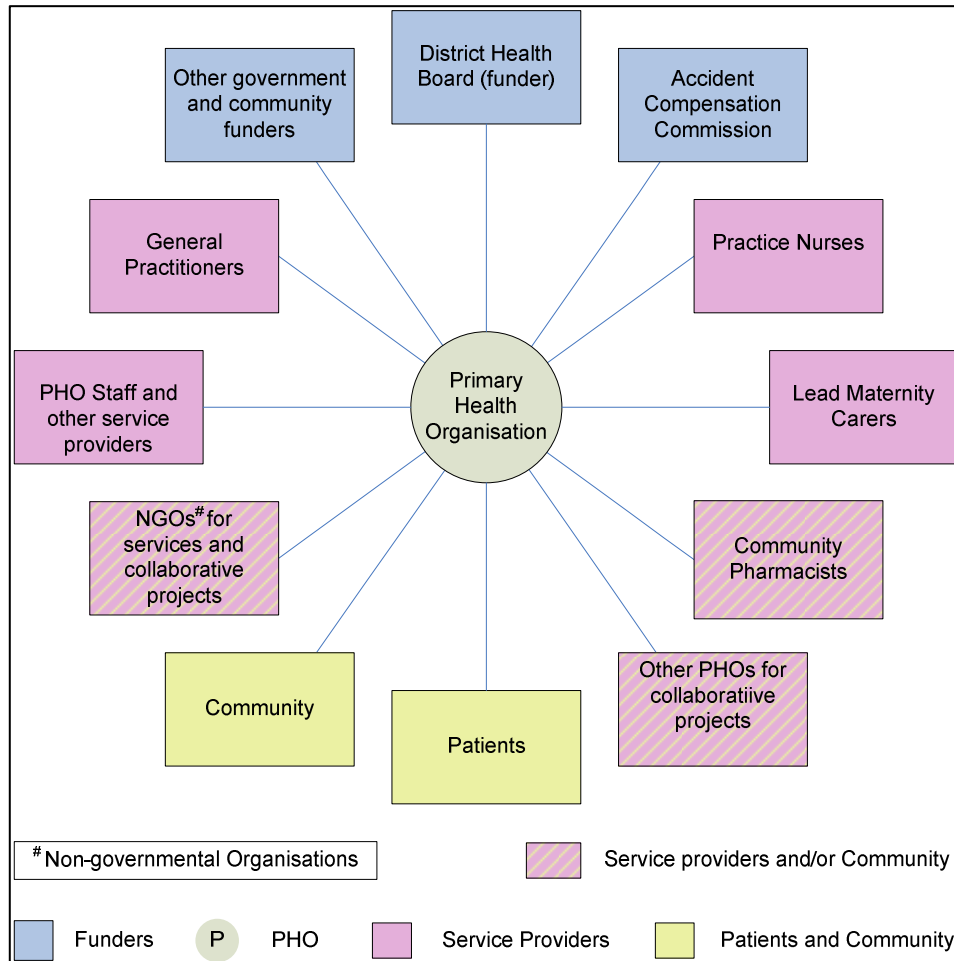
(derived from the *Primary Health Care Strategy*)

4.3. *Accountability and the social relationship*

4.3.1. *The acceptor and delegators*

This research is focused primarily on the discharge of accountability by PHOs – complex organisations with multiple accountability relationships (as reflected in Figure 4-1). PHOs accept delegated responsibility from funders, and contract to secure services from (or enter into Memoranda of Understanding with) profit-oriented providers as well as not-for-profit organisations, thus enabling them to deliver the health services agreed with their funders. Bovens (2005b) described the question of

who should be held responsible for the conduct of complex organisations as the 'problem of many hands' and argued for separate accountability models based on whether individuals or corporate entities enter accountability relationships. By specifically requiring PHOs *per se* to be 'fully and open accountable', the *Primary Health Care Strategy* (Minister of Health, 2001) seems effectively to accept the notion of organisational accountability and reject those of:

- individual accountability (as in the Biblical Parable of the Talents) where an individual is answerable for action (or inaction) to a single delegator for specific tasks, with singular consequences;

- individual-collective accountability – a joint and several notion where each member of a group has an equal chance of influencing the group's behaviour, the performance of, and reporting on, the responsibilities accepted by the collective. PHO's legal structures, which usually take the form of a limited liability company, incorporated society, or charitable trust (as described in Chapter 3) typically reduce the monetary liability of an individual to their initial contribution to the collective body.[99] While members of a PHO's governing Board may be held accountable for the PHO's non-financial performance, the notion of individual-collective accountability does not seem to be applicable to this study;

- individual-hierarchical accountability, whereby a responsible individual (for example, a CEO) is accountable to the delegator(s) on behalf of an organisation. Although management has a role to play in organisational accountability, Sinclair's (1995) interviews with 15 Chief Executives of Australian public sector organisations showed that their accountability discourses focused on matters that were internal to an organisation, rather than accounting to a broad range of external delegators.

Although organisational accountability provides the most appropriate framework for this research in that it is the PHO *per se* which accepts responsibility to deliver primary health care services to members and local communities, it is acknowledged that an individual (the CEO or Chairman), or a group (the Board) may also be called

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[99] For example, a PHO could be established with a vesting of $10 and Trustees' liabilities limited to that amount.

to account by those who delegate responsibilities to a PHO.

Figure 4-1 depicted a number of groups to whom PHOs are accountable when they accept responsibilities. For the purposes of this research these groups are termed stakeholders and normatively, Freeman (1994, p.46) defines a stakeholder as "any group or individual who can affect or is affected by the achievement of the organisation's objectives." As PHOs are not-for-profit organisations, the lack of a single focus on profit and the absence of shareholders as primary stakeholders means that they face competing demands from multiple groups "more acutely and more regularly than do private firms" (Ebrahim, 2003b, p.814). Conflicting expectations of multiple stakeholders (termed by Bovens, 2005b, the 'many eyes' of accountability) may disable PHOs from discharging accountability to each group of stakeholders effectively (Edwards & Hulme, 1996). Such a finding was a result in Koppell's (2005) study of a not-for-profit organisation that was beset by a 'multiple accountabilities disorder', due to disparate stakeholders. Lawry (1995) expands on how these conflicts may occur:

> *It may be the case for too many nonprofits that the expectations of different constituent groups are conflicting or even contradictory. One group may place a high value on efficiency. Another one on the cooperation of one nonprofit with another. (p.178)*

Not only may stakeholders expectations be contradictory, but the incentives offered and/or potential sanctions accompanying the conflicting expectations may cancel each other out, hindering the effective discharge of accountability (Heath & Norman, 2004).[100] This may occur in primary health care when the funder's expectations that primary health care managers will contain costs require the manager to trade off demands from the community for emergency equipment (such as a defibrillator), against demands from health care professionals for a programme to encourage patients to stop smoking, and scarce resources. As it is unlikely they will meet all expectations, the manager could choose to cut costs with answers that are sub-standard (a cheap defibrillator or a smoking cessation programme for diabetic patients only). Such a result was found in the study of Irish Credit Unions by Hyndman *et al.*

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[100] In their review of the public sector, Heath and Norman (2004) differentiated between 'multi-task' problems and 'multi principal' problems. Bovens' (2005b) problem of 'many eyes' is a 'multi principal' problem, whereas the requirement to be accountable for 'multi tasks' is considered in Section 4-5.

(2004); the organisations' managers were unable to prioritise and reconcile their multiple accountabilities and, as a consequence, they "were often unable to devote significant consideration to the wider issue of accountability" (p. 276). In order to overcome the difficulty of trying to satisfy simultaneously disparate accountability demands, a not-for-profit organisation may:

- prioritise funding relationships so that the dominant or 'upward' stakeholders (such as DHB funders) more readily obtain an account from the not-for-profit organisation than 'downward' or 'inward' stakeholders (for example, PHOs' patients and service providers) (Kearns, 1994; Lawry, 1995; Leat, 1990; Najam, 1996);

- focus on fee-paying services [such as General Practitioner (GP) consultations] at the expense of a core mission that may have a poorer funding stream (for example long term community development work) (Edwards & Hulme, 1996; Najam, 1996); or

- as in Chang's (2006, p.77) study of UK health services managers who faced multiple stakeholders, prioritise by acting "in line with the constituent's interest that was the most compatible to their own." From an organisational viewpoint, this may equate to resisting changes in focus or mission.

Lawry (1995) and Barrett (2001) contend that a taxonomy of stakeholders is instrumentally valuable to an organisation. If an organisation's stakeholders are not defined, this may lead to difficulties in developing effective responses to stakeholder accountability demands (Preble, 2005). O'Connell's (2005) study of government reform in a health-related transport programme in the United States indicated that accountability is more effectively discharged when relational stakeholders are identified at a local level and the organisation closely interacts with stakeholders. The study found that when stakeholders' demands were balanced by negotiation, improved programme outcomes ensued.

It seems to follow that the solution to the 'many eyes' of accountability problem lies, at least in part, in identifying and prioritising the organisation's stakeholders. In Cribb's (2005b) New Zealand study of four not-for-profit organisations, staff and Board members were asked to whom they believed they were accountable. The stakeholders prioritised by these interviewees were:

- clients ('downwards');
- secondly, internal stakeholders such as organisational members ('inwards'); and
- thirdly, government as the primary funder ('upwards').

Volunteers and peer organisations (potentially 'horizontal' or 'downwards' stakeholders) were not afforded priority.

This study seems at odds with other literature where funders are accorded primacy. However, Cribb's (2005b, p.109) study was based on managers' preferences, and she noted that "actual mechanisms to implement the perceived accountability to clients generally did not exist." Assuming constrained resources were to blame, she called for funders to modify their demands so that organisations could accommodate 'downwards' and 'inwards' stakeholders in their discharge of accountability.

In the PHO case, some stakeholders depicted in Figure 4-1 are readily incorporated into defined categories - funders are 'upwards' stakeholders, 'inwards' stakeholders are providers, and the PHO's patients and community are 'downwards' stakeholders. However, classification of two groups (NGOs and other PHOs) is less clear. PHOs are required to collaborate inter-sectorally with NGOs (such as primary mental health providers) and other PHOs in their community to reduce inequalities and promote healthy communities. Collaboration would suggest a 'horizontal' relationship. However, the concern (raised by the Health and Disability Sector NGO Working Group, 2005 and noted in Chapter 3) that collaboration is not occurring in all areas, suggests that NGOs and other PHOs may have little power to demand accountability and may not be perceived by PHOs as stakeholders, or may be accorded 'downwards' status.

Figure 4-2 therefore depicts the re-classification of stakeholders and the dotted arrow reflects this uncertainty.

Figure 4-2: Categorised stakeholder relationships of PHOs
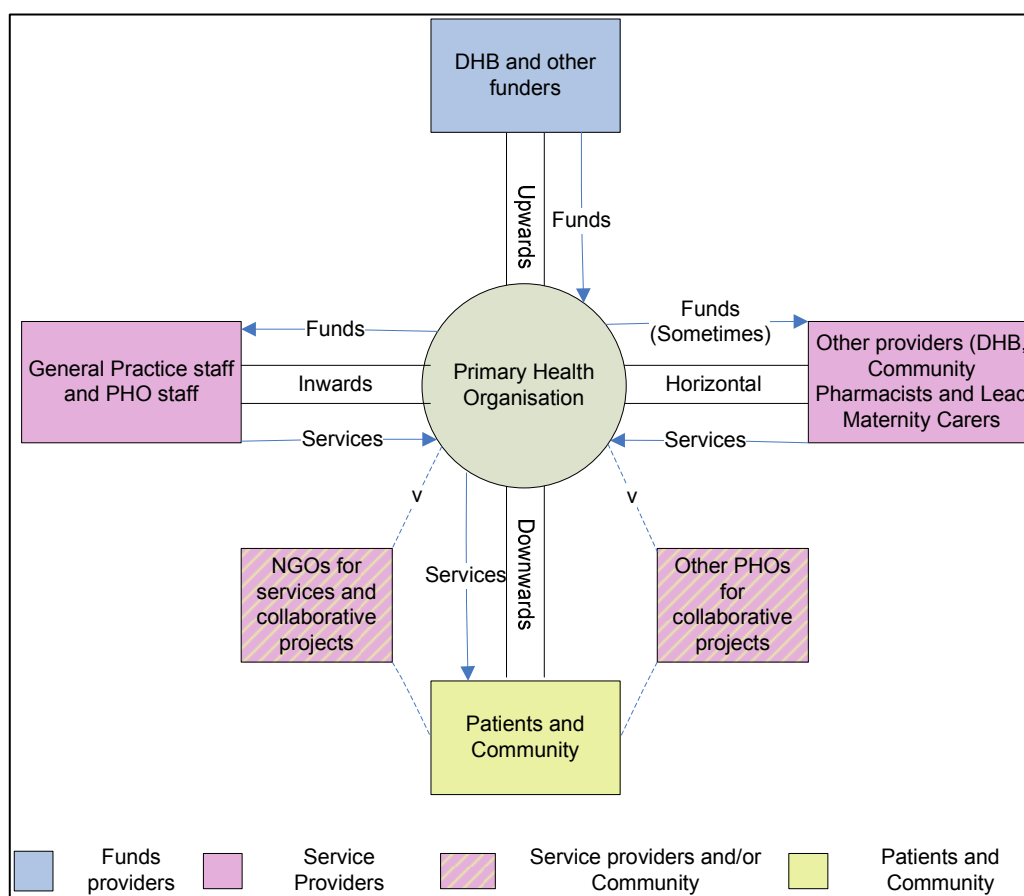
4.3.2. To whom is accountability owed in the accountability relationship?

(i) 'Upward' Accountability

Dubnick and Justice (2004, p.9) note "hierarchical cultures will generate one form of accountability, while egalitarian will generate another." Contractual relationships are typically hierarchical, comprising superiors with strong control over subordinates (Birkett, 1988; Bovens, 2005b; Laughlin, 1990; Roberts, 1991; Stewart, 1984) and PHOs' contractual accountability relationships with funders are likely to be 'upward' (as shown in Figure 4-2).[101] Chen (1975) supports the idea that hierarchical systems ('upward' accountabilities) are part of the classical stewardship concept while other commentators (Broadbent *et al.*, 1996; Cribb, 2005a) link hierarchical contractual

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[101] Contextually, market-based policies rely on reciprocity rather than accountability (Ouchi, 1980) and therefore lie outside the scope of the PHO accountability regime, although patient choice via the market remains an important 'exit' mechanism in the New Zealand 'contracting-out' primary health care system.

relationships to Agency theory and term controlling stakeholders 'principals' and acceptors as 'agents'. The nature of hierarchical contracts should result in clearly defined responsibilities and, when performance goals are agreed as elements of the contractual arrangements, little conflict should ensue (Fukuyama, 1995; Panozzo, 1996).

Mitchell, Agle and Wood (1997) contended that 'upward' powerful stakeholders are likely to be dominant in organisational relationships, especially when they are significant funders or can otherwise coerce organisations into complying with their demands, including those for accountability (Laughlin, 1990; Oliver, 1990). Flack and Ryan's (2005) research provides evidence to support the notion that not-for-profit organisations contracting with government are likely to discharge accountability 'upward' to government at the expense of 'downward' to beneficiaries and supporters. These Australian researchers recommended that, in order to equalise the focus of the acceptor's accountability discharge, the government partner (rather than contract) with not-for-profit organisations and combine partnering with long term funding to build capacity. These sentiments are replicated in New Zealand where Tenbensel, Mays and Cumming (2007) recommended that DHBs (as government agents) should partner with PHOs and play the role of a 'relationship-broker' rather than a 'director', so that PHOs can develop 'inward' and 'downward' relationships.

Partnering may be one answer to the dominance of 'upwards' accountability, but Barrett (2001) contends that regulation is needed to require not-for-profit organisations to account more evenly to all of their stakeholders. His case study research into a small New Zealand social service provider which received government funding found that accountability processes were overwhelmingly focused 'upwards' towards funding agencies. He urged that regulators such as the Charities Commission impose tighter regulatory control to force publicly funded organisations to be accountable to all of their stakeholders. Hayes (1996) also recommended increased regulation to extend the discharge of accountability to all stakeholders by the Irish charities she researched.

Conversely, Milofsky and Blades (1991) note that regulation provides a limited solution and requires high levels of resourcing to be effective. In addition, it is

jurisdiction specific, and relates to systemic responsibilities and expectations (as noted in Chapters 2 and 3 where regulatory mechanisms employed in primary health care were presented). In New Zealand, PHOs are subject to numerous Acts of Parliament (for example the Health and Disabilities Act 2000) in addition to their contractual obligations to the Ministry of Health. Patients (who may suffer as a consequence) can obtain re-dress for poor clinical delivery from the Health and Disabilities Commissioner who acts as a quasi-regulator. In addition, patients may also be able to seek accountability from health providers through lobbying those providers' professional associations.

(ii)   'Inward' and 'horizontal' accountability relationships

'Inward' and 'horizontal' relationships generate mutual expectations and Davis, Schoorman and Donaldson (2004) note that acceptors in these relationships are more likely to place a higher utility on attaining collective goals rather than individual goals. Birkett (1988) used the term communal accountability to describe these accountability relationships where the acceptor is responsive to a stakeholder's (or community's) expectations, while Munro and Hatherly (1993) termed it 'lateral' (this is the term which will be used in this study).[102] Lateral accountability is based on stewardship theory: the understanding that the acceptor is a steward for the common good (Donaldson & Davis, 1991).

Cribb (2005a) proposes that sanctions are not integral to lateral accountability, however Fry (1995) suggests that, even without an explicit contract, a desire for group acceptance (including reputation) will lead the acceptor to comply with group norms and thus, implicit sanctions and rewards. Potentially, lateral accountability relationships will invoke lower transaction costs than contractual accountability. However, lateral arrangements bear an increased risk of relational breakdown as inter-dependence establishes conditional group membership dependent on the acceptor's

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[102]   Laughlin (1990) also employed the term communal accountability. It is described as accountability in a "moral community within which relevant relationships exist" (Dubnick, 2002, p.10). Roberts (1991) defined a similar concept as "socialising accountability" in the workplace (and in Roberts, 2005, in Boards). These relationships assume relatively symmetrical power between the parties with accountability being discharged through informal, localised interaction that confirms relational interdependence, within a paradigm that continues to acknowledge a principal-agent, delegator-acceptor relationship.

actions (Roberts, 1991) and the relationship suffers (rather than a contract) in the event those actions do not meet expectations. Therefore, delegators and acceptors who do not enjoy robust relationships and shared values may prefer hierarchical, contractual accountability models (Roberts, 1991). In practice, both contractual and lateral accountabilities interweave, rather than acting as strictly demarcated accountability contexts (Roberts, McNulty, & Stiles, 2005).

As indicated in Figure 4-2, PHOs enter relationships with a number of 'horizontal' stakeholders in order to facilitate the delivery of services to their communities. These stakeholders ('inwards') include PHO staff and medical staff with whom PHOs' contract. In addition, PHOs may enter Memoranda of Understanding with Lead Maternity Carers and Community Pharmacists ('horizontal' relationships) to secure services that are not provided by the Medical Practices with whom they contract and which may not be otherwise readily available to patients. In the case of Lead Maternity Carers and Community Pharmacists, funding for services provided to PHOs' patients flows from the Ministry of Health or the relative DHB respectively. PHOs may also contract with providers for Health Promotion or Services to Improve Access (SIA) programmes.

While there is no extant literature reporting on PHO relationships with Lead Maternity Carers and Pharmacists, practitioner literature reports that medical staff (GPs and Practice Nurses) demand 'inwards' accountability from PHOs. In particular, a number of Practice Nurses expect PHOs to deliver educational support to raise service quality and to lobby for government funding that would encourage collaboration between medical staff (Minto, 2004; O'Connor, 2003). Some GPs have also voiced concern that PHOs have not negotiated sufficient government support and that GP funding contracts are less than satisfactory (Topham-Kindley, 2005; Yeats, 2006b).[103] Further, in late 2004 a survey found that over a third of GPs perceived that PHOs were not focusing on community health improvement as they expected (Hill, 2005). It seems the 'inwards' accountability relationships of PHOs to their contracted medical staff may be fragile.

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[103] One contractual negotiation was in respect of patient co-payment fee reviews. GPs contracted to PHOs may not increase fees beyond a certain level unless they have a ruling resulting from an audit of their Practice's financial statements. Many complained that their financial statements should remain private.

As noted above, the relational position between a PHO and other PHOs and NGOs that may be contracted by a DHB to provide specific primary health care services (such as primary mental health) in the same community as the PHO, is ambiguous. NGOs that were already primary health care providers before the *Primary Health Care Strategy* was launched have expressed concern that PHOs may not discharge their responsibilities to improve community health outcomes. The Health and Disability Sector NGO Working Group (2005, p.11) found that PHOs "have little insight into the importance of holistic care and the range of NGO community services crucial for recovery and maintaining wellness, or providing specialised services in specific areas of expertise." These NGOs may perceive PHOs to be competitors for government contracts, rather than as potential collaborators when PHOs use SIA funding to launch new services (for example translation services to a refugee community) that drive the NGO out of business. The effect of this may be to reduce community services if SIA funding does not cover the whole gambit of services previously delivered (for example if the NGO previously delivered translation and resettlement services) or if PHO priorities change. Accountability to NGOs (and other PHOs) may therefore arise from 'horizontal' collaborative relationships, or alternatively, comprise a 'downward' relationship if these organisations are subsumed into 'community'.

(iii) 'Downward' accountability

An important aspect of the accountability relationship 'downward' (to patients and community as depicted in Figure 4-2), is that these stakeholders have not specifically delegated duties to the PHO; rather, the delegation (along with funding from general taxpayers funds) is managed by the Ministry of Health through the relevant DHB. A derived contract exists whereby patients and taxpayers can expect PHOs to discharge their responsibility under the *Primary Health Care Strategy* to improve their communities' health outcomes and thus taxpayers and communities retain a moral as well as legal right. However, unlike 'upward' and 'horizontal' stakeholders, 'downward' stakeholders often lack power to demand that acceptors discharge accountability for the responsibilities delegated to, and accepted by PHOs, so that PHOs may take a dominant position and their 'downward' stakeholders are unable or unwilling to hold PHOs to account or sanction them.

Government policy suggests that 'Third Way' communitarian emphases in twenty-first century primary health care (as described in Chapter 2) present an alternative to the 'contracting-out' paradigm of contractual and lateral accountability and may equalise the focus of accountability discharge towards communities. The communitarian viewpoint of accountability is represented as 'bottom-up' (Awio, Lawrence, & Northcott, 2007). For example, in a Ugandan HIV/AIDS project researched by Awio *et al.* (2007), HIV/AIDS programmes are developed by a community, delivered by that community, and the community groups that deliver the services are accountable to the community through networks of local stakeholders. Although in New Zealand the *Primary Health Care Strategy* devolves responsibilities to locally-based PHOs, funding and direction remains centrally driven, indicating that a communitarian culture is unlikely to emerge. Indeed, Craig (2003) seems to believe that the warm language of 'Third Way' policies in New Zealand is merely rhetoric.

Furthermore, Arunachalan (2006), in his New Zealand study of the communitarian environmental management of Lake Taupo, found this paradigm to be characterised by weak sanctions. A lack of hierarchical control (Eberlein & Kerwer, 2004) led to a decision-making deadlock between parties with divergent interests (for example, local *iwi*,[104] the Territorial Local Authority and recreational fishermen) and eventually the Territorial Local Authority took control. Research in the UK health sector found similar problems when powerful relational acceptors (the GPs) over-rode enrolled primary health care patients' right to accountability. These patients had failed to form a close-knit community to practice communitarian accountability and therefore the experiment to network and build relationships failed (Cotton *et al.*, 2000; Hill *et al.*, 2001). Further, patients were unable to define mechanisms by which effective accountability could be discharged by the Medical Practice involved in the research. These examples of failures in communitarian ideals in practice suggest that PHOs, subject to specifically defined funding contracts, are unlikely to be measured by communitarian ideals under the *Primary Health Care Strategy*. Instead, PHO relationships 'upwards', 'inwards' and 'downwards' are likely to range along a continuum of stakeholder demands ranging from contractual to lateral accountability.

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[104] This is Mäori for tribe.

This posits a dilemma for PHOs; the *Primary Health Care Strategy* seems to suggest that PHOs may not select a single group of stakeholders to whom they are accountable, despite not-for-profit organisations' tendencies to discharge accountability to 'upwards' stakeholders rather than 'inwards' and 'downwards' stakeholders. A similar situation occurred in Ireland when government reforms required the charity organisations it funds to encompass a wider set of stakeholders (to go beyond funders and include beneficiaries equally) with holistic accountability. However, O'Dwyer and Unerman (2006) reported that the NGO managers they interviewed were at a loss as to how to implement holistic accountability and how best to encompass a wide set of stakeholders. It may be that PHOs face similar difficulties.

Nevertheless, O'Connell (2005), Kearns (1994) and Ospina *et al.* (2002) note that responsiveness to stakeholders is a key to effective accountability and Koppel (2005) describes responsiveness as a specific component of lateral accountability. A responsive organisation will communicate with 'downward', 'inward' and 'upward' stakeholders in a 'negotiated accountability'. A respondent to the study of successful not-for-profit organisations by Ospina *et al.* (2002) provides the key to responsiveness and negotiation:

> *How do you know to keep your ear to the ground and how do you interpret*
> *these things? Sometimes the strategy is to help people to change their views of*
> *some issues, while at the same time to be open to changing yours (p. 20).*

These negotiations will include the role that accountability plays in the varied relationships complex organisations (such as PHOs) have with multiple stakeholders.

4.4. *What role does accountability play in delegating relationships?*

Fry (1995) suggests that accountability is imposed within relational frameworks that include trust, the negotiation of co-operative action and the framing of common expectations. However, the role of accountability in not-for-profit organisational relationships is seldom researched (O'Dwyer & Unerman, 2006).

Four main roles for accountability within delegating relationships have been identified as pertinent to this research, namely, to effect:

(i) stakeholders' control of the acceptor's actions;

(ii) trust-enhancing behaviour of the acceptor towards stakeholders;

(iii) increased organisational construction/identity; and

(iv) organisational learning.

Each of these factors is discussed below.

4.4.1. *Control of power*

The act of delegation recognises that the delegator (i.e. stakeholder) considers the acceptor is capable of independent or autonomous action and therefore the delegator (stakeholder) will seek to impose accountability as a form of control over the acceptor, to ensure that the accepted responsibility is discharged in accordance with the attendant terms and conditions (Birkett, 1988; Porter, 1990). As noted by Leat (1990):

> …*accountability becomes an issue when power and resources are delegated. Power imbues any relationship where delegated authority is exercised. As a social relationship, this delegation implies relative independence, trust and inequality between those who delegate and those who are delegated to (p. 140).*

As the stakeholder delegates power to the acceptor, the possibility that the acceptor may abuse that power to pursue their own ends (at the expense of the delegator's) is raised (Armstrong, 1991). Ulrich and Barney (1984) proposed that all organisations (including not-for-profit entities) attempt to acquire greater control over scarce resources so that they can minimise their interdependence and maximise their autonomy. Even though PHOs must be not-for-profit organisations, Craig (2003, p.336) suggests that the legacy of the market-based policies of the 1990s has left "bruised and worn down health professionals" and (resource) "hungry" providers. As a consequence, PHOs may choose to deliver services only to 'lucrative' communities or patients, in order to meet performance targets. However such an action potentially reduces equity and the likelihood of achieving the *Primary Health Care Strategy's* aim of improved population health (Minister of Health, 2001).[105] In light of similar

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[105] The Ministry of Health has suggested that a reduction in enrolments in an Otago PHO may be caused by the PHO dis-enrolling "expensive" patients who visit their GP too often. If so, these patients may have been defined as casual patients and the PHO claimed funding for them under the pre-Primary Health Care Strategy General Medical Services scheme (Topham-Kindley, 2006). The

examples, Day and Klein (1987 p. 21) warned: "to be unaccountable is to be all powerful." Accordingly, as stakeholders delegate more power to acceptors, they may seek control through accountability demands (Bovens, 2005b) and acceptors may struggle for independence. Thus Fry (1995) suggests that the obligation to explain and justify actions fulfils a monitoring function to expedite control but, if reduced, can be an enabling process.

Mulgan (2000) also perceived accountability to be an important mechanism of controlling power, but argued that accountability is not a control in itself. Contractual remedies in hierarchical arrangements control an acceptor, but high transaction costs and resource restrictions may limit the use of these remedies in the event of non-compliance (Ashton *et al.*, 2004). The requirement to account may generate a desire to perform well, but the reporting itself does not control the acceptor unless it is accompanied by sanctions and likely repeat delegations (Birkett, 1988; Dubnick & Justice, 2006).

Control mechanisms create 'fields of visibility' similar to Foucault's panopticon (Strathern, 2000). As the acceptor responds to the threat of monitoring, the stakeholder wields a psychological control in addition to that imposed by demands for accountability combined with the threat of sanctions (Roberts, 1991, 1996, 2005). The psychological dimension brought about by the 'field of visibility' (Fry, 1995 termed this 'felt' accountability) may occur in hierarchical, as well as lateral relationships shaping behaviour through controlling power (Casciaro & Piskorski, 2005).

4.4.2.   *Trust and accountability*

The manner in which accountability is used to check the abuse of power in a delegating/accepting relationship may suggest a lack of trust by the delegator or the acceptor, yet trust has a key role in any cooperative activity (Davis *et al.*, 2004; Fukuyama, 1995). Strathern (2000, p.310) notes: "[a]s the term accountability implies, people want to know how to trust one another, to make their trust visible, while (knowing that) the very desire to do so points to the absence of trust." In the Reith Lectures, Onora O'Neill (2002) noted concern that "perhaps the culture of

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Otago PHO has vigorously denied these claims.

accountability we are relentlessly building for ourselves actually damages trust rather than supporting it." For example, 'upwards' accountability stakeholders in primary health care (DHBs) deal with the information asymmetry in their relationship with PHOs through regulation, monitoring arrangements and information requests that reflect distrust.

Stakeholder supervision may reduce when information provided as a result of accountability reporting reduces information asymmetry (Ezzamel, Hyndman, Johnsen, Lapsley, & Pallot, 2004). Accountability reporting – part of the process of accountability – may therefore generate increased trust through reduced uncertainty, although trust is multi-faceted and not developed through performance information alone (Fukuyama, 1995).

Consequently, in high trust situations shared values reduce demands for accountability as a form of control and reduce transaction costs (Broadbent *et al.*, 1996; McKinlay, 1999). Trust is also likely to precede contractual arrangements, as shown by Klein Woolthius *et al.* (2005) in their empirical research into four relationships between organisations supplying goods and services under contracts and Memoranda of Understanding. They found that contracts and trust substitute for, and are complementary to, each other. Contracts are useful to establish goals, as a sign of commitment, and as a safeguard when unforeseeable contingencies occur (Klein Woolthius *et al.*, 2005).

Romzek and Johnston (2005) suggest that, when market competition is absent and the cost of information is high (as occurs in primary health care), trust becomes the basis for relational contracting, thus reducing conflict, increasing interaction, and strengthening interdependence. However, Pallot (1990), in early conceptual work on New Zealand's public sector reforms, noted that the attributes of control and trust are not mutually exclusive, nor should they be contrasted as either 'good' or 'bad', as each is necessary for a functioning delegation. Handy (1990), in his commentary on relationships in not-for-profit organisations, also depicted control and trust as counter-balancing each other, rather than being mutually exclusive.

Yet, in attempting to suggest situations where trust and control could complement or

supplement each other, Roberts *et al.* (2005) were unsuccessful. Their study of Board control and trust of CEOs concurred with Romzek and Johnston's conclusion that trust is necessary, but proposed that it is better not to assume distrust or trust *ex ante* in an accountability relationship, but to employ accountability processes so that acceptors can display (and increase) stakeholders' trust. When this occurs, monitoring should reflect the inherent trust in the delegating relationship. However, less powerful stakeholders may not be able to demand increased reporting even when they distrust the acceptor (Goddard, 2004).

Cumming (2007) suggests that decentralisation (such as has occurred in New Zealand's health system since 2000) may promote trust because decentralised agencies (such as the DHBs and their contracted PHOs) are closer to communities, promote equity of access and are more responsive to local needs. However, although she found a gradual maturing of systems and increasing levels of trust, Cumming (2007) noted that the Ministry of Health's lack of trust in DHBs has led to "excessive monitoring [that] damages trust" (p.188). Further, in a report to Counties Manukau DHB, Smith and Ovenden (2007) found that PHOs in this region had called upon their DHB to "rebuild trust and work in collaboration" (p. 10). As a counterbalance to control, there are opportunities for PHOs to discharge accountability in such a way as to increase trust with all of their 'upwards', 'inwards' and 'downwards' stakeholders.

4.4.3. *Organisational construction and identity*

The interplay of control (emanating from intrinsic and extrinsic power) with trust suggests possibilities for accountability to contribute to the manner in which individuals, institutions and societies construct themselves and behave 'appropriately' (Bovens, 2005a; Fry, 1995). An acceptor will take into account extrinsically or intrinsically stated expectations in performing their accepted responsibilities. Further, accounting reports (for example *ex ante* budgets and *ex post* reports), internal controls and monitoring also create fields of visibility that direct the acceptor's behaviour (Munro, 2001; Roberts, 2005).

These fields of visibility that direct action may also conceal inaction, so that the acceptor may be able to perform outside the terms and conditions attaching to the

responsibility accepted without sanction (Strathern, 2000). For example, when the UK government required NHS Trusts to reduce their hospital waiting lists, Chang (2006) reported that one NHS Trust did so by undertaking 'easy' operations for 'tiny' problems, forcing people requiring joint replacements to wait longer. Consequently, the numbers of people on waiting lists became the field of visibility, rather than ailments or socio-economic determinants, with the result that health priorities were not met. The implied conditions of funding were ignored and the demand for high-level data allowed inaction on, for example, joint replacements, to be concealed. Fewer patients remained on waiting lists and the NHS Trust was constructed as an 'accountable' organisation, even though patients who were left would be more difficult to service.

While Roberts' (1991; 1996) studies focus on individual's identities and accountability, this research takes an organisational viewpoint, using the anthropomorphic concepts of identity (and in the next section, learning) and accountability. Hatch and Schulz (2002) draw similes between an individual's and an organisation's identity. Thus, organisational identity may be constructed from 'core' values and beliefs held by its members (including staff) (Empson, 2004; Gioia, Schultz, & Corley, 2000), but Hatch and Schulz (2002) suggest that external stakeholders' images dynamically interact with the organisation's identity and culture, mirroring and reflecting 'who' the organisation is, as depicted in Figure 4-3.

Figure 4-3: Components of organisational identity[106]
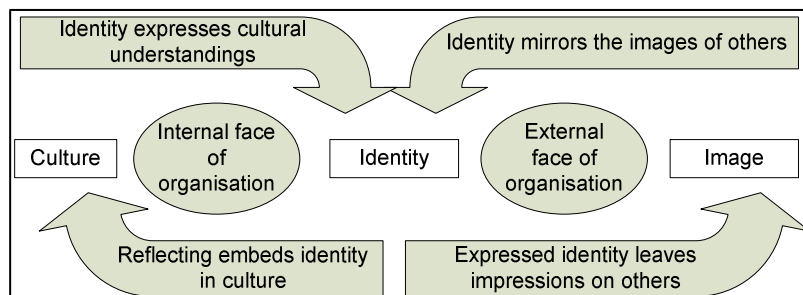
At the right of Figure 4-3 is the term 'image'. A number of theorists suggest that organisational image represents the way that internal members believe outsiders view the organisation (Dutton & Dukerich, 1991), although it may also include images

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[106] Adapted from Hatch and Schulz (2002).

projected in logos and slogans (Gioia & Thomas, 1996). It can therefore be deduced that organisational identity reflected externally (through, for example, community meetings, annual reports, media and stakeholder feedback) will create fields of visibility directing the organisation's behaviour.[107]

Figure 4-3 depicts identity as being dynamically affected by mirroring images and reflections and expressions of culture. While it is mutable, an organisation's identity is underpinned by an organisation's mission statement (Minkoff & Powell, 2006). The mission is a charter directing organisational performance of accepted, more detailed responsibilities, and affords a benchmark against which insiders and outsiders can measure performance. As stakeholders could hold an acceptor accountable for performance in the context of its mission, sanctions can be applied to effect changes to organisation's image and/or identity, while rewards may confirm image and/or identity.

PHOs are expected to "create an environment in which all parties have a shared vision and responsibility for health outcomes and value for money" (Ministry of Health, 2006b, p.8). Thus, 'inwards' and 'downwards' accountability relationships will interrelate with the PHO's mission and reflect its identity.

4.4.4. *Organisational learning and accountability*

The Ministry of Health (2006b, p.8) also expects PHOs to be accountable for creating: "a shared learning environment which enables local flexibility and innovation." This posits a fourth role for accountability in PHOs' relationships. Generating population health changes as envisaged by the *Primary Health Care Strategy* is likely to be a complex, non-linear, process with unexpected outcomes. Therefore, the role of learning recognises the need for innovative actions by PHOs in order for them to meet the aims of the Alma Ata Declaration (WHO, 1978). This will include community development programmes that may include multi-sectoral collaboration (for example, funding retro-fitting homes with insulation in a Healthy Homes project). Running pilots for innovative practices and programmes to address population health needs is

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[107] Goffman's (1959) dramaturgy provided an early analysis of this interplay on individual and team identities.

not without risk, and all projects may not achieve their full potential. However, responding to multiple stakeholders' demands should motivate learning, encourage improved performance and cooperative activity (Bovens, 2005b; Fry, 1995; Roberts *et al.*, 2005). The Office of the Auditor-General of Canada (2002, p.2) warns that demands for "accountability must be able to tolerate mistakes or adverse results provided that any risk taken can be shown to have been reasonable and the management of the risk to have been sound."

Organisational learning imposes an obligation on stakeholders to exercise their 'voice' by engaging with the acceptor to re-negotiate performance outcome expectations and other conditions of the delegation (Roberts, 2001; Weick, 1995), as shown in the study by Roberts *et al.* (1996) where active dialogue between relational parties developed and refined expectations. Improved performance may be obtained, but it does raise the issue of who contributes to the learning (and how they are chosen), how these demands are mediated, and how results are measured and communicated (Litovsky, 2005).

Thus, to create 'a shared learning environment' PHOs are likely to need performance feedback from all of their salient stakeholders, including communities. When PHOs are enabled through organisational learning the 'why' and 'for what' of accountability may also be re-negotiated.

4.5. *Conduct - for what are PHO's accountable?*

As noted in Chapter 1, PHOs are required to be accountable under the *Primary Health Care Strategy* (Minister of Health, 2001) to:

- provide essential primary health care services to their enrolled populations. These services include first-line service to restore patients' health as well as services to improve and maintain their communities' health;
- involve their communities in governance and demonstrate processes that identify needs and allow communities to influence PHO decisions;
- involve their providers and practitioners in governance so that one particular group does not dominate;
- identify disadvantaged groups and, through a community-development

approach reduce barriers, both in terms of additional services to improve health, and to improve access to first-contact services;

- support the development of services by Mäori and Pacific providers and ensure services are culturally competent and effective;

- encourage developments that emphasise multi-disciplinary approaches to services and decision-making;

- participate (with DHBs) in wider intersectoral activities that aim to address the social, cultural, and economic causes of ill health;

- demonstrate the quality and safety of the services provided by being openly accountable to the public for the quality standards they plan to achieve.

Notwithstanding this clear statement of the 'for what' are PHOs accountable, PHOs have expressed concern about the lack of definition of the 'for what' aspects of their accountability obligation (as well as the 'to whom') (Ministry of Health, 2006b). Kearns (1994) confirmed that the 'for what' aspect can be the 'ultimate moving target'.

At the broader level of not-for-profit organisations, numerous attempts have been made to categorise the theoretical foundation, or the 'for what' aspect, of accountability (e.g. Ebrahim, 2003b; Gray, 1992; Kearns, 1994; Stewart, 1984). A number of these are summarised in Figure 4-4 and include:

- Stewart's (1984) 5-step ladder of accountability developed for the public sector (and used by, for example, Broadbent *et al.*, 1996) has also been used in not-for-profit organisations;

- Leat's (1990) 4-step ladder developed from Stewart's (1984) to recognise that not-for-profit organisations differ from public sector organisations, in respect of "mission, philosophy, structure and standard operating procedure" (Kearns, 1994, p.186) and specifically in respect of governance;[108]

- Kearns (1994) criticised Leat's (1990) typologies as being focused on operational, rather than governance issues, and his framework stressed the strategic and tactical choices facing nonprofit organisations as they achieve

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[108] Laughlin (1990) and Cordery (2005b) found that, in practice, applying a ladder is difficult in not-for-profit organisations as the distinction between the different levels of accountability was not as evident as theory suggests.

their mission;

- Goodin (2003), Edwards and Hulme (1996), Najam (1996), Ebrahim (2003b), and O'Dwyer and Unerman (2006) further developed and augmented Kearns' (1994) dichotomy. These commentators suggest that the acceptor has a proactive, rather than reactive role and is required to involve stakeholders in dialogue and debate to shape the accountability framework and to agree upon the priorities that meet its constituents' needs. Proactive organisations will manage stakeholders' expectations (Dubnick & Justice, 2004).

These different terms reflect a context-based array of concepts. Cribb (2005b) outlined a dichotomy between accountability for specific obligations to perform delegated tasks (outputs), and accountability for achieving outcomes in line with the organisation's purpose or mission. This dichotomy is used in Figure 4-4 to order the varied terms for accountability employed by these authors.

While the listing in Figure 4-4 underlines the idea that the 'for what' of accountability covers a broad range, it is necessary for an organisation to reflect on its relationships and consider how to meet gaps in accountability discharge (Kearns, 1994). Mitchell and Shortell (2000) conducted a study of community health partnerships to identify problems that can occur in these organisations when attention is not paid to the gaps in the 'for what' aspects of accountability demands. Figure 4-5 maps the various concepts from Figure 4-4 against the highlighted problems. These problems may be evident in PHOs. Fisman and Hubbard (2005) further note that stakeholder monitoring through accountability is important if these problems are to be addressed.

Overlapping responsibilities is a further problem identified in New Zealand's health care system when the 'for what' is not agreed by delegating parties. For example, DHBs have accused the Ministry of Health of interference in operational issues that had previously been devolved (Barnett & Clayden, 2007), underlining the need for a proactive stance by the acceptor in managing stakeholder expectations.

Having developed the role of accountability, 'to whom' and 'for what' aspects of organisational accountability relationships, this chapter now turns to the process, or how accountability may be discharged.

Figure 4-4: 'For-what' aspects of accountability as named by commentators

Author	Accountability for performing delegated tasks (outputs)	Accountability for achieving outcomes/organisation's purpose
Stewart (1984)	*Accountability for probity and legality*: properly using funds and not exceeding legal powers (also in Glynn & Murphy, 1996). *Process accountability*: following appropriate procedures. *Performance accountability*: meeting required standards.	*Programme accountability*: achieving intended results. *Policy accountability*: (the highest and most difficult to discharge and measure) for policies government has, and has not, pursued.
Leat (1990)	*Fiscal accountability*: spending donations and funding as agreed. *Process accountability*: following proper procedures.	*Programme accountability*: delivering quality programmes. *Accountability for priorities*: (the highest level) fulfilling all stakeholders' expectations.
Kearns (1994)	*Codified or contractual* obligations are met as agreed.	Societal *values and expectations*.
Goodin (2003)		*Accountability for intentions*.
Edwards and Hulme (1996)	*Tactical accountability*: accounting for resources and the immediate (short-term) impacts of the organisation's work.	*Strategic accountability*: or the impact that the organisation has on wider environmental issues on a long-term basis.
Najam (1996) and Ebrahim (2003b)	*Functional accountability*: as *tactical accountability* above.	
O'Dwyer and Unerman (2006)		*'Holistic' accountability*: as the impact and accountability of the organisation to all stakeholders

Figure 4-5: Mapping types of accountability to specific not-for-profit problems

Prospective problems in not-for-profit organisations (extracted from Mitchell & Shortell, 2000)	Accountability type
- Senior staff excessively remunerated (also Chang & Tuckman, 1990) - Misleading fundraising - Self-dealing among not-for-profit managers (related party conflict)	Tactical accountability for resources and immediate impacts (Edwards & Hulme, 1996); functional, short term accountability (Ebrahim, 2003a; Najam, 1996); fiscal accountability (Leat, 1990)
- Failure to diversify staff and boards sufficiently - Concealment of profits through accounting accrual management (also Leone & Van Horn, 2005)	(As above tactical, functional accountability); process accountability (Leat, 1990)
- Lack of Board oversight and accountability - Failure to provide for citizen input	Strategic accountability (Ebrahim, 2003a; Edwards & Hulme, 1996; Najam, 1996); holistic accountability (O'Dwyer & Unerman, 2006); programme accountability (Leat, 1990)
- Loss of mission, inadequate public information about performance	Strategic accountability (Ebrahim, 2003a; Edwards & Hulme, 1996; Najam, 1996); holistic accountability (O'Dwyer & Unerman, 2006); accountability for priorities (Leat, 1990)

4.6.   *Discharging accountability – a process*

The process of accountability is described as a conversation (Czarniawska, 1998; Fry, 1995), an iterative process of asking, telling, checking, retelling and adjusting (Mulgan, 1997). Accountability processes, as conversations, require a common language in which the relational parties can engage in useful discourse about the delegator's expectations, the acceptor's performance and how it may be assessed (Day & Klein, 1987). This discourse will enrich the relationship as each party learns and re-negotiates joint objectives.

Mulgan (1997) conceptualises the accountability process as a step-wise process and Bovens (2005a) delineates these steps into three phases depicted in Figure 4-6. The accountability process is iterative, specific to a particular accountability relationship, and the steps may be delegated by the stakeholders to third parties external to the acceptors and stakeholders, by mutual consent (Mulgan, 1997).

Figure 4-6: Steps/phases in discharging accountability
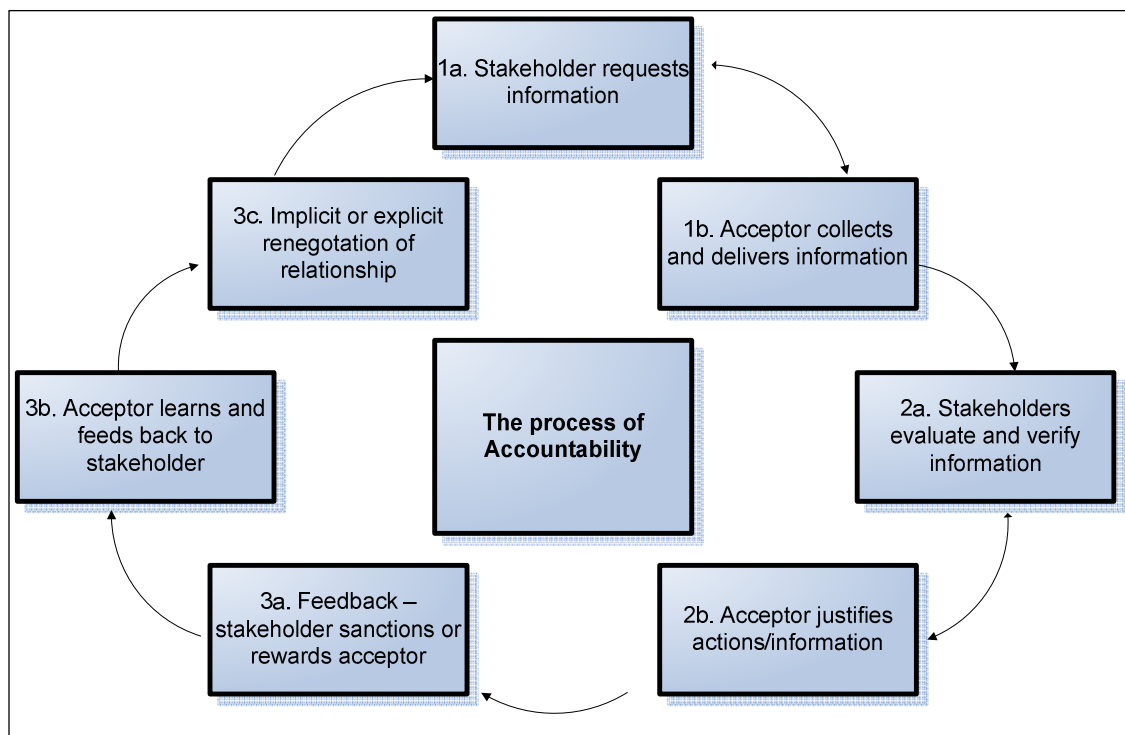
(adapted from Bovens, 2005a; Mulgan, 1997)

4.6.1. *Stakeholders request information – the acceptor responds*

An information request by a stakeholder followed by information collection and a response by the acceptor, is the first and essential phase to check on the discharge of delegated responsibilities as shown in Figure 4-6 (Mulgan, 1997). Stewart (1984) distinguished stakeholders with a formal 'bond' of accountability who were contractually empowered to call for information (such as the DHB or other funder of a PHO), from indirectly 'linked' stakeholders (for example, a PHO's community) who have no direct contract, suggesting that this step could be skipped in respect of some stakeholders. Conversely, Gray *et al.* (1996) argued that the right to call an acceptor to account is linked to the acceptance of delegated responsibility, rather than the strength of the stakeholder link, and Laughlin (1996) suggests that even a non-contractual relationship imposes moral obligations on an acceptor that requires them to respond to stakeholders. Mulgan (2003) asserts there is an obligation to account even when stakeholders fail to request information (through a lack of power or interest). Thus PHOs, required to be fully and openly accountable, could be expected to provide information to their multiple stakeholders whether or not those stakeholders specifically call them to account.

