THE IMPACT OF ACCOUNTING LED REFORM IN THE NEW ZEALAND PUBLIC SECTOR:

AN EMPIRICAL STUDY OF SCHOOLS AND GP PRACTICES

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DECLARATION

This thesis has been composed by the candidate and is based on the candidate's own work. The thesis does not include work submitted for any other degree or qualification. Some of the material contained in the thesis has already been published in academic journals. These articles were submitted with both supervisors' approval. Copies of the papers published and details of those awaiting publication can be found at the end of the thesis.

Kerry R. Jacobs Edinburgh 1998

Accounting and control – that is mainly what is needed for the 'smooth working', for the proper functioning, of the first phase of communist society.

V.I. Lenin (1917) *The State and Revolution*, Ch 5.4

ABSTRACT

There has been considerable academic interest in the recent public sector changes in New Zealand, as they were seen as characterising an international reform trend. This thesis employs a critical theoretical model to evaluate the development and impact of accounting-led reform in the New Zealand public sector. By combining an analysis of the reform initiatives in health and education, and longitudinal-case studies of schools and GP practices, this study examines the question of how teachers and doctors managed new forms of financial control and visibility. The critical theoretical model used here was derived from the Laughlin and Broadbent research on the accounting-led reform within the UK. The generalisability of their UK research was evaluated by applying their theory and methodology to the New Zealand context.

Although New Zealand now constitutes an important site for academic research, much of the existing literature has focused on the policy proposals for the reform of health and education. There have been few evaluations of the impact of changes in accounting practices and forms of accountability. Based on the Laughlin-Broadbent theoretical model it was expected that the reforms would be perceived by GPs and teachers as a threat to their autonomy and would consequently be 'absorbed', protecting the core values and real work of the organisations in which they practised.

The findings suggest that the theoretical framework as developed by Laughlin-Broadbent needed general modification. Their conclusion that small groups absorb change was found to be too simple and was extended in the study to recognise that change can also be absorbed at the institutional level. The concept of institutional absorbing structures is an important theoretical contribution of this study and also provides a link between the organisational focus of the Laughlin and Broadbent studies and broader social theory concerns. The case studies also revealed that while the financial and administrative reforms were absorbed, changes in the core work structures and practices could not be absorbed, indicating that the nature of the change process is under-theorised in the current framework and further work is required.

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LIST OF ABBREVIATIONS

ACC	Accident Compensation Corporation
AHB	Area Health Board (NZ)
BMA	British Medical Association
CHE	Crown Health Enterprise
DoH	Department of Health
EO	(School) Executive Officer
ERO	Education Review Office
FMI	Financial Management Initiative (UK)
GMS	General Medical Services (Benefit)
GP	General Practitioner
HBL	Health Benefits Ltd
HOD	Head of Department
HSPC	Health Services Personnel Commission
IPAs	Independent Practice Associations
LMS	Local Management of Schools (UK)
MRG	The Ministerial Reference Group
NHS	National Health Service (UK)
NPM	New Public Management (reform trend - Hood, 1991)
NZEI	New Zealand Educational Institute
NZGPA	New Zealand General Practitioner Association
NZMA	New Zealand Medical Association
NZQA	New Zealand Qualifications Authority
OECD	Organization for Economic Co-operation and Development
PHC	Public Health Commission (NZ)
PPTA	Post Primary Teachers' Association
PreMeC	Preferred Medicines Centre
PTA	Parent – Teachers Association
RHAs	Regional Health Authorities
SRHA	Southern Regional Health Authority
TFEA	Targeted Funding for Educational Achievement

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

There have been a number of calls for evaluations of the public sector reforms which have been implemented in many countries. Of particular interest is the role of accounting in the reform process (Hopwood, 1984; Broadbent and Guthrie, 1992; Hood, 1995b). However, an effective evaluation requires studies of the reform process in its contextually specific national setting. This thesis takes one step along this path by presenting an empirical study of the impact of accounting-led reform in the New Zealand public sector, focusing particularly on schools and GP practices.

The objective of this investigation is to evaluate the utility of the Laughlin-Broadbent theoretical model in the case of the New Zealand public sector. A number of themes emerged from the Laughlin-Broadbent studies of the UK health and education reforms. Among these were the impact of professionals on reform implementation, the importance of lifeworld values and resistance to externally imposed change. We would expect that the New Zealand health and education reforms would also involve successive attempts by the State to colonise health and education, as had been the case in the UK. Laughlin-Broadbent indicate that in such a setting there is the potential that professional staff such as doctors and teachers will resist the implementation of the State initiatives, particularly when they clash with core lifeworld values.

The next section introduces the New Zealand context and describes the core lifeworld values associated with the institutions of health and education in New Zealand. This is particularly important as many of these lifeworld values were subsequently challenged as part of the reform process.

1.2 THE NEW ZEALAND REFORMS

During the 1980s and 1990s New Zealand was subject to dramatic social and

economic restructuring. Holland and Boston (1990, p. 1) described this period as "perestroika, albeit with a particular New Zealand flavour". This perestroika involved transforming the economy from one of the most protected to the example of an entrepreneurial, free market economy (Osborne and Gaebler, 1992, p. 330). The operation of the public sector was also substantially restructured, with many of the State trading activities being privatised and the remaining core being subject to private sector management practices and performance measures. Reform of the education and health systems occurred in the context of these wider structural and economic changes.

Since the 1870s the New Zealand education system has been under the control of the State. The key argument for centralisation was to obtain uniformity of provision throughout the country, and over time, the ideal of equality of opportunity to all children, regardless of where they lived, became the central value of the system. The Department of Education sought to ensure that "wherever people lived they would have access to a school offering the same range of opportunities as any other school" (Gordon, 1996). Because the Department of Education tended to be staffed by teachers or ex-teachers (they were often seconded from their positions in schools), the Department reinforced the 'educational values' that were considered important within schools, particularly concepts of equality within and between schools, and excellence in teaching (Gordon, 1992b).

Following the recommendations of the Picot taskforce (1988) the Government dis-established the Department of Education and devolved management responsibilities to the schools. Each school was to be managed by parents elected as trustees. This restructure challenged the previously central principle of equality of opportunity. Equality of opportunity was also disturbed because the schools in the wealthier neighbourhoods could secure local funding while the schools in poorer neighbourhoods found this difficult. The other key value that was challenged was one of professional autonomy. While teaching staff were used to being subject to review by the Department of Education, this process was conducted by teachers and was not seen as a threat to professional autonomy. However, with the restructure, direct

monitoring and control were replaced with a series of indirect control mechanisms, which were no longer under the control of the teaching profession. The devolution of management responsibility to school trustees placed teaching staff under the direct control of parents. This posed a clear threat to teacher autonomy.

The basis of the existing health system was established in 1938. The core value that all citizens would have access to free health care on the basis of need was enshrined in the 1938 system. However, the concept of free access was also coupled with the notion that GPs would have the right to practice without a direct accountability to the Government. The development and operation of this system is explained in the first part of Chapter Seven. The taskforces appointed to review the health care system (*The Health Benefits Review*[1] in 1986 and *The Report of the Task Force on Hospital and Related Services*[2] in 1988) proposed a number of changes (see Chapter Seven) that challenged the principle of free public access to healthcare and made GPs directly accountable to the State. Based on Laughlin et al. (1994b) it was expected that GPs would resist this direct accountability. This expectation was also supported by Lipsky (1980) and Gorz (1989) who argued that groups such as GPs would be inclined to resist initiative that threatened their autonomy (see Chapter Two).

As with the reforms to education, the reforms to health care were seen by those affected as a threat to their autonomy. Because the teachers and the GPs were responsible for implementing the reforms it was quite possible that they would seek to change them in ways which would protect their autonomy and mitigate the impact of the reforms which impinged on their domain.

1.3 THEORETICAL FRAMEWORK

Chapter Three describes the theoretical framework used in this thesis and analyses

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1 Scott C., Fougere G. and Marwick J. (1986).

2 Gibbs A., Fraser D. and Scott J. (1988).

how Laughlin and Broadbent used it in their evaluation of the reforms in UK schools and GP practices. However, because this was a middle range theory (Laughlin, 1995) it was not static but evolving. As they conducted their empirical evaluations of the accounting-led reforms in the UK, Laughlin and Broadbent came to focus increasingly on the role of small groups of people within organisations, which they found were important in absorbing change in the schools and the GP practices studied.

The reason for selecting the Laughlin-Broadbent theoretical model was that it enabled the comparison between their UK findings and a study of the New Zealand reforms. At the time of the commencement of the thesis, their work was one of the few empirical evaluations of the public sector reforms that had been published. It was therefore a rational choice for a theoretical basis. The application of the Laughlin/Broadbent model was also informed by what Yin (1994, p. 39) called the multiple-case research design. Laughlin and Broadbent developed their theoretical model from case studies of the UK public reforms. It was unclear whether these models were generalisable to other settings. This thesis offered the opportunity to explore the external validity of the Laughlin-Broadbent findings by applying their theoretical framework to accounting-led reforms in a different country. Under the middle-range methodology (Laughlin, 1995) the objective was not to test this theoretical framework but to develop and extend it through the New Zealand empirical evidence.

1.4 KEY RESEARCH CONTRIBUTIONS

This thesis has produced a number of important research contributions.[3] The first contribution was the empirical study of the impact of the accounting-led reforms on the schools and GP practices. Previously there was little research on how these significant reforms were implemented. This thesis has extended the existing knowledge in this area.

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[3] Published papers from the project are listed in Appendix 1.

The second key contribution was extending the generalisability of the Laughlin/Broadbent finding to the New Zealand context. Although the New Zealand reforms were different to those studied in the UK, and the schools and GP practices had different histories and structures, the UK findings were very similar to the findings from the New Zealand studies. The concept of small work groups closely related to how the reforms were managed within the schools. However, the small group model did not fit the GP practices. This difference led to a modification of the theoretical model with the concept of an institutional absorbing mechanism. Although the Laughlin/Broadbent material adopted a social theoretical basis, most of the analysis was firmly anchored at the organisational level. This thesis found that change was not just absorbed within organisations but that, as in the case of the GPs studied, new institutional structures could be created to buffer organisations from change. Within the GP practices many of the contractual and administrative responsibilities were absorbed by an independent organisation, known as the Pegasus Independent Practice Association (IPA). By raising the analysis above the organisational level to consider the role of institutional absorbing structures, this thesis has made an important contribution to understanding the process of institutional development and by providing a link between the organisational analysis of Laughlin and Broadbent and broader social theory concerns.

1.5 STRUCTURE OF THE THESIS

This thesis comprises of an introduction chapter, three sections, and a conclusion chapter. The first section encompasses the background and rationale (Chapter Two) the theoretical framework (Chapter Three) and the research methods (Chapter Four). The objective of this section is to focus on the 'why' and 'how' issues associated with the research project.

The second section concerns the reforms to New Zealand schools and the empirical study of the response. It includes Chapter Five and Six: Chapter Five describes the historical development of the New Zealand education system and the reform changes while Chapter Six links to this by presenting an empirical study of four schools. Chapter Five is necessary for two reasons: first, it aids an understanding of the nature

of the reforms before any interpretation of the responses to those changes and second, many of the reforms were not well documented in the secondary literature. Much of the content of Chapter Five was the product of the studies conducted in the schools, material drawn from unpublished documents and, personal interviews with informants in government agencies.

The third section of the thesis concerns the New Zealand health reforms and the subsequent impact on the GP practices studied. It includes Chapter Seven and Eight which respectively describe the reforms to the New Zealand health care system and the empirical study of five GP practices. Because of the paucity of secondary sources the contents of Chapter Seven also draws heavily on original work.

Chapter Nine concludes the thesis by summarising the findings contained in the earlier chapters and drawing together the multiple-case study focus on health and education. Furthermore, the chapter suggests directions for future research.

CHAPTER TWO

BACKGROUND AND RATIONALE

2.1 INTRODUCTION

Since the 1970s many of the OECD countries have reformed their public sector structures and practices: activities owned and controlled by government have been sold into private hands and social welfare structures have been down-sized in an attempt to obtain more services for less money. While these changes have been described as "... one of the most striking international trends in public administration" (Hood, 1991, p. 3), few economists and policy theorists predicted the changes, seeing instead the growth of public bureaucracy as a certain long-term trend (Hood, 1995a). Fundamental to the change in public administration has been a new role for accounting in the public sector. Previously the focus of accounting within the public bureaucracy had been on issues of probity and compliance. However, as the structure and nature of public sector organisations started to change, so too did the role of accounting. Accounting, or as Laughlin (1992) called it 'accounting logic', expanded its role to become the archetype of economic rationalism (Pusey, 1991), managerialism (Hood, 1990) and a key feature of public sector reform in many countries.

Authors such as Broadbent and Guthrie (1992) have called for an international evaluation of the public sector reform process and of the emerging role of accounting technology in the public sector. This thesis seeks to answer their call by providing a case study of the health and education reforms implemented in New Zealand between 1993 and 1995 and the role of accounting in the health and education context.

The systems of health care and education in New Zealand have been subject to substantial reform, built on models of accounting control and economic rationality and involved the introduction of new accounting practices into public sector organisations. This thesis presents a study of how the reforms have been implemented and how those affected responded to the financial freedoms and the accounting controls that have

been introduced. The empirical research involved the description and analysis of how four schools and five primary health practices have responded to the reforms of the New Zealand education and health systems. The theoretical framework was based on the models developed by Laughlin and Broadbent (see chapter three for an extensive discussion of this material) for the evaluation of the role of 'accounting logic' in the UK health and education reforms.

Three key research choices were made in this thesis: first to focus on public sector reform, second, to focus on New Zealand and third to focus on GP practices and schools. The remainder of this chapter is devoted to describing the motivation and context of the thesis and explaining the rationale behind the key research choices. The next section describes the nature of the public sector reform trend while the third section describes the role of accounting in the reform process. This provides a rationale for why an accounting thesis should be concerned with public sector reform. The fourth section discusses the nature of the reform trend in New Zealand and makes a case for the significance of New Zealand as a research site. The fifth section presents the argument that professional groups have the power and the motivation to subvert policy initiatives that are seen as a threat to their autonomy or values. This analysis provides a justification for the focus on GPs and teachers as professionals that have considerable discretion in their work and therefore have the ability to modify policies as they are implemented. Based on existing literature both of these groups are seen as having opportunity and motivation to modify and perhaps subvert a threat to their autonomy.

2.2 A REFORM TREND

There seems little doubt that the last decade will be seen as a period of public sector reform on an international scale (Broadbent and Guthrie, 1992). This section describes the nature of the reform process and highlights international public sector reform as an important research area.

While there has been a consensus on the need for reform, two trends have emerged in the kind of reforms undertaken (Holmes, 1992, p. 473). For low-income countries

the emphasis has been on modernisation, as the role of government has changed from regulatory and systems maintenance, to national planning and development administration. In developed and middle-income countries there has been a greater emphasis on economy, value-for money and improving general public sector performance (Holmes, 1992, p. 473). While both of these reform trends are interesting, most of the research has been concerned with the public sector reforms initiated during the 1980s and 1990s in the 'developed' countries. Many of the OECD countries have undertaken public sector reforms (Hood, 1991). Examples of this kind of change have been the 'Next Steps' and the 'Financial Management' initiatives, which have radically altered the structure and operation of much of the civil service in the UK. In Australia there have been important financial management reforms and changes in the operation of federal, state and local government. In the USA the Clinton Administration has made the quest for government that 'works better and costs less' (Office of the Vice President, 1993) one of its top priorities. Hood (1991, p. 4) argued that rather than just an increased emphasis on improving public sector performance, a whole new model of public administration has emerged which he called New Public Management (NPM). This involved a move away from a rule-based public service that was clearly differentiated from the private sector and a move towards private sector models of funding, management and control.

2.3 THE REFORMS AND ACCOUNTING

The study of public sector reform and the emergence of NPM would seem to be an issue for political science and public policy rather than for accounting research. However, it has become clear that accounting is a central part of the language and practice of change. Hopwood (1984) was one of the first accounting researchers to comment on the growing emphasis upon accounting technology and accounting measurement in the management of the public sector. He argued that a changing view of the role of the State had led to a requirement for agencies of the State to account for their aims, actions and achievements in new ways. The basis of this change was a focus on cost, efficiency and 'value for money'. The growing emphasis on accounting was seen by Hopwood (1984) as a response to a period of economic difficulty,

particularly to the accusations of waste, maladministration and inefficiency in the existing public services. He also suggested that the introduction of accounting technology in the public sector would (among other things) function to make the local 'visible' to the centre and therefore make monitoring by the centre and imposition of central standards and requirements easier (Hopwood, 1984, p. 182).

Initially public policy theorists paid little attention to the growing importance of accounting as a part of the NPM process (see Aucion 1990; Hood, 1990). However, as researchers attempted to describe a reform trend, it became evident that accounting was playing an increasingly important role in public sector organisations. In 1991 Hood catalogued what he called the 'seven doctrinal components' of the NPM approach: (1) hands-on professional management, (2) explicit standards and measures of performance, (3) greater emphasis on output controls, (4) a shift to disaggregation of units in the public sector, (5) a shift to greater competition in public sector, (6) stress on private sector styles of management practice, and (7) greater stress on discipline and parsimony in resource usage. Although it was not explicitly stated, it can be argued that all of Hood's (1991) 'seven doctrinal components' were based on accounting technologies, highlighting the growing importance of accounting as a reform device. In 1995 Hood (1995b) recognised the accounting implications inherent in his NPM model and placed a more explicit emphasis on accounting as an important aspect of the overall public sector reform trend. He suggested that the changes in public sector accounting were central to the rise of NPM and that "accounting changes formed an important part of the assault on the progressive-era models of public accountability" (Hood, 1995, p. 93).

In 1995 Humphrey, Miller and Scapens analysed the growing emphasis on the role of accounting in public sector reform. They located 'accountable management' as central to the reforms of the UK public sector. They suggested that accounting practices had come to challenge and restructure the role of previously powerful professional groups within the public sector, such as head teachers, civil servants, social workers, university lecturers and general practitioners. These groups are "now required to assume more financially orientated modes of behaviour and to become budget holders

and entrepreneurs" (Humphrey, Miller and Scapens, 1995, p. 16). There seems little doubt that accounting and related practices have come to play an important, and maybe a 'taken for granted' role in the public sector of many countries (Humphrey, Miller and Scapens, 1995, p. 15).

2.4 THE SIGNIFICANCE OF THE NEW ZEALAND REFORMS

While researchers such as Hood (1991, 1995b) have argued that public sector reform is an international trend, most of the studies to date have been focused on the UK (Humphrey, Miller and Scapens, 1995) the USA (Osborne and Gaebler, 1992) and Australia (Guthrie and Parker, 1996). At the commencement of this thesis, relatively few accounting orientated papers had addressed how the reforms were implemented in countries such as New Zealand.

Although New Zealand is a small[1] and geographically isolated country, there has been considerable interest and comment on the dramatic reform of the public administration enacted during the 1980s and the 1990s. In their influential and widely read work - *Reinventing Government*, Osborne and Gaebler (1992) cite New Zealand as a leading example of how to transform a public sector from a semi-socialist economy to a reinvented market economy. They describe New Zealand as "furthest along the entrepreneurial path" (p. 330) and comment favourably on changes such as the development of a "mission driven and results orientated budget for their entire national government" (p. 165), full accrual accounting (p. 244), subjecting State owned organisations to competition (p. 82) and the elimination of direct and indirect subsidies (p. 217). Holmes (1992, p. 473) presented the New Zealand reforms as a dramatic example of systemic change while Hood (1991, p. 6) saw the reform proposals of the New Zealand Treasury as the 'closest thing to a coherent NPM manifesto'. Such is the interest in the public sector reforms in New Zealand that some

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[1] Population approximately 3.5 million.

commentators now refer to a 'New Zealand model' of public administration (Boston et al., 1996). Many government agencies have sent officials to New Zealand to obtain a first hand view of the reforms and to assess their possible relevance to their own national contexts (Boston et al., 1996, p. 3). Detailed reports on the reforms in New Zealand have also been commissioned by various agencies and governmental organisations (e.g. Office of the Auditor General of Canada, 1995; Scott, 1996) and there has been a steady stream of invitations to senior public servants and academics from New Zealand to explain the reforms at international conferences, in scholarly journals and before legislative enquiries into public sector reform (see, for example Treasury and Civil Services Committee, 1994, pp. xlix-li).

Following the change of Government in 1984 the newly elected Labour faced what was described as an economic crisis (see Scott, 1996, p. 6). The first step in addressing this crisis was a radical restructure of the economic policies: the exchange rate was floated, most of the producer subsidies were eliminated and the various import barriers were phased out. The economic reforms were followed by a number of dramatic structural changes to the New Zealand public sector. Many of the commercial activities associated with the public sector were restructured as business enterprises (corporatised) and subsequently sold to overseas investors (privatised). The remaining core public sector was subject to two central pieces of legislation; the State Sector Act (1988) and the Public Finance Act (1989). The State Sector Act (1989) had two main aims; the first was to redefine the relationship between ministers and permanent heads of departments. Departmental heads lost their permanent tenure, were appointed on contracts and became known as chief executives. The State Sector Act (1988) made it easier for Ministers to hold departmental chief executives accountable for departmental performance. The second key objective of the State Sector Act (1988) was to apply private sector labour-market regulations to the public sector. The Public Finance Act (1989) altered the Government appropriation process to focus on outputs rather than inputs and required that government agencies prepare regular performance reports and full financial statements in accordance with private sector accounting standards (Scott et al., 1990).

Most of the changes in the New Zealand public sector have been in broad conformity with the 'managerialist' or NPM trend and have shared common features with the reforms in Australia and the UK. However, the New Zealand reforms also had some particular characteristics, which were not so evident in other countries. The most striking feature of the New Zealand changes was their cohesive or holistic nature. While the public sector reforms in the UK and Australia were typical of the new-right concerns for less interventionist government, the actual changes were *ad hoc* and represented relatively separate responses to perceived problems in different areas of the public sector (Hood, 1991, p. 6). However, the New Zealand reforms were different because they were part of a carefully crafted, integrated and mutually reinforcing reform agenda (Boston et al., 1996, p. 3). This was due to the conceptual rigour and intellectual coherence that underpinned the reform process (Hood, 1991) and the dominant part in the process played by the New Zealand Treasury. The Treasury were responsible for advocating a reform model based around institutional economics theory (agency theory, public choice theory and transaction-cost economics) and for translating that model into specific policy proposals (Boston et al., 1996, p. 16). Although a reform agenda was never outlined in an official government paper the central features were contained in the Treasury's post election briefing papers *Economic Management* published in 1984 and *Government Management* published in late 1987.

The key components of the New Zealand reform proposals and the Treasury's theoretical model have been outlined by those from within the Treasury (see Scott and Gorringe, 1989; Scott et al., 1990; and Ball, 1990) and by academic commentators (e.g. Boston et al., 1991, 1996; Wistrich, 1992). Their papers describe the changes and explain the logic behind the reforms and some also actively debate the merits (or flaws) of the reform proposals. However, little serious attention has been paid to how the reform proposals were implemented. This was an important omission as policies often change as they are implemented.

2.5 POLICY IMPLEMENTATION AND THE PROFESSIONAL

The focus of this thesis is on how the New Zealand public sector reforms were implemented. Within New Zealand it was evident that the proposed reforms were in transition and were modified significantly as they were implemented (see Chapter Four and Chapter Six). This was particularly true of health and education where it may be anticipated that Treasury proposals for market competition and private provision would be modified because of practical implementation problems and resistance from professional staff. Because of this the health and education reforms provided a particularly interesting site and the decision was made to study how these reforms were being implemented, focusing on the experiences of specific schools and GP practices. Education and health consume high levels of State resources and are very sensitive areas of public concern, making a study of change in these areas highly relevant.

The rest of this section utilises some theories on policy implementation in professionalised domains to provide a basis for the focus on implementation and on the particular role of professionals (such as teachers and doctors) in that process. Two important points are made: first, policy as proposed is not necessarily the same as policy as implemented and second, professionals such as teachers and GPs are likely to resist changes that they perceive as a threat to their autonomy, values, income or status.

The lack of a comprehensive evaluation of the actual effects of the public sector reforms in New Zealand is curious because of the scale and cost of the changes. It is also well recognised that policies change as they are implemented (Ham and Hill, 1993, p. 97). Within the public policy literature one of the most influential studies was the work of Pressman and Wildavsky (1973). They found that organisations tend to transform policy and that the goals of the original policy makers were often subverted when policies were actually implemented. Later authors (see Barrett and Fudge, 1981) arrived at similar conclusions, suggesting that 'lower level actors' took decisions which effectively pre-empted top decision making or altered policies. This

is particularly interesting in the New Zealand context as many of those that have promoted the 'New Zealand Model' to an international audience have only discussed the proposed changes, rather than what was actually implemented.

One of the most influential studies of the role of 'lower level actors' in the policy process was the work of Lipsky (1980). He argued that most people do not 'experience government' through elected politicians but through those who deliver the services such as teachers, police, social workers, judges and health workers[2]. Because these workers have discretion in determining the nature, amount and quality of benefits and sanctions provided by government agencies, they effectively make the policy (Lipsky 1980, p. 13). Lipsky (1980, p. 25) concluded that students of policy and policy implementation should consider the capacity of 'policy deliverers' to influence the process and to resist changes.

While Lipsky (1980) argued that 'policy deliverers' have the power to subvert 'top-down' policies, Gorz (1989) has suggested a motive for why they might choose to resist policy directives in certain situations. Gorz (1989) presented a discussion of the place of work and economic reason in a contemporary capitalist society and argued that attempts to subject certain activities to economic rationality will be dysfunctional and will lead to unfavourable consequences. He called one category of these kinds of activities 'care' or 'assistance' and offered medical practice and education as practical examples. By way of illustration Gorz (1989) argued that incentives for doctors to maximise their productivity (that is the number of patients treated per hour) would undermine the doctor-patient relationship. As such the 'caring' and 'assistance' professionals should:

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[2] Lipsky (1980) referred to these people as street-level bureaucrats. I have avoided using the term because it has connotations about a bureaucratic nature and orientation that are not always appropriate.

> … perform their work out of a sense of vocation, that is an unconditional desire to help other people. Receiving remuneration for the help she or he gives should not be the doctor's basic motivation; such a motivation is in competition with a strictly professional motivation, which could or indeed must take precedence in case of need (Gorz, 1989, p. 144).

Gorz (1989) argued that because they are not primarily concerned with financial reward but with an unconditional desire to help other people that the 'caring' or 'assistance' professionals were resistant to the process of economic rationalisation. Economic rationality and the process of economic rationalisation (according to Gorz, 1989) involved reflecting life in terms of calculation and counting, and formalising experience as procedures. Accounting and other forms of control can be represented as characteristic of Gorz's (1989) notion of economic rationality (see Power, 1992).

Based on Gorz's (1989) view on economic rationality in general and accounting specifically, it is reasonable to expect that doctors and teachers will resist the intrusion of accounting controls into their work. Therefore, the New Zealand health and education reforms offer an interesting opportunity to study how two different social institutions and professional groups located within those institutions respond to the reform changes where there was potential conflict between their motivations and values and the provisions contained in centrally imposed policy changes.

However, it is clear that a number of different groups (and individuals) might have been inclined to resist the reforms. Why then should GPs and teachers be singled out for research attention? One answer to this question is that a number of implementation studies had been conducted in the UK focusing on GP practices and schools (Broadbent, Laughlin & Read, 1991; Laughlin, Broadbent & Shearn, 1992; and Laughlin, Broadbent, Shearn & Willig-Atherton, 1994a). By studying schools and GPs in New Zealand it would be possible to make some comparisons with the UK material (see Chapters Six, Eight and Nine).

In regard to the New Zealand context, both the education and the health care systems were changed considerably as part of the New Zealand reform process. While there were distinct differences between the health and the education reforms (see Chapter

Four and Six), both involved the introduction of accounting technologies. While other professional groups also had discretion in their work; they did not experience the same level of change, the same accounting controls or have the same opportunities to influence the implementation of the reforms as GPs and teachers.

2.6 SUMMARY

Of the many countries that have undertaken public sector reform, New Zealand has received particular attention. As well as being seen as a conspicuous example of public sector reform, the New Zealand changes have been notable for their conceptual rigour and intellectual coherence. While there has been some discussion of the concepts and the reform proposals there has been little evaluation of the implementation and impact of the changes, particularly the impact of new forms of accounting control and visibility. The application of the work of Lipsky (1980) and Gorz (1989) would suggest that the New Zealand reforms, underpinned by accounting, are very likely to conflict with the values of groups such as teachers and GPs. While this is clearly an interesting possibility, this expectation needs to be explored in a specific empirical context. For these reasons the subject of this research was the implementation and impacts of the health and education reforms in New Zealand.

The next chapter analyses the philosophical nature of research choice and describes those fundamental research choices that form the basis of this thesis. A theoretical model for this thesis is developed based on a literature summary of public sector accounting research and the central contribution of Laughlin and Broadbent.

CHAPTER THREE

RESEARCH FRAMEWORK

3.1 INTRODUCTION

Empirical research is still a relatively recent phenomena in accounting and it was only in the 1970s that the emphasis shifted away from normative theorising (Mattessich, 1980) to encompass examinations of practice. Much of the subsequent empirical research has viewed accounting as a technical practice and has been based on research methodologies derived from the natural sciences. However, during the late 1970s researchers such as Hopwood (1978) began to criticise accounting research for failing to consider wider contextual issues. The interest in a contextually informed approach to accounting research (Burchell et al., 1980) has since resulted in the application of research methods and theoretical insights derived from social sciences such as sociology, politics and history to accounting research (Laughlin, 1995). In this context of growing diversity in method, but more importantly methodology, it is necessary for a researcher to make a number of clear and deliberate choices about the nature of their research and how they view the subject being researched (Laughlin, 1995, p. 65).

Fundamental questions about the nature of reality and the role of the researcher are particularly problematic as they are based on the worldview or understanding held by the researcher. The best a researcher can do is argue that he/r choices are consistent and are grounded in a coherent research philosophy. Laughlin (1995) has suggested that all researchers (including accounting researchers) are faced with three general areas of choice in conducting research: "theory", "methodology" and "change". Theory choices involve making assumptions concerning the 'nature and reality' of the social world (ontology), what constitutes knowledge and how that knowledge relates to the current investigation (epistemology) (Laughlin, 1995, p. 66). Laughlin (1995) argued that it is necessary for accounting researchers to decide on the level of prior theorisation that can legitimately be brought to the empirical investigation. Laughlin

(1995) argued that high levels of prior theorisation are indicative of an assumed material world (which exists prior to the observer's projections and bias) which, despite empirical variety, has high levels of generality and order and has been well researched in previous studies (p. 66). Laughlin (1995) defined methodology as the researcher's position on the nature and role of the observer in the discovery process (what was described by Burrell and Morgan (1979) as the 'human nature assumption') and the level of theoretical formality in defining the nature of the discovery method (Burrell and Morgan's 'methodology'). The third choice dimension in the Laughlin (1995) framework was the 'change' dimension. This referred to the attitude of the researcher towards maintaining the status quo; in other words, should researchers be a change agent or an independent observer? Laughlin (1995) categorised a number of alternative approaches to research on the basis of their position within the three choice dimensions of his framework. He described those that adopted a medium position as middle-range research. This analysis is shown in Figure 3.1.

Figure 3.1 Characteristics of Alternative Schools of Thought

Methodological Choice: Level of theoretical nature of methods	Theory Choice: Levels of prior theorisation: High	Medium	Low
High	Positivism (L) Realism (L) Instrumentalism (L) Conventionalism (L)		
Medium		German critical theory (M)	Symbolic interactionism (Kuhn) (L)
Low	Marxism (H)	Structuration(L) French critical theory (L)	Pragmatism (L) Symbolic interactionism (Blumer) (L) Ethnomethodology(L)

Change choice: level of emphasis given to critique of status quo and need for change. (high/medium/low).

Source: Laughlin (1995, p. 70)

The author's position on the nature and reality of the social world and role as an observer is based in the image of the researcher as a craft worker. Watson (1994)

used the image of craft to describe intellectual working - drawing on the observation from C Wright Mills that 'social science is the practice of a craft'. A hand-made chair is the product of a craft worker, and as such is a reflection of their creativity and skill. However, the nature and shape of the chair is also influenced by the material used and by the demands of the person who is going to sit on it. While not adopting a totally relativist position Watson (1994) nevertheless maintains that the 'reality' of the research is mediated or interpreted by the researcher, s/he is implicated in the research s/he does and bias the research by he/r perspectives and through the choices s/he makes. This does not imply that there is no reality external to the researcher's interpretations, but that these 'realities' are interpreted and rationalised as they are experienced. The perceptions of the researcher, and those of any audience, are influenced by their backgrounds, experiences and by the process of communication itself. Watson (1994, p. S79) described the process of research as follows:

> I am not simply describing or reporting on what happened. I cannot be objective in that way. But I am not making up what I am writing. Management researchers select, interpret, colour, emphasise [and] shape their findings.

Because the values and background of a researcher are likely to influence the research, it is necessary to describe them. In relation to the subject matter of this dissertation, I have never been a school-teacher, a doctor or a policy analyst, although I have had contact with and discussed my research with people from these groups. I am principally an academic although I do have a background as an accountant and have spent time working as an auditor. Part of the time as auditor was spent in public sector organisations - which explains some of my interest in the public sector. Again, my education (New Zealand State school system) will inform my perspectives as does my sex, class and religion (male, middle class, European New Zealander, Christian).

The level of theorisation applied is also essentially a value choice by any researcher. Researchers who bring low levels of theorisation to their work would argue that one should approach their empirical work with no assumptions, theories or models and only derive their theories from the empirics (or indeed that empirics do not require

theory at all). The position adopted here is that theory cannot be drawn *ex nihilo*[1] from experience as no researcher comes to a project without any prior assumptions or theories, whereas an explicit theoretical framework makes the assumptions of a researcher visible and therefore contestable. Those at the high end of Laughlin's (1995) theory continuum (see figure 3.1) tend to argue that theory is pre-existent and can be proven (or disproved) by a researcher. If one accepts this position and seeks to prove or disprove a theory then there are a number of implications. First, one privileges the theory over the empirics. Second, one draws an arbitrary distinction between the theoretical and the empirical. Third, one assumes that it is possible to prove or reject a theoretical proposition (see Sheppard and Johnston, 1975, pp. 9-10 for a discussion of some of these issues).

Laughlin (1995) also maintained that the research methods utilised imply certain assumptions about the role of human agents in the research process. When there is a high theoretical definition then there is an implicit assumption that the observer is largely irrelevant to the process and that he/r subjectivity (which may be assumed not to exist) plays no part in the process. At the low end, the individual observer is involved in the observation process without regulations or theoretical rules on how that observation should be conducted.

Rather than seeking to prove or disprove theory, the research method utilised in this thesis is based on the concept of discourse (see Broadbent and Laughlin, 1995). Compared to other research methods discourse has a relatively low level of theoretical formality and fits with what Laughlin (1995, p. 81) called the middle-range approach, that is:

> . . . (it) takes aspects of both approaches on theory and methodology, while taking a less dismissive perspective on critique and change. It recognises a material reality distinct from interpretations while at the same time does not dismiss the inevitable perceptive bias in models of understanding. It also recognises that generalisations about reality are possible, even though not

[1] *Ex nihilo nihil fit* – nothing is created from nothing.

guaranteed to exist, yet maintains that these will always be "skeletal" requiring empirical detail to make them meaningful.

Within the middle range approach empirical detail has a vital importance. It complements and completes the 'skeletal' theory. It can also challenge and lead to change in the theory since it is from the empirical investigation that the 'skeletal theory' is derived. I would argue that this is a realistic approach given the social nature of accounting systems.

3.2 PUBLIC SECTOR ACCOUNTING RESEARCH

Despite the emergence of empirical accounting research, there was remarkably little interest in research in the public sector which was generally seen to constitute the domain of economists and political scientists (Perrin, 1981). However, this perception changed and by the early 1980s there was a significant level of interest in public sector issues among accounting academics, particularly costing and budgeting in the NHS (see respective British Accounting Review Research Registers). While it is difficult to identify a reason for this shift, there are two factors that appear to have been influential. First, the management and administration of public sector organisations had become a major political issue as many countries began to restructure their public services. These reforms challenged many historical administrative practices and opened new opportunities for both accounting practices and accountants within previously resistant public institutions. The second factor was that during the 1970s and early 1980s a small number of academics actively promoted the development of public sector accounting research. One of these was John Perrin who, in 1981, published a paper on the State of accounting research in the UK public sector. He observed that public sector institutions had received relatively little in the way of research attention during the decade of the 1970s (Perrin, 1981, p. 297) and argued that there was an urgent need for further research, because of the "many distinctive accounting problems" and the sheer scale of the public sector. Of particular concern was the fact that in the public services "... many of the 'managers' were also 'professionals' first and foremost and that their role as professionals (with obligations to clients, services, standards etc.) conflicted with the conventional role of

the manager in accepting hierarchical discipline over matters such as restriction of services and economising resources" (p. 310). This observation established a theme that was to become increasingly important in later research, the tension between the 'manager' and the 'professional'. To summarise, Perrin's (1981) paper was a call for further research and its major contribution was to highlight the need for public sector accounting research.

In 1988 Lapsley extended Perrin's (1981) work, reviewing research published in the UK, Australia and from the USA. He found that that by the late 1980s there had been some improvement as accounting academics had identified the public sector as an interesting and valid research setting. However, Lapsley (1988) also observed that many of the most significant issues remained unexplored. Financial accounting and accountability had received some attention in the UK and broader performance measurement, cash flow accounting and efficiency audits were studied by some authors. However, Lapsley (1988) argued that research activity was limited because of the lack of a theoretical model of public sector accounting, although some authors had tried unsuccessfully to develop such a framework (see Anthony, 1978).

Lapsley (1988) found that the most significant developments in public sector accounting related to management accounting, particularly the use of investment appraisal techniques and management controls in the public sector. Of particular interest was Perrin et al.'s (1978) study of financial planning and control in the UK NHS. Perrin et al. (1978) found that there were problems with budgetary controls in the NHS and potential conflicts between clinicians and the providers of financial information. The issue of budgetary control and value conflict became an important theme that was identified and extended in later studies (see Bourn and Ezzamel, 1986a, 1986b) and by the mid 1980s health care organisations in general (and the NHS in particular) had become important sites for accounting research.

Lapsley (1991) focused specifically on research in the UK NHS. While he mentioned a number of the same papers as the 1988 paper, the major contribution of the paper was to outline an agenda for future NHS research. Lapsley (1991) classified the

research opportunities into six areas: (1) the internal market in health care, (2) General Practice budgets, (3) capital asset accounting and charging system, (4) resource management systems (5) audit and (6) self-governing trusts. While there had been research done in some of these areas, Lapsley (1991) felt that they all needed further work.

In 1992 Broadbent and Guthrie presented another review of public sector accounting research. The Broadbent and Guthrie (1992) article differs from the earlier work by Perrin (1981) and Lapsley (1988) in that they attempted to define what the public sector was and they sought to focus on 'alternative' literature rather than public sector accounting research in general. Broadbent and Guthrie (1992) noted that the idea of what constituted the public sector was changing and that the role of accounting within public sector organisations was also changing. Public sector organisations were shifting away from a traditional administrative approach to control and towards new mechanisms such as enforced competitive tendering, internal markets and the separation of purchaser and provider roles (p. 4). Because of the changes in its nature and structure, the identification of what constituted the public sector had become somewhat problematic. Previously, the public sector comprised only two areas: one funded by grants from government and the other the monopolies which supplied the services and utilities which were seen as part of the wider infrastructure of society (p. 7). An important common feature of both of these areas was that the organisations were not owned by shareholders but by the public in general. However, programmes of privatisation moved many of the monopoly structures out of the public sector and into the hands of private shareholders. Broadbent and Guthrie (1992) called these organisations Public Business Enterprises and noted that, while they were not always under public ownership, many had retained important residual accountabilities that linked the organisations to government. Broadbent and Guthrie (1992) also identified a second group of organisations, such as health and education providers, which they called Public Institutional Systems. These institutions have complex and varying links to both central and local government structures. An example of this is that in the UK

education system which is the primary responsibility of local government agencies, although central government also fund, and seek to control the process. In New Zealand, education had been seen almost completely as a central government issue and local government has had minimal influence.

Rather than providing a simple distinction between 'alternative' and 'traditional' research, Broadbent and Guthrie (1992) described three different categories of research: technical research; that concerned with technologies in context; and that concerned with accounting's impacts on organisations as whole entities. The basis of their distinction was the perception of the importance of organisational context and the assumption about the power of accounting to lead to change in the public sector. The technical accounting approach assumes that accounting can lead to significant changes in the public sector but pays little attention to the issue of organisational context. Both technical contextual accounting and contextually technical accounting pay attention to the organisational context while increasingly questioning the role of accounting as a change agent.

Broadbent and Guthrie (1992) characterised traditional public sector accounting research as a call for 'technical rules' and 'conceptual frameworks'. Their summary of this research was brief and critical, arguing that it had failed to consider issues of value, power and the various influences and pressures both inside and outside an organisation. Important examples of research that had adopted 'contextually informed' approaches were Bourn and Ezzamel's (1986a, 1986b) studies of the construction of costing information and the role of culture in change in the NHS. Broadbent et al. (1991) also provided a macro study of the NHS changes, looking at the relationship between the NHS and the central government. An important theme that emerged from these studies was the relationship between accounting practices, organisational culture/values/lifeworld and change. Accounting was seen as having a significant influence on the values and perceptions of organisational members.

Broadbent et al., (1992b, 1993)[2] also adopted a contextually informed research model to study the implementation and effect of financial devolution on UK schools and Humphrey (1991) studied the application of the Financial Management Initiative (FMI) on the probation services in England and Wales. While he found that the new technology did have enabling potential, he also highlighted that accounting could lead to unintended dysfunctional consequences.

Broadbent and Guthrie (1992) suggested that there was a need for more public sector accounting research that recognised the social aspects of organisations rather than just simply market structures and accountability patterns. Broadbent and Guthrie (1992) also claimed that there was a need to study how the new accounting systems gave visibility to activities within the organisations, particularly where there was potential for conflict of values. The urgent need was for a critical, contextually sensitive evaluation of how the reforms were being implemented.

> There is little published work which is attempting to evaluate the changes critically ... there would seem to be a great need for extending our understanding by undertaking further study. Post hoc evaluation of the changes is therefore imperative (Broadbent and Guthrie, 1992, pp. 23-24).

In outlining a basis for a critical evaluation of public sector accounting research Broadbent and Guthrie (1992) made a number of important points:

- Because of the international nature of the changes taking place, there was a need for international comparisons and collaborations (p. 24).

- Future work must be of a contextual nature and be based in individual sectors or governmental institutions (p. 24).

- In order to understand the nature and role of accounting within the public sector it may be necessary to go beyond conventional accounting research and seek out understandings available from research in other disciplines. They suggested that

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[2] Broadbent and Guthrie referenced a 1990 working paper, which was published in 1993.

this might take accounting away from the organisational level and lead to a more societal type of analysis (p. 25).

- Key questions that needed to be addressed were why the 'new' accounting had developed, how the new accounting was maintained and how its influence was enhanced, how the new accounting was linked to other management technologies in the public sector and the observable consequences of the changes (p. 25).

By the commencement of this dissertation a number of researchers had began to evaluate aspects of the UK public sector reforms. In 1992 Glynn et al. presented an evaluation of the financial risks and rewards of the UK GP practice budgets. They argued that practice budgets (or budgetholding as it came to be called) represented a major departure from the original philosophy of the NHS.

In 1993 the King's Fund Institute published a review of the UK NHS reforms (Robinson and Le Grand, 1993). While they failed to provide a critical evaluation of the UK NHS reforms, Robinson and Le Grand (1993) did find that the new system was costing more (p. 244) and that the importance of GP fundholding within the NHS had grown. However, it was unclear whether the fundholding initiative had led to quality improvements for patients and that there was some danger of equity problems such as cream skimming (p. 259).

Another important evaluation project was the work of Laughlin and Broadbent. In 1992 Laughlin argued that 'accounting logic' was infiltrating the UK public sector. Both health and education were highlighted as clear examples of the growing importance of accounting logic. Laughlin (1992) concluded by outlining a research programme studying the impact of accounting logic in GP practices and schools in the UK. By 1993 Laughlin and Broadbent (and other collaborators) had published papers discussing the UK NHS reforms (Broadbent et al., 1991; Laughlin et al., 1992; Broadbent 1992) and the LMS (local management of schools) reform within English schools (Broadbent et al., 1992a, 1992b, 1993). These papers were followed in the next few years by others which also discussed the changes affecting GPs (Laughlin et

al., 1994b, Broadbent, 1994) and UK schools (Laughlin et al., 1994a).

In recent years, concurrent with this project, other researchers have also published evaluations of the role of accounting technologies in the UK health and education reforms. In 1994 Robson, Edwards and Ezzamel undertook a CIMA funded study of the LMS reform in England and Wales. During 1995 and 1996 they published the initial results of their study. Edwards et al. (1995) found that the budgeting requirements of LMS had remained 'uncoupled' from the 'productive' activities of the organisation (p. 313) and suggested that techniques such as budgeting were often related to external demands for legitimation rather than internal control. While Edwards et al. (1995) found that the reforms had enhanced the authority and influence of those responsible for administering them, the core activities of the schools were only marginally affected by LMS (p.314).

Edwards et al. (1996a) focused specifically on how the LEAs (Local Education Authorities) constructed and managed the school funding formula. They found that despite the rhetoric of comprehensive budgeting, the emerging systems in the LEAs were predominantly incremental (p. 27) and the formula was 'fabricated' to maintain historical patterns of allocation. Their working paper Edwards et al. (1996b) focused on the impact of the LMS reforms on individual schools, utilising a theoretical framework drawn from neo-institutional theory. They were particularly interested in how the LMS changes had served to introduce "new rhetorics, new debates, new scopes for action and revivified old conflicts" (p. 47). Essentially, accounting had focused attention on the budget surplus carried forward from one year to the next and had revived the debate over the lower relative funding of primary schools compared to secondary schools.

While Edwards et al. (1995, 1996a, 1996b) adopted a different evaluative basis, they generally supported the findings of Laughlin and Broadbent. They found that the LMS changes were managed by the senior staff within the school and had had little direct impact on the teaching staff or the core activities of the school. However, these new responsibilities were not without risk, as they altered the relationship between the

'Senior Management Teams' and teachers and created new forms of visibility and control.