The type of accountability information demanded will vary across the 'by whom', 'why' and 'for what' accountability is demanded (Ebrahim, 2005). Boyne, Gould-Williams, Law and Walker (2002) suggested that a range of performance data will compose a picture of the organisation's activities and that when government funding is involved, the public should be interested in the equity of service provision, the cost (inputs), the efficiency of the delivery of outputs and outcomes. Alternatively, 'upward' stakeholders may be more interested in targets and how the organisation has met these within its budget.

The acceptor must collect information and respond to the stakeholders' implicit or explicit demands, although this will not be without cost (Ashton *et al.*, 2004). It is assumed that the acceptor and stakeholders will have considered the costs to be less than the benefits generated through cooperative delegation.

4.6.2. *Stakeholder evaluation and acceptor's justification*

In addition to requesting information, stakeholders have a further two obligations as depicted in Figure 4-6: assessment or verification (step 2a), and feedback (step 3a is dealt with in section 4.6.3). Assessing and verifying information is the basis of stakeholder evaluation. As delegation becomes less prescriptive, it is more likely that performance evaluation will be increasingly judgement-based. Stakeholders should be encouraged to ask the 'right' questions, assessing the adequacy of information, thus making accountability meaningful (Leat, 1990). Mulgan (1997) perceives that improving stakeholders' scrutinising processes improves the accountability process.

Phase two becomes an iterative process as the acceptor justifies the information provided and their performance. The ensuing debate and judgement may require more information (Bovens, 2005a). Normanton (1966) described the accountability discharge process as follows: "[t]he accounts themselves are no more than the basic guide for the investigation … The outline must be filled in by systematic exploration; by obtaining explanations and documentation about all unusual features encountered" (p.2). Therefore the acceptor's conduct becomes visible through enforced or discretionary explanations and justifications (Mulgan, 1997, 2003) of past achievements that facilitate aspirations toward more ambitious, organisationally appropriate, future goals. As noted in Chapter 1, verification of PHOs' financial accounts is initially provided through audited annual reports and they may also be iteratively verified at a PHO's AGM.

4.6.3. *Stakeholder feedback/sanctions, learning and renegotiating*

AGMs, community meetings, reports and funder meetings are mechanisms used in phase three – a further iterative process where stakeholders provide the acceptor with feedback (including sanctions or rewards). This phase distinguishes accountability from answerability (Birkett, 1988; Harris & Spanier, 1976; Stewart, 1984). Monitoring without sanction may be meaningless, result in poor performance and missed opportunities for learning. In addition to contractual duties, the Directors of a PHO incorporated as a company under the Companies Act 1993 have a duty:

- to act in good faith (s. 131);

- to act with diligence and care (s.137); and

- not to trade while the company is insolvent (2.135).

The Charitable Trusts Act 1957 requires similar behaviour from trustees under s 13. Trustees must act prudently and in accordance with the trust rules and the powers bestowed on them by the Trust Deed.

Although legal and regulatory sanctions are core enforcement mechanisms, in primary health care, sanctions comprise more than merely legal remedies (Brinkerhoff, 2004) extending to, *inter alia*, shaming when negative publicity causes patients to 'exit' and thus brings financial losses that were not contractually specified (Harris & Spanier, 1976).

Romzek and Johnston (2005) concur with Mulgan's (2003) last step – the creation of new expectations that feed the delegating relationship to re-establish mutual expectations and responsibilities. This is informed by the learning and feedback as a cyclical process. Those who delegate tasks and resources morally and legally oblige acceptors to be responsible for their actions and to provide a transparent and honest account (Edwards & Hulme, 1996) on the 'for what' of accountability.

4.7. *Tools or mechanisms – 'how' accountability could be discharged*

Fry (1995) confirmed that when not-for-profit organisations become 'masters at conversation', by developing appropriate mechanisms with stakeholders, their performance reporting will comprise qualitative and quantitative justification of financial and non-financial resource usage (Drucker, 1990; Torres & Pina, 2003). Following on from the two main 'for what' aspects of accountability identified in Figure 4-4, it is most likely that quantitative mechanisms will report on outputs.[109] In order to discharge an

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[109] Adequate quantitative output reporting would discharge Stewart's (1984) requirement to be accountable for probity and legality, Leat's (1990) fiscal accountability, a majority of the obligations for Kearns' (1994) and Goodin's (2003) contractual accountability, Edwards and Hulme's (1996)

obligation to account for outcomes, quantitative reporting is likely to be augmented by qualitative reporting with a longer term focus.

Further, Ebrahim (2003a) suggests that formal mechanisms such as financial reports that focus on 'upward', external accountability are more developed than informal mechanisms (such as *ad hoc* press conferences, voluntary audits and community consultation) that potentially could enhance communication with 'downward' and 'inward' stakeholders. Acknowledging that different stakeholders may have different preferences for 'how' accountability is discharged, Figure 4-7 suggests a mapping of how PHOs may discharge accountability to stakeholders. Having considered the to whom, what for, and why accountability may be demanded in the delegating relationship, this mapping is tentative ahead of the development of the case study research.

Figure 4-7: Stakeholders and suggested tools to discharge accountability

Stakeholder	The control of power	The role of trust	Organisational construction	Organisational learning
'Upward'	Six-monthly special purpose financial reports, audits, ratio analysis, DHB funding sanctions.	Goals are stated and achievements are reported against. Assessment data meets constituent's demands (Buckmaster, 2002). Regulatory (and self-regulatory) mechanisms (e.g. the Health and Disabilities Commiss-ioner). Sanction through 'voice' and 'exit'.	Identity and relationships made visible. Sanction through 'voice' and 'exit'.	Active dialogue to develop and refine accountability and performance. Sanction through 'voice' and maybe 'exit'.
'Inward'	Regular management reporting (financial and non-financial) and control.			
'Downward'	Annual audited general purpose financial reports, public forums. Sanction through 'voice' and 'exit'.			
'For What'	Defined outputs	Outputs and outcomes	Outcomes	Outcomes

4.7.1. *Reporting of outputs*

It is conjectured that, when PHOs produce adequate output reporting (both financial and non-financial), they will discharge their contractual accountabilities but may not meet other stakeholders' expectations. This section considers the roles of financial and non-financial reporting that are typically *ex post* mechanisms, but acknowledges that presentation of budgets and self-regulation are two *ex ante* aspects of accountability that

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tactical accountability and the functional accountability used by Najam (1996) Ebrahim (2003b), and O'Dwyer and Unerman (2006).

may also be employed.

(i)   Financial reporting of inputs and outputs

Ijiri (1975) identified financial reports as the key disclosure statements for discharging accountability to resource providers. A particular strength of financial reporting is that it can be independently audited and verified (potentially by a third party) (Normanton, 1966). DHBs require PHOs to present an annual report on a mutually agreed date (Ministry of Health, n.d.). The report must also be made publicly available and includes details of the PHO's:

- current organisational structure and governance;
- performance against DHB/PHO agreement in respect of service delivery (as described in Chapter 1);
- performance reported against DHB service goals. These include the health gains made by High Users, reductions in health inequalities for Mäori and Pacific peoples, outputs in health promotion and quality improvement;
- a consumer satisfaction and complaints survey;
- current patient co-payment fees;
- service levels for enrolled patients (for example, reporting the ratio of GPs to enrolled persons);
- audited financial reports that comply with Generally Accepted Accounting Practice (GAAP) (Ministry of Health, n.d.).

As explained in Chapter 3, PHOs may choose from various organisational forms. This results in them facing different financial reporting requirements as noted in Figure 4-8. However where financial reports have been prepared and/or audited by members of the New Zealand Institute of Chartered Accountants, these members are required to comply with GAAP under the NZ Framework for Financial Reporting.

Figure 4-8: Financial reporting requirements by entity type

Organisational Type	Relevant Act/s	Financial Reporting Requirements
Limited Liability Company	• Companies Act 1993; • Financial Reporting Act 1993	• Financial Statements[110] must be prepared within 5 months of year end, presented to shareholders at an AGM and lodged with the Registrar of Companies (s.10). • Financial Statements must comply with GAAP[111] and provide a true and fair view of the entity (s.11). • Accounting records are kept to provide financial statements to comply with the Financial Reporting Act 1993 [s.194(1)(c)]. • Audited financial statements [(shareholders can pass a unanimous resolution to forego) s.196 (2)]
Charitable Trust	• Charitable Trusts Act 1957[112]	• No requirements to file annual accounts, or to have an audit. • From 2010, Trusts that are registered with the Charities Commission will have reporting requirements imposed, however these are still under development.
Incorporated Society	• Incorporated Societies Act 1908[112]	• Present at an AGM and send to the Registrar a Statement of Assets and Liabilities and an Income and Expenditure Statement (no requirement to comply with GAAP) (s.23) • No audit is required unless specified in the organisation's Constitution.

Research by Hyndman *et al.* (2004) into not-for-profit organisations' financial reporting in Ireland found that annual reports may be incomplete, inadequate and inconsistent. Although this was due in part to a lack of legislative guidance, deficiencies were

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[110] These will include a Balance Sheet and an Income and Expenditure Statement for not-for-profit entities and a Statement of Cash Flows (unless a Differential Reporting exemption applies). Exempt companies do not have to meet these requirements as, under the Financial Reporting Amendment Act 2004, s.3, these companies [which have assets valued at less than $450,000, are not a subsidiary of another company (or have their own subsidiaries) and have a turnover of less than $1,000,000] have simplified reporting requirements.

[111] For financial reporting periods ending on or after 1st January 2007, GAAP comprises compliance with NZ International Financial Reporting Standards (NZ IFRS). Organisations could voluntarily transition to NZ IFRS for financial reporting periods on or after 1st January 2005. In September 2007 the Accounting Standards Review Board announced that compliance with NZ IFRS was required of large or publicly accountable organisations only. ('Delay of the Mandatory Adoption of New Zealand Equivalents to International Financial Reporting Standards for Certain Small Entities' downloaded from the internet 1st October 2007 from http://www.asrb.co.nz/documents/Release14092007.pdf). In the PHO environment, NZ IFRS would apply to those organisations with greater than two of: $20 million in income, $10 million in assets and 50 staff. The remainder of PHOs may continue to comply with NZ Financial Reporting Standards current at 1st January 2007.

[112] The Financial Reporting Act is currently under review and may impose further reporting requirements on these bodies.

exacerbated by a lack of preparers' expertise. Despite the inadequacies, Hyndman *et al.* (2004) and Hyndman (1991) found that stakeholders perceived that the annual financial report was an accountability report they could use to assess the solvency of these organisations and that the audit report "was seen as a confirmation of the financial stewardship of the board of directors" (Hyndman *et al.*, 2004, p.264).

Flack and Ryan (2005) also found poor financial reporting in their study of Australian not-for-profit organisations involved in social service contracts. Although the lack of comparability and transparency they observed in reporting was due in part to multiple, irreconcilable differences in stakeholders' demands, they noted that some blame lay with the organisations. They called for the not-for-profit sector to "take the responsibility for demonstrating accountability for its performance" (Flack & Ryan, 2005, p.75) in order to encourage community support and build long term credibility. In respect of the irreconcilable demands, this was also an issue in Canada, so that both the Australian and Canadian governments are working with the not-for-profit organisations so that the financial reports demanded for accountability are helpful to government funders as well as the organisations that are funded (Office of the Auditor-General of Canada, 2002).

In PHOs, McCardle, Norgrove, Jordan and Gouldstone (2004) found the standard of annual financial reports varied widely and called for the Ministry of Health to impose minimum requirements.[113] One of the 15 PHOs they approached did not publish financial information. Analysing these findings, McCardle *et al.* (2004) surmised that PHOs' failure to comply with their contracts resulted from a lack of staff and funding; and the high expectations held that PHOs would launch innovative projects to improve the health of their community, resulting in little time for PHO administration.

In a separate study, Douglas (2006), a GP in Wanganui, has been critical of PHOs' annual reports; he found that many were unavailable, those he accessed did not comply with GAAP[114] and none had included a budget (which would potentially underpin trust

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[113] The DHBs require PHOs to provide six-monthly financial reports, however, the DHBs have not issued specific financial guidelines for this reporting.

[114] Specifically, the reports lacked detail about contingencies, turnover and information on staff earning

when *ex ante* and *ex post* information is compatible). He was especially critical of the Wanganui PHOs that the Ministry of Health had "congratulated … on the excellent work they were doing and, in fact, have said that Wanganui PHOs are two of the best" (Douglas, 2006, p.18). In response, the Minister of Health had confirmed that "there is no one in the Ministry of Health responsible for the reporting and collating of information on PHO's expenditure, costs, annual reports and plans" (Douglas, 2006, p.18). Technically, these concerns should be handled by the relevant DHB, but the DHBs were not asked to comment on Douglas' findings.

Financial statements represent one source of information and, when appropriately compiled and audited, potentially discharge output based financial accountability (Roberts & Scapens, 1985); however adequately discharging accountability also depends on non-financial reporting, in particular the provision of explanations of performance (Harris & Spanier, 1976; Normanton, 1971).

(ii) Non-financial reporting of outputs

In New Zealand, public sector entities are required to provide Statements of Service Performance (SSPs) as part of their general purpose financial reporting (New Zealand Institute of Chartered Accountants, 2006) but SSPs are optional for not-for-profit and profit-oriented organisations. Further, a lack of objective measurement standards for SSPs and the mismatch between indicators used and organisational goals, reduces their usefulness as an accountability mechanism (Thompson, 1995). In the ensuing decade since Thompson's research, New Zealand's Auditor General has researched and encouraged public sector organisations to improve their output reporting with SSPs (Controller and Auditor-General, 2002b) but no recent studies of the effectiveness of such documents in not-for-profit organisations have been undertaken. Other non-financial reporting is provided through the annual report and also may be contractually specific.

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over $100,000 per annum.

4.7.2. *Reporting of outcomes*

As outcome reporting considers the longer term impacts of the organisation on its community, it is likely that the manner in which it meets societal values and expectations cannot be discharged through quantitative reporting alone. Non-financial performance assessment and evaluation reports can also be a tool for learning, and as internal and external accountability mechanisms (Ebrahim, 2003a). Relevant qualitative reporting is considered under the following sub-headings:

  (i) performance reporting

 (ii) community participation;

(iii) social audit.

(i) *Performance reporting for outcomes*

The use of multi-sectoral performance evaluations as accountability mechanisms was discussed in Chapter 2 with the conclusion that these are potentially ambiguous. In addition, the underlying reason for generating of performance reports may reduce their usefulness as accountability mechanisms. Hoefer's (2000) survey of not-for-profit social service providers in Dallas, Texas found that performance reports primarily targeted at gaining legitimacy (and more funds) from funders led to poorly designed evaluations that lacked agreed verifiable measures. Levaggi (1995) also expressed concern that accountability may not be discharged when there were no objective measures and outcomes were not be able to be observed.

Measurement shortcomings are further elucidated by Adam and Gunning (2002) in their assessment of performance indicators used by NGOs in Uganda. They supported Levaggi's (1995) view as they found that frequently the indicators used by the Ugandan NGOs in their study failed to measure outcomes, either because of genuine difficulties with measurement or because external environmental effects impacted the outcomes able to be measured.[115] Performance indicators did not assist objective funding decisions but

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[115] For example, they noted that weight-for-age and height-for-weight measurements for children could be used for health outcome assessment, but the Poverty Eradication Action Plan refuses to measure health

were useful as monitoring devices; hence Adam and Gunning (2002) suggested that separate funding and monitoring indicators should be used. Separate indicators would make it easier for the acceptor to provide an early warning system of problems when they know which critical indicators will generate increased or decreased funder support.

The experience of Adam and Gunning (2002) concurs with Romzek and Johnston's (2005) study of Kansas-based not-for-profit social service providers. In that study, government contractual arrangements required numerous accountability reports but sanctions for poor performance were rarely invoked, therefore it was unclear to providers as to which evaluatory measures they should prioritise.

As noted in Chapter 1, PHOs may participate in a Performance Management Programme. Aside from that, under their contracts with the relevant DHB (Ministry of Health, n.d.), all PHOs are required to report 'upward' to the DHB:

- enrolled patient numbers (members) and specific features of these members (age, gender, socio-economic levels, ethnicity) on a quarterly basis;
- access to and utilisation of PHO services, by Mäori (compared to their needs) and any future initiatives the PHO has to improve Mäori health gains. (PHOs must provide annual narrative reports to the DHB on barriers and enablers of Mäori health gain.);[116]
- co-payment fee levels at PHO practices and any changes in those fees when they occur (a fees review process confirms or disallows these changes);
- PHO health promotion activities undertaken to maintain and restore members' health;
- the manner in which PHOs have coordinated with other providers for rehabilitative care, and developed patient-centric inter-sectoral care;
- compliance with the DHB 'agreed services' – for example, 'around the clock care'.

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improvements in this manner and states that these measurements are poverty indicators due to their reliance on non-health issues such as food availability or economic shocks (Adam & Gunning, 2002).

[116] PHOs with Pacific Communities must meet similar requirements in respect of these communities under the Pacific Health and Disability Plan.

The DHB/PHO contract requires all financial reports to be audited. The DHBs may also request audits and investigations under the Primary Healthcare Audit Protocol through regular 'programmed' audits (Ministry of Health, 2004c). Qualified auditors authorised by the DHB undertake audit programmes to inspect PHO members' clinical records, monitor compliance with the PHO Agreement and confirm that claiming behaviour is appropriate. Where a PHO's funding claim (or other behaviour) appears to warrant a DHB's special attention the DHB is also authorised to undertake 'selected' audits in those PHOs.

Despite these audits, McCardle *et al.* (2004, p.13) believed that PHOs had been deficient in meeting their obligations to their communities including not undertaking:

- performance monitoring and reporting requirements;
- formal business planning;
- research and analysis;
- community liaison;
- development of protocols;
- quality management;
- referral of services.

However the DHB does not audit, nor impose requirements as to how the PHO may discharge its requirement to 'downward' (and 'inward') stakeholders. Accordingly, it is incumbent on these stakeholders to call to account and sanction PHOs that are deficient in these matters. 'Downwards' stakeholders may receive non-financial reports such as newsletters, websites and notice-boards at health centres. Local media may also be used to inform and influence public opinion, although Hannis, Houston, Pfeifer, Cumming, Russell and Walker (2007) found that, in the case of DHBs, newspapers were most likely to focus on negative, sensational stories, and that 'good news' stories needed to be specifically bought to their attention. Ebrahim (2003a) also noted participation processes (public meetings/community consultation and board representation) are alternative means of channelling accountability communication.

(ii) Community participation

Community participation may be a proactive step organisations take to negotiate accountability relationships, and to improve the quality of their service (as discussed Chapter 2). Networking with communities can expedite change and reduce the power differential between service providers and service users (Adams, 2004; Fowles, 1993). For example, in the UK, Gustafson and Driver (2005) found that, when the community is involved in calling to account, the health programmes focus on that community rather than having a sole national focus. Potentially, citizen participation "heightens an organisation's commitment to accountability" (Beitsch, 2005, p.189), manages expectations and is more likely to result in culturally appropriate services (Butler *et al.*, 1999), enhanced trust and organisational legitimacy.

In New Zealand, the *Primary Health Care Strategy* requires that PHOs involve their communities in decision-making, specifically through citizens' involvement in boards (Minister of Health, 2001). Community participation through board processes may be impacted by the type of organisation (Neuwelt *et al.*, 2005). In the trial of the toolkit entitled *Community participation: a resource kit and self-assessment tool for PHOs in New Zealand,* Neuwelt *et al.* (2005) found that PHOs with a strong GP influence (a background as an IPA) were more likely to perceive community representatives as a threat, whereas community-oriented providers (from a not-for-profit organisational background) were more used to taking the community's input into account. Further, health care professionals in larger organisations of all types were more detached from community participation as they perceived the PHO as separate from their personal service provision. In a study of DHBs (that have a similar requirement), Tenbensel (2007) stated that good participatory practice depended on the personalities involved.

The Ministry of Health has not issued guidelines as to how individuals are to be selected for participation in PHOs, although Wilmot (2004) contends it would be preferable for Board members to be elected by their communities, as individuals who self-select may not necessarily be representative of key stakeholders. By contrast, appointments (rather than elections) allow for important skill gaps to be filled. The Canadian study by Church

et al. (2002) into decision-making in the health care sector, and Lockett-Kay (2005), who studied the establishment of a new PHO in a rural area of New Zealand, found that citizens' representatives were more effective in holding the health care provider to account when they:

- had an in-depth knowledge of the community and primary health care issues;
- had strong networks and interdependencies within the community (to feedback effectively, to mobilise a constituency if necessary and to represent the community as a whole, rather than on a single issue);
- were able to present a united front against powerful funders and providers;
- were adequately resourced and informed; and
- were effective speakers.

Beitsch (2005) further notes that participation is effective when:

- the proceedings of community meetings' proceedings are transparent;
- minutes and press releases are made available;
- new programmes are exposed to public input;
- all stakeholders, including community members and contracted staff compete for Board places.

To increase transparency, DHB Board meetings are required to be open to their community (Barnett & Clayden, 2007). No such requirements are imposed on PHOs however, they can engage in community participation through surveys, community consultation and public meetings (Figueras *et al.*, 2005; Lenaghan, 1999). Effective citizen participation requires a PHO to initiate a broad range of frequent interactions in a variety of venues, at varying times of the day (Beitsch, 2005). Stakeholders may also be involved through membership of committees or advisory boards, or through direct communication into web sites if community comments are welcomed and feedback received.

Notwithstanding opportunities to do so, the public may not wish to be involved. Newman *et al.* (2004) found that much time had been spent on community consultations and

forums in the UK without effecting tangible changes, although the results of other studies provide conflicting evidence (Litva *et al.*, 2002). Community consultation may be successful if the following barriers can be overcome:

- the cost of travel, time and effort in scattered communities (Fowles, 1993);
- the organisation recognising and embracing "those who are different from us" (Lehman, 2003, p.7) rather than following a set of pre-packaged rules;
- citizens being imbued with power rather than the consultation being merely a forum to voice disapproval (Arnstein, 1969).

PHO members have a tenuous link through to the PHO (as their relationship is with their GP) and their power to hold the PHO to account may be reduced. In a study of citizen participation in decision-making in the secondary health care sector in Canada, Church *et al.* (2002) found citizen control was hampered by two fundamental difficulties – asymmetry of information and differing interests. Because of the highly technical nature of health care information, citizens were less likely than the providers to engage in decision-making. Additionally health professionals, who were most affected by decisions, had increased incentive to influence the decision-making and their interests were less diffuse than those of lay participants. Therefore the powerful funders and providers were better resourced than the citizen representatives to effect change. This knowledge gap between professional and lay participants was also found by Meijer (2005).

Penney (2002) noted that, although the literature suggests citizen involvement is presently inadequate, it is silent on solutions. Her interviewees considered that it is important for communities to be involved in decision making so that the 'big-picture' for health could be determined, bringing health services closer to the community. Community involvement promoted accountability processes, especially with face-to-face accountability, such as occurs in meetings, when stakeholders can gain further insights (Roberts & Scapens, 1985). This information is typically more heterogeneous than that provided in written form, as, from meetings:

- the governing body reaches out to the community in 'another language' (verbal as opposed to written);

- the public can 'shame' governors, reducing their power and control, or show support for board members who are taking controversial policy stands;

- media coverage can attract attention, communicate with citizens and add urgency to community demands (Meijer, 2005);

- the community can set future agendas, including delaying governors' decisions until community concerns have been resolved (Adams, 2004);

- contractual accountability and lateral accountability can be discharged.

An AGM (required of many incorporated entities[117]) may be one way in which performance of providers may be evaluated against expectations (Ebrahim, 2003a). AGMs are a formal accountability tool (Cordery, 2005a) and are recommended by the Ministry of Health's governance document (Ministry of Health, 2007). However, it may be that only individuals with extreme views attend public meetings, biasing community consultations and AGMs (Adams, 2004). A more representative sample may be obtained through electronic meetings and small group settings. Hodges *et al.* (2004) commented on the few attendees at AGMs in the NHS Trusts they studied. A recent press article (Hamilton, 2007) derided one NHS Trust that paid £10 to each attendee, concurring with Hodges *et al.* (2004) that AGMs were a 'sham ritual' in that NHS Trust.

Roberts (2002b) reports on the benefits of dialogue where all parties are brought into relationship in order to work through issues and bring about jointly-brokered solutions. Such meetings may generate social capital through the cultural rituals, symbols and stories that serve to encode and reconstruct organisational community identity, form an external image for outsiders and inform organisational behaviour (Dutton & Dukerich, 1991; Dutton, Dukerich, & Harquail, 1994). This essential aspect of accountability is collectively described as sensemaking (Dubnick, 2002). Including community in accountability processes will encourage sensemaking that will not always be smooth and conflict-free (Mansbridge, 1980) but resolution enables communities to seek organisational change and improved service.

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[117] For example, New Zealand legislation requires AGMs to be held in entities registered under the Companies Act (1993) or Incorporated Societies Act (1908). Further, many organisations include this requirement in their Articles of Association or Charters.

Self-regulation is another mechanism suggested by Ebrahim (2003a) and describes the development of standards for behaviour within the organisation as an 'inward' accountability mechanism. As suggested in Chapter 2, self-regulation may lead to reduced government regulation and will result in formal codes of behaviour being proscribed. Within the PHO sector, contractors, such as GPs and Nurses, have professional codes. Similarly, employees who are members of the New Zealand Institute of Chartered Accountants are required to perform to a Code of Ethics. However, Glynn and Murphy (1996) note a reduction in the use of self-regulation since the New Public Management reforms have taken hold. It is unknown how these and other Codes are referenced by PHOs as professional accountability mechanisms which are complementary or supplementary to other accountability processes.

(iii) Social audit

Ebrahim (2003a, p.822) describes the social audit as "a complex process that integrates elements of many of the accountability mechanisms." In social audits acceptors commit to stakeholder dialogue, performance evaluation against benchmarks, and disclosing progress on 'continuous improvement'. However, these audits have not been widely adopted in the health sector. Although they integrate accountability processes, the cost, as found by Hill *et al.* (2001) may, initially at least, outweigh the perceived benefits.

Hill *et al.* (2001) undertook a social audit:
- to increase transparency of health care decisions to a variety of stakeholders; and
- to help patients become "co-producers in health."

Through formal representation or groups such as patient forums, stakeholders become central in the social audit process. However, Hill *et al.* (2001) found that patients (as 'downward' stakeholders) in UK General Practices were less likely to believe that a stakeholder group was required to influence Practice management. In addition, patients were interested in influencing Practices but not in making decisions. Further the intensity of the process led Hill *et al.* (2001) to conclude that social audits would not be effective

as accountability mechanisms until the costs could be reduced.

Accountability mechanisms implement accountability, yet there is little research to assess which practices are most effective or how stakeholders measure effectiveness. Meijer (2005) called for more research into how accountability is discharged, especially as to the effect of community consultations on accountability relationships when multiple stakeholders are being balanced.

4.8.   *Accountability summary and research gaps*

This chapter has outlined the definition of accountability adopted for this research; it is defined as a relationship between a PHO as an organisational acceptor and stakeholders (delegators) where the PHO is obliged to provide its agreed services and explain and justify its conduct. As part of the process, stakeholders pose questions, pass judgement, and sanction or reward the acceptors (Bovens, 2005b). The role of accountability to control and re-direct behaviour differentiates it from answerability. In this respect, research is required into the ability of PHOs' stakeholders to sanction PHOs' behaviour and to encourage PHO learning.

PHOs have multiple relationships with 'upward', 'downward' and 'inward' or 'horizontal' stakeholders who have the potential to call them to account for different aspects of their performance. Multiple stakeholders present challenges to the effective discharge of accountability as it is difficult to satisfy simultaneously the diverse needs and expectations of multiple stakeholders' needs. In line with the objectives of this research, it is necessary to understand how these stakeholders affect PHO accountability.

Stakeholders may call PHOs to account in order: to control the abuse of power, to build trust, create or enhance their identity and to facilitate learning. Yet little is known about the role accountability demands play and how this might impact, for example, the PHO's identity.

Regarding the 'for what' aspect of accountability, a range of literature suggested that

commentators have described a dichotomy: accountability for performance of delegated tasks (outputs) and for achieving the organisation's purpose (outcomes). This latter requires the organisation to negotiate with stakeholders to manage their expectations proactively. The process and 'how' – some tools of accountability – have been suggested. Chapter 5 outlines a methodology from which PHOs' implementation of the requirement to be 'fully and openly accountable' will be observed and analysed.

5.   RESEARCH METHODOLOGY

5.1.   *Introduction*

In order to achieve the research objectives, a literature review has been presented in Chapter 4 to locate gaps in the field of research and to link accountability theory to the Primary Health Organisation (PHO) environment. In addition, general document studies in respect of primary health care options and the composition of New Zealand's *Primary Health Care Strategy* have been presented in Chapters 2 and 3. The results of specific document reviews are presented in the following chapters through the case study data, which comprise the empirical stage of this research. This chapter provides an argument for the particular methodology chosen and other decisions made about gathering and analysing empirical data for this research.

5.2.   *Epistemology and theoretical perspective*

5.2.1.   *Social constructionism*

The aim of this research is to examine how PHOs might comply effectively with the requirement under the *Primary Health Care Strategy* to be 'fully and openly accountable' to multiple stakeholders. Accountability is a social construct, rather than a naturally occurring phenomenon. Therefore, both the accountability concept and the role of the PHO are defined through metaphors that highlight particular functional aspects of these concepts, while hiding others (Morgan, 1988). It is the position of this researcher that these complex notions can be represented only partially and are themselves subjectively co-created between the researcher and the researched. Therefore social constructionism is the subjectivist epistemology underpinning this research (Denzin & Lincoln, 2003).

The constructionist epistemology takes a relativist position in arguing that interpretations of the world are influenced by subjectively experienced contextual factors (Crotty, 1998). In making sense of the multiple realities that exist, the researcher explores commonly agreed subjective concepts in addition to meanings attached to objects. Social constructionism may encourage reification of objects and concepts as a way of dealing with complexity (Allard-Poesi, 2005). For example, accountability may become an end in

itself rather than a relationship and an account of performance; or a District Health Board (DHB) may be portrayed as a powerful ruler irrespective of DHB staff-to-PHO staff relationships. Peeling away such reification by exploring interactions, may lead to new understandings of concepts (such as accountability) that can be ambiguous and inconsistent in practice (Prasad, 2005).

Morgan (1988) called upon accounting researchers to 'come to grips' with the limitations of partial, realist views of complex realities and to recognise multiple socially constructed meanings applied by humans as they interpret the world in which they live and work. An acceptance of multiple (relativist) views means that social constructionism contrasts to positivism – a realist view that understands the world as objectively observable and testable through value-free research by seeking to explain and predict behaviour (Ryan, Scapens, & Theobald, 1992). A further contrast of constructionism is that, rather than seeking causal linkages, naturalistic, contextually based methods are used to ask 'how' and 'why' questions.

The researcher's interpretation is molded by social interaction, thus construction is not purely individualistic but arises intrinsically from the culture being studied (Geertz, 1993). Culture, represented by meaningful symbolic actions, selects and organises human experience so that individuals and groups can make sense of their lives (Rosaldo, 1989). Agar (1996, p.236) suggests that culture "is not something people <u>have</u>; it is something that fills spaces between them." Wherever groups form (for example at national, regional, community or organisational levels), cultures evolve. Thus, differences between people's experiences can be mediated through culture which is contextually situated and is 'visible' through description, rich with metaphor. These metaphors, although reductionist, provide access to core concepts (Morgan & Willmott, 1993).

Accountability, a subjectively socially constructed concept, is culturally specific in respect of; *inter alia*, expectations, discharge and sanctions. In addition, PHOs, New Zealand specific organisations, have subjectively constructed confines. While each PHO has a legal form, the reach of the influence of these organisations extends beyond that legal form in the manner of most organisations (Hines, 1988). As relatively new institutions, PHOs are also in the process of moulding their own organisational cultural traits.

5.2.2. *The interpretive tradition*

A deeper understanding of the manner in which accountability is socially constructed in practice will be assisted by analysing relevant theory. Theories may present alternative views of reality (Humphrey & Scapens, 1996). Interpretive researchers frequently analyse dynamic organisations (Klein & Myers, 1999). The interpretive tradition provides a perspective from which researchers may interpret, or understand participants' construction of their temporally-bound and context-dependent social meanings (Searcy & Mentzer, 2003). Using an interpretive perspective, the researcher explores the actors' understandings of these actions and cultural objects (Crotty, 1998). Thus, the personal bias of the researcher will affect the report and presentation as the researcher analyses cultural artifacts, to understand the subjectively created contextual world, rather than the people themselves (Geertz, 1993). As a Chartered Accountant with experience in small businesses[118] as well as in not-for-profit organisations (in voluntary treasurer and board positions) and now as a teacher and researcher, I believe that accounting has an important internal function as well as an external communication function. Following on from my Masters thesis, I have been exploring the manner in which not-for-profit organisations can communicate effectively with stakeholders in non-financial terms, especially through their Annual General Meetings. In that observation-based study, I found the discharge of accountability to be contextually bound.

Viewing empirical data of accountability processes though an interpretive lens may inform theoretical constructs (Ospina & Dodge, 2005). Further, Ryan *et al.* (1992) confirm that the dissemination of the findings of contextual pragmatist research using interpretivist perspectives can assist practitioners to perform in a more informed manner. Therefore, although change is not the prime basis for interpretive research (Crotty, 1998), greater understanding will effect change.

As this research is concerned with how PHOs implement accountability, or how PHOs construct meaning from their actions and employ those meanings to discharge 'accountability' to multiple stakeholders within the dynamic primary health care sector, accountability provides an appropriate theoretical perspective for understanding the

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[118] Particularly, before I was employed in tertiary institutions, as a Finance Manager of an innovative gas supply company and previously as a Member of the New Zealand Stock Exchange in my role as General Manager of a discount sharebroker.

meanings constructed by PHOs and their stakeholders.

5.2.3. *Theory development*

Theory may be understood in positivist research as ordered explanations with widely generalisable predictions. However, Llewellyn (2003) argued that theory is broader, especially in respect of qualitative, interpretive research of contextually related phenomena. Theories are applied to contestable meanings derived from: individuals' sensemaking, inter-relationships of events, and the cultural and historic context (Llewellyn, 2003). In addition, theory is a rhetorical device to interpret data and convince the research community as to the validity of the researcher's findings and interpretations (Humphrey & Scapens, 1996). Applying theory provides order to analysis, explains ambiguity and provides a resource base for social communication and reflection. Accordingly, theory, as a conceptual framing of the human experience, is understood at different levels: from fundamental and ubiquitous ideas through to abstract notions divorced from empirical data, and:

- grounds meaning in metaphors;
- categorises similarities and differences;
- introduces new concepts in order to discuss practical developments in the world (or develop existing concepts, such as has occurred with 'accountability');
- explains the wider setting and contexts, especially in relation to organising and organisations;
- theorises grandly as meta-narrative (Llewellyn, 2003).

Searcy and Mentzer (2003, p.142), in acknowledging the need for theoretical insight, state: "[t]he successful researcher is the one who can not only find a research problem, but also can define and develop theories to explain and solve the problem where the existing fund of knowledge is insufficient." However, this theory development is therefore not a linear transformation of meaning, but an interpretation of empirical data against current theory and issues that arise (Berry & Otley, 2004). Consequently, data collection, assessment and analysis form an iterative process, with ongoing reflection and development (Ahrens & Chapman, 2006). These reflections may be written as analytical memos to help to understand the nexus between the data and the theoretical contribution (Marshall, 2002).

O'Dwyer (2004) explained that data analysis was a three step process: of data reduction, data display and data interpretation. Data reduction is an open coding of raw data such as recordings of interviews, field notes on site visits and diary notes. It involves recording initial summary themes emphasising contextual information, then reflecting on the data and searching for patterns of meaning. Areas of significance are coded in 'synoptical comparisons' representing systematic associations and differences, iteratively checking the application of the codes against the raw data for consistency and reliability (Kelle, 2004).

The second phase is described by O'Dwyer (2004) as data display. This process involves reducing the open coding into core codes, seeking further themes and theory development by being open to a deeper understanding of the data. This may be accomplished through, *inter alia,* computer-assisted programs, tables or mind-maps of all data collected. Ahrens and Dent (1998) describe this phase as searching for patterns, synthesizing observations, examining and re-examining material to ensure that the "patterns adequately represent the observed world and are not merely a product of [the reviewer's] imagination" (p. 9).

Computerised databases offer "the possibility of more efficient data coding and management than had previously been available" (Marshall, 2002, p.58) and have been used by a number of accounting researchers to deal with the messiness of ethnographic data (e.g. Eller, 2005; Parker & Roffey, 1997). Use of an electronic database can speed the administrative aspects of coding and the researcher can use more indices than is practically possible in a manual coding system. Being able to extract audit trails of changes (Kelle, 2004), password protect and backup the data are extra safeguards to interviewees, as well as to the researcher. There are a number of computer-assisted programs, but NVivo was recommended and available as a suitable system for use in this research. In addition to the benefits listed above, data in NVivo can be searched, retrieved and displayed in matrix and graphic formats more easily than in a manual coding system.

However, there is concern that computer-assisted coding may reduce creativity by 'forcing' data into positivist-type causal relations (Marshall, 2002). In order to deal with these concerns, I transcribed all recorded events verbatim (meetings and interviews), entailing listening and re-listening to the recordings. As these were digital, they were able to be returned to often. The transcripts were coded and a set of codes developed that

included those emanating from the literature and the data.[119] No automatic (machine) coding was used and, as an iterative project, this research involved previously unrelated codes being merged or related to similar concepts where they overlapped. Also, other codes were extended to deal with the same concepts that may have initially been expressed in different terms. As well, memos were used for reflection and to link data.

Data interpretation is the third phase of data analysis to extrapolate possible findings to other situations (O'Dwyer, 2004). Through continued data immersion and reviewing the data reductions and data displays, a 'thick' description of the findings is formulated. Events and narratives from the field link to theoretical conversations (Ahrens & Dent, 1998) so that finally, by applying the chosen theoretical lens to interpret the data, a narrative is constructed (O'Dwyer, 2004).

Through narrative or report writing, the researcher shares their insights with the academic and wider community allowing readers to assess the reasoning of their conclusions and to convey the cultural understandings from the research sites to readers from other culture/s (Angrosino & Mays de Perez, 2003). Demonstrating how the research subject was identified and describing the enquiry may also show credibility and underpin the reliability of the theoretical insights (Marshall & Rossman, 1999; Strauss & Corbin, 1990). (In this study, these explanations have begun in this chapter and will continue in the remaining chapters.)

A key objective in the design of this research was to be able to make recommendations in respect of the implementation of accountability in PHOs both to policy makers and those involved in the practice of accountability. Identifying links between theory and practice makes this a pragmatist endeavour. Understanding organisational meanings requires an exploration of the relevant cultural symbols, thus the research lends itself to qualitative, rather than quantitative analysis. For this reason, an ethnographic methodology drawn from the study of culture (Baszanger & Dodier, 2004) is considered to be an appropriate methodology to employ in order to gain an understanding of the empirical data in relation to the research question.

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[119] In addition, all transcripts were returned to the interviewee for comment and changes where necessary.

5.3.   *Research methodology*

Applying an ethnographic methodology requires the researcher to observe social phenomena as though they are unfamiliar with the culture, with the aim of grasping the perspective of those who are being observed. Assuming cultural strangeness assists the researcher to document the perspectives and practices of the people involved in that culture (Crotty, 1998). As the ethnographic methodology continually questions what seems obvious, it moves beyond an individual's perceptions so that the researcher may portray events from the view of the actors as much as possible (Erickson, 1984; Patton, 2002). This is likely to involve presenting contested meanings in today's hybrid cultures (Angrosino & Mays de Perez, 2003).

Historically, anthropologists have studied the pagan rituals, non-Western traditions and other acts of 'strangeness' of 'the other' and compared them to more familiar cultures. In accounting and accountability literature reviewed in this study, Ahrens (1996) is one of the few researchers who specifically compared conceptions of accountability in particular organisations from two national cultures: German and English. More broadly, the rise of cross-national studies in accounting has led to debates on the issue of culture. In this respect, researchers such as Gray (1988) have employed Hofstede's cultural indices to categorise nation states as single-culture sites to generate cultural generalisations. As this type of research has been rejected in anthropology and sociology, Baskerville (2005; 2003) called for more in-depth accounting research into reasons for differences in accounting practice. Ahrens and Chapman (2006) concurred with her position.

Although the current study is not across different nations, it should not be expected that the research into solely New Zealand organisations, such as PHOs, will find one 'culture' shared by all organisations, nor even within these PHOs. These organisations and their communities to whom they discharge accountability will have different backgrounds and expectations, depicting different cultural traits between and among these hybrid organisations. Therefore it is expected that these organisations and communities have the potential to be culturally dissimilar and 'strange'.

However, each PHO and community is in New Zealand, the country in which I was born and have lived most of my life. It may be argued that these cannot be 'strange' sites.

While there has been some scepticism as to whether a researcher can research their 'own' culture, Czarniaswka (1998) confirms that modern day anthropological pursuits are more likely to include the study of people who are equals or superiors as 'symmetrical anthropology', rather than studies of 'lost tribes'.

Anthropologists seeking to undertake ethnographic research have been required to have long periods of immersion to learn the 'native' language. Ahrens and Chapman (2006, p.830) stated: "many elements of that which accounting researchers seek to understand when they visit an organisational site is already known to them" due to their professional training and experience. Thus, prior understandings suggest more of an 'emic' (member) viewpoint rather than an 'etic' approach, leading to more timely ethnographic studies due to the researcher's prior immersion in accounting. A combination of both 'emic' and 'etic' approaches will enrich the analysis (Efferin & Hopper, 2007).

Ethnographic research needs to move beyond mere descriptions if the role of theory is to be privileged as the *raison d'être* of academic research (Ahrens & Chapman, 2006). When derived from ethnographic studies, theory is integrally contextually bound as: "in ethnography, the office of theory is to provide a vocabulary in which what symbolic action has to say about itself – that is, about the role of culture in human life – can be expressed" (Geertz, 1993, p.27). As such, theory may be built from scratch or existing theoretical insights may become more established, or be extended. Multiple existing theories can deepen the understanding of empirical research. However theoretical understandings will always be provisional (Humphrey & Scapens, 1996) especially as cultural universals do not exist and ethnographic studies seek to theorise, rather than generalise, cultural sites (Baskerville, 2003).

Parker and Roffey (1997) and Baszangar and Dodier (2004) noted that an ethnography incorporating the researcher's understanding in addition to participants' interactions is a 'combinative ethnography' which has been increasingly employed by researchers in observing accounting in society and specifically by accountability studies (Ahrens, 1996; O'Dwyer & Unerman, 2006; Sinclair, 1995). The hallmarks of this research are that it is:

- representational (providing narratives and context);
- interpretive (in the way it makes comparisons and interprets culture);

- rhetorical (as it places textual order on the social world researched) (Jonsson & Macintosh, 1997).

This subjective exercise uses knowledge as contextually based, rather than independent of context and objectively derived. In terms of the methods (or means) to meet the end goal of understanding the research question, Searcy and Mentzer (2003) note interpretive researchers working within social constructionism find great utility from case studies. These include direct participation, observation, and in depth interviews as ethnographic methods.

5.4.   *Research method - the case study*

"Studies focusing on society and culture, whether a group, a program, or an organization, typically espouse some sort of *case study* as an overall strategy" (Marshall & Rossman, 1999). In addition, case studies are considered to be ideal to answer the 'how' and 'why' questions of research (Yin, 2003) as they provide rich, context-dependent data. (Flyvbjerg, 2004), to provide a holistic approach of organisational construction of meaning in relation to a cultural and environmental setting (Marshall & Rossman, 1999, p.61). [120] This is especially so where the understanding of particular practices is under-developed. Yin (2003) defined a case study as research comprising an empirical enquiry that:

- investigates a contemporary phenomenon within its 'real-life' context [as the PHOs in this research (see Section 5.5)];
- has ill-defined contextual-phenomenon boundaries (a PHO is an organisation that is responsible for purchasing first level GP and other services for patients that belong to it, but patients' primary relationships are with their GPs);
- uses multiple sources of evidence (as discussed below).

Case studies are becoming increasingly popular for accounting studies as researchers respond to calls to study accounting in its practical setting in dynamic situations (Irvine & Gaffikin, 2006; Ryan *et al.*, 1992). However, Scapens (2004) noted that case studies remain controversial and require clear research questions, a thorough understanding of the literature, and a well formulated research design. Interpretive case studies can provide

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[120] Emphasis in original.

rich understandings of accounting practice and will develop and extend theory (Scapens, 2004).

5.4.1. *Case study cautions*

Despite the usefulness of case study research to help to answer 'how' and 'why' questions, such research is not without its drawbacks. Irvine and Gaffikin (2006) confirm that qualitative research is messy, due to limitations in the context, confidentiality issues and the negotiated identity and understanding of the researcher. One reason for this messiness and a consequence of the 'real-life' context, is the role of negotiation necessary in case study research. In fact, Berry and Otley (2004) note that the 'problem' of access to study domains is a key compromise in qualitative case research that must be accepted for theory to be built. Czarniawska (1997) also recommended that, due to the relative lack of researcher control that exists in these 'real-life' settings and the way that the confines of the case unfold as the study progresses, researchers should remain open to evolving issues.

One limitation to access can be concerns for confidentiality. Even when confidential data is able to be accessed, reporting of that data may be limited (Ryan *et al.*, 1992). This was the experience explained by Irvine and Gaffikin (2006) where access to confidential data, availability of staff and issues of divulging the organisation's identity, all impinged on the theoretical reflections arising from the research. Ethical concerns and protection of identity were also concerns in this research and hence approval was obtained from the appropriate University Ethics Committee before the empirical research commenced.

In addition, understanding the data as a social phenomenon is dependent on the researcher's recording (Irvine & Gaffikin, 2006) as well as the negotiated situational identity. In this research, some meetings were unable to be recorded, or notes made concurrently, due to sensitivity of the attendees. Therefore field notes, which are reliant on the researcher's memory, were used more extensively in these cases. In addition, access to confidential documents and discussions were also limited. These are acknowledged limitations.

Actively seeking out case study sites, planning and undertaking interviews, observing

meetings and accessing confidential data, are processes that are negotiated collaboratively and will depend not only on individuals' backgrounds and experience, but also the worthiness of the research and the rapport generated by the ethnographer (Angrosino & Mays de Perez, 2003). Such interpersonal interaction brings richness to the research.

5.4.2. *Case study selection*

The strength of case studies is the in-depth observations to build and enrich theory through a fresh perspective. The opportunity to provide 'thick' or rich ethnographic data from case studies highlights particularities and inconsistencies and differentiates sites (Ahrens & Dent, 1998). But Eisenhardt (1989) noted that the richness of case study data may mean that the ensuing theory development is either too complex or idiosyncratic if there is an attempt to encapsulate all data gathered. This is because contextually dependent evidence generates limitless inter-relations, making it difficult to define the subject matter boundaries (Ryan *et al.*, 1992). To reduce 'information overload' a case study's context may be limited to a particular aspect whilst ensuring it does not ignore 'inconvenient' data (Ahrens & Chapman, 2006). It is important that the researcher is open to emergent issues (Seale, Gobo, Gubrium, & Silverman, 2004) although defining the research focus and research question before beginning the case study may reduce data overload (Eisenhardt, 1989). However, the focus may need to be adapted as conditions for access and data accessibility are negotiated. Particularly in this research, as noted in Section 5.5.3., one case study PHO did not allow access to consultations it held with certain of its communities. Therefore, a range of other data was sourced from the groups which were analysed to be that PHO's prime stakeholders. Access to some of these groups was subject to further negotiation as the research progressed.

A single case study, when the researcher can gain a deep appreciation of one setting, potentially provides the richest data, generating specific implications and theory (Klein & Myers, 1999). However, the findings from one ethnographic study may not be construed as being able to provide significant learning insights across whole populations. Multiple case studies with divergent properties may contribute to theory development when patterns are found across different case studies (Flyvbjerg, 2004). For example, Ahrens (1996) undertook two case studies in different countries to explore the construction of accountability and Eller's (2005) study of four Local Authorities across two different

countries was also able to highlight similarities and differences useful for building theory. The ethnographic research conducted by Ospina *et al.* (2002) observed how leaders in one hundred different organisations balanced multiple stakeholders to deliver effective accountability (a number of researchers were employed in this programme of study). Czarniawska (1997) built her theoretical insights into organisational change from over twenty organisations, again employing more than one researcher in the process. Eisenhardt (1998) suggested four to nine cases can provide opportunity for depth and theory development, especially when only one researcher is involved.

Ahrens and Dent (1989) warn that extending the number of cases to five or more, makes dissemination of findings to the academic community very difficult, due to space constraints. Further, they suggest that increasing the number of cases arbitrarily may harm the likelihood of the researcher gaining rich theoretical insights. Small samples provide the opportunity for contextual depth and a deeper appreciation of the accounting discipline in social settings as they allow a close engagement with a rich research field. Theory may be developed when findings are applied to more than one case. Selecting cases in order to lead to theory development calls for different choices than those taken if generalisability to a larger population is the goal (Scapens, 2004). Ryan *et al.* (2003) suggest that, in interpretivist research seeking to extend theory to a different set of circumstances, the selection of critical incidents or cases that are at the extremes of the population may be most appropriate.

5.4.3. *Case study methods*

In addition to multiple case studies, the use of multiple methods has been advocated as a way to corroborate assumptions reached from the interpretation of ethnographic case study data. Yin (1992) terms this method 'triangulation', where multiple data sources such as observation, interviews and reviews of documentation combine to reach a valid research conclusion. Multiple sources of evidence provide for more robust assessment of the data to corroborate the findings of the case studies. Yet, Ahrens and Chapman (2006) argue that this presumes an objective reality that the interpretive tradition does not support. Instead, as suggested by Denzin and Lincoln (2003) triangulation – the use of multiple methods – may add rigour, breadth and depth to qualitative research as the researcher iteratively seeks to generate a plausible fit between the data, the theory and the

problem. When the actors' voices are heard, the reader can analyse those voices separately from the researcher's theoretical interests to assess the rigour of the research process. Accordingly, multiple methods deepen the researcher's knowledge of the organisation and may:

- facilitate data collection (for example a written request for annual reports and dates of AGMs, observation of meetings, analysis of financial reports and interviews) guided by prior theory and other observations;
- be complementary to one another to provide different views of the research question (where checklists against processes may complement observation and interviews) (Brannen, 2004).

So as to be of maximum usefulness to the research participants, employing multiple informants or interviewees will also provide a form of triangulation (Dodge, Ospina, & Foldy, 2005). Interviews are social encounters (Rapley, 2004) enabling both the researcher and the interviewee to analyse events and the construction of social reality. Interviewees may represent their own views or those of their organisation, although the researcher should also work with the interviewee to construct a reality through dialogical negotiation (Denzin & Lincoln, 2003). Structured interviews, with pre-set questions, are of limited value in exploring deep understandings so that case studies typically use semi-structured and unstructured interviews in order to illuminate how people in organisations make sense of their actions (Czarniawska, 1998; Irvine & Gaffikin, 2006). In-depth interviews are most likely to be useful in terms of this particular project, to discern what individuals believe PHO accountability means to them.

A second method is direct observation, or *in situ* study. In much the same way as interviews are collaborative, so is observation. Although observation may include endogenous behaviour, the dynamics will be shaped by the researcher's presence. Accessibility may also be restricted by the researcher's membership role in the case study organisation, which can range from peripheral, through active, to being a complete member researcher. Similarly to Eller (2005), this study focuses more towards peripheral member research, where the ethnographer does not participate in activities that are core to membership in the case study organisations. For example, although able to attend community meetings, I was not a member of the PHOs chosen for case study sites and did not have a relationship with a particular General Practitioner (GP) in those PHOs.

However, in one case study site my enquiry about an AGM began a series of organisational conversations about engagement with stakeholders that otherwise might not have occurred. Hence, the researcher's enquiries and observations gleaned in this manner are not neutral, but involve collaborative understandings (Denzin & Lincoln, 2003). Observations from meetings provide data that may corroborate (or otherwise) that gleaned from interviews, especially when these meetings provide evidence of how PHOs interact with their stakeholders.

Covaleski and Dirsmith (1990) confirm that socially constructed meanings are constructed over a long period and therefore case study methods include combining archival data with interview and observation data to provide a more holistic view of the organisation. Field notes of access negotiations, AGMs and community consultation meetings and interviews will also assist. Document reviews of government policy provide a contextual base to this study, while specific organisational documents such as: the organisation's founding documents, contracts between the organisation and purchasers, annual reports and internet sites all provide specific understandings of the research sites. With the exception of my own field notes, written documents are separated from the author and therefore provide an external (non-member) perspective of the organisation. However, they also raise the issue of why they were produced and what functions they may perform. The content of these accountability documents will be analysed against current regulation (as outlined in Chapter 4), in addition to their narratives of PHO's performance.

The combination of observation, interviews and document reviews in a case study can be endless, however it is necessary to limit the collection of data to that which is relevant to the theory and initial questions. When the empirical data ceases to provide new linkages (either supportive or contradictory) in the theory developed, theoretical saturation is reached and direct data collection should cease (Ahrens & Dent, 1998). Indirect data collection continues as those being researched are provided with opportunities to review and feed back on the research findings.

5.5.   *The PHOs in this research*

In respect of this research, the desire to generate insights useful for practitioners provided

an argument against choosing only one PHO for case study research. However, a single researcher is limited in scope to a small number of cases and it was not practical to study all 80 PHOs existing in a number of organisational forms in New Zealand. From the arguments by Scapens (2004) for multiple studies, Eisenhardt (1989) for between four and nine and Ahrens and Dent (2006) for less than five, it was decided that four diverse PHOs should be selected as case studies. By identifying organisations that held characteristics more marked than the norm, it was hoped that theoretical insights would be at least partially applicable to other PHOs. Three stages of selection were followed in order to achieve this aim. These were:

i.   General search and sorting;

ii. Pilot AGM study;

iii. Selected approaches to PHOs.

5.5.1. *General search and sorting*

A spreadsheet was obtained from the Ministry of Health with a set of pivot tables that enabled data relating to PHO enrolments at 1 April 2006 to be analysed. In addition, data available from the PHO Yearbook (Ministry of Health, 2005b), PHO websites and other PHO specific data was analysed in order to identify extreme PHO cases. The characteristics of the PHOs were sorted on the following lines:[121]

- the 2006 level of funding (Access or Interim), dependant on the New Zealand Deprivation Index quintile of PHO members' residences;

- whether the PHO was small (with a population of less than 20,000), medium (population between 20,000 and 75,000), or large (population over 75,000); how many General Practices and GPs were contracted to the PHO (where able to be ascertained);

- the location of the PHO in a predominantly urban, mixed or rural area;

- the relative ethnic mix of the PHOs' members compared to the national averages;

- the relative age groupings of the PHOs' members compared to the national average, then re-sorted by Access and Interim (or mixed) funding levels;

- organisational type.

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[121]   For more detail, see Appendix 5.

Under the *Primary Health Care Strategy* (Minister of Health, 2001), PHO capitation has been based on members' socio-economic status and the number of members (size). The main factors for selecting PHOs, therefore, were: the socio-economic extremes of the members (PHOs with predominantly more members in quintile 5 or quintile 1) and whether the PHO was large or small. Further, concerns of the Strategy were addressed by refining the initial selection on measures such as ethnic diversity and age diversity. In addition a mix of city and non-city PHOs was sought in order ascertain challenges between small communities and cities. A final aim of the selection was to include a range of organisational types. This reduced the selection to 37 PHOs.[122] From these, it was decided that eight could be selected for initial contact from which to draw the final four case studies. The aim was to obtain publicly available annual reports and to attend AGMs or community consultations for eight disparate PHOs. PHOs with a predominantly Mäori or Pacific focus were also removed from the selection due to differing ethnic conceptions of accountability. As a New Zealand European, I believed that my ethnicity was less likely to cause difficulties in obtaining suitable access and that 'mainstream' organisations may be more likely to exhibit characteristics evident in extant accounting and accountability research.[123]

5.5.2. *Pilot AGM study*

The aim of this stage was to observe the AGMs of eight PHOs that may provide a database for selection of the four case studies. Each of the meetings attended in late 2006 were digitally recorded and transcribed and when referred to in the data analysis chapters following, are identified as noted in Figure 5-1.

Seventeen PHOs were approached within the parameters of the selection confines to obtain eight PHOs for the pilot study of AGMs. The remaining nine PHOs did not have public meetings at which their community could call them to account and, in many cases, would not provide annual financial or non-financial reports upon request.[124] In addition,

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[122] Of those with a high proportion of members in quintile 4 and 5, 1 was large and 25 were small. From PHOs with a high proportion of members in quintiles 1 and 2, 6 were large and 5 were small.

[123] Removing Mäori and Pacific PHOs reduced the group of small PHOs that also had a high proportion of members in quintiles 4 and 5 by a further 13 PHOs.

[124] This mirrors the experience of McCardle *et al.* (2004) in their study of 14 PHOs. Douglas (2006) also noted he could not obtain all financial reports, although he did not provide the parameters of his study.

all PHOs were contacted and asked for their annual report and for details of their AGMs to ascertain whether substitutes could be made for non-responses. In total, 19 annual reports were obtained but, as noted below, no substitution was required to be made.

Figure 5-1: Organisational characteristics of pilot study PHOs

PHO identification[125]	Organisation form	Characteristics	Public present[126]	Meeting site
PHO 1	Charitable trust (includes providers and members of local community)	Large, city-based mainly Interim funded.	30	Local function room
PHO 3	Charitable trust (includes providers and members of local community)	Small, Access funded, patients ethnically diverse, urban.	19	Church in local community
PHO 4	Limited liability company – shareholders include IPA & community health trusts	Small, mainly Interim funded, patients older, rurally situated.	15	Local community centre
PHO 5	Charitable trust (includes providers and members of local community)	Large, city-based, mainly Interim funded	22	Management Services Organisation's meeting room
PHO 6	Charitable trust (includes medical centre reps. and members of local community)	Small, Interim funded, patients ethnically diverse, urban.	10	Local community centre
PHO 7	Charitable trust (includes providers and members of local community)	Small, Access funded, patients mainly Māori and Pacific, urban.	1	Management Services Organisation's meeting room
PHO 8	Charitable trust (includes providers and members of local community)	Large, city-based, mainly Interim funded.	18	Local community centre (marae)
PHO 9	Charitable trust (includes providers and members of local community)	Large, mixed city and rural, mainly Interim funded.	14	Local function room

The ability to gain access is a key difficulty in accounting case studies (Irvine & Gaffikin, 2006), as organisations may feel the researcher will take too much time and/or may not wish to be 'completely open'. After my request to attend the AGM as part of the wider study, one PHO would not provide access and wrote to me saying:

> *The reason for the decline in your request is that xxx PHO [PHO 18] is a new PHO … The timing of your audit on our accountability systems is too early in terms of our organisational development. (Personal communication 13 October 2006)*

Given that my written request had not mentioned the term 'audit', nor was this the

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[125] The numbering follows the PHOs identified in section 5.5.3. PHO 2, which did not have a public AGM, is not included in this figure.

[126] These numbers have the researcher and board members removed, but do include providers and other parties related to the PHO.

intention, this reaction was unexpected. The implications of difficulty in access negotiations are that the sample successfully gained may effectively be self-selecting and therefore not representative of the population. This has an impact on whether the findings can be generalised to other PHOs, but, as this is not an objective of this study, this is a weakness of the research that can be accepted.

5.5.3. *Selected approaches to PHOs*

Subsequent to the preliminary AGM visits, Victoria University Faculty of Commerce and Administration ethics approval was obtained and access was negotiated with four PHOs as case studies for this research. PHO 2 (a limited liability company owned by an IPA) had not had an open AGM, but offered me access to a community consultation to be held in early 2007.[127] Due to its socio-economic and cultural characteristics, and the possibility of meetings to observe in the study period, it was decided to include PHO 2 in the study. As well as accessibility, the case studies were also chosen to provide a geographical spread and include organisations that had formed from both IPA and community backgrounds. The PHOs that assented to be used as case studies were as follows:

- PHO 1 – a large PHO with members that are mainly city-based, enjoy higher than average socio-economic conditions (previously mainly Interim funded Practices);
- PHO 2 – a large, city-based PHO with the majority of its members having lower than average socio-economic status (previously many Access funded Practices), and who are younger than the national average. It has a higher proportion of Mäori and Pacific Islanders than the national average;
- PHO 3 – a small, ethnically diverse, city-based PHO with members who have incomes below the national average (previously mainly Access funded Practices); and
- PHO 4 – a small, rural PHO with members who enjoy higher than average socio-economic status (previously mainly Interim funded Practices), and are older than the national average.

In addition, the PHOs approached and selected provided a structural snapshot as PHO 1 and PHO 3 are charitable trusts and PHO 2 and PHO 4 are limited liability companies.

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[127]   In the event, this community consultation did not eventuate.

The empirical research was planned to take in two annual financial reporting cycles and two AGMs (in 2006 and 2007) and to map the processes of accountability discharge during that period. As well, semi-structured interviews and document reviews were undertaken during this period and, as noted, each of the meetings attended and all of the interviews were digitally recorded and transcribed. Website material was also captured. The majority of documents reviewed were in the public domain, with the exception that each PHO also provided me with a copy of their DHB/PHO accountability report (a contractual document that has limited circulation). The document review provided information about the expectations of stakeholders such as the DHBs and PHO members, and also, by reviewing reports on performance, was informative as to current means by which accountability is being discharged.

5.5.4. *Semi-structured interviews and observations*

A number of formal PHO meetings with community were observed. In addition, in each PHO, semi-structured interviews were undertaken with key stakeholders. By asking what people perceive accountability to be, this research provides a benchmark against which the discharge of accountability can be judged. The goal was to select stakeholders who could provide an understanding of the informal and formal means the PHO uses to manage stakeholders' expectations and by stakeholders to control the PHO's behaviour. This builds on the theoretical analysis recommended by Glaser and Strauss (1967). Interviewees were selected to fulfil general categories as follows:

- 'upward' accountability relationships represented by the relevant DHB staff member;
- 'inward' accountability relationships represented by the PHO Chief Executive (or manager), the Board Chair and a spokesperson for the providers;
- 'downward' accountability relationships represented by
     a) a member of the media because of the role the media has in providing urgency to stakeholders' demands;
     b) the Mayor or other elected local representative;[128]

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[128] At the time the Kaikoura PHO was established, the Mayor was adamant that he or another political representative be part of the negotiations as he believed the local Council could speak for diverse community interests. The Chair of the PHO Establishment Committee suggested the Mayor may need to be assisted by someone "who knew something about health" (Mitchell, 2006). In being 'fully and openly accountable' PHOs may need to find ways to recognise and be held to account by

c) and d) a representative of an organisation that is contracting with the PHO on its Health Promotion activities and another community member who also represents a key focus of health funding in that PHO or a high-need health group in the community.

The questions asked in the semi-structured interviews were based on the themes arising from the literature. They recognised the inherent ambiguity of the accountability concept and the sometimes conflicting demands of stakeholders on not-for-profit organisations. The structured questions comprised the following:

   (i)   What do you think the role of the PHO is and to whom is it accountable?
  (ii)   Within accountability relationships, what is the key reason for accountability to be demanded of the PHO?
          a)   Is it to control the PHO?
          b)   Is it to build on extant trust?
 (iii)   How important is it for the PHO to have a separate identity (reputation)?
 (iv)   For what is the PHO accountable?
  (v)   In respect of the process of accountability:
          a)   What mechanisms are/should be used by the PHO?
          b)   Are stakeholders able to apply sanctions to the PHO and what is the role of learning in the application of these sanctions?

The interview data and the observations from the meetings attended, are analysed in the following two chapters, firstly by stakeholder groups (in Chapter 6) and then by PHO (in Chapter 7).[129]

Interviewees were also asked "what attributes comprise a not-for-profit PHO?" The analysis of this foundational requirement for PHOs is presented in Chapter 8.

5.5.5. *Case study feedback*

In addition to the case study observations and document reviews, each PHO was provided

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democratically elected representatives of their communities.

[129]   Not all interviewees were able to or wished to provide an answer to all questions and for this reason the numbers of replies to questions varied. In addition, replies were not always mutually exclusive.

with a report including a summary of the initial findings (both general and specific to each PHO). While the reports presented a history of the PHOs' accountability relationships during the study period, incorporating feedback recognised that the research findings cannot be solely those of the researcher and provided further rigour.

5.6.   *Summary*

This chapter has outlined the basis for this research. The underlying epistemology for this interpretive study is social constructionism. An ethnographic methodology will be used to analyse data obtained from four case studies including document studies, semi-structured interviews and observation of meetings. The raw data from these empirics will be analysed and coded to facilitate analysis of the accountability demands and the manner in which PHOs implement in a meaningful way, the requirement to be fully and openly accountable. In this analysis, the case study data will be grouped and sorted against the categories drawn from the accountability literature in order to make a contribution to relevant theory. In addition, so as not to force the interpretation of the data to particular codes, data will be reviewed to check that relevant phenomena have not been excluded from the codes generated by theory (Kelle, 2004). NVivo, a computer-assisted qualitative data administration program will assist in 'book-marking' and assigning codes and in cross-referencing the relationships between the different perspectives on the data represented by the codes.

The outcome of the negotiations for case study access and the data analysis of the document studies, semi-structured interviews and observation of meetings is presented in the following chapters that consider stakeholder and PHO viewpoints on accountability, the structure of the PHOs, and the ramifications for accountability concepts arising from these analyses.

6. VOICES FROM KEY STAKEHOLDERS

6.1. *Introduction*

As explained in Chapter 5, the data from the semi-structured interviews have been analysed on the basis of: (i) stakeholders and (ii) Primary Health Organisations (PHOs). In this chapter, the views of the stakeholders are reported; the findings of the interviews based on the case study PHOs are reported in Chapter 7.

Four groups of stakeholders were interviewed, namely:

- District Health Board (DHB) staff (termed 'DHB Reps') – staff members responsible for liaising with PHOs on funding issues;

- PHO staff/Chairs (termed 'PHO Reps') – the Chief Executive Officer (CEO) (or equivalent) and Chairs of the Board of each case study PHO;

- Contracted providers (termed 'Provider Reps') – a General Practitioner (GP) and a non-GP provider from each constituent PHO;

- Community (termed 'Community Reps') – including media, community members of PHO Boards, individuals working for organisations delivering primary health care services and elected Local Authority representatives.

The interviews sought to ascertain the stakeholder groups' views on determinants of PHO accountability, in particular, on the following issues:

(i) the role of PHOs and to whom PHOs are 'fully and openly accountable' (Minister of Health, 2001);

(ii) why accountability is demanded of PHOs;

(iii) for what PHOs are accountable; and

(iv) the process of accountability: mechanisms by which the accountability of PHOs may be obtained and sanctions imposed or rewards given.

As explained in section 6.2, analysis of the stakeholders' views on the role of PHOs and to whom they are accountable indicates the existence of a continuum, extending from stakeholders who consider that PHOs should give priority to the needs of their community at one extreme, to stakeholders who believe PHOs should prioritise meeting the needs of their funding and contracted service providers on the other. While there is a

tendency for the views of the different stakeholder groups to cluster around the centre of this community-provider continuum, analysis of interviewees' opinions based on PHOs rather than stakeholder groups (reported in Chapter 7) results in more distinct differences.

Analysis of interviewees' responses with respect to why accountability is demanded of PHOs signals the existence of another continuum, extending from the view that accountability is a mechanism for controlling PHOs at one extreme, to that of accountability as a mechanism to enhance extant trust at the other. (This control-trust continuum is discussed in section 6-3.) Mapping the control-trust continuum against the community-provider continuum and plotting the positions of the four stakeholder groups in the resulting quadrants provides insights into the similarities and differences between the opinions of the stakeholder groups.

Interviewees' responses to the question: "for what are PHOs accountable?" are diverse but are related to notions associated with the control-trust continuum. Similarly, in the final analysis section of this chapter, the range of processes (mechanisms and sanctions/rewards) the stakeholder groups consider appropriate for securing PHOs' accountability indicate that these are related to the community-provider continuum.

6.2. *The role of PHOs and to whom they are accountable*

As a means of establishing a foundation for determining stakeholders' views as to whom PHOs are accountable, the interviewees were asked what they understood the role of PHOs to be. Analysis of their responses indicates that, although most of the interviewees consider that PHOs have a role in catering to the needs of both their community and their providers of funding and/or contracted services, they conveyed the belief that PHOs have primary responsibility to meet the needs of one group or the other. The stakeholders' responses are summarised in Figure 6-1 and reported in more detail below.

Figure 6-1: Stakeholder responses to the questions "What is the role of PHOs?" and "To whom are PHOs accountable?"

Categories of responses	Total (36) No.	DHB Reps (4)		PHO Reps (8)		Provider Reps (8)		Community Reps (16)	
		No.	%	No.	%	No.	%	No.	%
Prioritisation accorded to the community									
(i) Delivering a total health service PHOs are intended to coordinate primary health care in the community. They are responsible for the totality of health care services in a community.	20	2	50	6	75	5	63	7	44
(ii) Community-driven organisations PHOs are expected to engage with communities, to have community representation on their Board and to use community providers for some relevant services.	13	1	25	4	50	4	50	4	25
(iii) Accountable to the community PHOs need to discharge accountability to the community as a generic term.	36	4	100	8	100	8	100	16	100
- community generally	31	4	100	7	88	7	88	13	81
- enrolled population	10	2	50	1	13	3	38	4	25
- Māori	9	2	50	2	25	0	0	5	31
- taxpayers	7	2	50	1	13	5	63	4	25
- community groups	6	1	25	1	13	4	50	3	19
Prioritisation accorded to the providers									
(i) 'GP-centric' view on wellness PHOs provide a framework for General Practices to roll out additional services. General Practices are the 'medical home' of the population.	14	1	25	2	25	5	63	6	38
(ii)(a) Following the direction of their DHB PHO's plans align with their DHB's District Annual and Strategic Plans.	9	2	50	3	50	0	50	4	44
(ii)(b) Supporting General Practice PHOs should provide administrative and clinical support to General Practices.	8	0		1		4		3	
(iii) Accountable to the funder PHOs must discharge accountability to the funder (as GPs have in the past)	32	4	100	8	100	7	88	13	81

Stakeholder Groups[130]

[130] As noted in Chapter 5, replies are not necessarily mutually exclusive, nor did all stakeholders answer all questions. Percentages are worked with the number of interviewees as denominator.

6.2.1. Prioritisation accorded to the community

(i) PHOs are responsible for delivering a total health service

As can be seen from Figure 6-1, 20 of the 36 interviewees expressed the view that PHOs should be responsible for delivering a total health care service to their community, with six of the eight PHO representatives sharing the vision of PHOs as coordinators (or integrators) of primary health care services; these include 'new' services (for example, health promotion programmes) as well as those traditionally delivered by GPs. Similar views were expressed by five of the eight provider representatives (including one GP), two of the four DHB, and seven of the 16 community stakeholder interviewees. Examples of statements by interviewees conveying this notion of PHOs as coordinators of a total primary health care service include the following:

> *Other than the obvious of providing health services, we see the role of PHOs in the future as being responsible for, not quite the totality of health services in terms of provision but at least considering the provision of health services for patient outcomes and population health, so it is far wider in scope than just primary care services. It would involve PHOs taking a far more holistic approach to health care and starting to think about other agencies and their roles. (DHB Rep)*

> *I see the PHO as an opportunity to bring together a variety of different people working in the broader area of health; all those things that affect health determinants. (PHO Rep)*

> *What's important is that for people requiring services there's a seamless transition amongst the providers of the services that they can access and that doors are open to them quicker and easier. (Provider Rep)*

> *I think the idea is that PHOs provide all primary health care so that they're trying to integrate all the different players, not just the GPs but physios, social workers, midwives and all the primary caregivers. (Community Rep)*

While some interviewees referred to this concept as 'holistic primary health care', others used the terms 'umbrella' organisation or 'coordinator'. The concept of PHOs as 'holistic' or 'umbrella' organisations requires PHOs to have a comprehensive awareness of their communities' needs.

(ii) PHOs are community-driven organisations

Thirteen of the 36 interviewees went beyond the notion of PHOs needing to be aware of

their communities' needs; they considered that these needs should be the main 'driver' of PHOs' activities. The following are representative of these views:

> *The role of a PHO is that it is a community-driven organisation that oversees the primary care services of that community … To me, the important thing is whether they are a community-driven organisation. (DHB Rep)*

> *Their role is to prioritise the primary health care in this area and to liaise with the community to see what they feel it should be. (Community Rep)*

This group of interviewees explained that community-driven organisations were expected to collaborate with non-governmental organisations (NGOs) to deliver programmes such as health promotion and primary mental health services, include community representation on the PHO Board, and consult with the community.

(iii) PHOs are accountable to community

Although 32 of the 36 interviewees indicated that PHOs should be accountable to the providers of their funding and/or contracted services, all 36 interviewees recognised the community as a primary stakeholder to whom PHOs should be accountable. The dichotomy embedded in the views of the interviewees is illustrated by the following representative examples:

> *I think [the PHO is] accountable to the community probably and responsible for the money back upwards to the DHB. I mean they give the money. The PHO is accountable for the money, but actually I think it is very responsible for what goes on in the community – the total health package in the community. (Provider Rep)*

> *The PHO has to be accountable to community. Obviously they have to be accountable to government because that's where the money comes from. So they have to be accountable upwards, but they have to be accountable down to us, I mean we are the people who they should be asking about how they spend it [the funds provided by the community]. (Community Rep)*

Figure 6-1 shows that, although all 36 interviewees considered that PHOs should be accountable to 'the community', their views on what 'the community' comprises differed quite markedly. Some (particularly the DHB and community representatives) segregated 'community' into a number of groups; they recognised, in particular, enrolled populations, Mäori, taxpayers, and community groups (represented by NGOs).

Thirty-one of the 36 interviewees expressed the view that PHOs are accountable to the community generally. They stated, for example:

I believe the PHO is accountable to the community at large. Now some of them are the enrolled population and some of them aren't, because there's all this cross boundary stuff. (PHO Rep)

The PHO is responsible to its enrolled population but, if it's going out to do some preventative work, like a thing on obesity, the PHO can't just say, "we'll deal with you, because you're one of us but not with you - you're the one that really needs it but you're not actually enrolled." So PHO accountability has got to be community wide. (Provider Rep)

I guess they are only funded for their enrolled community but I think the basis of PHOs was to benefit the health of all New Zealanders so I think that it perhaps should be a bit broader. (Community Rep)

I think the PHO accountability is wider than the enrolled patients – it's the whole population. (Community Rep)

As explained in Chapter 3, PHO funding is calculated not on a 'community' basis but on the population enrolled with the General Practices contracted to the PHO. It is not surprising, therefore, that 10 of the 36 interviewees conveyed the notion that 'community' is synonymous with PHOs' enrolled populations. For example, one PHO representative noted:

On one level the PHO is accountable to the DHB. I know the community is kind of a nebulous concept in some ways, but I still think the PHO is accountable to its enrolled population because it's actually their money. (PHO Rep)

Along similar lines, a DHB staff member explained:

As a DHB, we'd hold them [PHOs] accountable to their enrolled population. The Ministry of Health would think they're accountable to their enrolled population – if push came to shove, that's what it would be. But we know that the intent of the Strategy is to take a broader approach. (DHB Rep)

This last statement reflects a perceived tension between the intent and implementation of the *Primary Health Care Strategy*. This is explored further in Chapter 9.

Nine of the 36 interviewees who stated that PHOs are accountable to the community in general also specified that PHOs have an obligation under the Treaty of Waitangi (the Treaty) to be accountable to Māori. In the view of these stakeholders, the importance of honouring the Treaty obligation for Pakeha[131] and Māori to work together as partners in New Zealand's bi-cultural society combines with the *Primary Health Care Strategy* requirement that PHOs should target Māori (who consistently rank poorly in health

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[131]   Pakeha refers to New Zealanders of British or European ancestry who settled in New Zealand.

statistics) to indicate that priority should be accorded to Mäori. For example, one community representative noted:

> *Well I think they would say they are accountable to the whole population but the priority must be to Mäori. (Community Rep)*

As will be explained in the following chapter, PHOs have particular challenges in discharging their accountability to Mäori.

Six of the nine interviewees who specified that PHOs should be accountable to Mäori, together with one other interviewee, also expressed the view that PHOs are accountable to taxpayers. These interviewees noted, for example:

> *They're accountable to the public in general. That's you and I – the people who pay taxes. (DHB Rep)*

> *It's [the PHO is] accountable to the public because it's spending public money and providing public services. (PHO Rep)*

> *So when you think about it, it may be more [that the PHO is accountable to] the general people in New Zealand. The Ministry and the DHB are theoretically there to represent the people as they are agents of the government aren't they? (Provider Rep)*

This last observation conveys the view that PHOs are accountable to taxpayers (or the general public) but the latter rely on the providers of taxpayers' funds to the PHOs (i.e. the Ministry of Health and District Health Boards) to ensure that PHOs are held accountable for the responsible use of those funds. This suggestion is more fully explored in Chapter 9.

6.2.2. Prioritisation accorded to providers

In the introduction to this chapter it was noted that the interviewees tended to voice two alternative views, namely, that PHOs should accord priority to meeting the needs of (i) their community or (ii) the providers of their funds and/or contracted services. In this section stakeholders' views in respect of PHOs' responsibility to their funding and services providers are examined.

(i) PHOs are responsible for a 'GP-centric' view on wellness

From Figure 6-1 it may be seen that 14 of the 36 interviewees (including five of the eight

contracted providers[132]) seem to perceive health care service providers and PHOs as synonymous. Thus, they considered that PHOs support GPs as the 'medical homes' of the population; or, as termed by one of these interviewees, PHOs are 'GP-centric'. To an extent, this results in a change in the locus of some treatment. For example, one interviewee observed:

> *A lot of what the PHO does in the community used to be done in the hospital. If it can care for them in the community, in their homes, or they can come and see their GP without having to go to a hospital, I think the outcomes are actually more favourable. (Provider Rep)*

The provider representatives also noted that the *Primary Health Care Strategy* has resulted in a shift from an 'illness' to a 'wellness' focus. A number of the community stakeholders shared this viewpoint and expressed it along the following lines:

> *The PHO is a wellness clinic rather than somewhere you go when you are ill. (Community Rep)*

> *The PHO has a focus on prevention and wellness rather than illness and [receives a] funding formulae to prevent illness and pass the savings on to people. (Community Rep)*

The implication from these interviews, that PHOs are synonymous with their contracted service providers and are 'GP-centric,' possibly results from the manner in which PHOs' funding lines are based on patient/GP enrolment.

(ii) PHOs should follow the direction of their DHB

Two of the four DHB representatives, three of the eight PHO interviewees, and four of the 16 community stakeholders considered that it is important for PHOs to follow the direction of their DHB or the Ministry of Health. The following are illustrative of the views expressed:

> *The PHO is accountable for delivering health outcomes to the community … in line with the Primary Health Care Strategy which is in line with the DHB District Annual Plan which should be in line with the DHB's Business Plans. (PHO Rep)*

> *I think the role of the PHO is really two ways – it's actually agreeing to do something for [the DHB] and then ensuring that it can actually deliver it. So [it's the PHO] actually agreeing to a contract, making sure it delivers it and then is accountable – [the PHO is] the conduit to make sure it happens and the buck will stop with it. (Community Rep)*

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[132] Including all of the GPs.

These comments are reflective of the primary health care system that existed prior to the introduction of the *Primary Health Care Strategy.*

(iii) PHOs should support General Practice

As shown in Figure 6-1, four of the eight provider interviewees, three community and one PHO representative expressed the opinion that PHOs should have as a priority meeting the needs of health care service providers. They should achieve this by, for example, providing support and assistance to their constituent General Practices and their GPs and, possibly, lobbying on behalf of their GPs for increased funding. Such views were expressed as follows:

> *The PHO supports the GPs very strongly - it's about maintaining the viability of primary care services. The [PHO] Board knows how important it is to have a GP in the community. (PHO Rep)*

> *If a Practice is struggling, they should be able to go to the PHO and ask for help. (Provider Rep)*

> *So my view is that they take care of the Doctors. (Community Rep)*

Supporting General Practice may indicate the preservation of the primary health care system that existed before the *Primary Health Care Strategy.* However, it also underscores the integral role of clinical practitioners in PHOs, as well as measures such as the Performance Management Programme (explained in Chapter 3) that are designed to hold PHOs accountable for their General Practice-based service providers' clinical outputs.

(iv) PHOs are accountable to their funding and services providers

As noted in section 6.2.1.(iii), all 36 interviewees expressed the view that PHOs are accountable to their communities. Figure 6-1 indicates that almost all of the interviewees (32 of the 36) signified that PHOs are also accountable 'upwards' to the DHB, the Ministry of Health and, ultimately, to the Minister of Health. However, the DHBs, as intermediary funding-providers, seem to consider that they should be accorded priority. This view is reflected in the following quotations:

> *I think the PHO has difficulty in agreeing who they are accountable to. Their view on who they are accountable to is that it is the Ministry of Health and they don't like having that layer in between with the DHB. But my view, and it is true and*

correct, is that they are accountable to the DHB and ultimately to their population, to their communities. (DHB Rep)

Well they're accountable to the DHB. But the DHB, in turn, is also accountable to the community. We're just the monitoring arm, aren't we? (DHB Rep)

The understanding of the latter DHB representative is contrary to the legal position of those to whom DHBs are accountable. Under the Crown Entities Act 2004 (s.26) and the Public Health and Disability Act 2000 (ss.39-42), DHBs are accountable to the Minister of Health and the House of Representatives (as noted in Chapter 3). The perception of DHBs as accountable to their community probably arises because seven of the eleven members on each DHB Board are elected by their communities.

While the majority of interviewees signalled that PHOs are accountable to both their community and the providers of their funding and/or health care services, the second DHB representative cited above seems to suggest that some DHBs may consider themselves responsible for monitoring PHOs' performance on the community's behalf. The ramifications of this expectation are discussed in Chapter 9.

6.2.3.   Stakeholders' views on the community-provider continuum

Although, as reported above, most interviewees noted that PHOs are responsible for meeting the needs of both their communities and their contracted health service providers and/or funders, they considered that PHOs have a primary responsibility to one group or the other. Nevertheless, as reflected in the following provider representative's statement, stakeholders' views are dynamic and may swing from one viewpoint to the other:

> *I think there was value in PHOs moving from a clinician-led primary care system to a partnership of clinicians [i.e. service providers] and community and I personally bought into that for a period of time. The reality is that there's been a replacement effect, that clinical governance has been largely extinguished and been replaced by community governance. Clinical leadership is grudgingly tolerated rather than accepted as a healthy dynamic with community leadership. So to me, the pendulum has swung too far and I will continue to be active to try and bring it back to a better balance of clinicians and communities. (Provider Rep)*

This view, that the 'pendulum has swung too far', suggests that stakeholders may hold views which range from believing that PHOs should focus almost exclusively on the needs of their providers to the view that they should focus almost exclusively on the

needs of their community. This indicates a continuum of viewpoints.

Using the data provided in Figure 6-1 which summarises interviewees' responses to questions relating to the role of PHOs and the party(ies) to whom they are accountable, the 'average position' of each stakeholder group was determined in a manner explained in detail in Appendix 6. As may be seen from Figure 6-2, this resulted in a clustering of the opinions expressed by the four stakeholder groups.

Figure 6-2: Stakeholder group's views on the focus of PHOs' responsibility and accountability
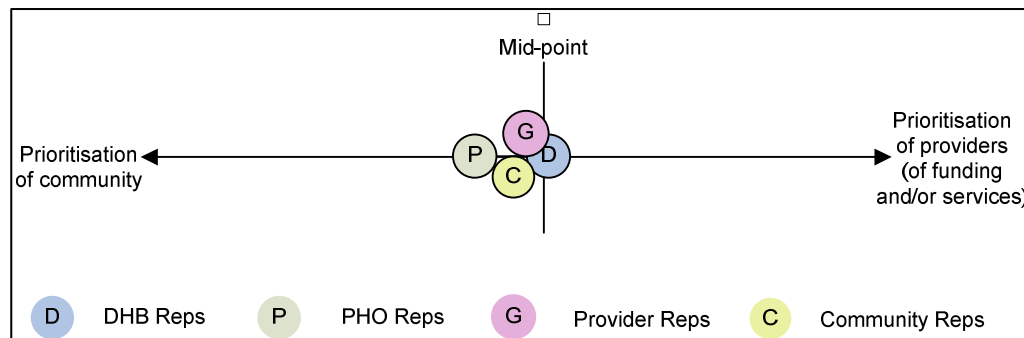
From Figure 6-2 it can be seen that the views of the four stakeholder groups were not significantly different. However, while the DHB representatives considered that PHOs are equally responsible for meeting the needs of both their community and their providers and the provider and community stakeholders held similar views, each of the latter groups indicated that PHOs should place slightly more emphasis on meeting the needs of their community than on meeting those of their providers. In respect of the provider stakeholder group this finding was unexpected, as research has suggested that providers are disinclined to increase their community accountability (Cotton *et al.*, 2000; Lapsley, 1994; Levaggi, 1995).

Although, like the other stakeholder groups, the PHO group recognised that PHOs are responsible for meeting the needs of their funding and services providers, they considered that PHOs should accord priority to meeting the needs of, and being accountable to, their communities. However, these interviewees also recognised that PHOs experience a tension as they try to balance meeting the needs of both their communities and providers. For example, one PHO representative noted:

> *We have an ongoing tension … because General Practice needs to be challenged*

to play nicely with others.[133] *[They need to] recognise that General Practice is key to a Primary Health Organisation but that, if we are going to do anything about the population's health, it's got to be a bit more than [General Practice]. (PHO Rep)*

Thus, some PHO interviewees may believe they are (or should be) driving a cultural change from a GP-centric system to one which encourages greater community involvement (as specified by the *Primary Health Care Strategy*).

The position of each case study PHO in respect of the community-provider continuum (as distinct from that of the four stakeholder groups), is discussed in Chapter 7.

6.3.   *Why accountability is demanded of PHOs*

As noted in Chapter 4, in delegating relationships accountability can be demanded by the delegator as a means of controlling the acceptor; alternatively, it may be used to underpin and enhance extant trust. The views expressed by the interviewees to the question, "Why is accountability demanded of PHOs?" are presented in Figure 6-3.

Figure 6-3: Stakeholder responses to the question "Why is accountability demanded of PHOs?"

| Categories of responses | Total (36) | Stakeholder Groups | | | | | | |
| | | DHB Reps (4) | | PHO Reps (8) | | Provider Reps (8) | | Community Reps (16) | |
	No.	No.	%	No.	%	No.	%	No.	%
PHO accountability as a controlling mechanism									
- DHBs use accountability to control PHOs	12	3	75	3	38	4	50	2	13
PHO accountability enhances trust									
- Accountability is a mechanism to enhance trust	11	1	25	4	50	2	25	4	25
Consequence of the control-trust continuum on a PHO's external image									
(i) PHOs do not require an external image	15	3	75	2	25	4	50	6	38
(ii) It is important for PHOs to have an external image	11	1	25	4	50	0	0	6	38

6.3.1. *PHO accountability as a controlling mechanism*

The notion of accountability as a controlling mechanism is explained by one interviewee as 'the big stick' in the following observation:

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[133]   The 'others' include community representatives, NGOs that deliver health services, and other providers that have entered the primary health care system.

Our relationship with the DHB is a bit like the [region's] weather, it changes. We have a healthy dialogue and we have divergent views sometimes, but we maintain a relationship. Is it healthy? Sometimes it's not. I think we are both flawed partners in the relationship. [The DHB's ability to control] is the big stick in the cupboard – we both know it's there, but they don't wave it around. (PHO Rep)

Thus, the notion of control is firmly embedded in the operation of a fluid relationship between DHB funders and PHOs.

From Figure 6-3 it may be seen that 12 of the 36 interviewees considered that DHBs demand accountability in order to control their PHOs. This opinion was expressed by three of the four DHB, three of the eight PHO and four provider representatives, and two community interviewees. One PHO representative traced accountability as a controlling mechanism from the Ministry of Health to DHBs and from DHBs to PHOs. This interviewee noted:

The DHB itself is under I don't know what level of monitoring from the Ministry – it used to be intensive because their budgets were blowing out - so naturally the Ministry are keeping a very close watch on [the DHB] about how they are managing their finances. And we suspect that [the PHO] is caught up as part of that equation. So while the DHB is under very strict requirements in terms of financial management and reporting and so on, the same level of detail is being applied to the PHOs [by the DHBs]. (PHO Rep)

The operation of strong 'upwards' accountability as a means of controlling PHOs was similarly identified by one DHB staff member who reflected:

I see it as a network of obligations and accountability. When you look at enforcing accountability and what you can do to hold people to them, usually it's the people who hold the money who can crack the whip. So the PHO is accountable to the DHB, the DHB is accountable to the Ministry of Health. The Ministry of Health is accountable to Treasury. But going the other way, if they want to make us accountable for things that we do or make the government accountable for decisions, well I'm sorry it just doesn't happen (laughs). So it's a one-direction accountability, even though we're meant to be in a relational environment. (DHB Rep)

The comment, "even though we're meant to be in a relational environment," points to a difference between the notions of collaboration and partnership embodied in the *Primary Health Care Strategy* and the operationalisation of that policy. This theme was echoed by a number of stakeholders, in particular, the provider representatives. For example, one GP commented:

We used to feel independent, we used to feel that we had a sense of influence over

our environment, so the major influence of the Primary Health Care Strategy has been to disempower, disenfranchise, demotivate General Practice. (Provider Rep)

A further effect of the controlling environment is the implied lack of DHB trust in PHOs and their service providers. As a provider interviewee (from a different region than the one above) noted:

These are hard concepts to verbalise but actually you don't go into ...medicine because you pick up $32.50 for every 15 minute slot or whatever, there is actually a pro-bono thing. One of the things I ought to have said about the DHB is about people not trusting us to act in other people's best interest. I read something recently which was a criticism about Doctors being involved in PHOs: that it's like having foxes in the henhouse.[134] I thought about that analogy long and hard because most of what I do every day involves trust and I have the opportunity, if I was like that, to misuse that trust to maximise my own income from it and I find myself frequently not doing that ... I see myself as trying to steer people through the system to get the best value for the least cost, especially for people that can't afford it. We [GPs] are used to all the time having people in front of us who we could easily manipulate in terms of lots of different dimensions; monetary and in terms of their psychology and their physical being and whatever but we don't do that. That's because of an inner spirit of trying to act in the good, professionalism or whatever it is. In the relationship we have with the DHB, there's no trust. (Provider Rep)

Similar ideas were expressed by another interviewee who suggested that this characteristic of accountability has an historical basis that is systemic. This PHO representative counterposed control with a reduction in the level of DHB/PHO trust in the following commentary:

We have felt and do feel ... the mandated accountability reporting [to the DHB] can be overly onerous. I believe this has come out of the changes that have happened to New Zealand in the last 20 years or so. That stronger and stronger focus on accountability in health and nailing things down to the last dollar and the last line and reporting on everything in sight [means] you've had to drop a level of trust. [They say], "We don't trust you to deal with this, you have to tell us [the funder] what you've done and you've got to tell us how." And I think that relationship could and should change. (PHO Rep)

The lack of trust may be reflected in controlling actions that reflect poorly on the funder's professionalism. An incident was reported during an interview as follows:

The [DHB's] Funding and Planning Manager got up to the Chairman of [a PHO] in a meeting the other day and told him that if he didn't do it his [the Planning Manager's] way, he would make sure his PHO 'withered and died'. (Provider

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[134] This was a reference to a NZ author, Howell (2007), who had argued against having GPs on PHO Boards as she noted their inherent conflict of interest. She termed such as structure as having "foxes in the henhouse" (p.2).

Rep)

While this incident may be an extreme case, the perception that DHBs and the Ministry of Health use accountability obligations to control PHOs (as a "big stick" or to "crack the whip") was not limited to PHO and GP interviewees. A non-GP provider interviewee, for example, noted:

> *There's a belief that we are actually rogues … you wonder whether the DHB thinks the doctors are rogues, pharmacists are rogues, rest-homes are rogues, everybody's a rogue. (Provider Rep)*

Some of the resentment evident in the provider interviewees' responses may have arisen from the manner in which the review of GP-patient co-payment charges ('fees review') was conducted during 2007. This is reflected in the following statement by a PHO interviewee:

> *I've told the Minister in no uncertain terms that I believe he has done a lot of damage with the fees review process and he listened to me too. I said, "You've got a long way to go to restore the faith that clinicians, for example, are valued." (PHO Rep)*

The ability of PHOs to express their displeasure at the highest level may be a signal that PHOs have some autonomy. Conversely, the concept that 'rogues' must be controlled may result in more regulation and reduced autonomy. As a PHO Board member observed:

> *Recently the Minister [of Health] has said the governance in the PHOs is not good … And he said, "We need some formal stuff there,"[135] which I actually agree with. But suddenly the Ministry [of Health] decides that some of the rules around that will go into the contract. And the PHOs are saying, "No, no, no, that's in our constitution, you don't impose other rules. Yes, we have to have a good constitution and you [the funder] have ticked it off previously – that's the only reason we've got to where we are. If one of the directors or trustees does something wrong, in our constitution we have the powers to get rid of them … We do not want you [the Ministry] telling us how to do it." (Provider Rep)*

The perceived 'interference' by the Ministry of Health in PHOs' affairs is illustrative of the manner in which control reduces autonomy (as noted by Edwards & Hulme, 1996). If PHOs are considered to be dominated by the Ministry of Health and their DHB funder they are unlikely to develop and possess a distinct independent identity (or external

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[135] The Ministry of Health appointed a sector advisory group to work with to develop *The Governance Guide for Primary Health Organisations* (Ministry of Health, 2007). This Guide clarifies the purpose and expectations of PHOs, the principles of good governance and the roles and responsibilities of board members. The Ministry of Health also introduced a training programme for PHO Board members.

image). This consequence is expanded in section 6.3.3.

6.3.2. PHO accountability enhances trust

Figure 6-3 shows that 12 interviewees indicated that they believe the DHBs use accountability requirements as a means of controlling their PHOs but another 11 expressed the view that accountability serves to enhance trust between the DHBs and their PHOs. One provider interviewee, for example, explained:

> *I don't really agree that control occurs [between the DHB and the PHO]. I think probably where I would see the PHO heading is one where they have a relationship [with the DHB] in the spirit of collaboration and best practice. If you have those values in place you are all going to work in the same direction ... I think that [the PHO] doesn't need a lot of control over the work that it does. There may be checks and balances which are useful to have, and to have the DHB as partners to provide checks and balances rather than control ... I think the DHB would only step in to have a high level of control if [the PHO was] not performing well or there was some concern about use of funds or some really major issue that became apparent. (Provider Rep)*

The suggestion that enhancing trust brings increased collaboration was reinforced at an Annual General Meeting (AGM) of one of the case study PHOs. The speaker at the AGM also noted that trust empowers the PHO to be innovative. S/he observed:

> *Much of where we are today is as a result of the enormous cooperation that we've had with [the DHB] ... We have had an enormously successful relationship. A relationship that's based on respect, not only for what we do, but how we're doing it, an acceptance to give all outcomes a try and to hope that in every case the success we hoped for is also the expectation that we deliver. We are very grateful for that relationship and I have to say it doesn't exist everywhere around the country. (PHO AGM)*

According to a PHO representative (of the same case study PHO), underpinning the respect in this trusting relationship is a transparency in reporting. This interviewee observed:

> *The PHO reports consistently and constantly outside of the reporting cycle ... so any time [the DHB] can have our financials because the Board papers are open as far as we are concerned and all of our financials go into the Board papers each month. (PHO Rep)*

In addition, before publishing its annual reports, this PHO chose to obtain feedback from the DHB, further highlighting transparency in the trusting relationship.

An outcome of a relationship built on trust was explained by a DHB interviewee who noted:

> *We get [the PHO's six-monthly] report... and it goes around the team and we write comments on it... Then [the Funding and Planning Manager] will provide feedback to the PHO. It means they are not just sending their reports into the ether and I guess we're showing our accountability to them by responding. (DHB Rep)*

A PHO interviewee, referring to the same DHB, recognised the DHB's response as beneficial. The PHO interviewee commented:

> *We know we've been accountable [to the DHB] when we get an acknowledgement letter to say, "Hey great report" and any questions they might have over something we've written. They don't question our accountability ... The letter from the DHB is an acknowledgement that they do read them [the six-monthly reports]. (PHO Rep)*

In addition to noting that trust is an attribute of DHB/PHO relationships, some interviewees observed that trust is evident in the relationships between PHOs and their communities. One community stakeholder specifically noted, for example, that accountability in the PHO/community relationship is based on trust. This interviewee explained:

> *Oh, we [the community] trust the PHO. I mean there is a Board and there are Trustees and there's been a whole process to get those people in place ...We put our faith in those guardians to be doing the right thing in their governance role to make sure it is happening right. (Community Rep)*

While community representation on PHO Boards can enhance community trust, seven interviewees observed that trust should also underpin PHOs' relationships with providers and NGOs for primary health care service delivery. One PHO interviewee noted:

> *We do have huge amounts of trust [between the PHO and its service providers]. But actually there's been a lot of recognition that actually trust sometimes isn't enough. and we do need to be a little bit careful in terms of accountability ... We do need to have contracts and letters of agreement in place to formalise the relationship. It also helps to clarify the responsibilities and accountability lines. (PHO Rep)*

The use of explicit accountability-related clauses in contracts may be considered a controlling mechanism; however this interviewee explained that contracts with the PHOs' service providers underpin the trust that has been built up over a long period and present shared goals in written form.[136] Such accountability may be described as 'enabling' when

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[136]   Klein Woolthius *et al.* (2005) also found that contracts were useful for this purpose.

it establishes and clarifies reasonable expectations that enable those to whom responsibilities are delegated, to work towards positive outcomes while retaining a distinct identity (Fry, 1995).

6.3.3. Consequence of the continuum on a PHO's external image

Accountability enhancing trust between PHOs on the one hand and their DHBs and communities on the other enables PHOs to exist as distinct entities in their own right. This position is a corollary to the perception that when the Ministry of Health and DHB as funders seek to control a PHO, limited autonomy causes the PHO's external image to be less distinct. As reported below, while 15 interviewees conveyed the notion that PHOs do not require a distinct identity (or external image), eleven were of the contrary opinion.