Llewellyn and Grant (1996) presented an evaluation of the GP fundholding initiative in Scotland. They argued that GP fundholding had emerged as a pivotal feature in the UK purchaser/provider structure. Llewellyn and Grant's (1996) study was different to Laughlin et al. (1994b) and Broadbent (1994) in that it focused on the fund-holding initiative which was voluntary as opposed to the changes to the GP contract which were imposed. However, Llewellyn and Grant (1996) found that the fundholding initiative had led to changes in GP behaviour. Llewellyn (1997) went on to argue that the purchasing power associated with the fundholding initiative enabled GPs to wage a 'turf battle' with hospital consultants by renegotiating territorial claims through the medium of contracting. The effect of the turf-battle was to re-establish the GP's jurisdiction over money in the British NHS. Llewellyn (1997) suggested that this experience illustrates the autonomy that agents have to mould the health reforms in particular ways (p. 57).

3.3 THEORETICAL FRAMEWORK

The theoretical framework or 'middle range theory' utilised in this dissertation is derived from the work of Laughlin and Broadbent. While the choice of any theoretical framework is contestable, there are several good reasons why this particular framework was chosen. First, as it had already been used to evaluate the implementation of the UK health and education reforms, it allowed comparisons to the UK empirical results. This opened the opportunity to extend and possibly challenge the generalisability of the Laughlin-Broadbent findings by exploring their applicability in a different jurisdiction. Second, the model was compatible with the methodological choices and philosophy of research adhered to by the author and outlined in the first part of this chapter.

The following section analyses the origin and development of the Laughlin and Broadbent theoretical framework. This is important because the framework forms the theoretical basis for this dissertation. While not seeking to prove or disprove these

theoretical propositions in a positivist sense, one major objective of the dissertation is to explore the applicability of the Laughlin and Broadbent framework to the New Zealand context. An analysis of the New Zealand context and experience may illuminate the middle-range propositions of the framework, thus leading to some possible re-working of the theoretical perspectives adopted.

3.3.1 Description

Laughlin (1987) made the case for applying a critical theory model to researching accounting. He argued that it was necessary to move beyond frameworks of analysis that restrict the nature of discovery to the technical and more tangible aspects of accounting systems and venture into what he called 'social space'. This was necessary as little was known about accounting's "social roots" or about the "interconnection and interrelationship between the social and the technical" (p. 479). Laughlin (1987) reviewed the work of a number of the critical theorists, and concluded that it was the work of Habermas that had the "greatest potential both as a methodological approach for understanding and changing accounting systems design and for investigating social phenomena more widely" (p. 485).

It has been suggested that Habermas' work can be divided into two main phases (Giddens, 1982). The first culminated in the publication of *Knowledge and Human Interests* in 1968. In this work Habermas sought to advance a novel conception of critical theory, on the basis of the constitution of knowledge through interests. Habermas argued that technology and science were not objective, but served pre-existent interests and took the role of substitute ideology in society (Habermas, 1986). Science was not an abstract search for truth but was concerned with technical issues of control and prediction. Of particular concern was what Habermas called the 'scientisation of politics' where social and political issues are turned into technical ones. Thus questions of debate are removed from the public arena and become the domain of experts.

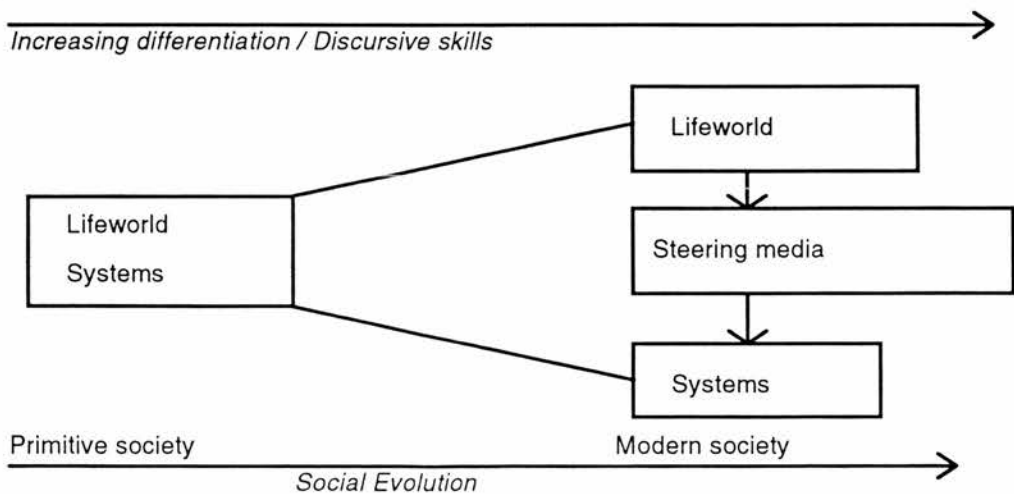
The second phase of Habermas' writings represents a shift from the attempt to ground a critical theory on epistemology to a focus on communication. This is most fully

articulated in *The Theory of Communicative Action*, published in two volumes in 1981 in German with English translations in 1984 and 1987. It is this phase and these books that provide the model of social development and evolution that Laughlin has used to study accounting. In his books Habermas argued that all action is mediated by language and language structures. He argued that communication is based on both (a) an inherent rationality and (b) the ideal of free and open communication. Habermas rejects the pure Marxist models of social evolution and offers a theory of social evolution built around increasing discursive skills. Fundamental to this model are the concepts of lifeworld (*Lebenswelt*) and system. The term lifeworld is used by Habermas to refer to the:

> . . . collectively shared background convictions, to the diffuse, unproblematic horizon within which actors communicate with one another and seek to reach an understanding. The life-world of a society or social group preserves and transmits the interpretative work of preceding generations. It forms the symbolic space, as it were, within which cultural traditions, social integration and personal identity are sustained and reproduced (Thompson, 1983, p. 285).

Habermas argues that key values of the lifeworld become expressed in tangible form as organisations (systems). Hence society can be conceived simultaneously as system and lifeworld. The concepts of system and lifeworld, which roughly correspond to the Marxist concept of base and superstructure, specify the key dimensions of Habermas' theory of social evolution.

Figure 3.2 The Process of Social Evolution



(Source: Broadbent et al., 1991)

The transition from clan societies through traditional State-organised societies to modern forms of social organisations are seen by Habermas as a progressive uncoupling of system and lifeworld as shown in Figure 3.2. This evolutionary process represents a shift from a society based on the integrative norms of the lifeworld to an increasing differentiation between the three objective worlds or domains (objective, social, subjective). The greater the sophistication of the discourse, the greater the lifeworld is differentiated (into the objective world of physical things, the social world of rules and norms and the subjective world of inner experiences and mental states) and the greater the resulting complexity and diversity of the organisational systems. The resulting social structure is seen as more typical of modern societies. This is because it is based upon progressive improvement in communication skills (Habermas, 1987, p. 145).

The problem with increasing social complexity and the separation between the lifeworld and the systems is that as social systems develop they start to move away from the lifeworld and develop their own values and norms, becoming increasingly difficult to control. Therefore, the systems are subject to what Habermas, following Parsons, called the 'steering media'. Steering media are intended to bridge the gap between the systems and the lifeworld and ensure that the developmental logic of the systems remains consistent with the values of the lifeworld.

Problems also emerge when the steering media move in directions that do not reflect the lifeworld demands. This was described by Habermas as "internal colonisation of the lifeworld" (Habermas, 1987, p. 332). The steering media transmit their values to the systems under their control and, if successful, ultimately colonise the lifeworld. Habermas (1987, p. 357) has illustrated the nature of internal colonisation by exploring the development of the legal system. By tracing the development of German law Habermas argues that it initially followed the dictates of the lifeworld, but ended up expending and restricting the freedom of individuals it was meant to protect.

An analysis of Laughlin (1991) and Broadbent et al. (1991) shows the twin streams of

organisational theory and Habermas' social analysis that underpin the Laughlin and Broadbent research model. Laughlin (1991) presented a unique blend of Habermas' social theory and models of organisational change. He argued that Habermas' three-part model of social development could be used to describe organisations and explain how they respond to change. However, Laughlin (1991) did not use the Habermasian terms (lifeworld, steering media and system) but derived a new set of terms from organisational theory (interpretative schemes, design archetypes, and sub-systems), particularly from the work of Hinings and Greenwood (1988). By adopting this organisational terminology Laughlin (1991) shifted the theoretical focus to the organisational level, however this was still strongly influenced by the Habermasian concepts.

Table 3.1 A Comparison of Laughlin (1991) and Habermas.

Habermas	Lifeworld	Steering media	System
Laughlin (1991)	Interpretative Schemes	Design archetype	Sub-system

Laughlin (1991) suggested that organisations are a combination of both tangible physical elements and less tangible structures and values. Organisations are therefore divided into three parts: Sub-systems, design archetypes and interpretative schemes.

1. The sub-systems represent the physical or tangible aspects of the organisation. The physical existence of buildings, machinery, people and behaviours and nature of these elements.

2. The design archetypes are the systems and practices of the organisation. The management structure, the organisational rules and control systems are all examples of design archetypes.

3. The interpretative schemes are the values, beliefs (Giddens, 1979) and ideology (Brunsson, 1985) of an organisation.

The key objective of Laughlin's 1991 paper was to develop a model of how

organisations respond to environmental change. Laughlin (1991) introduced to this model the Habermasian concept of "internal colonisation of the lifeworld" (p. 218) and argued that this also operated at an organisational level. Laughlin (1991, p. 220) outlined four change models or pathways, three of which were progressive forms of colonisation (rebuttal, reorientation, colonisation) and the fourth alternative was based upon open discourse and the weight of the better argument (evolution).

The rebuttal pathway represented an externalisation and/or deflection of the change disturbance so as to protect and maintain the organisation exactly as it was before the disturbance. It is assumed that there will be some change, but this will be contained within the design archetype and will have no lasting effect on the values or interpretative schemes of the organisation. In a reorientation pathway the environmental disturbance leads to change in the way things are done (design archetypes) and the physical aspects of the organisation (sub-systems). However, there is no real change in the values or direction of the organisation (the interpretative schemes). Laughlin (1991) called rebuttal and reorientation first-order (Levy, 1986) or morphostatic (Robb, 1990) change because the nature/values/interpretative schemes of the organisation remain unchanged.

In the category of second order (Levy, 1986) or morphogenetic change (Robb, 1990) Laughlin (1991) introduced the concept of a 'colonisation pathway' at the organisational level. In this pathway the organisational practices (design archetypes) and/or parts (sub-systems) change in response to the environmental disturbance and then proceed to change the organisational interpretative schemes. Laughlin (1991) argued, from a Habermasian perspective, that such change is regressive, unhealthy and dysfunctional for an organisation. By contrast he presented the evolution pathway, where there is a major change in the interpretative schemes of the organisation, but this change is "chosen and accepted by all the organisational participants freely without coercion" (Laughlin, 1991, p. 220). Here the notion of free and open discourse closely matches the Habermasian ideal of communicatively achieved consensus. The curious issue about the evolution model is that it shifts the focus for the change away from an external change agent and onto agents within the

organisation.

Laughlin (1991) represented a considerable advance in applying Habermasian theoretical analysis to practical empirical research. He also advanced the novel insight that Habermas' work could significantly contribute to our understanding of change within organisations.

Broadbent et al. (1991) developed Habermas' model of societal development and applied it to a study of financial and administrative changes in the NHS. Particular attention was paid to the nature of steering media, their colonising potential and the criteria for judging whether or not a particular steering media has 'colonising potential' (Broadbent et al., 1991, p. 6). However, Habermas' model of social development and colonisation was seen as being somewhat impractical in itself and Broadbent et al. (1991) argue that it needs a number of refinements before it provides a basis for empirical analysis. First, they advance the concept of organisational values or the micro-lifeworld.

> That societal steering media and systems . . . are themselves made up of a wide range of institutions and organisations with their own micro lifeworld, steering media and systems. As society grows in complexity both the steering media and the systems become diverse and institutionalised (Broadbent et al., 1991, p. 7).

To some extent this point was already argued in Laughlin (1991) however Broadbent et al. (1991) took this a step further and suggested that 'societal systems' are represented by a range of 'public, private and voluntary organisations'. Broadbent et al. (1991, p. 7) presented government, professional and financial institutions as examples of social steering media. This was a radical modification of Habermas' earlier concept of steering media, which were money and power. However, Habermas' (1992) more recent work on the theory of law (*Fakizitat und Geltung*) shows an increasing institutional turn to the concept of steering media.

The second key adaptation of Habermas' model was the suggestion that while it is impractical to study the societal steering processes as a totality (Broadbent et al.,

1991) one can focus on specific practices or mechanisms. As such one could determine the 'colonising potential' of a given mechanism by determining whether they were "amenable to substantive justification" or could only be "legitimised through procedure" (Habermas, 1987, p. 365). When a mechanism was comprehensible to the average individual, and therefore reflected informed common sense, it was consistent with the lifeworld. Where a mechanism was not intuitively comprehensible and it needed to be justified by elites and official bodies (Broadbent et al., 1991, p. 7), it had 'colonising potential'.

In order to make research practical Broadbent et al. (1991) proposed a third modification: they suggested that as researchers they should focus on ". . . judging constitutive or regulative characteristics (colonising potential) from the organisational systems viewpoint" (Broadbent et al., 1991, p. 10). As such the characteristic of the steering media were compared to the micro-lifeworld of the social system (proposed in Laughlin, 1991) rather than a meta-lifeworld of society as a whole. While this organisational (societal systems) focus makes statements on the global colonising potential of a given mechanism suspect, Broadbent et al. (1991) clearly recognise this and proceed to discuss the colonising potential of a particular set of initiatives (the NHS reforms) for a given organisation / societal system (the NHS) rather than society as a whole. The Department of Health (DoH) was presented as a societal steering medium and the NHS as a societal system. While particular attention was paid to the role of accounting; a number of investigations, reports and government initiatives were also considered as examples of steering media. They argued that that progressive changes showed "increasingly intensive efforts (on the part of the DoH) to attempt colonisation" (Broadbent et al., 1991, p. 17) and that this colonisation process involved bringing changes in the NHS steering media and systems. They present the reforms as "increasingly constitutive" and as representing some underlying and growing agenda (within the Department of Health) to restructure the fundamental nature of the NHS.

3.3.2 The empirical evaluations

According to Laughlin (1995) a middle-range theory cannot be static but must change in response to empirical evidence. This is certainly true of the Laughlin and Broadbent model. As they have published additional empirical work, Laughlin and Broadbent have modified their research framework adding new refinements and more strongly emphasising certain aspects of their original proposal. Since 1992 Broadbent and Laughlin have published a number of papers evaluating different aspects of the UK public sector reforms and have added a number of new elements to their theoretical framework. In 1993 Laughlin and Broadbent focused on the process of internal colonisation of the lifeworld, utilising Habermas' concept of juridification to describe the UK public sector reforms. They argued that the legal regulations that underpinned the UK health and education reforms were 'infiltrated by accounting logic' as characterised by the Financial Management Initiative (FMI). In general the legislative changes were seen as an attempt to constitute new forms of behaviour and relationships in those institutions and represented a threat to the core values of public sector institutions. The theoretical contribution of this paper was the strong emphasis on the colonising potential of legislation and the strong link between legislation and accounting logic.

The subsequent empirical evaluations of the schools and the GP practices indicated that a key factor in determining the change pathway is the role of key individuals or groups within the organisation. Broadbent et al. (1993) examined the implementation of the UK local management of schools (LMS) reforms in four UK schools. They found that the LMS responsibilities had not led to second-order change (colonisation or evolution) but they had been retained or 'absorbed' by a small group of people, which they called the LMS group. While the exact composition of the LMS group depended upon each school, it comprised a small group of the senior staff aided by some form of clerical assistance. The aim of the group was to manage the LMS situation and to protect the values of the school from change.

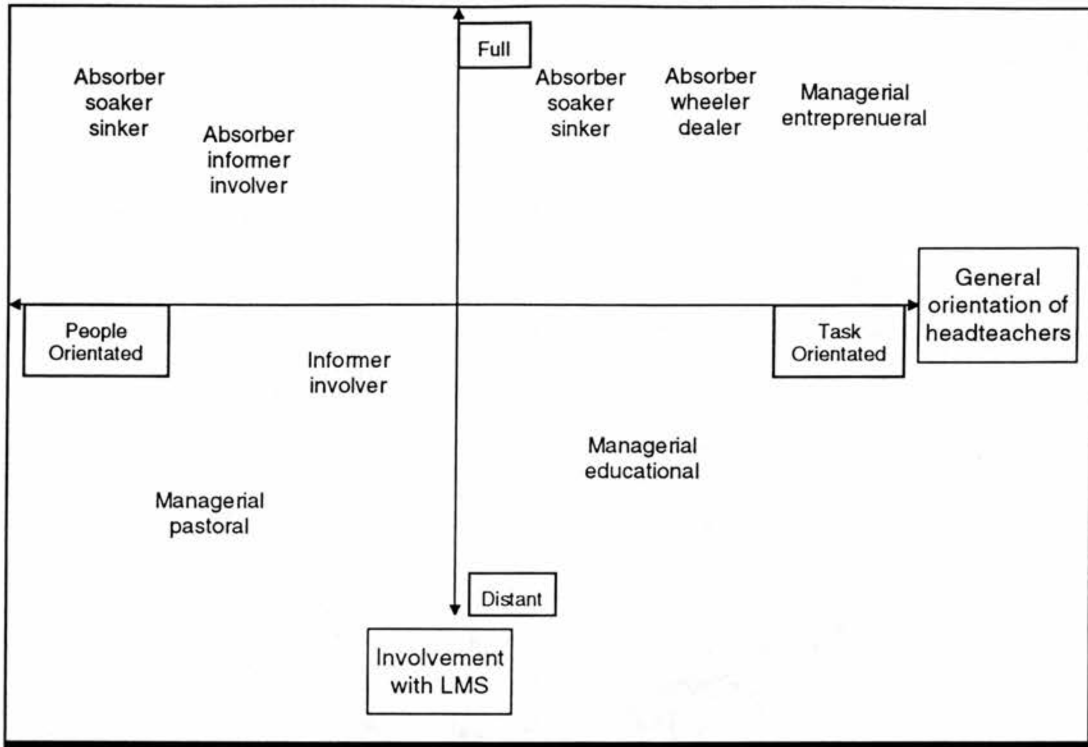
Laughlin et al. (1994a) extended the earlier work of Broadbent et al. (1993) by

studying 24 different schools. They also found that the LMS changes were absorbed by a small group of actors (usually the headteacher and other key staff such as a deputy head, a bursar or the chair of the board of governors) allowing the 'real work' of the school to go unhindered.

Laughlin et al. (1994a) devoted a significant section of their paper to theorising the nature and function of groups within organisations. They argued that in order to manage an anticipated or an unanticipated change disturbance an organisation will look at its arrangements (or design archetypes) and will assign a subgroup to manage the change. When the change is perceived as a threat, the role of the group will be to protect the core functions and values of the organisation. However, Laughlin et al. (1994a) noted that the creation of a small group is not without some risk. The very individuals intended to 'absorb' change could also become a force for change within the organisation and by redefining the core values, lead to the process of colonisation rather than reorientation.

In the schools studied by Laughlin et al. (1994a) it was found that the 'type' of headteacher was the most important factor in understanding how each school responded to the reforms and how the subgroup which managed the changes operated. The concept of small absorbing/colonising groups provided the basis for their analysis and they charted a range of 'types' based on the involvement of the headteacher in the LMS process and upon whether they were 'task' or 'people' orientated. Their Figure (3.3) is reproduced below.

Figure 3.3: Headteacher Change Orientations



(Source: Laughlin et al., 1994a)

Each group of headteachers were characterised by a particular title (i.e. absorber sinker soaker) and represented a number of the headteachers in their sample. Eight different headteacher orientations were identified:

Absorber sinker-soaker

Laughlin et al. (1994a) found that while 'absorber' headteachers had a dominant involvement with LMS, the absorber soaker-sinker took on most of the changes themselves and did not find it easy to delegate the responsibilities to others. Because these individuals were orientated to people rather than tasks, they saw it as their responsibility to protect the students and staff from the changes. LMS had a high personal cost for these head teachers and some decided to retire early because of the stresses they had experienced.

Absorber-informer-involver

The absorber-informer-involver type head teacher also sought to absorb the LMS responsibilities and shield the staff from the intrusion of the LMS. However, they were more enthusiastic about sharing the LMS responsibilities with other staff where possible. In small schools and primary schools the delegation process was difficult, as there were few colleagues with the capacity to assist the head teacher.

Absorber-autocrat

For the absorber-autocrat, the LMS responsibilities were really just another task to be managed. These heads were used to considerable responsibility and autonomy and dominated the new area just as they had other areas of school management and operation. Laughlin et al. (1994a) said that these individuals did not seem to experience particular stress from the LMS changes.

Absorber-wheeler-dealer

These heads also tended to dominate the small group that managed the LMS responsibilities within the school. However, the new freedoms were not seen as a threat or a chore but as an opportunity to exercise a latent marketing spirit. The tendency of these heads was to use the LMS freedoms to 'wheel and deal' and because of this they had the potential to become a threat to the other staff.

Managerial-entrepreneur

These head teachers had a strong task orientation. They were sharing the responsibility to manage LMS with others but also engaged in a number of other entrepreneurial activities, often with a strong financial bias. Laughlin et al. (1994a, p. 75) suggested that these head teachers had lost connection with the management of the school and had become more concerned with the projects they had initiated. While the managerial-entrepreneur was seen as an anomaly, they also highlight the potential dangers of colonisation associated with the LMS reforms.

Managerial education

While these head teachers retained a clear task orientation they tended to be less directly involved in 'doing LMS', delegating many of the responsibilities to others (particularly the Deputy Head). They often had a strong management concern and an interest in developing appropriate management structures within the school. Laughlin et al. (1994a, p. 77) suggested that many of these head teachers were already moving along a management path prior to the LMS change.

Managerial pastoral

These head teachers tended to distance themselves from the LMS concerns, delegating to others where possible so as to allow them to remain actively involved in the care of the staff and children. Their financial and administrative responsibilities as head teacher were not seen as important as maintaining a pastoral role within the school and therefore they played little role in the LMS group within the school.

Informer-involver

The informer-involver played a dominant role within the LMS management group, however they also managed to involve others in the management tasks. Because of the combination of involvement and delegation, these head teachers were under less pressure individually as their commitment was at a sustainable level, and yet the school as a whole could be protected from the changes. Laughlin et al. (1994a, p. 79) presented this approach as "a near optimal solution where 'doing LMS' was not perceived as an opportunity but as a delicate balancing act with a lot of bureaucracy and housekeeping involved."

The concern with the role of small groups in absorbing change was also evident in the Laughlin and Broadbent studies of the implementation of the GP reforms in the UK. Laughlin et al. (1992) focused on the changes to the UK NHS arising from the two White Papers (*Promoting Better Health*, 1987; and *Working for Patients*, 1989) and the National Health Service and Community Care Act of 1990. They argued that

these changes were characterised by financial and accountability concerns and had the potential to intrude on the professional autonomy of GPs. However, they found that the GPs had discovered ways to absorb the changes and to protect their real work and underlying values (p. 146). Laughlin et al. (1994b) explained more fully how the absorption process operated. They found that the management of the changes, particularly the responsibilities arising from the new GP contract, had been delegated to the practice nurses and practice managers. Laughlin et al. (1994b, p. 99) suggested that the hallmarks of the health reforms were a massive increase in bureaucracy and the introduction of multiple clinics. The practice managers managed the increase in bureaucracy and the practice nurses ran the clinics. So, in terms of the theoretical framework, the implementation of the new contract in UK GP practices led to first-order change or absorption, which protected the interpretative schemes of the organisations by changing the steering media (role and behaviour of the practice managers and nurses).

Having noted the importance of the absorbing group in both the schools and the GP practices Laughlin and Broadbent (1995) sought to explore the nature and importance of small groups. Following Bion (1968), they suggested that small groups arise in each organisation which manage basic anxieties such as protecting the whole from unwanted intrusions (fight/flight), provide needed leadership (dependency) and provide continuity through the reproduction of core values, concerns and activities (Laughlin and Broadbent, 1995, p. 7). The concept of the 'specialised work group' provided the basis to revise the research model. Laughlin and Broadbent (1995) suggested that these small groups were "a personification of the Habermasian steering media and the key foundation stone of all design archetypes in all organisations" (p. 8). Because of this important function within the design archetype, the 'speciality work groups' are critical in determining the change model or 'pathway' a disturbance takes within an organisation.

> For the rebuttal and reorientation pathways the specialist work group acts as a defender exercising primarily the fight/flight assumption role. In this case the group becomes an absorber of the disturbances so that the core activities of the organisation can go on unhindered. In relation to particularly the

> colonisation, but also the evolution pathway, the specialist work groups acts as a proactive agent – in the colonisation case this is through force and in the evolution alternative through discourse and gentle persuasion (Laughlin and Broadbent, 1995, p. 9).

However, there are two dangers associated with specialist work groups. First, they may adopt a colonising role and seek to change the core values of the organisation. The second danger is that the actual disturbances will be such that it can not be retained or absorbed by the specialist group and 'spills over' to the organisation as a whole. Laughlin and Broadbent (1995, p. 10) were rather unclear about the consequences of spill-over change, but argued that it considerably increases the dangers of colonisation.

Although the Laughlin-Broadbent research has been conducted over a number of years and has formed the basis for their papers on the UK health and education reforms, there are remarkably few criticisms of the research model. However, one example of critical comment has been the work of Roslender (1992, p. 147). He argued that Laughlin failed to consider the potential of the other critical theorists for understanding accounting in a contemporary society. Laughlin (1987) discusses the work of each of four of the key critical theorists, Horkheimer, Adorno, Marcuse and Habermas. While each of these theorists could contribute to an understanding of accounting, Laughlin (1987) argued that that it is Habermas' model that is most relevant as a methodological approach for understanding and changing accounting system design. Laughlin (1987, p. 485) presented three reasons for why he thought that Habermas has the most potential: first, Habermas' methodological approach is centred upon language and communication. Laughlin (1987) argued that accounting and accounting systems are examples of language and communication, and therefore are amenable to this kind of study. Second, Habermas, unlike the other critical theorists, does not presume some kind of a-priori idea state, but suggests that any ideal is discovered through the process of discussion or discourse. Laughlin (1987) argued that this means that we do not have to start with an ideal design for accounting systems but can discuss the nature of the systems and through this process discover the necessary improvements. Third, Habermas indicates the processes that are

necessary to generate understanding and change in a phenomenon, whereas most of the other critical theorists do not give such guidance.

Laughlin's (1987) points do present a reasonably persuasive argument. However, other arguments can be added. Within the German critical school, Habermas is a key figure and has been described as the leading spokesman for the field (Held, 1980). Habermas' work captures and analyses many of the concerns of earlier critical theorists. However, Habermas has also developed a more extensive social-theoretical analysis than almost any other theorist, a social analysis that has potential to provide a broader and more contextually orientated understanding of the role of accounting in society. While this does not preclude the application of theoretical insights from other critical theorists to understanding accounting, Habermas clearly provides an excellent point to start the process.

Roslender (1992) was also concerned with the use of a critical theory perspective for carrying out micro-level case studies.

> The general focus for critical theory has been on societal level issues as a consequence of it being one of the forms in which Marxism, as a meta-theory, has been developed in the twentieth century (Roslender 1992, p. 149).

Roslender (1992) raises an important point about the applicability of critical theory, and associated suggestions of socialist revolution, however, he also suggests that although difficult to operationalise, potentially rich and insightful material could be generated from case-studies informed by critically theory perspectives. While Habermas' does display a commitment to the concept of revolution, this is different to the Marxist concept of socialist revolution (Held, 1980). Habermas' concept is much more informed by the concept of free communication and the weight of the better argument. The social-theoretical perspective is also increasingly welcome in the context of accounting research as a number of authors have strongly argued that accounting research should be informed by social theory. Both Broadbent and Guthrie (1992) and Guthrie and Parker (1996) suggest that accounting practices should not be studied in isolation, but regarded as a social phenomena embedded

within their institutional and social settings.

Roslender's (1992) criticisms relate primarily to the Laughlin (1987) paper. Later work (see Laughlin, 1991 and Broadbent, 1991) attempt to provide a link between organisational theory and the work of Habermas. While the Habermasian concepts still play an important role, the combination of the social and the organisational theory is clearly more relevant to a micro-study of accounting changes.

While Roslender (1992) challenged Laughlin and Broadbent's use of Habermas, Gray et al. (1995) challenged their use of organisation theory. Gray et al. (1995) used the Laughlin-Broadbent theoretical model in their study of the role of environmental accounting and environmental accounts in organisational change. However, they were critical of Laughlin for 'assuming a too rigid, too defined concept of organisation' (p. 217) and therefore incorporated Llewellyn's (1994) concept of boundary management[3] into their framework. As both Gray et al. (1995) and Llewellyn (1994) were published after the commencement of this project, it was not possible to utilise their insights as part of the theoretical framework. However, the comments do not invalidate the Laughlin and Broadbent model and do highlight organisational boundaries and structure as a contestable space. It is intended to explore, as part of this thesis, the appropriateness of the Laughlin organisational model and to consider whether other models, such as boundary theory, might be more appropriate in the light of empirical evidence.

3.4 BUILDING A RESEARCH MODEL

The New Zealand health and education reforms provide an opportunity to apply the theoretical and empirical insights developed by Laughlin and Broadbent to a different social, organisational and jurisdictional context. This theoretical model was

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[3] Llewellyn (1994) argued that the boundaries between the organisation and the environment are not just relationships to be managed, but are what constitutes an organisation. These boundaries can take many different forms; the physical/productive, financial, psychological, legal and temporal. Llewellyn (1994, p. 4) suggested both management and financial accounting plays an important role in creating and managing boundaries.

developed from case-studies of the UK schools and GP practices and therefore is a poor basis for generalising beyond the UK. However, accounting-led public sector reform is an international trend and there is a need for international comparative work. Yin (1994) argued that multiple case-study research designs were particularly for comparative analysis and for improving external validity. Therefore, applying the Laughlin-Broadbent theoretical framework to a study of health and education reform in New Zealand had the potential to demonstrate the generalisability (or lack thereof) of the Laughlin-Broadbent framework and to lay the foundation for future comparative studies of accounting-led public sector reform.

The beauty of the New Zealand context is that it was both similar and different to the UK. The countries are similar in that New Zealand shared historical, legal, linguistic and cultural links with the UK. Many of the New Zealand reforms were broadly similar[4] to those implemented in the UK and there was a measure of cross-fertilisation between the two countries. However, there are also differences. First, they are different countries with different political and economic environments. Second, the key institutions (in this case schools and GP practices) were structured differently, had different histories and were facing different kinds of reform. It was the similarity that made the two countries comparable, and the differences, which meant that the generalisability of the Laughlin-Broadbent findings could be evaluated.

The other reason for selecting the Laughlin-Broadbent material as the theoretical basis for this thesis was that it represented the most obvious choice at the point of commencement. As clearly demonstrated earlier in this chapter, the Laughlin-Broadbent material represented one of the few published evaluations of the impact of accounting-led reform in health and education. Therefore, it was a reasonable choice for a theoretical and analytical basis for this thesis.

As characteristic of a middle-range theoretical model, the Laughlin-Broadbent

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[4] Hood (1995) classed both the UK and New Zealand among the high NPM group.

material provides a skeletal framework for an evaluation of the New Zealand public sector reforms. Based on this framework the New Zealand schools and GP practices are regarded as examples of societal systems designed to reflect certain lifeworld values (see Chapters Five and Seven for a discussion of these values). Laughlin (1991) provides a coherent model of organisation structure and suggests (as does Broadbent et al., 1991) that there is a dynamic relationship between environmental changes and internal responses to those changes. Broadbent et al. (1991) argued that structural reforms can be seen as examples of steering media and are often created with explicit colonising intentions.

It appears that the health and education reforms in New Zealand were a clear example of accounting-led reform where accounting controls were intended to constitute new forms of behaviour and relationships in schools and GP practices (Chapters Five and Seven). These changes fit what Laughlin and Broadbent (1993) called juridification or internal colonisation of the lifeworld and it is reasonable to expect that they would be seen as a threat to the values and to the autonomy of GPs and teaching professionals.

Laughlin's (1991) model of change indicate the 'tracks' the reforms may take in the schools and GP practices studied. It is questionable whether the teachers and GPs will be able to rebut the changes implemented, however reorientation, colonisation and evolution are real possibilities. Based on the empirical work conducted in UK schools and GP practices particular attention will be paid to the role of specialist work groups to 'managing' the change process in the organisations studied.

CHAPTER FOUR

RESEARCH DESIGN AND METHOD

4.1 INTRODUCTION

Chapter Three addressed the issue of theory and research methodology and identified Laughlin's middle range approach as the appropriate methodology for this project. This chapter addresses the question of method or, as Watson (1994) put it, the practical 'how' questions associated with research. However, methodology and method are invariably linked as the choice of a particular research method depends significantly upon the research methodology selected.

The first section of this chapter discusses how the school and GP sites studied were selected and how access to those sites was negotiated. The second section of the chapter describes how the research was conducted and the third section summarises the notion of discourse, which formed the basis of the analytical methods applied.

4.2 SITE SELECTION AND ACCESS

In order to conduct a grounded empirical evaluation of the New Zealand public sector reforms it was necessary to establish contact with a number of schools and GP practices. In order to evaluate the implementation of the New Zealand reforms longitudinal case study research was deemed necessary (see Yin (1994) for further discussion). However, longitudinal case study research is intensive and time consuming. It was necessary to limit the number of case study sites in order for one researcher to conduct the work. So four schools and five GP practices were selected from the Christchurch area. Of the four schools two were primary and two were secondary. An academic colleague who was on the board of trustees assisted initial contact with one of the secondary schools. However, the other schools were selected from a Department of Education list of local schools. The principal of each school was sent a letter inviting them to participate in the research.

Within this study the selection criteria matched the criteria used by Broadbent et al.

(1993) and Laughlin et al. (1994a). However, this criteria also made theoretical and practical sense in the New Zealand setting. Within a multiple case study design it is not appropriate to talk about a sample (Yin, 1994, p. 45) therefore no attempt was made to obtain a 'random' sample of sites. However, it is valid to apply replication logic and to select sites which would provide contrasting examples. Two key selection criteria were the school types (primary or secondary) and the socio-economic area (see Gordon et al., 1994). The distinction between the type of school was important because prior to the reforms they had different levels of autonomy (see Chapter Five). School type was also a surrogate for school size because primary schools tended to be much smaller than secondary schools.

The socio-economic location of the school was also important because it illustrated the principle of equality of opportunity. In the wealthy socio-economic areas schools were more likely to be able to raise funds from their community and would be able to provide more facilities to students. However, in the poorer areas schools would not able to secure the same levels of funding and would be unable to provide the same facilities.

One of the primary school principals contacted said that he was unwilling to participate as he was going to retire soon. Therefore another primary school was written to and the principal and board indicated that they were willing to participate. The summary details of the selection criteria for schools are shown in table 4.1.

Table 4.1: School Selection Criteria.

Matai School Primary School In a poor central city with falling rolls	**Aroha College** Secondary School In a poor suburb with falling rolls
Deans School Primary School In a wealthy suburb with growing rolls	**Straven High** Secondary School In a wealthy suburb with growing rolls

The identities of the schools participating in this study were disguised in order to maintain confidentiality. This involved using pseudonyms and removing any

references to special features of schools that would identify them.

The selection criteria for the GP practices were similar to that used for schools. Although there were lists of registered GPs, these gave no indication of the practice size or the population that they served. Initial contacts were established with one GP practice and advice was sought from a university department of General Practice on other practices that would provide some variety in both size and location (see the discussion above elating to school selection criteria). A direct approach was made to each practice and the author secured their agreement to become involved in the research.

Table 4.2: GP Practice Selection Criteria

Location Practice size	Poor area	Mixed area	Wealthy area
Small	**Practice 5**	**Practice 4**	**Practice 3**
Large	**Practice 2**		**Practice 1**

4.3 DOING RESEARCH

As any research text indicates, all researchers face specific choices about how they will conduct their work. However, research methods are not some kind of smorgasbord that you can freely choose from. Choice should be informed by the nature of the questions asked and the theoretical model used (Watson, 1994). As this project was specifically concerned with issues of change and response, a multiple case study design was used. This approach was consistent with the Laughlin-Broadbent theoretical approach. The research method was based on the work of Moustakas (1990), Broadbent and Laughlin (1997) and Rubin and Rubin (1995) and involved open-ended interviews, discussions and personal observation. The process involved a number of different individuals; in the schools these were the principal, teachers, administrative staff and school trustees; and in the GP practices, GPs, practice nurses, and practice support staff. Laughlin and Broadbent had found that these individuals had performed significant roles in relation to the reform of the UK health (Laughlin et al., 1994b) and education systems (Laughlin et al., 1994a). This empirical study was

conducted over a twenty seven month period between August 1993 and December 1995, with regular visits to each research site every six months. The study was conducted over an extended time-period to provide a richer understanding of the research sites and to capture processes within the schools and GP practices over a period of significant structural and social change.

The research process involved a range of different data collection methods. First an effort was made to spend time in each research site, to observe the operation of the organisation and to collect any background documentation available. In the GP practices this included regular practice newsletters and in the schools; annual reports, documents from trustee meetings charters and guidelines. However, the primary source of information was the unstructured interviews initiated by the researcher. The interviews and meetings were taped, transcribed by the interviewer and returned to the participants for their comments and amendments. While this was a reasonably simple process with a one-on-one interview, there were some problems associated with meetings and group interviews, as it was not so clear who the appropriate contact was. Over the course of the study the nature of the interviews changed. Initially the interviews were relatively formal and the comments provided by interviewees were somewhat guarded. However, as the study progressed, a measure of trust developed and interviewees were much more willing to volunteer comments and to engage in the process of discourse described in the next section of this chapter.

Generally one individual in each site took on the role of key informant and provided most of the information. While this may have introduced an element of bias to the study, the notion of key informant or conversational partners (Rubin and Rubin, 1995) is well recognised in the qualitative research literature and is not inconsistent with a middle-range methodology. Where there was a consistent perspective in the sites one quote was used to illustrate the collective position. However, when there were divergent views an effort was made to illustrate the different perspectives.

On a number of occasions it was possible to attend meetings in the practices and to observe the interaction between individuals in this context. Within the schools the

primary contact was with the school principal, although an effort was made to attend trustee meetings and meet teaching staff in all cases.

4.4 DISCOURSE

The discourse research method is informed by the Habermas' concepts of discourse and operationalised via the critical discursive models presented by Laughlin (1991) and Laughlin (1995). Although Laughlin and Broadbent used a discourse method in their studies of schools and GP practices in the UK, it was not published until 1997[1]. However, as it was the method associated with the theoretical framework used in this thesis, it should also be the research method applied in this thesis. Therefore, the next section describes the research methods applied by Broadbent and Laughlin and how those methods were applied in this project.

Broadbent and Laughlin (1997) presented the discourse method as a three-stage process. They called the first stage of the process 'formulation of critical theorems', the second 'enlightenment' and the third the 'selection of strategies'. Stage one involves the researchers in spending time within a specific research site in order to understand how the organisation works. These 'understandings', which Broadbent and Laughlin (1997) refer to as 'critical theorems', are then debated among the researchers in order to 'test' them and come to some sort of shared understanding.

The second stage of the process (enlightenment) involves presenting, and in some cases debating the understandings of the researchers with those in the research site. According to Broadbent and Laughlin (1997) the purpose of this process is to challenge and develop the research insights.

The third stage is the response of the researched to the 'enlightenment' process in the selection of some kind of practical response to what they have learnt about themselves and their organisation. Laughlin and Broadbent (1997) recognise that in their own

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[1] It has existed as a working paper since 1995.

work this stage is clearly problematic as it is in the hands of the researched rather than the researchers. While the researchers could act as 'sounding boards', their involvement in change strategies involved them stepping outside of the research role and into a management role, such as becoming part of the school governing bodies.

While Broadbent and Laughlin's (1997) three-stage model provided a useful guideline, it was necessary to modify a number of its aspects to make it relevant to the context of this study. The initial stage of familiarising oneself with the research context and forming the 'critical theorems' was consistent with the method described by Broadbent and Laughlin's (1997). However, because there was only one researcher, it was not possible to discuss the research and develop shared understandings with other researchers involved in the project. What was developed was a process of self-discourse or reflection based on the interviews and discussions. This concept of self-reflection as a research tool is expanded on in Moustakas (1990). The other modification of the three-stage model was the development of external discourse partners. In order to understand the nature and changes in education the researcher established contact with individuals from the local education service centre, College of Education, Ministry of Education and Education Review Office. In health, the researcher met with staff from the Southern Regional Health Authority, Ministry of Health, computer programmers, GP related agencies and public pressure groups. Contacts were developed with GPs and teachers who were unconnected with the research sites, and also with other academics that were interested in health and education. Initially the role of these discourse-partners was to provide background and to clarify issues that arose in the interviews. However, as the study progressed, they critiqued the critical theorems developed by the researcher. The 'stage of enlightenment' also involved discussing insights and understandings with those in the research sites and with the external discourse-partners. These discussions resulted in the development and modification of many of the ideas.

In practice, the third stage in the critical method (the selection of strategies) was difficult to evaluate. Broadbent and Laughlin (1997) acknowledge that the third stage depends upon the researched rather than the researcher. In this project the questions

and suggestions raised by the researcher did engender discussion within the schools and GP practices. However, it is difficult to determine whether there has been any specific response to this research project. While researchers have a privileged position seeing a number of different schools and practices it seems arrogant to argue that their insights as an observer were superior to those of the participants. In this case the process of enlightenment was a two-way rather than a one-way process, with the researcher being changed at least as much as the researched.

To summarise, although the approach adopted was based on the concept of discourse, in practice this had a number of variants. First, it was a process of discourse between the researcher and the participants as the researched. Second there was a related discourse between the researcher and the PhD supervisors in formulating and directing the nature of the study. Third, a number of other people were 'enrolled' as discourse-partners and commented on the research methods, contributed to the background on the New Zealand public sector reforms and described the history and nature of health and education in New Zealand. The contribution of both the research participants and the external parties changed as the project developed from informative to critique. Finally, as it was not possible to develop a discourse process between the researchers involved on the project, a model of self-discourse or reflection (based on Moustakas, 1990) was developed. Initially this was an internal process, but as the project developed this changed into a dynamic relationship between the writer and the text. While this can be seen as an extension of the process of self-reflection, the researcher was forced by the process of write-up to attempt to categorise his insights, to place in a linear form what was fragmented and to summarise different and, in some cases, conflicting voices. The theoretical framework described in Chapter Three provided the basis for this process and was the source of a set of categories to work with.

The next chapter is the start of Section Two, which commences the empirical aspect of this dissertation. As the theoretical and methodological basis of this work is the middle-range model of Laughlin and Broadbent, considerable attention is devoted to analysing the context of health and education in New Zealand. Indeed, Lodh and

Gaffikin (1997) argued that the common feature of critical research is the belief that accounting needs to be considered within a broader organisational and societal context. Broadbent and Guthrie (1992) also saw contextuality as the defining characteristic of 'alternative' accounting research. Therefore, as this thesis is within the critical or alternative paradigm, it is necessary to explicate the social, historical and institutional context of the New Zealand health and education reforms.

The importance of contextual detail is that it facilitates both analysis and comparison. In terms of analysis, contextual material provides the basis for an understanding of the existing institutions and the nature of the reforms. Contextual analysis also makes it possible to develop an understanding of how individuals and institutions respond to and modify the reform initiatives. Without contextual and historical background, the responses may be opaque. Context also provides a basis for comparison. While there were strong similarities between the institutions and the reform in New Zealand and those in the UK, there were also important differences between the UK and New Zealand. By providing a clear description of the New Zealand institutions and the New Zealand reforms, this dissertation provides a firm basis for the international comparative research called for by Broadbent and Guthrie (1992).

CHAPTER FIVE

FORMING AND REFORMING THE EDUCATION SYSTEM IN NEW ZEALAND

5.1 INTRODUCTION

This chapter represents a shift of attention away from issues of theoretical basis and research methodology and towards empirical concerns with the New Zealand education system. Habermas argued that institutions such as schools are the product of social evolution and reflect certain fundamental lifeworld values. However, as these institutions grow in complexity they also develop their own internal lifeworld. They also become subject to outside change forces. Some of these forces are a feature of the environment but some are what Habermas called 'steering media'. Following the work of Broadbent et al. (1991), the education reform initiatives are seen as examples of steering media, with 'colonising potential' from the perspective of the school.

The first section of this chapter provides a historical context to the New Zealand education system and illuminates the key lifeworld values that were involved in the establishment of the institution. It is important to describe the historical development and the pre-reform context because changes are best understood in relation to the pre-existent status-quo. The historical context is also critical in establishing certain key lifeworld values that were challenged by the reform initiatives.

The second section of the chapter describes and analyses the reforms to the New Zealand education system. In the narrative particular emphasis is placed on issues of autonomy, authority, administration and control. In order to simplify discussion the reforms were analysed in four categories. First, the structural changes, second the funding, third the accountability and control arrangements and fourth the quasi-market. The structural changes altered the existing system/steering media arrangements, relocating responsibility for management at the school level. Funding previously located at the centre was directly allocated to the school level, based on

centrally determined funding formula. There were major changes in accountability structures and monitoring arrangements between the schools and the State. New institutions were created to monitor and control school performance. While management responsibility was theoretically located at the school level, the new steering institutions exercised considerable control over finances, procedures, teaching content and teaching methods. The introduction of a quasi-market system was pre-figured in the earlier structural changes; however, it was not until 1991 that schools were granted the power to select their students and therefore compete directly with each other.

5.2 THE PRE-REFORM ERA

The purpose of this section is to illuminate the values and structures that characterised the education system in New Zealand. Formal education in New Zealand is predominantly funded and managed by the State. Access is free as of right (Education Act, 1989, Sec. 3) to students and parents and attendance is compulsory up to the age of 15. Individuals are free to 'opt out' of the State system and to attend 'private schools' however, less than 4% of all students take this option.