 (i) *PHOs do not require a distinct external image*

From Figure 6-3 it may be seen that 15 of the 36 interviewees (including three of the four DHB and four of the provider representatives) considered that PHOs do not need a distinct identity separate from the DHB and/or the wider public sector health system. One of the DHB interviewees noted, for example:

> *I see them [PHOs] as part of the public [sector]; they are spending public money, but they [the PHOs] don't get that. That is the biggest gripe we have – they are spending public money which is why we are clear about finding out what they are doing with public money ... My underlying concern is that I don't think that they have a great concept of it yet. That's where half of their antagonism comes from because they are thinking one thing and we are thinking another. They just don't quite get it and that bugs me because we have made it clear so many times. (DHB Rep)*

The control signalled by this DHB representative ("they just don't quite get it") and the observation that PHOs are part of the public sector (in the nature of a DHB subsidiary), suggests this interviewee does not recognise PHOs as possessing (or needing to possess) a distinct identity. Such a position seems to preclude PHOs from existing – and being recognised – as separate not-for-profit organisations as is required by the *Primary Health Care Strategy*.

Unlike the DHB stakeholders, the community interviewees were ambivalent about the importance of PHOs possessing an independent identity (six of the 16 considered it to be

unimportant; another six expressed the contrary view). However, an interviewee from each of these groups observed that a consequence of PHOs not possessing an independent identity is that they are able to escape the accountability spotlight and, thus, the blame for their actions or inactions. These interviewees commented:

> *Exactly whose failure is not always that easy to ascertain, because the PHO says, "That's the DHB," and the DHB says, "That's the Ministry." I would probably never say, "Right, that's the PHO failing in its job." (Community Rep)*

> *The PHO does not have a lot of influence about what happens above it or below it. It is in a sandwich of Ministry, DHB/PHO/Practice, provider … So it is not going to be connected with a complaint [about lack of funding] and it's not going to be involved with a clinical complaint. (Provider Rep)*

This suggests that the absence of an independent identity may mean that PHOs are able to evade the 'many eyes' (Bovens, 2005b) of multiple accountability demands.

(ii) It is important for a PHO to have an external image

In contrast to the views reported above, 11 of the 36 interviewees considered it is important for PHOs to have a distinct identity. Four of the eight PHO representatives, and six of the 16 community interviewees conveyed this view, but it was shared by only one of the four DHB and none of the provider representatives. It seems that, at least in the opinion of the PHO interviewees, notwithstanding its importance, this is the area in which PHOs have made least progress. A PHO CEO noted, for example:

> *I can't engage with a community that doesn't know I exist. In some ways we do get accused by General Practice in particular of creating more complexity. And in one sense we are … but that's the stage that we're in because we haven't finished building the picture yet and when all of the stuff that we're planning for comes on line we can then connect it all up, but at the moment it's coming in as pieces and we're getting bits connected. (PHO Rep)*

For PHOs which believe they have a responsibility to be 'coordinators' and 'community-driven', a distinct identity (or external image) is necessary. However, while the *Primary Health Care Strategy* envisaged the public would be informed about the new primary health care organisations (that were to exist as distinct not-for-profit entities), it was silent as to whose responsibility it is to inform the public. A DHB representative considered it to be the PHO's role, noting:

> *I think that … the community needs to see a value in participating in the PHO, in its health care to create something around which there is accountability. So then I*

guess the PHO has to raise awareness with people. (DHB Rep)

A PHO interviewee in a different region concurred with this view, commenting:

[The PHO has] had two PHO [newspaper] features where we talked about what we were doing ... it was stuff around fees and Care Plus and current programmes. [Interviewer: Was the DHB happy that you paid for such advertising?] We didn't care, we just did it. (PHO Rep)

PHOs also require an external image if they are to bring about change beyond their community. This idea was conveyed by another PHO representative as follows:

From a political point of view, we definitely do need [people] to know that it's a PHO that's doing what it does. We want to share ... how [what we do] can work for others and to be recognised for our [innovative practices] ... We are very active and very vocal and that's where [the PHO] as an organisation is very important. (PHO Rep)

Thus, in contrast to the interviewees who considered PHOs to not require external images, others believed PHOs need separate identities.

6.3.4.   *Stakeholders' views on the control-trust continuum*

Using the data provided in Figure 6-3, which summarise the interviewees' responses to questions relating to why accountability is demanded of PHOs and their views on using accountability as a mechanism to control, the 'average position;' of each stakeholder group was determined in the manner explained in detail in Appendix 6. As may be seen from Figure 6-4, this resulted in a clustering of the responses of the four stakeholder groups.

From Figure 6-4 it may be seen that the DHB stakeholders held the strongest views on the use of accountability as a mechanism to control PHOs. The provider stakeholder group conveyed similar opinions but to a lesser extent. Conversely, the PHO and community groups signalled that accountability mechanisms foster trust between PHOs and their DHBs on the one hand and their community on the other.

As for the community-provider continuum, the positions of the four case study PHOs on the control-trust continuum are presented in Chapter 7.

Figure 6-4: The reason for accountability in the DHB/PHO relationship – a stakeholder view
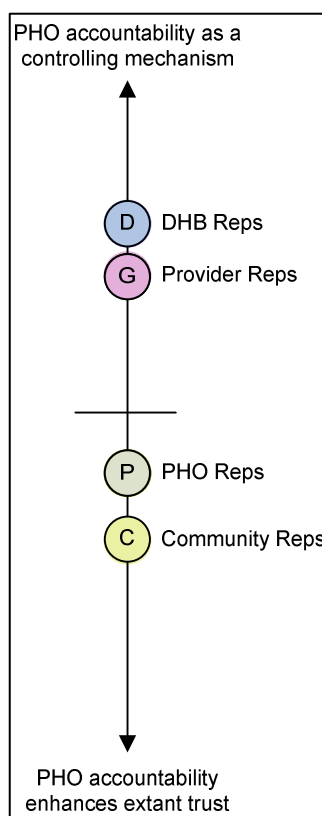
Prior literature (for example, Broadbent *et al.*, 1996) suggests that health care professionals react unfavourably to contracts that will reduce their freedom and potentially clash with their values. The position of the DHB representatives is also in line with their role as purchasers of primary health care and their need (as outlined by previous researchers, such as Robinson *et al.*, 2005) to mitigate the threats of incomplete information, in order to maximise scarce resources for population health gain. (Specific remedies are discussed in Chapter 2 and reflected in Figure 2-2). However, although the positions of the providers and DHB representatives are as might be anticipated, the differing views of PHO and DHB stakeholders were unexpected. This finding highlights a possible tension in DHB/PHO relationships that is further discussed in Chapter 9.

6.4.   *The position of the stakeholder groups in relation to the two continuums*

Mapping the community-provider continuum against the control-trust continuum generates four quadrants in which the four stakeholder groups may be located. The results of this mapping are presented in Figure 6-5.

It can be observed that, while the provider, community and DHB stakeholders recognise that PHOs are accountable fairly equally to their community and their providers (the provider and community groups according the community slightly more priority), only two of these groups, namely, the DHBs and providers, consider that accountability is required of PHOs as a controlling mechanism. The latter view was held most strongly by the DHB stakeholders. In contrast, the PHO stakeholder group considered that PHOs owe greater accountability to their community than their funding and service providers, and (along with the community group) that accountability is a mechanism to enhance trust between the PHOs, and their DHBs and communities.

Figure 6-5: Stakeholder groups in quadrants of accountability
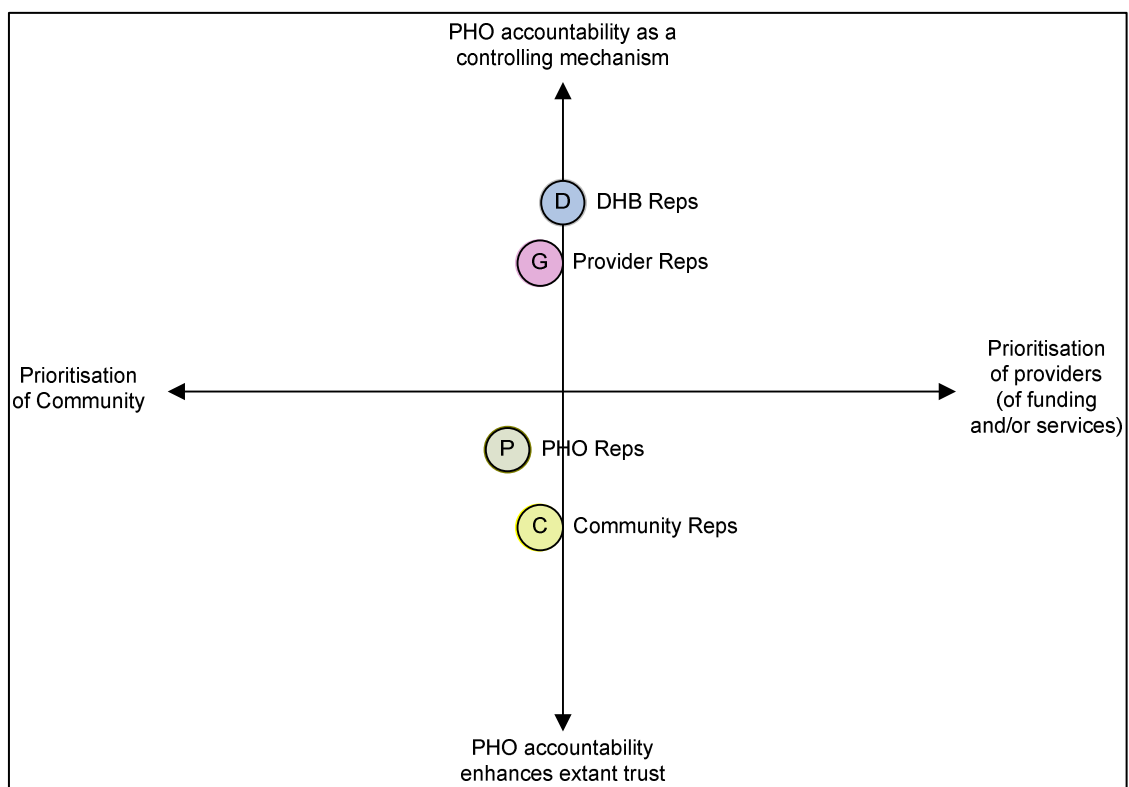
6.5.   *For what are PHOs accountable?*

As noted in the introduction to this chapter, a third key issue addressed in the interviews was: "for what are PHOs accountable?" Figure 6-6 summarises the interviewees' responses.

While a number of deliverables are listed in DHB/PHO contracts, interviewees were asked about their understanding of the specific delegations for which PHOs might be held

accountable. As indicated in Figure 6-6, their views fall into two broad categories, namely, PHOs being accountable for (i) health care outputs and (ii) health care outcomes. The requirement for not-for-profit organisations to be accountable for both outputs and outcomes was discussed in Chapter 4; there it was noted that this requirement has prompted researchers (such as Kearns, 1994) to describe the 'for what' of accountability as the 'ultimate moving target'.

Figure 6-6: Response to the question "For what are PHOs accountable?" by interviewee category

Categories of responses	Total (36)	DHB Reps (4)		PHO Reps (8)		Provider Reps (8)		Community Reps (16)	
	No.	No.	%	No.	%	No.	%	No.	%
Accountability for outputs PHOs are accountable for:	35	4	100	8	100	8	100	15	94
- careful use of funds	32	4	100	8	100	6	60	14	88
- high quality programmes and services	18	4	100	4	50	3	38	7	44
- efficient and effective procedures	14	2	50	3	38	5	63	4	25
Accountability for outcomes PHOs are accountable for:	32	4	100	8	100	7	88	13	81
- mission chosen and choices made	25	3	75	8	100	5	63	9	56
- managing stakeholders' expectations	13	2	50	6	75	3	38	2	13

Two interviewees summarised the situation:

> *I'd say there are many varying viewpoints on what they are accountable for … From a public health perspective, it is using resources most effectively and efficiently for all of those most in need [outcomes]. From a DHB or Ministry of Health perspective, it's probably about budgets and spending and cost-benefit analysis and those sorts of things [outputs]. (Provider Rep)*

> *I don't believe it's just around how they spend the money. I believe it's around staffing issues [outputs] and just what they do and the programmes they run. Like, if they are running health promotion programmes, that they are evaluating those programmes [outcomes] and that the reports on the outcomes of those evaluations are public documents. (Community Rep)*

6.5.1. Accountability for outputs

From Figure 6-6 it may be seen that 35 of the 36 interviewees expressed the opinion that PHOs are accountable for outputs. Thirty two of these interviewees stressed that PHOs are primarily accountable for the careful use of the funds derived from patients and the public purse. The latter includes capitation funding and also discretionary funding received for Services to Improve Access and Health Promotion programmes. Typical observations by interviewees include the following:

> *Well I think theoretically you can say we are accountable for the direction we're*

going, but really when it comes down to it, it is how we spend the money ... I think the money is the bottom line. (PHO Rep)

Well to me [PHO] accountability is for the dollars. [The PHO has] to be accountable for the dollars... and how they spend it. (Provider Rep)

[People] should know where the government funding of PHOs is going to. That's for their Health Promotion and other projects and of course the GP subsidies. (Community Rep)

Eighteen of the 35 respondents considered that PHOs are accountable for the delivery of high quality health care programmes and services; 14 interviewees also specified that PHOs are accountable for following efficient and effective procedures. The following are representative of the opinions expressed:

They're also accountable for the quality of services, that's right down to grass roots level ... the GPs, nurses, and community health workers have got the sorts of standards expected of them. (DHB Rep)

The PHO is accountable for clinical quality – to employ trained staff and set up clinical governance which is an important part of providing clinical oversight. (Provider Rep)

These findings support those of Leat (1990) and Stewart (1984), namely, that accountability for outputs includes following appropriate procedures, meeting required performance standards and properly spending funds provided.

6.5.2. *Accountability for outcomes*

While 35 of the 36 interviewees conveyed the opinion that PHOs are accountable for outputs, 32 of the interviewees also stated that PHOs are responsible for achieving their intended results thereby enabling the organisation to have a positive long-term impact on the health outcomes of their communities. A community representative observed, for example:

For me accountability would be, "What's your commitment to reducing inequalities?"... It's not about how much they are spending [they need to be] reducing inequalities. (Community Rep)

According to the interviewees, PHOs also consider that accountability for outcomes includes being accountable for the policies they adopt and the means by which they achieve their long-term goals. These interviewees noted, for example, that PHOs must listen to their communities and also provide feedback to those communities:

I think what the PHO can be most clearly challenged on is on where it chooses to

spend the money; as to how it's gone about that decision making and why it has chosen to invest. And I think that if in its processes and conversations and discussions with the community they tell the PHO that they think it should be going here and not there, then the PHO has to listen to that. (PHO Rep)

DHB interviewees observed further that the move within the *Primary Health Care Strategy* to a population health focus requires PHOs to be accountable for the way in which they work with their communities. Illustrative comments conveying this view include the following:

> *The DHB is most aware of its accountability under the Public Finance Act … that's primarily financial accountability. But a PHO is also accountable under the Strategy to improve population outcomes – that means they've got to be accountable for more than their core business. They could be accountable for their behaviour, for their working across sectors and so on. It is beyond just running the programmes or making sure that they've spent the money wisely. (DHB Rep)*

> *I think there are several areas of accountability. Other than financial [there is] planning, in terms of good planning processes … you know in terms of consultation and engagement, responsiveness, particularly in terms of iwi. (DHB Rep)*

Thirteen stakeholders considered that PHOs are also accountable for the proactive management of stakeholder expectations. One PHO representative conveyed this opinion in the following terms:

> *We're accountable …to sell the strategy and to understand the mechanisms that have to be put in place for us to do that successfully. If that means needing to defend a position [the PHO] takes then that is [the Chair's] job. (PHO Rep)*

The strategic aspects of accountability for outcomes are intrinsically linked to the organisation's mission. This may be a complex exercise (Ebrahim, 2005) and is inherently subjective. The lack of definitive key performance measures for outcomes suggests that PHOs are more likely to discharge this accountability if their relationship with their DHB and community is underpinned by trust. It is conjectured that accountability for outputs is likely to be emphasised by PHOs subject to a controlling relationship. The notion of the link between 'for what' PHOs are accountable and the control-trust continuum is developed further in Chapter 9.

6.6.   *The process of accountability: mechanisms, sanctions and rewards*

The fourth key issue addressed in the interviews is the process of accountability; that is, how PHOs should discharge their accountability and the sanctions that can be imposed on

and/or the rewards given to PHOs. The interviewees' responses are summarised in Figure 6-7. Following the categorisation of 'for what' PHOs are accountable into outcomes and outputs, the mechanisms are presented in similar cateogries. While this section is brief, a more detailed examination of mechanisms by PHO is provided in Chapter 7.

Figure 6-7: Stakeholder responses to the question "How should PHOs discharge their accountability?" and "What sanctions and rewards may be allocated to PHOs?"

Categories of responses	Total (36)	Stakeholder Groups							
		DHB Reps (4)		PHO Reps (8)		Provider Reps (8)		Community Reps (16)	
	No.	No.	%	No.	%	No.	%	No.	%
Accountability for outputs	28	4	100	8	100	5	63	11	69
To providers of funds									
- Contract reports and funder meetings	12	4	100	6	75	2	25	0	0
- Audits of financial reports and performance	9	1	25	6	75	1	13	1	6
To the community									
- Annual report	7	1	25	4	50	1	13	1	6
- Reduced patient co-payments	8	1	25	1	13	1	13	5	31
- Media reports	22	2	50	7	88	2	25	11	69
Accountability for outcomes	26	3	75	7	88	6	75	10	63
To providers of funds and services									
- Reporting to and by staff/contracted providers	19	1	25	7	88	5	63	6	38
To the community									
- Community meetings and AGMs	24	4	100	5	63	5	63	10	63
- Board representation	23	4	100	6	75	5	63	8	50
- Providing local employment	6	0	0	1	13	1	13	4	25
Sanctions and rewards	18	4	100	5	63	3	38	6	38
(i) Provider sanctions									
- Provider claw back or withholding of funds	7	4	100	3	38	0	0	0	0
(ii) Community sanctions									
- Community complaints	9	0	0	3	38	2	25	4	25
- Community disengagement	5	0	0	1	13	1	13	3	19

6.6.1. *Stakeholders' preferred mechanisms for accountability discharge*

As may be seen from Figure 6-7, the DHB interviewees indicated a strong preference for three PHO accountability mechanisms; namely, PHOs' reporting formally to, and meeting with, the DHB (in respect of outputs), engaging with the community through meetings, and ensuring community representation on the PHO Board in line with the *Primary Health Care Strategy* guidelines and to discharge accountability for outcomes.

The community representatives also identified three key mechanisms by which PHOs should discharge their accountability obligations. Like the DHB interviewees, they considered that PHOs should engage with the community through meetings and that

community representatives should be included on PHO Boards in order to discharge accountability for outcomes. However, unlike the DHB stakeholders, the community stakeholders identified that they sought PHOs to discharge accountability for outputs through media reports. In respect of media reporting, a DHB interviewee noted that this may generate negative comments:

> *PHOs don't have a huge budget to promote themselves and you have to question whether that's the best use of … health money. It's something the DHB struggles with as well. If we want to get a message across, how do we do it without being seen to be using public money in an irresponsible way? Every time I do anything I get told how many hip operations we could have bought with what we've just done. (DHB Rep)*

Figure 6-7 shows that the provider representatives also preferred three PHO accountability mechanisms; yet these were all focused on outcome reporting (rather than output reporting). Similar to the DHB and community stakeholder groups, the provider interviewees favoured PHO meetings with the community and community representation on PHO Boards. However, they considered that PHOs informal reporting to staff and contracted providers (themselves) presented opportunities for providers to impart the message of PHO performance to the enrolled population.

In contrast to other stakeholder groups, the PHO representatives identified five mechanisms as important for securing PHOs accountability. In addition to securing accountability to funding and service providers through output reporting to their DHB and reporting outcomes to staff, PHO representatives highlighted the role of audits as a third accountability mechanism. They identified two mechanisms focused on accountability for outcomes to communities, namely media reports and community representation on the PHO Board. These mechanisms suggest a range along the community-provider continuum and are equally divided between reporting on outputs and outcomes.

6.6.2. Sanctions and rewards

A number of commentators (for example, Birkett, 1988; Harris & Spanier, 1976; Stewart, 1984) distinguish the concept of accountability from that of answerability on the basis of the former including the ability of the delegator to impose sanctions on, or provide rewards to, the acceptor. As may be seen in Figure 6-7, eighteen interviewees referred to sanctions that may be imposed on PHOs if they fail to perform their responsibilities

satisfactorily. These fall into two broad groups, namely:

  (i) provider sanctions; and

  (ii) community sanctions and rewards.

As explained in Chapter 4, the sanctions imposed on an acceptor may range from legal and regulatory penalties to shaming or loss associated with fewer primary health care patients resulting from poor publicity (Brinkerhoff, 2004; Harris & Spanier, 1976).

(i) Provider-imposed sanctions

The DHBs (as PHOs' primary funder) constitute the party most able to impose sanctions on PHOs should the latter not discharge their accepted responsibilities satisfactorily. A readily applied sanction is the withholding of funds until the PHO in question meets its contractual obligations. A community representative, who is also an elected member of the PHO Board, commented on the application of this sanction in the following terms:

> *At the [PHO] Board we consider funding streams. For example with Care Plus[137] … suddenly the [General Practices] realised they had to be up to scratch otherwise they were not going to get their funding … The patient has to meet with the doctor and have nurses meetings and they have follow ups. But the PHO only gets the funding if it's all documented and everything's ticked off. (Community Rep)*

By withholding funds until the required performance is secured, the DHBs can pressure PHOs to perform in a certain way. However, according to DHB interviewees, once the funding is paid, sanctions are difficult to apply. As one DHB representative noted:

> *The DHB has short paid [PHOs] at times until they've met the requirement. Then we've paid the difference, but [the DHB has] a limited range of sanctions. (DHB Rep)*

Notwithstanding the limited sanctions available to DHBs, as regards specialised funding [such as Services to Improve Access (SIA) and Health Promotion funding], DHBs may stop funding a PHO until its previous funding has been spent or require funds to be spent on specific projects within a set time frame. This was explained by a DHB interviewee:

> *We are very aware that there has been a level of underspend throughout all of our PHOs … so we're actually looking at all the underspend … When we determine what the level of underspend is, then we will tell them what to spend it on. We're*

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[137] As noted in Chapter 3, Care Plus is a scheme that provides increased funding to PHOs for high users of health services.

not keen to take the money back, but we are keen to put specific requirements around them as to when they'll spend it. And we'll get tougher with them. (DHB Rep)

However, it seems that the DHBs may be reluctant to take action. As one DHB representative noted:

In the early days we didn't sign off the Health Promotion plan for [the PHO] but that became such a relationship nightmare ... So we ended up just signing it off ... We could turn the SIA funding off because they are not spending what they've got. That is something we haven't chosen to activate yet, but it is something that we might look at sooner rather than later. We have been fairly heavy-handed verbally but we haven't done anything to stop payments or anything like that. (DHB Rep)

This approach seems likely to typify DHBs for another DHB interviewee reflected:

It is really hard [to sanction]. We might say, "We're going to stop your payments until you [perform appropriately]," or, "We're going to claw money back," for something that we think is inappropriate ... The PHO contract is completely toothless in some respects, because you can't just go and find another provider like that (clicks fingers). You've got to really take a collegial approach. (DHB Rep)

The need for a collegial approach and the limited sanctions available to DHBs to impose on PHOs reflect the interdependence between the DHB funders and their PHOs. Even when there have been specific failures in PHOs' performance (including the failure to spend funding allocations), DHBs are unlikely to claw back funds or to stop funding. However, the threat of a DHB discontinuing funding is a sanction that can be used to direct PHO performance, as is the clinical reputation of PHOs' service delivery (in specific areas) as benchmarked through the Performance Management Programme. As a PHO representative noted, this programme may result in shaming when the results become widely known:

I've just received a paper that benchmarks us against all the other PHOs around the country. It was quite unexpected. I was a little bit upset because of the way in which people will probably read those graphs. It doesn't really reflect the context properly. But it's quite good to see ourselves and see how we're going compared to others. (PHO Rep)

Other PHO funders may have greater flexibility than the DHBs. According to a PHO interviewee, his/her PHO had applied to a community funder for a grant for a special project and the PHO's accountability to that funder was important. S/he noted:

The PHO has to show [that funder's] money on a separate line in the annual report. That's what the requirement is and if we don't do it, they won't get the

money next year. (PHO Rep)

While contracts and associated funding flows provide opportunities for DHBs (and other funders) to impose immediate sanctions on errant PHOs, a provider interviewee was sceptical of PHOs' accountability processes and suggested that his/her view was shared by other clinicians. This interviewee highlighted provider disengagement from the PHO's strategic direction for outcomes explaining:

> *I think that what we learn from looking at the UK is that clinicians disengage and I think we are very close to that in [our region] right now. (Provider Rep)*

Part of the reason for clinician disengagement in the UK is the overt focus on patient expectations over clinical quality (Johnston, 2005). Similarly, according to this New Zealand interviewee, the lack of clinical governance leadership in the PHO was the reason providers disengage. This provider also suggested that:

> *General Practice is funded by the PHO, but … since 1992 we've had seven funders. It would be implausible to say there won't be an eighth funder. So I think most people say, "Wait for the eighth funder and see if it's any better." (Provider Rep)*

While providers will continue to contract with PHOs, the notion of disengagement is reminiscent of Hirschman's (1980) 'exit'. Disengagement is also a sanction that a community may impose on a PHO as discussed in the following sub-section.

(ii) Community sanctions and rewards

As may be seen in Figure 6-7, nine interviewees indicated that community complaints about a PHO constitute a possible sanction. This community 'voice' (as it is termed by Hirschman, 1980) seeks to change organisational behaviour while remaining loyal to that organisation. As dissatisfaction with clinical services can be raised with the Health and Disability Commissioner, PHOs are more likely to receive complaints about other service aspects, for example patient co-payment charges and the cultural sensitivity of service providers. Such complaints must be reported to the relevant DHB in the PHO's six-monthly reports. One PHO interviewee provided the following example of the receipt of patient complaints:

> *There is a website address that they can come back to us on and we do get telephone calls and we do get letters about what [General Practices] charge … And on occasions we've had some service related complaints [from people] not*

being treated well enough, how they have been received or something like that. [PHO Rep]

On other occasions, complaints may be related to a wider issue – that of services not being provided by the PHO due to limited funding. For example, one interviewee observed:

If a patient had a complaint, it would be lodged and it would be passed onto the appropriate people. A pertinent complaint was, "Why can't I get free mental health visits to the psychologist?" Well, the short answer was that they were not Māori, Pacific Islander or living in a deprived area. And [the PHO] involved the DHB in that discussion and said, "Are you happy for us to refuse care to this patient because that's the rules of the SIA?" So we address complaints as we are able. (PHO Rep)

In the case in question, the PHO was able to show that they were in receipt of limited funding (that restricted the availability of a particular service to patients with particular characteristics) and that the DHB had agreed to those patient parameters. In another PHO, a Board member commented that further funding may be required to deal with a community problem that had been identified. This community representative, due to retire from the PHO Board, established the 'voice' component of complaints through community representation. The sanctions this person sought to impose were to "be a nuisance" as described in the following comment:

I want to follow it [the problem], because I won't let it go. Even if I am not there, my successor will have this problem because I will be following them up … I will be a bloody nuisance (laughs), but the PHO will handle it well. They're the professionals, so I expect them to be professional in [dealing with it]. (Community Rep)

Community organisations that contract with PHOs are also able to lodge complaints, but may be more discreet about their approach. As one community representative noted:

If I had concerns about the PHO's performance, then the first thing I would do is to pick up the phone and talk to someone I know [at the PHO]. I would say, "I am just a bit concerned, am I on the right path, do you have concerns here too?" … It would depend on what it was but normally you would try the informal routes first before the formal routes … We have to work in the community with these people and we have to maintain our relationships professionally and also we have to work collaboratively. (Community Rep)

As with the DHB funder, the issue of interdependence means that complaints progress to more severe shaming only after concerns become more serious. In two other instances, community representatives observed that the local Member of Parliament (MP) may be a

recipient of complaints about PHO performance. Each of these community representatives are from communities where the local MP holds a Ministerial position or is influential in the Opposition. One of these interviewees remarked:

> *I guess if you are not happy with what your PHO is doing then you go to your MP - you go up the line. Our MP … is well known in our community and he's well known to go in there and try and fight the battles (Community Rep)*

The personal touch of knowing the MP also brought this tactic to the mind of another community interviewee who stated:

> *If someone in our community says, "I want more services from the PHO," I would go straight to [our MP]. I work quite closely with [him or her] so I would go down and say, "This is your problem. This is what they want." (Community Rep)*

However, not all enrolled patients have the ability or desire to raise their concerns with their MPs, the relevant DHB, even the PHO. An 'exit' option related to market forces was mentioned by five interviewees as being the most likely community sanction. Examples of the 'exit' sanction that was also referred to as 'disengagement', are provided in the following observations:

> *The community will stop going to them if they don't get the service. It's a market type situation and as long as the public get the service, they don't care. I mean if you were a Doctor and suddenly you lost all your patients you would know there was something wrong, or the funders would know there was something wrong if there were no patients. The patients actually drive the accountability part there as well. (Community Rep)*

> *I don't think we're in a world where people sanction anything. They wouldn't, they would just disengage. (PHO Rep)*

> *As a reporter, I don't really get complaints from patients. If the system doesn't deliver them something, they just do without. (Community Rep)*

'Disengagement', or 'doing without' may arise because, as widely agreed amongst the interviewees, individual populations are not familiar with the concept of PHOs, resulting from the lack of an external image and the reluctance of DHBs to provide funding for media coverage of the PHO concept.

In contrast to those who stated that the community and service providers lack sanctions (other than to 'exit' or 'disengage'), one provider observed that this is a temporary state. This provider stated that, if the PHO system is maintained for a length of time, it will become part of the community, making it more likely that the community will engage with, and sanction, the PHO. This GP noted:

The community doesn't have any control, they disengage. There already is an existing system in place there … That's what they go back to … What [the PHO] wants to do is to say that … there are better systems out there. And once [the PHO] draws them [the community] out and shows them that they are better systems and that [the PHO] is there for the long haul not just for the next 3-6 years until a change of policy, then they will say, "Alright, now we believe you." … It is going to take some time, but we'll get there. (Provider Rep)

Not all sanctions are negative events and some interviewees noted that a community meeting (especially an AGM) is an opportunity to reflect on prior years' successes and failures and to reward the PHO. For example, a community attendee 'rewarded' the PHO by noting:

I want to congratulate you and your Board, your Chief Executive and your other staff on the absolutely stunning progress … that's been made in each one of the key areas, the results that are starting to show through so vividly. May I pass my warmest congratulations to all of you and through you to all those who have worked so hard including all those in General Practice and all those community organisations who've come in, I know, to assist with health promotion and trying to solve the problems … (PHO AGM)

6.7.   *Summary*

This chapter has presented stakeholders' views of the PHO accountability environment. Analysis of the interview data has generated a 'map' of accountability based on two continuums. Stakeholders' views have been grouped along a horizontal continuum representing PHOs' prioritisation of meeting the needs of providers to prioritisation of meeting the needs of PHOs' communities. Stakeholders' views on 'why' PHO accountability is demanded have resulted in a continuum ranging from accountability as a controlling mechanism to accountability enhancing trust.

Insights into 'for what' PHOs are accountable and stakeholders' views on the mechanisms and sanctions by which PHOs' accountability may be secured have also been provided. The DHB funders use limited sanctions related to withholding (or threatening to withhold) funding. Other sanctions include community complaints and also disengagement. However, researchers (for example, Birkett, 1988; Harris & Spanier, 1976; Stewart, 1984) suggest that the disengagement of PHOs' contracted providers and their communities is a weak sanction and possibly reduces PHO accountability to answerability, indicating a deficient accountability process. It is incumbent on PHOs (as acceptors) to invite scrutiny (Leat, 1990; Mulgan, 2003).

The manner in which PHOs view these aspects of accountability and consider the views of stakeholders is discussed in the following chapter.

7. VOICES FROM PRIMARY HEALTH ORGANISATIONS

7.1. *Introduction*

In Chapter 6 the interview data are reported based on Primary Health Organisations' (PHOs) four key stakeholder groups. In this chapter the interview findings and also observations from the case study PHOs are examined based on the PHOs *per se*.

As in Chapter 6, the interview data are analysed in four sections as follows:

(i)   the role of PHOs and to whom PHOs are 'fully and openly' accountable (Minister of Health, 2001);

(ii) why accountability is demanded of PHOs;

(iii) for what PHOs are accountable; and

(iv) the process of accountability: mechanisms by which the accountability of PHOs may be obtained and sanctions or rewards allocated. In this section the interview data are complemented by observations from the case study PHOs.

Similar to the interview findings based on the stakeholder groups, the findings relating to the question: "to whom are PHOs accountable?", when analysed on the basis of the four case study PHOs, lie along a continuum ranging from the community at one extreme to the PHOs' funders and service providers at the other. Likewise, the interviewees' responses to the question: "why is accountability demanded of PHOs?" lie along a continuum extending from the view that accountability is a mechanism for controlling the PHO at one extreme, to that of accountability as a mechanism to enhance trust at the other. Mapping the control-trust continuum against the community-provider continuum, and plotting the positions of the four PHOs in the resulting quadrants, provides insights into the similarities and differences in the views of the case study PHOs' representatives regarding the nature of accountability in their PHO. In addition, the mechanisms through which stakeholders considered PHOs should discharge accountability are compared to the mechanisms PHOs currently use to discharge accountability. This analysis is presented in section 7-6.

7.2. *The role of PHOs and to whom they are accountable*

The interviewees' responses to questions addressing the role of PHOs and to whom PHOs are accountable, analysed on the basis of the four case study PHOs, are presented in Figure 7-1. The responses are reported in more detail below.

Figure 7-1: PHO responses to the questions "What is the role of the PHO?" and "To whom are PHOs accountable?"

Categories of responses	Total (36)	PHO case study sites							
		PHO 1 (9)		PHO 2 (9)		PHO 3 (9)		PHO 4 (9)	
	No.	No.	%	No.	%	No.	%	No.	%
Prioritisation accorded to the community									
(i) Delivering a total health service	20	6	67	3	33	7	78	4	44
(ii) Community-driven organisations	13	4	44	2	22	5	56	2	22
(iii) Accountable to the community	36	9	100	9	100	9	100	9	100
- community	31	7	78	7	78	8	89	9	100
- enrolled population	10	2	22	2	22	5	55	1	11
- Mäori	9	3	33	3	33	2	22	0	0
- taxpayers	7	2	22	3	33	2	22	0	0
- community groups	6	2	22	2	22	1	11	2	22
Prioritisation accorded to the providers									
(i) 'GP-centric' view on wellness	14	2	22	5	56	3	33	4	44
(ii)(a) Following the direction of their DHB	9	2	33	4	33	0	11	3	22
(ii)(b) Supporting General Practice	8	2		3		1		2	
(iii) Accountable to the funder	32	8	89	7	78	8	89	7	78

7.2.1. *Prioritisation accorded to the community*

As may be seen from Figure 7-1, of the 20 interviewees who expressed the view that their PHO is responsible for delivering a total health service (to act as an 'umbrella' organisation or 'coordinator'), six (30%) were from PHO 1 and seven (35%) from PHO 3. Similarly, of the 13 interviewees who considered their PHO to be community-driven organisations, four (31%) were from PHO 1 and a further five (38%) from PHO 3. This compares with approximately 15% of interviewees in each of PHO 2 and PHO 4 expressing such views.

Reflecting the community orientation of PHO 1, a collaborative project to employ a community health worker was discussed at an Annual General Meeting (AGM) of this PHO. This involved the PHO performing a 'coordinator' role, extending the delivery of primary health care services into the community. At the AGM, the CEO explained the partnering of a number of PHOs:

This is an exciting project from our perspective … The funding was actually to pay for a full time equivalent health coordinator. She's based in our PHO, but works across all [the other] PHOs … It took a while to get the 'working together' working properly … but now its working really, really well. (AGM PHO 1)

The concept of partnering with various community groups was also discussed at an AGM of PHO 1. For example, the PHO Chair noted:

There isn't an enormous amount of new money in primary health, but there is an enormous opportunity to partner with many organisations … to roll out good initiatives that help our community … We can only offer our share of that opportunity and the organisations we approach and work with have also been incredibly generous in the way that they have responded either to our initiative or we've been able to respond to theirs. (AGM PHO 1)

This strategy appears to be similar to networking as described by Podolny and Page (1998) where organisational members subjugate their power to develop shared relationships.

Interviewees in PHO 1 also conveyed the importance of the PHO being 'community-driven'. One of the community interviewees expressed this in the following terms, by contrasting PHOs to DHBs:

It's good to have something embedded in the community … DHBs are such a juggernaut (Interviewee PHO 1)

Like PHO 1, PHO 3 also sought to respond to other organisations' community development initiatives. PHO 3 had obtained funding from its DHB in order to improve access to primary health care by disadvantaged groups in its community.[138] The CEO described the arrangement as follows:

We got our HEHA[139] contract which was about enhancing current groups and not starting anything new. It was based on helping community groups become more sustainable and access the things they need to. (Interviewee PHO 3)

The CEO explained that the funds were being used to enable the community groups to resource a coordinator to access services such as: those from dieticians, to provide subsidised access to socialisation and exercise opportunities, and to provide healthy snacks during group meetings. In order to determine an appropriate prioritisation for the allocation of its discretionary funding [including its Services to Improve Access (SIA)

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[138]   In order to preserve this PHOs' anonymity, the groups are not identified.

[139]   HEHA is an acronym for the Healthy Eating Healthy Action programmes funded by DHBs.

funding], the PHO consulted with community groups at open meetings and through other media. This enabled the PHO's Board to identify the most effective projects for improving the community's access to primary health care and to be transparent in its spending of public money. One speaker at a community meeting suggested that the process for ranking the suggested SIA projects and making recommendations to the PHO Board could be enhanced as follows:

> *Speaker 1: I guess that if any ... organisation felt there wasn't an appropriate process to evaluate their particular project they could ask that the initial evaluation include a wider reference group ... (Community meeting PHO 3)*

The second and third speaker concurred with this suggestion, noting:

> *Speaker 2: I think that would be an opportunity. It doesn't have to be a big reference group ... That's actually then an opportunity because they can also have some peer reference at the same time. Also there's an opportunity of member organisations to be looking at the whole rather than just what their organisation is doing.*
>
> *Speaker 3: That's a good idea ... I think more of a reference group that offers learning and feedback. (Community meeting PHO 3)*

As explained in Chapter 2, Mays (2000) recommended generating community prioritisation (such as will be achieved by this reference group) for primary health care services, as it conveys to the community that SIA funds are scarce and prioritisation is necessary. The ensuing decisions are also more likely to have increased legitimacy amongst disadvantaged populations (Pross & Webb, 2003; Simmons & Birchall, 2005; Taylor, 2004).

Figure 7-1 shows that all 36 of the interviewees considered that PHOs should be accountable to 'the community' but that their views on who 'the community' comprises covers a range of stakeholders; from patients (the enrolled population) to taxpayers. It is reported above that the interviewees from PHO 1 and PHO 3 conveyed that these PHOs place primary emphasis on meeting the needs of their community. Therefore, it may be expected that these interviewees would have broad concepts of 'the community'. However, Figure 7-1 shows that five (55%) of the interviewees from PHO 3 indicated that the PHO is accountable to its enrolled population, the narrowest concept of 'the community'. Despite this surprising finding, further analysis of their responses reveals that all of these interviewees mentioned other categories of 'the community' in addition to the enrolled population. For example, one interviewee from PHO 3 observed:

I think [PHO 3] is accountable to lots of different people really. It's accountable to the public because they are spending public money and providing public services. They are accountable to the Ministry and the DHB because they are the government organisations that provide the money and also have some leadership role in designing population and public health programmes and spending strategies. I mean we get money to do all that and we need to show there is some sort of outcome there. I think [PHO 3] is accountable to the health workers in the area because there are important linkages that need to happen between the [PHO 3] Board and [PHO 3] and the other health working groups – of which primary care practices are one, but you have also got pharmacies, and occupational health, and physios, and a whole range of other people ... The enrolled population is part of the primary care practices and community. (Interviewee PHO 3)

Further, identification of the enrolled population by PHO 3 interviewees may also stem from the manner in which the PHO delivers its services. PHO 3 has a number of staff on specific contracts to deliver health services in addition to contracting for services from General Practices and non governmental organisations (NGOs). This may explain why the interviewees from this PHO mentioned the 'enrolled population' more frequently than interviewees from the other case study PHOs that do not have staff delivering services directly.

7.2.2. *Prioritisation accorded to the providers*

Unlike the interviewees from PHO 1 and PHO 3, those from PHO 2 and PHO 4 expressed views conveying that their PHOs accord priority to the providers of the PHO's funds and/or health care services. This emphasis on providers is reflected in the fact that, of the 14 interviewees who expressed the view that their PHO is responsible for a 'GP-centric' view on wellness [to support General Practitioners (GPs) as the 'medical homes' of the population], five (36%) are from PHO 2 and four (29%) from PHO 4. Similarly, of the 9 interviewees who considered that PHOs should follow their DHB's direction, four (44%) were from PHO 2 and a further three (33%) from PHO 4. This compares with the remaining 22% of interviewees from PHO 1 (and none from PHO 3) who expressed such views. However, somewhat at odds with this finding is the fact that eight (89%) of the interviewees from each of PHO 1 and PHO 3 considered the PHO is accountable to its funder, while only seven (78%) of the interviewees in each of PHO 2 and PHO 4 expressed this view. This finding may reflect the small number of interviewees in the sample selected as the numerical difference is minimal.

Figure 7-1 shows that, of the four case studies, PHO 2 accords the greatest priority to health care funding and service providers. Interviewees from PHO 4 appear to be ambivalent: while four interviewees from this PHO expressed the idea that the PHO should focus on improving patients' health outcomes, a further four noted that the PHO should prioritise the needs of the community by being an 'umbrella' organisation to coordinate health services.

The emphasis in PHO 2 and PHO 4 on meeting the needs of their providers was reflected in responses from the interviewees. For example, in contrast to asking the community to rank SIA and/or Health Promotion funding streams (as occurs in PHO 3), interviewees from PHO 2 and PHO 4 explained:

> *We look to get alignment in the programmes that we've actually designed with the DHB's District Annual Plan. (Interviewee PHO 2)*

> *The outcomes are prescribed to a degree because any submission we put in for Health Promotion has to align with the DHB's local priorities which in turn align to the national priorities. (Interviewee PHO 4)*

The primary reason for discretionary funding being aligned with DHB planning appears to be to reduce tension in the DHB/PHO relationship (as described in Section 7-3-1). Capitation funding, the largest single income stream for PHOs, may similarly be directed by the DHB funder. Typically, PHOs pass on capitation funding directly to General Practices which are independently managed and can autonomously determine patient co-payment charges. However, interviewees from PHO 4 noted that, following the deconstruction of the Interim PHO funding system through the roll-out of increased funding for particular age groups of patients (as explained in Chapter 3), the Minister of Health threatened not to increase that PHO's funding unless it ensured that the General Practices with which it contracted reduced patient co-payments by a set amount. The interviewee noted:

> *The PHO didn't want to get involved in the practices, but the Minister advised it that it should. Of course that was just before the fee introduction and the subsidies and I can see that now … Most of the Practices didn't have their fee structure right to be able to give the Minister the pleasure of saying that there had been a $27 reduction … The Minister has said he is coming down and, "There will be no subsidy coming to [this region] unless you get yourselves in order." (Interviewee PHO 4)*

While the number of interviewees from PHO 2 and PHO 4 stating that their PHOs were accountable to their funding or service providers was not larger than the number of

interviewees from PHO 1 and PHO 3, their responses seem to indicate that PHO 2 and PHO 4 seek to develop close relationships with their funders and service providers.

7.2.3. PHOs' positions on the community-provider continuum

Using the data provided in Figure 7-1, the 'average position' of each PHO was determined in a manner explained in detail in Appendix 6. The 'average position' of each PHO is presented on the community-provider continuum in Figure 7-2.

Figure 7-2: PHOs' views on the focus of PHOs' responsibility and accountability
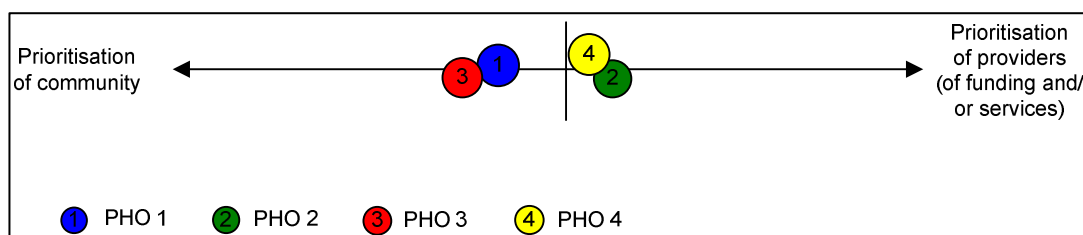
Analysing the responses of interviewees from the case study PHOs regarding the role of the PHO and to whom it is accountable, differences are evident in the attitudes of the two PHOs that prioritise meeting the needs of their communities and the two PHOs that focus on meeting the needs of the providers of their funding and/or contracted services. However, from Figure 7-2 it is evident that PHO 4 accords only slightly greater emphasis to its providers than to its community.

7.3.   Why accountability is demanded of PHOs

Differences in the attitudes of the interviewees from the four case study PHOs are more evident in the responses to the question, "Why is accountability demanded of PHOs?" Their responses are summarised in Figure 7-3. In addition to exploring this general question, PHO and the DHB representatives from each of the four PHOs were asked specific questions about how accountability as a mechanism for control or to enhance trust reflected practice. Figure 7-3 reveals that the interviewees from PHO 4 indicated that their DHB's actions are more controlling than was reflected in the responses of the interviewees from the other case study PHOs. In contrast, interviewees from PHO 1 expressed the opinion that their DHB's actions enhanced trust. A number of actions in PHO 2 and PHO 3 were also linked to trust.

Figure 7-3: PHO responses to the question "Why is accountability demanded of PHOs?"

Categories of responses	Total (36)	PHO case study sites							
		PHO 1 (9)		PHO 2 (9)		PHO 3 (9)		PHO 4 (9)	
	No.	No.*	%	No.*	%	No.*	%	No.*	%
PHO accountability as a controlling mechanism									
(i) DHBs use accountability to control PHOs	12	3	33	4	44	1	11	4	44
(ii) Answers to specific questions regarding DHB control in PHO relationship									
- Demands for financial and non-financial reporting to the DHB more often than required by contract	1	-		-		-		✓	
- DHB reporting is unable to be used by the PHO for internal management/other purposes	2	-	0	-	33	✓	33	✓	100
- DHB does not use PHO reports to others as a basis of the discharge of accountability[140]	2	-		✓		-		✓	
PHO accountability enhances trust									
(i) Accountability is a mechanism to enhance trust	11	2	22	1	11	6	67	2	22
(ii) Answers to specific questions regarding DHB actions to enhance extant trust in PHO relationship									
- Demands for financial and non-financial reporting to the DHB limited to that required by contract	3	✓		✓		✓		-	
- DHB reporting is able to be used by the PHO for internal management/other purposes	2	✓	100	✓	67	-	67	-	0
- DHB uses PHO reports to others as a basis of the discharge of accountability[141]	2	✓		-		✓		-	
Consequence of control-trust continuum on the PHOs' external image									
(i) PHOs do not require external images	15	4	44	5	55	4	44	2	22
(ii) It is important for PHOs to have external images	11	3	33	1	11	3	33	4	44

* If this observation supports the statement, it is represented by a ✓ and counted, otherwise it is represented by a – and not counted.

7.3.1. *PHO accountability as a controlling mechanism*

As may be seen from Figure 7-3, 12 interviewees expressed the view that accountability is demanded of PHOs as a controlling mechanism: four (33%) of these interviewees were from PHO 2 and a further four (33%) from PHO 4. This compares with three interviewees (25%) from PHO 1 and one (9%) from PHO 3. The interviewees from PHO 4 conveyed that central control began in this PHO when the *Primary Health Care Strategy* was 'imposed' upon GPs. While the Minister of Health (2001) announced that the PHO

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[140] Except for the contractual requirement that PHOs must produce an annual report.

[141] For example DHB attends AGM, may review publicly available material.

structure was not mandatory and fee-for-service funding would continue for GPs who chose to remain outside of the system, the perception remained that GPs had little choice. For example, the Minister of Health used the rural funding regime to ensure PHOs were established in rural areas. As an interviewee from PHO 4 explained:

> One of the carrots to hook people into PHOs in rural New Zealand is that prior to PHOs there was a dollop of money that came with each patient depending on the category of who we saw, and then in order try to improve rural medicine they had things like rural retention and reasonable rosters etc, etc. That was quite a bit of extra money going into those country Practices and that was the carrot – or stick really. They said that if you stuck with the old system you couldn't have access to that funding any more. So, in order to have that funding, people had to move into a PHO model. It wasn't a particularly willing marriage, but it seems to have worked so far. (Interviewee PHO 4)

Although this interviewee noted that the model "seemed to have worked so far," s/he further explained the implementation of the *Primary Health Care Strategy* as follows:

> I think there was the political vision which was the kind of shared vision of the partnership between the Māori and the providers and community to improve the health of the people. And that was a really good idea using capitation so that we have a fixed cake you can slice as you chose, so I think it was a really good philosophy. But operationally it is flawed in the way that it has been devolved. There is such a bureaucracy and we spend a lot of time going through bureaucratic loops. The DHB is not empowering. The PHO is very restricted in what we can do there, so the vision of being able to make a difference isn't really being achieved, but people do get lower cost of access. (Interviewee PHO 4)

It appears that strong DHB control reduces the likelihood that responsibility for primary health care will be devolved to this PHO to enable it to become a 'coordinator' of health care services or community-driven. The ensuing lack of autonomy can be frustrating for the PHO as noted by one interviewee:

> The bureaucracy frustrates our Board members because we prepare a proposal and it goes to the [PHO] Board and they say, "Yes that looks fine, no worries, get it done." And then it goes into the DHB and then it comes back, "We'll get back to you with comments." And then the comments come back, "Please reply to our comments." We reply and attempt to set up meetings and then once they have it all tidied, it goes off to the Ministry ... A lot of the comments could easily be answered if the programme was approved and we were getting on with it. But the DHB won't submit it to the Ministry for tick off until everything's been ticked off ... It's like a maze ... And we just said to them, "You need to acknowledge that around our Board table we've got very skilled businessmen and mature community reps." You know, they are accountants and the like and the guys have been running businesses for years and years. Why don't you give us delegated authority up to a specific level? (Interviewee PHO 4)

When the DHB processes delay proposals, the effectiveness of community representation at PHO Board level [encouraged under the *Primary Health Care Strategy* (Minister of Health, 2001)] is likely to diminish. Further, interviewees from PHO 4 were unsure why they were subjected to DHB delays, especially as:

> *… already the programmes we've got going are more than delivering the outputs, they are gaining momentum … that would be the record we would fall back on and say, "You had concerns about this, but look at how it's gone." (Interviewee PHO 4)*

At the time the interviews were conducted, a significant proportion of the discretionary funding for PHO 4 remained unspent because approval was pending for projects that would allow the PHO to spend the funds. In that region, the DHB control did not seem to be limited to the case study PHO. It was reported that another local PHO sought to apply SIA funds to employ a community worker to locate and enrol individuals who were not currently accessing the benefits of PHO enrolment (for example, reduced co-payment charges for visits to the GP and cheaper pharmaceuticals). However, this PHO's request to spend its SIA funding in this way was not supported by the DHB. An interviewee from PHO 4 reported that, in respect of the community worker proposal, the DHB:

> *… has just refused [the other PHO's] request to have a community based linkage worker because they say it is going to bring people into the Doctor and put more income into the Doctor and they don't want to do that … It is not conducive to their objectives. (Interviewee PHO 4)*

Further, although (as explained in Chapter 3) the Performance Management Funding is allocated to PHOs for supporting and enhancing primary health care practice, the DHB of PHO 4 will not disperse Performance Management funding until the DHB has approved the spending of those funds.

Answers to the question "why is accountability demanded of PHOs?" were explored further with PHO and DHB representatives from each of the four case study PHOs. In PHO 4, the DHB held weekly meetings with the PHO (see Section 7-6) at which minutes were taken. The frequency of these meetings exceeds the reporting required under the DHB/PHO contract. Further, the reports that the PHO provided to the DHB were not useful for internal management purposes and therefore constituted additional information that needed to be collected and collated. Asking whether the DHB substituted or augmented the reports it demanded from the PHO to secure its accountability by using mechanisms that the PHO prepared for others, resulted in a negative answer. Instead,

PHO 4 asked for a DHB representative to be present at the PHO's AGMs in order to present the DHB's viewpoints, but the DHB declined and did not attend either of the PHO's AGMs held during the case study period. Munro and Hatherly (1993) suggest that demands for more reporting and surveillance implies the use of accountability as control, but that lateral accountability enhancing trust draws upon self-audit and existing mechanisms.

Tight DHB control also surfaced as an issue in PHO 2, especially in respect of the PHO's discretionary funding streams. An interviewee from PHO 2 noted, for example:

> *While the Health Promotion and SIA money sits in the PHO's bank account … the PHO actually can't use it … All of it has got to go through a formal approval process at the DHB. The PHO does not go ahead on an initiative until the DHB has actually signed it off and the PHO has some service specs in place to deliver it. (Interviewee PHO 2)*

Additionally, even when a programme is approved, the DHB's control means that changed priorities may be imposed upon the PHO. This was the case when the DHB required PHO 2 to use its SIA funds to introduce screening for Cardio Vascular Disease (CVD) amongst high-risk patients. An interviewee from PHO 2 reported:

> *We're actually looking over the next year at an exit strategy of one programme in order to bring in CVD. We've only got a set amount of money and my understanding of the DHB, and we've had quite a lot of discussion with them, is that the Ministry are not going to provide further funding for this … So we've had a lot of discussions – the Board, myself, the DHB – well which programmes shall we all look at and see what we're actually going to stop? Because that's what it comes down to, we're going to have to stop something in order to pick up CVD Risk screening. (Interviewee PHO 2)*

When the balancing of local needs and DHB priorities was discussed with a DHB representative, the representative acknowledged, "There is a tension between the PHOs and DHBs around micro-management." However the DHB interviewee noted that the DHB has the right to control PHOs under contract and explained the process as follows:

> *Because of the way that PHOs are set up and the way our contracts are structured with them, they're required to go through an agreement process with us around how they spend some of their discretionary funding. (Interviewee PHO 2)*

This provides an example of strong funder control imposed to limit the PHO's power and to direct the PHO's spending of its funding allocation. In addition, as many of the proposals for new PHO programmes encroach on areas that were formerly DHB domains,

tension between the PHO and DHB results. An interviewee from PHO 2 explained:

> *The DHB felt their power threatened - is that a word I am allowed to use? The DHB used to be able to spend that money themselves, but now we've got it, but we have to account for the spending of it to the DHB so there's a power struggle … a lot of personalities and that sort of thing. (Interviewee PHO 2)*

While the notion of 'contested space' may apply to the perception that PHOs encroach on DHB territory, 'contested space' also arises as a result of the complexity of the health care system. As another interviewee from PHO 2 observed:

> *The health sector's really diverse and really complicated, not only in a financial sense but also around clinical interactions and roles and responsibilities, say, "Who's actually responsible for a patient?" and, "Is there a single gatekeeper or not?" … and for the DHB as a provider of secondary services, "Where does its responsibility start?" … A lot of the DHB's services are actually based in the community so it also has a primary care role. That's where the complexity lies and that's where the PHOs see some of their roles as being limited by the DHB. But it's actually the DHB's responsibility and not the PHOs. (Interviewee PHO 2)*

Disagreement about 'contested space' arising from a lack of clarity between PHOs and DHBs on the boundaries of their respective responsibilities creates tension in the DHB/PHO relationship and this, in turn, reflects DHBs' use of accountability as a control (or trust-enhancing) mechanism. This notion of 'contested space' is further developed in Chapter 9.

In PHO 4, the operation of control by the DHB reduced stimulus in the PHO for collaboration and community input into decision-making. Along similar lines, in PHO 2 a struggle with the DHB over appropriate programmes and priorities resulted in reduced community engagement because of a concern about the outcome. As a PHO 2 interviewee explained:

> *I think for me the one thing I find most difficult is community engagement – both doing it well and, if you do it really well, what's the outcome of that? Are we really going to change as a result of that, because it might mean putting a whole heap behind us and starting new initiatives that might not be that evidence based either? (Interviewee PHO 2)*

The interviewee explained that PHO 2 has already been required to accommodate DHB demands for programmes that were additional to those identified for implementation by the PHO.

The case study data indicates that when a DHB uses accountability as a controlling

mechanism, the affected PHOs do not readily seek opportunities to engage with their communities and are less likely to participate in collaborative activities with community groups. A model depicting the nature of PHO accountability relationships that result from accountability being used as a controlling mechanism is presented in Figure 7-4. A PHO for which this archetypal model applies has strong 'upwards' accountability to its DHB and indirect accountability to its enrolled population. This accountability is discharged through the PHO's contracted providers (including any NGOs that the PHO chooses to contract with). These third party organisations are also in hierarchical relationships with the PHO, as depicted in Figure 7-4. The responses from interviewees from PHO 2 and PHO 4 indicate that this model (or variations thereof) applies to these PHOs.

Figure 7-4: The hierarchically controlled PHO accountability model
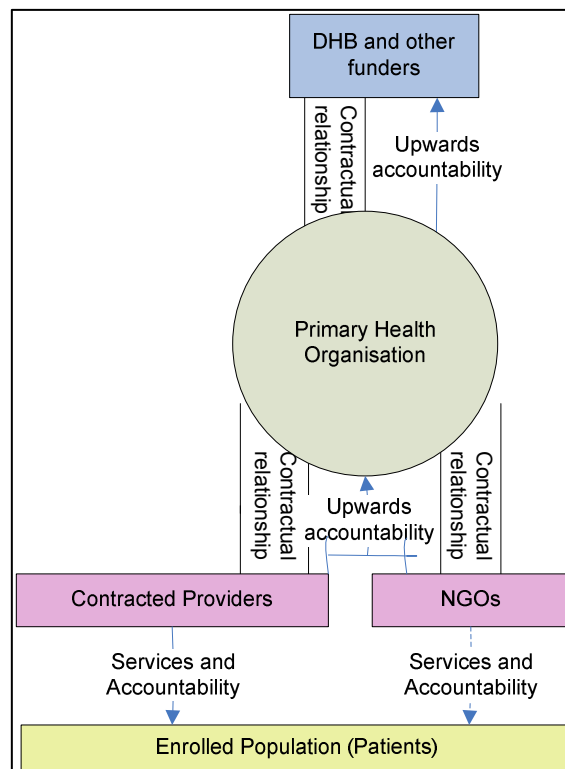
7.3.2. *PHO accountability enhances trust*

In contrast to PHO 2 and PHO 4, the responses of interviewees from PHO 1 and PHO 3 indicate that their PHO/DHB accountability relationship enhances trust. From Figure 7-3 it may be seen that of the 11 interviewees who perceive accountability as a mechanism to enhance trust, six (55%) were from PHO 3, two (18%) were from PHO 1 and PHO 4 and 1 (9%) were from PHO 2.

A dimension of using accountability to enhance trust is that of a shared vision or shared goals. Such shared goals were identified by an interviewee from PHO 3 as follows:

> *We've always seen our role as being more than those people enrolled with us and we've always seen our role as being far wider than the Medical Practices involved in the PHO. That's never been significantly questioned within the PHO. Actually, one of the things that brings us together is that we have a shared vision about what we are actually trying to achieve. While we may disagree with how each of us go about doing it sometimes, we still agree with the end goal and that's who we want to get to. (Interviewee PHO 3)*

Interviewees from this PHO conveyed that staff and contracted providers subscribe to the organisational mission to deliver a total health service to improve the health of a disadvantaged population. An interviewee from PHO 3 noted a further benefit of a trusting environment:

> *We have a high level of respect and I think that means you can raise some quite difficult issues quite safely and work them through. (Interviewee PHO 3)*

Fry (1995) observes that shared goals comprise one aspect of trust-enhancing accountability that allows for the negotiation of co-operative action. The following observations from both PHO 3 and PHO 1 reflect the operation of accountability to enhance trust and collaboration:

> *The new structure … has in my view allowed more collaboration … For somebody … in quite a different sector … to work alongside a health provider and give a framework because there is a common goal. (Interviewee PHO 3)*

> *[An NGO] said, "We need some resources there" and so we said, "OK, give us a project plan." And they did, so we've committed $x per annum over three years to it. We report back to that group so the progress reports go to [the NGO] and [the NGO] comments on them and determines the direction of the project actually. (Interviewee PHO 1)*

As indicated in section 7.3.1, an important means by which DHBs secure the accountability of PHOs is to demand that the PHOs report various matters to them (i.e. the DHBs). In a controlling environment, as in PHO 2 and PHO 4, such reporting is extensive, however, where trust exists, it may be reduced. This was reflected in comments from interviewees from PHO 3. An interviewee from this PHO, who was also a DHB staff member, noted for example:

> *I think maybe, the accountability, now that we have all this data, now that the PHOs are really up and running and the base line data is excellent, that the accountability pendulum might need to swing back a little bit, just cut them a bit of slack … I do think that we're asking a lot of a small organisation and that doesn't seem very accountable (laughs), that doesn't seem very fair … But the quid pro*

quo of capitation funding and certainty of income is being able to show that you've done something with it, so maybe this is as good as it's going to get. (Interviewee PHO 3)

Another interviewee from PHO 3 identified the need for balance in the reporting that is required. About the reporting s/he stated:

It is a bit of a nuisance to be honest; it's a paper war ... We agree that we should be reporting back for the funding, but it would be nice to have better processes around it ... We would rather be out in the community doing ... not behind the computer writing reports. To do the six monthly reports takes quite a while, but it's trying to get that balance ... (Interview PHO 3)

Answers to the question "why is accountability demanded of PHOs?" were explored further with PHO and DHB representatives. Those from PHO 3 observed that, while PHO 3 was in regular contact with its DHB, the reporting demanded by the DHB was limited to that required under the DHB/PHO contract. Further, senior DHB representatives attended the two AGMs held by PHO 3 during the case study period, suggesting that this DHB endorses the reports this PHO makes to its other stakeholders. Similar remarks apply to senior DHB representatives attending the AGMs PHO 1 held during the case study period.

PHO 1 was also able to use reports it prepared for internal reporting purposes as the basis for its DHB contractual reporting. A PHO 1 interviewee explained:

Our own reporting is designed to inform our Board and what the Board needs to know and we actually report really fully to the Board ... The [DHB] reporting is at a much higher level and just really involves taking our own reporting, aggregating it and putting it in another format and sending it off. (Interviewee PHO 1)

Where a DHB and PHO enjoy a trusting relationship, this may result in the PHO having greater autonomy over use of its funds. As an interviewee from PHO 3 observed:

I think the better the relationship you have between the PHO and the DHB ... that you actually say, "We're going to give you x number of dollars for services," and have the faith that they're going to be delivered without putting an onerous or significant reporting on top of that. (Interviewee PHO 3)

The responses of the interviewees, particularly those from PHO 1 and PHO 3, indicate that a PHO for which accountability is used to enhance trust and shared values is characterised by the generalised accountability model presented in Figure 7-5.

Figure 7-5: The PHO accountability model based on trust
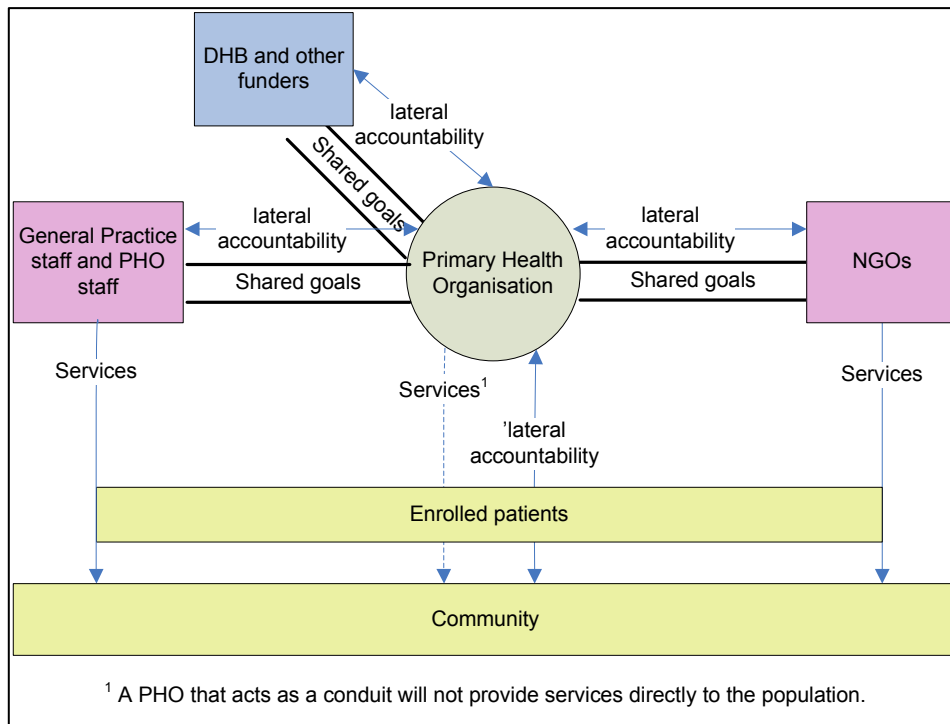
From Figure 7-5 it may be seen that, rather than the 'upwards' accountability that characterises a PHO which is controlled by its DHB, PHOs that enjoy a trusting relationship with their DHB have lateral accountability to the DHB and also to their staff members, contracted General Practices and NGOs that deliver primary health care services. In addition, these PHOs have a direct lateral accountability relationship with their community at large, rather than being limited to the enrolled population and discharged indirectly through providers (as in the control model in Figure 7-4). The responses from interviewees from PHO 1 and PHO 3 indicate that this archetypal model (or variations thereof) reflects the accountability relationships of these PHOs.

7.3.3. *Consequence of the continuum on a PHO's external image*

As explained in Chapter 6, interviewees considered that an important feature of developing a trusting relationship between the DHBs on the one hand and the community on the other is that the PHO possesses a distinct external image. However, from Figure 7-3 it may be seen that, contrary to expectations, interviewees from PHO 1 and PHO 3 considered that PHOs do not require an external image. Nevertheless, the Chair of PHO 1

stated that an autonomous PHO is required in order for the PHO to continue to improve. S/he asked the attendees at one of the PHO's AGMs to "keep the PHO before the public," saying:

> *At the end of the night we have laid bare our successes, our hopes and our aspirations. I hope they satisfy you, but I also hope that you challenge us to continue that progress, because if we don't continue that progress, we're only sitting on our laurels. That's not what we intend to do, it's not what we're charged to do, so keep us on our toes, keep us working, keep us supported and keep us before the public. (AGM PHO 1)*

A media reporter (from PHO 4) also commented that PHOs need to be proactive in respect of their external image and expressed surprise that in the case of PHO 4:

> *The Press Releases we get are from the District Health Board. I am surprised because I would have thought it was the PHO's responsibility. I used to live [in another region] and the PHO there was quite proactive. They had to get their message out and tell people about what they were doing. (Interviewee PHO 4)*

In respect of PHO/DHB relationships where accountability is a controlling mechanism, five (55%) of interviewees from PHO 2 expressed the view that an external PHO image is not required. However, four of the interviewees (44%) from PHO 4 which is tightly controlled by its DHB and does not have a strong independent identity, expressed the view that it is important for a PHO to gain an autonomous external identity. An interviewee from PHO 4 noted, for example:

> *We don't want to be involved with anyone else just yet ... otherwise it would have just muddied the whole process and structure that we had set up ... The PHO is so new, we are having to establish ourselves and prove ourselves, so we have to get some runs on the board for ourselves to show we have matured. (Interviewee PHO 4)*

This observation suggests that the early stages of this controlled PHO have been marked by an internal focus that reduces the capacity or willingness of PHO 4 to work collaboratively with other stakeholders.

7.3.4. *PHOs' positions on the control-trust continuum*

Using the data provided in Figure 7-3, the 'average position;' of each PHO was determined in a manner explained in detail in Appendix 6. The 'average positions' of each PHO are presented in Figure 7-6 on a control-trust continuum.

From Figure 7-6 it may be seen that the interviewees from PHO 4 and PHO 2 conveyed that the DHB in their regions use accountability to control their respective PHOs. In contrast, the interviewees from PHO 1 and PHO 3 signified that for their PHOs, accountability is used as a mechanism to foster trust between the PHO and the relevant DHB on the one hand and both their enrolled population and the wider community on the other.

Figure 7-6: The reason for accountability in the DHB/PHO relationship – a PHO view
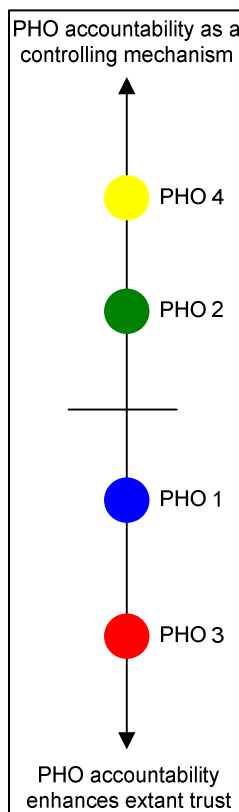
7.4.   *The position of the PHOs in relation to the two continuums*

Mapping the community-provider continuum against the control-trust continuum generates four quadrants in which the four PHOs may be located. The results of this mapping are presented in Figure 7-7 and the quadrants are labelled A to D from left to right and top to bottom.

From Figure 7-7 it may be seen that the four case study PHOs fall into two main quadrants, that is:

- quadrant B describes a model where the PHOs prioritise meeting the needs of funding and service providers over those of the community and are subject to strong control from their DHB (PHO 2 and PHO 4 are located in this quadrant); and

- quadrant C describes a model where the PHOs prioritise meeting the needs of the community over those of their providers and where the DHB/PHO accountability relationship enhances extant trust (PHO 1 and PHO 3 are located in this quadrant).

Figure 7-7: PHO case study sites in quadrants of accountability
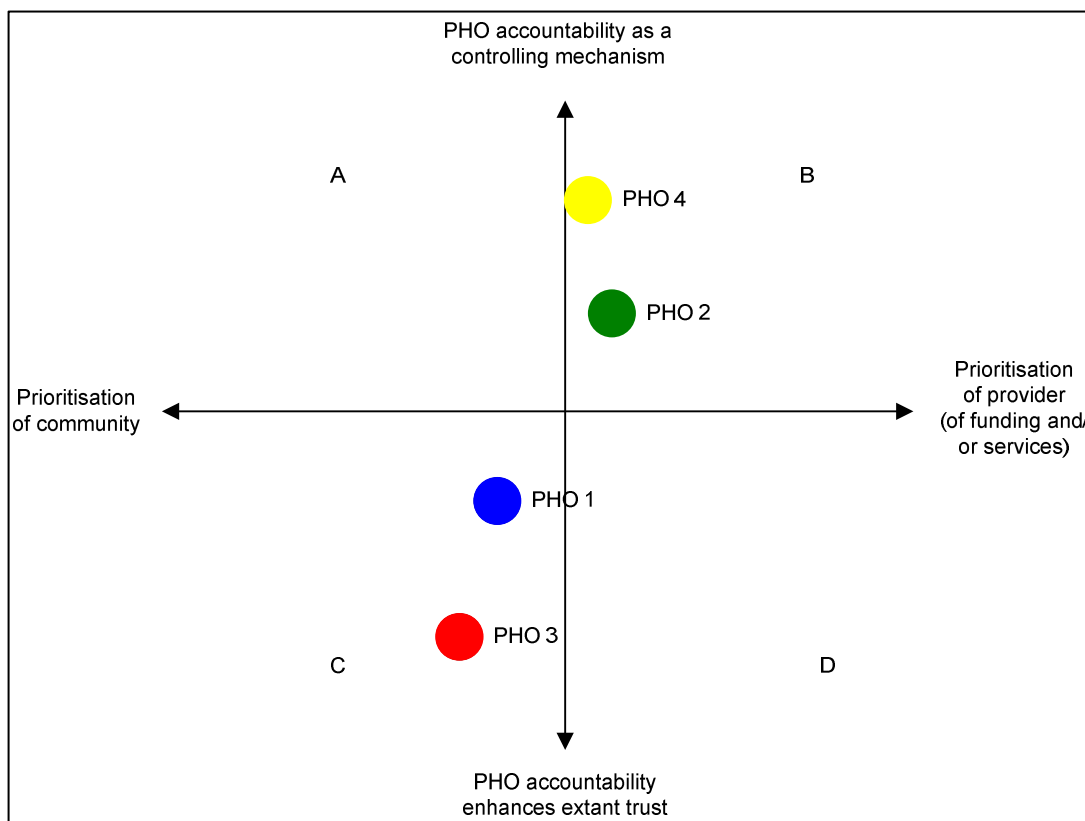
The interview data from which the models depicted in Figures 7-4 and 7-5 are derived appear to confirm the hypothesis of Dubnick and Justice (2004) that hierarchical and egalitarian cultures generate different forms of accountability. The PHOs selected for this research display distinctly different attributes (as explained in Chapter 5) and the clustering of PHO 2 and PHO 4 on the one hand, and PHO 1 and PHO 3 on the other, cannot be explained by the numeric size of their enrolled population, the PHO's geographical location, or the socio-economic, ethnicity or age characteristics of their enrolled populations. Analysis of the PHOs' structures (including organisational type) and suggested reasons for the identified clustering, are provided in Chapter 8.

7.5. *For what are PHOs accountable?*

As explained in Chapters 5 and 6, in addition to asking the interviewees about the role of, and to whom their PHO is accountable, and why this accountability is demanded of PHOs, they were asked, "For what are PHOs accountable?" Their responses, analysed on the basis of the four case study PHOs, are presented in Figure 7-8.

Figure 7-8: PHO responses to the question "For what are PHOs accountable?"

| | | PHO case study sites | | | | | | | |
| | Total (36) | PHO 1 (9) | | PHO 2 (9) | | PHO 3 (9) | | PHO 4 (9) | |
Categories of responses	No.	No.	%	No.	%	No.	%	No.	%
Accountability for outputs	35	8	89	9	100	8	89	9	100
PHOs are accountable for:									
- careful use of funds	32	8	89	8	89	9	100	7	78
- high quality programmes and services	18	4	44	3	33	6	67	5	56
- efficient and effective procedures	14	2	22	6	67	5	56	2	22
Accountability for outcomes	32	8	89	8	89	8	89	8	89
PHOs are accountable for:									
- mission chosen and choices made	25	6	67	7	78	5	56	6	67
- managing stakeholders' expectations	13	3	33	4	44	3	33	3	33

From Figure 7-8, it may be seen that the majority of interviewees in all four of the case study PHOs consider that their PHO is accountable for both outputs and outcomes. In terms of outputs, 35 of the 36 interviewees expressed the opinion that PHOs are accountable for outputs, including:

   (i) the careful use of the funds derived from patients and the public purse;

  (ii) providing quality programmes and services; and

 (iii) developing and implementing efficient and effective procedures.

In respect of the careful use of funds, the PHOs were similar and there were few differences between the PHOs as to accountability for high quality programmes and services. However, in Chapter 6, Figure 6-6 showed that providers mentioned accountability for efficient and effective procedures more frequently than other interviewees and in Figure 7-8 it can be observed that, when these were displayed by PHO, both PHO 2 and PHO 3 interviewees mentioned procedures more frequently than those in PHO 1 and PHO 4. This may be due to PHO 2 being closely aligned to its IPA providers and the amount of service provision undertaken directly by PHO 3.

Regarding PHOs' accountability for outcomes, 32 of the 36 interviewees noted that PHOs should be accountable for:

(i) the mission they chose and the choices they make; and

(ii) for managing their stakeholders' expectations.

There was little variation in the views of interviewees from the four case study PHOs.

7.6.   *The process of accountability: mechanisms, sanctions and rewards*

Despite the opinions of interviewees from the four case study PHOs being fairly similar as regards the outputs and outcomes for which PHOs should be held accountable, their views on how PHOs should discharge their accountability differed markedly. The accountability processes occur after the accepted responsibility has been performed and, therefore, may be regarded as 'the post-mortem of action' (Bovens, 2005b; Normanton, 1971). The *Primary Health Care Strategy* (Minister of Health, 2001) requirement for PHOs to be 'fully and openly accountable' seems to suggest that:

- mechanisms should exist through which PHOs can be held to account (these appear to involve reporting of some sort); and

- the accountability reporting does not allow PHOs to hide their failures or inadequacies [by emphasising 'fields of visibility' (Strathern, 2000)].

The interviewees' responses to questions about how PHOs should discharge their accountability and the sanctions and rewards that may be allocated to PHOs in appropriate cases are indicated in Figure 7-9.

Figure 7-9: PHO responses to the questions "How should PHOs discharge accountability?" and "What sanctions and rewards may be allocated to PHOs?"

Categories of responses	Total (36) No.	PHO 1 (9) No.	%	PHO 2 (9) No.	%	PHO 3 (9) No.	%	PHO 4 (9) No.	%
Accountability for outputs	28	7	78	7	78	6	67	8	89
(i) To providers of funds									
- Contract reports, funder meetings	12	2	22	4	44	4	44	2	22
- Audits of financial reports and performance	9	5	55	2	22	1	11	1	11
(ii) To the community									
- Annual report	7	3	33	1	11	0	0	3	33
- Reduced patient co-payments	8	0	0	1	11	3	33	4	44
- Media reports	22	6	67	6	67	3	33	7	78
Accountability for outcomes	26	8	89	8	89	6	67	4	44
(i) To providers of funds and services									
- Reporting to and by staff/contracted providers	19	7	78	4	44	4	44	4	44
(ii) To the community									
- Community meetings and AGMs	24	7	78	6	67	5	56	6	67
- Board representation	23	7	78	6	67	5	56	5	55
- Providing local employment	6	2	22	2	22	1	11	1	11
Sanctions and rewards	18	5	55	6	67	4	44	3	33
(i) Provider sanctions									
- Provider claw back or withholding of funds	7	2	22	1	11	2	13	2	0
(ii) Community sanctions									
- Community complaints	9	3	33	1	11	3	33	2	22
- Community disengagement	5	1	11	4	44	0	0	0	0

7.6.1. Accountability for outputs

(i) To providers of funds

Under their contractual agreement with their DHB (Ministry of Health, n.d.) PHOs must present annual and six-monthly reports to their DHB that include narrative (non-financial) information; these may be styled as Statements of Service Performance.[142] As may be seen in Figure 7-9, 12 interviewees stated that PHOs' contractual reports to their funding providers were a means for PHOs to discharge their accountability. Of these interviewees, four (33%) were from each of PHO 2 and PHO 3. This compares with two (17%) interviewees from each of PHO 1 and PHO 4. As is shown in Figure 7-10, in response to specific questions, the interviewees revealed that all of the case study PHOs regularly

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[142]   These are discussed briefly in Chapter 4 in section 4-7-1.(ii).

communicate with relevant DHB staff members through contractual reporting, meetings, and other mechanisms.

Figure 7-10: Contract reports and funder meetings through which the case study PHOs discharge accountability to their DHB

	PHO 1	PHO 2	PHO 3	PHO 4
Mechanisms required by contract				
Audited annual report	✓	✓	✓	✓
Contractual 6 monthly reporting	✓	✓	✓	✓
Mechanisms not required by contract but demanded by DHB				
Annual meeting between PHO and DHB Boards (or their representatives)	✓	✓	✓	✓
PHO staff meet formally with DHB staff monthly or more regularly (about contract)				✓
Monthly or other regular written reporting required				✓

As previously noted, PHOs are required to provide six-monthly and annual reports. These reports mainly focus on outputs as explained by one DHB interviewee:

> There's very little I can get out of the financial data ... it's rather high level and ... is largely around widget counting. It's about outputs and very little about what that five hundred thousand dollars has actually delivered. (Interviewee PHO 2)

Accordingly, the DHB staff also require non-financial reporting, as described by another DHB staff member who commented on the PHO reporting as follows:

> We're looking to see that they're being accountable for the resource that they've got and we rely on the dispassionate data of the raw numbers and then the complementary data of the narrative to find out if that's what they're actually doing. In terms of narrative we want something to complement the numbers, some kind of process or activity report. What's happening out there, what's being done, what's the problem, what have they done to solve it, do they need more money? ... Sometimes it's what's not said that brings things to the forefront. (Interviewee DHB 3)

One reaction to accountability as control is to adhere strictly to the contract, so that in PHO 2 the CEO noted:

> I used to give the DHB quarterly reports. I now make them six-monthly reports because against the contract only a six-monthly reporting is required. (Interviewee PHO 2)

This was further explained by the relevant DHB staff member who noted that requests for greater transparency had not achieved the desired effect. This interviewee commented:

> The contract only requires six-monthly reporting, but we had an arrangement whereby [PHO 2] provided it quarterly because they were accusing us of micro-management. We said, "Fine, we'll leave you alone if we know what's happening, which means greater transparency, which means greater reporting." ... It's not

happening now, but you can see what the tension was. (Interviewee PHO 2)

For PHO 4, the DHB control resulted in the PHO being required to attend meetings with the DHB on a weekly basis. Minutes of these were kept and agreed actions circulated. Other reporting was also demanded more frequently than required by contract, as explained by the CEO:

> *I meet with Primary Care Policy Analyst every week. We take minutes ... I do a monthly report for the DHB ... that's a full report of what we've done in the month and what's happening including progress on the programmes and the initiatives ... It's just purely a non-financial report. (Interviewee PHO 4)*

In contrast, building a trusting relationship through transparent, voluntarily provided information was described by the CEO of PHO 1 as follows:

> *We report consistently and constantly out of the reporting cycle. [The DHB] gets copies of every status report we do on Health Promotion which we do monthly. They get copies of the stuff that I send out around SIA, so they are always actually in the loop. (Interviewee PHO 1)*

DHBs may require additional meetings that are not in the PHO/DHB contract. For example, the DHB Board of each case study PHO invited the PHO Boards to meet with them as a chance to build relationships and potentially to encourage a joint strategic focus. In addition, the DHB/PHO meetings also presented an opportunity for the DHB to account to the PHO, enhancing trust through relationship building. One DHB staff member commented on the DHB Board meetings with PHOs as follows:

> *The Board to Board meetings are good, because it brings all the PHOs forward in the Board's mind ... I think it's about primary health, it's about accountability, it's about building relationships. It could well be more for the [DHB] Board's benefit and the Board's exercising its own accountability, so the Board knows what's going on. (Interviewee PHO 3)*

Figure 7-9 shows that nine interviewees indicated that external and internal audits are an integral element of the accountability process. Five (56%) of the interviewees expressing this view were from PHO 1, two (22%) from PHO 2, and one (11%) each from PHO 3 and PHO 4. While DHBs audit General Practices and PHOs on their claiming behaviour (as noted in Chapter 4), PHO 1 audits a sample of their contracted General Practices on their fees and claiming operations.[143] The rationale for this was provided by the Chair of PHO 1 who explained:

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[143] This is an example of the manner in which control and trust may balance each other. This concept is further explored in Chapter 9.

I believe audits are important ... Since there are enormous amounts of money being put into primary health in the sense that there's a ring-fencing, we can't afford bad publicity, we can't afford bad outcomes, we can't afford misuse of money, we can't afford rotten eggs in the system. So essentially we've got to be very vigilant in the process. (Interviewee PHO 1)

The capitation funding constitutes the largest funding stream to PHOs (see Figure 3-7) and is paid, almost exclusively, to contracted General Practice service providers. In respect of discretionary funding streams, the audit programme of PHO 1 does not extend to the NGOs with which it contracts, but the NGO contracts are closely monitored. While the Chair's comment above suggests that vigilance in expenditure is one reason for the audit, another interviewee from this PHO noted that robust systems rendered an organisation auditable; a continuing audit programme confirmed, not only that financial goals were being met, but that the organisations the PHO contracted with were well-organised and operated.

As noted in Chapter 3, the service performance of providers is subject to professional self-regulation and disgruntled patients may refer their case to the Health and Disability Commissioner. Before this escalation occurs, however, an audit may uncover a problem so that corrective measures may be implemented. This aspect of the PHO support was noted by one Board member when they commented:

If somebody has been doing a lot of one type of service we might send one of the clinical governance GPs along, and say, "Why are you doing that?" "Well we thought that this was how it was supposed to be." "Well actually no." So there is that kind of audit going on at a level, but I would be very uncomfortable knowing the names of providers at the Board level ... I just want to know that it is dealt with in the clinical governance forum at the appropriate level and in a confidential way, in a supportive way, but with teeth if they need it. (Interviewee PHO 2)

One of the community stakeholders also noted that audits provide a mechanism that enable the public to be assured that services are being provided appropriately:

I'm not very good at financials, but I would like to see audits of service published, whether they provided the service they said they would ... where they've been given some money ... are they providing quality of care? (Interviewee PHO 1)

While the Ministry of Health and DHBs have authority to undertake such audits, the outcomes of those audits are not publicly available, nor were they undertaken of any of the case study PHOs.

(ii) To the community

From Figure 7-9 it can be seen that seven interviewees stated that PHOs should discharge accountability through annual reports. These are a contractual requirement and were mentioned by three (43%) of the interviewees from PHO 1, and PHO 4, one (14%) from PHO 2 and none from PHO 3. While one Chair noted that "nobody reads them," the annual reports of the case study PHOs were presented at their AGMs.

In Chapter 6 it was observed that of the eight interviewees who stated that one role of the PHO is to effect lower fees for health care services, five (83%) of these were community stakeholders. Figure 7-9 shows that four (50%) of the interviewees from PHO 4, three (38%) from PHO 3, one (12%) from PHO 2 and none from PHO 1 mentioned reduced patient co-payments in their interviews. One interviewee noted:

> *I don't know if people understand PHOs. Then again I don't know if they need to. Perhaps all they need to know is that the GP fees are cheaper. I don't know if they understand the whole structure and all that, but if they are aware that the fees are cheaper perhaps that's the main thing. (Interviewee PHO 3)*

As PHO 4 and PHO 3 are the smallest of the case study PHOs, it appears that reducing fees is an issue of small PHOs, rather than large. However, it may also be related to the socio-economic level of the enrolled population. An interviewee from PHO 3 (characterised by an enrolled population with a low socio-economic level and the smallest of the four case study PHOs) reported that, at a community meeting held by a General Practice service provider contracted by PHO 3, the level of fees was highly important. S/he observed:

> *The big thing the community wanted to know is if the government changed, would fees be kept low. That was their big concern (laughs). So then they all decided that everyone should vote Labour (laughs)[144] … as fees were seen as quite a barrier. They had a lot of concerns about suddenly being back into having to pay a lot and that was a big area of concern for two or three people at the meeting. (Interviewee PHO 3)*

Reducing patient co-payments aligns with the World Health Organization's (1978) challenge to provide equitable access to quality primary health care.

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[144] The Labour party was the major coalition party in power from 1999-2008 and was responsible for the *Primary Health Care Strategy*. The meeting referred to in the interview was held approximately 12 months before the 2008 election. Public opinion was trending against the Labour coalition at that time with the inference that a National-led collation may be able to form a government after the 2008 elections. At the time National's position on primary health care funding was unknown.

As may be seen in Figure 7-9, 22 interviewees mentioned media reports (including the local newspaper, newsletters, local radio and TV) as a mechanism through which accountability should be discharged by PHOs. Seven (32%) of the interviewees were from PHO 4, six (27%) from each of PHO 1 and PHO 2, three (14%) from PHO 3. The types of media reported by interviewees as currently being used by the four case study PHOs are summarised in Figure 7-11.

Figure 7-11: Media through which PHOs discharge accountability

	PHO 1	PHO 2	PHO 3	PHO 4
Newspaper articles	✓	✓	✓	✓
Appearances on local TV				✓
In-house magazine/newsletter to contractors (incl. NGOs)	✓	✓	✓	
In-house magazine to enrolled population		✓		
Internet site	✓	✓	✓	✓

External media reports, such as newspaper articles (used by all four PHOs) and television appearances (used by PHO 4) may be used to augment PHO publications and website information in order to reach a wider population base. One Board member, when asked about the role of the PHO, described success as being when:

> … *we have achieved our mission in terms of communicating and improving primary health care. (Interview PHO 2)*

Although media reports are a one-way communication stream, the ensuing increase in community awareness of the PHO may also result in the development of a PHO's external identity. Despite that, media reports are not always seen as positive events. One interviewee, for example, noted:

> *I have no intention of ending up on the front page of the paper having $x being misspent somewhere by this organisation, because we would kill the process … this is the first time we've had primary health money ring-fenced and blow-outs are not acceptable and neither is misspending of money. It's not just my reputation; it's the reputation of the PHO. And it's the accountability of spending the public's money. (Interviewee PHO 1)*

However, rather than fearing a scandal, PHOs could use the media to publicise events. Interviewees conveyed that it was not uncommon, especially in the two smallest PHOs (PHO 3 and PHO 4) where staff and Board members were more widely known within their respective communities, for people to comment on media reports to PHO staff and Board members. A PHO Chair noted, for example:

> *It's funny that there is a big difference in people. There are people who know what is going on. You might never see them or hear them and then you'll meet them and*

they will say, "Oh the PHO is doing a good job," or, "The PHO should have been doing that." And I will say, "How did you know that?" and they will say, "I just read it in the paper." (Interview PHO 4)

While the PHOs used a variety of media, coverage was not extensive and a number of the community stakeholders suggested that PHOs' media usage could be increased so that information about the PHO was more readily available. One noted, for example:

To me there are two sides to it. I mean there are people like me who should have the nous to search it out if they want it. But there are probably a lot of people who would find it very interesting if it was handed to them on a plate. In fact it might well give them a step into something else if they had that information. It's a part of their learning and life skills that they are missing out on because they don't know how to search for it. (Interview PHO 4)

As part of each case study, a health reporter from the local newspaper was interviewed. Each of these individuals attends their DHB's Board meetings and two specifically bemoaned the fact that the PHOs do not also open their Board meetings to the public. However, one of the PHOs about which a health reporter complained does open a portion of its Board meetings to the public[145] but 'the public' seldom avail themselves of the opportunity to attend. Further, each of the reporters was asked if they had attended, or would go to, a public PHO AGM and they responded in the negative. It appears that the media representatives expect the PHOs to draw to their attention relevant information, rather than the media representatives seeking it out.

One reason the health reporters gave for not reporting PHO matters was that terminology is a stumbling block that reduces stakeholders' understanding. One reporter noted, for example:

They use technical terms, even when you're interviewing doctors, they stick to their medical terms. I have to go back through and work out all the technical terms … It means that I have to spend an extra half an hour deciphering everything, or ringing them up to get them to clarify it. I think they need to simplify it. That makes it more accessible, not only for me, but for anyone in the public who is interested enough to go and pick up a copy of their latest report … There are a million other things to do and it's putting aside that time to work out what they're going on about. (Interview PHO 2)

PHOs' difficulties in obtaining positive news reports may be similar to those experienced by DHBs as reported by Hannis *et al.* (2007).

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[145]   In addition, one other case study PHO also sets aside time for a public forum in its Board meetings.

Figure 7-11 shows that, in addition to using external media, three of the case study PHOs provided formal information (in the form of printed or emailed newsletters) on a regular basis to their contracted providers and community groups. Further, each of the case study PHOs maintains an internet site through which information may be obtained.[146] PHO 3 also sends a weekly email to interested community groups about relevant issues. This communication plays a triple role of raising the profile (and increasing the external image) of the PHO, linking groups in the health sector through information sharing and, to a limited extent, discharging accountability to interested parties.

7.6.2. *Accountability for outcomes*

(i) *To providers of funds and services*

As shown in Figure 7-9, 19 interviewees mentioned reporting to staff/contracted providers as a means by which their PHO could discharge accountability. It is significant that this means of discharging accountability was mentioned more frequently by interviewees than the formal reporting to the DHB (see Figure 7-9). Seven interviewees from PHO 1 (37%) and four interviewees (21%) from each of PHO 2, PHO 3 and PHO 4 identified reporting to staff and and/or contracted providers as a mechanism for PHOs to discharge their accountability. Each of the PHOs provided peer (or cell) group training for General Practice staff – either running and funding these events themselves, or enabling the related Independent Practitioners Association (IPA) to run them on their behalf. An interviewee from PHO 2 described how GPs assess programmes in terms of their own practice or what they perceive their patients will accept from the PHO. S/he noted:

> *At those meetings, particularly when some one is presenting a programme they'll say, "I wouldn't do that," "They're not going to do that," or, "They won't like that." "What they're asking for is this" … I mean they're quite challenging forums if you're looking at a programme (laughs). It's like when this CVD thing came out, they said, "We told you that four years ago, how come it's taken you four years." (Interviewee PHO 2)*

Providers have daily contact with the enrolled population, affording a mechanism both to communicate with the enrolled population, and to hold the PHO to account on the population's behalf.

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[146]   GPs were required to upload their fees onto the internet in order to access extra capitation from July 2006 and accordingly, the case study PHOs undertake this for their contracted GPs.

(ii) To the community

Figure 7-9 shows that 24 interviewees expressed the view that PHOs may discharge accountability through AGMs and other meetings with their community. Seven (29%) of these interviewees were from PHO 1, six (25%) from each of PHO 2 and PHO 4 and five (21%) from PHO 3. In addition to meetings, informal feedback may ensue as, in PHO 3 the comment was made:

> *We have a strong link back to our community. All our PHO does impacts on the community and we will hear back from them if we've aggrieved them in any way or we've done something a bit silly. (Interviewee PHO 3)*

Further, as reflected in Figure 7-12, PHO 3 held more meetings with its community during the case study period (2006 and 2007) than any of the other case study PHOs. As noted in Figure 7-12, notwithstanding six interviewees from PHO 2 identifying meetings with the community as a mechanism by which it should discharge accountability, this PHO did not hold open meetings for their communities to attend during the research period.

Figure 7-12: Community meetings held and observed in 2006 and 2007 through which PHOs discharged accountability

	PHO 1	PHO 2	PHO 3	PHO 4
Annual General Meetings (AGMs)	2	0	2	2
Community Meetings	2	0	5	1

Meetings between the PHO and communities or groups in the community were perceived by the interviewees to be the most useful means by which the PHO could inform its community about the PHO, and for the PHO to account to the community for its past and present performance (in terms of both the use of funds and provision of services). Part of that process was described by a community stakeholder:

> *I think too, looking not just at PHO accountability, but accountability in any community-owned NGO or not-for-profit organisation, it is about saying what you are going to do and doing what you say you were going to do. (Interviewee PHO 4)*

During the initial stages of their establishment, all the case study PHOs had run community meetings to explain the reasons for establishing the PHO and to obtain feedback on the planned direction of the PHO. Not all of the PHOs had continued such meetings with their communities. An interviewee from PHO 2, for example, commented:

> *I think the problem was that we didn't formalise it and say "We're going to report*

back to you and we're going to have another one in 6 months' time." It was a one off and didn't have the follow through, so whilst it wasn't a bad idea it just wasn't implemented well. (Interviewee PHO 2)

This interviewee noted that some of the PHO's staff felt a "burden of integrity" to ensure that ongoing meetings would be sustained. However another interviewee from the PHO noted that it was unlikely that the PHO would implement changes as a result of community feedback. This interviewee noted in connection with early meetings the PHO had undertaken with Mäori:

I now would probably have been at about 10 hui[147] where they've been asked this very open question and each time it's come back as, "Don't worry about the kuia[148] and kaumatua,[149] we want you to worry about our children and get that right. We want all child health programmes." Yet there is the kuia and kaumatua who are chewing up the health dollar and not living very long as a result ... We are actively running programmes to find elderly Mäori and clinically case manage them and trying to increase the uptake of [programmes for them]. We haven't got funding to do Child Health. They don't understand what the consequences are if we withdrew [the programmes] already in place ... Yes, we can do as they ask, but they don't realise that they would shorten maybe their life by maybe another 5 years in doing so. They don't actually want that either. (Interviewee PHO 2)

This interviewee conveyed the notion that prior assumptions made by this PHO about appropriate programmes for Mäori were considered by the PHO to be 'right' and it was unwilling to negotiate with affected communities about the programmes which should be funded. This finding resonates with that of O'Dwyer and Unerman (2006) who suggest that organisations institutionalise narrow accountability to funders rather than establishing mechanisms to discharge and negotiate accountability to a wider set of stakeholders. Such reasoning may also explain PHO 2's reluctance to hold public AGM or other community meetings.

Another PHO 2 interviewee blamed community confusion generated by other organisations' consultation processes as another reason as to why the PHO had not continued open meetings, by noting:

Last year the PHO was holding community meetings, [the DHB] was doing a consultation, the [local] Council was doing their Annual Plan and at the same time they were actually doing a traffic survey in [our area] as well. People got

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[147] *Hui* is a generic term for a Mäori gathering or meeting.

[148] *Kuia* is a Mäori female elder.

[149] *Kaumātua* is a Mäori elder (male).

totally confused as to who was doing what review and did it relate to transport, did it relate to roads, was it really health ... I spoke about three weeks in a row to ... groups because they were little old ladies panicking about what was going to happen. Could they still go along to the Medical Centre or was it all going to change? It was information overload I think. (Interviewee PHO 2)

An interviewee from PHO 1 noted apathy as a reason that community does not engage by attending meetings, commenting:

There's so much going on, nobody wants to do all these things unless it affects them. I think it's the PHO's concern to act on behalf of the community to do all these things ... we are just a body out there that should be looking towards the primary health of the community. (Interviewee PHO 1)

While recognising that consulting with the community at large may present difficulties, to segment the population into small enough groups to meet with presents another challenge. One interviewee noted:

I think you take advantage of any opportunity you get to talk with the community and its segments. I mean you can't get [all the PHO's population] in a room and even if you could, it would be a rabble. (Interviewee PHO 1)

Taking "any opportunity" to communicate with the community is a laudable sentiment but this interviewee also noted that the pressure of time is a further reason for PHOs to be less able to hold meetings with their enrolled population and wider community.