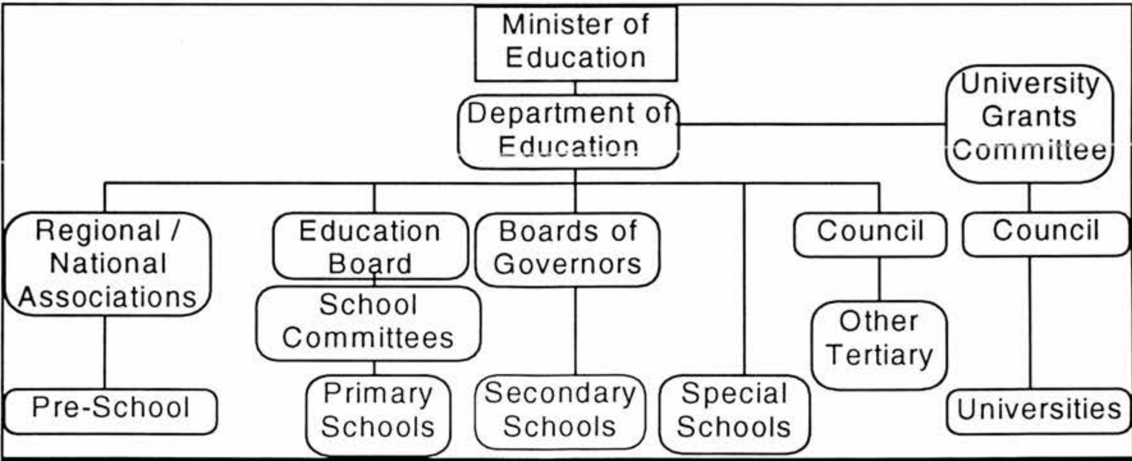
The origin of a formal education system in New Zealand can be found in the initiatives of the first missionaries, particularly the Anglicans, Methodists and the Roman Catholics, to educate and convert the local Maori community (Cummings & Cummings, 1978). With the arrival of the European settlers in the 1850s, the provision of education was extended to include the children of settlers. Where the church was not forthcoming, individuals took responsibility for the establishment and running of local schools (Colquhoun, 1993). With the establishment of a representative government in 1853, education became the duty of the provinces, which established school committees and started to levy the local population to pay for schooling. However, in the 1870s the central government sought to secure control over education. The key argument for this process was that the regional management of education had led to disparity in the quality of provision. By centralising the control it was envisioned that the government would be able to ensure

the uniformity of education provision throughout the colony. The Education Boards Act 1876 and the Education Act 1877 saw the establishment of a Department of Education, ten regional education boards and individual school committees. The Department represented the central government concerns while the regional education boards and the school committees were meant to provide a degree of local control. However, in practice the system became highly centralised (Gordon, 1992b) and the Department of Education effectively dominated the process, a result that was quite intentional on the part of the legislators (Cummings and Cummings, 1978, p. 94). This lead to a highly centralised and highly interventionist system of State education.

> New Zealand's education system has been for many years one of the most centralised in the world. Whilst Britain's system relied heavily on the intermediary role of the Local Education Authorities, New Zealand had only a minimal regional level of organisation mainly focusing on the primary schools and playing a servicing rather than a policy role (Gordon, 1992b, p. 281).

Elementary schooling was the major form of educational provision throughout the nineteenth century. Each school answered to the regional education board which controlled a significant proportion of their funding. As secondary schools developed, they were run by a board of governors. They were not accountable to the local education board but dealt directly with the Department of Education. This structure is shown in Figure 5.1 and is characteristic of the structure of education in New Zealand from the 1890s until it was reformed in the late 1980s.

Figure 5.1: Education Administrative Structure in New Zealand, 1890s – 1980s



(Source: Picot 1988)

5.2.1 Primary Schools

Because they answered to different authorities (see Figure 5.1) there was a clear distinction between the autonomy allowed to primary and to secondary schools in the pre-reform era. In primary schools the school committee was responsible for the day-to-day administrative functions. The committee was elected from (and by) the residents in the area and was responsible for routine administrative matters such as the buying of textbooks and library books, cleaning, heating and the maintenance of buildings and grounds. They were also responsible for matters of religious instruction and out-of-hours use of the school buildings. School committees participated, but did not vote, in the appointment of the school principal and were advised on the appointment of teaching staff although they had no formal authority in the matter. Hiring, firing and discipline rested with the local education board and Department of Education. The Department, through the Educational Services Committee (ECS), negotiated teachers' salaries and employment conditions on a national basis with the primary teachers' union (the NZEI - New Zealand Educational Institute). Within an individual school, teachers progressed through each of three salary scales. This progress depended on a regular assessment performed by the Department of Education (who often worked out of the education board offices). Inspectors were also responsible for checking that the school maintained national educational standards.

Staffing levels were determined nationally but allocated to individual schools at the discretion of the local education board. Salaries were paid to individual teaching staff by the education boards who also handled all other government funding for primary schools. Each board was allocated State funding on the basis of pupil numbers and the types of school buildings in their district. The local education board then had the discretion to allocate the money to individual schools. Once the schools received, or were entitled to spend funds, they were subject to precise and detailed input controls. Individual schools were not allowed to move funds from one area of spending to another. School committees had little option but to accept what they were granted and were unable to vary the spending guidelines established by the education board.

The Education Department funded the purchase of grounds and the erection of school buildings (which were owned by the Crown), while the local education boards were responsible for maintenance. The boards were also responsible for purchasing and providing equipment and teaching consumables for primary schools. The school itself had little say in determining the nature or timing of maintenance contracts. Their only avenue of complaint was to lobby their education board. All matters that required expenditure were referred to the education board and then, if necessary, to the Department of Education. Any reply to the school would be communicated through the education board.

5.2.2 Secondary Schools

As secondary education developed in New Zealand the schools were administered by a board of governors who were elected from parents with representation from teaching staff, students and, in many cases, the local university. Because there were so few secondary schools when the Education Act was drafted in 1877, they were not subject to the education boards. Within the secondary schools the boards of governors had considerable powers and responsibilities. They hired, fired, disciplined teachers (including the principal) and controlled the use of school buildings, although the ownership was vested in the State (Picot, 1988). Most boards had regular contact with the Department of Education, which was responsible for all maintenance and capital works. Boards sought advice from the Department on regulations, training and curriculum and purchases of equipment. The Department also intervened as a mediator in situations of school/school or school/community conflict.

The Department of Education maintained control over funding and teaching within secondary schools. The funding was allocated to the schools along strict budget lines, which gave schools little financial discretion. For example, funds available for textbooks had to be spent on textbooks. If the schools required equipment such as computers or photocopiers they had to raise money from the local community. Teachers' salaries were negotiated annually between the teachers' union (PPTA - Post Primary Teachers' Association) and the Education Services Committee. Individual

teachers progressed along a basic salary scale and schools could promote a teacher to a position of responsibility (PR), however, these positions were awarded to a school by the Department of Education. Once awarded PRs were difficult, if not impossible, to take away from an individual or from the post they filled. Promotions to senior positions (senior teacher, deputy principal and principal) were advertised nationally by the Department of Education although the actual appointment was made by the school's board of governors.

In many areas secondary school councils were established. These councils acted as accountants and secretaries for the board of governors of a number of secondary schools. Although they held the funds for the school and paid most of the bills they had no discretion over expenditure and could only spend the funds as they were authorised by the school or the Department of Education.

The Department of Education maintained control over student access to secondary education and over teaching standards. Most of the secondary schools were subject to a zoning system that required that they accept all of the students from the area specified by the Department as 'their zone'. Education Department inspectorate also inspected secondary schools although there was no inspection of individual teachers as in primary schools.

5.2.3 Lifeworld Implications

One source of values in New Zealand schools were the churches and religious organisations that played an important role in the development of education in New Zealand. It seemed natural that they would have some influence on the nature and purpose of education in New Zealand. Both Laughlin (1984, 1988) and Booth (1991, 1993) argue that churches have a strong and coherent set of values (lifeworld) and maintained that accounting techniques were resisted when they conflicted with these values. Laughlin (1988) suggested that the same coherent value set might also characterise other organisations, particularly those such as schools with historical links to the church.

However, the religious dominance of education provision was over a hundred years ago and since then most primary and secondary schools have been controlled, directly or indirectly, by the Department of Education. While the involvement of the Department of Education would have altered the lifeworld of schools, the Department tended to be staffed by teachers and educationalists and was generally seen as supporting staff within the schools. The 'educational' orientation of the department was reflected in the following statement:

> The Department of Education is basically an educational institution. Its interests as an educator colour the advice it gives to government. If the government asks the department for advice on funding it is like asking a child how much it wants for pocket money. When the government asks the department to set standards for education it is actually asking the Department to check up on itself (Lange, 1987, p. 28).

Between 1877 and 1988, the Department of Education can be seen as the primary steering mechanism concerned with the operation of schools. The 1930s saw the emergence of the social welfare structure in New Zealand, reflecting democratic and egalitarian values. Education was based on the comprehensive ideal and promised equality of opportunity to all children, regardless of where they lived. Within this system the Department of Education became the guarantor of this equality and sought to insure that "wherever people lived they would have access to a school offering the same range of opportunities as any other school" (Gordon, 1996). The Department reinforced the 'educational values' that were considered important within schools, particularly concepts of equality within and between schools, and excellence in teaching (Gordon, 1992). However, many of these values were challenged by the reforms to the New Zealand education system.

5.3 THE EDUCATION REFORMS

The reform to the education system occurred in the context of substantial structural reform in New Zealand. In 1987 the document *Government Management* clearly indicated the intentions of The Treasury to introduce reforms to the education sector. What was particularly notable was the fact that one volume of the two volume briefing papers was entirely devoted to issues of education and was characterised by a

new-right agenda (Lauder, 1987). A major reason for Treasury interest was the size of the education sector. At $3 billion or NZ$1,000 per New Zealander, education was one of the largest enterprises in the country and represented a significant proportion of the annual government expenditure.

Table 5.1: Education Reform - Publication Timeline

1987	*Government Management*
July 1987	Taskforce to Review Educational Administration announced
April 1988	Report of the Taskforce (Picot Report)
August 1988	*Tomorrow's Schools* (Lange)
1989	Education Act
April 1990	*Today's Schools* (Lough Report) review of the education reform
July 1991	*Education Policy*
1993	*Three years on*

The Treasury document, *Government Management*, raised a number of issues and suggestions for change. Education was seen as a commodity rather than a public good, and the Treasury argued that there was little justification for State funding, and even less for State provision of education (Grace, 1990). The Treasury (1987, p. 293) claimed that the costs of specific State interventions in education could be reduced and the benefits increased by following three steps. First, clearly identifying the purpose of State involvement in education and minimising the involvement to what was 'clearly justifiable and cost effective'. Second, the State should support rather than replace the contract between the customer and the suppliers of education by directing funding to individuals as purchasers rather than to institutions as suppliers. Third, when the State must be involved, they should seek methods of management and accountability that 'counter the problems' of their involvement such as clear targets, incentives and sanctions and timely information on performance.

Government Management represented an unprecedented attempt on the part of The Treasury to influence education policy. Although they appeared to have no immediate effect, Grace (1990) argued that The Treasury played an important part in focusing public and political attention and creating a perceived crisis in the state of education in New Zealand. The government's response to this 'crisis' was to establish a number of taskforces to review various aspects of education. This resulted in three published reports: *Education to be More* (1988) (Meade Report) on early childhood education; *Report of the Working Group on Post Compulsory Education and Training* (1988) (Hawke Report) on the tertiary sector and *Administering for Excellence* (1988) (Picot Report) on primary and secondary schools.

As this thesis is primarily concerned with the changes to schools, the discussion is restricted to the Picot Report. There is some evidence of Treasury influence on the Picot findings as one of the committee members complained that the Treasury attempted to hijack the process (Jesson, 1989, p. 123). However, the Picot recommendations were also influenced by educational interest groups (Grace, 1990, p. 184). As a result the report represented a complex mix between new-right ideology and traditional educational values such as equity, equality and cultural sensitivity.

The Picot Report was critical of the 'serious weaknesses' in the existing education system: over-centralisation of decision making, complexity, lack of information and choice, lack of effective management practices and general feelings of powerlessness.

> Effective management practices are lacking and the information needed by people in all parts of the system to make informed choices is seldom available. The result is that almost everyone feels powerless to change things they see needing change. To make progress radical change is now required (Picot, 1988, p. xi).

Three months after the publication of the Picot Report, *Tomorrow's Schools* was released. This set out the policy position adopted by the Labour Government following its consideration of the Picot recommendations. Grace (1990) argued that the recommendations derived from Picot and the policy document, *Tomorrow's*

Schools, were based on five principles:

1. The principle of parent and community empowerment,
2. The principle of efficient school site-management,
3. The principle of strong accountability,
4. The principle of alternative or contestable provision and
5. The principle of local determination of conditions of employment for principals and teachers.

One problem with these principles was that they were internally contradictory. The principle of local management and community/parental empowerment contradicted the principle of strong accountability, particularly when the objective was to strengthen the accountability to the centre. It is also reasonable to think that there might be some resistance to these changes as devolved management and community empowerment ran contra to the values of equality of access and equality of opportunity which had characterised the New Zealand system since the 1880s.

Despite the concerns from the public and the teaching profession the principles in *Tomorrow's Schools* were incorporated in a major revision of the Education Act (The Education Act, 1989 and The Education Amendment Act, 1990) and led to significant changes in the way schools operated. These changes can be grouped into three broad categories: changes in structure of education delivery, changes in funding of schools and changes in modes and requirements of accountability.

5.4 STRUCTURAL CHANGES

A key structural recommendation of the Picot Report and *Tomorrow's Schools* was that local education boards be disbanded and that the Department of Education be replaced by a 'policy only' Ministry of Education. This was implemented via the Education Amendment Act 1990. The support functions of the education boards and the Department of Education were turned into private and therefore contestable

service providers and the new Ministry of Education was concerned only with providing policy advice for the Minister of Education. Other functions of the Department were separated into new 'stand alone' organisations (Parent Advocacy Council, Early Childhood Development Unit, the Special Education Service, Quest Rapuara (The Careers Service), the Education and Training Support Agency, The Education Review Office (ERO) and the New Zealand Qualifications Authority (NZQA). Grace (1990) argued that the elimination of the Department of Education was essentially a political move rather than an educational one:

> The replacement of a mediated relationship between the State and the school by a direct relation raised large questions about exactly who had become empowered as a result. A diffuse collection of boards of trustees and community forums throughout New Zealand was unlikely to constitute a significant power bloc, which Treasury would have to deal with in future struggles over education policy (Grace, 1990, p. 181).

5.4.1 Trustees

In 1990 parents were invited to stand as trustees of primary and secondary schools. The board of trustees also included the school principal, an elected staff member and an elected student. The trustees were the key to the local management of schools in New Zealand and were described in *Tomorrow's Schools* as "the basic building block of education administration" (p. 1). The trustees were legally responsible under the Education Act (1989, Sec. 64) for all of the aspects of the school performance. While the trustees had the freedom to decide how to run the school, they were required to respond to community educational needs and to comply with national guidelines for education. The image of a school managed by the parents was reinforced by a national advertising campaign, which suggested that if parents could manage their child they could manage a school. *Tomorrow's Schools* identified three broad areas of trustee responsibility: staff management, property and budgets. The introduction of trustees represented a more significant change for primary schools than secondary schools as they already had a measure of self-governance.

Staff Management

Boards of trustees became the legal employer of teaching and support staff (Education Act 1989, Sec. 65). With the restructuring of the Department of Education and the wider public sector change brought about by the State Sector Act 1988 (see Boston et al., 1996, p. 204), the centralised staff management arrangements were eliminated. Boards were required to appoint a principal, prepare job descriptions, establish performance agreements and conduct annual performance reviews. They were also responsible for the appointment and appraisal of teaching and support staff, approval of leave, staff development, discipline and review. In practice this work tended to be delegated to the principal. While national awards and salary scales were maintained, trustees were required to advertise nationally for staff and to observe equal-employment-opportunity principles.

The respective role of the principal and the trustees was the source of some confusion and conflict. The Lough (1990) Report argued that this confusion was because their roles were unclear. The report recommended that the board of trustees should be held responsible for the governance of the school while the principal should be responsible for its management.

Property Management

In most cases The Crown retained ownership of school property. However, the responsibility for maintenance was split between the board of trustees and the Ministry's property unit. The trustees were responsible for maintenance that could be expected to occur within a ten year cycle while the Ministry of Education retained responsibility for maintenance beyond that ten year time frame, capital works and damage caused by major vandalism, fire, flood or earthquake.

Financial Management

Funding for State schools was calculated on the basis of nationally determined formulae. Funding was made directly to schools as a bulk grant, with the exception of

teachers' salaries, which continued to be administered by the Ministry of Education.[1] Responsibility for managing the allocated funds and approving a budget prepared by the principal and staff rested with the trustees. Although the trustees were not liable for a 'loss in good faith' they could be personally liable for fraud or wrong-doing (Education Act 1989, Sixth Schedule, Sec. 4). The board was also responsible for the preparation and audit of the school's accounts.

5.4.2 Community Education Forum

Although the institution of locally elected Trustees was one step towards the objective of community empowerment, the Picot Report also proposed that community education forums be established. These were intended to provide an opportunity for the views of the community to be brought together on matters of educational importance. Picot (1988, p. 54) outlined five objectives of these forums. To:

- Identify and gather together the views, both professional and consumer, of all educational sectors on issues of importance.
- Identify and gather views within sectors.
- Discuss and, if possible, settle local conflicts of interest.
- Discuss policy initiatives proposed by the Ministry and provide feedback on these to the proposed Education Policy Council (later called the Parent Advocacy Council).
- Initiate policy ideas to be considered by the Education Policy Council.

Most of Picot's ideas on community education forums were incorporated in *Tomorrow's Schools*. The result was a strange mix between community empowerment and central control. While the forums were to be set up by the community, the appointment of a convenor was the responsibility of the Minister of

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[1] The issue of how these budgets were calculated is discussed later in this chapter (5.3) and in Appendix 4.

Education.

5.5 FUNDING

As suggested earlier, an important part of the initiative was the shift from indirect funding through the Department of Education and the education boards to direct funding of the schools. Under *Tomorrow's Schools* it was planned that all funding would come to the schools as a bulk grant, but with two distinct components: one for teacher's salaries and one for operational activities.[2]

The teaching salaries grant was calculated by the Ministry and was based on national standards for staffing (with some recognition for a particular institution's needs). Each school would have some leeway on the number of teachers and their levels of experience (and therefore the rate they were paid) although a national award system for salary levels and employment conditions was still maintained at this point. This was negotiated between the State Services Commission and the teachers' unions[3]. It was proposed that the funding associated with salaries would be passed directly to the school as a 'bulk salaries grant'. However, this was strongly resisted by the teachers and the teacher unions, who argued that the devolution of salary funding to schools would constitute a first step in the breakdown of national salary agreements, and would put pressure on schools to cut salaries or increase class sizes (Gordon, 1992b, p. 285). Because of this resistance the payment of teaching staff salaries remained the responsibility of the Ministry of Education (Education Act 1989, Sec. 89).

The operational grant covered administration, ancillary support, maintenance and non-salary aspects of teaching. It was calculated on the basis of a nationally (Ministry) determined formula. While direct funding was a new experience for primary schools, the major change for the secondary schools was that the grant was not broken down into specific categories of expenditure. Trustees and teaching staff within the school

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2 These are discussed in more detail in Appendix 4.

3 New Zealand Educational Institute (NZEI) and Post Primary Teachers' Association (PPTA).

were responsible for budgeting and managing the grant. Each institution was free to establish its own priorities and to transfer funds from one area to another. The other major change was that schools became allowed to 'purchase' services from whoever they chose rather than being under compulsion to purchase from an education board or from the Ministry.

Tomorrow's Schools suggested that the funding formula needed to be "sensitive to the varying needs of different institutions in different areas, and weighing for equity considerations and the particular costs of running rural schools" (Lange, 1988, p. 12). Based on these concepts, the main formula components for the State schools were as follows:

- Base funding - a 'fixed' funding component to help smaller schools who did not have many students. This fixed component disappeared as student numbers increased.
- Per pupil funding - this was allocated at four different rates to reflect the respective costs of different class levels.
- Special education pupils - this was based on two different rates to reflect the respective level of student need.
- Equity funding - where schools were located in low socio-economic status areas they could apply for special 'equity' funding. In September 1994 the basis for the equity grant changed. It was renamed targeted funding for educational achievement (TFEA) and was allocated by the Ministry on the basis of a ranking of socio-economic factors deemed by the Ministry to indicate social deprivation.
- Remoteness grant - based on the location of the school.
- Vandalism - allocated in five categories, low to extreme.
- Maori language factor - this was based on the Maori language courses offered in the school. In 1994 this changed to the number of Maori students on the school

roll.

- Maintenance - based on property measurement.
- Heat, light and water - based on average costs.
- Minor capital works - based on property measurements.
- Relief teacher funding - based on staff numbers.
- Other funding - to recognise attached units, transition, link or community education programmes.

(Based on Ministry of Education circulars 1994/25 and 1994/26).

Although *Tomorrow's Schools* suggested that schools would be able to move funds between the teaching and the operating grant this has not occurred. Schools are not permitted to use their operational grant to employ additional staff without approval from the Ministry (Education Act 1989, Sec. 80).

5.6 ACCOUNTABILITY AND CONTROL

The 1989 educational reforms represented a major change in accountability structures and relationships. Within the Picot Report and in the subsequent *Tomorrow's Schools* policy document there was a clear concept of school accountability to the local community in general and to parents specifically. While this did take the form of locally elected trustees and community education forums, the focus actually shifted to accountability to the State and to the new State institutions established in the wake of the old Department of Education. The key element in the new accountability relationship was the school charter.

5.6.1 School Charters

The preparation of a charter was the task of the boards of trustees (in collaboration with the principal, the staff and the community and within the national guidelines). The objective of a charter, as stated in both the *Picot Report* and *Tomorrow's*

Schools, was to:

> . . . define the purpose of the school and the intended outcomes for students. It was also to define the ways in which the school's programmes would take account of the particular needs of students and potential students, the special skills and qualifications of staff, the resources of community and the particular needs of community (Lange, 1988, p. 3).

This task proved to be both controversial and problematic. In the *Picot Report* and *Tomorrow's Schools*, the charter represented both a partnership between the school and State and between the school and the community. By the time the Education Act 1989 was passed through parliament the concept had changed to that of a contract:

> . . . every charter has effect as an undertaking by the board (of trustees) to the Minister (of Education) (Education Act 1989, Sec. 64).

The charter was reinterpreted as a contract for the supply of educational services between education providers (schools) and education purchasers (Minister). Little freedom was given to trustees in drafting the charter as over 80% of the content was determined nationally. Gordon (1992a) argued that educational groups significantly influence the implementation of the reforms through the national charter requirements, much of which related to equity issues and effectively placed restrictions on competition between schools.

Tomorrow's Schools required that the board of trustees report regularly to the community on the objectives of the institution's charter and on how well the objectives were being achieved. They were also expected to inform the community of educational achievements of the schools as a whole. However, review of the performance of the board and the school was not the responsibility of the community but of a 'review and audit agency'.

5.6.2 Educational Audit

It was originally intended that the monitoring organisation would be called the Review and Audit Agency but was renamed as the Education Review Office (ERO). Although the ERO was a new organisation it adopted some of the responsibilities of

the old 'school inspectorate' system that existed under the Department of Education, particularly the performance monitoring and reporting role. *Tomorrow's Schools*, (p. 21) indicated that the role of the ERO was to:

> . . . hold institutions accountable for the government funds that they spent and for meeting the objectives set out in their charter.

Within an agency theory perspective, the ERO provided a monitoring mechanism to ensure that schools fulfilled their charter (contractual) obligations. The ERO answered directly to a Government Minister (the Minister responsible for the Education Review Office) and reviewed both school and trustee performance. Each school was subject to biannual audits (not so frequent now - about twice in five years) from the ERO. The proposal for the formation of the ERO was another curious mix of the managerial and the educational. The monitoring role of the ERO was clear and explicit, however the ERO was also meant to help a board to meet their own objectives and to assist the board to review their own performance.

Although it was initially unclear what form the ERO reviews would take, they developed a review methodology with two distinct types of review: the assurance-audit and the effectiveness-review (Education Review Office, 1995a). The assurance-audit evaluated the compliance of schools and trustees with legislation, ministry regulations and specific undertakings contained in the school charters. Schools were required to respond to issues raised by an assurance-audit within 15 days of receiving the report and to outline the actions they had taken or planned to take to correct the unsatisfied requirements (Education Review Office, 1995b). Both the report and the responses were sent to the Secretary for Education, the Minister of Education and were released to the public.

The effectiveness-review attempted to identify what achievement and progress of students is related to the activities of the school. It was based on the concept of 'value added' which attempted to measure what a student learned from the programmes provided by the school. An effective school was one that can provide 'demonstrable evidence of the value of education to the child'. In order to provide

this evidence teachers were required to explicitly measure and quantify many aspects of student activity and to match the assessment to specific learning objectives (Education Review Office, 1995c). This process illustrates the NPM ideals of (a) explicit standards and measures of performance and (b) greater emphasis on output controls.

5.6.3 National Guidelines for Education

The national guidelines provided an important mechanism for the State to specify particular aspects of education and for translating central policy into local reality. In many ways this was no different from the edicts that emerged from the pre-reform Department of Education. *Tomorrow's Schools* (p. 26) described the national guidelines as:

> The means of setting, maintaining and developing national standards of achievement in education, and will be an expression of matters of national interest. The national guidelines will set the parameters within which each individual institution will work.

The nature of the national guidelines is already evident in the discussion of the formation of the school charters. However, guidelines were also issued covering areas such as codes of conduct for trustees and principals, expressions of the principle of equity as the underpinning of educational administration and details of national curriculum objectives. The obligations within the national guidelines have equivalent force to the obligations within a specific school charter. However, the most significant of the guidelines have been the national curriculum requirements.

5.6.4 National Curriculum

Within *Tomorrow's School* the establishment of national curriculum objectives was retained as a responsibility of the Ministry of Education. The actual development of the curriculum tended to be 'contracted out' by the Ministry to teachers and educationalists. They have produced (or are developing) "curriculum guidelines" for the "seven essential learning areas" (languages, mathematics, science, technology, the social sciences, the arts, health and physical well being). These guidelines standardise

the curriculum taught in New Zealand schools and specify the achievement aims and the objectives for learning. All schools are required to comply with the guidelines.

5.6.5 National Qualifications Framework

Together with the reform and standardisation of curriculum came the establishment of a unified, national system of qualifications. The government policy document *Learning for Life* (Ministry of Education, 1989) and the Education Amendment Act (1990) saw the establishment of a single qualifications authority with responsibility for all nationally recognised qualifications - the New Zealand Qualifications Authority (NZQA). NZQA adopted the assessment and qualifications activities of the Ministry of Education and other vocational, trade and academic qualification authorities.

NZQA have established a modular qualifications and curriculum structure known as the 'national qualifications framework'. Unit standards were established by the NZQA for a wide range of academic and vocational topics. Institutions were accredited (or registered for private institutions) with the NZQA as suitable to provide courses based on the requirements of the unit standards. Students could study the courses provided by the accredited institutions and their results were recorded on the NZQA national database. Once students received sufficient credits (regardless of where they are taught) they were eligible for a national certificate or diploma. This enabled a modular approach to education (courses provided in one institution provide the basis for courses elsewhere), with complete transferability of all qualifications under a standardised national qualification system. All unit standards and qualifications were assigned a difficulty level. This was an eight-point scale that ranged from secondary school training at grade 1 to post graduate university qualifications and degrees at level 8.

Because the first four NZQA grades were taught within secondary schools NZQA had a significant influence on schools. Schools had to gain accreditation from NZQA and adjust their teaching curriculum to comply with the unit standards defined by NZQA. Although the existing school qualifications were still in place, NZQA planned to phase them out by 1997. To maintain their accreditation schools had to participate in a

moderation system to ensure that the standards were being applied consistently and that comparability was achieved with other providers. All accredited organisations were also subject to review from the NZQA and needed to be re-accredited after a period of 2 to 5 years.

New student performance measures were the product of both the curriculum changes and the NZQA framework. As students could move between different institutions, measures of individual performance become more formalised and more explicit. This became necessary in order to develop the comparable 'building blocks' of the national qualification framework. As schools were required to apply for accreditation from NZQA, they were also required to comply with the measurement system.

5.6.6 Accounting Control and Performance Measurement

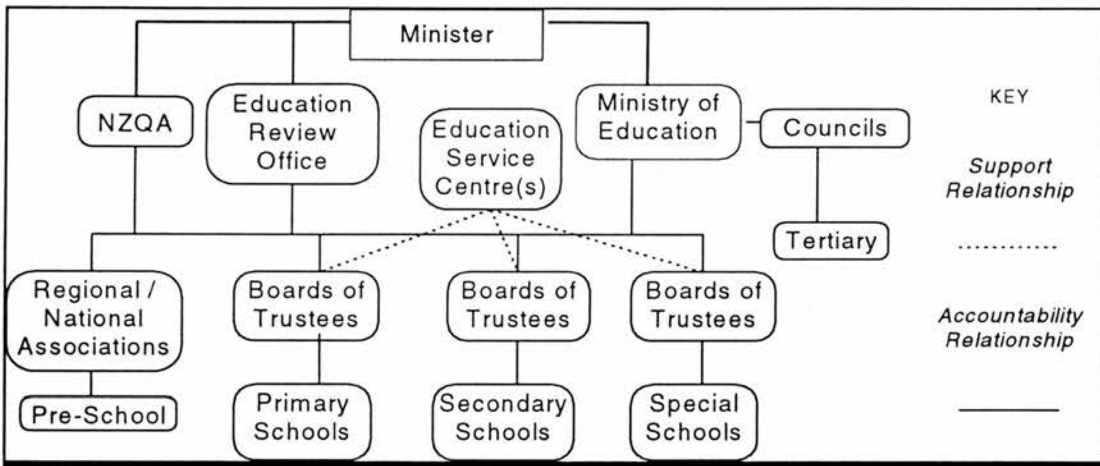
Many of the former education boards were restructured into private companies known as 'education service centres' and a number received direct government funding to assist in this transition. It was expected that the education service centres would provide the schools with financial and property services, recreating the administrative 'safety-net' previously provided by the Department and the education boards. Broadly the education service centres compete for contacts from the schools. Individual school boards could choose whether nor not to pay a service centre (or anyone else they chose) to manage the accounting responsibilities and to provide administrative and secretarial services to the trustee meetings.

Under the Education Act 1989 and the Public Finance Act 1989 each school is required to prepare annual financial statements for the Crown. These financial statements must include the standard private sector statements of accounting and the public sector 'statement of service performance'. Under section 84 of the Education Act 1989 the financial statements and the school financial management system are

subject to audit by Audit New Zealand.[4] The audit report comments on school compliance with the Education Act 1989 and the Public Finance Act 1989 and whether the statements fairly reflect the financial state of the school.

The changes proposed under Picot, accepted by the Government under *Tomorrow's Schools* and legislated under the Education Act 1989 represented perhaps the most significant change ever to the administration and delivery of education services in New Zealand. The structure of education in New Zealand subsequent to these changes is shown in Figure 5.2.

Figure 5.2: Post-Reform Education Structure in New Zealand



(Source: Picot 1988).

5.7 THE QUASI-MARKET

In 1990 there was a change in government from the Labour to the National Party. Generally the National Government endorsed the earlier structural reforms of education and most of the alterations made by the Labour Government remained. In their 1991 budget document - *Investing in People: Our Greatest Asset* (Smith, 1991) the new Education Minister commended the reforms, particularly the national curriculum structure and the NZQA national qualification system. However, he did

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[4] Often this audit process was delegated to local accounting firms who contracted with Audit New Zealand to provide this service. Audit New Zealand were also interested in receiving copies of the school accounts as they were

signal his commitment to a new-right agenda by cutting the community empowerment structures such as the parent advocacy and the community forums, which he considered to be an 'unnecessary layer of bureaucracy'. The 1991 Budget also reduced the funding to the new central agencies (ERO, Quest Rapuara, Special Education Service and the Ministry) and indicated the political support for 'bulk funding' of all teachers' salaries to the schools. The first step in the introduction of 'bulk funding' for all salaries was the devolution of the funding for relief (supply) teachers to schools from 1991 and the funding for 'management' staff (principal and deputy principal) salaries from 1993. The Ministry document *"Three Years On: The New Zealand Education Reforms 1989 to 1992"* (Ministry of Education, 1993) and the government discussion document *Education for the 21st Century* (Smith, 1994) did not represent a significant change in policy.

The most dramatic change following the election of the National Government in 1991 was the introduction of a quasi-market in education. Upon their election the National Party made it clear that their aim was to "make schools more like businesses" (Gordon, 1992a, p. 288). So while the Labour reformers were unwilling to take the final steps towards competition and markets in education, those steps were taken by the subsequent National Government. Gordon (1992b, p. 289) argued this very point, suggesting that:

> The Picot reforms in education set up a system amenable to neo-liberal market education reforms: they provided, as it were, the necessary but not sufficient conditions for a market education ... The National Government, over the past 18 months, has attempted to progressively remove all emphasis on equity in education, and it put in its place a full market system.

Under the 1991 Education Amendment Act home zones were abolished and enrolment schemes were only put in place when the school was at a serious risk of overcrowding. Hughes et al. (1996, p. 4) describe how the zoning policy operated and how the 1991 Education Amendment Act made so much difference. Before the *Tomorrow's Schools* reforms, the Department of Education granted a geographical

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consolidated into the National Accounts for New Zealand.

zone to each State secondary school in New Zealand. All students who lived within that zone had the right to attend their local school, and the number of out of zone students was limited (McCulloch, 1990). Following *Tomorrow's Schools* a maximum roll was set for each school. Local students (from the home zone) had priority; however, out of zone applications could be accepted up to the maximum roll number. Where there was excess, out of zone enrolments were decided by ballot. This legislation was only in place for one year before it was replaced by the Education Amendment Act 1991. In 1992 home zones were abolished and local students were no longer guaranteed attendance at their local school. Schools that were at risk of overcrowding could operate an enrolment scheme. These enrolment schemes set a maximum number for the school (negotiated with the Ministry of Education) and selection procedures were left to the discretion of the individual school. Therefore popular schools could accept students from any part of the city (and therefore maximise their funding and staff entitlement) and could select for academic achievement (and maximise their perceived success). So the New Zealand education system was transformed from norms of co-operation and consensus to models of market and competition. Market and competition principles represented a fundamental challenge to the core values of equity and equality which had characterised the New Zealand education system.

The structural changes of the Labour Government eliminated the institutional power of the Department of Education and diluted the educationalist voice in the policy process. As indicated by Broadbent et al. (1991) steering media become embodied in governmental and professional institutions. It seems clear that there was a strong relationship between the values of the Department of Education and those fostered and developed within New Zealand schools (Gordon, 1992a). This relationship was clearly recognised by those that wanted to restructure the education system. Forms of financial measurement and control came to replace many of the direct controls that existed under the pre-reform Department of Education, transforming the accountability arrangements in the schools from socializing to individualizing forms of accountability (Roberts, 1991). These controls were reflected in the financial

accounting reports each school had to prepare and submit to the Ministry of Education. At a structural level, new forms of financial and administrative visibility were contracted through the process of audit and review initiated by the Audit Office, ERO and NZQA.

Within the quasi-market reforms of the National Government in 1991 the schools were constructed as separate and competing education providers. The role of the principal teacher was restructured as a 'Chief Executive' who must attract students in similar or increased numbers year after year to retain government funding and existing teaching staff. As New Zealand schools were granted more autonomy than virtually any other country (OECD, 1994), the accounting control gained new significance in monitoring the decentralised decision-making and the quasi-market. Schools were given complete control over their budgets and funding (with the exception of teacher salaries and some capital development). They could buy services from the private sector, borrow money and fund capital development.

5.8 SUMMARY

This chapter has provided the contextual aspect of a middle range analysis of the New Zealand education reforms. While there have been accounting and accountability changes, these have not been abstracted from the changes in structure, in curriculum and performance measurement. As such the schools did not experience the accountability changes separately from the other reforms and their response to them was influenced by their organisational and historical context.

Based on Laughlin and Broadbent (1993) the New Zealand education reforms had colonising potential. As such they were an attempt to regulate behaviour within the schools and challenged core lifeworld values of equality of access and co-operation. Within the Laughlin (1991) pathways rebuttal was not a serious option as the change was imposed via Government legislation. The individual schools lacked the political influence to reverse government policy and the restructure of the Department of Education into a Ministry meant that rebuttal would receive little support from that direction. Clearly it was possible that the schools could adopt an evolutionary

pathway. However, the reforms were not developed through a process of discourse involving teaching staff but were imposed upon the schools.

Based on the empirical studies of UK education reform described in Chapter Three, one could expect that the reforms would lead to the re-orientation pathway, as schools altered their structural arrangements in order to protect core lifeworld values. Broadbent et al. (1992a, 1993) and Laughlin et al. (1994a) found that this re-orientation process focused on the activities of a small group of actors who absorbed the financial and administrative responsibilities of LMS and protected the 'real work' of the schools. However, they also warned that a small group established to absorb change could also become a change agent and shift the school from a re-orientation pathway to a colonising one. This issue is explored in the next chapter in the context of an empirical study of four New Zealand schools.

CHAPTER SIX

AN EMPIRICAL REVIEW OF CHANGE EFFECTS ON FOUR SCHOOLS

6.1 INTRODUCTION

The school case studies presented in this chapter provide the empirical 'flesh' to the 'skeletal' Laughlin-Broadbent theoretical framework (Laughlin, 1995). Both Broadbent et al. (1993) and Laughlin et al. (1994a) suggested that the orientation of the head teacher to their new responsibilities was key in determining how the LMS (local management of schools) reforms affected individual schools. However, it is necessary to explore how the schools and the staff responded to the changes in a particular organisational context. This chapter seeks to explore whether these findings can also be 'fleshed out' in the context of the New Zealand schools studied.

There are three main sections within this chapter. The first sketches the organisational context of four schools studied and the second analyses how the schools were affected by the restructure of the New Zealand education system outlined in the previous chapter. The third section of the chapter presents an analysis of the case studies and reflects on whether the schools fitted the Laughlin-Broadbent model of change pathways, absorbing groups and dominant head teachers.

The changes described in the previous chapter, particularly those directly affecting the operation of the schools can be seen as a potential threat to the autonomy of teaching staff and an intrusion to the organisational lifeworld. The new financial and administrative responsibilities were a significant change to the way schools operated and had evident colonising potential. Previously the education boards, the secondary schools councils, or the Department of Education managed most of the financial responsibilities. However, with the closure of most local support mechanisms or steering media, the administrative and accounting tasks previously undertaken by the State became the direct responsibility of the schools, particularly the management of

property, finance and personnel. There were also new accountability requirements associated with devolved local management, which introduced new steering media or design archetypes into education institutions. Schools were expected to prepare regular accounting and budgetary performance reports. Regular audits, both financial and performance, were also initiated, placing a strong emphasis on system and documentation and creating new levels of visibility for school activity.

When this study began in 1993, the schools had already started to adjust to the changes; they had elected their second Board of Trustees, they were no longer exempt from producing financial statements and the Education Review Office (ERO) had started reviewing school performance. It was clear, from the newspapers and from talking with parents, which schools were considered 'successful' and which were 'failing' in the quasi-market environment.

6.2 SCHOOL 1: MATAI

6.2.1 Profile of the school

Matai was a coeducational contributing state primary school, which was built in 1945. It was located on the poorer side of Christchurch where much of the local housing was developed in the late 1940s and early 1950s as state rentals. In the past forty years the neighbourhood became increasingly industrial with the drift of people to the suburbs although there are still a significant number of state and private tenants in the area. Many of these tenants were solo parents and there was a higher than average number of immigrants, Maori and Pacific Islanders. The area was one of the poorest in New Zealand and had a high level of unemployment (12.5% compared to a 6% national average). Many of the local families did not have a telephone or the private transport that would be the norm in most New Zealand homes.

In 1993 Matai had a roll of 177 students and 15 teachers. The proportion of Maori and Pacific Island students within the school was significantly above the average for other schools in the city. Under the quasi-market arrangements Matai found it difficult to attract and hold students and they experienced an unusually high student

turnover (over 65% in one year). An unusual feature of the school was the special unit, which serves the surrounding primary and intermediate schools.

The school facilities were a combination of pre-fabricated classrooms and 'old style' wooden buildings. During 1994 there was a major redevelopment of the school environment. A majority of the school buildings were relocated, new grassed areas were established, a number of trees and shrubs were planted and a new adventure playground was installed.

Many of the students in the school had social and learning difficulties. The teaching staff suggested that 30% of the children had problems and 10% had acute problems, compared to 4% internationally. The teachers argued that the main cause of these problems was a lack of parenting skills:

> A lot of the parents don't care about their children's education. Their parenting is an example of the blind leading the blind. Many of them were outcasts, they don't have the necessary skills and have no idea about how to bring up kids (Teacher Matai, June 1994).

Interviews were conducted with teachers, trustees, the Principal and support staff within the school between September 1993 and December 1995. The key contact and informant within the school was the Principal.

6.2.2 Responses to the education reforms

When the *Tomorrow's Schools* changes were implemented the Principal at Matai was nearing retirement. He suggested that the major effect of the reforms was to change his role. Between 1991 and 1993 he had absorbed most of the administrative and financial responsibilities that had been passed to the schools from the Education Board and the Department of Education. He felt that because of his administrative workload he could no longer provide effective pastoral and curriculum support:

> The administration responsibilities now take up much of my time. Principals should be responsible for the development and implementation of curriculum and for looking after the welfare of students and teachers. Once I had the time to get to know each of the kids personally, but now the administrative

> responsibilities take up 95% of my time. I only have 5% to devote to curriculum and welfare issues (Principal Matai, October 1993).

The Principal retired at the end of 1993 and his successor was appointed at the beginning of 1994. The new appointee recognised that the school had problems and that he needed to change the way the school operated.

> But I do enjoy the challenge of the position. It has been difficult because there are existing systems and ways of doing things. But over time I will organise things my way. I think that I have a more democratic style that the previous principal (Principal Matai, April 1994).

The administrative workload was particularly acute during 1994 because of a major redevelopment of the schools' physical environment.

> As Principal most of what I do now has little directly to do with the school. I have to deal with all sorts: today there was an engineer, an architect, an electrician and a plumber (Principal, Matai, April 1994).

There were also problems with the election and the operation of the Board of Trustees, which made delegation to individual trustees difficult. Few parents within the school were willing to stand as trustees and those that were elected were unreliable in their attendance. The Board secretary was nearly removed from her position for missing three meetings in a row. Most of those who were elected as trustees were unemployed or were on government benefits and did not have the professional or managerial skills of parents from more middle-class areas.

Initially there was not a good relationship between the trustees and the teaching staff. The trustees tended to be reticent in dealing with complaints and legal challenges to the school and relied heavily on the Principal who carried much of the direct responsibility for the finances and the property management. However, the Principal encouraged the trustees to contribute what they could to the operation of the school.

Over the period of the study certain trustees responded to the encouragement from the Principal and began to take an increasingly active role in the school, providing secretarial/administrative support and working as teacher aids in the classroom.

Turnover in trustees was significantly reduced and the constant contact between the trustees, the teaching staff and the Principal meant that much of the Board work was conducted on an informal basis.

> We all know each other and we get on well. Our last Board meeting took 47 minutes. It is good. Mind you, I see X the chairperson every day. She comes in here - so we actually pre-empt a lot of the business. We virtually made a decision - not just her and I, as the other trustees are here too and we are talking about it, so when we actually get to the meeting there is very little to decide. Which is good. Also I see X every day we sit down and have [a talk]. I deal...with [X] the Chairperson and she contacts the others and it works really good (Principal Matai, September 1995).

The Principal actively encouraged board members to take the responsibility for co-ordinating school fund-raising activities and actioning board decisions. All of the trustees who were elected in 1993 stood for a second term at the 1995 election. An additional trustee was elected to the Board who took some of the responsibility for the school property.

> The man who got on to the trustees, I am starting to feed him more of the property issues - which is good. I am probably still over-viewing the area but I am getting him to do more. Like saying "You go and find out what painting needs doing and you go and ring up engineering firms and get quotes". It is also helping him because he feels that he is doing something. We have just put him in charge of the school alarm system and he is feeling really good about his new responsibilities (Principal Matai, September 1995).

The Principal delegated some of the day-to-day financial responsibilities to the school secretary. In addition to her existing responsibilities she collected money from the students, banked all cash received, paid and coded the invoices. However, accounting details were not entered on a school computer but were sent to an external accountant for processing.

The teaching staff suggested that they were not directly affected by the new administrative responsibilities. However, they did notice that the Principal was unable to provide the same levels of curriculum, teaching and pastoral support.

> Because of the administrative load we have effectively lost a teacher. We used to get curriculum release time from the Principal to allow us to develop

> resources. That's gone now. There are 10 to 12 curriculum areas to deal with. In a large school you can share that out but in a small school you have to deal with more than one area (Teacher Matai, October 1994).

> We also spend a lot of time doing social work. One girl's sister got raped a few days before. You can't send them down to the Principal like you used to - he is too busy with administration (Teacher Matai, October 1994).

The loss of the curriculum support provided by the Principal was an important issue because of the changes to the national curriculum. Within the primary schools teachers had to remain conversant with all of the changes rather than just one or two specialist areas. In order to ease the burden on the teaching staff the Principal decided that the school would focus on just one of the curriculum areas each year.

> We are doing one every year. Last year maths and this year science. We are doing the same as any other school. Some schools like to do two or three a year but we are just doing one. Next year language is our main area. I have planned it right through to the year 2000. Because this year science was the main one, the staff had 24 science days. I sent the whole staff onto courses, which cost the school heaps. I also gave the staff two days to do their personal courses. Next year they will all go on language courses. Poor schools can do planning just like big flash schools too you know (Principal Matai, September 1995).

Throughout the first two years of the study, Matai was in a perpetual state of financial crisis. The budget for the school was approximately $155,000. The Principal described money as the biggest problem for him and for the school. In order to 'balance the budget' he had to lay-off two cleaning staff and two teacher aids. However, the school still overspent their 1993 funding and expenses were carried forward into the 1994 year. During 1994 a team from the Ministry of Education came and investigated the school's financial deficit. They checked through the school spending and found that the cuts that could be made had been made and there were no more areas of spending that could be reduced. The Ministry of Education offered to loan the school the difference but the trustees and staff were not happy with this solution. They said:

> They expect us to make a profit, but the school is not about making profits. Money is seen as the real issue by the political powers. We want to offer the

> quality of education that they can offer in the richer parts of the city (Teacher Matai, October 1994).

The major problem within the school was the lack of local funding. In other parts of the city it was possible to raise a significant amount of money from the parents and the local community. However, this was not a serious option for Matai because most of the parents were quite poor.

> We have 120 families in the school. The school donation was only $21 but only 12 people paid. We set up a swimming programme. We couldn't afford to keep the school pool. We were going to use the money saved to subsidise professional lessons by 50%, which would cost parents $20 for 10 lessons. Only 40 kids out of 170 went swimming. Other kids can go swimming but ours can't. $60 for my three kids is not feasible on a benefit (Trustee Matai, October 1994).

> I don't know if you read in the paper yesterday about the school. It received a glowing report from ERO and is doing everything well but because of a high population of low income families they just can't get the money and now they have got a deficit of $12,000. The community was too poor for fund raising — they had even been doing their own lawn mowing and stuff. We are just as poor like that too. We just get the basic amount of money. It's hard to get more (from parents). Our school fees are only $15 and we got more this year than we have ever had. We have only got 20-30 families who have actually paid (Principal Matai, October 1994).