In addition, supporting the findings of other researchers (for example, Newman *et al.*, 2004), interviewees from the case study PHOs observed that it is difficult to engage with particular segments of the community at large through meetings. For example, an interviewee commented on being accountable to Mäori in the following manner:

I would say it is harder to be accountable to Mäori in [this region] ... because to be accountable, you need to report back to them and it's very hard. If you are still paying off the car, paying of this and paying off that, and your kids have got a snotty nose, are you really interested in going, in turning up to a PHO meeting to tell them what you need? You're in survival mode. (Interviewee PHO 2)

Nevertheless, the idea of meetings as an accountability mechanism was well understood by the interviewees. As an interviewee from PHO 3 expressed:

I think the ... meetings are a form of accountability and the Board meetings are open – you know people can come, it's not secret. (Interviewee PHO 3)

The meetings noted in Figure 7-12 were held by PHOs to discharge their accountability and also to ascertain the community's needs. At one such meeting of NGOs, the Chair

noted:

> *The Board is very conscious of the fact that … the PHO has a real responsibility in primary health to ensure that it is talking to the community … The reality is that we probably do need to set up a process by which we are talking to you on an ongoing basis so that we're getting a far clearer understanding of your issues. (Community Meeting PHO 1)*

One benefit of PHOs' meetings with the NGOs is that they provide a forum for the NGOs to provide input for PHOs' decision-making. They may also go some way to ameliorating NGO concerns (raised by the Health and Disability Sector NGO Working Group, 2005) that PHOs are unaware of the range of community services already being delivered. In Chapter 4 it was noted that giving voice to otherwise unheard voices is a proactive step that organisations can take to improve service quality and reduce the power differential between service providers and service users (Adams, 2004; Fowles, 1993; Gustafsson & Driver, 2005). Citizen participation also brings greater commitment to negotiated accountability (Beitsch, 2005). Thus, in PHO 3, the NGOs were used as "community networks" as described by one interviewee:

> *I think the PHO uses a lot of community networks and information is given to them and then received back and goes between each other, so there is a lot of shared knowledge. I think that is a really important way to demonstrate accountability. (Interviewee PHO 3)*

One interviewee from a Territorial Local Authority identified a practical way forward that may provide at least a partial solution to poor attendance at PHO meetings.[150] This representative noted:

> *Maybe when [the Territorial Local Authority] has community meetings, concept planning etc and we are discussing what communities see for their future, maybe the PHO should be very much a part of that and be there. (Interviewee PHO 4)*

One benefit of this arrangement (of incorporating PHO meetings with their community in local authority community meetings) would be to reduce duplication of effort that may otherwise be imposed upon the different entities. Community members may also be more inclined to attend a combined meeting about their community and its needs, rather than a number of meetings about specific aspects thereof (including primary health care).

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[150] In New Zealand all city, district and regional councils are called Territory Local Authorities. These bodies are required under the Local Government Act 2002 to care for the social and environmental aspects of their communities. Therefore, although they do not have a specific responsibility for primary health care, they are required to consult with their communities and to consider health issues in these wider forums.

From Figure 7-9 it may be seen that 23 interviewees identified community representation on the PHO's Board is a mechanism to secure the accountability of PHOs. Seven (30%) of these were from PHO 1, six (26%) from PHO 2 and five (22%) from each of PHO 3 and PHO 4.

According to these interviewees, having community representation on the PHO Board enables feedback to be provided to the Board from the community and, further, the PHO can disseminate information through the community representatives to a range of groups in the community. At a meeting called by PHO 1 to discuss the election process for community representatives, the Chair commented that such representation would be the PHO's "lifeline":

> *Community input for Primary Health Organisations is going to be its lifeline. All the other parts are being heard in the health sector at present, but the community area is quite fuzzy for the messages that all those in health are getting. We need to improve that because that's what Primary Health Organisations are about. I believe that this is one of our most important parts to make sure that the sort of messages that we are getting from our community groups are just as well enunciated and supported as any of the others. We need to make sure they are part of everything in our member services. (Community Meeting PHO 1)*

All the case study PHOs are concerned to gain the 'right' people for the Board and the role of elections and appointments to PHO Boards was discussed. However, only PHO 1 and PHO 3 have open elections for Board members; for PHO 2 and PHO 4, the Board members are appointed by the shareholders, primarily based on the recommendation(s) or nomination(s) of community and/or provider subcommittees.[151] The latter practice is at odds with the conclusion of Beitsch (2005), namely, that Board places should be competed for by all stakeholders. In the present context, this would include community representatives and staff of contracted providers. Beitsch's (2005) view is shared by the Chair of PHO 1 who stated:

> *What I suppose must concern us through this process is that all must have a voice. In other words the large mustn't overawe the small. The small voice mustn't be too raucous either, but they need to be heard. (Interviewee PHO 1)*

In recognising the right of all stakeholders to have a 'voice', this interviewee implicitly

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[151]   In line with a requirement to work in the spirit of the Treaty of Waitangi, all PHOs must have adequate Māori representation at Board level. All of the case study PHOs have sub-committees to advise on Māori issues and, where supported by the ethnicity of the local population, also had sub-committees representing their Pacific Island populations.

acknowledged the need for the PHO to negotiate performance outputs and outcomes with stakeholders. As noted in Chapter 4, 'voice' offers a positive alternative to 'exit' and leads to organisational construction and learning.[152]

A further mechanism for securing the accountability of PHOs identified by the interviewees, is that of providing local employment. This was identified by six interviewees: two (33%) from each of PHO 1 and PHO 2, and one (17%) from each of PHO 3 and PHO 4. Although the number of interviewees spontaneously mentioning the provision of employment as an accountability mechanism is relatively small, it is the same as the number who identified reduced patient co-payments, and almost equal to those who identified PHO annual reports as an important accountability mechanism.

The broad range of mechanisms identified by the community to inform their decisions to complain or disengage from their PHO, support the assumptions of Stewart (1984) and the findings of Beitsch (2005), that community stakeholders require a range of opportunities to provide input and feedback to publicly-funded organisations.

7.6.3. *Sanctions and rewards*

It can be observed from Figure 7-9 that 18 interviewees referred to sanctions that may be imposed on PHOs if they fail to perform their responsibilities satisfactorily. Chapter 6 described these sanctions in terms of provider and community sanctions and rewards. While the use of accountability mechanisms to providers is robust with sanctions imposed if the PHO does not comply, the greatest difficulty in accountability mechanisms lies in the lack of 'voice' sanctions applied by communities to their PHOs.

7.7.   *Summary*

This chapter has presented PHOs' views of their role and why accountability is demanded in PHOs' relationships. The data collected during this research has been analysed to present a 'map' of accountability on two continuums. As a result of these observations,

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[152] Starfield (1996) labelled the 'exit' option the marketing approach to accountability. Therefore, although it will also deliver organisational learning and an identity, it is based on the hypothesis that primary health care can be delivered as a market-based commodity. Chapter 2 reported the WHO's (2000, p.63) conclusion that: "markets work more poorly for health care" than in sectors where quality and pricing are more transparent.

two archetypal PHO models were derived. One model (represented by PHOs in quadrant B) depicts PHOs that prioritise the needs of providers and experience a relationship with the DHB where accountability is used to control the PHO. The second model (represented by PHOs in quadrant C) depicts PHOs that prioritise their community and where the DHB uses accountability to enhance trust.

In addition to these models of PHO accountability, this chapter detailed PHOs' accountability mechanisms, considering those through which they can best discharge accountability for outputs and outcomes.

The following chapter considers underlying structural aspects of the case study PHOs, providing further explanations for the differences depicted.

8. STRUCTURAL MATTERS: ADDRESSING SIMILARITES AND DIFFERENCES

8.1.   *Introduction*

In the previous two chapters it was noted that the case study data, analysed on the basis of (i) Primary Health Organisations' (PHOs) stakeholders and (ii) the PHOs *per se*, indicate the existence of two different models of accountability relationships in the PHO case studies, namely:

 (i) a model observed in which accountability is used as a mechanism for control and the PHO is considered to be primarily accountable for meeting the needs of funding and service providers. Accountability relationships are mainly contractual (as shown in Figure 7-4). This model is represented by quadrant B in Figure 7-7 and applies in general terms to PHO 2 and PHO 4;

 (ii) a model observed in which accountability is used as a mechanism to enhance trust and the PHO is considered to be primarily accountable for meeting the needs of the community. Accountability relationships are mainly lateral (as shown in Figure 7-5). This model is represented by quadrant C in Figure 7-7 and generally applies to PHO 1 and PHO 3.

Given that all PHOs in New Zealand have been established as an outcome of the *Primary Health Care Strategy* (Minister of Health, 2001), it might be expected that their accountability relationships would be similar. The question arises as to why PHO 2 and PHO 4 on the one hand, and PHO 1 and PHO 3 on the other, are similar to each other in terms of their accountability relationships, while those of the two pairs of PHOs differ markedly. Possible explanations are explored in this chapter through the re-examination of the key characteristics of the four case study PHOs and an analysis of the manner in which they have implemented the requirement to operate as not-for-profit organisations. As PHOs contract for essential service delivery from both not-for-profit and profit-oriented organisations, PHOs that do not comply with the expected not-for-profit structure may be subject to the critique of 'sector-bending' highlighted by James (2004). The conclusion is reached that, in addition to the models represented by the quadrants noted above, the accountability relationships that characterise the PHOs arise from the historical-structural development of these organisations.

8.2.   *Characteristics of the case study PHOs*

As explained in Chapter 5, the four case study PHOs were selected based on a wide range of criteria including: the socio-economic status, size (large or small), location (rural or urban), ethnicity, and age of their enrolled population, their geographical spread [resulting in each PHO being funded by a different District Health Board (DHB)] and their legal form: the two principal legal forms adopted by PHOs (that is, limited liability companies and charitable trusts) were to be represented in the case study PHOs. The objective was to select PHOs that displayed widely differing characteristics, as can be seen in Figure 8-1.

Figure 8-1: Characteristics of case study PHOs

PHO	Enrolled Population Characteristics					PHO Legal form
	Socio-economic [153]	Size [154]	Location	Ethnicity	Age	
PHO 2	Mainly Access	Large	Mainly urban	Higher than average proportion of Mäori and Pacific Islanders	Younger than average	Limited liability company. Independent Practitioner Association (IPA) is shareholder.[155]
PHO 4	Mainly Interim	Small	Rural	Mainly Pakeha	Older than average	Limited liability company. Shareholders include IPA and community health trusts.
PHO 1	Mainly Interim	Large	Mainly urban	Mainly Pakeha but has a significant Mäori and Pacific Island population	Not specifically different	Charitable trust (includes providers and members of local community).
PHO 3	Mainly Access	Small	Urban	Ethnically diverse	Not specifically different	Charitable trust (includes providers and members of local community).

Despite the characteristics of the PHOs differing quite markedly, as noted above and explained in Chapters 6 and 7, the interview data indicated the existence of two pairs of PHOs (PHO 2 and PHO 4; and PHO 1 and PHO 3) with the PHOs comprising each pair sharing similar accountability relationships. It thus appears that an explanation for the similarity in the accountability relationships of PHO 2 and PHO 4 on the one hand, and of PHO 1 and PHO 3 on the other, and the differences between the two pairs of PHOs, lies in factors that are linked to structural factors, rather than every characteristic mentioned

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[153]   The socio-economic status is taken from the prior funding regime of Access (for deprived populations) and Interim (for least deprived populations). The funding regime is explained in Chapter 3 and the selection process is further explained in Chapter 5 and Appendix 5.

[154]   As noted in Chapter 5, the parameter of a large enrolled population is more than 75,000 and that of a small population is less than 20,000.

[155]   The IPA shareholders are medical professionals (mainly GPs) who contract with the IPA.

above.

8.3.   *Implementing the requirement to be a not-for-profit organisation*

The *Primary Health Care Strategy* requires PHOs to be not-for-profit entities (Minister of Health, 2001) As noted in Chapter 3, a number of PHOs were established from existing arrangements that operated in the pre-PHO era, although many of these had not been not-for-profit organisations. As reflected in Figure 3-5, these prior Primary Care Organisations were identified variously as IPAs, Contracting Parties, Community-owned Organisations (including Mäori and Pacific providers), and other loose networks of General Practitioners. Resulting from the historical bases of PHOs, the pace at which the 80 PHOs were formed within the first 18 months of the *Primary Health Care Strategy,* subtle differences in the demands of the 21 funding DHBs, and variations in the demographics and health needs of PHOs' enrolled populations, a range of structural PHO forms have emerged and are tolerated by DHB funders (Abel *et al.*, 2005).

Recognising the pre-reform primary health care organisations existed in a variety of forms, the Minister of Health stated that channelling the new funding through not-for-profit organisations would "guard against public funds being diverted … to shareholder dividends" paid out by profit-oriented providers (Minister of Health, 2001, p.14). The requirement for a not-for-profit organisational form, therefore, may have been a reaction to the perceptions noted by commentators such as Craig (2003), who observed that the legacy of the 1990s market-based policies was (resource) 'hungry' providers who divert primary health care funding away from services and into providers' purses.

From the Minister of Health's (2001), statement (noted above) it appears that a non-distribution constraint is the defining factor of a not-for-profit organisation.[156] However, the common definition of the term 'not-for-profit organisation' is far broader and includes (as described in Chapter 2) an orientation towards organisational mission and building social capital in the communities in which they work, instead of profit. As noted in Chapter 2, when not-for-profit organisations network within communities to build trust they generate social capital that enables them to assess local needs, thus reducing the

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[156]   Statistics New Zealand (2007) also identifies the non-distribution constraint as the sole factor by which not-for-profit organisations can be defined.

likelihood of over- or under- utilisation of publicly funded services (Weisbrod, 1988) such as primary health care.

The manner in which PHOs have implemented the requirement to operate as not-for-profit organisations is reflected in the data obtained from a range of sources, including the case study PHO interviews, and the annual reports and Annual General Meetings (AGMs) of the case study and non-case study PHOs. (These sources are described in Chapter 5.) In this chapter, the PHO case studies are referred to by the pseudonyms used throughout this thesis, the pilot study AGMs by the numbering system provided in Figure 5-1, and the additional annual reports received from PHOs by sequential numbers. The analysis of the data derived from these sources is presented below in the following four sections:

(i) PHOs' goals to make no profit;

(ii) PHOs' earnings management to meet goals to make no profit;

(iii) Structural hindrances to PHOs' meeting goals to make no profit; and

(iv) PHOs' development of social capital.

8.3.1. *PHOs' goals to make no profit*

During the interviews, 12 of the interviewees specifically answered the question, "What do you understand by the term not-for-profit in relation to PHOs?" Nine (75%) focused solely on the profit (or surplus)[157] arising from operating with a not-for-profit organisational form. For example, a DHB staff member interviewee from PHO 2 noted:

> *They are a not-for-profit because they make no profit. (Interviewee PHO 2)*

Two other interviewees from the same PHO similarly observed:

> *It means not-for-profit and not-for-loss … Not-for-profit means that your primary focus isn't to make a profit … A profit for us is embarrassing. We don't want to make a profit. We aim not to, but we don't want to be inefficient and sloppy with the money either. (Interviewee PHO 2)*

> *Basically there's no commercial gain in the PHO. It spends its money on goods and services and that's how it goes. (Interviewee PHO 2)*

The desire not to have a surplus, but to match all income and expenditure, was explained by the Treasurer of a non-case study PHO at an AGM. He noted:

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[157] The terms 'surplus' and 'profit' are used interchangeably. While a not-for-profit organisation will technically make a surplus of income over expenditure rather than a profit, interviewees tended to use the term 'profit' to refer to this concept.

In a perfect world a PHO would have income in and expenditure out and it would have absolutely nothing on its balance sheet. It all comes down to timing ... Someone at some point decided to appoint balance dates and so accountants were called. And balance dates? Well, get rid of them and I can head off home, but not to be. (AGM at PHO 6)

These stakeholders suggest that the pecuniary goal of a not-for-profit PHO – to make no profit – is the defining characteristic. In order to examine this notion in practice, the financial reporting data of the 19 PHOs that provided their financial reports for the years 2005 and 2006 were examined.[158] As may be seen from Figure 8-2, 13 of these 19 PHOs (69%) were constituted as charitable trusts, five (26%) as limited liability companies and one (5%) as an incorporated society. Each PHO's surplus (or deficit) was compared to the revenue for the year in which it was realised. In order to make meaningful comparisons and to eliminate variations resulting from differences in the size of their enrolled populations, PHOs' surpluses (or deficits) were calculated as a percentage of their revenues. These percentages are presented in Figure 8-2.

Figure 8-2: Analysis of 19 PHO financial reports for 2005 and 2006
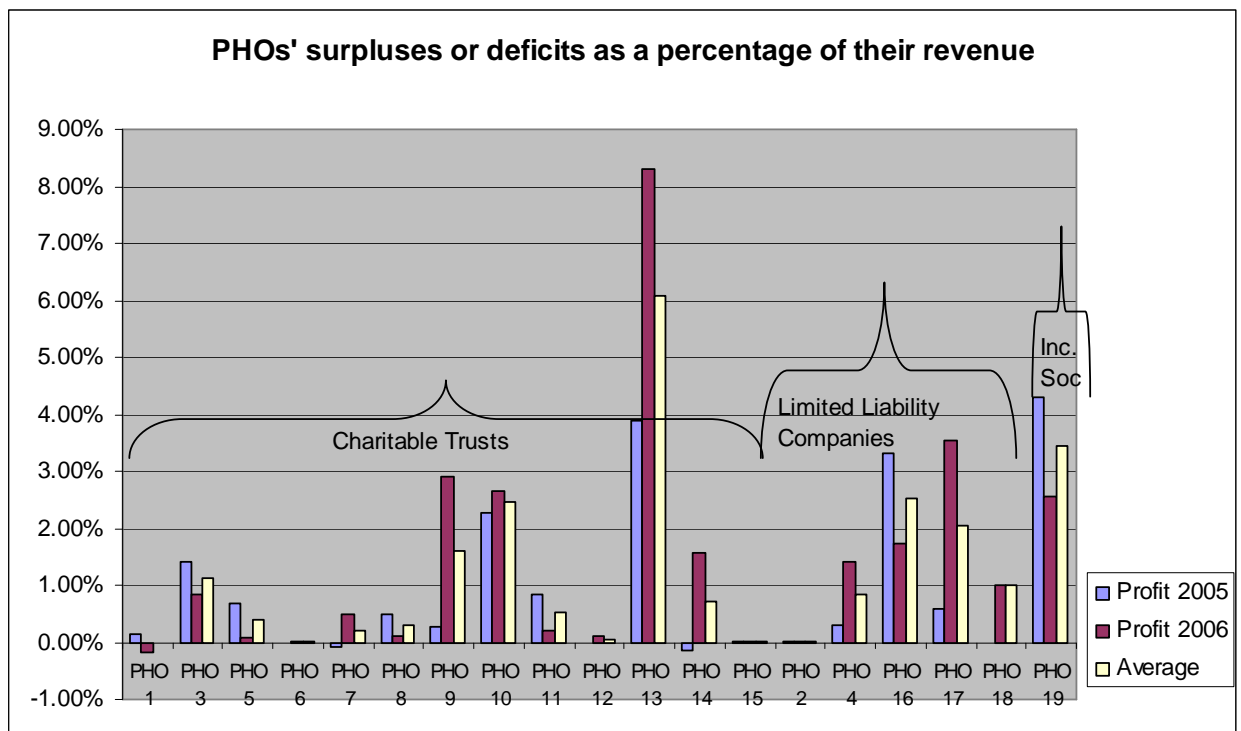
Figure 8-2 shows that 13 of the 19 PHOs (69%) realised an average surplus equal to or

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[158]   As explained in Chapter 5, all 80 PHOs were requested to provide their 2005 and 2006 financial reports but, despite repeated requests, reports were received from 19 PHOs only.

less than 1% of revenue, and a further five (26%) recorded average surpluses of less than 3% of revenue.[159] The deficits recorded were minimal and no PHO recorded deficits in both years. While the sample of PHOs is small, there appears to be a correlation between the organisational form and PHOs' reported surpluses, in that more limited liability companies reported a surplus than did charitable trusts. In addition, although most PHOs typically sub-contract for health services and employ no or few staff, some directly employ staff to deliver programmes (for example, for Health Promotion or Services to Improve Access). From the PHOs' annual reports, there did not appear to be any correlation between PHOs' staffing levels and reported surpluses.

The concentration of PHOs' surpluses and deficits in the zone of less than 3% of revenue appears to suggest an unwritten rule or assumed target to be "not-for-profit and not-for-loss." In order to ascertain whether PHOs establish such pecuniary goals, an attendee at an AGM held by PHO 3 asked the question:

> *Is there, or was there an intention to have a certain amount of surplus, or is it by chance? (AGM at PHO3)*

The Chair explained:

> *Our aim as a Board is to make sure we have enough money to pay all the liabilities we have and to have enough money there to cover redundancies. We are not looking for profit to reinvest the profit in the Board or anywhere else, but we can actually make profit on our contracts and our intention in this organisation is to be the best in terms of being able to put value back into the services that we provide. (AGM at PHO 3)*

Thus, the Chair implied that this not-for-profit PHO is concerned to use any pecuniary gains to improve the services it provides to its community rather than distributing them to the charitable trust's Board. Statements made at the meeting showed that PHO 3 also recognised the need for a robust infrastructure to support its contractual and moral obligations so that the actions of the PHO enabled its goals to be achieved.

The surpluses earned by PHO 13 appear unusual compared to the other PHOs. As noted in Section 8.3.2 below, of the 19 PHOs whose financial reports were analysed, PHO 13 applies the most stringent test to its accruals of unspent discretionary funding. This results

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[159] In the USA study by Chang and Tuckman (1990) 26% of health care institutions reported earnings between a surplus of 3% and a deficit of 3%. Their sample included not-for-profit hospitals, hospices and nursing homes as well as clinics and thus represented a broader range of organisations than the PHOs in this study.

in it recognising profits and losses on contracts sooner than the other PHOs. PHO 19, the only Incorporated Society, also revealed significant surpluses. In contrast to the other PHOs whose equity comprised only recent retained earnings, this Society pre-dated the *Primary Health Care Strategy* by a number of years and retained significant reserves when it became a PHO. It is possible that these reserves may have increased its earnings capacity. Apart from PHO 13 and PHO 19, a number of PHOs (PHO 10, PHO 16 and PHO 17) report an average surplus of over 2% of revenue. These PHOs were not involved in the case studies but analysis of their financial reports indicated that they are currently accumulating those surpluses to fund projects planned for the future.

Although it appears that most PHOs (at least of the 19 whose financial reports were examined) have the aim of not making a surplus, Abel *et al.* (2005) expressed concern that some PHOs may be operating a profit-oriented, rather than a not-for-profit model. James (2004) uses the term 'sector-bending' to describe the operation of a not-for-profit organisation from a profit-oriented mindset. This 'sector-bending' may be observed when pecuniary goals affect not-for-profit PHOs' output and pricing decisions potentially resulting in reduced mutual benefit and less trust in accountability relationships.[160] As noted in Chapter 2, DHBs or other funders may increase their monitoring of PHOs if 'sector-bending' results in scepticism of the not-for-profit organisational form. Increased monitoring may reduce the cost-effectiveness of contracting with these not-for-profit organisations.

8.3.2. *PHOs' earnings management to meet goals to make no profit*

While the analysis of the PHOs' annual reports shows a general tendency for PHOs to meet a goal of 'not-for-profit and not-for-loss', 'sector-bending' appears to be present in IPA-based PHOs. Prior researchers have identified two ways in which 'sector-bending' may conceal profits. These comprise:

    (i)   Abel *et al.* (2005) and Howell (2005) who noted that not-for-profit PHOs may be used as a conduit for profit-orientated organisations to extract excessive service

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[160] The concept of mutual benefit was explained in Chapter 2 as the notion that not-for-profit organisations' governors will simultaneously demand and manage resources for the mutual (public) good. The result is enhanced trust.

fees and (along with Mitchell & Shortell, 2000) that 'inappropriate' dealing with related parties may occur, thus leading to a lack of accountability; and

(ii) Leone and Van Horn (2005) who noted that not-for-profit organisations may conceal profits through accounting accruals management.

As explained below, similar ideas were expressed in the case study PHO interviews and at PHO AGMs.

(i) Not-for-profit PHOs used to extract excessive service fees for related parties

Surpluses may result from PHOs focusing on revenue, rather than 'balancing the books'. A DHB interviewee from PHO 4, for example, observed that PHOs with which s/he was familiar seek to maximise their revenue. S/he noted:

> [Of the PHOs I deal with] I did find the Chairs really fiscally motivated and a lot of them are ex-accountants and things like that. The pure motivation was getting the money in and I had a problem with that as they didn't understand the concept of what the PHO was actually doing and what they should be doing with that money. (Interviewee PHO 4)

Howell (2005) has also noted that surpluses may result from PHOs overstating their funding needs as a consequence of close contractual arrangements between not-for-profit PHOs and their profit-oriented General Practices. Howell (2007) has been particularly scathing of PHOs that are owned or managed by (profit-oriented) IPAs on the grounds that, when service providers (mainly GPs) hold positions on PHO Boards and comprise the major set of related parties, the PHOs' related party transactions are less than transparent. As noted in Chapter 3, IPAs were formed between 1992 and 2001 to undertake fee-claiming and contract negotiations on behalf of General Practices. Some PHOs continue to contract with the predecessor profit-oriented IPAs for management services and may have ownership interests in PHOs. For example, PHO 2 and PHO 4 are limited liability companies that are, at least partially, owned by IPAs. While DHBs contract with PHOs incorporated with various legal forms, DHB staff are likely to be concerned about PHOs that are structured as companies owned by IPAs. As a DHB interviewee from PHO 2 noted:

> That's my point around structures … On paper the PHO is not-for-profit but obviously all the money went into [the IPA]. Therein lies our problem. (Interviewee PHO 2)

This interviewee considered that the PHO structure facilitates the concealing of profits as the PHO is a conduit for the service fees to be channelled to the IPA. A staff member interviewed from this PHO described the 'balancing act' required when considering the programme demands of a not-for-profit PHO seeking to respond to its community, and the programmes the profit-oriented IPA was prepared to deliver for its management service fees. S/he explained:

> *We've had a lot of discussions over programmes … It's like a balancing act really, because from the Management Services Organisation there's always the temptation to want to retain the ones [PHO contracts] that produce the best management fee for them. And some of them are clearly more lucrative than others. Although in saying that, they're looking at a costing activity model that can be applied across all programmes, so it lessens the impact. I mean, here's an example. Some programmes that have been running for a long time, economies of scale and the fact that they have been running for three years means that they're getting quite a reasonable management fee with them for not quite as much work as something that is in the development phase. So I'm always conscious that we have a management organisation that if I was in there, I may look at with a commercial interest as opposed to looking at what's best for the population. I mean the management company is a for-profit business otherwise they just wouldn't be here. (Interviewee PHO 2)*

The need to make a profit on the management of programmes may lead to preferential treatment of particular stakeholders. As an interviewee from the same PHO (PHO 2) observed in respect of the PHO's IPA owner:

> *There is quite a significant philosophy behind [the IPA] structure which is saying that, "Yes we are there for profit," not for super-profits, but we are there for the benefit of our shareholders and endeavour to increase the value of what we provide to General Practice. (Interviewee PHO 2)*

These comments by PHO 2 staff interviewees appear to suggest that this PHO may be operating a private sector model of primary health care (a concern raised by Abel *et al.*, 2005) and, as expressed by James (2004), be 'sector-bending'. A DHB interviewee commented on why this may be allowed to occur generally, as follows:

> *You're obliged to be a mentor and be supportive because it's a health environment … because if thousands of people didn't have health care suddenly, it would be a big disaster, and a political disaster. (DHB Rep)*

Another matter raised by interviewees is that of 'excessive remuneration' paid to senior staff, resulting in a waste of scarce health dollars and a lack of accountability (Mitchell & Shortell, 2000). Although an interviewee from PHO 3 noted it is important to recognise a "doctor should be making a good living," external interviewees from PHO 2 conveyed

that the IPA's staff and executives should not be "making a good living." An informed community member from PHO 2 observed in relation to the PHO's IPA shareholder:

> *They actually don't make much money but they've got to make a profit, they've got to pay executives down there who get paid huge money. They've got to suck money out of the PHO to pay for it. There's no other way they get their money. (Interviewee PHO 2)*

Another community stakeholder noted that the actions of PHO 2 and its IPA are not necessarily aligned with the PHO's pecuniary goal to make no profit; this interviewee reflected on the IPA:

> *They are definitely operating in the private health sector I would have said. Their objectives are not that way inclined. I don't think their goals or their vision statements are about making money but they don't operate in that typical NGO context … I find it interesting that a not-for-profit organisation can (sigh) pay or act like a private organisation. Do you know what I mean? I work very closely with … a lot of struggling NGOs in the public health sector and they don't put lunches on for a meeting, they don't pay in the high end of the salary bracket [like the IPA does]. Those sorts of things I guess is something that is not familiar for me in a not-for- profit. (Interviewee PHO 2)*

These interviewees expressed strong opinions about their experience with PHO 2 and, to the external observer, it appears that the structure and operation of at least this PHO does not accord with the notion of a not-for-profit entity, as it extracts service fees from the PHO to increase the income of a related party, its IPA owner. A consequence of PHOs (who are wholly or partially owned by profit-oriented IPAs) seeking to maximise the returns to their IPA owners, is that they may fail to purchase services from not-for-profit non-governmental organisations (NGOs) as the *Primary Health Care Strategy* (Minister of Health, 2001) encourages them to do.

Perceptions of 'sector-bending' may lead NGOs and other stakeholders to misunderstand the mode of delivery of other PHOs and this may, in turn, result in concern by those who contract with these latter PHOs. For example, at an AGM of PHO 9 (a charitable trust) a provider of health services to the PHO noted:

> *I read with trepidation that we are a private [provider][161] – we are not that … we are a subsidiary of the PHO. We're a non-profit venture … (AGM PHO 9)*

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[161] The type of care this provider was offering is typically run by profit-oriented organisations but the PHO had specifically responded to a need in the area and obtained funding themselves for the not-for-profit venture.

Related party transactions also include PHOs making loans to managers or governors. Analysis of the 19 PHOs' annual reports revealed that four PHOs (PHO 5, PHO 10, PHO 11 and PHO 12) recorded a loan in both 2005 and 2006 to the IPA that acts as their Management Services Organisation. No further details were available, although the notes to the accounts reported that the loans were "approved by the Board" of these charitable trusts. The surpluses of three of these PHOs (PHO 5, PHO 11 and PHO 12) are less than 1% of revenue, and those of PHO 10 are less than 3% of revenue. While it does not appear that these loans are instrumental in these PHOs meeting a goal to make no profit, the use of public funds either to enhance the cash flow of the IPA-based Management Services Organisation, or for it to extract increased service fees, signifies a lack of accountability.

(ii) Profits being concealed through accounting accrual management

As noted above, analysis of the annual reports of the 19 PHOs reflected in Figure 8-2 indicates that the tendency of PHOs to manage their income around zero is not limited to any one legal structure. However, other researchers (for example Leone & Van Horn, 2005) have concluded that profits in a not-for-profit organisation may be concealed through earnings management. Goodin (2003) warned that excessive trust can encourage opacity in financial management.

From the analysis of the 19 PHOs' financial reports, it appears that some PHOs have accrued discretionary funding (Health Promotion and SIA funds paid to PHOs to fund specific projects) to 'manage' their surpluses to be close to zero. Funds are received at the beginning of each quarter irrespective of whether a specific project has been selected by the PHO. It might be expected that the portion of these discretionary funds which a PHO had spent would be recorded as revenue and expenses; committed (but unpaid) expenses would be recorded as 'accrued expenses', and profits or losses from projects would thus be reported through the Statement of Financial Performance. In respect of uncommitted funds, these would be recorded as 'revenue in advance'. However, the 19 PHO's annual reports for 2005 and 2006 revealed three broad methods of accounting for unspent discretionary funding:

(i) all unspent funds accrued as a single item as either 'revenue in advance'[162] or 'expenses accrued'[163] irrespective of whether or not a portion of those funds has been committed, or if expenses have already been incurred. No notes are provided to enlighten the reader.

(ii) unspent funds accrued as in (i), but note disclosure provided as to the categories in which the funds will be allocated in the future,[164] or, as in PHO 7 and PHO 8, provide details as to under- and over-spending in those categories (in PHO 7 and PHO 8 the profits and losses in the contracts are disclosed, but they are not recognised through the Statement of Financial Performance);

(iii) PHO 13 applies a stringent test for each project funded. Surpluses and deficits on each project are taken to the Statement of Financial Performance: the resulting retained earnings are separately identified as being available for Health Promotion, SIA and other projects.

The engagement partner for the audit of one of the PHOs in group (i) noted his concern that, although all unspent funds were termed 'funds received in advance' these funds included profits and losses on programmes already completed. When the stage of completion of this PHO's current projects was assessed by the audit firm, it was found that the 'funds received in advance' included realised surpluses and also losses for projects which were unable to be completed within the funds allocated. When this audit firm required the PHO to change its financial reporting to realise the profits and losses on its projects, the PHO refused and has since changed its auditors.[165] The auditor's concern was that PHOs following the methods identified above as (i) and (ii) may understate their liabilities and/or conceal profits by managing liabilities or revenue. Such management of earnings through manipulation of accruals has also been identified previously in the not-for-profit sector by Leone and Van Horn (2005) whose statistical study indicated management of discretionary earnings in not-for-profit hospitals in the United States, seemingly in order to maintain surpluses and deficits close to zero. The DHBs employ

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[162] This practice was followed by PHO 1, PHO 2, PHO 12 and PHO 16. (Varying terms are used, including 'funds received in advance' and 'deferred income'.)

[163] This practice was followed by PHO 4, PHO 9, PHO 14, PHO 17, PHO 18 and PHO 19.

[164] This practice was followed by PHO 3 (for 2005 and 2006), PHO 5, PHO 6, PHO 10, PHO 11, PHO 12 and PHO 15.

[165] Despite being almost totally government funded, each PHO selects and remunerates its own external auditor.

qualified staff to analyse all of their PHOs' financial statements and funding, and the DHB Funding and Planning managers deal with problems raised by these analysts on an exception basis. In none of the case study PHOs did the relevant DHB express concern about the quality of PHO financial reporting, nor the potential qualification of audit reports.

PHO 13, the Group (iii) PHO, reports surpluses in a manner which is markedly different from the other PHOs as projects are assessed and profits and losses brought through to equity. Profits are held as reserves and therefore PHO 13 does not appear to manage their earnings. Further, in 2007, PHO 3 followed a similar accounting treatment to PHO 13 with a corresponding dramatic increase in its surplus. Community members present at the AGM were enthusiastic that their PHO was receiving 'more appropriate' levels of funding. Their DHB has made no comment about the increase in its surplus.

From the analysis of the four case study PHOs' annual reports for the years 2005 and 2006, it appears that the pecuniary goal to make no profit may have resulted in pecuniary actions (management of accruals) designed to conceal surpluses in all but PHO 3 (in 2007). For quadrant B PHOs that experience accountability as a controlling mechanism and are considered to be accountable primarily for meeting the needs of funding and service providers, the IPA ownership of these PHO companies may enable the PHO managers (i.e. the IPA) to extract PHO funds through excessive remuneration for IPA staff and other related party transactions. Further, by managing discretionary accruals, these PHOs may be able to conceal the true cost of delivering primary health care services.

8.3.3. *Structural hindrances to PHOs meeting the goal to make no profit*

In addition to actions that bring into question PHOs' operational commitment to not-for-profit goals, James (2004) drew attention to the fact that public funding may be lost to tax payments when not-for-profit organisations are profit-oriented. Tax privileges enjoyed by New Zealand's not-for-profit organisations are:

- charitable donee status (where donations generate tax rebates for individuals) ; and
- tax-free status of profits used for charitable purposes.

While none of the 19 PHOs whose annual reports were analysed received charitable donations, two of them (PHO 2 and PHO 18) paid tax. These PHOs were both formed as limited liability companies with IPA shareholders. It is understood that the Inland Revenue Department investigated the ownership structures of these two PHOs and deemed that, notwithstanding a non-distribution constraint in their constitutions, their profit-oriented IPA owners wield sufficient control for the PHOs to be adjudged profit-oriented taxable entities.[166] Although PHO 2 recorded no profit, PHO 18 made a net profit after tax of 1% of its revenue. Notwithstanding that this taxable profit appears to be at odds with the requirement for the PHO to be a not-for-profit entity, it was not possible to negotiate access to the PHO in order to explore this in more depth. The first PHO to establish in this geographical area failed (as a result of ongoing conflict between the PHO and its contracted GPs) and this may have contributed to its DHB being willing to 'turn a blind eye' and contracting with the PHO despite its status as a taxable (profit-oriented) entity.

While PHO 2 reported a nil profit in both 2005 and 2006 and the PHO thereby avoided paying income tax on surpluses, Resident Withholding Tax was deducted at source from its interest income. The DHB pays Health Promotion and SIA funds to its PHOs at the beginning of a funding period but PHO spending against that allocation typically does not occur until the DHB approves specific projects. Any time-lag between receiving and spending the funds means that, at times, significant funds may be held on short-term deposit with a bank. As explained by one staff member from the PHO, this funding and approval process was unexpected:

> *I don't think it was ever envisaged that there would be that amount of interest being earned which would cause concern of a massive tax bill. But I think it took a while to get the wheels in motion, to get the expenditure more in line with funding if you like. As a result of that the interest earned has been much more than anticipated ... I don't think that earning interest and paying tax was a major factor in the structural discussion at the commencement. And it follows that any change from that ... would involve re-opening constitutional discussions with the District Health Board and I don't think that it was felt that it was worth doing that, even with the amount of money being earned and for which tax is being paid. The interest in future years is forecast to decline significantly with the catch up in expenditure... We are spending the money ... at a faster level than we were before. (Interviewee PHO 2)*

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[166]   This was confirmed in a discussion with the audit partner from one of the PHO's auditors.

Apart from the Resident Withholding Tax paid on the interest income, as with all the PHOs, the net interest was made available to primary health care projects:

We have taken up the interest that we have been earning and transferred it to deferred income in our SIA programme. (Interviewee PHO 2)

Although the tax on interest paid was unavailable to the PHO for spending on health care services, the IPA owner could apply the tax paid to any distributions it made from profits realised from its other operations. Thus, potentially PHO revenue could be distributed to the IPA's shareholders. From this interviewee's comments it appears that, when PHO 2 was established, the receipt of significant taxable income was not considered and that, to counteract this structural shortcoming, the PHO was keen to reduce its cash surpluses in order to show that it was a not-for-profit organisation.

8.3.4. Developing social capital

In addition to the non-distribution constraint, the government's requirement for PHOs to be not-for-profit organisations may be related to the perceived wisdom that these organisations will assess local needs and reduce the likelihood of under- and over-utilisation of services provided with public funds. Putnam (1995), Fukuyama (1995) and Bryce (2005) suggest that this will occur when not-for-profit organisations build strong networks based on trust. These networks are termed social capital. While there are diverse understandings of social capital, and no consensus as to its measurement, Bryce (2005) contends that to grow social capital requires an organisation to draw on intimate local knowledge, working with community through voluntary staff, networks and regular meetings with the community and organisational members.

As noted in Chapter 2, 'Third Way' policies include governments using private organisations to increase social capital through community engagement (Callinicos, 2001). The *Primary Health Care Strategy* (Minister of Health, 2001, p.20) encourages PHOs to "take a community development approach to find appropriate solutions for disadvantaged groups." In addition, it requires PHOs to demonstrate that they involve communities in decision-making, as outlined in the Alma Ata Declaration (WHO, 1978, Declaration VII). Hence, as one Board member noted:

I think that the Alma Ata has probably been the key driver of some of the policy people in the Ministry – the concept that people and communities should

ultimately design the health system that serves them. (Interviewee PHO 1)

According to Bryce (2005), PHOs show their commitment to developing social capital when they:

   (i) seek to build social capital on extant community structures; and

   (ii) use volunteers and donated time to advance primary health care.

(i)   Building social capital on extant community structures

It was noted in Chapter 2 that social networks reduce social tension and thereby lower transaction costs as a consequence of reduced monitoring (Putnam, 1995). Further, strong social capital (in the form of community involvement) may provide legitimacy for primary health care resource allocation decisions (Mossialos & King, 1999; Wilmot, 2004), and lead to appropriate levels of resource utilisation (Weisbrod, 1988).

An interviewee (the CEO) from PHO 4 acknowledged that strong networks already existed in the PHO's rural communities. S/he said:

> *The amount of interaction there is in communities and volunteer groups is actually quite astonishing. There are very strong networks, particularly around health and emergency services and community-type issues. These rural communities are really strong … [People] will be St John volunteers, on a trust board or the school, doing library books, or meals on wheels. Their reliance on volunteers in those small communities is under-rated actually. In some cases it's astonishing what they do. (Interviewee PHO 4)*

Thus, this interviewee recognised the depth of community interaction, although (as noted in Chapter 7) PHO 4 was only beginning to tap into that depth through community meetings. Involving communities may include PHOs actively building on services that already exist in the community. As another PHO CEO interviewee observed:

> *There was already a lot of health promotion happening so we employed a coordinator to just help coordinate that and share information across all the services and help coordinate health promotion between everybody … There's so much resource out there … so it's actually just someone to help them coordinate. (Interviewee PHO 3)*

This concept of developing health care networks was also discussed at an AGM presentation that continued as follows:

> *The obvious overall aim is to improve access to primary health services for all our communities so that the overall health and wellbeing of our communities*

improves. That's not exactly rocket science but that's what we're here for ... [not working] in isolation but rather through working in collaboration and partnership with communities, service providers, initiatives and funders. The idea is to get everyone pulling in the same direction. And we'll see how far we've come tonight ... There's a couple of things I'd really like to emphasise. One is that nothing happens without everyone pulling together and a lot of challenges are easy once you've done it once. But ... you've got to get people on board. So one of the things I'm hoping you'll notice from today is that even though its actually quite tough, quite hard going, there's a lot of enthusiasm to make the best of the opportunity we've been given through the primary health strategy for the creation of PHOs to actually start running with the ball. Not to take off down all by ourselves but to bring the community and to share with our community service, community rich, the whole shooting match and to get the community aligned to actually pull in one direction. (AGM at PHO 9)

Although PHOs are relatively new organisations, it appears that the staff and Boards of the PHOs are working to build networks on extant community structures through Board representation as well as contracting arrangements. However, the PHO may need to build its own capacity in order to generate community alignment. PHO 3 found that it needed to employ more staff in order to achieve its goals. An interviewee noted:

First of all we saw the PHO as a conduit and an organising organisation. It wouldn't be involved in delivery, but it would be involved in facilitating contracts ... and then basically pass those contracts along [to not-for-profit providers]. That was the ideal and we worked that way for quite a while, but I think the reality is a little different. There are some services that don't provide an income, some services that aren't or can't be delivered or provided by a single practice and need to be delivered by the PHO itself and thus we've employed the pharmacist and the outreach nurses and the social workers. (Interviewee PHO 3)

By the end of the case study period, this PHO had grown significantly by employing individuals to fill particular roles in the organisation. This growth provided new challenges to the PHO, requiring it to define quite carefully the services for which it was responsible and those that were being delegated amongst its networks. In respect of the different relational structures, the PHO Chair noted it was necessary to partner and engage with like-minded providers in order to achieve joint goals from networking:

I think it's really important for the PHO that we all share the same overall belief. If we had people there that were coming with a profit motive, then that would cause significant problem, because their underlying belief is different from everybody else's. But because everybody has the same general belief, people will have vigorous and vicious discussions with each other arguing their points out across – but at the end of the day, they still believe in the same outcome. (Interviewee PHO 3)

These 'beliefs' are difficult to define, but it was noticeable that the two case study PHOs

with strong NGO relationships were formed as charitable trusts and Trustees included representatives of NGOs and other not-for-profit providers.

(ii)   Using volunteers' time to advance primary health care

In each of the PHOs, members of the governing Board were able to claim Directors' fees and expenses, but it was noted these were relatively low compared to profit-oriented enterprises. Accordingly, in line with the notion of building social capital, interviewees stated that Boards derived from communities tap into volunteers' time to develop population health aligned with their community's needs. As one PHO Board member noted at an AGM:

> *The government wishes to enrol the community and get volunteer work out of people. And they will get masses more out of it … It's the whole philosophy of the Community Organisations' Grants scheme[167] or the education system, getting people on the Boards and so on; I think it has actually improved things in [our area]. And in the PHO it has made the [General Practices] look outward and start talking to people and take a more preventive focus too. (Discussion at AGM PHO 6)*

While this PHO Board member attributed the impetus for community-based Boards squarely on the government, at another AGM the Chair conveyed pride in the community being involved with the PHO, suggesting that the gifting of volunteer time was reflective of that involvement. Following the presentation of the financial accounts, a speaker asked in a jocular fashion:

> *Just a very small point Mr Chairman. What does the PHO get for its legal fees of $10?*

After some banter, the Chair responded to this question:

> *We're very fortunate that we have good people in the community, with people that are prepared to work for next door to nothing. I just need to emphasise that PHOs stand up on a community basis and there are people that work for us for nothing. You will also have noticed that the Board members' fees have reduced this year. (AGM at PHO 4)*

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[167]   The Community Organisation Grants Scheme is a community-driven government-funded scheme. Thirty-seven Local Distribution Committees comprising volunteers (supported by Department of Internal Affairs), consider and make decisions on grant applications to provide essential support to groups in their local communities. Information downloaded from the internet 24th May 2008 from http://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Community-Funding-What-is-COGS?Open Document.

In addition to the benefit of building social capital, in this PHO the reduced Board fees meant management services funding could be applied to other discretionary projects the PHO sought to run in the community.

In another PHO (PHO 1), meetings were held to discuss nominations for the replacement of a community member on the Board so that the Board attained the 'ideal' structural composition. Discussions were centred on the requirement that a nominee should represent community 'consumers' adequately, rather than providers of health services. In addition to considering the type of organisation that was eligible to nominate such candidates, it was noted nominees must be community volunteers. A current representative, who was retiring from the PHO Board, referred to the Consumers' Health Forum of Australia that provides advice on who should represent community 'consumers',[168] and explained:

> *Well for actual membership on the Board, you are not able to be nominated, we suggest, if you are provider of health services such as a health professional or … a manager … The Australian forum focused on whether the Board members are volunteers … That doesn't mean that their expenses may not be reimbursed, but they are not actually being paid. (Community meeting PHO 1)*

While it was important for this Board that its membership was balanced between community and provider representatives, the discussion that developed at this community meeting sought to define community representation in terms of the volunteer composition of the group nominating and voting for these Board representatives.

In another PHO, a Green Prescription programme[169] had begun. The PHO was providing resources to support that programme, but the coordinator was a volunteer. This was explained by a Board member as follows:

> *The [PHO's] Health Promotion team spent over 2 years … making people aware of it. At present they have started with volunteer coordinators … Give it 6 months and we will see the difference. The idea is to change people's exercise and eating habits and I think that can be maintained and there'll be a ground swell from the bottom … [The PHO] will then probably go up another level in that it may well pay to have a speaker going in and so on. (Interviewee PHO 2)*

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[168] This is Australia's national voice for health consumers and advocates for good health policy and programmes. Information available from the internet from www.whf.org.au.

[169] As noted in Chapter 2, a green prescription is a health professional's written advice to a patient to be physically active, as part of the patient's health management. It may also involve community exercise and education programmes resourced by PHOs.

PHOs have recognised that volunteer input is useful and necessary for reaching out into the community. While PHOs may commence programmes, they require communities to become involved before these programmes change community habits. This aspect of change was highlighted by a PHO Chair at its AGM:

> *Our Board members I believe are coping with change and new opportunities. There are threats in that but there are also wonderful opportunities to do new and innovative things within our community. They're happening every day. In many cases they're unheralded. There is an awful amount of the volunteer work being done in the community daily that doesn't get acknowledged appropriately. It doesn't probably get recognised by the media. Tonight I want to acknowledge that, but I want to acknowledge that my Board has worked very hard over the last year to work with new opportunities and to work in some cases with new people, to make exciting opportunities for a number of problems that have be-devilled New Zealand society for years. (AGM at PHO 1)*

While it was noted in Chapter 2 that 'Third Way' networking is a manifestation of the government's desire to reduce costs through, for instance, the use of volunteers, in the case study PHOs at least, this rather negative criticism has been met with volunteers who are willing to be part of positive change in their communities.

8.4. *Summary*

This chapter has sought to explain the similarities found in PHO 1 and PHO 3 on the one hand and PHO 2 and PHO 4 on the other. Although the four case study PHOs were selected for their demographic variations, the PHO similarities observed in Chapters 6 and 7 do not relate to socio-economic or size characteristics of their enrolled populations or to geographical factors. From the analysis provided in this chapter, it appears that the reason lies in the PHOs' structures which, in turn, reflect the PHOs' historical origins. PHO 1 and PHO 3 constituted as charitable trusts including providers and members of their local communities, while PHO 2 and PHO 4 formed as limited liability companies in which an IPA was a shareholder.

While the *Primary Health Care Strategy* requires PHOs to form as not-for-profit organisations to limit diversion of public funds to private gain (Minister of Health, 2001), an analysis of PHOs' financial reports bore out concerns that related party transactions and accounting accruals management may obscure surpluses and deficits. It appears that, of the case study sites, PHO 3 alone does not practise accrual management. In addition,

IPA control of PHO 2 has resulted in the Inland Revenue Department adjudging that the PHO must pay tax on interest income and profits. Through PHOs' ownership structures and the contractual relationships they enter into with profit-oriented providers, 'sector-bending' may result. DHBs tolerate these models to avert 'political disasters' and to ensure continuity of care for their communities.

As noted in Chapter 2, community involvement is perceived as the key to achieving primary health care aims, highlighting the importance of social capital development by PHOs. PHO 1 and PHO 3 provided evidence of PHOs building on extant strong community networks, as Board members were drawn from local community groups and worked with the PHO towards jointly agreed goals. PHO 4 is also aware of its community, but has a less structured approach in this respect. While PHO 2 was using volunteers in its Health Promotion programme, its reticence (noted in Chapter 7) to change its programmes and priorities due to community input, along with its structural orientation towards providers, has resulted in limited community involvement in this PHO.

The following chapter reflects on this analysis against accountability theory and assesses the relevance of this study to findings from studies in other not-for-profit organisations.

9. DIMENSIONS OF ACCOUNTABILITY

9.1. *Introduction*

In Chapters 6 and 7 analysis of the case study data was presented and two continuums were derived. These were:

 (i) the community-provider continuum, which represents the priority Primary Health Organisations (PHOs) accord to the needs of their communities at one extreme and to their funding and service providers at the other; and

(ii) the control-trust continuum, depicting the role of accountability as a mechanism to balance control and trust in PHOs.

The intersection of these two continuums generated an accountability 'map' of four general models of accountability (as presented in Figure 7-7). The case study data suggested that PHO 2 and PHO 4, which, in general, are subject to contractual accountability, are located in quadrant B, and PHO 1 and PHO 3 which are broadly characterised by lateral accountability, are located in quadrant C. In chapter 8 reasons for the case study PHOs clustering in these two quadrants were explored and the conclusion was reached that organisational historical-structural development, at least for the case study PHOs, influences PHOs' accountability relationships.

In this chapter the contextual data from which the two continuums and accountability 'map' emerged are examined in the light of extant literature. Each continuum and the accountability map is considered separately, thus the analysis is presented in three sections, namely:

 (i) The *community-provider continuum*: the interview data suggests that the PHOs respond to the demands of their multiple stakeholders by prioritising the community at one extreme and the providers of funding and services at the other. In Chapter 8 it was suggested that these core values arise, in part, from PHOs' historical-structural features. It appears that these core values also give rise to metaphors describing distinct external images. This phenomenon is referred to as PHOs' 'sensitivity to identity';

(ii) The *control-trust continuum*: the interview data indicates that DHBs and communities impose accountability requirements on PHOs as a mechanism to

control their activities or to enhance existing trust in them. The data also indicates that, where the relevant District Health Board (DHB), as primary funder, does not define its role, PHOs are subject, and react, to 'encroachment' by their DHB. This is referred to as their 'sensitivity to contested space'. Where contested space arises, the DHB may usurp the community's right to secure accountability from its PHO;

(iii) The *accountability 'map'* derived from the intersection of these two continuums provides a basis for analysing the mechanisms by which PHOs may discharge 'full and open accountability' as required by the *Primary Health Care Strategy* (Minister of Health, 2001). The case study data supports the findings of Ebrahim (2003a) and O'Dwyer and Unerman (2007) (relating to not-for-profit organisations in general), namely, that there is a deficit in PHOs' discharge of holistic accountability.

Following exploration of the ideas outlined above, a framework of accountability mechanisms is proposed to address PHOs' deficit in holistic accountability.

9.2. *The community-provider continuum: a sensitivity to identity*

9.2.1. *The community-provider continuum*

In Chapters 6 and 7 it was found that the case study interviewees' responses conveyed PHOs have a primary responsibility to meet the needs of, and be accountable to, the community on the one hand, or funding and service providers on the other. However, the interviewees also indicated that the needs and demands of the communities and providers may differ and that PHOs' responses to those needs and demands are not polarised but, rather, lie on a continuum from meeting the needs of the community at one end, to meeting those of the funds and services providers at the other.[170]

The emphasis in the *Primary Health Care Strategy* (Minister of Health, 2001) on population health (with a focus on community wellness rather than patient illness) may give weight to a proposition that PHOs are intended to prioritise the needs of their

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[170] On a number of occasions the case study interviewees noted that PHOs maintain collaborative relationships with both providers and the community (rather than one or the other) and the postulation of a continuum to represent their views reduces the likelihood of an artificial reification.

community, rather than those of their funding and service providers. Indeed, some commentators (for example Fountain, 2006) conjecture that, in promoting the establishment of PHOs, the government had the ulterior motive of deflecting public funding away from General Practitioners (GPs) as traditional providers of health services to their patients, to organisations representing the wider community. However, the government's support of the DHBs in their role as primary PHO funder, and its introduction of the Performance Management Programme in 2006[171] (which focuses on provider quality), mediates the view that PHOs should concentrate solely on the needs of the community and neglect those of their funds and services providers. Thus, rather than a polarisation, with PHOs having a primary responsibility to *either* services and funds providers *or* the community, the *Primary Health Care Strategy* (and subsequent government policy) appears to suggest that PHOs should give equal emphasis to the needs of providers and those of their communities. This politically 'ideal' position can be mapped at the centre of the community-provider continuum, as shown in Figure 9-1.

Around this 'ideal' position, PHOs may have varying foci. This was reflected in the comment of a funder, who described the DHB/PHO contract as:

> *… quite a soft contract, but that's a political decision. I mean you had to have something that most people could sign up to. (Interviewee PHO 3)[172]*

This interviewee recognised the political expedience of DHBs contracting with PHOs to deliver primary health care, despite PHOs' proclivity to give priority to the needs of either their providers or their community.

In addition to locating the politically 'ideal' position of PHOs on the community-provider continuum, Figure 9-1 shows the 'average position' of each case study PHO (based on the responses of the PHOs' interviewees as presented in Chapter 7) and also the 'spread' of views expressed by the stakeholder groups that constituted the interviewees of each PHO (as presented in Chapter 6). The data from which the 'average position' and 'range of views of stakeholders' for each PHO are derived, are presented in Figure 9-2.

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[171] This programme is outlined in Chapter 1 and more detail is provided in Chapter 4 (in Section 4.7.2).

[172] This DHB employee was discussing PHO contracts generally, rather than that of a specific PHO.

Figure 9-1: The focus of PHOs' responsibility and accountability
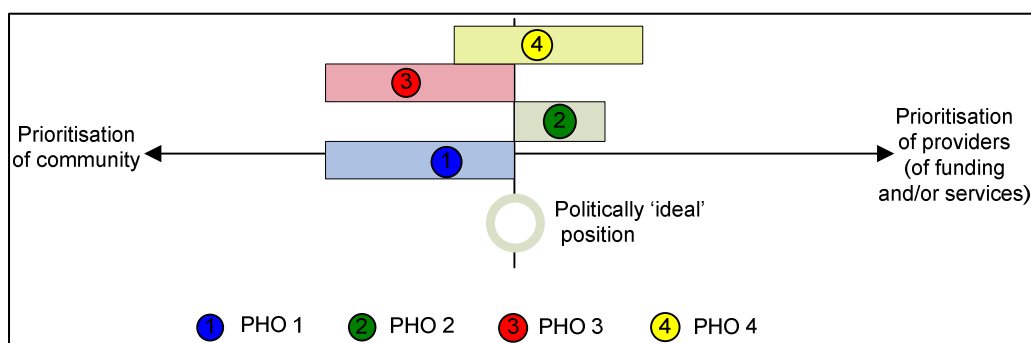
Figure 9-2: PHO range on the community-provider continuum

Categories of responses	Total	DHB Reps		PHO Reps		Provider Reps		Community Reps	
	No.	No.	%	No.	%	No.	%	No.	%
PHO 1									
- Prioritisation accorded to the community	19	2	67	6	75	5	56	6	50
- Prioritisation accorded to providers	13	1	33	2	25	4	44	6	50
PHO 2									
- Prioritisation accorded to the community	14	2	50	3	38	4	50	5	42
- Prioritisation accorded to providers	18	2	50	5	62	4	50	7	58
PHO 3									
- Prioritisation accorded to the community	21	2	50	6	75	4	67	9	64
- Prioritisation accorded to providers	12	2	50	2	25	2	33	5	36
PHO 4									
- Prioritisation accorded to the community	15	1	33	3	38	4	44	7	58
- Prioritisation accorded to providers	17	2	67	5	62	5	56	5	42

From Figures 9-1 and 9-2 it can be seen that the stakeholder groups of PHO 1 and PHO 3 consider that their PHOs should prefer the needs of the community over those of the providers; the stakeholder groups of PHO 2 hold the contrary view. It is only the stakeholder groups of PHO 4 who conveyed that the PHO should meet the needs of both the providers and the community, but, overall, they gave greater emphasis to the former.

The Ministry of Health policy-makers, who required PHOs to be not-for-profit organisations, rather than the pre-existing, mostly profit-oriented, Independent Practitioners Associations (IPAs) and Primary Care Organisations, may not have planned

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[173] As noted in Chapter 5, replies are not necessarily mutually exclusive, nor did all stakeholders answer all questions. Percentages in this table are calculated on the number of replies in each representative group.

for the variety of expectations of PHOs that were reflected by the case study interviewees. However, without specifying 'to whom' PHOs should be accountable, policy-makers stipulated they should be 'fully and openly accountable' (Minister of Health, 2001). Acknowledging a requirement to be accountable to multiple stakeholders, one PHO Chair noted:

> *I suppose the damn problem is that I'm accountable to everybody. I'm accountable upwards and I'm accountable downwards if you put it that way. And I'd reverse the procedure. I'm accountable upwards to the population firstly and I'm accountable downwards … (Interviewee PHO 1)*

The main concern arising from PHOs' seeking to balance the needs and expectations of multiple stakeholders is that stakeholders' measurement of organisational performance is benchmarked against their individual expectations of PHOs (Minkoff & Powell, 2006) and, as reflected in Figure 9-2, stakeholders' expectations may be ambiguous and contradictory. As a result, accountability becomes 'the ultimate moving target' (Kearns, 1994) and choices need to be made as to which stakeholder group's needs should be accorded priority. This was particularly evident in the case of PHO 2 which was required by its DHB to terminate a Services to Improve Access (SIA) programme it had begun to implement in favour of one the DHB demanded it deliver. As for all other PHOs, this PHO's discretionary spending is required to be pre-approved by its DHB and, accordingly, its activities are limited by its DHB's preferences. The manner in which the preferences of the DHB, as funder, are accorded priority (even though this may not be voluntary), supports similar findings by Hill *et al.* (2001), Kearns (1994), Koppell (2005) and Lawry (1995) that not-for-profit organisations prioritise 'upwards' accountability to their funders.

In addition to these findings, the data presented in Chapter 6 and Figure 9-2 indicate that the interviewees who constituted the PHO representative stakeholder group (PHO Reps; the PHO CEOs and Chairs of PHO Boards) hold views that rank consistently at the extreme end of their PHO's position on the community-provider continuum. Therefore, the PHO Reps appear to be drivers, rather than barometers, of their PHO's prioritisation of meeting the needs of the community or those of the funding and service providers.[174] The varying positions of the case study PHOs on the community-provider continuum, and

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[174] It is pertinent to note that the views of the DHB representative stakeholder group clustered around the 'ideal' position, rather than being related to those of the PHO Reps. The views of community and provider representatives were broadly similar to each other within each PHO, but varied across PHOs.

the views of these representatives, provides support for the findings of prior researchers. These include Ospina *et al.'s* (2002) study which found that the choice of the key stakeholders to whom not-for-profit organisations might discharge accountability, is made primarily by the leaders of those organisations;[175] and Chang's (2006) finding, that health sector managers 'manage' multiple stakeholders' needs by prioritising those constituents whose interests are most aligned with their own.

The assumed importance of CEOs and PHO Chairs within the PHO structure, and their position at the extreme of views expressed by the interviewees of each case study PHO, suggests these PHO Reps may be instrumental in establishing their PHO's priorities. However, in Chapter 8 it was reported that PHOs' expectations and organisational priorities are also linked to PHOs' organisational structures; the provider-focused PHOs (PHO 2 and PHO 4) are limited liability companies with providers as shareholders, while the community-focused PHOs (PHO 1 and PHO 3) are charitable trusts with community members included as Trustees. Thus the PHO Reps may also be reflecting the perceived expectations associated with stakeholders they identify as being salient.

9.2.2. *PHOs' sensitivity to identity*

The notion of PHO identity (or external image) draws from the establishment of PHOs as autonomous entities, contracted to their DHB (under the Ministry of Health, n.d.). It has also been shown by prior accountability researchers, such as Roberts (1991; 1996) and Schweiker (1993), that accountability acts as a 'mirror' whereby delegators' judgements (and perceived judgements) clarify and construct the acceptor's identity in a delegating relationship.

Following from this, it is suggested that metaphors or labels ascribed to PHOs by the case study interviewees serve to clarify a PHO's external image.[176] The metaphors voiced by

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[175]   While the literature on the relationship between the CEO and organisational performance undertaken in leadership studies offers some understanding of the inter-relationship between shareholder returns and stakeholder relationships, it is beyond the scope of this project on organisational accountability in not-for-profit organisations.

[176]   This organisational phenomena was theorised by Hatch and Schulz (2002) and depicted in Figure 4-3 (in Chapter 4). Figure 4-3 highlights the mutability of organisational identity as culture, image and identity inter-relate. The internal 'face' or culture of each PHO may be ascertained from the responses of interviewees who were internal stakeholders in each PHO, as they provide insights into the core values and beliefs held by the organisation, considered by Gioia *et al.* (2000) to be the basis of

interviewees and during PHO meetings are presented in Figure 9-3. Analysis of Figure 9-3 indicates that PHOs that afford priority to providers of funds and services rather than to the community (PHO 2 and PHO 4) have differing external images from those that prioritise the needs of their community (PHO 1 and PHO 3).

Figure 9-3: Metaphors in the PHO environment[177]
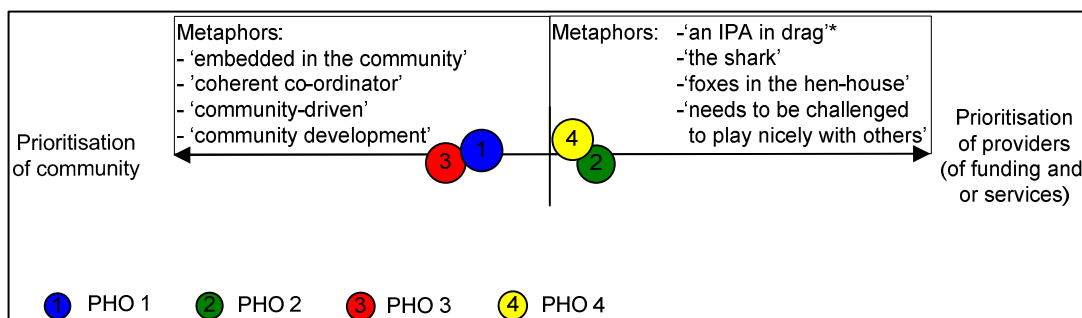
(i) Identity/image: metaphors associated with PHOs that prioritise providers

The metaphors used to describe PHOs that prioritise meeting the needs of providers of funds and services can be disabling. For example, the interviewee comments of "an IPA in drag" evokes an external image that is incongruent with the perceived purpose of a PHO; "the shark" and 'foxes in the henhouse' (Howell, 2007) have predatory characteristics, and there is something akin to derision for GPs that were described by an interviewee as "need(ing) to be challenged to play nicely with others" in the PHO environment.

As explained in Chapter 8, the two case study PHOs that prioritise the needs of their providers of funds and services (PHO 2 and PHO 4) were formed directly from the IPA structures which existed in the 1990s. In both cases they are limited liability companies with GP owners, although, during the case study period, the shareholding in PHO 4 was broadened to include community trusts. With the establishment of these PHOs as new (not-for-profit) organisations, the break from the competitive practices of the prior decade provided the opportunity to develop a new (PHO) external image. PHO 4 chose a

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organisational culture.

[177] The comment 'IPA in drag' may have specifically been targeted at PHOs that share the IPA name. This strategy may also have been taken up in order that the brand could weather changes in government policy (and a possible '8th funder').

geographical name for its PHO, rather than its former IPA identity. However, PHO 2 adopted the same name as its forerunner IPA and, as a consequence, appears not to have developed a new, distinct external image.

A DHB interviewee referred to any provider-focused PHO that derived from an IPA background as an "IPA in drag." S/he explained:

> *When you look at … PHOs that have been driven solely out of IPAs, we talk about them as an IPA in drag (laughs). They don't seem to have the autonomy that [PHO 1] seems to have because of its structure. (Interviewee PHO 1)*

Another interviewee noted:

> *Other people call [PHO2] the shark! They have all the money and all the practices and they just seem to want to get bigger. (Interviewee PHO 2)*

Most PHOs that are "driven solely out of IPAs" are owned by a profit-oriented IPA (as noted in Chapter 8). However, the Chair of PHO 2 expressed surprise about the incongruent metaphor that implied the IPA controlled the PHO. S/he stated:

> *I think that when you look at the ideology that the IPA-run PHOs aren't good … you know the word shareholder almost never comes into our discussion. We kind of see us and [the IPA] as kind of like this (fingers intertwined), not as us and them. We don't say, "We've got to do this because the shareholder wants it." We think, "What do the providers want, what do the people want and need?" That's more the flavour of our discussion than what the shareholder wants. (Interviewee PHO 2)*

Another interviewee from this PHO explained how the IPA identity benefitted the development of the PHO:

> *The identity of the PHO piggy-backed on the existing reputation of [the IPA]. So Day 0, before Day 1 there was no PHO, there was no brand, Day 2 it was attached to the [IPA] brand and it already could build on that. You know [the IPA] had done publications in the [regional paper] and had all these different things so it was already out there … I think it's important that people have a trusting relationship with their own GP and they don't change just because of some entity that actually doesn't directly provide the service to them. (Interviewee PHO 2)*

Notwithstanding the views of the interviewees noted above, other interviewees from this PHO (PHO 2) were not reconciled to the idea of 'branding' for a not-for-profit organisation. These interviewees found the promotion of a logo to highlight the PHO's brand to be a dissonant concept for a PHO. In the words of one of these interviewees:

> *A constant battle that we face every time we work collaboratively on a project [with PHOs] is we pull out the communication material and constantly there are*

*questions, "Where does our logo go?" and, "Where can we put our logo on this?"
It's not about who does the work, it's about the work being done and that it is of
the best possible quality and that is the one thing that really rubs me up the wrong
way. You should have enough faith in the knowledge that this is contributing, that
you don't really need to have the logo on it to recognise that. (Interviewee PHO
2)[178]*

Thus, these PHOs that are closely associated with their forerunner IPA and focus on the
needs of providers (PHO 2 and PHO 4) may earn metaphors which potentially aggravate
collaborative effort.

(ii) Identity/image: metaphors associated with PHOs that prioritise community

In contrast to the metaphors attributed to the provider-focused PHOs, those used to
describe PHOs that prioritise community are potentially enabling. Such PHOs (for
example, PHO 1 and PHO 3) are viewed as being 'embedded in the community' and, as
'coherent coordinators', they also appear to attract metaphors that are suggestive of 'Third
Way' networking principles.[179] PHOs that are viewed as being 'community-driven' and
involved in 'community development', have metaphors that accord with principles of the
Alma Ata Declaration (WHO, 1978) and the community-oriented primary health care
movement (explained in Chapter 2).

Rather than mirroring pre-existing IPA structures, the two case study PHOs that
experience accountability as a means to enhance trust (PHO 1 and PHO 3) have been
established as (i) a new partnership of Primary Care Organisations in the case of PHO 1,
and (ii) from long-established community provider organisations in the case of PHO 3. In
each case, the PHO is a charitable trust with a range of provider and community
representatives elected as Trustees.

Although the interviewees from these two PHOs generally supported the notion that a
PHO should have a distinct identity, they conveyed that the PHO as an entity is not
widely understood by the public. These PHOs addressed this lack of community

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[178]   The DHB representative and some other interviewees stated that the PHO was not well known in the
        area, although the IPA brand was well recognised. However, the use of a consistent brand may insulate
        the IPA against changes arising from mutable primary health care policies and funding schemes.

[179]   'Third Way' policies in relation to health were summarised in Chapter 2 and are evident in the *Primary
        Health Care Strategy*.

awareness in different ways. In PHO 1, two strategies to raise the awareness of its enrolled population about the PHO's existence and programmes were explained by interviewees as follows:

> *We have just negotiated with the local community newspapers to take an editorial and run a health feature … We are trying to raise awareness about the PHO's programmes, and to be a reliable credible source of information … We need to do this, because we can't engage with a community that doesn't know we exist. (Interviewee PHO 1)*

> *I do believe that people need to understand that we exist so that they understand who is driving the Primary Health Strategy. If the community doesn't understand which one [PHO] they belong to, they may not believe that either the money is being well spent or that it's creeping down to where they might want it to be. We are also discussing at present putting its logo on top of the Practices' notepaper, so that people might well understand that this is a partnership between that Practice and the PHO. (Interviewee PHO 1).*

The use of the logo in this case was to strengthen the link between the PHO and a patient's relationship with their own GP, rather than (as expressed by the interviewee from PHO 2) to push a 'GP-centric' view that the PHO is largely irrelevant to patients.

PHO 3, which is considerably smaller than PHO 1, has used different tactics to raise awareness of its existence: the PHO has held frequent meetings with its community, used an email newsletter to link with community groups, and also invited the community to provide input to its strategic planning. As a consequence, interviewees from this PHO stated that the PHO has an important role to play in 'community development'.

The small size of PHO 3 may also have helped to generate familiarity. As the CEO explained:

> *[Others] are closer to the ground than I am, often on a daily basis. However I do like the fact that I can walk down the street and someone from the … community will come up and say, "Hi," because they know who I am. Knowing them personally means that we can negotiate with them rather than taking a top down approach. We really support the grass roots up and that's what we advocate for and that's what we promote. (Interviewee PHO 3)*

Interviewees from this PHO were aware that not all PHOs share these enabling metaphors and reflected on others' fear of predatory actions. For example, one interviewee observed:

> *There's a bit of a fear about what the PHOs can do and whether they going to take NGO funding and cut the NGOs out. So there's quite a lot of apprehension from NGOs about what the PHOs are going to do. (Interviewee PHO 3)*

In order to address this fear and to underline the 'coherent coordinator' role of the PHO, at the PHO's AGM, the interviewee explained:

> *[The PHO is] not trying to take money from NGOs, it has to try and bring them in so it is all part of the same mix. The PHO should be looking for projects that really focus on NGOs and engage with NGOs to look at the overall benefit for health, because looking at primary care is not the full picture. People's health is driven by most things outside the health sector predominantly. Look at housing, look at income, and look at employment. Those are the sort of key things that drive our wellbeing and health. To make changes in that we have to work with the NGOs and work out ways of strengthening those relationships and make it work better. (AGM at PHO3)*

By raising NGO engagement as an issue, the interviewee appeared anxious to change the external image (held by NGOs at least, as observed by the Health and Disability Sector NGO Working Group, 2005) that PHOs are attempting to poach 'business' from NGOs.

The strategies adopted by these PHOs (PHO 1 and PHO 3) to inform and involve the community resulted in metaphors reflecting their prioritisation of the needs of their communities. This finding, and that of the prior sub-section, suggest that the identities of the case study PHOs are affected and reflected by the metaphors that are used to describe them, as theorised by Hatch and Schulz (2002). Roberts (1991; 1996) and Schweiker (1993) theorise that accountability is instrumental in that reflection. Yet, the image may not be positive, or one sought after by the PHO. For example, in Chapter 6, a provider's reaction to the name 'foxes in the henhouse' was that such external images reduced trust.

9.3. *The control-trust continuum: a sensitivity to contested space*

9.3.1. *The control-trust continuum*

In Chapters 6 and 7 it was reported that the interviewees indicated they perceive accountability as a mechanism which is used to control, or to enhance the existing trust in, their PHO. Roberts (1991; 1996) and Strathern (2000) have previously suggested that powerful stakeholders may use accountability to control the acceptor of responsibilities rather than to demonstrate and confirm trust and, as a consequence, trust may be undermined. Pallot (1990) and Handy (1990) posit that control and trust are not mutually exclusive, as do Romzek and Johnston (2005), who note that, while control is necessary for relational contracting, trust reduces conflict and increases interaction and inter-

dependence. These propositions were developed further by Roberts (2002a) and Roberts *et al.* (2005) but they concluded that developing an ideal matrix of trust and control was difficult.[180] Nevertheless, Casciaro and Piskorski (2005) maintain that a balance between the relational extremes of control and trust is important because, if control is dominant, it shapes performance (as will trust) and, by association, impacts the discharge of accountability. Thus, the analysis in this research has used a continuum, rather than a matrix, to depict gradations of trust and control in relational contracting.

It thus appears that the 'ideal' situation is for a balance to be achieved whereby accountability is used as *both* a controlling mechanism *and* to enhance trust, placing the 'for what' of accountability in the central zone of the control-trust continuum proposed in Chapters 6 and 7 as presented in Figure 9-4.

Figure 9-4: Continuum of the DHB/PHO relationship for accountability

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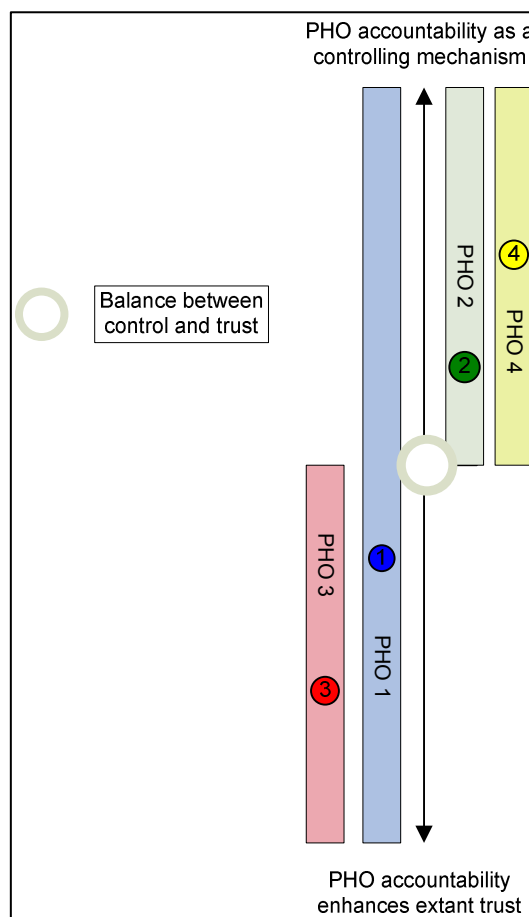
[180] As reported in Section 6.3.2, a PHO representative from PHO 3 conveyed similar ideas, noting that the PHO had "huge amounts of trust," but also required contracts "to clarify responsibility and accountability lines."

In Chapters 6 and 7, based on the interviewees' responses, the 'average' position of each case study PHO was postulated to be *either* in the 'control' portion of the continuum (PHO 2 and PHO 4) *or* in the 'trust' portion (PHO 1 and PHO 3). The range of views expressed by the interviewees in PHO 2, PHO 3 and PHO 4 (and reflected in Figure 9-4) support the contention that these interviewees perceive accountability being used as a mechanism for control (PHO 2 and PHO 4)[181] *or* to enhance trust (PHO 3). Conversely, the interviewees from PHO 1 appear to recognise that, at least for their PHO, accountability is used *both* to control and to enhance trust.

The data from which the 'average' and range of views expressed in the case study PHO interviews are presented in Figure 9-5. An additional response row has been added to this Figure to report the number (and proportion) of interviewees who expressed the view that both trust and control are operating in the accountability relationships of their PHO.

Lapsley (2001) (reflecting on the UK health care system) and Smith and Ovenden (2007) who conducted a New Zealand study, observed that funders sought to 'command and control' service providers. Similarly, the case study interviewees (especially those from PHO 2 and PHO 4) inferred that DHBs, the primary funders of PHOs in the New Zealand setting, use accountability to control their PHOs.

Conversely, some interviewees from PHO 1, but more especially those from PHO 3, concur with Cumming's (2007) hypothesis that increased decentralisation in the health system (as occurs with PHOs) paves the way for increased trust. Along related lines, Considine and Lewis (2003) suggest that partnering and trust are a characteristic of the post-NPM environment.

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[181] For PHO 4, the interviewees signalled that the relationship between the Ministry of Health and their DHB was instrumental in the operation of control in the PHO/DHB relationship. It was considered that the Ministry of Health tightly controlled the DHB and thus the DHB used accountability to control the PHOs in its district. Not only did this PHO's interviewees perceive the DHB to be controlling, but this was borne out by the DHB's demands for frequent meetings with, and reporting by, their PHOs that far exceeded that required by the DHBs of the other PHO case studies.

Figure 9-5: Continuum of the DHB/PHO relationship for accountability

Categories of responses	Total	Stakeholder Groups[182]							
		DHB Reps		PHO Reps		Provider Reps		Community Reps	
	No.	No.	%	No.	%	No.	%	No.	%
PHO 1									
PHO accountability as a controlling mechanism	3	1	100	0	0	2	100	0	0
PHO accountability enhances trust	2	0	0	2	100	0	0	0	0
PHO accountability is a balance of trust and control	2	0	0	0	0	0	0	2	100
PHO 2									
PHO accountability as a controlling mechanism	4	1	100	1	50	1	50	1	100
PHO accountability enhances trust	1	0	0	1	50	0	0	0	0
PHO accountability is a balance of trust and control	1	0	0	0	0	1	50	0	0
PHO 3									
PHO accountability as a controlling mechanism	1	0	0	1	50	0	0	0	0
PHO accountability enhances trust	6	1	100	1	50	2	100	2	67
PHO accountability is a balance of trust and control	1	0	0	0	0	0	0	1	33
PHO 4									
PHO accountability as a controlling mechanism	4	1	100	1	50	1	50	1	25
PHO accountability enhances trust	2	0	0	0	0	0	0	2	50
PHO accountability is a balance of trust and control	3	0	0	1	50	1	50	1	25

9.3.2. A role for learning

A further role for PHOs, implied in the *Primary Health Care Strategy* is that of learning (Minister of Health, 2001). In this regard, researchers such as Bovens (2005b) and Ulrich and Barney (1984) contend that the stronger the delegator's control over the acceptor, the less autonomy the acceptor experiences which potentially leads to reduced learning. This proposition is supported by the findings of O'Dwyer and Unerman (2007) in their study of Irish NGOs, namely, that the addition of learning to policy is a 'laudable' objective, but such a policy is meaningless without a change in the balance of control. This is reflected in the contrasting observations reported below.

In PHO 2 and PHO 4, control by their respective DHBs, combined with the risk-averse nature of DHB funding, has apparently limited the role for PHO learning. As an

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[182] As noted in Chapter 5, the interviewees' responses were are not necessarily exclusive, nor did all stakeholders answer all questions. Percentages in this table are calculated based on the number of replies from each stakeholder group.

interviewee from PHO 4 observed:

> *It's all about control absolutely and that's the DHB's problem. There is no enabling. If you wanted the PHOs to succeed, I think the best thing to do would be to enable people to go about what they do. Sure some are going to struggle and some are going to have accidents and fall over and learn. We are all going to learn from other people's mistakes, but that would be the way to go. (Interviewee PHO 4)*

While risk aversion is offered as an excuse for a disabling environment, the following comment by a DHB interviewee suggested that, in a trusting environment, learning will be enabled:

> *In terms of accountability, I think because it is public money there is a great deal of risk aversion. And I think that the expectation that innovative projects succeed is probably unrealistic if you look at how many things fail in the private sector ... if you're drilling for oil or something like that ... With health projects you don't see the results that fast ... A one-off out of SIA you could say, "Oh this worked," or, "This didn't work." So I guess that's the place where the innovation happens, all the trying out, but the whole SIA and Health Promotion year to year thing might not be very suitable in the long term. You might want to have a three year plan so you can be a bit more strategic about it. (Interviewee PHO 3)*

Accordingly, it is suggested that policy-makers who are serious about encouraging PHO learning (as described in the *Primary Health Care Strategy*) should take the strategic decision to reduce control to provide space for 'failure' and thus, learning.

9.3.3. PHOs' sensitivity to contested space

At the local level, DHB staff assume the strategic role of deciding who is a legitimate recipient of government health care funding. Thus, private organisations (such as PHOs) must compete with NGOs and the DHB for the right to deliver government-funded services and obtain discretionary resources to enable them to do so. This may result in a "power struggle" (as noted by an interviewee from PHO 2) between the DHB and its PHOs, with each "looking after their patch" (as noted by an interviewee from PHO 1).

Any "power struggle" may be exacerbated by the *Primary Health Care Strategy's* objective of reducing the delivery responsibilities of DHBs by transferring some of their former responsibilities, such as health promotion, to the PHOs (Minister of Health, 2001). This devolution of responsibility to PHOs for the well-being of their community, may provide an explanation (additional to the historical-structural differences highlighted in

Chapter 8) for the diversity of views expressed by the case study interviewees about the reason to demand accountability from PHOs.

The transfer of responsibilities has, however, resulted in what may be referred to as 'contested space'. As the Chair of PHO 4 noted at the PHO's AGM:

> *As I explain to people, PHOs really are coming on to new ground that was already occupied by DHBs. They had a responsibility for primary health and PHOs were put in there to facilitate the funding of primary health so it has been a wee bit stressful. We now have a Memorandum of Understanding with the DHB ... hopefully that's going to be a useful document because it sets out where we both stand and how we achieve cooperation. (AGM at PHO 4)*

A Memorandum of Understanding may assist PHO 4 in defining its responsibilities;[183] nevertheless, a community representative from PHO 2 contended that 'contested space' should be addressed at a higher level (that is, by the Ministry of Health). S/he observed:

> *PHOs need to decide where their place is in the framework. They are trying to be deliverers on the ground ... and they are trying to work with others ... and sometimes they are trying to do the planning the policy and direction. The DHB is just as bad. They are deliverers, they are policy setters, they are funders. I think there needs to be from the Ministry perhaps better role definition around the parameters and the roles of these organisations because I think if everyone is trying to be too much that's where everyone gets on each other's toes and it doesn't actually benefit the community. (Interviewee PHO 2)*

For PHO 2 and PHO 4, the operation of 'contested space', and the need to gain the approval of their DHB in order to obtain and apply funding to their preferred programmes, may explain their emphasis on 'upwards' accountability. Such a conclusion accords with the findings of research conducted by Cribb (2005a) and Flack and Ryan (2005). However, in contrast to the findings of prior research, DHB interviewees from these two case study PHOs recognised that, in addition to their 'upwards' accountability to the DHB, PHOs must discharge 'downwards' and 'horizontal' accountability to other stakeholders, including the community. Despite this, one of the DHBs of these PHOs represents itself as a "partner with the community" (thus fulfilling the role apparently envisaged by the *Primary Health Care Strategy* for PHOs).

Further, some interviewees appear to be content with the notion that a PHO may discharge its accountability to its community via its accountability to its DHB. For

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[183]   It should be noted that, as explained in Chapter 4, responsibility boundaries also define 'to whom' and 'for what' PHOs (and DHBs) are accountable.

example, a provider interviewee from PHO 4 observed that DHBs: "represent the people as they are agents of government." From observations such as this, it appears that the community (at least that of PHO 4), believe that the DHB is cognisant of the community's needs, is able to judge the PHO's performance in meeting those needs and is, therefore, in a position to be a surrogate recipient of the PHO's accountability to the community. The prominence of DHBs was offered as a reason for community members 'voicing' their needs and/or disapproval in respect of PHO services to their DHB (rather than the PHO). This usurping of community accountability by the primary funders (DHBs) has not previously been documented in the literature.

The apparent assumption of PHOs' accountability to the community by DHBs may afford the latter an excuse to strengthen their demands on PHOs to be 'upwardly' accountable and to curtail their activities – for instance by discouraging PHOs from informing their communities of primary health care matters through the media. The DHB of PHO 2, for example, complained to the PHO about its advocacy for health promotion and SIA programmes on ethnic radio, terming it 'social marketing' and contending that it is an inappropriate way to spend public money.[184]

Thus, while the *Primary Health Care Strategy* envisaged significant community input to primary health care delivery at the local level, the operation of contested space (and assumption by some DHBs of what should be the PHOs' role in their community) appears to reduce, for some PHOs, the significance and effectiveness of community input into their decision-making and planned programmes. The observations from the PHO case studies provide support for the conclusions of Goodin (2003) and Considine and Lewis (2003), that the full benefits of community input, and collaboration between NGOs and government funders, are promises of 'Third Way' policies that currently are not being fully realised (at least in the realm of primary health care).[185]

It may be that, similar to the UK (as suggested by Hudson & Henwood, 2002; Milewa, 2004; Newman *et al.*, 2004; Sullivan, 2002), the current structures in primary health care in New Zealand encourage inconsistent practice and opacity between the policy-makers

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[184] The use of the IPA logo or brand in the messages appeared to be the main cause of the objection.

[185] 'Third Way' policies, described in Chapter 2, emerged as a consequence of negative reactions to the competitive nature of New Public Management (NPM) policies of the 1980s and 1990s.

and citizens, and serve to reinforce PHOs' 'upwards' accountability to DHBs and from DHBs to central government. This appears to be at odds with the objective of the *Primary Health Care Strategy* which seems to envisage clearly defined responsibility delegations (to DHBs and PHOs respectively) and associated accountabilities.

9.4.   *The accountability 'map': is there a deficit in holistic accountability?*

Holistic accountability is context-specific, but prior researchers have proposed that the 'for what' of holism subsumes accountability for outputs (however derived)[186] and embraces accountability for outcomes in terms of: programme accountability (Leat, 1990; Stewart, 1984), accountability for priorities (Leat, 1990), for intentions (Goodin, 2003), for meeting societal values and expectations (Kearns, 1994), and for long-term environmental impact (Edwards & Hulme, 1996).[187]

Thus, holistic accountability is fully discharged when the organisation is accountable for its impact on all stakeholders and proactively works with those stakeholders to shape an accountability framework that meets organisational and stakeholders' needs (O'Dwyer & Unerman, 2006). That framework should describe the processes and mechanisms through which accountability is discharged.

Since their inception, PHOs in New Zealand have been required to discharge 'full and open accountability' (Minister of Health, 2001). Accordingly, the case studies in this research differ from previous studies of holistic accountability (for example, Jonsson, 1998; O'Dwyer & Unerman, 2007) in which the organisations examined experienced an imposition of accountability upon prior structures and processes. The PHOs in this research have the opportunity to custom-design appropriate frameworks that will enable them to become 'masters at conversation' (Fry, 1995) and thus, to meet their own needs and those of their salient stakeholders.

In Chapters 6 and 7 the intersection of the community-provider and control-trust

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[186]   In Chapter 4, Figure 4-4 provides a range of descriptions that include: accountability for probity and legality (fiscal accountability) (Leat, 1990; Stewart, 1984), performance or process accountability (Leat, 1990; Stewart, 1984), and tactical accountability (Edwards & Hulme, 1996).

[187]   Outcomes (achieving an organisation's purpose) require negotiating between delegators and acceptors of responsibilities. They may also be prescribed by policy documents (for example, from the Ministry of Health) as they are less likely to be addressed in contracts.

continuums generated a 'map' of four quadrants to describe the stakeholders prioritised by the case study PHOs, and the role of accountability in these PHOs. This section addresses the remainder of the accountability framework that includes for what PHOs are accountable, and the mechanisms used to discharge holistic accountability.

In Chapter 4 a number of accountability mechanisms were presented through which not-for-profit organisations may report their performance in terms of outputs and outcomes. It was suggested that different mechanisms may be preferred by different stakeholders. In Chapter 6, the responses to questions asked to ascertain interviewees' preferred mechanisms for PHOs' discharge of accountability were sorted by stakeholder group. In Chapter 7, these responses were sorted by PHO and the mechanisms used by these PHOs during the case study period were analysed (to obtain an organisational viewpoint). These analyses are combined in Figure 9-6 with checks alongside the mechanisms identified. In addition, the most preferred means by stakeholder group and by PHO are highlighted.

From Figure 9-6 it can be seen that there is a disconnection between the expectations of the stakeholder groups and PHOs' preferred accountability mechanisms (as shown by the shading). Accordingly, it is unlikely that the needs of both the stakeholders and the organisation are being met. Subtle differences between the case study PHOs may reflect their position in a particular quadrant in the accountability 'map' (particularly in respect of PHOs' accountability for outcomes). Thus, PHOs' frameworks for holistic accountability are analysed in three categories in this section, namely:

   (i)   accountability framework: mechanisms for reporting outputs;

  (ii)   accountability framework: mechanisms for reporting outcomes; and

 (iii)   accountability framework: sanctions and rewards.

Figure 9-6: Accountability mechanisms preferred by stakeholders and PHOs

Categories of responses (note: the shading shows the most preferred mechanisms by respondent)	Mechanisms identified by stakeholders as effective in meeting their needs				Mechanisms identified and used by PHOs			
					Quadrant B		Quadrant C	
	DHB Reps	PHO Reps	Prov. Reps	Com. Reps	PHO 2	PHO 4	PHO 1	PHO 3
Accountability for outputs **To providers of funds**								
- Contract reports and funder meetings	✓	✓	✓	✓	✓	✓	✓	✓
- Audits of financial reports and performance	✓	✓	✓	✓	✓ 2	✓ 0	✓ 5	✓ 1
- Reports/meetings beyond contract						✓		
To the community								
- Annual report	✓	✓	✓	✓	✓†	✓	✓	✓
- Reduced patient co-payments	✓	✓	✓	✓	✓	✓	✓	✓
- Media reports	✓	✓	✓	✓	✓	✓	✓	✓
Accountability for outcomes **To providers of funds and services**								
- Reporting to and by staff/contracted providers	✓	✓	✓	✓	✓	✓	✓	✓
To the community								
- Community meetings and AGMs	✓	✓	✓	✓	✓	✓	✓	✓
- Board representation	✓	✓	✓	✓	✓*	✓*	✓	✓
- Providing local employment	–	✓	✓	✓	✓	✓	✓	✓
Sanctions and rewards **(i) Provider sanctions**								
- Provider claw back or withholding of funds	✓	✓	–	–	✓	✓	✓	✓
(ii) Community sanctions								
- Community complaints	–	✓	✓	✓	✓#	✓#	✓	✓
- Community disengagement	–	✓	✓	✓	✓	✓	–	–

† The annual report of this PHO has limited circulation.

* This PHO has a range of stakeholders on their Board, however, rather than an open election process, the Board members are appointed by the shareholders, primarily based on the recommendation(s) or nomination(s) of community and/or provider subcommittees.

While interviewees provided examples of patient complaints in this PHO, no example resulted in a change of PHO behaviour, although it is likely that changes did occur.

9.4.1. *Accountability framework: mechanisms for reporting outputs*

The relevant case study data shows that these PHOs discharge their accountability to their DHB (and Ministry of Health) for outputs. However, Figure 9-6 demonstrates that the PHO representatives who were interviewed displayed particular sensitivity to audits as an accountability mechanism[188] but that this was not otherwise widely mentioned.[189] As noted

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[188] As noted in Chapter 4, DHBs may request audits and investigations under the Primary Healthcare Audit Protocol (Ministry of Health, 2004c) in addition to the requirement for PHOs to have an independent audit of their annual financial statements (Ministry of Health, n.d.).

[189] In Section 7.6.1 the analysis showed that one media reporter would, "like to see audits of service published." No other interviewee identified this mechanism as being desirable. As noted in Chapter 2, the extension of such sentiments has resulted in indicators against national performance measures being

in Figure 9-6, specific performance audits had been conducted on three of the case study PHOs since their establishment, respectively: five in PHO 1, two in PHO 2 and one in PHO 3. In none of these audits was a major concern raised and an interviewee noted their PHO had been told by some audit teams that they were, "the best we've seen in the country." In respect of audits to the providers of funds for outputs achieved, this interviewee therefore noted:

> *I think the Ministry and HealthPac and the rest of them are a bit obsessed because they like to be able to tick boxes. To do an audit is good for them because it means they can come down and they can fill 20 pages of questions and answers and they'll get all sorts of reports and whatever. And they can go back and say "We've checked them out and they look good." It doesn't actually have any effect on the patient. I agree that you need accountability and transparency, but you don't need 6 or 8 people all doing the same thing, you should be working out what you want and then you should say, "What they are supposed to do is to deliver that service to that many people. Are they doing it?" If they are not, "Why aren't they doing it? How can we help to change a few things round to do it?" Whereas at the moment its very much sort of, "My job is to give you the money and I want to make sure it's being spent correctly, so I need all these boxes being ticked." … Providing all the things are flowing, let's concentrate the time of the [PHO] Executive on patient benefits, rather than audit. (Provider Rep)*

These comments are similar to those reported in Chapter 6. For example, an interviewee noted that DHB and Ministry of Health reporting and audits "can be overly onerous." DHB meetings (identified as excessive in the case of PHO 4), reporting and audits are an area where the provider of funds and PHOs should negotiate a balance between the funders' needs for accountability and the PHOs' autonomy and need to deliver "patient benefits".

In respect of discharging accountability for outputs to the community, Figure 9-6 shows that the circulation of the annual report from PHO 2 was limited to a small group of stakeholders and thus did not reach the expected audience. Figure 9-6 also highlights media reports as a preferred mechanism of community interviewees. While PHO 2 and PHO 4 (quadrant B PHOs) identified and used media reports, interviewees from both of these PHOs were reported in Chapter 7, as desiring more (and less technical) media reporting. It may be that PHOs need advice on how to utilise media more effectively.

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published in the UK and also in many of the States in the United States of America. Potentially, the instigation of this in New Zealand would strengthen market-based accountability ('exit') but not necessarily give 'voice' to community stakeholders. Further, O'Neill (2002) argued that 'league tables' generated from published audits aggravate already declining public trust in professionals (such as GPs).

9.4.2. *Accountability framework: mechanisms for reporting outcomes*

As to accountability for outcomes, the 'to whom' comprises the providers of funds and services as well as communities. In Figure 9-6, it can be seen that interviewees who were provider representatives desired PHOs to discharge accountability to them (through peer or cell group meetings[190]) and through them (from their daily contacts with patients). While all the case study PHOs used these different methods, PHO 1 is also developing other ways to strengthen the PHO-service provider relationship (for example, by including its logo on GP's letterheads).

For PHOs' communities, the findings of Cumming *et al.* (2005) were that PHOs struggle to engage in processes to discharge accountability to multiple stakeholder groups, especially the community. This has been borne out in this research. Of the quadrant B PHOs, while PHO 2 readily identified community meetings as an appropriate mechanism, it had been unable to sustain a cycle of public meetings, and exhibited a paternalistic attitude that stated the enrolled population was unlikely to 'know best'. The provider-based metaphors ascribed to this PHO with a 'GP-centric' view, combined with DHB control, may provide explanations for this attitude. Further, the community meetings held by PHO 4 were event-driven rather than planned to facilitate dialogue between the PHO and its stakeholders on a regular basis, potentially limiting the community's use of 'voice' mechanisms to sanction or reward the PHO.

In addition, despite the opportunity to encourage democracy through diverse stakeholder representation on their Boards, PHO 2 and PHO 4 (quadrant B PHOs) relied on a narrower group of stakeholders for nominees than those of PHO 1 and PHO 3 (quadrant C PHOs). Perera *et al.* (2003) noted that a prior community network assisted newly established PHOs to engage with their community, and this notion would support the success of PHO 3 in obtaining community representatives. However, the 'voice' of community is also a structural matter. For example, in PHO 3, an interviewee reflected that:

> *[In some PHOs] NGOs aren't on [PHO] Boards and they're not asked to participate in the PHO so they've got absolutely no say. Without being recognised as a stakeholder and someone who inputs, they [NGOs] will never have a say in*

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[190]   These meetings are used for training and support and may also provide clinical governance to a PHO through a caucus arrangement.

SIA funding and they will never have a say in Health Promotion funding. We believe it is very important that community has a say in those funding streams. (Interviewee PHO 3).

When combined with a general lack of public awareness of PHOs (especially in PHO 2 and PHO 4), limiting Board representation further reduces the likelihood that enrolled populations will call to account through 'voice' or effective sanctions.

9.4.3. Accountability framework: sanctions and rewards

In respect of sanctions, Figure 9-6 shows that the DHB and PHO stakeholder representatives who were interviewed recognised the DHB (as funds provider) could claw back or withhold funds from PHOs, even though such sanctions were used seldom. The manner in which DHBs require increased reporting from some PHOs, yet rarely invoke sanctions mirrors the experience of Adam and Gunning (2002) and Romzek and Johnston (2005). As outlined in Chapter 4, these researchers called for funders to clarify a small number of critical indicators for reporting, so that acceptors would be clear on which measures to prioritise. This is relevant to PHOs working in contested space, as knowing when and how sanctions will be applied by DHBs should result in more defined delegation.

The community representatives who were interviewed identified both complaints ('voice') and disengagement ('exit') as responses to PHO performance not meeting their expectations. All of the case study PHOs noted they received complaints from their enrolled patients; typically these were in respect of co-payments charged by General Practices. As these co-payment levels are established by independent General Practices, however, PHOs were not in a position to change the charges levied.