In 1994 the Ministry also threatened to cut the teaching resources in the school. Historically the special unit had provided services to both private and state public schools. However, the Ministry of Education chose to recognise only the state enrolment for staff entitlement, effectively ignoring 25% of the load of the unit. On this basis the staffing entitlement for the special unit dropped by two. The Principal was forced to stop providing the service to private schools because of the way the staffing entitlement was calculated.

> The private schools had been coming here for a very long time, they were very good clients. Last year we had nine hundred children using the attached unit but two hundred and fifteen were from private schools. As far as the Ministry were concerned they were ghost children. I had to tell them all to go, we felt awful but we had no choice because they weren't being counted. Now we have got more state students in (Principal Matai, September 1995).

By the end of 1995 there was a general improvement in the situation facing the school. There was an increase in staffing entitlement, the ERO report was positive and the government funding was increased. First, the Ministerial Reference Group (MRG) released their report *Resource Entitlement for School Staffing* which recommended a complete restructure of existing staff entitlement ratios. While the general teaching did not receive additional regular teachers the attached unit got two more. Second, the Education Review Office (ERO) report on Matai said that the school was making good progress towards meeting the Board's priorities for the development of basic skills and commended the quality of the teaching and teaching staff. The Principal saw the review as a positive statement on the school as a whole.

> We actually got a good report. It said we were doing everything within our power. It was a bit like the Ministry review - they realised our difficulties because of our area. We are on the decile rate, from 1-10 we are 1, which is really low. Under the problems we have got, we were doing well and ERO went round and were very pleased with the teachers. Their only concern was that there wasn't an overall review of the school but we have fixed it this year. We have got school reviews going. So it was a good report - the teachers were doing their job, the Board were doing their job and I seem to be doing my job (Principal Matai, September 1995).

The third major improvement was in government funding. A number of schools throughout the country were entitled to additional or special funding. The most significant of these grants was called the equity-fund, which was available where schools had a high proportion of students with 'cultural and social learning disadvantages'. In 1994 the Ministry of Education reviewed the Equity Fund and renamed it Targeted Funding for Educational Achievement (TFEA). Previously schools had qualified for funding by writing to the Ministry and making a case for the needs of their school. Staff at the Ministry argued that allocation of the TFEA funds should be based on the needs of the area and not on the persuasiveness of the Principal. The Ministry of Education selected a number of factors that they thought related to poor socio-economic status and consequential lower educational achievement. Schools were placed in one of ten different bands based on the socio-economic data for their local area. Funding grants were made to schools in the

bottom three bands, staggered so those which were classified in the bottom band received the highest grants.

Matai was assessed in the lowest banding and received the full TFEA funding, much of which was used to subsidise activities such as drama, school trips and swimming where many parents would be unable to pay even nominal charges such as $1 or $2 per child. The Ministry of Education was directly involved in setting spending guidelines for Matai for the 1996 year. The Principal was hopeful that he would at least 'break-even' and possibly put some money aside for maintenance.

> We haven't been able to do maintenance, just to survive has been the goal. But next year with a bit of careful planning and a bit more money from the Government, we should be able to start putting some money aside, touch wood, unless something major blows up and I have to spend it on that. Being a Scotsman, I like to be able to put something aside, we haven't been able to so far (Principal Matai, September 1995).

6.2.3 Summary

When interviews began, Matai was in a state of financial and administrative crisis. The principal was trying to cope and saw the new responsibilities as a distraction from his true role in pastoral and curriculum support. He had absorbed many of the financial and administrative tasks and was typical of what Laughlin et al. (1994a) called the absorber soaker-sinker type of headteacher. Laughlin et al. (1994a) suggested that the absorber sinker-soaker type was placed under a lot of personal pressure by the changes and sought to insulate the staff and the students from the reforms. In summary this kind of approach was destructive for both the school and for the individual as the individual tends to burn out and often left the education system, while the school lost pastoral and curriculum leadership from the principal who was forced to spend much of he/r time on administrative tasks.

The new principal intended to delegate more of the responsibility associated with the implementation of the reforms. Initially this did not prove possible because of the redevelopment project and because of the lack of professional and managerial expertise within the Board of Trustees. He addressed this issue by developing a

number of the more committed trustees into a support group. The interesting fact about this support group was that while the trustees did assist with the administrative and the fund-raising activities, they also became directly involved in the school as teacher aids. This arrangement did not neatly fit any of the 'absorbing' models described by Laughlin et al. (1994a) as the trustees were not carrying the financial or administrative responsibilities or 'protecting' the school from change but were directly involved in the education delivery.

Another interesting feature of Matai was the direct involvement of the Ministry of Education. The financial crises within the school brought it to the attention of those within the Ministry who monitored the school budgetary system and financial arrangements. The direct involvement of the Ministry was welcomed within the school as the financial situation was seen as a central rather than a local issue. The transfer of financial responsibility back to the centre and the additional resources from the centre was an important part of the recovery of the school.

6.3 SCHOOL 2: DEANS SCHOOL

6.3.1 Profile of the school

Deans was a coeducational contributing state primary school, situated in an exclusive suburban area in the north of Christchurch. It was considered a wealthy suburb and the property prices in the area were among the highest in the city (double the city-wide average). Many of the residents were employed in professional and managerial jobs (73% of the parents in the school) and a large percentage had degree qualifications. The net family income was $10,000 p.a. higher than the national and the city-wide average.

In 1993 Deans had a roll of 413 students. Very few of these students were from Maori or Pacific Island families, although there was a significant Asian presence. The students at Deans tended to be high achievers, as might be expected from an educated middle-class area, and maintained academic and musical standards above the national average. During the study the school had as many students as they could

accommodate and considerable effort had been devoted to restricting additional enrolments. In 1995 the school had 18 teaching staff which increased to 22 in 1996.

The first classrooms were built in the 1950s and additional teaching, library and administrative facilities were built in the 1970s. In 1995 a number of new classrooms were provided to meet the growing school roll and the administration block was extended.

The key informant at Deans was the school principal. He was an important source of information on the operation of the school and was crucial in obtaining access to the school. Interviews were also conducted with teaching staff, administration staff and trustees and the researcher observed a number of the Board of trustee meetings.

6.3.2 Response to the education reforms

When the study commenced in 1993, local parents saw Deans as a desirable school and as one of the 'success' stories of the reforms. However, this very success was a source of problems to the school. Because of the growing roll there was a serious shortage of classroom space. The Board of Trustees attempted to restrict new enrolments to the school. However, this was not sufficient to alleviate the growing pressure on space and the growth in class sizes. The trustees made submissions to the Ministry of Education, as there was concern over the school's ability to meet the needs of students in its zone. Initially the Ministry suggested that the students should be sent to other primary schools in the local area, which did not have such a shortage of accommodation. Recognising the unwillingness of the Ministry to provide additional classrooms, the trustees looked seriously at purchasing additional classrooms themselves.

In February 1995 the Ministerial Reference Group (MRG) released their report entitled *Resource Entitlement for School Staffing*. This altered the national staffing entitlement ratios. Deans school was significantly favoured under this adjustment as the staff entitlement changed from 17.9 in 1995 to 21.7 in 1996. Because of the

increase in teaching positions the Ministry agreed to provide five additional classrooms to the school.

Despite the shortage of space, those responsible for managing the school welcomed the increased autonomy as they considered that the school could be more efficient without the direct involvement of the local education board and the Department of Education. On contacting the school, the researcher was offered a copy of the school charter and policy documents. The researcher was not offered these documents by any other school although they were meant to be foundational to school operation.

Because of the new responsibilities the Principal found that his role and responsibilities altered significantly. In addition to the traditional professional and educational leadership of the school, the Principal carried a number of new management and personnel responsibilities. He explained his new role as follows:

> Now I am basically running a business, I am the chief executive officer for the Board of Trustees. The Board create the parameters and I manage within these parameters. I love the new freedom; I can be entrepreneurial; I can have a vision for the school and the Board will support me. I can also react to what the community wants. One example is the holiday computer course we ran, it served a community need and raised funds for the school (Principal Deans, July 1994).

While enjoying the new freedoms, the Principal also noted that the reforms had significantly increased his workload. His work hours increased from 40-45 hours per week to 60-65 hours. During the first interview the Principal presented a list of twenty-four new responsibilities that he had since the implementation of the education reforms. This list is reproduced below:

Table 6.1 New Responsibilities of School Principals

Charter development	Extra curricular music	Policy writing	Staff appointments
Securing contracts	Public relations	Budgeting	Asset register
Financial management	Vastly increased paperwork	Property management	Releasing staff for in-class support
'Special needs' management	Implementation of new record cards	Attendance at training courses	Knowledge of awards re good employer
Introduction and certification of trainee teachers	Performance appraisals for all staff	Setting up supplier and contract files	Immigration Officer re foreign students
Negotiating property agreements	Staff development plan	Writing references	Community consultation meetings

There was little in the way of training and support for these new roles. Although the Principal attended a number of seminars he had to "learn the role as he went along". This learning process was assisted by several of the trustees.

> The Board of Trustees have also helped train me in some of the business skills I have needed. I have learnt a lot off them (Principal Deans, July 1994).

Supported by the expertise of the trustees, the Principal adopted a private sector style of management and implemented a number of new procedures within the school. The Board of Trustees at Deans included lawyers, accountants, management and property consultants. Regular 'strategic planning days' were organised by key trustees for the Board and the Principal. The trustees organised annual 'customer satisfaction surveys', asking for written comments from the parents on the operation and performance of the school. To ensure that the written comments were representative, ten per cent of the non-respondent parents were telephoned by the trustees. During 1995 the Principal introduced 'exit interviews' for any staff who were leaving the school.

Although the Principal did play an important role in the financial management and administration of the school, the trustees and the Bursar also assisted him. The ongoing responsibility for maintaining the accounting records rested with the Bursar. She was an ancillary staff member who had been employed as a teacher-aid. As the Bursar she collected any monies from the students, banked any cash received, checked and paid all accounts, coded any documents and entered the details on the computer. The Bursar produced monthly reports, which detailed the income and expenditure against budget levels. The monthly reports were presented to the Board of Trustees. Annual financial reports were also prepared by the Bursar, who was assisted by the Treasurer of the Board of Trustees (a qualified accountant and partner in a local accounting firm) and the Principal. The Principal explained the development of their accounting system like this:

> I had no financial knowledge when I first became a principal. I had to implement a financial management system at the previous school that I was at. An accountant (my father) helped me to set up a system at that school. At this school, the chairperson of the Board of Trustees understood accounting and set up a system. He was helped by a person contracted out by Rotary (club) (Principal Deans, October 1993).

The total direct funding managed at Deans was approximately $240,000. Funding was not such a critical issue as Deans were able to secure significant donations from the local community. The ability of the school to secure local funding was illustrated by the annual school fair, with a profit in excess of $21,000. The ability of the school to raise local funds enabled the school to upgrade the administrative block. In late 1994 the project was initiated and the trustees were required to find half of the funding before the Ministry of Education would provide the rest. The school took a $75,000 loan to fund the expansion to be repaid over 10 years. Within the first year (1995) the trustees were able to repay more than $10,000 which had been received through donations. However, with the growth in local funding, both trustees and teachers suggested that the ideal of free state education was being lost. One trustee suggested that as parents they were being required to fund their children's education twice, once out of their taxes and once out of their pocket. Another trustee suggested

that the State was 'delegating' the cost of public education to the parents and the issue of funding was fundamentally a governmental rather than a local problem.

> There is a myth about us, that we can do it all ourselves. We probably can but it is a dangerous principle. We would have to fund-raise to cover basic educational needs (Trustee Deans, August 1994).

The trustees actively embraced the ability to make decisions at the school level and the day-to-day financial and managerial autonomy that the education reforms brought. Considerable resources were invested in additional teaching support and programmes such as music tuition, remedial reading, drama, maths extension, Maori language, etiquette and manners; and, in some cases, tutors for specific 'special needs' children. However, the trustees and the teaching staff did not have the same view on the reform changes. One teacher expressed it like this:

> Many of the trustees are from a business setting. They regard the school as a business and us as producers and try to tell us what to do. They believe we have the same values as them and are producing an educational product. However, teaching is more of a vocation than a business. We are not producing a product, we are part of a process (Teacher Deans, November 1994).

The trustees were keen to become directly funded for teaching staff salaries while teaching staff saw these changes as threat to their security and autonomy and the direct funding as a threat to their job and income. The tension between the staff and the trustees was recognised by the Principal who suggested that the problem was essentially a problem in communication rather than a fundamental clash of values.

> There has been a little tension between the trustees and the teaching staff. I think the Board have had to learn to move a bit slower in these kinds of areas. There have been some nervous moments with the development of some of the policies. The Board have learnt that it is important to consult the staff before the policy is developed rather than presenting them with a draft policy. This communication has also be facilitated by informal breakfast discussions that now happen twice a term (Principal Deans, July 1994).

While the Principal was supportive of some of the managerial aspirations of trustees he found himself in the role of mediator between the Board and teaching staff and as

the moderator of those within the Board that wanted to bring rather than absorb change.

> The staff were taken too far and too fast. One of the trustees wanted privatisation of the school properties and bulk funding of teacher's salaries. He developed a personnel manual and wanted to take teachers off their collective contracts and put them onto a school based agreement. I thought that it was time to catch our breath and bed down the changes that we have already made. We need to get off the treadmill of change we have been on. That is where the Board is focusing now, developing practical policies to implement all of the good ideas we have had (Principal Deans, October 1995).

By 1995 the trustees discovered that they could not implement change when faced by teaching staff resistance. The issue of bulk funding salaries was strongly opposed by the teachers and the Board of Trustees withdrew the bulk funding proposal. In 1995 only one of the existing trustees stood for a second term. However, the new Board of Trustees still had an impressive depth of professional expertise: both the chair and the secretary of the Board were lawyers and the treasurer a chartered accountant. The new trustees were different in that they saw their role as absorbing change rather than introducing change into the school and were keen to restore positive relations with teaching staff. This difference between the old and the new trustees is best illustrated in a discussion of performance pay incentives. The previous Board of Trustees had set aside a fund to reward teachers that performed particularly well during the year. The new Board rejected the idea of rewarding individual teachers for their performance and instead used the fund to give a bottle of wine at Christmas to all teaching staff (both part and full time).

> They have slotted in very well. This Board is doing very well in the PR stakes. Were having a Board thank-you, we have always had them, this Friday. They have been more perceptive of who to invite. They have just got, there is a couple of them - two woman on it, have got this empathy thing. And everyone on the staff, it doesn't matter whether they are full time or part time, they are going to get a bottle of wine as a 'thanks very much' piece. Just a nice little touch that hasn't happened in the past. We have decided that we are not going to spend that on money (sic), we are just going to give everyone the same regardless of whether they are part time or full time (Principal Deans, December 1995).

The Picot Report (1988) maintained that the management of the school should be a partnership between the professional teaching staff, the trustees and the community. This also led to tensions within the school. The emphasis on being more accountable to parents involved notifying parents of a number of the teaching programmes and of any school trips. However, a number of parents were not satisfied with a notification and wished to actively participate in and critique classroom activity. While parents were encouraged to show an interest in their children's schooling and to discuss this with teaching staff, teachers suggested that there could be a fine line between interest and interference. One teacher said:

> They (parents) feel that they can assess our teaching and know more about what should happen than we do. Some come right into the classroom during the day and want to know why you are doing what you're doing (Teacher Deans, November 1994).

Another major source of concern for teachers was the curriculum changes and measurement and assessment requirements. These changes introduced another level of visibility into the classroom process and many teaching staff were uncertain how they should deal with new systems of student assessment and measurement. A number felt that the emphasis on measurement was detrimental to their teaching.

> All we seem to do is measure everything. When the ERO and the Ministry visit, you feel that you should produce more data - you should have numbers for everything. They try to prove that teaching is more effective with statistics (Teacher Deans, November 1994).

> It is hard to do assessment because of the way that we teach. We try to take a personal approach and adjust what we do for individual student needs. That

> makes it difficult to measure. Accountability involves statistics, paperwork and measurement. I have to conduct my physical education classes with a clipboard in one hand and a whistle in another. This is because I have to write everything down in order to be accountable and satisfy the Ministry. There is more paperwork for everything (Teacher Deans, November 1994).

Again, there was an attempt by the Principal to 'manage' the changes by focusing on a limited number of areas, giving teaching staff time to become familiar with the new systems and to adjust to the changes.

> I get very worried about assessment. There is an assessment frenzy going on right throughout New Zealand and everyone is running around like their heads were chopped off. We are trying to get off the treadmill, this year we are only looking at four subjects. We are looking at reading, maths, handwriting and swimming. We are trying to develop achievement statements at each class level for those four subjects. We have found that it has been impossible to get everyone interpreting it in the same way. So therefore we have got to go back again and ask what do we mean when we are looking at the reading age of an eight year old. So people are using the GAP test and some are using running records and everyone is using different running records. So we have got to standardise, we have now found our glitches (Principal Deans, October 1995).

6.3.3 Summary

In many ways Deans was the textbook success story for the quasi-market reform of education. The school was popular, it had an excellent reputation and lots of parents wanted to send their children there. Deans was the show-school for other less-successful schools in the Christchurch area. Yet, on closer investigation the school seemed to be a victim of its own success. Despite the rhetoric, resources did not follow a growth in roll and reputation. Because it was successful, parents wanted to enrol their children in the school. However, this placed pressure on teaching staff, classrooms and administrative facilities and the trustees were forced to cap additional enrolment.

One important factor in the 'success' of the school was a wealthy, well-educated local community. Because of this most parents had a commitment to education and a strong interest in the welfare of their children. While this contributed strongly to the educational achievement within the school, it could also be a threat to the teaching staff as some of these parents were happy to challenge what the teachers did.

Because of a wealthy local community the school was able to raise substantial levels of local funding. However, this created some tension as the school received less from the State and were expected to fund their own projects. The school was able to elect a board of trustees who were the envy of most other schools. However, this was a mixed blessing. The trustees had a different agenda to the teaching staff and, at times, were not just absorbing the reforms but actively promoting managerial changes within the school. This colonising threat was reduced with the election of new 'empathic' trustees in 1995.

At Deans, the pressures for change came from two directions: those within the school, particularly key trustees, who had an ideological commitment to the change process and from the new institutions that were formed after the 1993 legislation, particularly the ERO and the Ministry of Education's national curriculum demands. While the administrative changes were absorbed, some trustees were a potential colonising force, committed to private sector practices. However, they could be resisted by the teaching staff and were therefore less of a threat than the ERO and the Ministry whose initiatives directly impinged on the teaching work.

The Principal played an important role in how the school managed the reforms. Generally he welcomed the new freedoms; the freedom to introduce new practices into the school and the freedom to take entrepreneurial initiative when he felt that it would benefit the school. During 1995 the Principal initiated a major project to install information technology which would cost well over $150,000. In order to finance this he planned to get local businesses to pay the cost of the equipment. He also planned to get one of the major computer companies to sponsor the school as a reference site.

The Principal of Deans fitted what Laughlin et al. (1994a) described as the absorber wheeler-dealer. While he does show strong entrepreneurial tendencies, he is not detached from the operation of the school or alienated from the teaching staff. This was evident when the Principal became the mediator between the managerial tendencies of the trustees and the values and concerns of the teaching staff. The

Principal also established himself as gatekeeper, determining what changes would be acceptable and what would be resisted.

The Bursar tended to absorb many of the day to day financial responsibilities, freeing the Principal to plan, or as he puts it – "dream dreams" (Principal Deans, July 1994). However, he also took any opportunity to make money or obtain additional resources when he considered that it would benefit the students. He expressed this philosophy in the following quote:

> The key questions that I always ask myself are "What's in it for the kids?" and "Am I spending this year's money for this year's children?". It is really an issue of being transparent in what you are doing (Principal Deans, July 1994).

6.4 SCHOOL 3: STRAVEN HIGH

6.4.1 Profile of the school

Straven High was a state coeducational secondary school and it was built in a middle class suburb in the north of the Christchurch. The average income of the local community and the proportion employed in professional and managerial positions were higher than the national average.

The pre-reform 'school zoning' systems had a significant influence on local property prices. Families would 'buy into the area' in order to send their children to Straven. The Straven High Board of Trustees chose to maintain a zone or 'enrolment scheme' restricting third form enrolment to the local 'zonal' area. The school continued to experience demands for enrolment from students outside of the 'zone' many of who were declined. Despite the continued external and growing internal (within the zone) demand for student places, the Straven roll remained relatively constant over the period of the study. However, the trustees were concerned about the population growth in the area and suggested that the school 'zone' might need to be reviewed.

Straven High came into being during the post 'baby boom' expansion of the school population in the 1950's and 1960's. Further buildings were added to the school during the late 1960's and early 1970's. In 1993 the roll was over 2,000 students and there were more than 100 teaching staff, which made Straven one of the largest

schools in the region. The school has a reputation for high levels of academic achievement in state examinations.

6.4.2 Response to the education reforms

Straven was often regarded as one of the success stories of the education reforms. Part of this image of success was due to the size of the school, which made it practical to appoint staff and to implement systems to handle the new administrative and financial responsibilities. The Principal regarded the changes as a challenge, he welcomed the new freedoms that were offered and led the school in a very pro-active response to the reforms. He argued that the changes could benefit the school and pupils rather than seeing them as only a threat.

> We prefer to lead rather than follow and will maintain a high level of energy in developing new programmes to ensure that students gain maximum advantage during this period of change (Principal Straven, 1992 Annual Report).

In particular, the devolution of financial and administrative responsibility provided the opportunity to make decisions within the school rather than having to wait on approval from the Department of Education. The reforms provided the Principal with the opportunity to restructure the way that the school ran and re-modelled the management structure of the school along more commercial lines.

> I feel that there is a flaw in the management structure of schools. A manager should deal with policies not implementation. In this school we have both an associate principal and a deputy principal. Now our management structure was such that the Principal directly supervised the associate principal, the deputy principal and thirteen HODs. The efforts of the chief executive, so to speak, were spread too thinly. Now I had the associate and the deputy principal that were on a high seniority level but they had no real management function, they only looked after the pastoral care of students. So I lifted their work responsibility so I could use their energies better. So I left myself with supervision of the HODs of guidance, mathematics and the Finance and Administration Manager and shared out the responsibility for the supervision of the other HODs to the associate and the deputy principal (Principal Straven, September 1995).

To reflect the change in his role the Principal changed his job description to Principal/Chief Executive, to reflect the combination of professional leadership and

management responsibilities (Principal Straven, July 1994). Very little formal training was available for the principal / chief executive role. However, some of the private sector courses were useful. He mentioned a course run by a group of private sector managers to introduce school principals to management techniques such as strategic planning and total quality management. Many of those techniques he then applied in running the school.

Straven High had a stable Board of Trustees with a low turnover. Most of the trustees stood for two terms (six years) and a number continued for three terms (nine years), maintaining a continuity of experience and expertise.

> Many of the people who were on the first Board of Trustees stood for a second term. However, a number felt that 6 years was quite enough and only three of the seven parent representatives remained on the third Board. When the treasurer resigned, the second Board co-opted a professional accountant as the new treasurer who, together with the three parent representatives who were re-elected, ensured good continuity after the 1995 election (Chair Straven Trustees, September 1994).

The ability to co-opt additional trustees with professional skills meant that accounting and property management were maintained as areas of strength within the Board. All of the three boards elected had professional accountants and engineers as members. This was further supported with teaching, legal and managerial expertise.

> We have been able to get a very well qualified Board from the [local] parents. We have expertise in the accounting and finance area from both the previous treasurer and in [X]. [X] used to be on the PTA committee and has a child in form three. We are also strong in the property area. [Y] is an engineer and is responsible for property management at the airport. The abilities of these people has been a big help in coping with our responsibilities under *Tomorrow's Schools* (Principal Straven, September 1995).

Much of the work of the Board was conducted at the committee level. There were six committees: staffing, finance, property, student welfare, curriculum and employment conditions. Three additional committees were also established to oversee the work experience unit, plan a major building construction and to develop the community education programme. Each committee made a regular report to the

Board. Although Education Services[1] provided secretarial services to the Board prior to *Tomorrow's Schools*, this responsibility shifted to the Deputy Principal.

In order to support the new accounting, property management and administrative responsibilities within the school a new position was created, the Finance and Administration Manager. In 1989 the Principal and Board of Trustees decided that the school would manage their own accounting rather than employ external accounting services. With the assistance of the Head of Department (HOD) of Commerce, the trustees and Principal designed an accounting system for the school and purchased the necessary software. Initially the financial management of the school was the responsibility of the Executive Officer. However, this arrangement was considered unsatisfactory and Ernst & Young were asked to review the situation. They recommended that a new position be created to oversee the accounts and administrative staff. A Finance and Administration Manager was appointed on a part-time basis in 1991 and was re-employed full-time from 1992. He was responsible for the accounting system, internal and external reporting, the administration computer network and oversaw the secretarial section. He answered directly to the Principal and played an important role in the finance committee of the Board of Trustees. Responsibility for property and ancillary services was delegated to the Property Services Manager (ex Executive Officer).

The Finance Manager supported the HOD's budgetary responsibilities. He provided easily accessible accounting advice, which was invaluable in the HOD's preparation of departmental budgets. The HODs also appeared to be more willing to adopt financial responsibilities because there was an expert available who could quickly and clearly answer any queries they may have. The fact that the Finance Manager had teaching qualifications and was actively involved in the teaching programme also increased his credibility within the school.

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1 Education Services was previously the Secondary School Council. Under the reforms they were restructured into a private, contestable support service.

With the restructure of responsibilities at Straven, the Executive Officer became the Property and Services Manager. He oversaw all maintenance and administrative staff, was responsible for planning maintenance and building within the school and played an important part in the property sub-committee of the Board of Trustees. He answered to the Associate Principal rather than directly to the Principal.

The need for financial expertise at Straven becomes evident when one considers that the funds managed by the school changed from $140,000 before the reforms to $1.2 million (although $600 thousand was senior staff salaries) after the reform. The 'bulk funding' of the operation grant significantly increased the freedom of school principals and boards to make decisions at the local level without having to consult the Department of Education (or Ministry of Education).

> We do have a lot more autonomy than we used to. We do not have to ring the Department (of Education) when we need to do something. Minor capital works are a good example: we don't have to waste time negotiating with the Department, we just go out and do the maintenance we need (Principal Straven, July 1994).
>
> Historically, we could not move money from one budget to another. We could not use book money to buy calculators even if we had bought all of the books we needed. Therefore, we would always spend all of a particular budget even if we did not need what we bought (Principal Straven, July 1994).

Because a significant part of the operational grant was based on student numbers, the obvious way of increasing the funds (and teaching positions) available to the school was to increase the number of students attending the school. Therefore, as schools became aware of the funding and staff implications they started to seriously compete for available students. The Principal at Straven commented that he was reluctant to share his plans and experiences with other principals because they might "steal a march" (Principal Straven, July 1994) on him. Because of their academic reputation the school was able to attract a number of fee-paying overseas students, which also had direct financial benefits for the school. However, these benefits were costly. The Principal was involved in several overseas trips to promote the school, particularly in the Asian-Pacific area. Extra staff was employed to teach the overseas students and

additional costs were incurred to build new classrooms. However, the financial contribution from overseas students was recognised by the chairman of the Board of Trustees who stated in the 1993 school accounts that:

> The Board has noted the difficulty that would exist in financing the school's operations if it were not for the contribution made to the operating budget by the overseas fee-paying students (Chair of the Board of Trustees Straven, Financial Accounts 1993).

Overall, the school consistently maintained a surplus on operations and there was significant level of local fund-raising. The ability of the school to generate local funding became evident as in 1995 when the trustees prepared plans to construct a new auditorium for the school. In total the project would cost around $200,000 and much of this amount was to be raised through local fundraising.

While the school was able to raise funds, they had been adversely affected by the changes to the staffing formula. The 1991 cuts to the secondary staffing formula had caused a loss of 4.5 equivalent teaching positions at Straven.[2] This resulted in a reappraisal of teaching staff, two permanent staff being "redeployed" and four part-time staff losing their jobs. The Board of Trustees decided to reduce by one the number of counsellor positions within the school because of the Ministry reduction. An external consultant reviewed this decision in 1994 and the Board was advised to reinstate the position. This was achieved by "rearranging staffing allowances within the school" (Interview September 1995). Two of the staff affected by the 1991 cuts restructured their work on a job-sharing basis. This "enabled them jointly to make a full teaching contribution to the school while raising their young families" (Interview September, 1995). This job-sharing agreement was initially on a trial basis but became permanent in the following year. While the changes were clearly a response to the economic necessity, the central thrust was to protect the 'mainstream' teaching of the school. The redeployment exercise was initially driven by financial factors but

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2 See Appendix 4.

the ultimate results were decided by the educational imperative of providing the best possible education for students and the needs of the staff.

As in most other schools, the teaching staff were concerned about the growth in measurement and assessment. The measurement issue had two aspects, measurement of school performance and measurement of student performance. The ERO review process measured and assessed the school and the teaching staff. The 1992 ERO review of Straven School recommended further measurement and analysis:

> The data the school has on student achievement should be more extensively analysed especially in regard to the performance of equity target groups and the progress students make in their time at the school (ERO Report, Straven, August 1992).

However, in discussion the Principal also raised some major issues about the operation of the ERO and the benefits (or lack of benefit) of the review for the school.

> The ERO reviews do not have a big effect on the way the school runs. They just come in and remind us that we have certain legal obligations and that there are certain rules and regulations we must adhere to. They come in with some ideas, but they aren't real practical. The problem is that they don't have teaching credibility. A lot of people in these government organisations are people who didn't succeed as professional teachers and are attracted towards those places. You don't expect innovation from them. Just procedure and technique, not innovation in education (Principal Straven, September 1995).

The tendency towards measurement was the Ministry of Education 'Assessment Initiative' and measurement requirements of the NZQA qualifications framework which required teachers to explicitly measure and quantify student performance. The Principal was supportive of the qualifications framework, arguing that the unit standards would assist teachers in analysing how their subject was built up, would clarify what needed to be taught, and would clearly indicate how one subject related to another. However, he was dismissive of the process of implementation and the over-emphasis on measurement:

> But my concern is that we are trying to drive a tack with a sledgehammer, that the assessment part is overtaking the learning. And every extra hour you

spend on assessment you are going to spend one less hour on learning. And that is a great concern to me. It is the assessment part that I think is getting too much time and I am not sure why.

And some of the solutions they have for the difficulties worry me as well. I have one department setting re-tests after school. If you don't pass your unit you have a chance to do it again. But most teachers are not going to retest their students after school. This department is involved in a trial, but most teachers can't do that. It is this jolly re-testing all of the time.

The NZQA's latest solution is for teachers to walk around the class and look at their books. If it looks like they are doing their examples well, there is no need to re-test them and you can tick them for it. From the sublime to the ridiculous.

(Principal Straven, September 1995).

6.4.3 Summary

Parents and the media saw Straven as a successful school under the reforms. The school had a stable and skilled Board of Trustees, they were able to raise a significant level of local funds, they had a growing roll and they could attract as many overseas fee-paying students as they were willing to accept. The students scored consistently well in local and national examinations and the school had a strong reputation for their sporting and musical achievements.

The introduction of new financial and administrative responsibilities flowing from the implementation of the education reforms led to a major review and restructure of the responsibilities within the school. An accountant was appointed as Finance and Administration Manager and the Executive Office took responsibility for the management of the buildings and grounds. The two administrative staff at the school were assisted by the Treasurer (from the Board of Trustees), who was also an accountant. The Principal welcomed the increased freedoms to make decisions and to restructure the school and saw the reforms an opportunity that could be turned to the advantage of the school and would therefore benefit students. Rather like the Principal at Deans, the introduction of managerial practices and orientations were accepted because it was thought that this would most benefit students.

The Principal, the Finance and Administration Manager and the Executive Officer absorbed the administrative and financial responsibilities and protected the teaching staff from most of these changes. However, it was not possible to protect the teaching staff from the new forms of measurement and explicit accountability arising from the ERO reviews and the NZQA requirements.

The role of the Principal in the management of the reforms was interesting because it illustrated both engagement and disengagement. The Principal distanced himself from the day-to-day management of the reforms so that he was free to provide direction for the school, or, as he put it, to be the chief executive. The restructure of staff supervision within the school was also explicitly designed to free the Principal from 'administration' to focus on 'policy'. While the Principal did not engage in particularly entrepreneurial activities, he took a managerial orientation towards the school and spoke of the school in strongly corporate terms. This corporate orientation also extended to his relationship with other schools, which had shifted from one of co-operation to one of competition in the quasi-market environment.

Within the Laughlin et al. (1994a) framework the Principal had a 'managerial educational orientation'. Of all of the principals studied, the one at Straven seemed to fit the Laughlin et al. (1994a) types the best; he had delegated many of the financial and administrative responsibilities to others (the Finance and Administrative Manager and the Executive Officer), he had a strong management concern and an interest in developing appropriate management structures in the school and had already started becoming interested in management prior to the reforms.

6.5 SCHOOL 4: AROHA COLLEGE

6.5.1 Profile of the school

Aroha College was a state coeducational secondary school located in the east of Christchurch. The school was established in 1961 as part of a high school building boom throughout the city and the facilities were reasonably standard for a state secondary school. Most of the buildings were erected in 1961; a gym was added in 1966 and additional teaching space and a school library were provided in 1969.

Although the school was built for nearly 1,000 students, in 1993 they had a roll of 647 students. The school had 43 teaching staff in 1995 although this had dropped to 38 in 1996.

Aroha College was located in a working class area where most of the residents were on an average or below-average income. However, Aroha also drew students from some of the poorest areas of the city. There are two reasons for this: first, Aroha has developed a reputation for dealing with 'difficult' children, and therefore tended to attract students with both social and educational difficulties and second, Aroha was seen as the 'school of last resort' - taking children who had been rejected from other state schools for behavioural problems. The Principal argued that the philosophy of open access to all students was linked with the school mission '. . . to encourage students to believe in themselves and to reach their fullest potential' and as such the purpose of the school was not strict academic achievement.

> The most important thing is always to get the kids to believe in themselves. A lot of them come here when they can't get in anywhere else – we become the school of last resort for the whole city (Principal Aroha, October, 1994).

The key informant in this school was the Principal. However, she was absent (research fellowship to America) for one year during the study and the key contact became the Deputy Principal during that time.

6.5.2 Response to the education reforms

Aroha did not 'compete well' in the post-reform quasi-market. Aroha was based in a relatively poor neighbourhood and did not find it easy to raise funds from the local community or patents. They also did not have a strong academic reputation like Straven did. Therefore, although the school adopted an 'open roll policy' they did not find it easy to attract students and, over the study, experienced a fall in student numbers. By 1995 the roll had dropped below 500. The difficulties were made worse by problems associated with student discipline and financing.

> The school is looking good. I have also been tough on the kids, both how they look and how they behave. This had led to a drop in vandalism and

> improvement in the school's image. Part of this is an attempt to market the school to overseas students. But you can't predict how kids will behave. Parents also tend to blame the problems experienced on the school, when most of the problems are a reflection of the problems existing in the community (Principal Aroha, July 1994).

Unlike the other schools studied, the Principal at Aroha was a woman. She described her role as having four key functions: pastoral, leadership, visionary and political and said that her concern for students was the main motivation to remain in the education system. Her leadership style was quite different from the other principals interviewed in that she placed a much stronger emphasis on her pastoral responsibilities. The Principal also played an important political role as advocate for the school. Within the local community the Principal was the 'front person' for the school and at a national level the Principal actively opposed moves that would disadvantage the school and monitored the changes in government education policy by regularly visiting Wellington and actively confronting politicians.

At Aroha the School Executive Officer (EO) supervised all support staff, even handling hiring of new staff when necessary. The EO began as the Principal's secretary in 1979 but was appointed as EO in 1992. The EO had oversight for both property and finance and the supervision of support staff, carrying direct responsibility for property and grounds, tendering for maintenance contracts and monitoring the budget. As such the EO was involved as part of the buildings and grounds committee of the Board of Trustees.

The direct responsibility for accounting and finances was delegated to the Bursar. She answered to the EO. The Bursar's responsibilities included collecting and banking all cash, paying and coding invoices (which were then sent to Education Services) and overseeing the balance on all government grant accounts. She was also responsible for running the school stationery shop. Together with the EO the Bursar was a member of the finance committee of the Board of Trustees. The Principal restructured the financial and administrative procedures in the school so that teaching staff were buffered.

> Teaching staff do not handle money. That is all handled by the Bursar now. Teaching staff are inclined to lose money or leave it around where it could get taken. So we have improved the system for cash control. Teaching staff do not naturally consider financial issues so we attempted to institute systems to help them be better managers (Principal Aroha, September 1993).

Because of the Principal's ability to co-opt people, Aroha was able to build a reasonably solid Board of Trustees. Additional members were co-opted to provide appropriate financial and property expertise and to provide representation from the local Maori and Samoan communities. Aroha continued to employ the Canterbury Education Services to act as secretary for the Board of Trustees. Both the Board and the Principal adopted a very co-operative style, regularly involving parents, staff and students in evaluating policies and programmes. The Principal appeared to have little direct input to meetings although the Board paid a lot of attention to what she did say. One might suspect that key issues were well discussed prior to the meetings. Much of the work of the Board was conducted in committee. There were six committees: finance, buildings and grounds, curriculum, personnel, student welfare and the management group (which handles the disabled and the work experience units within the school). While trustees attend these committees they were also attended by teaching staff, ancillary staff and, in some cases, students. Decisions were made by the committees and then reported to the Board of Trustees. The composition of the Aroha Board of Trustees had been reasonably constant. There was no need for a trustee election in 1995 as all of the previous parent representatives stood again unopposed. The Board generally had the confidence of the teaching staff and were seen as 'being thorough and doing a good job' (Comment from a trustee meeting October 1994).

The increased autonomy and the freedom to make decisions at the school level rather than having to seek approval from the Department of Education was seen as one of the most positive features of the reforms.

> I like the independence for making decisions that have come from the reforms ... the delegated autonomy of *Tomorrow's Schools* has allowed us to let our

> own contracts and employ our own carpenter and therefore bring minor maintenance in-house (Principal Aroha, September 1993).

Funding continued to be a problem within the school and the financial situation became worse in 1994 when the school lost the equity grant (see the section on Matai school and appendix 4 for more details on this grant). Aroha was no longer considered particularly deprived as this grant was targeted at the very worst schools in the country. The Principal contacted the Ministry on a number of occasions to argue that Aroha was a special case and that they should receive special funding. However, she was unsuccessful and the school financial situation became worse.

> The finance area has become a real concern. There is a noticeable and growing gap between the rich and poor schools. This gap is particularly noticeable in a socio-economic area like ours. We can't raise the local finance that a richer school could. This also shows in our school fees. If we tried to increase them much they just wouldn't get paid. We also have very few overseas fee paying students. So these things are a struggle for us. I am also concerned about how the system is changing. The equity grant system is inadequate in meeting the special needs of schools such as ours. There is also talk about changing the funding system to advantage large schools more (Deputy Principal Aroha, July 1994).

Serious attempts were made by the school to attract local funding. Aroha approached local business for support and the school ran a second-hand sale to raise some cash. Aroha also let out school facilities to a commercial English language school and reluctantly decided to seek foreign fee-paying students to assist the financial situation.

> I have been forced to prostitute myself and advertise for overseas students in an attempt to balance the books (Principal Aroha, September 1993).
>
> There is no way that we should have to fund education for our kids by taking in fee paying students from overseas. That is morally unacceptable. But the reality is that there is probably no school in Christchurch that could balance their budget if it didn't have overseas fee paying students. That is the reality. We have seven or eight overseas students now and that will increase (Deputy Principal Aroha, September 1995).

However, none of these initiatives solved the problem. Therefore, the Principal argued that their financial situation was a central rather than a local problem and that

the Ministry had to decide whether it wanted to fund the school adequately or close them down.

> Well, we made lots of cases to the Ministry but we are not regarded as a crisis situation. Lots of schools are running deficits and I don't think they are concerned quite frankly. What it means is that we have got no money in the bank to look at maintenance and so (teaching) blocks are not going to be painted and that sort of thing. So there are real problems here (Acting Principal Aroha, September 1995).

> I am philosophical about finance. I do the best I can with what we are given. But if we go broke the government can bail us out or shut us down. They have under-funded us so it is their problem not mine. I won't lose any sleep over what I can't control (Principal Aroha, October 1994).

> We are running a deficit budget this year. We had the Manager of Finance from the Ministry of Education down here at a meeting. He asked how many Principals were running a deficit budget and three quarters of us were. We need $25,000 so we are probably one of the worst (Principal Aroha, October 1994).

Because Aroha was located in a less affluent neighbourhood there was a real concern that some students would be denied a quality education because of other social, behavioural or psychological needs that they had. Health and social welfare agencies had experienced a reduction in their funding and were reluctant to assist in any but the worst cases. In consequence many of the 'lesser incidents' were left to the schools to deal with. School staff, particularly the Principal and the Deputy Principal, found themselves acting as *de-facto* social workers which reduced their ability to address the educational needs of the students.

> We face so many demands. Although our job is to promote learning, schools are expected to deal with issues of social welfare and health. Our kids cannot leave these things at the gate when they come to school. If schools could only be institutions of learning (which is what we should be) and not have to deal with other matters we would do our job well (Deputy Principal Aroha, July 1994).

While teaching staff were buffered from the administrative responsibilities, they did feel the effects of staff cuts. At the end of 1995 the Ministry told Aroha that the school was going to lose a further 5.3 teaching positions in the next year. The

projected school roll for 1994 had been 600 students. However, on 1 July 1995 it was discovered that Aroha only had 480 students enrolled. Therefore, the guaranteed minimum staffing for 1996 dropped to staffing the school for a roll of 484. At the end of the year the Acting Principal initiated a 'redeployment process'.

> It is going to be a difficult term. Because we had a drop in the roll in the last eighteen months we are going to lose 5 1/3 staff so we are going through a redeployment round. It is still a very nasty process. We also lose positions of responsibility - PR units. So people are going to be demoted within the school as well. So it is a nasty situation and a very hard one to live through. I think that the school staff have confidence in the process and if you have confidence in the process and you make sure that the process is used that does help. But it affects all staff. Not only do you have the people who lose their positions and lose PR units but you have larger classes next year and people go who do all sorts of things around the school which need to be picked up by the people who are left. There are all sorts of implications which means that it affects everyone in actual fact.
>
> Also because you have fewer numbers the whole funding is decreased and you have got to look at your whole budget and areas like ancillary staff which takes almost half of the schools' bulk grant budget. So you have got to look at making reductions there.
>
> (Acting Principal Aroha, September 1995).

6.5.3 Summary

The research revealed that at Aroha the reforms have proved to be a mixed blessing. While the Principal and trustees welcomed the new autonomy and the freedom to make decisions without consulting the Department of Education (as they had done in the past), the local area was not particularly wealthy and the school found it hard to raise funds. As a consequence, finance became an important focus within the school. However, this was always secondary to the needs of the staff and students.

The Aroha Principal generally fitted what Laughlin et al.'s (1994a) managerial pastoral headteacher category because although she took a direct role in managing the reforms she also delegated many of the financial and administrative aspects to other staff in the school. The finance and administrative tasks were transferred to the Bursar and the Executive Officer, while the NZQA accreditation process was managed by the Deputy Principal. The pastoral role of the Principal was emphasised

more than any other school studied. However, it would be wrong to say that the Principal distanced herself from the reforms. She created an explicitly political role for herself as an advocate for the school at both a local and national level. Much of this advocacy role was concerned with the financial position of the school, but it was more than that. It also involved defending the reputation of the school in the local community and co-opting individuals with the skills needed by the Board of Trustees.

By late 1995 there was a distinct shift in the attitude of the Principal towards the reforms. When she found that they could not balance the budget, even though they were taking on overseas students and leasing school facilities to outside bodies, she argued that they faced a central funding problem which could not be resolved locally and the government had to choose either to fund them sufficiently or to close them down.

6.6 ANALYSIS OF SCHOOLS

The research model presented in Chapter Four provides the initial basis or 'set of categories' (rebuttal, absorption, colonisation and evolution) for the interpretation of the interview/discussions and observations of the researcher in relation to the schools studied. Both the rebuttal and the evolution pathway were considered unlikely based on the facts of the reform process (see Chapter Five Para 5.8). However, both absorption and colonisation were possible.

The empirical evidence in this chapter suggests that there was an example of what Laughlin (1991) called the re-orientation pathway. The reforms led to changes in the way things had been done, but did not appear to have altered the core values of the schools or directly impact the teaching process (which would be required for evolution). This conclusion was based on a number of findings. First, the elected trustees absorbed a considerable amount of the administrative workload delegated to the schools under the reforms, effectively doing voluntarily what the Department of Education and the local education boards had been paid to do (Gordon 1992b, p. 188). This absorbing role was particularly important in the areas of accounting and property management. Second, in all of the schools studied there had been a

significant change in the role of the principal within the school. While this was most obviously the case at Matai, all of the principals interviewed found that they were carrying a heavier administrative load and that their role had become more managerial and less pastoral. At Deans and to a lesser extent Straven this process appeared to be welcomed while at Aroha the process was resisted by a principal who argued that her role should remain a mix of the pastoral and the managerial. Part of the pastoral role involved shielding teaching staff from as much of the financial and administrative responsibilities as possible. The third factor that indicated re-orientation was the growing importance in all of the schools of administrative support staff. These individuals were required to carry the responsibility for financial and property management within the schools. The two high schools - Straven and Aroha, created new positions and the two primary schools altered the role of the school secretary (in the case of Matai) and teacher aid (in the case of Deans).

The absorbing process observed in this study showed a strong parallel with Laughlin et al.'s (1994a) account of how schools responded to the LMS (Local Management of Schools) reforms in the UK. Laughlin et al. (1994a) argued that small groups made up of the headteacher, deputy teacher and supported by administrative and/or secretarial staff were central in absorbing or managing the financial and administrative responsibilities associated with LMS. While there were many similarities between the responses in the schools studied and the responses of headteachers discussed in chapter two, the only real example of an absorbing principal was Matai where there was not the trustee support for the principal to delegate effectively. Once he established his position and developed the necessary skills among the trustees, he moved closer to the managerial educational 'type'. The absence of 'absorber' type principals was a key difference between this project and the UK studies. One of the discourse partners who had a long involvement in education argued that there had been a number of 'absorber' type principals in the Christchurch area who had taken early retirement or left education 'unable to cope' with the changes. On this basis one could conclude the absorbing type was not viable in the long-term. However, this proposition requires further research.

The type of principal found in this study was the 'managerial' rather than the 'absorbing'. However, the types of managerial orientation identified by Laughlin et al. (1994a) were difficult to find. The orientation of the principal at Aroha fitted both the managerial pastoral and the managerial educational 'type' while the principals from Deans and Straven fell somewhere between the managerial educational and the managerial entrepreneurial types. While it seemed reasonably easy to distinguish between absorbing and managerial principals, one might question whether the sub-categories are distinct. However, all of the principals interviewed expressed a strong commitment to education and to the students and justified their actions in educational terms.

> ...we only want to give our kids the same quality education that other kids get (Principal Matai, October 1994).

So, on the basis of these case studies, the New Zealand education reforms generated a re-orientation, closely paralleling the absorbing groups, which developed in the UK schools. However there are a number empirical elements that were not fully captured by the re-orientation model:

1. One Board of Trustees (at Deans) became an active force for change within the school. A process that brought them into open confrontation with the teaching staff.

2. The structural loss of the Department of Education as a significant steering media and the impact of fragmenting its role into new organisations such as the NZQA and ERO is not addressed.

3. While teachers and teaching staff were relatively unaffected by the financial and administrative changes implemented, they were deeply affected by the changes in curriculum and assessment procedures.

The first issue highlights the theme in the Laughlin-Broadbent framework that the absorbing group has the potential to turn into a colonising force within an organisation. The dominant presence of management-orientated individuals at Deans

caused a significant clash of values between the teaching staff and the trustees. Teaching staff suggested that the trustees viewed the school as a business and education as a product. It seems clear that these trustees succeeded in introducing some changes into the school such as private sector management practices and financial performance rewards. While many of these changes seemed to be tolerated by the teaching staff, the threat to trial bulk-funding of salaries generated a strong and vocal resistance from the teachers. While changes in the way the school operated seemed to be acceptable; to give the trustees direct control over their salary, and therefore over their job, was not acceptable. Therefore the attempt by the trustees to introduce change into the school was unsuccessful and the Principal was forced to act as mediator between the trustees and the teaching staff. Very few of the trustees stood for re-election in 1995. One of those who was very keen to introduce change was advised by the principal to "leave it for a term and maybe stand again next time" (Principal Deans, December 1995). So although the trustees did have clear colonising tendencies they were not able to overcome the resistance of the teaching staff. It is interesting to note that the point of resistance was not an issue of how to teach but about their own job security and income. Perhaps it is a threat to income and therefore individual security that leads to resistance rather than a challenge to the more abstract interpretative schemes / lifeworld values.

The restructure of the Department of Education highlighted the structural impact of change. The elimination of the Department of Education and its replacement with a Ministry, removed a major institutional buffer for teaching staff and schools. The Department was a steering media, which monitored the performance, activities and values of individual schools. It did this by controlling many aspects of how the school operated such as setting staffing entitlements, salary levels and employee conditions and defining curriculum. It took major responsibility for recruiting teachers and exercised some control over procedures for appointments. The Department also had a secondary role as a buffer between the political demands of government and the needs of schools. As such it typified the progressive public administration values described by Hood (1995). Because the Department of Education had a history of

being lead by educationalists (Nash, 1989, p. 116) it shared with teaching staff a common core of values. A telling comment on the change from the Department to the Ministry of Education was made by one of the top managers at the Ministry who observed "it is very hard to find an educationalist here when you need one these days"! (Interview Ministry of Education, August 1994).

New external institutions were created by the reform process, which lacked the buffer role that the Department of Education had and were intended to act as colonising steering media. The ERO provided an assessment of school and trustee performance. Any school that did not comply with the government requirement or was not deemed to have effective student progress was identified and publicly reported. Schools had no option but to comply with the requirements of these reports. Both the NZQA and the Ministry of Education defined and regulated the school curriculum. These steering media provided a continuing change influence and pressure for explicit educational performance measurement within the schools studied.

The nature of the changes also proved to be an important factor in determining the colonisation pathway. The introduction of financial accounting controls into the schools appeared to have a limited impact on the school as a whole. Generally accounting information played a planning and co-ordination role which was managed by the 'absorbing group'. Initially it appeared that the Ministry of Education used the accounting information to monitor individual schools. However, upon investigation, it proved that the financial reports were not used for any decision making process at the Ministry and no significant feedback was provided from the Ministry to the school (Interview Ministry of Education, November 1994). The accounts did form part of the published national accounts and fulfilled the statutory financial reporting obligations of the school. By preparing and submitting financial accounts in compliance with the Public Finance Act (1989) schools were seen to be accountable and to be exercising sound governance and management practices. This finding was consistent with Edwards et al. (1996a) who argued that accounting practices served to structure visibility within UK schools. The primary objective of the accounting

system was to provide legitimacy for both externally and internally initiated changes. Further research is required on the question of the role and validity of the accounting measurement and reporting in educational institutions.

While the administrative and financial reforms were absorbed by the principal, administrative staff and/or trustees and only had a limited direct influence at the teaching level, the curriculum reforms and NZQA changes had a real and significant effect at the classroom level. Why were the administrative changes absorbed while the changes to curriculum and teaching were not? Perhaps because the curriculum and qualification changes directly impacted what teachers were required to deliver in the classroom it was not possible to absorb the changes. This highlights a new area for research. Perhaps change can only be absorbed when it does not directly impact the 'real work' (Laughlin et al., 1994a, p.65). Change that does impact the 'real work' is more likely to lead to colonisation and alter the interpretative schemes.

The next chapter introduces Section Three, which addresses the second and contrasting contextual area studied in this dissertation, the institution of general practice within the New Zealand health system. The health system illustrates the theme of conflict between lifeworld values and managerialist reform initiatives as it was subject to major structural and financial reforms. Chapter Seven analyses the context of general practice in New Zealand and summarises the reforms implemented between 1986 and 1993.

CHAPTER SEVEN

FORMING AND REFORMING THE HEALTH CARE SYSTEM

7.1 INTRODUCTION

The first section of this chapter describes the development of the New Zealand health care system. While a complete summary of this process is clearly the subject of a dissertation in itself (and one in another subject) an attempt is made to identify lifeworld values that have played an important role in the establishment and evolution of the New Zealand health system. It was necessary to provide a historical context in order to analyse the objectives of the government in reforming the system and the responses of the GPs studied to those reforms.

Much of the modern health system was the product of the 1938 Social Security Act and particular attention is paid to the role of general practitioners in the formation of that act and the system that developed. The second section of this chapter details the relationship between the steering media (the State) and the system (GPs). As a result of the confrontation between the GPs and the State in 1938 (see section 7.2), GPs established high levels of autonomy and relatively little control from the State and a relatively open-ended fee for service budget. Between the 1940s and the 1990s there were a number of reform initiatives whereby the State attempted to gain more control over GPs and to cap the open-ended fee-for-service budget. These skirmishes demonstrated the ability (and inclination) of GPs to resist government initiatives (colonisation forces), particularly initiatives that were likely to impact their autonomy and/or income.

In 1991 the government announced a quasi-market structure for the health care system. This structure became law in 1993 and fundamentally altered the funding relationship between GPs and the government from the fee-for-service to a contractual arrangement. The last section of this chapter describes how GPs in New Zealand have responded collectively to the changes. While there were a number of government documents that described the policy proposals, little study had been done

in how the initiatives were developed and how they were implemented. Therefore the content of the second and third sections of this chapter was substantially original research. Other authors have been referred to where possible, however a significant proportion of the material was drawn from interviews and unpublished documentation.

7.2 HISTORY OF HEALTH CARE IN NEW ZEALAND

The State was involved in the provision of health services from the beginning of European settlement in New Zealand. From 1841, civil servants designated as Colonial Surgeons, or Health Officers, were appointed to each principal settlement to meet the medical needs of the imprisoned, the insane, the impoverished and the indigenous (*Wellington Independent*, 29 April 1846). Colonial hospitals were also established by the State to "offer the fruits of Pakeha civilisation to the Maori" (Dept of Health, 1974, p. 12) and to address the issue of native susceptibility to European illnesses. During the provincial period (1854-76) benevolent societies were established in various centres to organise health services for groups whose needs were not met by the State. The benevolent societies were involved in the establishment of hospitals, funded partly by local subscription and partly from the State and managed by locally elected hospital boards.

The development of a comprehensive health system was hampered by the view that hospitals were a place for the poor, and the wealthy were generally treated in their own homes. However, by the 1920s the attitude towards the hospitals had changed from the view that 'the hospital was an act of charity' to 'health care was the right of all citizens' (Department of Health, 1974). This change was coupled with the fact that the growing complexity of medical and surgical techniques made entry to hospitals necessary for adequate treatment.

The first Labour Government was elected in New Zealand in 1935 and it remained in office until 1949. Crucial to their election success was the promise of wide ranging social and economic reforms, of which the reform of health care formed a small but significant part. The Labour Government recognised the need for a change in the

provision and availability of health care services and sought to implement a tax-funded health system which would provide all citizens with access to free health care on the basis of need. The policies of the Government were to establish:

a) a universal general practitioner service, free to all members of the community requiring medical attention,

b) free hospital or sanatorium treatment for all,

c) free mental hospital care and treatment for the mentally afflicted,

d) free medicines and

e) free maternity treatment, including the cost of maintenance in a maternity home.

7.2.1 General Practice

The policy of free access to health services promoted by the government was strongly resisted by doctors in the form of the New Zealand branch of the British Medical Association (B.M.A). The doctors saw the State funding of health care as a threat, undermining their direct, fee-for-service, relationship with their clients, and as a means of giving the State a long-term stake in the oversight and control of their work.

As a result of the stance of the B.M.A. there was a three year struggle (1935-1938) between the doctors and the State. The struggle was resolved with a partial compromise. All citizens would have free access to public hospital care financed from taxation, while tax financed subsidies were made available to those choosing to use private hospitals. Primary health care would not be directly funded by the State. Instead, subsidies would be paid by the State covering the cost of consultation and prescribed pharmaceuticals. These subsidies were gradually extended to cover a range of other diagnostic and therapeutic services utilised by GPs. This compromise between the State and the doctors became enshrined in the 1938 Social Security Act.

In defence of their right to charge a fee-for-service the medical profession managed to entrench a high level of autonomy and control. This was most obvious in primary health care. General practitioners enjoyed the right to practice where they chose, as

they chose, for the price they chose, while being able to draw on state subsidies for their fees and for resources, especially pharmaceuticals, used in the practice of medicine. As patients required a referral from a GP before they could use state-funded secondary services, the GPs were effectively enfranchised as the gatekeepers to secondary care services and to the services of other health care providers such as physiotherapists. This system placed the GP in a position of power and created a split between the funding of GP based primary care services and the funding of hospital based secondary care services (Fougere, 1993).

7.2.2 Lifeworld Implications

The development of the New Zealand health care system in the 1930s did not have the strong religious influence found in other countries or in the development of the New Zealand education system. However, it is possible to identify two key values that formed the basis of the system. The first value was expressed by the State and was that health care was the right of all citizens. This 'value' became quite central to the health system as it developed. The other (perhaps contradictory) value was the right of the medical profession to practice without being in a direct accountability relationship with the State. Because the GPs retained the subsidised fee-for-service arrangement, they were not employed by the State, but claimed the fee-for-service subsidies on their patients behalf. This maintained the autonomy of the medical profession and protecting them from direct control by the State.

7.3 REFORM OF HEALTH CARE

After the establishment of the Social Security Act 1938 the New Zealand health sector grew rapidly in size and cost. While the growth in health care expenditure was considered acceptable in times of economic prosperity, the economic crisis that emerged from the middle of the 1970s led to significant attention being devoted to curbing public sector expenditure. The health care system was subject to criticism which was expressed in several major reports. In 1974 the Labour Government's White Paper, *A Health Service for New Zealand,* advocated major reform of the health care system to achieve greater cost-effectiveness. The 1974 White Paper

proposed the regionalisation of health services through the creation of 14 Regional Health Authorities. Initially the Regional Health Authorities were to be responsible for publicly provided hospital and public health services but this was to extend to primary care in the longer term. Although these proposals were bitterly resisted by the medical profession and seemed to be shelved after a change of government in 1975, the idea of regionalisation and the integration of the split between primary and secondary health services continued to gain political support. In 1983 the National Government introduced the legislation to enable the formation of regionalised health organisations known as Area Health Boards. However, it was not until 1989 that all of the Hospital Boards were dissolved and Area Health Boards were fully implemented.

During the 1980s two more reports were produced: *The Health Benefits Review*[1] (*Choices*) in 1986 and *The Report of the Task Force on Hospital and Related Services*[2] (*The Gibbs Report*) in 1988. *Choices* was concerned with the options for funding and purchasing health care and offered two broad alternatives. First, the government would remain the dominant funder of health care, but services would be provided on a competitive basis from private and public providers. Second, the government would remain the residual funder of health care, to ensure access for all individuals to health services, but most of the funding would come through regulated private insurers and health maintenance organisations. The second option, involving compulsory health insurance and private provision, was rejected by the Labour Government.

In 1988 the Labour Government commissioned the Hospital and Related Services Taskforce to produce a review of the existing New Zealand public hospital services. The taskforce were asked to examine the existing structure of the health system and to propose an overall programme of reform. Their report entitled *Unshackling the*

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[1] Scott C., Fougere G. and Marwick J. (1986).

[2] Gibbs A., Fraser D. and Scott J. (1988).

Hospitals was released in April 1988 and became know as the '*The Gibbs Report*' after its chairman Mr Alan Gibbs.

The Gibbs Report targeted three key areas within public hospitals which needed attention: poor management performance, lack of management information and the need for restructuring to create a competitive market for health. The taskforce was critical of the existing triumvirate model of management where responsibility rested with three executives: a nurse, a doctor and an administrator, rather than with a single chief executive. The taskforce claimed that this structure led to poor management relationships, poor decision making and inefficient organisations. The central negotiation of staff salaries and conditions by the Health Services Personnel Commission (HSPC) was seen as detrimental to productivity. Central negotiation and triumvirate management were replaced in the State Services Act (1988) and the 1988 amendment to the Area Health Board Act (1983). All public organisations were required to have a single general manager responsible for performance and the HSPC was disbanded and the responsibilities were delegated to the individual institutions. The taskforce stated that it was impossible to evaluate the current efficiency of health care organisations with the lack of costing and management accounting information and considered this to be another major short-coming of this sector.

The most radical of the recommendations made by the taskforce was the creation of a competitive market for health. It argued that the dual obligations of the Area Health Boards to 'purchase' and to 'provide' health services were inconsistent. This proposal was foreshadowed in the options outlines in *Choices* and the suggestion of more private sector involvement in the provision of health care. The thinking of the taskforce was also influenced by key Treasury staff who had already shown their support for a competitive market in health care (Treasury, 1987, p.159).

The structural reforms proposed by the taskforce sparked considerable debate throughout the country. Although the fourth Labour Government chose not to implement any of the major structural changes recommended in either of the two reports, it did follow a direction more in line with the *Choices* recommendations. The

Minister of Health of the 1987 Labour Government chose to continue with the establishment of Area Health Boards. As part of the push for greater efficiency rudimentary performance contracts were introduced between the Minister of Health and Area Health Boards. Each board was required to sign performance orientated accountability agreements (Ashton, 1992, p. 149).

December 1990 saw an election and a resulting change in government from the Labour to the National Party. Although the National Party's slogan for the election campaign was 'Creating a Decent Society', it immediately revealed a policy of targeting welfare and reducing public expenditure. Before the end of December the newly elected Government established yet another health sector task force to 'identify and investigate the options for defining the roles of the government, the private sector, and individuals in funding, provision and regulation of health services'[3]. The taskforce didn't release a report to the public, however they did produce a document (known as the *April Report*) which was based on the earlier work of *Choices* and *Gibbs*. The *April Report* outlined a number of options for the future of the health system, and formed the basis of a later government strategy paper - *Your Health and the Public Health* (Upton, 1991), generally known as the *Green and White Paper*. This was released in July 1991 as a 'statement of government policy for reform of the New Zealand health care system' (Upton, 1991). The Paper announced that all Area Health Boards were to split into separate purchaser (Regional Health Authorities) and provider (Crown Health Enterprises) organisations. All state owned hospitals become Crown Health Enterprises (CHEs) and were required to contract, on a competitive basis, with Regional Health Authorities (RHAs) for state funds. RHAs would receive a population based funding pool and would be responsible for purchasing health services for a geographical area.

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[3] Description of the task as outlined in the Terms of Reference for the taskforce published as Annex 1 in Upton (1991).

The health sector taskforce did not seek public submissions and its activities were not publicised. Therefore most the details of its activities and the relationship between the taskforce and the subsequent Government policy document only became evident through a series of personal interviews with key taskforce members (see Barnett and Jacobs, 1997). In theory, several issues raised in the *Green and White Paper* were open to public discussion: how the new system would be funded (from government or from some form of social insurance), the nature and definition of core health services; and the concept of health care plans as a competitive alternative to the RHAs. However, in reality most of the key decisions had already been made and there was relatively little opportunity for the public to influence the proposals. Easton (1994) maintained that this was an intentional device on the part of the Government, a device he called 'Policy Blitzkrieg'. Under this approach political pressures from special interest groups (principally the medical profession) and from the public as a whole could be reduced by moving rapidly through the proposal and implementation stages. As soon as the *Green and White Paper* was presented to parliament in 1991, the Government began to take steps to implement the proposals (Easton, 1994, p. 224).

The essential features of the *Green and White Paper*, with the exception of the proposed health care plans, were incorporated into the Health and Disability Services Act 1993. A number of other organisations were established as part of the 1993 Act. The two main ones were the Core Services Committee and the Public Health Commission. The Core Services Committee (The National Advisory Committee on Core Health and Disability Support Services) was an independent advisory committee appointed by the Ministry of Health. They were required to advise the Minister of Health on the services which New Zealanders could expect to receive from a publicly funded health care system. In reaching their conclusions the Core Services Committee were required to consult widely with the public and with health and disability support professionals. This original concept of generating a public consensus on what services should and should not be provided by the State effectively failed (Cummings, 1994) and the Core Services Committee focused instead on the development of a series of best practice guidelines.

The public health responsibilities of the Department of Health were separated under the 1993 Act and became the responsibility of the Public Health Commission. It was considered that a centralised public health body would provide better planning and co-ordination of initiatives than the RHAs. The Commission's role was to assess public health needs and to advise the Minister of Health on policy. The Commission did not provide any health services themselves but purchased services from providers on behalf of the government. In 1995 the Minister of Health decided to re-absorb the Public Health Commission into the Ministry of Health.

In July 1993 the Department of Health was restructured into a policy advice unit (Health Amendment Act 1993, Sec 38) known as the Ministry of Health. The restructure of the Department of Health resulted in a number of new organisations which were previously part of the Department, two of which relate directly to general practice. The first, Pharmac, was formerly the Health Department's drug tariff unit. It became a separate organisation which was owned by the four RHA's. Pharmac negotiated with pharmaceutical companies for the subsidy level for each medicine on the pharmaceutical schedule.

The second, Health Benefits Ltd, was formerly the Benefits Payment Office of the Health Department. This was also owned by the four RHA's. Health Benefits Ltd (HBL) administered, on behalf of the RHAs, all the primary care subsidies that were paid to providers. Examples of provider groups paid by HBL are general practitioners, laboratories, midwives and practice nurses subsidies. Health Benefits Ltd also acted as the clearing house for the processing of GP prescriptions and therefore providing information on GP prescribing behaviour. Currently HBL is responsible for a post-payment claim audit programme intended to identify any cases of fraud. This resulted in a prison sentence for a GP who was convicted of fraud (*NZ Doctor*, 9 June 1995, p. 9).

7.4 GENERAL PRACTICE - GOVERNMENT INITIATIVES

7.4.1 Social Security Act 1938

The basis for the State subsidy of general practice was established as part of the 1930s negotiation between the State and the medical profession. The General Medical Services Benefit (GMS) was available to any medical practitioner who provided medical services for patients. Essentially, any registered practitioner could claim the GMS. There were also a number of other benefits that could be claimed: travelling fees, rural practice bonus, immunisation fee and fees payable in respect of general medical services provided on public holidays and at night. Additional subsidies were also available for the employment of practice nurses[4] and attendance at maternity cases. Although the State provided funding for the medical services there was little attempt to control how or where GPs practised. Individual GPs were free to set up their practice wherever they liked and to practice medicine as they chose.

The subsidy system was intended to ensure that the public had free access to medical care but this was never strictly the case. From the beginning patients were required to pay part of the cost of a visit to the GP. The subsidies were subject to regular revision, through the Social Security (Medical Fees) Regulations, but did not keep pace with levels of inflation and the real value of the GMS fell from around 75% of the total fee when it was first introduced in the 1930s to less than 20% in 1992 (Ashton, 1992, p. 149).

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[4] Currently this stands at $11 per hour for 30 hours a week. Which leaves the GPs paying out of practice income about $235 per week for a full time practice nurse.

Table 7.1: GP Change Timeline

1938	Social Security Act (1938) - the establishment of the 'access by need' health system.
1986	Commerce Act (1986) – GPs free to advertise
1990	GP contracts
1992	Restructure of the GP subsidy system
1992	Uniservices report on the formation of Independent Practice Associations (IPAs)
1993	Health and Disability Services Act (1993): the separation of purchaser and provider. GPs required to contract with local Regional Health Authorities (RHAs) rather than the State.

7.4.2 Commerce Act 1986

The first major change to influence general practice was the deregulation of the primary health market. The aim of the Commerce Act (1986) was to promote competition in New Zealand markets. Under the provisions of this act it became possible for doctors to advertise and to take a more market approach to the provision of primary health care. It was expected that this would introduce an element of competition into the health care market.

7.4.3 July 1990 Budget and 1990 GP contracts

From 1989 the Labour Government was involved in an internal policy debate on how to fund and manage primary care services. Much of this debate centred on the Primary Care Project Group within the Department of Health and in the Office of the Minister of Health. The work of this group was driven by both equity and economic concerns. From an equity perspective the group focused on the growing cost to patients of visiting a GP and they were concerned that this cost might represent a barrier to access, particularly for people on low income. From an economic perspective the project group were influenced by the NPM contracting models promoted by Treasury and the fact that formal performance contracts were successfully established between the Area Health Boards and the Minister of Health.

Within New Zealand there were only a few medical practices that had formal contracts and were funded on a capitated rather than a fee for service basis. These practices were generally run by one of the trade unions and provided subsidised medical services to their members while paying the GP an annual salary. These practices provided a model for the proposed change in the GP funding structure. Under the proposal GPs would be funded on a direct contract rather than subsidised through the existing GMS system. Unpublished project group discussion papers outlined five objectives of a GP contract:

1. Better access for users (financial, time, geographical, cultural, knowledge of entitlements).
2. Move towards population-based care; more health promotion and health protection.
3. More attention towards quality assurance and improved quality in primary medical care.
4. Better management of government expenditure on primary health care (one implication was that government needed better information about what was happening in primary medical care).
5. Control of government expenditure on primary medical care and on referred services.

(Unpublished Papers, 1989 - Primary Care Working Group: Ministry of Health).

In the budget of July 1990 the Minister of Health publicly announced the concept of GP contracts and offered GPs who would sign a contract with her a higher level of government funding. The funding was such that all patients who visited a contract practice received free services. The provisions of the contracts are summarised in Table 7.2.

Table 7.2: The 1990 GP Contract Provisions - Ministry of Health (1990)

Provisions of the Standard Contract for the Provision of Medical Services (9/90)

1. General obligations of general practice

Each practice must comply with the New Zealand Health Charter, the attached codes of General Practice and Nursing Services and participate in a programme of quality assurance. They had to co-operate with other bodies in the achievement of "The New Zealand Health Goals and Targets". Practices had to provide 'appropriate' range of primary health care services. Any new employees or associates who joined the practice later are required to accept the contract also.

2. Obligations to provide primary health care information

Each practice was required to actively co-operate with the collection of information on patient details (name, address, patient number, sex, occupation and ethnic group), claim records (patient number, claim details and treatment referrals). On a periodic basis the Director-General could request any information for monitoring health goals and policy and practice records could be accessed for audit purposes.

3. Obligations to effectively administer primary health care

Each practice was required to fill in any forms or comply with any administrative requirements deemed necessary.

4. Obligation on Fees

The practice was not permitted to charge fees in excess of those stipulated by the Minister. Subsidies would be adjusted according to the Consumer price index. Each practice was required to display the current schedule of fees for the public to see.

5. Obligation on nursing services

The Minister would pay the practice nurses salary at 90% of the award agreement. Each practice nurse has to provide a range of specified clinical and promotion/educational services. Practice nurses were also required to report on patient contact and services provided, participate in ongoing continuing education and in quality assurance activities.

6. Rural bonus

An annual cash grant would be available to practices who have significant consultations and were isolated from other GPs and from the nearest general hospital.

7. Termination of contract

Three months notice was required by either party for termination of the contract. The practice was also obliged to notify the Director-General if there was a significant change in the structure of the practice.

The 1990 GP contract contrasted sharply with those introduced in the UK. While there was some attempt in New Zealand to define and influence the role of the practice nurse there was no real attempt to define GP behaviour or the nature of

general practice. The principal obligation was a restriction on practice fees, compliance with ethical codes and provision of additional information to the Department of Health. The GP contract scheme was formally abolished by the National Government from March 1991.

7.4.4 1991 Green & White Paper and Health and Disability Services Act 1993

In 1990 the newly elected National Government rejected the health policies and reforms of the previous Labour Government and turned to the quasi-market models advocated in the *Choices* and the *Gibbs* Reports. Although the 1991 policy paper *Your Health and the Public Health* made little or no reference to general practice, interviews conducted with the taskforce members and data extracted from the taskforce files indicate a considerable interest in primary health (see Barnett and Jacobs, 1997). References were made to studies of managed competition, GP fundholding as developed in the UK, and a strong emphasis was placed on the integration of public budgets for both primary and secondary care:

> The Government plans to integrate the funding for all personal health services - visits to doctors, prescriptions, other community based services, hospital services - and to place the responsibility for managing all this funding with the Regional Health Authorities (RHAs) . . . (Upton, 1991, p. 41).

As the RHAs held the budget for both primary and secondary services GPs would be required to establish some form of direct contract with their local RHA. Upton (1991) presented five different forms that the contracts between GPs and the RHAs might take:

- Salaries – salary contracts are often accompanied by performance agreements which specify what hours should be worked and what responsibilities should be fulfilled.
- Fee-for-service – Under this arrangement the provider is paid a fee for each consultation or procedure. Sometimes the doctor sets this fee; sometimes it is a fixed amount negotiated between the doctor and the insurer or government agency which pays the fee.
- Capitation – the doctor or other care provider is paid an annual fee for each patient enrolled in their practice.

- Risk-sharing contracts – doctors can be placed on contracts under which they bear a share of the cost of any prescriptions, diagnostic tests, hospital admissions, and so on, which they order for their patients. These kind of contracts can be used to encourage doctors to choose cost-effective care for their patients, and strive to prevent their patients needing high-cost care.

- Budget-holding contracts – budget-holding is a type of risk sharing contract. The doctor is given an annual budget for each client enrolled with their practice, and required to meet all of the costs of their prescriptions, diagnostic tests, and perhaps the costs of some other referrals, from this budget. This type of contract, with some modifications has been introduced in some general practices in the United Kingdom.

(Upton, 1991, p.48).

The Health and Disability Services Act 1993 translated the government policies into law. Although most of this Act was concerned with the structure and operation of hospital services, GPs were included as a 'provider' of health services. Each GP had to negotiate a purchase agreement with their local RHA. The nature of the agreement was flexible and there was no restriction within the Act on the type of 'purchase agreement' which a RHA could establish or the kind of 'provider' from which they could purchase.

Some concern was expressed by the NZMA (New Zealand Medical Association) that certain GPs might be unwilling to enter into explicit purchase agreements with the RHAs. In order to maintain the continuity of services for patients of such GPs a special provision was made under Section 51 of the Health and Disability Services Act for a pseudo contract.

Table 7.3: Section 51 Health and Disability Services Act 1993

Arrangements relating to payments for health and disability services
(1) Where the Public Health Commission or a Regional Health Authority gives notice of the terms and conditions on which the Commission or authority will make a payment to any person or persons, and, after notice is given, such payment is accepted by any such person from the Commission or Authority, then —
(a) Acceptance by the person of the payment shall constitute acceptance by the person of the terms and conditions: and
(b) Compliance by the person with the terms and conditions may be enforced by the Commission or Authority as if the person had signed a deed under which the person agreed to the terms and conditions.

Regional Health Authorities were permitted to publish what is known as 'Section 51 notices' specifying a set of terms and conditions of medical service. A GP who refused to sign a formal contract could make a subsidy claim under Section 51 without signing any contract.

The effect of the Section 51 provision was that formal contracts were voluntary and GPs could choose to maintain an effective status quo by claiming under the Section 51 provision. The Section 51 agreements were to remain in force for two and a half years and conditions could not be changed within that time without agreement by both parties. Individual GPs could withdraw from the coverage of the notice by giving four weeks notice. After the 1 July 1995 the RHA could change the agreement with six months notice to the GP. However, by 1995 the RHAs did not show much interest in changing this arrangement as a significant proportion of GPs (over 60%) were already operating under a formal contract.

7.4.5 Patient targeting and charging

In 1991 the newly appointed Minister of Health announced that the existing GP subsidy would be cut. Medical subsidies were restricted to children, beneficiaries, the old and the chronically ill. Under this system subsidies were based upon targeting and patient means testing, so government subsidies for GP visits were only available for high users, those with 'low income' and children (Ashton, 1992, p. 146).

The subsidy system was announced in the 1991 budget and came into force from 1 February 1992. Subsidy entitlement was based on what was initially called a 'Kiwicard' and was later renamed the 'Community Services Card'. Those who received a welfare benefit paid by Income Support Services were automatically issued with a Community Services Card. Other individuals had to apply for one. Although application forms were held by GPs, the cards were managed by the National Community Card Centre (a unit of the Income Support Service). In order to qualify for a card joint family income had to be below a specified level (e.g. Single $16,500 p.a., Married $26,000 - as at 1995).

High use and chronically ill patients were also subsidised. If a patient with an ongoing condition visited their GP (or hospital outpatients) more than twelve times within twelve months they qualified for a High User Card and experienced the same subsidies as those with the Community Services Cards. Patients applied for a High User Card through their GP but the cards were processed and managed by Health Benefits Ltd for the RHAs.

There were three major benefits of holding a card. First, adult patients were subsidised $15 per GP visit (children under 5 get $25 and children over 5 get $20). Adults that did not hold a card did not get subsidised (although children are subsidised $15). Second, card holders were only required to pay a $3 part-charge for prescription item while others paid a $15 charge per item. Third, those who held a card received free outpatient treatments at public hospitals.

The targeting system was a mix of social concern (access to health care for the poor) and Treasury economic logic (financial incentives, cost-shifting from the State to the public). It might seem strange that so much effort was devoted to restructuring this system with the 1991 proposals under way. However there were two reasons for this:

1. The subsidy restructure was an attempt to save money (*Examiner*, Feb. 21 1991: p. 1) or at least cap the growing public health budget (Scott, 1992) at a time that the government thought that they were in a financial crisis (Scott et al., 1990).

2. The targeted system represented the status quo prior to the 1993 restructure and therefore formed the basis for all of the Section 51 agreements and the starting point for all contract negotiations between GPs and the RHAs. So although the system was no longer mandatory from 1993, it did have a significant influence on the subsequent agreements.

7.5 GENERAL PRACTICE - PROFESSIONAL RESPONSES

The New Zealand medical profession rarely took a passive response to governmental initiatives. This was clearly illustrated in the historical role of the medical profession in the structure of the 1938 system and the formation of the GMS benefit. In the light of this historical tension there was surprisingly little response to the Commerce Act (1986). The main reason for this was that the Commerce Act (1986) had a very broad scope. It applied to all companies and all professional groups. Its implications for the medical profession did not become evident until some time after the Act was passed.

The Commerce Act (1986) had a limited impact on general practice. Most practitioners were reluctant to compete or advertise and there has been no visible impact on fee levels (Bell and Fay, 1991). However, there was a small number of GPs who responded eagerly to the new opportunities and a number of new central city practices which advertised extensively, opened longer than usual hours and offered set price fees. These practices tended to be regarded with disdain by other GPs (Kearns and Barnett, 1992).

There was no doubt that the 1990 contract was intended to directly impact on GPs. The response was immediate, vocal and wary (*Press*, July 25 1990, p. 3). The Minister of Health stated that she did not choose to consult with the medical profession in the development of the GP contracts because of "their aversion to restrictive charges" (*National Business Review*, 26 July 1990, p. 3).

Some GP practices chose to accept the contracts seeing immediate financial and access benefits for patients, some were strongly opposed seeing a threat to their

autonomy and an intrusion by the State. The 'opposition' group said that they were suspicious about signing any contract that limited their fees because they did not trust that the Government would fulfil their end of the agreement and keep subsidies in line with inflation (Press, 27 July 1990). Initially some of the executives of the NZGPA (New Zealand General Practitioner Association) supported the concept of contracts, however, because of the resistance to the contract proposal within the membership, most of these people were removed from office and replaced by others who strongly opposed the contracts. The NZMA (New Zealand Medical Association) and the NZGPA took the Minister of Health to court, arguing that a direct contract with the State was a threat to the primary relationship between the GP and the patient. While the NZMA and NZGPA lost their case, the combined resistance to the contracts and the change in government in 1990 saw an end to the contract scheme. However, relationships between the government and the GPs were seriously soured as a result of this conflict.

It is not surprising, following the 1990 experiences that the proposals of 1991 and subsequent legislation in 1993 were also regarded with suspicion and, in some cases, outright fear by many GPs. The introduction of the RHA into the funding process and the requirement for GPs to contract directly with 'the State' was also perceived as a threat to GP autonomy and control:

> We fear an amoeba-like Health Department with its pseudopodia interfering even more with our prescribing, our diagnostic investigations and our ability to help our patients (Marshall, 1992).

The response of the medical profession to the 1991/1993 changes took many forms. However, a key change was the proposal and formation of IPAs (Independent Practice Associations).

7.5.1 IPAs

The competitive threat from new entrepreneurial practices had provided the incentive for doctors to group together and establish after-hours practices in many places around the country. Therefore, establishing a collective front was seen as a sensible

response to the requirement to contract with RHAs and the 'threat' from the 1991/1993 changes to their funding arrangements.

In June 1992 a group of academics based at the University of Auckland were jointly commissioned by the New Zealand General Practitioners Association (NZGPA) and the Health Reforms Directorate to advise on the formation of policy for primary health care in the new environment. They recommended that 'providers' organise themselves into groups called Independent Practice Associations (IPAs) as an effective way to address the financial and managerial complexities faced by GPs, to maintain the autonomy of GP practices, to reduce potential transaction and administrative costs and to facilitate risk sharing between the health providers and the RHAs (UniServices, 1992, p. 9).

To some extent the concept of the IPA was similar to the Stockle and Reiser (1992) suggestion that medical professionals could adopt unionisation, for the purpose of bargaining with institutions or purchasers, as a way of protecting themselves against change and the threat of corporatization. The Health Reforms Directorate, who were responsible for driving the reforms, had no clear idea of how primary health contracting would operate. The concept of IPAs was sold to the Health Reforms Directorate by GPs who argued that IPAs would provide an effective way to pass the risks associated with the open-ended fee-for-service payments from the RHAs to the primary health care providers. The IPAs were also promoted as an effective way to simplify the process of negotiating contracts. In effect, the IPA would act as an agent in the contract negotiation between member GPs and the RHA. Therefore the RHA's contracting costs would be cut as they would only need to contract with a few IPAs as compared to hundreds of GPs. There were also strong incentives for GPs to group together. Malcolm (1993) argued that there were six different factors which motivated the development of the IPAs from a GP perspective:

(1) Providing some protection for GP interests;

(2) A stronger negotiating body with the RHAs for the development of services;

(3) Through budget holding the GPs would be able to provide a more flexible range of services for their patients;

(4) Improving patient care through working more collaboratively with other providers including nurses, CHEs etc.;

(5) Shifting the balance of care from secondary to primary and;

(6) Improving the health of patients and community.

Factors (1) and (2) were linked with the fear of the changes and the threat of interference to medical autonomy. Malcolm (1993) indicated that many GPs thought that they would be 'left alone to get on with the job' if they were a part of a large group. Factors (3), (4) and (6) were concerned with improving the quality of medical services and 'being better doctors'. Factor (6) involved both obtaining resources and political action. This showed the potential of the IPAs to become an active change agent rather than just a passive change absorber. Later work conducted by Malcolm & Powell (1996) found some empirical support for factors (1) protection and (2) negotiating contracts. Research conducted by Forsearch (1995) also came up with a similar conclusion.

In 1995 about 40 IPAs were established around the country and over 50% of the GPs were members. Two different types of IPA emerged: one was provider orientated and the other was patient orientated. Most of the IPAs were of the first type and were based around a provider grouping in a specific geographic area. Generally these were focused on GPs but some also included practice nurses, midwives and other primary care providers in their membership. The second type of IPA was based around a specific group of patients. These commonly involved Non-European ethnic groups and offered alternative services in addition to those provided by most general practices. One example of this kind of IPA was the health centre based on the Kirikiriroa Marae in Hamilton. This was a capitated centre with approximately 1500 people on the register, many of whom had a particularly poor health status. The health centre provided free or low cost health services based on the patient's ability to pay. It was staffed by a full time GP, a community health worker and a nurse. The

local Kaumatua also provided spiritual advice and traditional Maori medicine as required.

7.6 SUMMARY

In many ways the Social Security Act (1938), can be seen as pivotal in the emergence of the modern health care system in New Zealand and is important in establishing the concept of 'access by need' as a core lifeworld value in health care. However, from this early point GPs challenged the state/steering media initiatives in order to ensure their autonomy and financial security. From the 1940's to the early 1990s there were a series of initiatives to restrict this GP autonomy and the open-ended financial obligation of the state connected with it. These initiatives culminated in the Health and Disability Services Act 1993 which required GPs to negotiate a formal contract for their service with their local Regional Health Authorities (RHA).

While the New Zealand GPs had been able to generate a rebuttal pathway in relation to the 1990 contract proposal, they did not have the power to reverse the structural changes implemented in 1993. By the time that they identified the threat the changes were firmly entrenched in Government policy. The explicit intention to exclude the medical profession from the policy process meant that the reforms were not the product of a process of open discourse and the weight of the better argument. Therefore it is not particularly credible to argue that the reforms were an example of the evolution pathway. The reform of the New Zealand health system dislocated the existing steering media arrangements and the equilibrium between the State and the GPs. Under the new arrangements a equilibrium needed to be re-established. The obligation to negotiate a formal contract with the RHA represented a new form of financial control and visibility for the GPs and a perceived threat to their professional autonomy. Under the Laughlin (1991) model, a change in steering media will lead to either a re-orientation or a colonisation pathway. This is consistent with the UK studies of GP reform analysed in Chapter Three. Laughlin et al. (1994b) found that the new responsibilities arising from the UK GP contract led to a reorientation within

the practices studied where the changes were absorbed by the practice nurses and practice managers.

The next chapter explores how the changes were managed in five New Zealand GP practices. Based on the studies of the UK health reform described in Chapter Three and the analysis of the New Zealand reforms in this chapter, one could expect an example of the reorientation or the colonisation pathway. The exact nature of this change process will depend on whether the new responsibilities were absorbed by specialist work groups within the practices or whether the creation of IPAs as an intermediate organisation between the GPs and the RHA introduced a new element into the relationship. Based on Laughlin et al. (1994a), it seems that such a group has the potential to manage the perceived threat to GP autonomy and income, protecting the 'core work' of the GP practice.

CHAPTER EIGHT

AN EMPIRICAL REVIEW OF CHANGE: FIVE CASE STUDIES OF GP PRACTICES

8.1 INTRODUCTION

The objective of this chapter is to describe and analyse the five GP practices studied and how the practices 'managed' the reform changes they experienced. This chapter contributes the empirical 'flesh' to the Laughlin-Broadbent model of change pathways and absorbing work groups. The reforms described in the previous chapter were perceived as a threat to the lifeworld values, the autonomy and the income of GPs. Therefore, since GPs were unable to rebut the changes it was expected that they would attempt to resist the change in some way. However, it was also clearly possible that the reforms may produce fundamental changes in the 'real work' of the medical practitioners and result in the process of colonisation.

The research interviews began in September 1993. By this time the 1990 GP contracts had been abolished, although there was a legacy of tension and distrust between GPs and the State. This tension was highlighted when one GP stated:

> The Government has historically been malevolent, not supporting GPs. They have taken a publicly derogatory approach, suggesting that GPs are ripping off the system to the tune of about $40,000 each (GP1 Practice Three, November 1993).

The Commerce Act, 1986 altered the work environment for GPs. Prior to 1986, GPs and other professional groups were exempt from the legislation prohibiting price fixing arrangements and anti-competitive behaviour. Ethical restrictions tightly defined what was considered acceptable advertising and promotion for a GP even to the point of defining the lettering size permitted for signs. The introduction of the Commerce Act, 1986 was part of a shift away from protection for professional groups. Since the Act GPs have operated in a more contestable and competitive environment.

GPs experienced increased competition from both 'insiders' and 'outsiders'. In terms of 'outsiders', other professional groups, such as midwives, have gained much more recognition and acceptance. Following the Nurses Amendment Act 1990 midwives were able to establish themselves independently of GPs and claim full subsidies for delivery and maternity care. This move brought the midwives into direct competition with the many GPs who also provided maternity services and the drop in maternity cases attended by GPs was directly traced to the growth in independent midwives.

Practice nurses have also expressed an interest in establishing independent practices. This has also been combined with political pressure to allow other professional groups prescribing rights (Shaw, 1994). While this did not move beyond the discussion stage, it placed GPs under direct competitive pressure and generated a clear defensive reaction (see *NZ Doctor*, 1 September 1990).

Increased competition also came from 'insiders' within the medical profession. A few GPs saw the change process as an opportunity to earn more money and adopted a more entrepreneurial approach to medical care. Most commonly this involved establishing practices in the high traffic central city areas, advertising and offering reduced fees. Established GPs felt that these new practices were 'creaming off the easier jobs' (GP1 Practice One, December 1995) and saw them as a threat to their patients and income levels. However, few patients chose to switch to the cheaper practices.

The subsidy changes and the patient targeting system introduced in 1991 had major implications for GP/patient relations and for practice income. From a GP perspective, the targeting system categorised the patient population into the subsidised and the unsubsidised. Patients were only entitled to a State subsidy while they maintained a valid community services card. However, these changes did not generate much response from the medical profession. There appear to have been two reasons for this: first, alterations to the GMS subsidy system were not unusual as the government had altered the subsidy levels many times since the system was introduced. Second,

the subsidy changes were obscured by the larger and more threatening reform process (Ashton, 1992, p. 160).

The most important issue that faced GPs in 1993 was what kind of contract they would establish with the local RHA. Although the reforms were announced with surprisingly little public discussion, the time between the announcement of change in 1991 and its implementation in 1993 allowed considerable time for debate. The initial implications of the proposals for GPs were somewhat sketchy but over time two clear facts emerged (1) the responsibility for primary health budgets were delegated to the RHAs and (2) GPs would have to contract with the local RHA for subsidies.

During 1993 the GP practices had to choose between three different kinds of contract arrangement. First, GPs could continue to claim their existing fee-for-service subsidies under the Section 51 arrangements. Second, GPs could develop their own contracts with the RHA. Third, GPs could join together into Independent Practice Associations (IPAs) and develop collective contracts with their local RHA. The pressure on GPs was further reinforced by a general feeling of uncertainty, negative feelings about what the government would do next and a conviction that whatever was going to happen, it would not benefit GPs:

> We had no confidence that any system conceived by politicians and bureaucrats would be good for us. There were also all sorts of extraordinary rumours about what the reforms would involve. Anything from insurance companies taking over and setting up major health care plans to budget-holding, abolition of GMS and abolition of the practice nurse subsidy. There was a lot of uncertainty and we had no confidence that anything that anyone from the Minister of Health down would come up with would be any good for us (GP1 Practice Two, March 1995).

The next section analyses the five GP practices studied and how they responded to the reforms.

8.2 PRACTICE ONE

8.2.1 Practice Description

Practice One was located in an upper socio-economic area on the north-west side of Christchurch. It was a well established practice, had celebrated its 25th anniversary and they had 14,500 people on the regular patient list.

The practice was established by two doctors in 1970 and one of the founding doctors was still part of the partnership. The buildings were purpose built as a medical practice and were owned by an external landlord. The fact that the buildings were intended for only two doctors placed some pressure on space. A multi-service centre was established in 1994 next door to the medical centre and contained a pharmacist, psychologist, dietician, child health nurse and podiatrist. Although it was independent the practice works closely with the new centre, particularly with the pharmacist.

There were five GPs associated with the practice. There was one full time receptionist, two who were part time, three full time practice nurses and one full time practice manager. Most of the administration was dealt with by the practice manager and one of the GP partners who took on the 'staff partner' role, setting agendas, chairing partner's meetings, dealing with salespeople and external contacts and resolving any conflict that emerged within the practice. The financial structure made the doctors more like associates rather than partners as each practitioner had he/r own patient list and retained he/r own profits while sharing expenses. As one of the GPs put it, "technically we are in competition with each other, but in a very co-operative sort of way" (GP1, June 1995). All other staff were employees of the practice.

Practice One was part of an after-hours collective, which meant that health services were available to all patients of the practice outside of regular practice hours. The GPs had an orthodox approach to medicine. The only kind of alternative treatment available was acupuncture and, according to the GPs, "that is pretty mainstream now" (GP1, June 1995). The stated philosophy of the practice was:

- To maintain a friendly, caring, professional relationship with patients.

- To provide a high standard of personalised health care for our patients.
- To meet both the physical and emotional needs of the patients.

(Practice One Newsletter, 1995).

The practice provided a full range of primary medical services although they did not run any specialised clinics or seminars. They argued that health education and prevention was important but because there was no funding for preventative care. The GPs also found that patients were reluctant to visit 'unless they are sick'.

> Prevention is pretty opportunistic and forms part of the consultation where possible. Unfortunately there is not funding for preventative care and there aren't all that many people willing to spend money to come to a doctor without anything wrong with them so we don't do preventative care except when we have the opportunity (GP1, June 1995).

Patient's emotional needs were addressed by one GP who had an interest in psychotherapy treatment. The practice also provided full maternity care and specialist expertise in diving medicine.

> X is interested in diving medicine, he had qualifications in that, a diploma in diving medicine, so he sees a lot of divers, recreational and commercial. He also had an interest in psychotherapy, he does a lot of psychotherapy counselling. One of use does a lot of maternity and obstetric work but the rest of use are generalists (GP1, June 1995).

The practice nurses worked closely with the GPs although they were not assigned to a particular GP. The nurses generally checked a patient before they were seen by a GP, conducted tests or changed dressings when required. They also managed the patient recall system and for conducting immunisation and cervical smears. There was very little in the way of independent practice-nurse function.

Between 1993 and 1995 the practice did not experience a significant change in patient numbers. One of the practice nurses suggested that this was because they had a significant number of accident cases that were funded through the State ACC (Accident Compensation Corporation) insurance programme. The consistent patient

numbers were also related to the fact that they were dealing with a relatively wealthy community.