The frequent mention of disengagement also suggests the operation of a market-based accountability model. While 'exit' mechanisms have a role to play, Meijer (2005) notes that 'voice' mechanisms are necessary in health care systems because patient loyalty and a lack of options reduce the choices for 'exit'. Accordingly, wide community engagement on such programmes as Services to Improve Access and Health Promotion is likely to be the most effective way for PHOs to hear the 'voice' of community and enable the discharge of holistic accountability.

9.5.   *Addressing a deficit in holistic accountability*

It appears that none of the case study PHOs achieves holistic accountability – that is, being fully accountable to all its stakeholder groups – and maintains effective 'voice' and 'exit' mechanisms. Ebrahim (2003a) found mechanisms to discharge full and open accountability were under-developed in not-for-profit organisations required to discharge holistic accountability. O'Dwyer and Unerman (2006) similarly reported that Irish NGO managers were 'at a loss' as to how to discharge the requirements of holistic accountability.[191] Yet, the interviewees from the four case study PHOs identified numerous mechanisms through which PHOs may discharge a requirement to be 'fully and openly' accountable (as discussed in the prior section). These are summarised, along with the corresponding sanctions and rewards, in Figure 9-7.

A lack of particular mechanisms is not the only cause of a deficit in accountability. Holistic accountability is not an excuse for stakeholders to 'over-demand' accountability. Thus, where organisations (such as PHOs) are required to undertake accountability reporting in excess of contractual obligations, a deficit may also arise. For example, the prior section identified excessive demands from some DHBs for reporting, meetings and performance audits, and it was suggested that these demands be re-assessed to reflect more adequately the benefits and PHOs' needs. Further, the expectation that PHOs will provide (or promote) local employment is not generally support by the *Primary Health Care Strategy* and thus could be perceived as an excessive demand by community stakeholders. Figure 9-7 accordingly presents these 'over demands' as outliers on the accountability 'map' as they lie outside the 'ideal' position on the community-provider continuum and control-trust continuum.

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[191]   The lack of accountability sanctions from 'downwards' stakeholders is also supported by the literature from different paradigms (for example, Arunachalam, 2006 found that sanctions were weak in the communitarian accountability paradigm).

Figure 9-7: A framework of accountability mechanisms to discharge holistic accountability

PHO accountability as a
controlling mechanism

Provider 'over-demand'
- Meetings beyond contract
- Excessive performance
audits (Sanction: claw back or
withhold funds

Prioritisation
of community

Prioritisation
of provider
(of funding and/
or services)

Mechanisms and sanctions to discharge holistic accountability (at 'ideal' position on accountability 'map')		
	Accountability mechanisms	**Sanctions and rewards**
Outputs: to providers of funds	- Contract reports and funder meetings - Audits of financial reports and performance	- Provider claw back or withholding of finds - Provider claw back or withholding of finds
Outputs: to the community	- Annual Report - Reduced patient co-payments - Media reports	- None - Community complaints, disengagement - Community complaints, disengagement

Outcomes: to providers of funds and services	-Reporting to and by staff/contracted
	   providers
		- Contracted provider complaints
		   disengagement

Outcomes: to the community	-Community meetings and public AGMs	- Community complaints, disengagement

Community 'over-demand'
- Providing local employment
(Sanction: complaints,
disengagement)

PHO accountability
enhances extant trust

Underpinning the delegations that give rise to the accountability mechanisms listed in Figure 9-7, is an understanding that DHBs and PHOs will agree clear responsibilities in respect of primary health care provision and that resources will not be wasted during arguments or disagreements in respect of 'contested space'. Clarity around 'acceptable' PHO structures and 'appropriate' metaphors to describe PHOs, may result in relationships that are more stable than that expressed by a PHO Representative ("Our relationship with the DHB is a bit like the [region's] weather, it changes … I think we are both flawed partners in the relationship."). The first step is likely to be enhanced trust to work in the spirit of the *Primary Health Care Strategy*.

9.6. *Summary*

This chapter has reviewed the prior analysis against the literature that underpins this research. It found stakeholders' demands conflict, as they expect PHOs to prioritise either community or their funding and service providers. While the Chairs of the PHO Boards and their CEOs manage PHOs' directions to prioritise accountability to a particular group, organisations and communities that are in relationships with the PHO will attempt to make sense of the discharge of accountability through the lens of the PHO's image. Therefore, PHOs' external images reflected in labels applied by stakeholders as metaphors, influence not only PHOs' identities, but also PHOs' accountability relationships.

The use of accountability to control PHOs reduces learning and also gives rise to the notion of contested space. This concept results from DHB assertions (supported by other interviewees) that they are the appropriate organisation through which PHOs may discharge their responsibility to all stakeholders.

Finally, this chapter considered a framework of 'for what' PHOs are accountable and the mechanisms through which PHOs may discharge accountability against the accountability 'map'. While an apparent deficit in the holistic accountability processes in the case study PHOs bears out other similar research, this chapter has suggested a framework to align stakeholder demands and accountability mechanisms for PHOs to discharge holistic accountability. The next chapter provides a conclusion and policy recommendations.

10. CONCLUSION

10.1.   *Introduction*

Accountability as a concept reflects cultural and contextual nuances that result in ambiguous understandings of to whom, for what, why and how it should be discharged. Yet accountability is fundamental to the *Primary Health Care Strategy* and the delegating relationships Primary Health Organisations (PHOs) enter into because of it (Minister of Health, 2001). This research has explored how four PHOs implement accountability as a situated concept and how they manage conflicting stakeholder expectations. This chapter reflects on how this research informs accountability theory. In addition, this concluding chapter makes policy recommendations, signals limitations in the research and offers suggestions for future research.

10.2.   *Reflections*

In respect of resources and delegating relationships, PHOs, established as autonomous entities to deliver primary health care in their communities, are in a favoured position, as their District Health Board (DHB) contracts include an 'evergreen clause'.[192] This clause imbues an organisational stability and continuity, especially when it is combined with limited DHB sanctions (the PHO contract was described by one interviewee as "completely toothless"). Accordingly, although commentators such as English (2005) suggest government contracting-out systems may transfer the financial risks of incorrectly assessing community's needs, or inadequately purchasing services, to non-governmental organisations such as PHOs, this does not appear to have occurred in these case studies. A possible explanation is that DHBs' dependence on PHOs (as highlighted in Chapter 8) has insulated PHOs from sustained financial losses.

In return for these favourable contracts, PHOs are required to be 'fully and openly accountable' (Minister of Health, 2001). The imposition of accountability in New Public Management (NPM), and the more recent post-NPM or 'Third Way' policy making could

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[192]   This was explained in Chapter 3. PHOs' contracts have termination provisions, but they are not required to be re-negotiated and tendered for annually as many other contracting organisations must (Ministry of Health, n.d.).

be dismissed by others as merely government rhetoric that has limited effect. The reaction of PHOs to this suggestion was negative: accountability was felt to be a 'real' imposition and was experienced as a "big stick." Alternatively, accountability was perceived as an enabler through which PHOs can innovate and collaborate so that some DHBs are described as "partners to provide checks and balances rather than control." PHOs' relationships with their DHBs were therefore found to be fundamental to the understanding of accountability in this research.

As noted in Chapter 1, Davies (1989, p.87) derided the NPM health reforms (in the late 1980s) for their "conflicting and confusing accountability structure." The NPM reforms reflected a free market period where New Zealand's health policies could have resulted in a system that was similar to that in the US, if it were not for concerns in respect of equity and (more recently) the principle of health promotion. However, it appears that New Zealand's attempt to emulate overseas practice did not reduce the conflicts over who should be accountable for what, due to the unique mix of public and private funding and delivery in this country.

The criticisms of accountability structure could be levied at the primary health care reforms of 2001. Despite assessing international models to derive the best system to deliver primary health care in New Zealand (as described in Chapters 2 and 3), the interplay of multiple funders to PHOs and diverse expectations of many stakeholders has still lead to a conflicting and confusing accountability structure. It is unsurprising therefore that, similar to other research in not-for-profit organisations (for example, Cribb, 2005a; O'Dwyer & Unerman, 2007), PHOs may recognise they have multiple stakeholders to whom they are accountable, but are less able to identify for what, how and why they should discharge that accountability.

This research observed two PHO models existing along a stakeholder 'to whom' continuum: those that prioritised the needs of, and accountability to, funding and service providers on the one hand and those that prioritised communities' needs and accountability on the other. PHOs' historical-structural factors appear to provide a basis for these priorities leading to the selection of PHO Chairs and CEOs that reinforce these core values. The PHOs' preference of particular stakeholders to whom they may discharge accountability also gives rise to distinct external images that are potentially

disabling (predatory) or enabling. Thus, the process of accountability, and perhaps choices regarding the balance between control and trust, are related to a PHO's external image.

Notwithstanding this prioritisation by PHOs, the *Primary Health Care Strategy* suggests they may not select a single group of stakeholders to whom they are accountable, even though researchers (for example, Cribb, 2005a; Flack & Ryan, 2005) note not-for-profit organisations have a tendency to discharge accountability to 'upwards' stakeholders rather than 'inwards' and 'downwards' stakeholders. Strong PHO 'upwards' accountability accordingly led to some DHBs using accountability to control PHOs rather than to enhance extant trust in the relationship. Thus, it was noted that learning is reduced, due to risk-averse DHB funders. The tendency to discharge accountability to 'upwards' stakeholders may also lead to an emphasis on mechanisms (such as audits and investigations) that aim to control PHO performance, but that few stakeholders perceive to be important. Thus, resources can be wasted.

Further, in the case of some PHOs, the 'upwards' stakeholder appeared to command 'contested space' and posited itself as able to arbitrate community needs, thus usurping communities' rights to secure PHO accountability. Where the community appeared to acquiesce to this notion, PHOs omitted to engage with community groups who might also actively negotiate with the PHO and sanction its performance through 'voice' mechanisms.

Although the managers from Irish non-governmental organisations (NGOs) interviewed by O'Dwyer and Unerman (2006) were at a loss as to how to implement holistic accountability and how best to encompass a range of stakeholders, the stakeholders in this research readily identified numerous accountability mechanisms. However, the case study PHOs in this research lacked clear processes to identify their key stakeholders and the most appropriate mechanisms, therefore PHOs may both under- and over-supply accountability reporting. Accordingly, this thesis has made recommendations for mechanisms linked to the theoretically 'ideal' PHO position on the community-provider and control-trust continuums. These recommendations take into consideration the preferences of stakeholders to whom PHOs owe contractual and moral obligations under the *Primary Health Care Strategy*.

Stakeholder feedback and re-negotiation of the delegating relationship are important features of accountability (Mulgan, 1997) and yet these are also stakeholder-specific as 'upwards' stakeholders are more likely to impose 'voice' sanctions and 'downwards' stakeholder impose 'exit' sanctions by disengaging. Birkett (1988), Harris and Spanier (1976) and Stewart (1984) suggested that disengaging may not be an effective sanction and thus inferred that 'downwards' stakeholders lack the power to impose accountability as they do not have direct legal contracts. Notwithstanding that, the case study interviewees perceived that 'exit' and 'voice' sanctions are both valid components of the accountability process when a PHO seeks to be responsive to its community. The broadening of accountability in the *Primary Health Care Strategy* has not been accompanied by education campaigns about PHOs as new political structures and, therefore, a lack of PHO visibility does reduce the likelihood that communities will hold PHOs to account. In addition, the negligible collaboration some PHOs have with NGOs, underscores the concerns of The Health and Disability Sector NGO Working Group (2005) that PHOs are not taking opportunities to work with community organisations. Such limited PHO/NGO collaboration may be an unintended consequence of the *Primary Health Care Strategy* and reduces the capacity of organised groups to impose 'voice' sanctions on PHOs. Nevertheless, a number of interviewees expressed the view that, should PHOs continue for a number of years, an ensuing increased profile and permanency should lead to more robust accountability processes. (This will be dependent on future political decisions and the manner in which PHOs address their historical-structural bases.)

10.3.   *Policy recommendations*

Chapter 2 considered a number of funding and delivery options from which governments may choose an ideal primary health care system in three broad categories: a monopoly, free market and contracting-out. The experience of other nations in reforming systems was described in Chapter 3. The deficiencies of monopolistic systems include the risk of provider over-supply and patient over-demand and this option is the least preferred internationally. An alternative, free-market competition, is less likely to deliver equity of access for citizens, nor effective health promotion. While the Netherlands (which has a free market system) has improved equity through additional social welfare payments, New Zealand has, along with many other nations (such as the UK), preferred

'contracting-out' policies to meet the aims of the World Health Organization's (WHO) (1978) Alma Ata Declaration.[193] The *Primary Health Care Strategy* also requires PHOs to be not-for-profit organisations (Minister of Health, 2001) to maintain the public focus of government funding and the possibility that PHOs will work towards goals that are generated through wide engagement and mediated by local needs, grow social capital and provide legitimacy to decisions made on health care issues. However, few guidelines are offered as to how to achieve this effectively.

This analysis of the PHO experience appears to suggest that, as in the United Kingdom (UK), there is a significant gap between policy and practice (Dean, 2003; Green *et al.*, 2007). While the *Primary Health Care Strategy* expected that PHOs would discharge full and open accountability (Minister of Health, 2001), there are apparent deficits in that discharge. In respect of such deficits, Barrett (2001) and Hayes (1996) recommend increased regulation. Further, the need for more regulation in not-for-profit organisations is recommended by Fisman and Hubbard (2005) due to the propensity of these organisations to manage earnings (in particular they found a relationship between lower levels of oversight and higher perquisites).

While Chapter 8 reported interviewees' suggestions that 'sector-bending' may be resulting in earnings management and potentially inappropriate related party transactions in some PHOs, this research found that contractual mechanisms between PHOs and their funders are relatively strong. Further, the adverse effects of excessive control to force accountability for funds have been noted (i.e. contested space and reduced community engagement). Therefore this research recommends that regulation not be increased beyond that already imposed. An alternative is to return to free market policies, such as used by the Netherlands to ensure cost containment and high clinical quality. However, the WHO (2000) along with other researchers (for example Smith *et al.* 2005; Anderson and Blegvad, 2006) found that market policies work more poorly for health care.

The stakeholder to whom accountability is most weakly discharged is the community. Further, the *Primary Health Care Strategy* does not define an 'acceptable level' of accountability to these stakeholders, nor how PHOs can balance DHB demands against

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[193] Australia attempts to combine free market and contracting-out policies, but has only recently stated that primary health care will become a priority. The impact of this policy is yet to be observed.

those of their community. In one New Zealand sector that is required by legislation to consult with community (Territorial Local Authorities) the Local Government Act 2002 s.14 obliges local authorities to take a principles-based approach to performing their role. The Controller and Auditor General (2007) noted recently that good practice is evolving in this sector. Use of 'best practice' guides (such as those published by the Auditor General), rather than legislation, guide such organisations in their community accountability. It may well be that PHOs could learn from their experience and work with the Ministry of Health to develop principles in respect of defining their roles and discharging accountability to their communities.

The following policy recommendations arose from the research.

10.3.1. Government

Despite the requirement under the *Primary Health Care Strategy* for PHOs to be not-for-profit organisations, PHOs evidence different understandings of this requirement. A small number of PHOs are not recognised as not-for-profit organisations by the Inland Revenue Department, although they were approved to be established by their DHB. This may mean public resources are being diverted to private gain.

While the literature suggests that not-for-profit organisations are beneficial in terms of the non-distribution constraint and ability to grow social capital, PHOs and their DHBs appear more concerned that PHOs report earnings showing neither a surplus nor a deficit. The lack of emphasis on social capital (especially cognitive assets[194]) leads to reduced community regulation and monitoring in some PHOs. As noted in Chapter 4 (see Figure 4-4) limited shareholder engagement reduces the likelihood of accountability being negotiated (this is defined as strategic accountability by Ebrahim, 2003a; Edwards & Hulme, 1996; and distorts the discharge of accountability for priorities Leat, 1990; Najam, 1996; and holistic accountability O'Dwyer & Unerman, 2006). A better alignment of practice and policy is required so that government expectations are clearly stated and PHOs can negotiate alignment with these and those of their communities.

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[194] As noted in Chapter 3, Bryce (2005) defines reputation as a cognitive asset that underpins trust in not-for-profit organisations.

Due to extremely limited public information, few communities are aware of PHOs. This factor adds to the deficiencies in the discharge of PHO accountability to their community. As some communities are not aware of PHOs' existence, they are less able to hold PHOs to account.

10.3.2. Community relationships

The findings of this research, that accountability mechanisms to community are under-developed, concur with the findings of Cribb (2005a) and yet PHOs have little central support for developing mechanisms. Peckham *et al.* (2005) found similarly that the concept of community/public participation was underdeveloped in the UK. While some PHOs partner with community, restricted funds and limited training to use media effectively means PHOs fail to make themselves visible.

Increased encouragement for PHOs to report 'downwards' is required. PHOs should be supported to develop policies that show how their mission aligns with their relationships. Some of this may emanate from increasing use of the methods recommended by Neuwelt *et al.* (2005), but the processes to discharge accountability should be matched to particular stakeholder's needs. Further, encouragement to work inter-sectorally with the Local Authorities in their area (as has occurred in the UK) could provide PHOs with visibility and linkages that would be helpful.

Practically, DHBs and PHOs should agree on boundaries of care delegations and performance measures in order for responsibilities to be well understood. Without such an agreement the requirement for PHOs to be accountable to their community will not realise its potential.

10.3.3. DHB relationships

This research found some DHB staff members perceive the DHB/PHO relationship should be one of control, and do not always employ processes to enable them to observe trust. Smith and Ovendon (2007) also noted this. In the UK context, Munro and Hatherley (1993) stated that the use of 'more accountability' is counter-productive and O'Neill (2002) called for 'intelligent accountability'; reflecting the frustration that can arise when

control limits autonomy. Even when policies such as Earned Autonomy are developed, studies (such as Mannion *et al.*, 2007) show that managers have been unable to realise the promised freedoms. Arising from these case studies, it is suggested that strong DHB control does not encourage PHO learning and that the imposition of increasing numbers of audits is questionable. It would be useful for DHB staff to reflect on the manner in which their accountability demands and control of funds restrict the ability of PHOs to undertake innovative projects due to a fear of failure that stifles learning. It would be useful to consider in what way PHOs are empowered to develop unique external identities.

The Controller and Auditor General (2002a) highlighted DHB staff turnover as being disruptive to the PHO relationship, especially when PHOs are attempting to drive cultural change to a population health approach. This remains an issue.

This research found that a lack of definition of 'space' (what is the PHO responsibility and what is the DHB responsibility and where they meet and/or merge) encourages competitive practices rather than collaboration. Interviewees reflected that "the DHB is contracting around us." Contested space is also suggested as a reason why communities do not hold PHOs to account, as they do not know where the responsibility lies.

10.4.   *Limitations*

This data is temporally and contextually bound. Each PHO that participated in the research has continued to change and adapt to its environment and ongoing mutability cannot be captured in a thesis such as this. Further, the need to negotiate access to appropriate case study sites and to limit these to a manageable number (Berry & Otley, 2004; Irvine & Gaffikin, 2006) were limitations of this research discussed in Chapter 5.

Findings of this research, that accountability discharge is related to PHOs' organisational identity and that image is influenced by PHOs' historic-structural cultures and their inter-relationships, are also affected by PHOs' contexts. Should more PHOs have been chosen and consented to be part of this research, other clustering variations may have been observed. For example, as the PHOs that agreed to be participants in this research were in separate parts of the country, each had different funders. The findings are quite likely to

have been different if PHOs have one DHB funder. Therefore, the disparate nature of the PHOs is a limitation but, because of their extremes, it was also an advantage in this research.[195]

10.5. *Further research*

A natural extension of this research would be to other PHOs to assess their context against the current findings. This would provide a deeper understanding of how the four PHOs chosen for this research were similar or dissimilar to the population of PHOs. If more than one PHO was observed in the same DHB's region, it would allow for a contextual extension of the data on DHB/PHO relationships.

In addition, observing the PHOs involved in this research over a longer time period would enable a tracking of changes over time, both within the communities in which PHOs are embedded and also within the PHO and its accountability processes. This may provide a deeper understanding of whether PHOs are tending towards one end of a continuum over time or whether the situation is more akin to a pendulum as was suggested by one interviewee.

10.6. *Conclusion*

This research aimed to meet the challenge of Ebrahim (2003a, p.814) to undertake an integrated look at how particular not-for-profit organisations deal with "multiple and sometimes competing accountability demands" from their stakeholders. In so doing, this research has defined accountability arising from an underlying relationship in which an organisation (the PHO) accepts delegated responsibility from stakeholder/s (Mulgan, 1997). The delegators – in this case the DHB, contracted providers and community – have the right to receive reports, and to impose sanctions or provide rewards in respect of PHOs' performance. This research has considered accountability as a relational concept where to whom, why, for what and how PHOs are accountable needs to be defined. PHOs are diverse in organisational form and structure. The four PHOs chosen for this study were no exception: their attributes varied in respect of the number, socio-economic and

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[195] As outlined in Chapter 5, the PHOs were selected as critical cases to enable theory extension as suggested by Ryan *et al.* (1992).

demographic characteristics of their enrolled members, their geographic location, historical background and organisational type.

The *Primary Health Care Strategy,* a 'Third Way' policy, required PHOs to be not-for-profit organisations. Due to the communitarian nature of 'Third Way' policies, PHOs may have been expected to build social capital in addition to their non-distribution constraint. Notwithstanding this assumption, this research found that PHOs' ability to build social capital was less well-developed and was related to historical-structural factors inherent in decisions on the PHO's identity. It appeared to be more important for PHOs to be able to report to stakeholders that they had made no (or minimal) surpluses and deficits, than that PHOs' relationships and the transactions they have with related parties do not allow for the diversion of public funds to profit-oriented providers. PHOs' underlying relationships also generated distinct external images for these organisations, and these may have impacted stakeholders' demands for accountability mechanisms.

While PHOs are responsible for improving their community's health status, this is a responsibility they share with other providers, including their DHB. Demands for 'upwards' accountability to their DHB appears to generate contested space so that the funder posits itself as the arbiter of community needs. In so doing, DHBs reduce the alignment of the *Primary Health Care Strategy* (Minister of Health, 2001) to the call of the WHO's Alma Ata Declaration (1978) for communities to be well informed and motivated to be active in the design and delivery of their own primary health care. Consequently other key stakeholders (namely contracted providers and the community, including NGOs) were less likely to be afforded priority by PHOs when DHB accountability was imposed as a controlling mechanism. Further, when they were subject to accountability as a controlling mechanism, PHOs experienced reduced autonomy and were less likely to be empowered to undertake risky projects that would encourage learning.

PHOs appear to take the requirement to be 'fully and openly accountable' seriously, yet, while the funders' demand and receive accountability for outputs; the discharge of accountability for outcomes to community is under-developed, *ad hoc* and sanctioned by disengagement or 'exit' rather than 'voice'. The under-development of 'voice' mechanisms reduces opportunities for negotiation between PHOs and their community

and provider stakeholders. While the discharge of holistic accountability appears patchy, community-oriented PHOs reflecting community partnerships were found to deliver a wider range of accountability mechanisms aimed at multiple stakeholders.

Unlike the DHB stakeholders, community representatives prefer media reports about the PHOs' activities as accountability mechanisms. All stakeholders favoured community consultations [including Annual General Meetings (AGMs)] and Board representation as important mechanisms through which PHOs could discharge accountability, yet not all PHOs' AGMs were public meetings and Board representation may not arise as a result of democratic election processes.

Despite a deficit in holistic accountability, PHOs are managed by committed individuals who continually balance competing demands, so that, as one PHO Chair noted:

> *At times I think to myself, "Yes I could do this, should do this, maybe that's a good idea," but just literally don't have the time. When I talk to other Chairs they say the same thing.*

Another community representative described working in primary health care as the "tyranny of the urgent." For this, as well as historical and structural reasons, some PHOs lack processes by which they can involve and discharge accountability to stakeholder groups beyond the funder (including NGOs and communities). This is exacerbated when those demands are excessive from any one stakeholder. This research provided a matrix of mechanisms through which PHOs may choose to discharge their obligations (see Figure 9-7).

As noted, PHOs are relatively new organisations operating in a complex and changing environment. Formed to be responsible for delivering quality clinical services through contracted providers, negotiating the additional delegation of improving population health with all interested parties is proving to be challenging. This research has observed how four PHOs have responded to the challenge to account externally for their actions and concluded that deficits need to be addressed. It is hoped the recommendations made in this thesis may help in some small way to encourage that development of holistic accountability.

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APPENDIX 1: GEOGRAPHICAL LOCATIONS OF DHBS AND PHOS IN NEW ZEALAND

A map of the regions covered by District Health Boards and a listing of the Primary Health Organisations that contract to them. Information and map downloaded from the Ministry of Health website www.dhb.govt.nz 22nd May 2008.

Hauora Hokianga Integrated PHO
Kaipara Care Incorporated
Manaia Health PHO
Te Tai Tokerau PHO Ltd
Tihewa Mauriora Charitable Trust
Whangaroa Primary Health Organisation

Northland

Coast to Coast PHO (North Rodney)
Harbour Health
HealthWest
Procare Network North Ltd
Te Puna PHO
Waiora Healthcare Trust

Auckland PHO Ltd
AuckPAC Health Trust Board
Langimalie Health Clinic Tongan Health Society Incorporated
Procare Network Auckland Ltd
Tamaki HealthCare Charitable Trust
Tikapa Moana (Waiheke Island)

Auckland

Waitemata

East Health Services
Mangere Community Health Trust
Peoples Healthcare Trust
Procare Network Manukau
TaPasefika Health Trust
Te Kupenga O Hoturoa Charitable Trust
Total Healthcare Otara

Counties Manukau

Bay of Plenty

Eastern Bay of Plenty PHO Ltd
Kawerau Interim Primary Health Organisation
Nga Mataapuna Oranga
Te Ao Hou Primary Health Organisation
Western Bay of Plenty PHO

Waikato

Hauraki PHO
Toiora Primary Health Organisation Coalition
North Waikato PHO
Waikato PHO

Lakes

Tairawhiti

Ngati Porou Hauora Incorporated
Turanganui PHO Limited

Pinnacle Incorporated
Taranaki PHO Ltd
Te Tihi Hauora O Taranaki PHO

Taranaki

Lake Taupo PHO Ltd
Health Rotorua PHO

Hawke's Bay

Hawkes Bay PHO Ltd
Tu Meke PHO
Wairoa District Charitable Health Trust

Taumata Hauora Trust PHO
Whanganui Regional PHO

Whanganui

Capital and Coast

MidCentral

Horowhenua
Manawatu PHO
Otaki
Tararua PHO

Nelson Marlborough

Wairarapa

Wairarapa Community PHO Trust

Kimi Hauora Wairau
Nelson Bays Primary Health Trust

Hutt

Capital PHO
Kapiti PHO
Karori
Porirua Plus
South East and City Primary Health Organisation (SECPHO)
Tumai mo te Tangata Inc

West Coast

West Coast

Family Care PHO
Mid Valley Access
Piki te Ora ki Te Awakairangi
Ropata Community PHO
Tamaiti Whangai
Valley PHO

Canterbury Community PHO
Christchurch PHO
Hurunui Kaikoura
Partnership Health Canterbury
Rural Canterbury PHO

Canterbury

South Canterbury

Aoraki PHO

Otago

Dunedin City PHO Ltd (trading as Well Dunedin PHO)
Mornington PHO
Otago Southern Region PHO
Rural Otago PHO
Taieri and Strath Taieri PHO

Southland

Hokonui PHO
Takitimu PHO)
Invercargill - Te Ara A Kewa PHO
Wakatipu

Public Health Intelligence
Public Health Directorate
MINISTRY OF HEALTH
MANATU HAUORA

50 0 50 100 150 200 250 300 Kilometers

307

APPENDIX 2: PHO CAPITATION FUNDING FORMULAE AS AT 1 JANUARY 2006.

Table 1: Capitation for Interim Practices

Service		First Contact Services		
Age Group	Gender	Community Service Card Holder	Non high User	High User
0-4	F	N/A	$308.12	$471.96
	M	N/A	$327.99	$471.98
5-14	F	N/A	$79.33	$302.61
	M	N/A	$75.18	$302.61
15-24	F	Yes	$78.90	$291.50
		No	$36.09	$291.50
	M	Yes	$42.38	$291.50
		No	$20.79	$291.50
25-44	F	Yes	$72.61	$291.50
		No	$7.32	$291.50
	M	Yes	$43.16	$291.50
		No	$5.91	$291.50
45-64	F	Yes	$88.74	$319.27
		No	$12.22	$319.27
	M	Yes	$67.96	$319.27
		No	$9.57	$319.27
65 +[196]	F	Yes	$191.27	$342.40
		No	$191.27	$342.40
	M	Yes	$64.95	$342.40
		No	$164.95	$342.40
65 +[197]	F	Yes	$191.27	$342.40
		No	$191.27	$342.40
	M	Yes	$164.95	$342.40
		No	$164.95	$342.40

Extracted from Primary Health Organisation Agreement (Version 17)

Table 2: Capitation for Access Practices

Service		First Contact Services	
Age Group	Gender	Non high User	High User
0-4	F	$315.73	$471.96
	M	$332.42	$471.98
5-14	F	$99.94	$302.61
	M	$93.54	$302.61
15-24	F	$92.22	$291.50
	M	$50.75	$291.50
25-44	F	$81.04	$291.50
	M	$52.38	$291.50
45-64	F	$110.99	$319.27
	M	$82.90	$319.27
65 +	F	$191.27	$342.40
	M	$164.95	$342.40

Extracted from Primary Health Organisation Agreement (Version 17)

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[196] These capitation amounts are for Interim practices who have consulted with their DHB regarding Patient fee setting and the manner in which capitation has reduced those fees.

[197] These capitation amounts are for Interim practices who have not satisfied the DHB consultation process. Note only funding for patients in the over 65 age group are affected.

Table 3: Health promotion capitation for DHB-agreed PHO proposals

Age Group	Gender	Community Service Card Holder	Non High Use Health Card Holders			
			Mäori/Pacific		Non Mäori/Pacific	
			Deprivation Decile 1-8	Deprivation Decile 9-10	Deprivation Decile 1-8	Deprivation Decile 9-10
All ages	F	Yes	$2.22	$2.59	$1.85	$2.22
		No	$2.22	$2.59	$1.85	$2.22
	M	Yes	$2.22	$2.59	$1.85	$2.22
		No	$2.22	$2.59	$1.85	$2.22
		No		$12.22		$319.27

Extracted from Primary Health Organisation Agreement (Version 17)

Table 4: PHO capitation for Services to Improve Access (high need groups)

Age Group	Gender	Non High Use Health Card Holders			
		Mäori/Pacific		Non Mäori/Pacific	
		Deprivation Decile 1-8	Deprivation Decile 9-10	Deprivation Decile 1-8	Deprivation Decile 9-10
0-4	F	$63.15	$126.29	$0.00	$63.15
	M	$66.48	$132.97	$0.00	$66.48
5-14	F	$19.99	$39.98	$0.00	$19.99
	M	$18.71	$37.42	$0.00	$18.71
15-24	F	$18.44	$36.89	$0.00	$18.44
	M	$10.15	$20.30	$0.00	$10.15
25-44	F	$16.21	$32.41	$0.00	$16.21
	M	$10.48	$20.95	$0.00	$10.48
45-64	F	$22.20	$44.40	$0.00	$22.20
	M	$16.58	$33.16	$0.00	$16.58
65 +	F	$38.25	$76.51	$0.00	$38.25
	M	$32.99	$65.98	$0.00	$32.99

Extracted from Primary Health Organisation Agreement (Version 17)

Table 5: Management fee rates to PHOs as at 1 July 2005

PHO Enrolled Population	Rate as at 1/7/2005	Rate as at 1/1/2004	Prior rate
Up to and including 20,000[198]	$13.88	$9.46	$6.32
Between 20,001 and 40,000	.80	As in 40,001-75.000 bracket	
Between 40,001 and 75,000		$4.60	$5.74
Greater than 75,000		$5.17[199]	$5.17

(Source: HealthPAC, Ministry of Health and Primary Health Team, Ministry of Health)
Downloaded from the internet 16th December 2005 from http://www.moh.govt.nz/primaryhealthcare

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[198]   As at 1 July 2005, 39 PHOs had less than 20,000 enrolled patients.

[199]   PHOs with populations of up to 75,000 will get $9.46 for the first 20,000 enrolees and then $4.60 for every enrollee after that.

Table 6: General Medical Services subsidy for casual users

		Fee for Medical Consultation (Excluding GST)
1	A child, under 6 years of age	$31.11
2	Holder of current Community Services Cared	$13.33
3	A child, 6 years of age or over, who is a holder of a Community Services Card	$17.78
4	Holder of current High Use Health Card who is not a child	$13.33
5	A child, 6 years of age or over, who is a holder of current High Use Health Card	$17.78
6	A child, 6 years of age or over, who is not within Community Services Card or High Use Health Card categories above	$13.33

Extracted from Primary Health Organisation Agreement (Version 17)

APPENDIX 3: NEW ZEALAND HEALTH STRATEGY GOALS AND OBJECTIVES.

Goal	Objective
1. A healthy social environment	1. Assess public policies for their impact on health and health inequalities. 2. Support policies promoting universal access to high-quality education and training. 3. Support policies promoting workforce participation. 4. Support policies that reduce income inequalities and ensure an adequate income for all. 5. Eliminate social exclusion or discrimination against people on the basis of their health status or disability.
2. Reducing inequalities in health status	6. Ensure accessible and appropriate services for people from lower socioeconomic groups. 7. Ensure accessible and appropriate services for Māori. 8. Ensure accessible and appropriate services for Pacific peoples.
3. Māori development in health	9. Build the capacity for Māori participation in the health sector at all levels. 10. Enable Māori communities to identify and provide for their own health needs. 11. Recognise the importance of relationships between Māori and the Crown in health services, both mainstream and those provided by Māori. 12. Collect high-quality health information to better inform Māori policy and research and focus on health outcomes. 13. Foster and support Māori health workforce development.
4. A healthy physical environment	14. Support policies and develop strategies and services that ensure affordable, secure and safe housing. 15. Support policies that improve access to public transport. 16. Support policies that ensure access to an adequate supply of nutritious food. 17. Support policies and develop strategies and services that ensure all people have access to safe water supplies and effective sanitation services. 18. Reduce the adverse health effects of environmental hazards.
5. Healthy communities, families and individuals	19. Support and promote community development. 20. Develop and implement healthy workplace programmes. 21. Further develop health-promoting schools. 22. Ensure adequate support for parents and young families. 23. Ensure adequate support for caregivers in families with dependent members. 24. Support policies and programmes that enable people to be cared for in the community. 25. Support policies and programmes that support breastfeeding. 26. Support policies and programmes that promote positive ageing. 27. *Reduce the incidence and impact of violence in interpersonal relationships, families, schools and communities.
6. Healthy lifestyles	28. *Reduce smoking. 29. *Improve nutrition.

	30. *Reduce obesity. 31. *Increase the level of physical activity. 32. Improve sexual and reproductive health. 33. *Minimise harm caused by alcohol and illicit and other drug use to individuals and the community.
7. Better mental health	34. Reduce the incidence and impact of stress. 35. Reduce the incidence and impact of depression. 36. *Improve the health status of people with severe mental illness. 37. *Reduce the rate of suicides and suicide attempts. 38. Reduce stigma and discrimination associated with mental illness. 39. Reduce the impact of dementia.
8. Better physical health	40. *Reduce the incidence and impact of cancer. 41. *Reduce the incidence and impact of cardiovascular diseases. 42. *Reduce the incidence and impact of diabetes. 43. Reduce the incidence and impact of asthma and other lung diseases. 44. Reduce the incidence and impact of musculoskeletal disorders including arthritis. 45. Reduce the incidence and impact of neurological disorders. 46. *Improve oral health. 47. Reduce the incidence and impact of infectious diseases.
9. Injury prevention	48. Reduce the incidence and impact of road traffic injuries. 49. Reduce the incidence and impact of falls in older people. 50. Reduce the incidence and impact of injuries (other than traffic) in children and youth. 51. Reduce the incidence and impact of workplace injuries.
10. Accessible and appropriate health care services	52. Ensure access to appropriate secondary care services. 53. Ensure access to appropriate palliative care services. 54. Ensure access to appropriate primary care, maternity and public health services. 55. *Ensure access to appropriate child care services including well child and family health care and immunisation. 56. Ensure accessible and appropriate services for young people/rangatahi. 57. Ensure accessible and appropriate services for older people. 58. Ensure access to appropriate mental health services. 59. Ensure access to appropriate services for people living in rural areas. 60. Ensure services are patient-centred. 61. Ensure information about services is accessible for consumers.

APPENDIX 4: RISKS OF NOT REQUIRING ACCOUNTABILITY

Question	Risk that is solved by effective accountability
Who is the actor that is called to account?	• Unless the appropriate actor is identified, no-one may take moral or legal responsibility for tasks and accountability discharge. • Stakeholders will not be able to use accountability processes to affect the actor's behaviour
Who are the stakeholders who call to account?	• The appropriate stakeholders need to be identified, for the accountability relationship to have form • Recognition of stakeholder demands enables them to be negotiated and met • Prioritisation of numerous stakeholders enables accountability to be discharged to the most salient stakeholders • If salient stakeholders' needs are not met, the organisation may lack an appropriate focus and potentially under-perform.
Why is the organisation held to account?	• Unless reasons to be accountable are understood, the accountability relationship will be undefined • The reason why will inform accountability discharge and the mechanisms used e.g. ex-post mechanisms without sanctions cannot control power; relationships and discourse are required to build trust; a shared vision mapped against the organisation's construct provides focus for organisational performance; organisations can learn when guided by stakeholders who hold it accountable.
For what is the organisation held to account?	• Unless the goals (for what) of accountability are defined, the organisations will be directionless and those delegating will be disappointed • Resources will be wasted if: funds are inappropriately used; the procedures in place are ineffective; the programmes run are not appropriate for the community; the policies followed do not meet expectations
What is the process for accountability to be discharged?	• If there is no assessment or verification, the report may be misguided • If there is no justification by the actor, there may be no learning from mistakes • If there is no sanction, accountability is not discharged and again, no learning will ensue • If there is no renegotiation of demands, the relationship is likely to erode
What are the tools or mechanisms in the accountability process?	• Unless appropriate mechanisms are employed, the language of accountability reports may not meet that demanded by stakeholders, and result in ineffective accountability • If common tools are not used, reports will suffer from a lack of comparability to others in similar relationships • If performance is not evaluated, it is impossible to assess whether it has met the specifications • If stakeholders do not engage in the mechanisms, the processes may not be culturally instituted • Accountable behaviour will not be modeled if the mechanisms are not angled towards discharging responsibilities to the public and will result in private-oriented behaviours from public resources

APPENDIX 5: DATA ANALYSIS OF PHOS FOR SELECTION IN CASE STUDY

PHOs' characteristics were analysed from a spreadsheet of all Primary Health Organisations (PHOs) obtained from the Ministry of Health. This analysis guided the selection of PHOs that reflected extremes (Ryan *et al.*, 1992). In addition, data was obtained from the Ministry of Health Yearbook (2005b) and PHO websites in respect of the number of General Practices, General Practitioners (GPs) and organisational type. While all PHOs exhibited different characteristics, two main areas of differences selected for analysis were: the relative economic status of enrolled patients, and the relative number of enrolled patients in each PHO. In addition a rural/urban mix of case study PHOs was sought. Each of these is discussed below, as are other factors of heterogeneity that were considered.

Once the spreadsheet was sorted, the selection of PHOs to approach was made from those that resided at the extremes.

1. Economic status of enrolled patients

In order to identify extremes of economic status, PHOs were ranked against two measures. These were the Ministry of Health funding levels (Access/Interim) and the census analysis of deprivation which should have a confirmatory effect. Thus, PHOs with the most deprived populations will be at the opposite end to those with the least deprived populations.

a. Deprivation

The New Zealand Deprivation Index 2001 (NZDep2001) is used as the key indicator of socioeconomic status. It is an area-based index of deprivation based on census data variables (including, *inter alia*, income, house ownership and the individual's educational qualifications) which is calculated at meshblock level and also at census area unit (CAU) level (Salmond & Crampton, 2002). New Zealand is divided into over 22,000 meshblocks with at least 100 people in them. Dimensions of personal deprivation are based on the following in terms of decreasing emphasis:

- Income (on a means tested benefit)

- Employment

- Income (below an income threshold)

- Communication (no access to telephone)

- Transport (no access to a car)

- Support (under 60 years of age and in a single parent family)

- Qualifications

- Home ownership

- Living space (related to bedroom occupancy thresholds)

In addition to the personal deprivation, the CAUs and meshblocks are mapped in relation to deprivation. In the Ministry of Health data, CAU domicile codes are divided into five quintiles, where quintile 1 is the least deprived and quintile 5 the most deprived (approximately twenty per cent of the population resides in each quintile).

In the database provided by the Ministry of Health, as well as enrolled populations in Quintiles 1-5, PHOs also had individuals whose addresses were not matched to meshblocks. These were designated as Quintile 0. The data was analysed both with this 0 and without. No significant differences arose.

b. *Ministry of Health Funding level*

As noted in Chapter 1 and Chapter 3, PHOs were initially funded as Interim, Access, or Mixed (Interim/Access) organisations according to the enrolments at the General Practices contracted to them. Access practices are the most deprived and initially received the most funding. This distinction reduced by 1 July 2007 as government increased primary health care funding.

2.   Size of PHO

In order to identify extremes of size, it was initially intended to rank PHOs against three measures. These were the relative numbers of enrolled patients (in the Ministry of Health funding brackets), the number of General Practices in the PHO and the number of GPs in the PHO. However, data on the latter two was limited and the most robust data (that from the Ministry of Health data table) was used only.

a. *Number of enrolled patients*

The literature reviewed in Chapter 3 highlighted the need for greater government funding of small PHOs due to high fixed costs. This further increased the management fees available to small PHOs compared to large PHOs. It is therefore expected that there could be differences between small and large PHOs. The PHOs were sorted on the Ministry's administration funding bases into three categories, namely:

- enrolled population > 75,000
- enrolled population > 20,000 but < 75,000
- enrolled population < 20,000

b. *Number of Practices*

In addition, the number of General Practices per PHO was assessed to provide another view of 'small' or 'large'. PHOs with more, small Practices may result in different accountability measures to PHOs with a small number of large Practices. Each PHO was assessed from the information available in the Ministry of Health Yearbook (2005b) and PHO websites. This data was found for only 34 PHOs. While an initial assessment was made of these 34 PHOs (the average number of Practices was 18), this was not used as a measure in determining the sample of PHOs. However the number of Practices was kept in mind during the research period.

c. *Number of GPs*

The number of GPs supported by each PHO was also assessed as it was assumed that the presence of a large number of contracted GPs may result in different accountability measures in PHOs. However, data for this was only available for 13 PHOs. While an initial assessment was made of these 34 PHOs (the average number of GPs was 62), this was not used as a measure in determining the sample of PHOs.

3. Rural/Urban

The literature reviewed in Chapter 3 highlighted the pressures on rural PHOs due to workforce retention. In addition, socio-economic characteristics of rural populations may mean they suffer restricted access to primary health care (Panelli *et al.*, 2006). While the number of PHOs in NZ with rural populations is smaller than those with urban populations, the aim was to locate at least one PHO within the economic and population

characteristics already described which had rural patients.

4.   Organisational Type

The heterogeneity in PHO organisational form was noted in Chapter 3. No specific study has assessed whether organisational form impacts the discharge of accountability, therefore prior literature could not provide a guide as to how to find extremes. The intention was to further refine the list of possible PHOs (identified from the economic status of patients and PHOs' size) into a possible sample set that reflected organisational heterogeneity. This information was not widely available and also information varied between different reports. However the organisational type (as found in the data sets listed above) was kept in mind in case study selection.

5.   Other factors showing heterogeneity

PHOs enrolled populations were also assessed against ethnicity and age data to highlight hetero- and homo-geneity in the PHOs to be approached as case studies.

a. Ethnicity

The PHO ethnicity data is coded by the MOH according to New Zealand Statistics criteria. Ethnicity is categorised into six main groups: Asian, European, Maori, Pacific Island, Other and Not Stated. PHO enrolment data from the MOH spreadsheet was compared to the midpoint of the population in each of these categories in order that diversity could be observed.

b. Age of population

Age groups of enrolled patients were also analysed. The total number of enrolled patients in all PHOs was assessed and the mean for each age grouping calculated. This was to aid observation of extremes between PHOs.

APPENDIX 6: ANALYSIS OF THE 'AVERAGE POSITION' OF INTERVIEW RESPONSES

In Chapter 6 and Chapter 7, the interviewees' responses are aggregated by stakeholder group and by PHO respectively. In addition, the aggregated responses are plotted as an 'average position' on the community-provider continuum and the control-trust continuum. A simple average method was used to locate this 'average position' as follows:

a) Total number of unique responses in each category was added (in row A and B)

b) Overall total number of responses calculated (A+B = C)

c) Total number of responses in overall category expressed as a percentage of total responses (i.e. A/C and B/C)

The aim in these calculations was not to provide statistical rigour, but to express the stakeholders' responses in a manner that was able to be visualized for analysis. There was no weighting of responses to favour a particular dimension of any category. Accordingly, each analysis table is re-stated below to show the 'average position' (Tables 7-10).

Table 7: Re-statement of Figure 6-1 to show the 'average position' of stakeholder interviewees

Categories of responses	Total (36) No.	Stakeholder Groups[200] DHB Reps (4) No.	%	PHO Reps (8) No.	%	Provider Reps (8) No.	%	Community Reps (16) No.	%
Prioritisation of community									
(i) Delivering a total health service	20	2	50	6	75	5	63	7	44
(ii) Community-driven organisations	13	1	25	4	50	4	50	4	25
(iii) Accountable to community	36	4	100	8	100	8	100	16	100
A: Total [(i), (ii) & (iii)][201]	69	7	50	18	57	17	52	27	53
Prioritisation accorded to the providers									
(i) 'GP-centric' view on wellness	14	1	25	2	25	5	63	6	38
(ii)(a) Following the direction of their DHB.	9	2	50	3	50	0	50	4	44
(ii)(b) Supporting General Practice	8	0		1		4		3	
(iii) Accountable to funder	32	4	100	8	100	7	88	13	81
B: Total [(i), (ii) & (iii)][201]	60[202]	7	50	13	42	16	48	24 [202]	47

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[200] As noted in Chapter 5, replies are not necessarily mutually exclusive, nor did all stakeholders answer all questions. Percentages are worked with the number of interviewees as denominator.

[201] The total percentages are worked by dividing the number of responses to each sub-section by the total number of responses.

Table 8: Re-statement of Figure 6-3 to show the 'average position' of stakeholder interviewees

Categories of responses	Stakeholder Groups								
	Total (36)	DHB Reps (4)		PHO Reps (8)		Provider Reps (8)		Community Reps (16)	
	No.	No.	%	No.	%	No.	%	No.	%
PHO accountability as a controlling mechanism									
(i) DHBs use accountability to control PHOs	12	3	75	3	43	4	67	2	13
A: Total (i) percentage of replies	12	3	75	3	43	4	67	2	33
PHO accountability enhances extant trust									
(i) Accountability is a mechanism to enhance trust and shared values	11	1	25	4	57	2	33	4	25
B: Total (i) percentage of replies	11	1	25	4	57	2	33	4	67

Table 9: Re-statement of Figure 7-1 to show the 'average position' of PHO interviewees

Categories of responses	PHO case study sites								
	Total (36)	PHO 1 (9)		PHO 2 (9)		PHO 3 (9)		PHO 4 (9)	
	No.	No.	%	No.	%	No.	%	No.	%
Prioritisation of community									
(i) Delivering a total health service	20	6	67	3	33	7	78	4	44
(ii) Community-driven organisations	13	4	44	2	22	5	56	2	22
(iii) Accountable to community	36	9	100	9	100	9	100	9	100
A: Total [(i), (ii) & (iii)][201]	69	19	59	14	44	21	64	15	47
Prioritisation of providers									
(i) GP-centric view on wellness	14	2	22	5	56	3	33	4	44
(ii)(a) Following their DHB's direction	9	2	33	4	33	0	11	3	22
(ii)(b) Supporting General Practice	8	2		3		1		2	
(iii) Accountable to funder	32	8	89	7	78	8	89	9	78
B: Total [percentage of (i), (ii) & (iii)][201]	60	13 [202]	41	18	56	12	36	17 [202]	53

Table 10: Re-statement of Figure 7-3 to show the 'average position' of PHO interviewees

Categories of responses	PHO case study sites								
	Total (36)	PHO 1 (9)		PHO 2 (9)		PHO 3 (9)		PHO 4 (9)	
	No.	No.	%	No.	%	No.	%	No.	%
PHO accountability as a controlling mechanism									
(i) DHBs use accountability to control PHOs	12	3	33	4	44	1	11	4	44
(ii) Observations of DHB control in PHO relationship	5	0	0	1	33	1	33	3	100
A: Total [(i) & (ii)][201]	17	3	38	5	63	2	20	7	78
PHO accountability enhances extant trust									
(i) Accountability is a mechanism to enhance trust and shared values	11	2	22	1	11	6	67	2	22
(ii) Observations of DHB enhancing extant trust in PHO relationship	7	3	100	2	67	2	67	0	0
B: Total [(i) & (ii)][201]	18	5	62	3	37	8	80	2	22

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[202] These figures represent unique responses (for example, in Figure 7, of the 7 community reps responding to (ii)(a) and (ii)(b), there were 5 unique respondents).