In 1989 the practice computerised the patient database and accounting system. This involved the purchase of computer equipment and of the Alumni software (a brand of computer software used extensively by GPs in the Christchurch area). By 1990 the age/sex register, patient recall system and all accounting/claims were managed via the computer. Patient details were entered by the receptionist and computer generated invoices were presented when the appointment was completed. The same data formed the basis for subsidy claims (e.g. GMS, ACC, immunisation and maternity) which were automatically generated by the system.

One of the GPs in this practice (GP1) had been involved in the local Area Health Board and remained well informed on the state of the changes. As the research progressed this individual became the key informant and was an important source of information on the state of the changes generally and on how those changes were affecting the practice. Although interviews were conducted with the other GPs, the practice nurses and practice manager, GP1's comments were often the most informative and therefore, are the principal source for quotations.

8.2.2 Response to the reforms

From 1993 the GPs in Practice One chose to be part of the Pegasus IPA and to accept the contract negotiated by Pegasus. Those involved felt that the Pegasus agreement would put them in a better position than accepting the Section 51 arrangement.

> On the 1 July the Government decentralised the health funding. GPs fell under section 51 of the Health and Disabilities Services Act. This was all very detailed and GPs automatically became a party to this. Pegasus restated the Section 51 material in 16 pages. Those who signed the Pegasus contract did not have to try and comply with Section 51. This was a strong incentive to sign with Pegasus (GP1, October 1993).

> Pegasus have acted as a buffer for the individual GP. They have more clout that an individual GP. Both Pegasus and the medical association (NZMA) are pretty influential (GP1, October 1993).

While the reforms did not have a major impact on the operation of the practice, membership of Pegasus did bring some changes. Pegasus announced that GP subsidy claims would be audited on a regular basis. This led to changes in the way the practice allocated work between the GPs and the practice nurses.

> Therefore, we have altered what we claim for under the GMS system. Historically you could claim GMS for any medical service provided, but the doctor had to see the patient. The practice nurses often treat patients for warts. The patient had to wait to see to doctor before the nurse could treat the warts (otherwise we would not be able to claim the GMS). We decided that there was no point in them seeing the doctor (because they had to wait unnecessarily) and had the nurses deal with it. Now we no longer claim GMS for this service, but we have to charge the patients directly, much to the reluctance of some of the nurses (GP1, May 1994).

As the study progressed, the contractual arrangements had little or no influence on the operation of the practice. However, membership of the Pegasus IPA did. A number of the GPs in the practice became involved in the Pegasus laboratory utilisation project and the pharmaceutical-prescribing project.[1] Earlier attempts to change prescribing were criticised by GP1 as there were no financial incentives.

> They (PreMeC)[2] conduct prescription analysis, which is interesting but has little impact on my prescribing behaviour. Prescription analysis provides details of a GP's prescribing costs over a four-week time period and a comparison to the prescribing levels of other GPs. But there is no incentive to be a more economic prescriber. Maybe if we had a budget for pharmaceuticals it would make a difference, but currently I can see no reason why I should not give my patients the best available. So although these systems are being introduced to measure expenditure in the different areas there is still no real incentive to change behaviour (GP1, May 1994).

Within a year he had changed his mind and argued that there were incentives to change his behaviour as a GP. These incentives came from the Pegasus projects and the contracts between Pegasus and the RHA. Although individual GPs did not benefit financially, savings made were retained by Pegasus to be used for patient services.

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[1] See Appendix 2

[2] See Appendix 3

> Basically it is the fact that the Pegasus group has got a contract with the RHA so we get to retain control of some of the savings made. That is the incentive and it is quite powerful. Without that you are only doing it for the good of the general person - it is a bit vague (GP1, March 1995).

In Practice One the participation in the Pegasus projects went beyond passive involvement. One of the GPs became a facilitator and convenor for one of the pharmaceutical project groups.[3] This not only involved co-ordinating the pharmaceutical group meetings but also attending steering meetings organised by Pegasus.

> Well, one, I get paid for it, but that wasn't really the incentive. The pharmacy project, I feel it could be quite exciting. I have known for years that there are big savings to be made in prescribing - it is just simply a matter of us applying grey matter to it and yes, it's an opportunity to put it into practice and I was keen to get involved in that. So by being facilitator for my little group (12 GPs) I think that it gives me an opportunity to influence peoples' prescribing for the better. The idea is that all of this makes the use of the money more cost effective. I guess it just comes back to the fact that I believe in what I do and anything that can keep up the standards of service quality has got to be good (GP1, June 1995).

The researcher suggested to some of the GPs strongly involved in the Pegasus projects that they had bought into what they were trying to avoid in the 1990 contract attempt. However, they did not accept that, arguing that the central problem with the 1990 contracts was the attempt to control GP income.

> The problem with the GP contracts was that there was going to be government control over what we could charge and inevitably, over the years, our fees would not keep up with expenses and inflation and that would mean a decrease in our incomes. There was no way we were going to have that. Changes are more acceptable coming through Pegasus. Yes, we are in control, these are contracts that we have negotiated and accepted on our terms. I guess we regard ourselves as self-employed and do not wish to have our work conditions regulated. Basically it boils down to money and income. If there was going to be State control over our fees that will lead to a drop in our income and that is the bottom line (GP1, March 1995).

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[3] See Appendix 2

8.2.3 Summary

Practice One was a large practice, which was relatively well informed about the changes. From the beginning it was clear that it was the local IPA, Pegasus, that was the change influence rather than the State or the RHA. GP involvement in Pegasus led to a review of the practice claim procedures and developed into active participation in the laboratory and prescribing projects. Although there was an earlier interest in prescribing behaviour and involvement in the PreMeC prescription reviews, there were no real incentives to change. The Pegasus budgetholding projects provided the required incentive. What was driving the interest was the concept of 'doing better medicine'. The leaders in Pegasus were seen as actively working towards this end and seeking to improve the status of primary health care. As part of Pegasus, individual GPs felt that they too could contribute to that goal.

8.3 PRACTICE TWO

8.3.1 Practice Description

Practice Two was well established and had been operating for over twenty years. It was located in the South of Christchurch on the border between a wealthy and a poor community. Over 13,000 patients were enrolled with the practice.

The facilities were purpose built in 1972 and were owned by the GPs. The building was originally intended for four doctors and the expansion of the practice over the years lead to considerable pressure on space. Together with the consulting rooms, nurses station and emergency room, there was also a pharmacy and a physiotherapy clinic on site. Both of these services leased their space off the GPs.

Practice Two provided a full range of primary health services but saw promoting healthy living as a key aspect in the practice philosophy (Practice Two Newsletter, 1995). This was linked with an emphasis on preventative care, particularly of children, which involved a well-developed immunisation programme and the provision of free health checks for children. Attempts had been made to provide outreach clinics in medial specialities such as diabetes. Four of the doctors practised obstetrics and maternity services (two nurses had midwifery qualifications). Other staff also had

specialist interests including family planning, child abuse, psychotherapy, care of the elderly and alternative therapies.

The practice ran its own accident and emergency service, which was staffed by a doctor and a practice nurse during practice hours. The centre was also part of the after hours collective.

There were seven full time equivalent practitioners working at the centre, with the same number of practice nurses (Practice Two Newsletter, 1995). The Practice Manager was responsible for the overall running of the practice and was assisted by five receptionists/telephonists and two secretaries. A project manager was appointed separately for a budget-holding initiative project. The practice was structured as a full partnership, which was somewhat unusual, in that all of the doctors shared both costs and income. All non-GP staff were employed by the partnership.

The practice nurses played a critical role in the provision of service to patients. Each nurse worked with one doctor in a team approach to patient care. Patients identified with a doctor/nurse team and had open access by mobile phone. If no appointments are available, the patient was able to talk to the appropriate nurse in the first instance and in this way many day-to-day problems were speedily dealt with.

> I started in 1973. Then we did what the doctor directed; the doctor rang the bell and you answered. Now we work as a team. Jointly the doctor and the practice nurse run the practice. I do a lot more on my own initiative since the changeover from GMS to capitation and have my own patient list seeing me, including things like 'Well Woman's Clinics' and Child Checks. I also do education like family planning, asthma advice and counselling. Each time I see a patient it is recorded on the patient records so the doctor knows what goes on (Practice Nurse, February 1994).

While the practice had computerised its patient records, appointments, recalls and accounting a number of years ago, they decided that the system needed to be updated. In 1992 the practice employed a consultant to advise on the best computer solution for the practice. A new system was implemented involving a networked PC cluster providing word-processing, presentation and communication software which were primarily used by the practice manager, the secretaries and the project manager. The

upgraded medical software was installed in 1993 on a UNIX system. The practice computer system was further enhanced in 1995 to enable the practice to down-load data from the laboratory and incorporate that directly into patient records. It was proposed to extend that to x-rays in 1996.

There were three individuals who were willing to be interviewed on a regular basis and who became key informants within Practice Two. These were the GP who had supported and initiated the fund-holding project (GP1), the Project Manager and the Practice Manager. Comments that were not possible to attribute to a particular GP (group interviews) have been identified as (GPs).

8.3.2 Response to the Reforms

Practice Two was exceptional; it already had a reputation, for what some would describe as strange, and others, innovative behaviour. This was reflected in the full partnership structure of the practice and the team arrangement between the GPs and the practice nurses. One GP observed that "they (other GPs) are used to us being different here. That is nothing new" (GPs, August 1995).

Rather than becoming part of the Pegasus collective arrangement, Practice Two chose to develop their own contract with the RHA. In order to make early progress prior to the reforms being implemented in 1993, the Department of Health called for proposals for projects aimed at trialing new ways of delivering primary health care services. The Department emphasised their interest in fund or budget-holding strategies. Practice Two were one of the few sites around the country that became involved in this trial.

The project began in July 1992 with a capitated budget for patient subsidy rather than the traditional fee-for-service subsidy. Capitation meant that the practice received a fixed dollar amount of State subsidy rather than a subsidy per qualifying patient visit. However, as two-thirds of patients were above the income level for subsidy eligibility, Practice Two continued to rely on a significant portion of practice income being raised from direct consultation fees paid by patients or their insurers.

The process of negotiating an initial contract between the practice and the Health Reforms Directorate proved to be slow and difficult. Much of the first year of the contract (1992-1993) was spent in setting up the budgets, protocols and procedures. There were two reasons for this delay: first, there were no precedents for this type of contracting which involved everything being negotiated from the beginning. Second, there were difficulties in the negotiation process. Those involved in Practice Two suggested that there was some hesitation on the part of the purchasers to conclude a contract without a risk-sharing arrangement (in which the practice would become liable for any overspending – see 7.7.4). In order to "get something signed" a component of risk was accepted by the practice in the capitation agreement.

> We found them (the Health Reforms Directorate) very inflexible and very ideologically set in their thinking. I think that they were largely Treasury led or driven and they had this concept about budget-holding which needed refining in a number of ways - principally in the area of risk sharing (GP1, March 1995).

> Risk sharing seemed a very silly idea to us. In fact, we fortunately came out on the right side of the ledger and we agreed to share, to take a small amount of risk because the project would have never got off the ground otherwise. We would have just got into an argument for the whole year. If we had came out on the wrong side of the ledger they would have found it quite hard getting any money out of us because we would have complained loudly and vigorously that the budgets had been set on an inaccurate basis. As it turned out we didn't need to do that. We came out ahead to the tune of about $800 (GP1, March 1995).

In July 1993 Practice Two signed a more extensive contract covering not only capitation but also immunisation, pharmaceuticals, laboratory tests and direct funding for administration costs. At this point the responsibility for the budget-holding project transferred from the Ministry of Health to the local RHA. While Practice Two held actual funds associated with patient capitation and immunisation, pharmaceuticals and laboratory test budgets were nominal. Pre-project levels of practice expenditure were used as a starting point for setting budgets. Adjustments for expected national increases were negotiated between the practice and the RHA to provide the budget for the forthcoming year. From the practice's perspective no cash was involved in the pharmaceuticals or laboratory budget-holding although separate

records were kept by the RHA and any 'savings' were apportioned on a negotiated basis between the practice and the RHA. The RHA also retained control over how the practice was to spend their share of 'savings' specifying that they could only be used to 'directly benefit patients' rather than to boost practice income in any way. The contract between Practice Two and the RHA was re-negotiated in 1994 to include bulk-funding of the practice nurse subsidy. At the end of 1995 the existing contract was rolled-over to facilitate re-negotiation in early 1996.

There were three reasons why Practice Two became involved in budget-holding. First, some of the staff were frustrated with previous change initiatives which they saw as highly prescriptive and forced on GPs. By becoming involved in a relatively unformed project at an early stage GP1 felt that they could influence the reform process to the advantage of both patients and themselves.

> Change was inevitable, so the budget-holding project gave us a chance to be involved in the process rather than having change forced upon us. We felt that the budget-holding project would give us a chance to be pro-active and a have a say in future developments in general practice. Unless we became involved we would be left out in the cold (GP1, March 1995).

Second, there was the potential for significant advantages for the practice, particularly in the development of computing and information systems. The idea of technology as an incentive was also evident in the reviews of the UK budget-holding practices (Robinson and Le Grand, 1994 p. 83). Third, there was strong leadership from one member of the practice who saw the budget-holding as an important professional challenge. He took the principal responsibility for setting-up and co-ordinating the project. Once the Project Manager was appointed and the budget-holding process was running his role changed to resource person. When asked why he was willing to take on the additional responsibility and workload he said:

> I have been the one who was interested mainly, I suppose. I read that most of the budget-holding practices in the UK had someone who is the motive force. That person has to take on some kind of directorial role. It usually seems to be someone in their forties who requires a change or an extra interest in their lives. Well, going back to the original motivation, I suppose it was a challenge. But I quite enjoy it really but I am not sure why, I just do. The GP

> life can become pretty mundane otherwise. Also I have become an expert on something, which I quite like (GP1, March 1995).

In the UK these kind of people characterised the first-wave of budget-holding. Robinson and Le Grand (1994, p. 83) described these people as follows:

> For many of the first wave, this was the leading edge thing to do. They were teaching practices, which had made all the improvements they could. Some of the younger doctors in their late thirties or mid career had got a little bored with general practice and this was the next mountain to climb.

8.3.3 Effect on the practice

It was recognised that budget-holding would increase the administrative workload of the practice, and so the project specifications included a full time Project Manager (who was appointed in August 1992). She was responsible for dealing with the external contracts and managing the workload associated with the project within the practice.

The principal external contact was with the purchasing authority, now the RHA. The Project Manager had to negotiate the contracts based on agreed budgets, obtain approval for expenditure of "savings" and prepare regular reports as agreed in the contract. Within the practice her role extended beyond a pure focus on the budget-holding project to include an involvement in practice quality assurance and planning. She monitored financial, medical and patient trends for feedback to the practice. Data was obtained on GP prescribing patterns and test ordering which were analysed by the Project Manager and presented at weekly peer-review meetings. The feeling within the practice was that without the additional support from the Project Manager, the administrative burden would have been unacceptable and the practice would not have got involved in the project.

> Well, the project has provided a full time job for one highly competent manager. There is no way we could have managed it without her. Without a manager we would never have done it, it would have been an absolute disaster (GPs, August 1995).

The Practice Manager dealt with the remaining administrative workload. She was responsible for co-ordinating the administrative aspects of the practice, overseeing the

accounts, wages and computer system and making sure that the practice ran smoothly. This work was not new and was not a direct result of the reforms or the budget-holding process. In the past, the partner of one of the GPs was employed to administer the practice. But because of the size of the practice and the money involved, they found it necessary to employ a full-time staff member. This also made it possible to bring 'in-house' functions such as accounting that had been done externally. The Practice Manager argued that it was cost-effective for the doctors to pay her to do the administration as it freed the GPs to deal with more patients.

The direct effect of the budget-holding process on the patients was minimal.

> The budget holding project doesn't affect patients in that they won't notice any difference when they come into the practice. However, in the long-run, we expect that there will be savings and improvements in the practice that the patients will notice (Project Manager, February 1994).

However the effect on the behaviour of the GPs seemed to be real and significant. Because of the contract requirements, it was necessary to collect and report information on practice activity to the RHA. This meant that GP activity became much more visible and subject to review. In the past there was a danger of records of patient visits being lost and no GMS claim being made. Under the budget-holding contract it became necessary to keep a full record of consultations in order to establish a claim rate to the satisfaction of the RHA. This record keeping process quantified the consulting rate of each GP/practice nurse team and made it visible to all of the practice.

> The doctors have better information (including costs) on what they do e.g. prescribing and lab tests. We now ensure that we get a full record of consultations (we were losing some consultations). We need to keep a record of the consultations so we can tell the RHA what our consultation rate is. Now that we are capitated we do not get paid GMS (per person) as people attend rather our funding is paid monthly based on our patient register and the national consultation rate (Practice Manager, February 1994).

With a budget established, significant attention was also devoted to GP prescribing behaviour and test ordering. Studies were conducted of prescribing and ordering behaviour and the levels of laboratory tests were significantly reduced.

> Yes, it was really easy to drop down the lab tests ordered by about almost 25% straight away. It was quite clear that with some motivation we could make savings there easily (GP1, March 1995).

Changing prescribing behaviour proved to be more difficult. However, reductions were made through a combined process of 'best practice protocols' and peer review.

> With prescribing we saved an insignificant amount of money in the first year. But the second full year we held our prescribing costs to the same level whereas the rest of the country have gone up about 8%. It was part of our deal that our budget goes up in line with the national increases. Bearing in mind that we are historically low prescribers. The year before I went into budget-holding I ordered about $35,000 worth of laboratory tests which is well on the low side of the Christchurch average which ranges from $30,000 to $105,000 per GP. The person ordering all of those tests are obviously seeing more people but it is doubtful that they would be three times busier. So there are obviously other reasons for it (GP1, March 1995).

> We managed to come in under budget last year and it looks like we will this year too. We have significantly reduced expenditure on lab tests, but pharmaceutical expenditure is erratic. There is considerable seasonality which can be captured for forecasting purposes. However, there are influences which are outside of our control such as when we get a new patient with an expensive drug. We have little control over that sort of thing as most of the drugs are maintenance. We can also get a peak fluctuation in winter when more people tend to get sick (e.g. flu) (Project Manager, February 1994).

> Because of the size of the practice there is a lot of peer review and discussion of prescribing patterns. The GPs and nurses have regular meetings and these have acted as a spur to rationalise referrals and lab tests. The GPs have discussed current prescribing levels and were unable to identify any immediate changes. We have developed in house treatment protocols for specific conditions e.g. asthma (Project Manager, February 1994).

Significant savings were made within the practice by monitoring GP prescribing behaviour and the use of laboratory tests. These savings were used to provide additional services for patients rather than to increase practice income. However there was some concern that the RHA had taken a strict interpretation of the contract agreement, which precluded the practice from benefiting from an initiative.

> We have been allowed to spend money on ear, nose and throat surgery for children, employing a counsellor/psychologist within the practice and we have proposed a terminal care fund, but they have not approved that yet. They haven't allowed us to reduce the fees for children (GPs, August 1995).

> Other people seem to get all the benefits. A lot of our expertise is unpaid for. A huge amount of the work we do, which we are experts at, we get no money and no return for our effort at all. We think that it is time we got something out of our efforts. We used the savings for ENT (ear nose and throat) operations. The CHE (Crown Health Enterprise) benefits because they don't have to pay for ENT consultations that we are paying for in private. The RHA benefits because they don't have to pay the CHE so much in ENT. The patient benefits because they get free consultations with a private specialist and the specialist benefits because they get paid for it. The silly buggers who did all the work, us, don't get anything. Everyone else benefits except us. We are saving the money but we don't get anything and the RHA only let us spend it on what they would otherwise pay for. The southern RHA will not allow us to use savings to reduce fees for non-cardholding children. Yet in Wanganui this is trumpeted as a great benefit from budgetholding that the children get seen for free (GPs, August 1995).

> With the savings, the RHA only let us spend them on things that save them more. Our income has dropped; we are working even harder and we aren't making more money. We can't do anything. I would like to make alterations (to the practice buildings) but the RHA won't let us spend any savings on that. I would like to alter the access to the toilets so people in wheel chairs can get in without one of the nurses having to carry them (Practice Manager, August 1995).

By the end of 1995 there was some relaxation in the RHA position. While the practice was still prohibited from directly benefiting from their savings, the RHA was willing to consider projects that might indirectly benefit them.

> We can more or less do what we want with the savings now. Other people started doing the things we wanted to do and they (the RHA) kept telling us that we couldn't do them. Like docs in Wanganui were able to use their savings to make cheaper visits for children. It was also a practical issue. The RHA simply didn't understand how this place worked. They assumed that each doctor would benefit from the individual savings made. And it doesn't work that way. It doesn't describe what happens here (Practice Manager / Project Manager, December 1995).

While the practice nurses had always had an unusually high level of freedom within the practice this freedom had been increased by the shift from the GMS subsidy to a capitated budget. To claim the GMS required that the patient must see the doctor. This placed a strict limit on the 'chargeable' role of a practice nurse. When the practice became capitated the practice nurse began to take a much more active

preventative and educational role. This was seen as one of the most positive benefits of the capitated funding.

8.3.4 Summary

Practice Two was a large and innovative practice. During 1992 key individuals within the practice responded to an invitation from the Ministry of Health to pilot budget-holding. There were a number of different motivations that led them to get involved: first, there was a reaction to the change process. Change was seen as dictated from the politicians and bureaucrats. Effectively, their response was to become pro-active and seek to have an effect on the developments. The practice also received some direct benefits in terms of a new computer and a staff position, which were funded as part of the project. However, a major reason for their involvement was an enthusiast within the practice who was looking for a challenge.

The staff within the practice argued that the actual operation of the budget-holding had minimal immediate effects on patients. However, there were some significant changes in GP behaviour. The budgets focused attention on the laboratory tests ordered and prescribing behaviour. This was combined with a process of peer review and best practice protocols. As a result some significant savings were made. Most of these savings have been spent on providing additional patient services. The shift from the GMS system to a capitated budget fitted well with the flexible role of practice nurses. They were no longer restricted by the fact that they could not claim GMS.

Although the practice remained separate from Pegasus to start with, they joined in 1995 (although they have maintained their own contractual arrangements). There were two reasons for this: first, there was a desire to share what they had learnt with other GPs and second they felt that they would have more political clout as part of the larger group.

8.4 PRACTICE THREE

8.4.1 Practice Description

Practice Three was located in a middle to low socio-economic area of Christchurch. There were 1800 patients on the practice list. The stated emphasis of the centre was on preventative health and care for the whole person, as reflected in their mission statement:

> The general medical practice provides a full range of medical services including maternity with an emphasis on preventative health and care for the whole body (Practice Three Newsletter, 1995).

The practice was established in 1980 by one of the GPs who was operating out of his own house. In 1988, he joined with two others and established a combined counselling training course, a Christian counselling centre and a medical centre. They purchased the current site and re-designed it to suit the medical practice / counselling programme.

The centre offered a range of specialist services including counselling and psychotherapy. In 1989 they were joined by a second GP although they ran relatively independent practices, effectively operating as two independent GPs. Only one of the two GPs (referred to as GP1 in this section) was willing to be interviewed. This was not considered a critical problem as the two GPs operated quite separately.

Practice Three provided the typical GP services, some minor surgery and some counselling.

> My practice is a relatively typical general practice ... in broad terms we provide general practice services; general medical services ... under general practice you have got all of the nuts and bolts types of things, and a little bit of minor surgery. Sew people up if they come in with cuts, and then it is just referral of people if they need to go on [to secondary services] (GP1, June 1995).

Although he had previously done maternity work, the numbers had fallen to the point that he had decided to stop altogether. He attributed the drop in maternity cases to the growth of independent midwife services and the fact that the second GP was a

woman and patients preferred to see her for maternity care. The two unusual features about Practice Three were that the GPs were involved in the counselling and the training program, and, because of referrals from counsellors, the GPs treated an atypical number of patients with depression. GP1 had a special interest in addictions and was the visiting medical practitioner for a local alcohol addiction programme. He was also involved in several community based psychiatric half-way houses.

There were three staff who shared the receptionist's role on a part-time basis, in total equivalent to one full-time position. There was one practice nurse who shared her time between the two GPs and a specialist practitioner who was also associated with the centre. The practice nurse was responsible for immunisation, cervical smears and managing the recall process. She also conducted specific services such as blood pressure checks as requested by the GPs. While working out of his home GP did not have a practice nurse and so he still worked independently of the practice nurse.

In 1987 Practice Three installed a computer system, which managed the patient lists, billing, government claims, immunisation recalls and accounting. One unusual aspect of this system was that it included computer based patient records. Each GP had their own terminal where they recorded patient notes and prescriptions after each consultation. When GP1 was asked why he had included patient records, when most practices just computerised the patient list and the accounting, he said that:

> It seemed to me that to do anything efficiently you had to get it computerised . . . it also seemed to be a way of doing a bit of research on your data, I would be interested in that. And the reason for doing the whole thing, I couldn't see the point in just doing accounts and it's been the right decision, I've never regretted computerising. I don't understand why other doctors don't do it (GP1, June 1995).

8.4.2 Response to the Reforms

At the first interview the GP said that he had been able to ignore the earlier changes (such as the 1990 GP contracts) which basically 'blew over'. However, he was not able to ignore the 1993 health reform changes and felt a lot of stress about what was going to happen (GP1 November, 1993). However, he decided to join Pegasus and accept the collective contracts as he did not want to negotiate his own contract. He

argued that although he could not trust the government (and by extension the RHAs), he would have some protection and would receive better treatment as part of the Pegasus group.

> There are market forces everywhere else but we are not allowed to compete fairly. I don't want contracts because I don't feel that I can trust the government. They are quick to point out faults but don't recognise the good will that does exist. I have cut my costs and reduced my prescribing levels (GP1, November 1993).
>
> I am part of Pegasus because I am keen on GPs showing solidarity. This is a way for GPs to act as one rather than being picked off. This is a danger because the government has historically been malevolent, not supporting GPs (GP1, November 1993).

Joining Pegasus caused very little change in the way the practice operated. Basically the funding and claim requirements were maintained and the only difference was that claims were sent to Pegasus rather than the Department of Health. GP1 wasn't keen to be directly involved in the change process and saw his involvement in Pegasus as a way to pass the politics onto someone else.

> I only have a low involvement in Pegasus. I tend to avoid the politics. I am happy for others to do it but see that solidarity is important. NZGPA is still a very powerful political group. It represents the national body and provides input at the governmental level. They deal with things such as the maternity benefits and the relationship with the midwives. Pegasus has more input at the RHA level. They manage the bargaining with the RHA and the administration and pay-out of the GMS (GP1, May 1994).

However, although he was not directly involved in any of the Pegasus project groups[4] he did start to change his use of laboratory tests as a result of some of the changes underway.

> I have noticed some competition between the labs. We have received details of the costs of all of our lab tests. This has had some influence on my behaviour as I have tried to reduce "pointless" tests and am now less inclined to tick boxes that I don't absolutely need (GP1, May 1994).

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[4] See Appendix 2

> I'm sure that the focus on costs of lab results has influenced me quite strongly. Knowing it costs roughly $20 to do a swab, it quite influences you about swabs knowing that liver function tests costs you about $21-$22 makes you think "is it really necessary". So I would say I've probably reduced. I don't think I was a high user of those things in the first place but I've reduced them considerably (GP1, June 1995).

GP1 was already concerned about his own prescribing but found these concerns were strengthened by the educational material provided by Pegasus and from the PreMeC prescribing review process. He got involved in the PreMeC prescription analysis programme[5] to provide feedback on his own prescribing. However, he was already reluctant to prescribe more expensive drugs unless there were clear medical benefits.

> Sometimes I get pressured by the patients (and the salesmen) to prescribe the more expensive drugs. I would generally prefer to prescribe a cheaper drug if it is as effective (GP1, May 1994).

> Plus some data they get through from Pegasus about prescribing of antibiotics in bronchitis which said that it has not been proven to be effective, influences you to try to reduce prescribing ... The prescribing things are more educational. More like information about treatment things like medications to use for say urinary tract infections, what cost it is and what people are using (GP1, December 1995).

8.4.3 Summary

GP1 was concerned about the relationship between GPs and the State prior to the implementation of the 1993 restructure. Many of these concerns were based on previous attempts by the State to change GP behaviour. However, as part of Pegasus he experienced a rollover of terms and conditions. He joined Pegasus as an act of solidarity with other GPs and was happy to let others deal with the politics and negotiate the contacts. He was not directly involved in the Pegasus leadership, meetings or projects. However, he was affected indirectly by the focus on laboratory tests and prescriptions, the new cost visibility and monthly budget reports. Generally he saw the changes brought by Pegasus as being a positive improvement to GP practice. He placed a heavy emphasis on the 'educational' role of the Pegasus

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[5] See Appendix 3

information (Dec 1995) and did not appear unduly concerned about the budgetary monitoring because "the way it is being done at the moment is not interfering, it is simply feedback and the choice on prescribing is still an independent choice" (GP1, December 1995). The fact that Pegasus was being run by GPs whom he respected rather than managers or accountants seemed to reassure him about the changes underway.

> They are good people. Mostly I think I would be in tune with those sorts of people anyway. People like ... I respect them and I have worked with them and I don't think that they see [things] too much differently from how I do. I respect them from having seen the kinds of stances they take – the kinds of values that they hold in terms of integrity and standards of practice (GP1, June 1995).

8.5 PRACTICE FOUR

8.5.1 Practice Description

Practice Four was originally started in 1946 and was purchased by one of the current partners in 1974, the second partner joining a few years later. The current site was bought soon after 1974 and was in an unusual location with State housing on one side and one of the more wealthy areas of Christchurch on the other.

There were four staff involved in Practice Four; two doctors, a full time receptionist and a full time practice nurse. The receptionist was responsible for the financial tasks such as the collection of cash and the completion of the ACC, GMS and immunisation claims. Most of her medical work involved supporting the GPs in tasks such as taking samples and measuring patient temperatures. Although she saw some patients herself, they also had to be seen by one of the GPs and when she was required to provide advice to patients that telephoned the practice she generally recommended that they come and see the doctor and provided little advice herself.

Both GPs shared the same facilities and staff, but ran relatively separate practices with separate patient lists. One GP had a relatively elderly practice because of the patients inherited from the original 1946 practice. He took a special interest in geriatric medicine and had an active interest in a number of the local residential homes. The

second partner had a specialist interest in occupational and forensic medicine. The practice provided a full range of primary health services including accident and emergency services and full maternity care. The concept of 'full service' was strongly ingrained in the practice ethos. It was interpreted as a willingness to make house calls, and a commitment to see a child immediately if the parent was concerned. There was also some criticism of younger GPs who lacked the skills that were historically expected from a GP such as simple surgery and maternity services.

> I qualified with a hundred deliveries under my belt. Nowadays I am taking medical students and they have never seen a delivery (GP, May 1995).

Although it was possible to increase the practice size, it has been kept small by choice, both in terms of the number of practitioners and the patient list. This was part of the practice ideal of building a relationship with patients and offering 'traditional' quality service.

In 1993 Practice four purchased the Alumni computing package. They did this because the accounts were 'becoming a shambles and were time consuming' (GP, May 1995). The system automated the accounting and the subsidy claims (GMS and ACC). The incentive to 'tidy the accounting' was reinforced by the threat of a claim audit from Pegasus, which meant that practices needed to provide an audit trail, and the pressure from the RHA to computerised patient registers. The Alumni system automated the existing patient recall system, which was seen as particularly important for child immunisation. In the middle of 1995 the Practice Four also added a computerised appointments schedule. Since the practice nurse maintained the patient recall system the responsibility for the computer was shared between her and the receptionist.

While there are two GPs in Practice Four, only the second partner was willing to be interviewed. This was not considered a problem as the two GPs ran relatively independent practices. Any quote identified as (GP or GP1) refers to the partner interviewed.

8.5.2 Response to the Reforms

When asked in the first interview what changes the health reforms had caused the immediate response from GP1 was that there was more paper work now. Reports and invitations to meetings had come from the Ministry of Health and both the RHAs and the CHEs had sent material for GPs to read. He suggested that he could not read all of the material he had been sent. He also had some real fears about what the contracting arrangements would involve and how that would affect the practice and felt that others (particularly non-GP administrators) were trying to tell him what to do and how to run his practice.

> I have been a GP for 20 years now. After that amount of time you know what you are doing. You know how to relate to patients and know what does and doesn't work. There has been a significant growth of different groups trying to tell us what to do. I am often sceptical regarding their purported level of knowledge (GP, October 1993).

> They talk about empowering patients. The pressure groups often have a significant influence of non-medical administrators. Looking back over the last 10 years there has been a significant growth in the power of these pressure groups (GP, October 1993).

Practice Four chose to join Pegasus and accept the collective contract with the RHA. GP1 thought that by joining Pegasus they would not have to negotiate with the RHA themselves and would 'get the best deal from the RHA'. He also saw Pegasus membership as an important way of providing stimulation and peer support that they would not get in a small practice.

> The IPA allows us to focus attention onto areas where we have some power. We would be like a fish out of water without Pegasus. It means that we are less vulnerable than we would be by ourselves and we get the best deal possible from the RHA. Really, it means that we deal with the RHA more efficiently than if we tried to negotiate as individual practices (GP, October 1993).

> In a big practice you get lots of input. But in a small practice like this, Pegasus provides a measure of community or support. The IPA: it means that we are less vulnerable than we would be by ourselves. Because we are part of Pegasus we get the best deal from the RHA and we deal with the RHA more effectively as a group (GP, October 1993).

During 1994 GP1's attitude towards the reforms began to change from reserved wariness to conditional approval. This change was due to a number of factors. First, it had become clear that most of the conditions/rights of GPs, such as the fee-for-service, had been maintained under the changes.

> I have always said that the best fee we receive is what we get directly from the patient. You do a good job, you receive your money and you have a happy patient. There are no political strings attached (GP, May 1994).

Second, as he became more familiar with the new structures he become more confident that he could ensure good care for their patients.

> I am now more familiar with the new system and know where to send people and the right individuals to deal with - the informal contacts are being re-established (GP, May 1994).

> In November we ran up against the Radiologists. It was a monetary and organisational issue rather than a professional one. They didn't want the GPs muscling in, "GPs aren't qualified to run radiology". We don't want to run radiology but we can organise it so our patients get the best service. There is an important 'Patient Advocacy' role for the GP in secondary care (GP, May 1994).

Third, the issue of how the reforms were to affect General Practice had become clearer and it was clear that the New Zealand changes were different to what had happened in the UK. GP1 had worked in the UK and saw aspects of the UK NHS reforms as undesirable.

> The doctor delegates a lot of the work to the nurses. Sometimes they (GPs) only sign their name at the bottom. I found that system unsatisfactory. I like to do the job of being a doctor. I enjoy the hands on aspects, I am not a form signer (GP, May 1994).

Fourth, GP1 became more involved in Pegasus and was better informed on what was happening. Because of this he developed a belief that the changes could benefit general practice.

> I have become more involved in Pegasus and have attended a number of their meetings. I can see that targeting is there to help people. The regular Pegasus meetings have been helpful (GP, May 1994).

The active involvement in Pegasus also extended into a number of other areas. GP1 became involved in the Pegasus laboratory, prescribing and outpatients project. He argued that the Pegasus projects were really just an extension of the peer review process, a process that would make GPs reflect on what they were doing which would lead to better treatment for patients.

> It is really, it is a huge peer review process. I go along and the whole thrust of Pegasus is to look at what we do, do it well and keep nudging forward in areas. It was like a self-audit - it was making ourselves look at what we do, questioning assumed ways of doing things. It's good! ... Basically it involves me submitting what I do to other people's scrutiny. I guess that's the simplest way of putting it. Because I've got identifiable laboratory and prescription pads, they can tell what it is I'm up to (GP, May 1995).

Involvement in the laboratory and the prescribing process did lead to some change in drug and test usage. However, the main issue was seen as quality rather than cost. A regular theme in the interviews involving GP1 was a concern to maintain the standard of service provided to customers. The concern for standards was reflected in 1995 when he was invited to become part of the Pegasus audit committee. Although this involved additional work, he accepted the job and explained the role of the audit committee as follows:

> We are like the Fire Brigade. We are really only auditing things when they go wrong. We audit the stuff ups, or a doctor gets himself into trouble, or wheeled out and we sit down and decide what course of action, and what best to do. It is peer audit and claim and financial. What we have noticed is the two very quickly spill into each other. If there's a stuff-up you often find there's a claim stuff-up as well at the same time. That's where it gets contentious and where we get involved. I am pleased to say we haven't had a hell of a lot of big work done. There's been a bit come through, but not excessive (GP, May 1995).
>
> I think it's (Pegasus) a mutual association - it's like an old fashioned guild or a collective and we are all volunteers, there are financial incentives, other than that there is no strong - there are quite a few people who chose not to - its like an old fashioned guild of like minded people getting together and saying "Well let's do this well" or "Let's do this to the best of our ability". And a lot of us

> are different - we range from the ultra dry to ultra wet (managerial vs. service to the poor), if I may use that term - there is scope for tons of different people still to be part of Pegasus. There is no heavy hand that says we've got to think like this, or do like this, or do like that (GP, May 1995).

While many of the changes initiated by Pegasus were now seen as being positive, GP1 did have some reservations about the 'privatisation' of healthcare. He told a following story to illustrate his concern that the move to private provision was going too far and the public health system would not remain intact.

> I think the health reforms are broadly in the right direction. But I'm getting a little bit worried - when I got this in the mail from Dr X, a gastroenterologist. Dr X is a very upstanding, honourable doctor, a very religious person, very much involved in his church. Dr X is a very genuine, hardworking person and he was a very strong supporter of the public health system. He had no desire to be part of what he essentially saw as the business of medicine. In other words charging patients. Now Dr X has started up a private practice. Even those dedicated to the ideal of a public health system have been forced to turn to private practice. Maybe the reforms have gone a bit too far down the private road. People are going into private practice to survive ... that doesn't save anyone any money (GP, May 1995).

8.5.3 Summary

GP1 had initial reservations about the changes of 1993 and how they would affect the practice and that 'outsiders' would try to tell him what he should be doing. Once implemented there was no real change in how the practice was run or funded. There was, however, a noticeable increase in paperwork. Both GPs became part of Pegasus and felt that they would be less vulnerable as part of an IPA. They also thought that they would obtain a more favourable contract as part of an association than they would as individuals. The fringe benefits of joining Pegasus were peer contact and support from other GPs.

By 1995 GP1 saw that his autonomy was not seriously threatened and his attitude towards the changes warmed. He became directly involved in Pegasus, regularly attending meetings, was actively involved in the laboratory and prescribing projects and, ultimately, becoming part of the 'audit committee' for Pegasus. The changes coming through Pegasus were welcomed as they were seen to improve the quality of

general practice and the status of general practitioners. However, he was concerned that the 'public health system' and free access to those in need were disappearing.

8.6 PRACTICE FIVE

8.6.1 Practice Description

Practice Five was established by a sole practitioner over 18 years ago and it was located on the east side of Christchurch. One of the current partners bought a share of the practice in 1983 and was joined by the second partner in 1989. They moved to their present location in 1990 which they purchased from a property developer and renovated to serve as a medical practice. Practice Five was fairly small with 2800 patients on the register. The local area was noted as one of the poorest in New Zealand with a low average income (one third lower than the rest of the city) and high levels of unemployment.

The practice was made up of three GPs, two men and one woman although two of these doctors worked part-time. There were two practice nurses (sharing half time each), and two receptionists (who also worked half time each). The emphasis on job sharing led one patient, in jest, to label the place the 'part time practice'. The partners had separate patient lists but shared expenses. All of the other staff were employed by the GP partners.

Interviews were conducted with the two GPs. The third (female) GP was not a partner and was employed by the partners on a part-time basis. She was not available for interviewing. The partners were referred to individually as GP1 and GP2. Interviews were also conducted with three of the practice nurses and one of the receptionists.

While both partners had a generalist approach to medicine, one had a particular interest in acupuncture treatment and the other in industrial medicine. One of the partners had an active maternity practice, but the maternity cases had decreased since 1993 to virtually nothing. He attributed this decrease to the growth in independent midwife services:

> There were basically less and less deliveries because the midwives were doing more and more. So I was left with the more difficult ones, spending the night on the phone and ending up not even delivering the baby anyway, it became more and more unsatisfying and stressful. Unsatisfying being on call all of the time and doing stuff-all. So I thought well, what is the point? Why lose the sleep? I always said that when I hit forty I would give up delivering babies and it took me a year longer than that. But it was really the political thing, the midwives are really taking over and I was getting less and less to do (GP2, December 1995).

The ideals of this practice were described as 'community and family orientated medicine with a strong preventative stance' (GP2, December 1995). The preventative approach was reflected in a number of free health screening clinics offered by the practice: Well-Children-Checks and weight loss and cholesterol lowering clinics aimed at adults. The practice nurses ran the clinics. Even though these services were free to the patients they were not well patronised by the community. The practice nurse suggested that this was because people were reluctant to visit the doctor when they were not sick (Practice Nurse, March 1995). Disease prevention also received a strong emphasis in the practice newsletter (1995). Here patients were encouraged to take steps to lower the chances of getting cancer. The practice nurses had an unusually high direct patient contact - they handled the telephone contacts and patients saw them directly for things such as blood tests, blood pressure or weight/diet advice. In these cases, the patients would only see the doctor if the nurses considered that it was necessary.

The low average income of the local community had a big impact on the nature of the practice. Some patients do not have the cash to pay for their visits so the practice receives little or no income from these people. Many of the patients that telephoned the practice nurses wanted basic advice such as how to fold and put nappies on a baby and when a baby should be given solids. One of the practice nurses explained it like this:

> You do a lot of things that if people were mothered properly in the first place you would never need to do. Things like girls coming in and you have to teach them to fold nappies properly and put them on their babies ... GP2 said that what he would like to prescribe for patients is friends, money and a holiday and a lot of the people we deal with will never have any of them. It is

> quite tragic really. We make jokes about putting depro provera in the water to stop 15 year olds having babies. I mean the only way you handle what we are doing is to make a joke out of it because the whole system is quite tragic (Practice Nurse, March 1995).

In 1995 Practice Five installed a new computer system running the Alumni computer package. The GPs were encouraged by the receptionists and practice nurses to computerise, because most of the administrative responsibilities were handled by the receptionists and/or the practice nurses. The new computer system simplified the issue of patient billing, outstanding accounts and subsidy claims. The patient recall system, which was the responsibility of the practice nurses, was also computerised.

8.6.2 Response to the Reforms

From the first contact with Practice Five, the GPs were very concerned about the 1993 health reforms. They felt threatened by the obligation to contract with the RHA and the power of the government changes to affect their income.

> The Government can legislate and affect our practice. Historically they have been pretty anti-GP. All of the money and power has gone to secondary care. If we didn't spend our budgets, we didn't get enough next year and we lost any of our savings to secondary care (GP1, October 1993).

The practice nurses interviewed also expressed some concern about the reforms and how they would affect their positions. Some of the nurses saw the changes as a threat to the practice nurse subsidy.

> The changes are making us feel uneasy. But it is a generalised uneasiness. It would be interesting if you talk to the other practice nurse, because she runs much more scared about the whole process than me. She is quite sure that some day soon the nurses' subsidy is going to come off and we will lose our jobs. I don't see it that way (Practice Nurse, March 1995).

Because of their concern and their reluctance to get involved in 'politics' the GPs were content to let Pegasus conduct all of the negotiating with the RHA and to establish a contract for them. They felt that as part of Pegasus they had more influence than they would as a separate practice.

> As part of the Pegasus group we have more clout than we would individually. I wouldn't trust anyone in the RHA. We get to define the GP role with Pegasus rather than the RHA defining the role of a GP (GP1, October 1993).

In later interviews the ongoing contact with Pegasus led to increased confidence on the part of one of the GPs. This was also combined with a feeling that Pegasus would enhance the position of GPs in dealing with secondary care services.

> I am feeling quite a bit happier about the changes than I was earlier. I have only had a very limited involvement in Pegasus, but I see them acting as an effective counterfoil to the power of the Southern RHA (GP1, May 1994).

> I have an older practice. I can see a potential threat from the geriatric specialists as their funding is cut. Currently they are providing an excellent service, but they may be forced to attract my patients in order to extend their budget. But we now have some defence against the power of the specialist groups as Pegasus gives us more clout as GPs (GP1, May 1994).

GP2 had some reservations about the Pegasus contracts. While membership of Pegasus protected the practice from politics and from budget cuts by RHA, he still did not trust the RHA.

> Pegasus certainly gives us more negotiating clout and they also gave the RHA what they wanted. The RHA still presents a threat, but they are reasonable just now. Everybody is working together at the moment, the GPs, Pegasus and the RHA (GP2, May 1994).

> The pilot studies initiated by Pegasus are going well, but there is still the danger of budget cuts, especially if the pilot studies don't deliver savings. There are always cuts and restrictions. The levels of paperwork are just the same, but there is now more frequent audit. The waiting lists are just the same in the public clinics. However, patients are saying that the ACC case managers are making life easier for them (GP2, May 1994).

Although the two GPs were not involved in Pegasus project groups, the contact with Pegasus and the focus on laboratory tests and prescribing had led to some changes in their behaviour. Both of them become more aware of which tests they were ordering and which drugs they were prescribing.

During 1995 Pegasus started to track individual GP spending on prescribing and laboratory tests. All GPs were required to record an identification number on all of their prescriptions and on all of the tests they ordered. This gave Pegasus the ability

to analyse, pinpoint and to monitor individual prescribing and laboratory use.[6] GP feedback on monthly lab expenditure became a regular feature in 1995 and in 1996 similar reports were introduced for prescribing.

> I didn't have a clue how I was prescribing before. So it has been useful in that respect. I don't look at it for ways of saving me money; I just look at it for ways for maybe I can improve. It provides feedback for me (GP1, March 1995).

> They send out reports on a monthly basis showing your costs compared with other GPs and compared to the numbers of patients seen. It just jogs in your mind that tests cost money and so it is quite good. I have probably made a couple of changes - I'm not doing quite so many tests but it's not because of costs it's just because I sense that is appropriate at the time. I have been jogged along by cost but I don't look at a test and say "My God, that's expensive I'm not going to do it". I just do more of what is an appropriate test rather than ticking everything (GP1, March 1995).

There was clearly some tension created by the new forms of visibility. Both GPs in Practice Five claimed that the prime objective of the monitoring was education and improving prescribing rather than cost cutting. And yet the reporting system was focused on how much different drugs and tests were costing.

> Cutting costs isn't the prime objective but there is appropriate prescribing and there are bad habits - its just an educational thing looking at what is appropriate and if there are ways and means of doing things which would save money but would still work, then that's fine ... I think at the end of the day they are trying to educate people to look at their prescribing habits - improve it really, cost being a secondary effect as far as I'm concerned. If there are ways and means of improving prescribing, which at the end of the day saves money, then I suppose that's fine ... they have been giving out information sheets on how much laboratory tests cost and things like that and again little educational brochures on what is appropriate for different tests and what you may achieve out of them and things like that (GP1, March 1995).

GP1 argued that the prime objective of the prescribing and the laboratory projects was not to save money but 'to be doing better or more appropriate medicine' (March 1995). This involved making savings without 'any loss to patient management or

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6 See Appendix 2

ongoing care' (March, 1995). The changes to GP prescribing and laboratory usage were not perceived as a threat for two reasons: first GPs had some choice in how involved they became and second the changes were initiated by other GPs rather than being imposed by the government or the RHAs.

8.6.3 Summary

Initially there were some questions and concerns about how the 1993 changes would affect Practice Five, however both of the GPs argued that things had remained the same. Pegasus was seen as a protection against the RHA and GPs thought they would have more clout and get better contracts as part of an IPA. Having a large GP group would also give them an effective voice and enable GPs to get a better share of the resources that had traditionally gone to secondary care. Even so, one of the GPs still had reservations about potential budget cuts and the growing waiting lists.

Although they were not involved in any of the Pegasus project groups, the focus on laboratory tests and prescribing had led to changes in their own behaviour. Educational material and cost information provided by Pegasus led to a reduction in tests ordered.

8.7 ANALYSIS OF CASE STUDIES

The research model presented in Chapter Four indicates that there are four different change pathways: rebuttal, re-orientation, colonisation and evolution. However, based on an analysis of the reforms in chapter Seven, the rebuttal and the evolution pathways do not fit the evidence. Prior to 1993 it was difficult to identify how the reforms would affect GPs, as the change was only one small part of a larger reform. It was unclear how the contracting relationship would operate. Because of this, perhaps intentional uncertainty, it was not possible for GPs to resist and rebut the change as they did the 1990 contract proposal. Even if they chose to accept the Section 51 agreements they were still getting a contractual arrangement and were still subject to the control of the RHA. If they did not accept any form of contract the GPs would lose a significant proportion of the practice income. Evolution was not a serious possibility as the medical profession had been excluded from the policy

formation process under a strategy of policy blitzkrieg (Easton, 1994). Therefore, the kind of discursive process necessary for evolution was not possible and there would be either a re-orientation or a colonisation pathway.

In the GP case studies two different responses to the contracting requirements emerged. Practice two chose to engage with the changes and develop their own contract with the RHA. The other practices studied chose to group together and accept the collective contract negotiated on their behalf by Pegasus. This next section reflects upon these two different responses, how they fit with the Laughlin (1991) change models.

8.7.1 Practice Two

The most exceptional case was Practice Two. This practice stood out from the other practices studied (and from most of the practices in the country) as they chose to develop their own contractual relationship with the RHA. Rather than responding to the changes imposed Practice Two sought to take an active role in forming the changes. However, this active role led to new administrative responsibilities within the practice. Although all of the practice partners were 'budget-holding' the primary responsibility was restricted to the lead GP and the Project Manager. Both the political (negotiation) and administrative (budget-holding) responsibilities were delegated to this small group, freeing the other staff to continue with their medical responsibilities. This change to the structure within Practice Two can be seen as characteristic of the reorientation pathway and was similar to the UK findings.

It seems curious that Laughlin et al. (1994a) devoted so much effort to theorising the role of small groups in schools and the influence of key individuals in those groups and yet they did not apply the same analysis to the GP practices. If the lead GP was a headteacher Laughlin et al. (1994a) might well have suggested that he was an absorber-wheeler dealer or even a managerial-entrepreneur as he showed clear entrepreneurial tendencies in the way they he encouraged his practice to become involved in the budget-holding initiative. Therefore, could this case actually be an example of colonisation rather than re-orientation because of the entrepreneurial

tendencies of the lead GP? In order to have colonisation the lifeworld values of the practice must be altered by the change in the organisational structures. Based on the interviews it was clear that Practice Two was already considered radical so their willingness to become involved in the budget-holding initiative, while being unusual, was consistent with their existing tendencies. It also became evident that while the lead GP had entrepreneurial tendencies, these were not shared by all of the other members of the practice. Yet the other practice members were happy (for the greater part) to allow the lead GP and the project manager to handle the financial and administrative responsibilities associated with the budget-holding project. This was more consistent with the re-orientation pathway where change is absorbed by a small group than the concept of evolution. However, it was evident that evolution remained a real possibility within Practice Two.

8.7.2 IPA membership

The most perplexing issue in the study of the other four practices was the apparent lack of response to the Government-initiated changes at the practice level. There was no real change in values, the way they practised or in the tangible elements of the practices. Initially this suggested that the reform initiatives may have been resisted by these practices (an example of the rebuttal pathway described in Chapter Three). However, this seemed unlikely as the changes were legislative and structural and somehow the reforms had to be accommodated and/or absorbed. This accommodation/absorption function came through membership in the local IPA and illustrated a previously unknown form of the re-orientation pathway. The practices responded to the requirement to contract by joining the Pegasus IPA. It was the IPA structure that provided an important 'absorbing' mechanism at an institutional rather than a practice level. The IPA served to absorb the changes initiated by the State and to provide security against perceived threats to GP autonomy. Historically, collective action provided GPs an effective strategy to resist government imposed change and the IPA structure provided a logical extension of that response. Rather than managing change on an individual practice level, the change was managed through what Walker and Mitchell (1996) call the supra-organisation. Individual GPs could

delegate change (and threat of change) to the IPA to manage rather than having to contract individually with the RHA and could settle back to 'being-good-GPs'. This absorbing role became clear in the interviews:

> I think that Pegasus is a security blanket for a lot of doctors in the area who thought, "What the hell is going to happen?" Pegasus was seen as a group doing something and anyone could join and be swept up under their skirts (GP Practice 2, March 1995).

> Pegasus is the great white hope, it has kept the RHA off GP's backs (Dialogue Partner One, May 1994).

The concept of an institutional absorbing mechanism represents a significant extension of the Laughlin et al. (1994a) work, which only focused at the organisational level and did not consider the possibility that an absorbing group could operate at the supra-organisational level.

Another interesting extension of Laughlin et al. (1994a) becomes clear when one focuses on the kinds of change that were absorbed. Laughlin (1991) was concerned with how organisations absorb external change forces. The imposition of the 1993 legislation was an example of this kind of change. However, organisations also faced internal change forces stemming from inherent contradictions and conflicts. The development of IPAs provided a new way to manage the professional / financial tension. Not only did the IPA buffer the GPs from government reforms (at least those that joined), it also buffered them from economic-rationality, absorbing the financial contracting, the financial management and budgeting associated with the contractual accountability model.

GPs operating in New Zealand have always had to balance a tension between their professional obligations and the financial necessity to charge patients. In Gorz's terms, general practice was both subject to economic rationality and not subject to economic rationality. Some of the GPs interviewed commented explicitly on this professional / financial tension.

> A fellow in this afternoon, I didn't charge him - he was in tears - he's had every possible, imaginable, conceivable form of deprivation - he's been sexually

abused, physically abused, in jail, drugs, you almost feel sorry for the poor little bugger, there's no way you can charge people like that. You pick up what the Government offers, end of story. You can't do anything else, there's no way you can charge people like that. But on the other hand, in a strictly business sense, why should I provide a half hour service, I want to be businesslike and tough, why should I give him half an hour of my time for fifteen bucks and the very next person who came in, as it happens, after a gap, was a young mother - her husband's a successful self-employed tradesman with a good business and works hard - but I charge her $17, get $15 from the Government - $32. There's not much logic in that - it's not quite right (GP Practice 4, May 1995).

> The perennial tension that all GPs experience is that they must run a business and they must care for their patients. Some find it very frustrating. A good example is terminal care. You may visit a lot but you can't charge them much. They need what they have for funeral expenses. In providing the patient care that is needed you are financially disadvantaging yourself and it is not as if your costs go away (Dialogue Partner One, June 1996).

Historically the tension between the professional ideal and the financial were managed by delegating the economic or financial aspects to the practice nurses, which freed the GP to behave as a carer (as they did in the Laughlin-Broadbent studies). The practice nurses collected the fees of patients, followed up the outstanding debts and submitted the claims for State subsidies. Often the practice nurse made the financial decision to charge or not to charge a patient.

> When a patient doesn't have the money to pay us, then we don't charge. We have a huge patient debt, thousands of dollars, and that is debt that we have tried to charge for and we have got a lot of patients that we don't charge. A solo-mum coming in with child under five and she opens her purse and says I have got $2 and the doctor says that that won't even pay for my prescription, we will get a prescription out of the cupboard and not charge them as they go out of the door. We can get a certain amount of antibiotic on practitioner supply order which is free - you get so much a month. But if you do it too much people expect free medical help and they are not necessarily the ones who can least afford it (Practice Nurse Practice 4, March 1995).

With the requirement for GPs to contract directly with the RHA, the financial impinged on the professional in a new and threatening way. This was a process that could not be managed by a practice nurse or even a practice manager but had to directly involve the GPs. Most GPs were not willing to manage their own budget like Practice Two. There were two reasons for this: first, managing their own budget

meant that GPs had to place their income at risk and second, if GPs decided to manage their own budget they would have to deal directly with the financial responsibilities.

Pegasus' role in resolving the financial / professional tension became clear in the discussion on how the savings would be used. Many GPs felt that they could not charge for treatment of terminally ill patients. However, this decision meant that the GP lost money. The creation of a 'special needs benefit for patient with terminal illnesses' by Pegasus meant that a GP could care for those in need without being concerned about their ability to pay them.

The downside of Pegasus absorbing this financial/professional tension and the responsibilities associated with budgetary negotiation and management needed to be managed by someone. In the case of Pegasus some GPs were willing to take on an active role. This was the case with GPs in Practice One and Practice Four who became directly involved in Pegasus and welcomed the reforms as a way to improve the quality and status of general practice. However, in Practice Three and Practice Five the GPs were reluctant to become strongly involved in Pegasus. They were reluctant to get involved in 'politics' and were deeply suspicious of both the Government and the RHA. These individuals saw Pegasus as both a buffer and an absorber. A buffer in that it provided protection against the RHA and an absorber as it absorbed the administrative and financial responsibilities associated with the contacting arrangements. However, as indicated by Laughlin et al. (1994b) the danger of an absorbing group is that it will develop colonising tendencies. Pegasus IPA was clearly established to absorb the financial and administrative risks associated with the New Zealand health reforms. However, within the practices studied the GPs accepted the new forms of visibility and financial control that came from Pegasus while they had previously resisted changes initiated by the State.

> That's why I like the idea of Pegasus, it's been sort of a relatively powerful group, it might just tone down things a bit, as long as they don't go over the top and get too politically motivated themselves (GP Practice Four, May 1995).

> The Pegasus guys are very clever. They have managed to walk the line between doctors' autonomy and managed health care. Autonomy has been stripped away and the doctors stand naked with their order forms. That they have got as far as they have is a real tribute to the way it has been run. The Pegasus guys are very clever. There is a strong belief that by making these changes everyone will be better off; the GPs will cement their position in healthcare and savings will end up coming back to the GPs (Dialogue Partner Two, June 1995).

The first quote indicates GP concern about the colonising power of Pegasus while the second quote highlights the interesting contradiction between a loss of autonomy, visibility and the GPs' belief that these changes would benefit them. It has become clear that Pegasus is not just an absorbing institution, but that it also has colonising tendencies. Since the end of 1994 there has been little effort by the RHA to initiate change as Pegasus had adopted the responsibility to change GP behaviour as part of their budget-holding programme.[7] Involvement in Pegasus did begin to change the way individual GPs behaved. But when they were challenged regarding their prescribing and laboratory testing they argued that the changes involved practising better medicine and that saving money was only a secondary concern. The changes were justified in terms of a professional rationality rather than an economic one. Pegasus also became an important force to 'balance' the GP / secondary consultant relationship and a voice for GP concerns (or the concerns of the Pegasus leadership) in both local and national issues.

> GPs have had minimal political clout. If we needed something we had to pay for it out of our own pocket. Specialists can get political support and generate political pressure if they need anything. GPs have always been the poor cousin of secondary care. But things may get better because of Pegasus. Already some specialists have started delegating work to the GPs. Patients have to pay but they don't have to wait on waiting lists or in a clinic to be seen (GP Practice Four, May 1994).

> These groups (Pegasus and the NZMA) have acted as a buffer for individual GPs. They have more clout as a negotiator than does an individual GP. Both Pegasus and the medical association are pretty influential (GP1 Practice One, October 1993).

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[7] See Appendix 2

Whether further changes will also be accepted so easily remains to be seen. Morgan and Willmott (1993) argue that a key role of accounting is to create visibility. Pegasus used information technology and accounting to record and monitor individual GP prescribing and laboratory spending. At the time of the study the financial controls appeared to be accepted, but there was some evidence that early savings were the easiest to secure and resistance would grow as there was pressure for ongoing financial gains.

The contractual accountability requirement seemed to have been resolved through the IPA structure. GPs only had to account to other GPs for their action while the government could cap the budget and establish contractual accountability with the IPA as a whole. Whether this would be sustainable in the long term was also open to question as there was increasing evidence that other IPAs around New Zealand were adopting a business-like stance, and a number are now managed by people who are not GPs (for example PrimeHealth in Tauranga which is linked with Etna). In the long run it may prove that those appointed to absorb the financial and political responsibilities become a greater colonising threat to GPs than the Government ever was.

CHAPTER NINE

CONCLUSION

9.1 INTRODUCTION

While considerable attention has been devoted to the New Zealand public sector reforms, there has been little empirical study of how these changes were actually implemented. Therefore the objective of this dissertation was to present a contextually informed study of the impact of reform in schools and GP practices in New Zealand. Both the conduct of the study and the analysis of the findings were informed by the work of Laughlin and Broadbent (Laughlin, 1991; Broadbent et al., 1991; Laughlin, 1995). However, the generalisability of the Laughlin-Broadbent work was limited because their studies only focused on the UK context. This dissertation provided an opportunity to explore the applicability of their findings and their methods in a different national setting. This question of generalisability is important because it underpins the feasibility of international comparative study of the role of accounting technologies in public sector reform.

From their empirical study of the UK public sector reforms Laughlin et al. (1994b) argued that GPs had delegated the unwanted elements of the UK GP contract to nurses and practice managers, leaving their own practices relatively unchanged. Broadbent et al. (1993) and Laughlin et al. (1994a) argued that the managerial aspects of UK Devolved / Local Management of Schools initiative were, on the whole, resisted by teachers and were absorbed by a small group within the schools. Based on the theoretical model developed and applied by Laughlin (1991), Broadbent et al. (1991) and Laughlin et al. (1994a), the New Zealand schools and GP practices were regarded as examples of 'social systems'. These systems were developed over a long period and reflected certain social (lifeworld) values on the education of children and the treatment of the sick (see Chapters Five and Seven). The New Zealand public sector reforms were seen as having colonising potential (Broadbent et al., 1991). Four schools and five GP practices were selected (see Chapter Four for a discussion

of the selection methodology) to provide an opportunity to study the impact or change pathways (Laughlin, 1991) resulting from the reforms.

Since the early 1980s New Zealand has been in a process of reforming State institutions and practices. These changes have seen an increase in the importance of accounting as a basis for accountability and control. Under these changes teachers and GPs found themselves subject to accounting controls and responsible for budgets. However, public policy literature indicates that the goals of original policy makers can be subverted as policies are implemented (see Ham and Hill, 1993). This is particularly true when 'lower level actors' have significant autonomy in how the changes are implemented and delivered (Lipsky, 1980). Gorz (1989) argued that actors such as teachers and doctors have a strong incentive to resist and subvert changes of an economic rationalist nature. It therefore seemed reasonable to expect resistance from GPs and teachers to the economic rationalism inherent in the New Zealand reforms as they have both motive and capability.

9.2 SUMMARY OF FINDINGS

This project involved a study of five GP practices and four schools. Interviews were conducted within these research sites over a period of twenty-seven months. The next section of this chapter provides a summary of the findings of this project and reflects on the strengths and limitations of the Laughlin-Broadbent theoretical model, as a framework for analysing and interpreting these findings.

9.2.1 Schools

The *Tomorrow's Schools* (Lange, 1988) reforms restructured the education system within New Zealand. The Department of Education was disbanded and new organisations were established with an explicit responsibility to monitor and control trustees and schools. Individual schools were given more autonomy as to how the school was managed, and they became responsible for many of the administrative and financial tasks, which were previously performed by the Department of Education or the local education board.

Within the schools studied there were significant changes to accommodate the new management roles. The presence (or absence) of professional and managerial skills on the elected boards of trustees had a significant influence on how well the schools adjusted to their new responsibilities. The elected trustees carried a considerable amount of the administrative workload delegated to the schools under the reforms, effectively doing voluntarily many of the jobs that the Department of Education and the local education boards had previously been funded to perform (Gordon, 1992a, p. 188). The professional skills of the trustees were particularly important in dealing with issues of accounting and property management. The role of the principal within the school also changed, becoming more administrative and managerial. All of the schools studied appointed a new staff member or designated an existing staff manager to oversee the financial aspects of the school management.

The changes within the schools fitted what Laughlin (1991) called the re-orientation pathway, in that the reforms led to changes in the way things had been done, but did not alter the core values of the schools or directly impact on the teaching process. As in the UK, the 'absorbing group' involved the principal and key support staff. However, in the New Zealand the absorbing groups also involved one or more of the trustees, which broadens the understanding of who can be actively involved in the absorbing process. The distinction between the more active trustees found in New Zealand and the less active trustees in the UK may have been influenced by the legislative context. In New Zealand the legal responsibility for the schools rested with the trustees while in the UK it rests with the head-teacher / principal.

In the New Zealand schools there was some evidence of the broad 'headteacher-types' identified by Laughlin et al. (1994a). There were examples of principals who adopted a managerialist and those who adopted a pastoral approach to the changes. However, the more detailed groupings described in Figure 3.3 were not supported in this case. This was because it was difficult to apply the categories in practice as some of them were very similar and the principals tended to exhibit characteristics of more than one type. Another concern was that the typology overemphasised the importance of the principal and tended to ignore the role of other individuals in the

process. This was inappropriate in the New Zealand context where the trustees played such a significant role.

While the general concept of absorbing groups was a powerful tool in understanding the impact of the reforms on the schools, there were certain aspects of the New Zealand empirics that were not explained by the Laughlin-Broadbent framework. The theoretical model tended to obscure questions of socio-economic status of the school communities. Within the New Zealand school sites, the socio-economic status had a major influence on how the schools responded to the education reforms. Schools in wealthy areas (Deans and Straven) had access to financial and professional skills, which were unavailable to schools in poor areas (Matai and Aroha). These skills were critical in dealing with the devolved management and accounting responsibilities. However, the distinction of 'rich' and 'poor' schools is too simple and the differences observed could be better understood by adopting a broad concept of wealth, which recognises differential resources in financial, human, social, cultural and natural capital.

While tasks could be absorbed, the impact of the changes in funding arrangements had subtle implications for the school as a whole. In the 'rich' schools the changes in funding arrangements had little impact on the teaching process as the community could supplement the resources available to the school, although this meant that education was being privatised by stealth, a process which received little public attention or debate. The 'poorer' schools were unable to supplement the financial and administrative resources by drawing on the local community and increasingly sought to return the problem to the centre. In effect, they rejected the process of devolved management and re-emphasised the government's obligation to the principles of equality of opportunity and provision.

While it is not appropriate to generalise on the basis of such a small sample, it was evident that wealth was a key factor in understanding how different schools managed the reforms. The Laughlin-Broadbent empirical studies identified socio-economic community as a potentially important contextual variable in the school sites studied.

However, their focus on absorbing groups within the school obscured the importance of the socio-economic community and ignored the nature of the resources and skills available to each school, which were central to the ability of a school to respond to the reforms.

In the New Zealand educational context the nature of the changes implemented seemed to have a significant influence on how they were managed within the schools. While financial and administrative changes were often absorbed, as predicted by the Laughlin-Broadbent framework, the changes to curriculum, and the new forms of accountability associated with increased measurement seemed to directly impact on the teaching staff. While the Laughlin-Broadbent framework does theorise change, it focuses more on the change impact or pathway rather than the nature of change itself. Within the school studies it became evident that the nature and focus of the different reform initiatives had a significant influence on how they were managed. While the financial and administrative changes (the most obvious examples of economic rationality) were generally absorbed within the schools by the principal, administrative staff and/or trustees, the curriculum and qualification changes seemed to have a direct impact on teaching staff. Maybe absorbing groups function best if the changes are peripheral to the central function or 'real work' as in the case of administrative changes observed in schools. Laughlin et al. (1994a, p. 65) makes a distinction between the real (authentic) education work and the tasks managed by an absorbing group. However, Laughlin et al. (1994a) fail to recognise the potential implication of this distinction, which is that the emergence of absorbing groups may be a function of nature of the change itself rather than a response to the changes. Currently the link between the nature of the change initiatives and the change pathway is under-theorised within the Laughlin-Broadbent model and there is a need to further explore the relationship between the focus of change initiatives and how the change is actually managed within organisations.

While the organisational focus of the Laughlin-Broadbent theoretical model highlighted the role of small groups within schools in managing change, the role of agencies external to the schools were ignored. In New Zealand the pre-reform

Department of Education and post-reform organisations such as the Ministry of Education, the ERO and the NZQA had a significant influence on how change was managed within individual schools. Prior to the reforms the Department of Education was an advocate for education in general and a buffer between the political demands of government and the schools. As the Department was staffed by teachers and educationalists, it shared many values in-common with the teaching profession. The replacement of the Department of Education by organisations such as the Ministry of Education was initiated with a clear agenda to eliminate 'provider capture' and to reduce the power of the teaching profession. The new organisations were responsible for promoting change within schools rather than resisting it. The understanding that these organisations, which are external to the school, can play an important role in both promoting and resisting change is a significant contribution of this dissertation and an important extension of the Laughlin-Broadbent theoretical model.

9.2.2 GP Practices

The health reforms in New Zealand were linked to the 1991 government policy paper – *Your Health and the Public Health* (Upton, 1991). These reform proposals were legislated through the Health and Disability Services Act 1993. This Act introduced quasi-market arrangements into the New Zealand health care system and required that GPs form contractual arrangements with the Regional Health Authorities in order to continue receiving State subsidies.

The relationship between GPs and the State was quite different to that between teachers and the State. Although the Department of Health was also restructured into a Ministry, this had little direct impact on GPs as the relationship was principally a funding arrangement rather than the bureaucratic control exercised by the Health Authorities and the Department of Health in the UK (see Jacobs and Barnett, 1996). Therefore these funding / contractual arrangements became the key issue in, and the basis for, the development of the IPA structure.

Laughlin et al. (1992, 1994b) argued that GPs responded to the UK health reforms by delegating the new responsibilities to the practice nurses and practice managers. In

effect, the changes were absorbed and the core work of the GP practice was protected. There was some evidence that prior to the reforms in New Zealand the practice nurses and practice managers had absorbed the financial and administrative arrangements associated with the government subsidy arrangements. However, only one practice in the study fitted the 'specialised work group' (Laughlin and Broadbent, 1995) model. Practice Two developed their own contractual relationship with the RHA and made a clear structural change within the practice. They appointed a project manager who, together with one of the GPs, absorbed most of the administrative responsibilities associated with the project.

The other GP sites studied did not fit the theoretical model and were not consistent with the empirical findings for the UK. All of the other practices studied did not negotiate their own contracts but accepted the collective contract negotiated on their behalf by the Pegasus IPA. They did not deal with the reform changes at the practice level but delegated the changes to the IPA, which absorbed the changes at the supra-organisational level (Walker and Mitchell, 1996). Historically collective action provided GPs with an effective strategy to resist government imposed change and the IPA structure provided a logical extension of that response. Rather than managing change on an individual practice level, GPs could delegate change (and threat of change) to the IPA to manage.

The concept of an institutional absorbing mechanism represents an important extension of the Laughlin (1994a) work, which was only focused on the organisational level and did not consider the possibility that an absorbing group could operate at the supra-organisational level. Another extension of the UK empirical findings (Laughlin et al., 1994a) becomes clear when one explores the kinds of change that were absorbed. Laughlin (1991) was concerned with how organisations absorb external change forces. The imposition of the 1993 health legislation was an example of this kind of change. However, organisations also faced internal forces stemming from inherent contradictions and conflicts in the role of the GP. GPs operating in New Zealand have always had to balance a tension between their professional obligations and the financial necessity to charge patients (unlike those operating in the

UK). Some of the GPs interviewed commented explicitly on this professional / financial tension. The development of IPAs provided a new way to manage the professional / financial tension. Not only did the IPA buffer GPs from government reforms, it also buffered them from economic rationality, absorbing contracting and the financial management / budgeting associated with the contractual accountability model.

In the light of the New Zealand empirics it became evident that while the Laughlin-Broadbent theoretical model highlighted the importance of externally imposed economic rationality, it failed to consider the tension between the economic rationality and the professional responsibility of the GPs. It also failed to adequately explain why the GPs in Practice Two chose to willingly take on budgetholding responsibilities while other practices joined the IPA structure. From a theoretical perspective, the reform initiatives were contrary to their lifeworld values and they should have found the financial and administrative responsibilities a threat to their professional autonomy. However, it was evident that they were willing to accept these new responsibilities regardless. This raises important questions about the nature of the lifeworld at the individual / organisational level. Different individuals and practices had different values and these were not adequately explained within the Laughlin-Broadbent model.

9.3 THEORETICAL REFLECTIONS

A key objective of this dissertation was the evaluation of the applicability of the Laughlin-Broadbent theoretical model in the New Zealand context. In this study the theoretical model provided an important contribution both to understanding the macro reform context and to studying the micro-changes within the schools and GP practice sites. During the empirical study it became evident that the Laughlin-Broadbent theoretical model was really two related theoretical frameworks, one which is micro focused and built on organisational theory (Greenwood and Hinings, 1988; Smith, 1982; Robb, 1990) and group theory (Bion, 1968; De Board, 1978), while the second broader framework was based on the Habermasian social theory, particularly the concept of colonisation. There was a strong relationship between the two

frameworks as many of the micro or organisational concepts closely mirrored the macro societal concepts. The broad focus of the two perspectives also highlighted an important relationship between the New Zealand social/structural changes and the micro-changes in the organisations studied. However, the study revealed that there were also limitations and aspects of the empirics that were not well explained by the theoretical framework. These issues will be explored in the rest of this section.

The macro Habermasian framework contributed to the historical analysis of schools and GP practices within New Zealand, providing a powerful language to analyse and interpret the development of education and health in New Zealand. However, aspects of this framework, such as the concept of lifeworld proved to be difficult to identify in practice. Through reflecting on the origin and development of health and education it was possible to identify some principles or values that were fundamental to the process (see Chapter Five and Seven). However, it is not possible to say for certain that these reflect lifeworld values in the sense understood by Habermas or whether they were actually the values of a political or professional elite. Another problem was that the macro-theoretical framework does not effectively theorise changes in the lifeworld values. Although systems may be established to reflect lifeworld values, clearly the lifeworld values can change over time. Therefore, it would seem reasonable that the values embodied in certain systems should also change over time if this restores the balance between the lifeworld and the system. From the micro organisational perspective this change which would appear to be a destructive internal colonisation as it challenges the internal values / lifeworld of the system. However, from a macro perspective, because it restores the balance between the system and the lifeworld, it would actually be a process of evolution in a wider societal sense, and therefore be positive. In effect the Laughlin-Broadbent theoretical model would misdiagnose the change pathway and condemn as unhealthy (colonisation) a process that is actually healthy and necessary (evolution). While Broadbent et al. (1991) acknowledge this problem, their solution is to focus on the process from the system/organisational perspective. This is a fundamental problem with the Laughlin-Broadbent model as it challenges the change-pathway distinction, which is central to their work.

Although the Habermasian framework highlighted major social-theoretical themes associated with the development and operation of health and education in New Zealand, many of these concerns were obscured during the empirical study by the organisational focus on change pathways and absorbing groups. On reflection the theoretical framework led to an over-emphasis on the micro-level change response and a reduction on the social-theoretical elements. In effect many of the broader Habermasian concerns with issues such as communication, differentiation and social development have been obscured by the micro concerns with absorbing groups and change pathways. This dissertation seeks to re-emphasise the link between the micro and the macro perspective by focusing on the role of institutions such as the Department of Health and the IPA. However, further work is needed to integrate the micro-organisational concerns with the macro-social theoretical perspective and to re-emphasise the broader Habermasian concepts identified above.

The micro-theoretical perspective highlighted how change disturbances could be managed within an organisation and emphasised the importance of small groups in this process. However, there are a number of general issues that remain unresolved within this aspect of the theoretical model. The identification of change disturbances is a problem. While, in a tautological sense, change disturbances are what brings change within an organisation, this does not provide a lot of practical guidance at the onset of a study. In this case there was a clear suspicion that there would be change disturbances, however their exact nature did not become evident until well after the empirical study had commenced.

In the empirical studies there were real difficulties in assessing whether there has been a change in organisational values, the fundamental criteria for distinguishing between the Laughlin (1991) change pathways. While it was possible to observe changes in behaviour, it was very difficult to observe values. Therefore, any judgements relating to changes in values were a process of inference based on changes in behaviour and expressed attitudes. This does raise some important questions about the validity of an analytical distinction based on inference of value changes.

During the research stage of this study it became evident that the structuralist organisational focus of the micro-theoretical model was flawed. It was found that by blurring the internal / external distinction that the organisational boundaries could be re-drawn and organisations such as the IPAs or the Department of Education could either absorb the power of a change disturbance or could further amplify the change experienced in the schools and GP practices. The importance of supra-organisational groups in both the school and the GP study and the challenge to the internal / external distinction does indicate that there may be some validity in Grey et al.'s (1995, p. 217) criticism that Laughlin-Broadbent have a too rigid, too defined concept of 'organisation'. Grey et al. (1995) proposed that organisational models such as boundary theory (Llewellyn, 1996) be used instead. The blurring of the internal / external distinction and the fluid concept of 'organisation' found in boundary theory is more consistent with the supra-organisational groups that were evident in the New Zealand empirics.

In conclusion the Laughlin-Broadbent theoretical model provided a valuable skeletal framework for the empirical 'flesh' of this study. While there were clearly limitations and areas of the empirics that were not addressed by the framework, it is the concept of the dynamic relationship between the theory and the empirics that is its best feature. It is evident that the Laughlin-Broadbent framework has changed in response to the empirical insights from the UK studies and it is also clear that this study adds to the change and development process. By recognising the limitation of this work and of the theoretical framework, the opportunity is opened for future researchers to address these limitations, to expand our understanding of accounting as a contextual phenomenon and to construct an international comparative evaluation of the changing role of accounting in the public sector.

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APPENDIX 1

PUBLISHED PAPERS

1.1. A GP Budgetholding Experiment in New Zealand, *Financial Accountability and Management*, Vol 12 (2) May 1996 p. 107-123. Joint authorship with Pauline Barnett. First Published by Blackwell Publishers Ltd, 1996.

1.2. A Reforming Accountability: GPs and Health Reform in New Zealand, *International Journal of Health Planning and Management*, Vol 12 (Jul – Sep 1997), p. 169-185. First Published by John Wiley and Sons 1997.

1.3. Costing Healthcare: A Study of the Introduction of Cost and Budget Reports into a GP Association. *Management Accounting Research,* Vol 9 March 1988 p. 55-70. First Published by Academic Press Ltd.

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A BUDGETHOLDING EXPERIMENT IN NEW ZEALAND

Kerry Jacobs and Pauline Barnett*

INTRODUCTION

Over the last decade there have been numerous attempts to understand and research accounting in the context of health care systems (Lapsley, 1991). While much of this discussion has focused on hospitals, particularly hospital cost accounting and budgeting (Bourn and Ezzamel, 1986), there has also been some interest in the context of general practice (Laughlin et al., 1992) particularly in the issue of GP practice budgetholding and contracting (Glynn et al., 1992; and Glennerster, 1994).

In the 1930s the first Labour government in New Zealand sought to create a tax-based health care system which was free to all citizens. Following protracted negotiations between the medical profession and the state, a compromise was reached whereby the public hospital system was financed from taxation, with access to subsidies for private hospital care. General practitioner services were not directly funded by the state, but by a series of fee-for-service subsidies for the consultation, pharmaceuticals and diagnostic services. From a consumer perspective this created at that time a universal, virtually free service. However, it separated primary health care financing, planning, management and accountability from secondary heath care, and created a primary care sector driven by fee-for-service reimbursement payments (Fougere, 1993). This contrasted with the UK, where the later post-war establishment of the NHS was able to incorporate general practitioners under capitated payment arrangements.

This paper will briefly review recent health sector developments and the way in which budgetholding in general practice has evolved in New Zealand, comparing key features of the fundholding developments in the UK. There will then be a discussion of a case study of a New Zealand general practice, with an emphasis on the impact of budgetholding on practice management. The paper will conclude with an analysis of the prospects for budgetholding and the development of managed care.

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PUBLIC SECTOR RESTRUCTURING IN NEW ZEALAND (1984–93)

Hood identifies two broad 'streams' of ideas which have underpinned much of international public sector reform: the 'new institutional economics' and 'business-type managerialism' (Hood, 1991, p. 5). New Zealand's decade of public sector restructuring began in 1984 under a Labour government. According to Hood (1991, p. 6) the changes reflected both the theoretical and the new managerialist 'streams' with 'unusual coherence'. The reforms were motivated mainly by the overall weakness of the New Zealand economy with its high public debt and poor performance in both public and private sectors (NZ The Treasury, 1984). The government's first term (1984–87) focused on reducing intervention in the economy by deregulating financial markets, removing subsidies and other economic protection, and reducing the state's participation in commercial activity (Duncan and Bollard, 1992). The second term concentrated on wider reform of the core public sector (Scott and Gorringe, 1989), including the corporatisation of public agencies, the introduction of general management and a new public financial management system which required the detailed measurement and reporting of outputs.

The electorate, exposed to major change over the previous six years, voted for a new government in 1990, but found it to be at least as radical as its predecessor, particularly in deregulating the labour market and reducing government involvement in social services. The level of social expenditure was seen as a significant cause of New Zealand's debt burden, encouraging welfare dependency and undermining the prospects for economic growth (Scott, 1994). Policy initiatives of its first term (1990–1993) included reducing welfare benefit levels and restructuring social services such as education, housing, welfare and health (Boston and Dalziel, 1992).

HEALTH RESTRUCTURING IN NEW ZEALAND 1984–93

Between the 1930s and 1980s health services in New Zealand were organized in three discrete sectors. Primary health care was delivered by private practitioners usually operating in groups, with partial fee for service subsidies from the state for consultations, pharmaceuticals and laboratory tests. The secondary care sector was provided regionally via locally elected hospital boards serving a defined population with hospital and, to an increasing extent, community support services. They operated with block grants from central government, which evolved through the 1980s into a population based formula (Fougere, 1993). Population, or public health, services were organized centrally by the Department of Health and delivered through regional offices.

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Labour Government and Health: 1984–90

The Labour government sought to restructure health in a way consistent with its objectives of restraining overall expenditure, improving efficiency and effectiveness and ensuring accountability. Major restructuring in 1989 focused on a regional approach to assessing health needs and contracting for services. Fourteen Area Boards were established which integrated population health with hospital and related community-based services. The boards had, as their primary responsibility, the protection and promotion of health, the provision of a balanced range of hospital and community services, and the co-ordination of the government and non-government sector. Boards received capped, capitated budgets for their defined populations (Malcolm, 1990). This restructuring reflected the overall theme of public sector reform, with the introduction of general management into Area Health Boards and broadly defined contractual relationships between Boards and the Minister of Health (Davies, 1990).

Primary health care, however, remained outside any accountability structure. Driven by fee for service and open-ended subsidy entitlements, government expenditure on this sector increased at approximately six percent per annum (inflation adjusted) during the 1980s (Malcolm, 1993), despite the use of both market and administrative strategies to contain costs. Market deregulation provided for increased competition but in fact there was little evidence of successful entrepreneurial behaviour and no impact on fee levels (Bell and Fay, 1991; and Kearns and Barnett, 1992). In 1990 the Minister of Health offered a new administrative structure for GPs — the option to contract with the government for capitated rather than fee-for-service payments. This was strongly opposed because it attempted to place additional controls on practitioners, including limiting the fee that could be charged to the patient (Matheson and Hoskins, 1992).

National Government's Health Reforms 1990–93

In a 1990 review of the health sector the new National govemment considered the role of the state, the private sector and individuals, with additional attention to targeting and greater competition (Scott, 1994). While it might be thought that the restructuring of 1989 had hardly had time to demonstrate its effectiveness, the new government considered that the system was flawed. They claimed that it was inefficient and inequitable because of cost shifting, provider capture and management incompetence (Minister of Health, 1991).

Proposals for reform (consolidated as the Health and Disability Services Act 1993) were framed around the integration of public budgets for both primary and secondary care and, progressively, for disability support and accident insurance payments. The separation of purchasers from providers occurred through the establishment of four Regional Health Authorities (RHAs) which

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now act as purchasers of all health and disability support services for a geographic area. They purchase in a semi-competitive market which includes public, private and voluntary providers. The 14 area health boards were abolished, and reconstituted as 23 Crown Health Enterprises (CHEs) i.e. corporatised provider units which, while owned by the state, are expected to operate in a market along with other providers.

The reform proposals (Minister of Health, 1991) identified innovation in primary health care as an important component. A few commentators have seen this as the main innovation of the reforms, providing opportunities to contain hitherto open-ended expenditure, to increase accountability and perhaps alter the balance between primary and secondary services (Malcolm, 1993). As in the UK, there were no details of how these strategies might be implemented, other than general themes of contracting, capitation and budget holding. Significant attention was paid by the Ministry of Health and the Health Reforms Directorate to the idea of GP fundholding.

GP BUDGETHOLDING

The concept of fundholding (or budgetholding as it is called in New Zealand) in general practice was first formulated in the UK in the mid-1980s (Maynard, 1986). The concept is based on the principle that general practitioners, being close to the patient, are in a good position to act as a proxy for the 'expert consumer' necessary to operate effectively in a market, and therefore should hold the funds for purchasing health care, at least at the primary level and possibly for secondary care too.

Characteristics of the fundholding scheme for the United Kingdom were laid out by the Department of Health (1989). These guidelines indicated that only large, well-organised practices, originally with lists of at least 11,000 patients (later reduced to 9,000) could be considered. Financial inducements were provided, including 75 percent of the costs of leasing, purchasing or upgrading necessary computer systems, and 70 percent of information staff costs. Moreover, in the preparatory year an allowance would be paid to cover the extra administrative costs of preparing the practice for fundholding status. Approximately 7 percent of practices joined the scheme in the first year (about 300), with this increasing to 25 percent by 1993/94 (Glennerster et al., 1994). Practice budgets included provision for providing primary health care through the practice, and purchasing selected secondary services, diagnostic services and pharmaceuticals. Following the implementation of fundholding in the United Kingdom in 1990, a number of papers have reviewed progress, either from the perspective of individual practices (Bain, 1992) or more widely (Day and Klein, 1991).

Some research suggests that a significant effect has been to divert both interest and resources towards primary health care (Ham, 1993; and

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Glennerster et al., 1994). A longitudinal approach has been taken by Glennerster and colleagues who undertook reviews at early stages of implementation (Glennerster et al., 1992) and with subsequent 'waves' of recruits to fundholding (Glennerster et al., 1994).

General practitioners in New Zealand expressed significant reservations about the health reforms, about contracting with a purchaser and about alternatives to fee for service payments (Baker, 1995). In early 1992 the New Zealand Department of Health called for proposals for projects aimed at trialing new ways of delivering primary health care services in order to make progress prior to the 1993 implementation of the reforms. The ten projects that were selected from the 75 proposals received, covered a range of providers and services, with a number focusing on examining the feasibility of both holding an agreed budget for all kinds of primary health care services (i.e. moving away from individual fee for service subsidies or other benefits) and holding funds to purchase secondary services on behalf of client groups.

The management of the pilot projects was taken over by the specially formed Health Reforms Directorate in 1992 and eventually by the RHAs in 1993. A number of reviews have been undertaken of these early and subsequent initiatives (Barnett, 1993; Kirk, 1994; and KPMG Peat Marwick, 1995). Those patterns of contracting which emerged were somewhat different from those in the UK, mainly because of the rapid growth of independent practice associations (IPAs)[1] in New Zealand. An important common issue at the microlevel, though, is the way in which the new arrangements are influencing the management of individual practices. This paper therefore presents a case study of a single practice in the southern city of Christchurch as a means of illustrating the adaptation to budgetholding.

CASE STUDY: THE HEALTH CENTRE

Case Study Methods

This case study was based on documentary analysis and interviews with key participants. Documentation from the practice included project proposals, negotiated contracts and progress reports to the Department of Health. Formal interviews and informal discussions were held with key staff of the practice. Interviews were normally tape-recorded and transcribed.

Monitoring reports were prepared based on the interviews and documentation. These were reviewed by practice staff, as was this paper, for matters of fact and interpretation. Staff within the practice were also actively involved in commenting on the working notes and illuminating the content of documents.

This materiel forms the basis of a case study of the implementation of budgetholding. It is not intended to be a basis for generalisation, but to present

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a scenario of experiences as a guide for policy makers, practitioners and others engaged in change processes in general practice and perhaps other similar organisations. The strong link between practice and research found in case studies means that the results are more clearly relevant for a non-academic audience (Lapsley, 1991).

The Practice

The Health Centre is a well-established practice, located in a socially and economically mixed community of a small, thriving city in the South Island of New Zealand. The practice has a tradition of providing comprehensive family health care, integrating preventative and curative services. Approximately 11,000 patients are enrolled with the practice, two-thirds of whom, on the basis of their income level, receive no government subsidy. The practice runs its own urgent medical service and is part of an after-hours surgery arrangement and of a large Independent Practice Association (IPA). Services are provided by a practice team of around 30 people which includes seven full time equivalent general practitioners, seven practice nurses, a practice manager and project manager, five receptionists and a secretary. A retail pharmacist and physiotherapist also lease space in the building.

Initiating the Budgetholding Project

The development of the project is outlined in Table 1. The project was initiated in early 1992 when the Health Centre volunteered to participate in the Department of Health alternative funding initiative as an experimental capitated budgetholding practice. The practice proposed to test the feasibility of budgetholding and develop the data base necessary for further budgetholding for the personal health care of a defined population. In its proposal the practice listed the following objectives:

- To investigate, negotiate and trial budgetholding for some outpatient services, domiciliary nursing services, laboratory testing and prescribing.
- To develop a data base for use in further budgetholding developments.

The proposal also stipulated that the practice be funded for a full time project manager to run the project and for a new computer system to collect and analyse the data on the operation of the project.

The proposal became the basis for a contract between the Department of Health and the practice. The responsibility for managing the initiative and negotiating contracts was passed at an early point to the Health Reforms Directorate. When the reformed structure was introduced in 1993 the management and the co-ordination of the budgetholding contract became the responsibility of the local RHA.

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Table 1

Project Timeline

Date	*Event*
Early 1992	Health Reforms Directorate initiatives contract – seeding grant to investigate and trial budgetholding – capitation contract (November 1992 to June 1993)
1993	Signed first Regional Health Authority contract – capitation contract – bulk funding for immunisation – budget (nominal) for pharmaceuticals and laboratory – payment for administration
1994	Signed second Regional Health Authority contract – capitation contract – bulk funding for immunisation – budget (nominal) for pharmaceuticals and laboratory – payment for administration – bulk funding for practice nurse subsidy – established domiciliary nursing project (November)

Notes:
Independent Practice Associations (IPAs) are a voluntary association of GPs in a local area. The practice studied in this case chose to negotiate its own contract with the RHA, but the local IPA has negotiated a collective contract for most of the other practices in the area. This has had the effect of absorbing some of the overheads of budgetholding, including some information systems development, negotiating and even carrying the risk of capitation to allow members to continue on fee-for-service subsidy arrangements.

Motivation for Involvement

There appear to have been three general reasons for the practice becoming involved in budgetholding. First, there was the frustration with previous change initiatives which had been seen as highly prescriptive and forced on GPs.

> We had no confidence in any system conceived by politicians and bureaucrats would be a good thing for us. There were all sorts of extraordinary rumours about what the reforms would involve — anything from insurance companies taking over and setting up major health care plans to budgetholding, abolition of GMS and abolition of the practice nurse subsidy. There was a lot of uncertainty and we had no confidence that anything that the Minister of Health would come up with would be any good for us.

By becoming involved in a relatively unformed project at an early stage this group of practitioners felt they could influence the process to the advantage of both patients and themselves, although this view was not widely shared by their colleagues outside the practice. Secondly, there was the potential for significant advantages for the practice, particularly in the development of computing and information systems. Thirdly, there was strong leadership

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from one member of the practice who saw this as an important professional challenge.

> I have been the one who was mainly interested. My original motivation was that it represented a challenge. I am not sure why but I quite enjoy a challenge — the GP life can become pretty mundane otherwise. Also I have become an expert on something, which I quite like.

Negotiating Contracts and Budgets

It was recognised that budgetholding would increase the administrative workload of the practice, and so the project specifications included a full time project manager who was appointed in August 1992. The project manager's responsibilities include two key areas. The first involves the maintenance of relationships with the purchasing authority, now the RHA. This included negotiating contracts based on agreed budgets, obtaining approval for expenditure of 'savings' and preparing regular reports as agreed to in the contract. The second area was monitoring financial, medical and patient trends for feedback to the practice. This involved providing information on GP prescribing patterns and test ordering which formed the basis for peer-review discussion in weekly meetings. To some extent this role extended beyond a pure focus on the budgetholding project to include an involvement in practice quality assurance and planning.

The project began in July 1992 (Table 1). A contract with the Minister of Health for patient capitation rather than the traditional fee-for-service subsidy was achieved in November 1992. Capitation meant that the practice received a fixed dollar amount of state subsidy rather than a subsidy per qualifying patient visit. However, as two-thirds of patients were above the income level for subsidy eligibility, the practice continued to rely, as before, on a significant portion of practice income being raised from direct consultation fees paid by patients or their insurers.

The process of negotiating an initial contract between the practice and the Health Reforms Directorate proved to be slow and difficult. The first eight months were involved in setting up the budgets, protocols and procedures. There were two reasons for this delay: first, there were no precedents for this type of contracting with everything being negotiated from the beginning. Second, there were difficulties in the negotiation process. Those involved in the practice suggest that there was hesitation on the part of the purchasers to conclude a contract without a risk-sharing arrangement where the practice would be liable for any overspending. In order to 'get something signed' a component of risk was accepted by the practice in the initial budgetholding agreement. This covered pharmaceuticals and laboratory tests from March to June 1993.

When the responsibility for the budgetholding project transferred to the local RHA in July 1993, the Health Centre signed a more extensive contract

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covering not only capitation but also immunisation, pharmaceuticals, laboratory tests and direct funding for administration costs. While the Health Centre held the funds associated with patient capitation and immunisation, pharmaceuticals and laboratory test budgets were nominal.

Pre-project levels of practice expenditure were used as a starting point for setting budgets. Adjustments for expected national increases were negotiated between the practice and the RHA to provide the budget for the forthcoming year. From the practice's perspective no cash was involved in the pharmaceuticals or laboratory tests although separate records were kept by the RHA and any 'savings' were apportioned on a negotiated basis between the practice and the RHA. The RHA also retained veto over how the practice was to spend their share of 'savings' specifying that they could only be used to 'directly benefit patients' rather than to boost practice income in any way. The contract between the practice and the RHA was re-negotiated in 1994 to include bulk-funding of the practice nurse subsidy while maintaining the other provisions of the earlier agreement.

Practice Information System

The development and implementation of an upgraded computer system was an integral part of the project. The practice had had a system for patient lists, appointments, recalls and accounting for a number of years. Because of the interest in computerising all clinical records, the existing system was reviewed and updated. The practice employed a consultant to advise on appropriate systems and implemented a mixed UNIX-PC based system.

The state of the patient register had important financial consequences for the practice because of the capitation contract arrangement. Under capitation the funding received from the state depended upon the number of patients who were entitled to subsidised treatment on the practice register. Therefore, if the patient records were not correctly maintained, including income eligibility of patients as determined by the Social Welfare Department, the practice was in danger of losing part of their funding.

IMPACT ON THE PRACTICE

New Patient Services

From a patient perspective, budgetholding made no immediate difference, but there were significant subsequent effects on patient services. The most explicit benefit from the budgetholding project were the extra services the practice was able to fund from the savings. These included:

- Employment of a part-time counsellor. It has been the experience of the

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practice that counselling services were only readily available to those who could afford to pay, and that many patients were excluded for this reason.

- Purchase of initial referrals to private specialists for children with ear, nose and throat problems. This also extended to some private operations for children on the public waiting list for tonsillectomy.

Those within the practice accepted that the savings were to benefit patients rather than to increase practice income. However, they were disappointed that a strict interpretation taken by the RHA precluded important service initiatives which might possibly be seen as benefiting the practice. The consequence of the RHA position that there should be no direct or indirect benefits to the practice was that some practitioners felt that neither they nor their patients were getting much benefit from their hard work in creating savings. One suggestion was that savings could be used to offer free or reduced consultation fees for children. While this was permitted in other geographic areas, the local RHA was not keen on this suggestion as they felt that it would financially benefit the practice.

Professional Roles and Behaviour

Within the Health Centre practice nurses had always had unusually high levels of autonomy and direct patient contact and many felt that capitation was just the next step in this process. The historical fee-for-service subsidy, which required that all patients see a doctor, placed a strict limit on the 'chargeable' role of a practice nurse. With the move to capitation the practice nurses were free to take much more active preventive and educational roles. This was seen as one of the most positive benefits of capitated funding.

The capitation approach also had direct effects on the doctor-patient relationship. GPs felt that the consultations were longer than they had been previously. Although no clear reason was given for this trend it was felt that more contact meant that patients were getting a better service. There was some debate among the GPs about how much the project had affected the nature of their work. One of the GPs said:

> I don't think that it [the budgetholding] has made much difference. I come to work and do much the same kind of work that I did ten or twenty years ago. Life at the coal face just goes on . . . I don't think that there has been a radical difference in the way I practice.

It was pointed out by the other GPs that there had been a decline in the number of laboratory tests ordered. The provision of information on individual prescribing and laboratory usage, regular peer review meeting and the establishment of in-house protocols for treatment of certain conditions had had a significant effect on GP behaviour. Changes in laboratory usage had been particularly important (tests ordered dropped by about 25 percent) but changes in prescribing behaviour proved much more difficult to achieve. This

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was attributed partly to the fact that the practice was already at the lower end of prescribing rates.

Practice Management Issues

A percieved benefit of the budgetholding experiment was an increase in communication between the staff members. They suggested that there was increased collegiality within the practice. While it is difficult to determine how substantive this was the regular weekly meetings provided an opportunity for all staff to be actively informed about and to play a part in the ongoing budgetholding project. However, there were also clear frustrations due to increased time that staff needed to devote to meetings.

Because of the contract requirements the administrative workload increased far beyond initial expectations. Much of this administrative responsibility was handled by the project manager and it was suggested by other staff that her support was critical to the success of the project. Practice staff also listed funded administrative support as an essential requirement for any practice considering budgetholding. However, the increased administration was not restricted to the practice manager. Most of the staff experienced increased pressure in an already busy work environment.

Secondary Care Relationships

Budgetholding for some secondary services and for domiciliary nursing services was one of the key aims in the project proposal. However, this has proved difficult to achieve. The practice had difficulties in establishing links with secondary care services of the local Crown Health Enterprise (CHE). The CHE had difficulty providing the necessary cost data and those who could have ensured its provision regarded the data as commercially sensitive information.

Studies were conducted by the project manager into patient use of health services such as outpatients and community nursing care. The practice successfully established a link with a Diabetes Treatment Centre and an experimental outpatient clinic for diabetes was run within the practice for about 18 months. Records were also kept of attendance by the diabetics registered with the practice at hospital-based outpatient clinics. Cost information was collected but it was considered impractical to allocate the costs from the hospital to individual practice patients. Therefore, real budgets could not be established and the clinics were discontinued after 18 months, at the request of the Diabetes Centre.

Negotiations were conducted with local domiciliary nursing services for contract budgetholding. A special project was established from 1 November, 1994, involving the practice, a local CHE and a community nursing network. While there has been no attempt to hold a budget in the normal sense, the

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project involved the practice in providing clinical case managers (GP and practice nurse teams) to oversee each patient referred by the practice to the community nursing network. This significantly improved the levels of communication between the practice and the nursing services, keeping the medical staff up-to-date with the patient's care situation and facilitating speedy response to any change of circumstances.

The major difficulty experienced was the fragmentation of funding of home based care. The source of funds for home based care for patients who are discharged from hospital is different from that for patients who are referred to nursing services through their general practitioner. A patient is eligible for funding from the CHE for nursing services for up to six weeks following an episode of hospital care. Should care be needed for a longer period this is no longer funded directly by the CHE but through a budget held by the CHE for GP-referred nursing services. The practice was only able to involve patients in this second category in this project. This led to some issues of continuity of care and, in one case, to two different nursing care providers being involved with different clients in one house.

There was disappointment within the practice with the lack of progress in extending budgetholding to other areas of secondary care. This was seen as a logical extension of the current arrangements and one offering great potential for patient benefit. However, they felt that it was not a practical option for a single practice. Practice members felt that they did not have enough leverage to deal with hospital-based services for two main reasons. First, the large sums of money and the complex negotiations involved required access to management and commercial expertise that would be difficult to maintain given their size. Second, the relatively small district population base and distance to other secondary services meant that there was no real alternative secondary care providers (the nearest alternative public surgical service is two hours drive away).

Contract Relationships

The relationship with the purchaser appears to have become less comfortable as the project has progressed. In the early stages of the project the practice reported working closely with the Department of Health and the Health Reforms Directorate, with any delays due mainly to lack of experience and expertise. More lately the practice has seen their relationship with the purchasing RHA as more difficult, mainly because of the strict interpretation of the use of savings, an interpretation not necessarily shared by other RHAs. Those within the practice felt that their experience was contributing to the development of expertise and understanding in the RHA but, apart from subsidy of some administrative overheads, the RHA did not recognise this contribution.

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DISCUSSION

It appears from our case study, and other recent reviews (KPMG-Peat Marwick, 1995), that budgetholding in New Zealand has been more experimental and has progressed at a slower pace than in the UK. Initial practitioner motivations, however, appear similar, with individual leadership as a critical factor. At the Health Centre the project was clearly seen as driven by one of the GPs. He was influential in the original project application and in gaining wider practice support for the project. When explaining this interest he outlines the similarities between his role and those involved in the 'first wave' of fundholders in the UK. Glennerster et al. (1994, p. 83) characterises the doctors most willing to take on new challenges as looking for the 'next mountain to climb.' Beyond this initial motivation there are some important issues which demonstrate contrasts and similarities in the way in which fundholding in the UK and budgetholding in New Zealand have developed.

Risk Structures

Weiner and Ferris (1990) suggested that serious attention should be paid to the risk structure associated with budgetholding as there is potential to introduce undesirable incentives. The central concern is that financial incentives may encourage doctors to act in their own financial interest rather than in the interest of their patients.

In New Zealand the question of how budgetholding savings should be dealt with generated a significant debate. One of the most influential statements was a report on the ethical issues in budgetholding from the Otago Bioethics Research Centre (1994). This argued that direct financial incentives for practitioners created 'unethical distortions into the process of professional decision-making and therefore have a damaging effect on patient care'. Therefore, savings should not contribute towards practitioner or practice income but should only be used for the direct benefit of patients. A consequence of the very strict interpretation by the local RHA of what constitutes 'direct benefit' to patients and in the 'practice's interest' has meant a restrictive approach by the RHA to the use of savings, and a level of disillusionment on the part of some of the staff within the practice. An inherent danger is that in seeking to avoid 'perverse' incentives, it is possible to create a system that lacks any incentives at all. Those involved in this case study clearly felt that they were not being rewarded for the time and effort they had put into the budgetholding project. There appears to be more flexibility and clarity in the use of savings in fundholding in the UK, with no evidence in the literature of significant tension or uncertainty in this regard (Glennerster, 1994; and Pirie and Kelly-Madden, 1994).

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Practice Management

While the Health Centre had accounting and performance measurement systems prior to involvement in the budgetholding project, the project did place greater emphasis on these areas. More attention is now paid to the maintenance of the patient register, utilisation patterns for consultations, laboratory and pharmaceuticals. Much of this information formed the basis of regular feedback to individual GPs on their consulting rates, and their use of laboratory and pharmaceutical resources, and also formed part of the reporting requirements of the contract.

In the UK, fundholding clearly increased the administrative and financial workload of practices. The administrative workload for the New Zealand projects was further increased by the lack of a history of capitation. This meant that developing and maintaining basic systems for managing a register were particularly urgent and an overriding pre-condition of participation. Even when this was achieved, there still remained the administrative and accounting systems necessary, because of income-tested patient subsidies, to maintain a private fee-generated income stream to ensure practice income. Security of income and cash flow, therefore, were only partially guaranteed by participating in the pilot scheme and could not be considered a significant incentive.

Budgetholding for Secondary Care

In New Zealand there has been a focus on controlling primary health costs such as the laboratory and pharmaceutical usage, but less emphasis so far on budgetholding for secondary care. While within the Health Centre there was a clear desire to manage a budget for secondary services, this met with only a limited success because of the lack of 'negotiating clout' by a single practice and the reluctance of the secondary services to relinquish funds and control.

In listing the potential challenges facing budgetholding in the UK, Weiner and Ferris (1990) suggest that even a practice the size of the Health Centre might not be large enough to support the complex contracting arrangements. While size was clearly a problem in this case, it is not the only factor to explain the difficulties experienced in developing the necessary relationships with secondary care providers. The feasibility of secondary care budgetholding in New Zealand is likely to be limited by the small and dispersed population which preclude budgetholding practices from having the choice of altemative secondary service providers. This contrasts with the UK where it is estimated that, at least in more densely settled areas, up to three-quarters of hospitals may be subject to competition (Appleby et al., 1994, p. 45). The absence of equivalent critical mass of both population and services in New Zealand will make it difficult for a practice to trade off one secondary provider against another. However, the relatively successful involvement with the district

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nursing project indicates that budgetholding itself may not be necessary in order to have a significant influence on the provision of some services, although whether this can be extended to secondary care remains to be seen.

CONCLUSION

The prospects for budgetholding in New Zealand are much more fragile than the fundholding experience of the UK might suggest. It is our assessment that this has much to do with the historical framework for primary health care, namely the fee-for-service system. While this has resulted in practice information systems being relatively underdeveloped for budgetholding purposes, it also relates to the broader health sector structures on which budgetholding must be built.

The fee-for-service system had meant that the only relationship most practitioners had with statutory health authorities was administrative, for routinely claiming patient fee subsidies. There had been no equivalent of a Family Health Service Authority, or its predecessor organisations, and the relationship with a contracting agency had to be developed from the beginning. This has clearly been a source of difficulty in this case study, with the level of mutual trust and common accord which characterised the contracting relationship during the early stages of the pilot scheme appearing to decline. This has been exacerbated by the practice's perception that they have received few benefits from their involvement, have been unable to influence the use of savings adequately, and have carried an unreasonable proportion of the administrative overheads.

The establishment of effective negotiating relationships between practices and the purchasing RHAs has been slow to develop around the country, and will be critical for the future of budgetholding. While this may be overcome in time, a more fundamental problem in many areas is the lack of critical mass and potential competition in secondary care and the possible inability of GPs to exert purchasing leverage.

It is estimated that nearly half of all GPs (Malcolm, 1995) have sought strategies to deal with both infrastructure and critical mass issues through the formation of Independent Practice Associations (IPAs). These voluntary locality based groups have undertaken to absorb some of the overheads of budgetholding on behalf of their members, including some information systems development, negotiating and even carrying the risk of capitation to allow members to continue on fee-for-service subsidy arrangements. IPAs expect to introduce a greater level of equality and sophistication into negotiating with purchasers and more strength in dealing with the secondary care sector. While, to some extent, this mirrors multifund or consortia developments in the UK (Smith and Harris, 1994), it is likely to be a much more critical variable in determining the success or failure of budgetholding in New Zealand. Of interest in the future will be the extent to which IPAs

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develop a more corporate structure in order to achieve the aims of their members and, in so doing, perhaps put at risk the individualism and autonomy of general practitioners so jealously guarded over the last fifty years.

NOTES

1 Independent Practice Associations (IPAs) are a voluntary association of GPs in a local area. The practice studied in this case chose to negotiate its own contract with the RHA, but the local IPA has negotiated a collective contract for most of the other practices in the area. This has had the effect of absorbing some of the overheads of budgetholding, including some information systems development, negotiating and even carrying the risk of capitation to allow members to continue on fee-for-service subsidy arrangements.

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A REFORMING ACCOUNTABILITY: GPs AND HEALTH REFORM IN NEW ZEALAND

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SUMMARY

Over the last ten years or so, many countries have undertaken public sector reforms. As a result of these changes, accounting has come to play a more important role. However, many of the studies have only discussed the reforms at a conceptual level and have failed to study how the reforms have been implemented and operated in practice. Based on the work of Lipsky (1980) and Gorz (1989), it can be argued that those affected by the reforms have a strong incentive to subvert the reforms. This prediction is explored via a case study of general practitioner (GP) response to the New Zealand health reforms. The creation of Independent Practice Associations (IPAs) allowed the State to impose contractual-accountability and to cap their budget exposure for subsidies. From the GP's perspective, the IPAs absorbed the changes initiated by the State, and managed the contracting, accounting and budgetary administration responsibilities that were created. This allowed individual GPs to continue practising as before and provided some collective protection against the threat of state intrusion into GP autonomy. The creation of IPAs also provided a new way to manage the professional/financial tension, the contradiction between the professional motivation noted by Gorz (1989) and the need to earn a living. (©1997 by John Wiley & Sons, Ltd.)

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INTRODUCTION

There seems little doubt that the last decade will be seen as a significant period of international public sector reform. In the UK, there have been the 'Next Steps' and the 'Financial Management' initiatives which have radically altered the structure and operation of much of the civil service. In Australia, there have been important financial management reforms and changes in the operation of federal, state and local government. In the US, the Clinton Administration has made the quest for government that 'works better and costs less' one of its top priorities and there are a number of reform initiatives.

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Many other OECD countries have also undertaken public sector reforms, involving a move away from a rule-based public service and a move towards private sector models of funding, management and control (Hood, 1991).

A number of authors have argued that accounting measures and controls have played an important part in the reform process. Hopwood (1984) was one of the first to comment on the growing emphasis upon accounting technology and accounting measurement in the management of the public sector. Laughlin (1992) noted a growing emphasis on financial devolution, budgetary control and performance measurement in the UK Public Sector. Hood (1995) suggested 'accounting changes formed an important part of the assault on the progressive-era models of public accountability' (Hood, 1995). Humphrey *et al.* (1995) claimed that accounting was central to notions of a 'new public sector management' and was implicated in the reforms of the UK public sector.

However, much of the discussion has been concerned with these policies at a conceptual level as opposed to the policies in practice. This lack of attention to the actual impact is curious as it is well recognized that policies change as they are implemented (Hill, 1993). Pressman and Wildavsky (1973) drew attention to the issue of policy implementation and focused on the ways in which organizations tend to transform policy. They claimed that the goals of the original policy makers were often subverted during implementation. Later authors (see Barrett and Fudge, 1981) argued that 'lower level actors' took decisions which effectively limited the hierarchical influence, and pre-empted top-down decision making.

Lipsky (1980) has highlighted the importance of those that 'deliver the policy'. He argued that most people do not 'experience government' through elected politicians but through those who deliver public services such as teachers, police, social workers, judges and health workers. Because these workers have discretion in determining the nature, amount and quality of benefits and sanctions provided by their agencies, in-effect, they made the policy (Lipsky, 1980). Because of this, top-down controls and attempts to limit the autonomy of those that 'deliver the policy' are likely to be subverted. Lipsky (1980) concluded that those who wished to study policy and policy implementation need to consider the capacity of 'policy deliverers' to resist changes.

Gorz (1989) presented a motive for why those who deliver the policy may choose to subvert that policy. In his discussion of the place of work and economic reason in a contemporary capitalist society, he argued that work is not a unitary concept and that there are different kinds of work. Some work is subject to 'economic rationality' and therefore amenable to accounting and accounting measurement. However, not all activities can be subject to economic rationality. Gorz (1989) maintains that there are four characteristics of economically rational work. The activities must: (a) create value; (b) exchange as commodities; (c) be in the public sphere; (d) operate in a measurable amount of time and at as high a level of productivity as possible.

On this basis, certain categories of work do not satisfy all four conditions and are therefore 'beyond the limits of economic rationality'. Gorz (1989)

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labels one of these categories 'care or assistance'; and, offers medical practice as an example and suggests that in activities that meet a need for care, assistance or help, productivity is impossible to measure and therefore impossible to maximize. Starting from the example of police and fire officers he argues that the question is whether or not they are on duty, rather than if they are productive. Their task is to intervene should the need arise, but it would be better if they did not have to do so. These people are paid independently of their productivity.

Gorz (1989) then turns his attention to activities which meet a need for 'care, assistance and help', such as the medical profession. He maintains that the efficiency of such activities are also difficult to quantify as the number and nature of demands for assistance is independent of the carer. As such, the quantity of patients seen is not necessarily an indicator of efficiency. This is complicated by the fact that the service provided cannot be defined independently from the people whose needs are being catered for.

Gorz (1989) maintained that the basis of the relationship between the carer and those with 'needs' must be the belief that the care is provided in the patient's interest rather than in the interest of the carer; and, as such, this work should be performed out of a sense of vocation rather than desire to make money.

> 'Receiving remuneration for the help she or he gives should not be the doctor's basic motivation; such a motivation is in competition with a strictly professional motivation which could or indeed must take precedence in case of need . . . the money they earn should be a means of exercising their profession and not its end. Somehow, earning their living should not, so to speak, come into the bargain' (Gorz, 1989).

The New Zealand reform process has been regarded as the most dramatic example of systemic public sector reform (Holmes, 1992) and the archetype of economical rationality (Hood, 1991). Therefore, this article focuses on New Zealand as a prime example of the introduction of models of economic rationality and accounting control into the public sector. Health care, particularly general practice (GP) is chosen as an example of what Lipsky (1980) called 'street-level bureaucrats' and what Gorz (1989) referred to as 'care or assistance'. On the basis of both Lipsky's and Gorz's analysis there would appear to be some conflict between the nature of the New Zealand reforms and the motivations and values of those affected.

The first section of the article describes the development of the New Zealand health care system, paying particular attention to the role and place of GPs. This is followed by a summary of the reforms as relating to GPs and a case study of GP responses to the reforms in one area of New Zealand. Interviews which form the basis of the case study were conducted between 1993 and 1995. Based on the case study, it is argued that GPs did resist the economic rationality of the reforms through the creation of Independent Practice Associations (IPAs). This involved the delegation of contracting and financial

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management responsibilities to a small group. However, the IPAs not only acted as a buffer against the changes imposed by the government, they also provided a useful mechanism for GPs to manage the professional/financial tension.

HEALTH CARE IN NEW ZEALAND

The State was involved in the provision of health services from the beginning of the European settlement movement half way through the nineteenth century. While the emergence of the voluntary hospital in the UK was essentially an act of charity to the poor, the absence of a wealthy class in the first years of colonization of New Zealand meant that the voluntary hospital system never appeared. In each settlement, a Colonial Surgeon or Health Officer was appointed and as such health care was a charitable move, developed in order to 'offer the fruits of Pakeha (European) civilization to the Maori' (NZ Dept Health, 1974).

Benevolent societies were established in various centres to organize health services for the groups who were not deemed to be poor and, thus, whose needs were not met by State. These organizations were involved in the establishment of subscription hospitals managed by locally elected bodies and funded partly by local subscription and partly by the State.

By the 1920s, the attitude towards the hospitals had changed from the view that 'the hospital was an act of charity' to 'health care was the right of all citizens'. This change was coupled with the fact that the growing complexity of medical and surgical techniques made entry to hospital necessary for adequate treatment. The first Labour government recognized the need for a change in the provision and availability of health care services. They were elected in 1935 in the midst of world depression and remained continuously in office until 1949. Crucial to this election success was a series of wide-ranging social and economic reforms, which the reform of health care formed a small but significant part. Labour sought to implement a tax-funded health system that provided all citizens access to free health care on the basis of need. The policies of the government were to establish:

- a universal general practitioner service, free to all members of the community requiring medical attention;
- free hospital or sanatorium treatment for all;
- free mental hospital care and treatment for the mentally afflicted;
- free medicines; and,
- free maternity treatment, including the cost of maintenance in a maternity home.

The concept of free access to health services was strongly resisted by local doctors in the form of the New Zealand branch of the British Medical Association (BMA). They saw the State funding of health care as a threat,

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undermining their direct, fee-for-service, relationship with their clients, and giving the State a long-term stake in the oversight and control of their work.

The result of the stance of the medical profession was a 3-year struggle between the doctors and the State. The struggle was resolved with a partial compromise. All citizens would have free access to public hospital care financed from taxation, while tax-financed subsidies were made available to those choosing to use private hospitals. Primary care would not be directly funded by the State. Instead, a variety of patient subsidies would be paid covering all or most of the cost of consultation, fully subsidizing prescribed pharmaceuticals and gradually extending to subsidizing, in full or in part, a range of other diagnostic and therapeutic services.

In defence of their right to charge a fee-for-service the medical profession managed to entrench a high level of autonomy and control. This was most obvious in primary care. General practitioners enjoyed the right to practise where they chose, as they chose, for the price they chose, while being able to draw on State subsidies for their fees and for resources, especially pharmaceuticals, used in their practice of medicine. As patients must obtain a referral from a GP first, the GPs were effectively enfranchised as the gatekeepers to secondary-care services and to the services of other health-care providers such as physiotherapists (Fougere, 1993).

NEW ZEALAND HEALTH REFORMS

Fundamental to the New Zealand public sector reforms was a concept of accountability based on formal contractual arrangements and the distinction between outputs and outcomes. Each government department had a chief executive appointed on a fixed-term contract. Each chief executive was held directly responsible for the outputs produced by their departments (i.e. the number of clients attended), a responsibility expressed in their performance agreement and in the contract between their department and the responsible minister. The ministers were responsible for outcomes produced and to 'purchase' the necessary outputs to that end.

The provision of State subsidies for visits to the doctor and for pharmaceuticals did not fit into this contractual model of accountability and was highlighted as an area of concern by the Treasury (NZ Treasury, 1987). The other cause for Treasury concern was that the GP subsidies were open-ended. There was no limit to what could be claimed as it depended on the number of patients a doctor saw and the drugs they prescribed. In a context of a fiscal deficit, growing government debt, and the perception that the New Zealand standard of living was dropping, attempts were made to cap the open-ended arrangements.

In the July 1990 budget the Minister of Health publicly announced the concept of GP contracts and offered GPs who would sign a contract with her a higher level of government funding. The funding was such that all patients who visited a contracted practice received free services. The 1990 contract contrasts

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sharply with the compulsory GP contracts introduced in the UK. While there was some attempt to define and influence the role of the practice nurse, there was no real attempt to define GP behaviour or the nature of general practice, as was the case in the UK. The principal obligation was a restriction on practice fees, compliance with ethical codes and provision of additional information to the Department of Health.

There was no doubt that the 1990 contract was intended to directly impact upon GPs. The response was immediate, vocal and wary. The Minister of Health stated that she did not choose to consult with the medical profession in the development of the GP contracts because of 'their aversion to restrictive charges'. Interviews with key staff indicate that she did not consult with the Department of Health much either. However, it is difficult to categorize GPs as a whole as there was a range of responses. Some practices chose to take the contracts, seeing immediate financial and access benefits for patients. Some were strongly opposed to the contracts, seeing a threat to their autonomy and a growing intrusion of the State. However, most GPs took a pragmatic response and chose to wait and see if the Government would be elected for another term before making a decision. The vocal resistance to the contracts and the change in government at the next election saw an end to the contract scheme in March 1991.

The key impact of the 1990 contract attempt was to seriously sour the relationship between the GPs and the State. The GPs saw 'the State' as a threat to their autonomy.

> 'We fear an amoeba-like Health Department with its pseudopodia interfering even more with our prescribing, our diagnostic investigations and our ability to help our patients' (Marshall, 1992).

Those within the Department of Health and Treasury learnt that a direct attempt to cap the GP budgets was a dangerous strategy, as GPs had managed to thwart the 1990 proposals. The problem of capping GP budgets and of introducing contractual accountability was therefore approached as one element of the overall restructure of all of the New Zealand health service.

In December 1990 the government established a health sector task force to 'identify and investigate the options for defining the roles of the government, the private sector, and individuals in funding, provision and regulation of health services'. This report was never officially released to the public but it outlined a number of options for a future health system, based on the work already done in earlier reviews (Scott *et al.*, 1986; Gibbs *et al.*, 1988), and formed the basis of a later government strategy paper — *Your Health and the Public Health*, generally known as the Green and White paper. This was released in July 1991 as a 'Statement of government policy for reform of the New Zealand Health Care System' (Upton, 1991). The Paper announced that all Area Health Boards were to be split into separate purchaser (Regional Health Authorities; RHAs) and provider (Crown Health Enterprises; CHEs) organizations. All State-owned hospitals became CHEs and were required to

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contract, on a competitive basis, with RHAs for State funds. RHAs would receive a population-based funding pool and were responsible for purchasing health services for a defined geographical area.

Although the policy paper *Your Health and the Public Health* made little or no direct reference to general practice, interviews conducted with the taskforce members and documents extracted from their files indicate a considerable interest in primary health. References were made to studies of managed competition, GP budgetholding as developed in the UK, and a strong emphasis was placed on the integration of public budgets for both primary and secondary care.

> 'The Government plans to integrate the funding for all personal health services, visits to doctors, prescriptions, other community based services, hospital services and to place the responsibility for managing all this funding with the Regional Health Authorities . . .'

In effect, this meant that GP subsidies claims would be capped and that GPs as a 'provider' group would be required to contract with the RHAs for patient subsidies rather than claiming these directly from the State. This was brought about via the Health and Disabilities Services Act, 1993.

It is not surprising that the 1991 proposals and subsequent 1993 legislation were also regarded with suspicion and in some cases outright fear by many GPs. It therefore seemed reasonable that they should turn to a strategy that had served them well in the past, i.e. that of presenting a collective front. This came in the form of the Independent Professional Associations (IPAs).

THE IPA — A GP RESPONSE

In June 1992 a group based at the University of Auckland were jointly commissioned by the New Zealand General Practitioners Association and the Health Reforms Directorate to advise on the formation of policy for primary health care in the new environment. They recommended that 'providers' organize themselves into collective groups called IPAs as an effective way to address: the financial and managerial complexities faced, to reduce potential transaction and administrative costs, and, to facilitate risk sharing between the health providers and the RHAs (Uniservices, 1992).

The Health Reforms Directorate, who were responsible for driving the reforms, had no clear idea of how primary health contracting would operate. The formation of IPAs was seen positively by the Reforms Directorate as a way of passing the risks associated with the open-ended GP budgets onto someone else. The IPAs would also significantly simplify the process of negotiating contracts. In effect, the IPA would act as an agent in the contract negotiation between member GPs and the RHA. Therefore, the RHA's contracting costs would be minimal as they would only need to contract with a few IPAs as compared to hundreds of GPs.

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By 1995 there were over 40 IPAs around the country and over 50 per cent of GPs were part of these groups. However, because the IPAs were independent and locally based, it is no longer appropriate to make national generalizations; rather, a case-study approach is needed to understand the nature and function of particular IPAs. This article now presents a case study of the development and function of an IPA based in Christchurch, New Zealand.

Of all the IPAs in New Zealand, the Pegasus group in Christchurch stands out. The Pegasus IPA came into existence in March 1993 as an incorporated society. Currently about 90 per cent of the local GPs are part of this group. All of the other IPAs around the country are significantly smaller than Pegasus. The size, combined with the cooperative attitude of the local RHA, has meant that the Christchurch area has become the experimental pilot for the country. While there is a widespread interest in forms of budget holding and capitation, other areas tend to look to Pegasus and to the Southern RHA to see how well they work.

Motivation of GPs for forming/joining Pegasus

In the interviews conducted, GPs showed a number of different motivations for joining Pegasus. First, Pegasus provided some form of protection against the proposed changes, particularly in the light of perceived animosity from the State.

- *'I think that Pegasus is a security blanket for a lot of doctors in Christchurch who thought like us — Hell what is going to happen? Pegasus was seen as a group, doing something that anybody could join and be swept up under their skirts.'*
- *'I am part of Pegasus because I am keen on GPs showing solidarity. This is a way for GPs to act as one rather than being picked off. This is a danger because the government has historically been malevolent, not supporting GPs.'*

Second, GPs felt that they would get a better contract from the RHA as part of an IPA group than they could negotiate as individuals.

- *'Pegasus have acted as a buffer for the individual GP. They have more clout as a negotiator than does an individual GP.'*
- *'Being part of an IPA means we are less vulnerable than we would be by ourselves. We get the best deal from the RHA and deal with the RHA more effectively.'*

A third reason for getting involved in groups like Pegasus was that this was seen as an effective way for GPs to gain more control over the reform process. The change was seen by many as being unavoidable. From that perspective there was a simple choice: either for GPs to be involved in the process; or, they would lose their historical power, autonomy and control over resources to someone appointed by the State. This view was expressed as follows:

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- *'It seems to us that if there is going to be a bureaucracy it was much better for it to be controlled by GPs used to running in a lean way, than any third party.'*

GP involvement in Pegasus

Within Pegasus, three different levels of involvement have emerged. First, most of the rank-and-file members were happy to let someone else deal with the contracts and the politics so they were free to 'get on with being a GP'. For these people, Pegasus has guaranteed maintenance of the status-quo fee-for-service arrangements and continued access to the same services and resources. GPs in this group only have a limited involvement in the Pegasus activities and projects and tend to see membership as a way to avoid change.

- *'Many of the other members have been protected from the change by Pegasus. These are similar to the third or fourth wave fundholders in the UK. They have experienced no change and see Pegasus as protection from the State and the RHA.'*
- *'What people want is mastery over their own destiny and to protect their autonomy. Strangely enough, the managed care path of Pegasus involvement has secured more autonomy than those who stuck with the Section 51 agreements. Those people are more controlled and subject to the whim of RHA middle managers.'*

The second group consists of those actively involved in attending the Pegasus meeting and in being part of the projects underway. Pegasus provided these people with a way for them to be actively involved in improving the standards of general practice. For them Pegasus has been an active change agent, but these are changes that they have chosen to be involved in.

- *'I was interested in being an active part of Pegasus, it seemed like a good thing to do. It seemed like a way of influencing, to a small degree, the way we practice and for the better.'*

The third group is the core of about seven GPs who are the leadership of the Pegasus IPA. One GP described these people as the 'next mountain to climb brigade'; similar to the first-wave budget holders in the UK, middle aged and looking for a challenge. These people are highly committed to Pegasus and have become the driving force of the change process.

- *'What has made the difference in Christchurch is the core of smart/driven people who are dedicated to making things better and see this as a way to get rewarded for their skills.'*

These individuals were seen by other GPs as the movers and shakers in the city. They have had previous involvement in medical politics, are experienced in dealing with the public, and are very experienced in the use of computer

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technology. Because these people are respected as GPs in the local area, their leadership has been widely accepted by the other member GPs. Many of these individuals already held a level of legitimacy from initiating and generating GP support for a co-operative after-hours surgery. GPs interviewed felt that one of the most positive features of Pegasus was that it was being run by other GPs rather than by a group of civil servants or businessmen.

The contract

On the 2 November, 1993 a contract was signed between the Southern RHA and the Pegasus Medical Group. The Southern RHA agreed to pay Pegasus on a fee-for-services basis, effectively replicating the existing general medical subsidy (GMS) and subsidy fee schedule and Pegasus agreed to 'co-ordinate and deliver primary health care services in Christchurch'. Pegasus had the right to subcontract the provision of the medical services to whoever they chose. The fund-holding projects represented the only deviation from the historical fee-for-service arrangement. Pegasus agreed to accept some level of risk negotiated in a specific agreement for each project, although overall guidelines were established for these risk-sharing arrangements.

The fund-holding projects

The major fear on the part of GPs was that the contracts with the RHA would place restrictions over the GMS and thus effectively cap practice income. However, documents released by the Southern RHA in September 1994 indicated that the GMS was not the major area of concern. There was only a 1 per cent annual growth in the GMS charges in the Southern Region but Ministry of Health forecasts showed an 8–9 per cent annual growth in pharmaceuticals and laboratory tests. Therefore, these areas were highlighted by the Southern RHA as an important target and led to Pegasus's involvement in notional budget holding for laboratory tests and for pharmaceuticals. A number of other projects were also initiated: immunization, maternity services, primary care nursing and better integration with hospital outpatient services. As yet, there has been no move to place Pegasus member GPs on capitated funding and the de-emphasis of GMS indicates that this may not be the key issue.

Laboratory

Pegasus negotiated a contract with the RHA providing a form of budget holding for laboratory tests. If the Pegasus group could prove that they saved money on laboratory costs they would get to retain some of the savings to spend on patient care. All Pegasus members were sent a letter asking them to think carefully about laboratory tests ordered and that any savings made would come back for the group to spend on primary care. Members were also invited to join a pilot group which paid particular attention to their laboratory

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usage. About 30–40 of the Pegasus members responded to this invitation and attended a number of educational meetings on the topic. They were also split into smaller peer-review groups to discuss test-ordering behaviour. Those involved maintained that the goal was not to save money but to think more carefully and only order tests that were going to give useful information. The laboratories were also asked to print on the order forms the costs of each different test. The letter from Pegasus, the provision of cost information, and detailed monthly reports on what each GP spent, led to quite dramatic results. Although the project had only been going for 9 months there was a 30 per cent decrease in laboratory usage in the Canterbury area and a net saving of over one million dollars. The interesting factor was that the savings were not just generated by the GPs involved in the pilot group but from most of the Pegasus members. Significantly, many of these were people who had joined Pegasus expressly to avoid change.

Pharmaceuticals

A similar contract was negotiated between Pegasus and the RHA to cover pharmaceuticals. This project started in December 1994. Pegasus members were invited by letter to attend a meeting on the project. About 40 GPs expressed an interest. They were split into four smaller groups, each chaired by a GP facilitator, with a pharmacist involved. The groups met once a month to discuss their prescribing behaviour and to provide a 'peer review' forum. Data on individual GP prescribing was provided by Pegasus to the GP facilitators to provoke discussion and to 'get the GPs thinking about their prescribing'. Three specific groups of drugs have been targeted as representing a significant chunk of the pharmaceutical budget: antibiotics; asthma drugs; and, gastro-enterological anti-ulcer drugs. There is also a significant educational component to this project. Pegasus runs regular 'educational' meetings for those involved, addressing the nature and benefits of available drugs.

Although the Pegasus prescribing project did not directly reward GPs who prescribed more economically, the fact that Pegasus retained control over any savings made was a powerful incentive.

GPs involved in the project do get paid $100 an hour for the time involved in attending meetings and in peer review meetings. These payments and the costs of administering the project were met by a direct government grant.

Outpatients

The outpatient project involves the gastroenterology and respiratory departments at the local hospital. GPs who were part of this project had far more control over what happened to their patients attending those two departments. The GP could specify which consultant each patient should see and the time-frame in which they should be attended.

The other projects, immunization, maternity services and primary care nursing, are far smaller in scale, concerned more with the reorganization of services rather

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than with saving funds. However, the immunization project caused a strong reaction among practice nurse staff. This was because the management and provision of immunization services is conducted by practice nurses and the Pegasus project was seen as impinging on their work responsibilities.

Savings

At the Pegasus AGM in 1995 it was announced that there were already significant savings from the projects, particularly from the laboratory budget holding. After running costs, there was a surplus of over $750 000.

The existence of savings opened the question of what it was going to be spent on. The terms of the contract between Pegasus and the RHA required that any savings be spent on 'the improvement of Health Services'. The RHA also retained the right of approval on the expenditure of savings. An initial suggestion was the creation and funding of a Chair of General Practice at the local medical school. Although there was strong support for this proposal, there was some resistance from the RHA who were concerned that such a use of funds would not 'relate directly to patient welfare'. There was also some tension between Pegasus and the University over who would control the funds.

Two other suggestions were also put forward. First, that they fund a gastroscopy service to which GPs could have open access. Second, that a terminally ill benefit be established, which will fully subsidize the cost of GP visits to people who are terminally ill where GPs are caring for them in the patient's own home.

- *'When you have a terminal patient it often means you are visiting 2, 3 or 4 times a week. As the situation stands at the moment, either we don't charge them or the bill gets very high very quickly, so there is a proposal to create a new benefit. Pegasus funds should be spent on that to enable good care and a fair reimbursement for us.'*

To date, Pegasus has announced free mammography screening to prevent breast cancer, and a 'special needs benefit for patients with terminal illness'. This looked very much like the terminally ill fund proposed earlier. Other proposals included free hearing checks for children under five, free urea breath testing, and a hardship fund.

The impact

While membership in Pegasus did lead to a few administration changes, the changes were mainly voluntary. GPs who were reluctant to be involved found it reasonably easy to pass-off the new administrative responsibilities to the practice manager/receptionists or to the practice nurse and, therefore, the change has had little or no effect on them.

Pegasus introduced a process of audit, to check the validity of subsidy claims made. The process involved the selection of a number of practices to review.

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One week of claims were selected and letters were written to all patients that visited the practice in that week. Patients were then asked if they were seen by the GP on that day. While claim audit did have some direct influence on GP behaviour, the major effects were on the practice managers and practice nurses as they were responsible for recording patient details and sending in subsidy claims.

Combined with the claim audit was a general sense of visibility or review. As part of the contractual obligations, GPs were required to record an identification number of all of their claims. One doctor suggested that Pegasus was collecting data on everyone's prescriptions. This was corroborated in another review where one of the Pegasus officers was using computer technology to download prescribing data. This, together with the laboratory data, gave Pegasus the ability to analyse, pinpoint and monitor individual prescribing, laboratory use and subsidy claims if they so desired. GP feedback on monthly lab expenditure became a regular feature in 1995. They also proposed to produce similar reports for prescribing in 1996.

- *'But, when you do order a test someone else will know what you have done and you may be asked to explain. I think that there is a desire in Pegasus to be very scrupulous in the way they do GMS (general medical subsidy) and things and have regulations or audits set in place to make sure that happens. Doctors by-and-large are an honest group but . . . I think we all suspected that certain doctors in Christchurch had a rather liberal approach in their GMS claims. That was all very well when it was coming out of some bottomless pit, but now it is coming out of someone else's slice of the Pegasus cake.'*

DISCUSSION AND CONCLUSION

This final section of the article addresses the question of what the case study shows about how GPs have managed the reforms; or, as Lipsky (1980) put it, their capacity to resist top-down imposed change.

It seems clear that the New Zealand government was attempting to gain some control over GPs' behaviour by implementing a contractual model of accountability and capping their budgetary exposure for subsidies. This agenda seems consistent with what occurred in the UK. Broadbent *et al.* (1991) have argued that the UK changes were clearly intended to change or colonize GP behaviour. Laughlin *et al.* (1992) present the UK health reforms as a State intrusion into the medical autonomy of the GPs and a breakdown of the trust that existed hitherto between the GPs and the State.

While there may have been a relationship of trust between the GPs and the State at some point, since 1935 the New Zealand history has been more of the nature of an ongoing skirmish, generally won by the GPs. The attempt in 1935 to restrict GP autonomy and freedom was opposed by the BMA; the attempt to require contracts in 1990 was also resisted by most of the GPs. However, very few GPs seemed to be aware of the consequences of the 1991 proposals

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and, by the time they were implemented in 1993, had little choice but to accept the new status-quo.

Laughlin *et al.* (1994a) argued that GPs in the UK were unable to successfully resist many of the reforms initiated, particularly the introduction of a new GP contract. However, what could not be resisted, could be absorbed as GPs delegated or displaced the 'undesirable' aspects of the reforms to the practice managers and practice nurses. This allowed the GPs to continue to conduct medicine in the way they saw fit, while delegating to the practice nurses the tasks they were required to perform by the contract.

These insights from the UK provide a starting point for the analysis of the New Zealand changes. GPs operating in New Zealand have always had to balance a tension between their professional obligations and the financial necessity to charge patients. In Gorz's terms, general practice was both subject and not subject to economic rationality. One of the GPs interviewed told this story:

- *'A fellow in this afternoon, I didn't charge him — he was in tears — he's had every possible, imaginable, conceivable form of deprivation — he's been sexually abused, physically abused, in jail, drugs, you almost feel sorry for the poor little bugger, there's no way you can charge people like that. You pick up what the Government offers, end of story. You can't do anything else, there's no way you can charge people like that. But on the other hand, in a strictly business sense, why should I give him half an hour of my time for fifteen bucks and the very next person who came in, as it happens, after a gap, was a young mother — her husband's a successful self-employed tradesman with a good business and works hard — but I charge her $17, get $15 from the Government — $32. There's not much logic in that — it's not quite right.'*

This was managed by delegating the economic or financial aspects to the practice nurses which freed the GP to behave as a carer. Often they are forced to make the financial decision to charge or not to charge a patient.

Question: *'What happens when they don't have the money?'*
Practice nurse: *'We don't charge. We have a huge patient debt, thousands of dollars, and that is debt that we have tried to charge for and we have got a lot of patients that we don't charge. A solo-mum coming in with a child under five and she opens her purse and says I have got $2 and the doctor says that that won't even pay for your prescription. We will get a prescription out of the cupboard and not charge you as you go out of the door. We can get a certain amount of anti-biotic on a practitioner supply order which is free — you get so much a month. But, if you do it too much, people expect free medical help and they are not necessarily the ones who can least afford it.'*

Although there were some exceptions to this arrangement (exceptions that Gorz would regard as dysfunctional), it clearly highlighted a tension between the professional and the financial roles.

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With the requirement for GPs to contract directly with the RHA, the financial role impinged upon the professional role in a new and threatening way. This was a process that could not be managed by a practice nurse or even a practice manager but had to involve the GPs directly.

While clearly providing some protection against the threat of the State intrusion, the development of IPAs also provided a new way to manage the professional/financial tension. Rather than having to contract individually with the RHA, individual GPs could delegate that to the IPA executive and settle back to 'being-good-GPs'. Not only did the IPA buffer them from government reforms, it also buffered them from economic-rationality, absorbing the financial contracting, and the financial management and budgeting associated with the contractual accountability model.

The tension between the financial and the professional was also clear in the discussion on how the Pegasus savings were to be used. Many GPs felt that they could not charge for treatment of terminally ill patients. However, this decision meant that the GP effectively lost money in such cases. The creation of a 'special needs benefit for patients with terminal illnesses' meant that a GP could care for those in need without being concerned about their ability to pay them.

The downside of Pegasus absorbing this financial/professional tension, and the responsibilities associated with budgetary negotiation and management, was the responsibility needed to be managed by someone. As indicated in the discussion, these were a small core of seven GPs who were willing to take on the responsibility. Laughlin *et al.* (1994b) noted that the danger of any absorbing group is that they will develop colonizing tendencies.

- *That's why I like the idea of Pegasus, it's been a sort of relatively powerful group, it might just tone down things a bit, as long as they don't go over the top and get too politically motivated themselves.'*

There is some evidence of colonizing potential in this case. Since the end of 1994 there has been little effort by the RHA to initiate change as it is clear that Pegasus had picked up the responsibility to change GP behaviour as part of their budget-holding programme. Involvement in Pegasus started to change the way individual GPs behave. But, when they were challenged regarding the changes that said that they were about practising better medicine, saving money was only a secondary concern. The changes were justified in terms of a professional rationality rather than an economic one.

Whether further changes will also be accepted so easily remains to be seen. Morgan and Willmott (1993) argue that a key role of accounting is to create visibility. The use of information technology and accounting by Pegasus to record and monitor individual GP prescribing is already present. At the moment that appears to be accepted, but there is some evidence that early savings are the easiest and resistance may grow if there is ongoing pressure for financial gains.

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- *'The Pegasus guys are very clever. They have managed to walk the line between the doctor's autonomy and managed health care. Autonomy has been stripped away and the doctors stand naked with their order forms. That they have got as far as they have is a real tribute to the way it has been run. There is a strong belief that by making these changes everyone will be better; the GPs will cement their position in healthcare and savings will end up coming back to the GPs.'*

The contractual accountability requirement seems to have been resolved through the IPA structure. GPs only had to account to other GPs for their actions, while the government could cap the budget and establish contractual accountability with the IPA as a whole. Whether this is sustainable in the long term is also open to question as there is increasing evidence that IPAs are adopting a business-like stance, and a number are now managed by people who are not GPs. In the long run, it may prove that in attempting to avoid the financial, GPs may have traded the frying pan for the fire.

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Costing health care: a study of the introduction of cost and budget reports into a GP association

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This paper describes a case study of the development of cost and budget reports in a group of general practitioners in New Zealand. There have been numerous attempts to introduce management accounting tools in hospitals, however, little attention has been paid to the role of management accounting in a primary care setting. While accounting is often represented as a threat to medical autonomy it was found that GPs did not perceive accounting as a threat, but rather as a process of peer review and education. One reason why the accounting controls were accepted was that they played an important boundary function in creating and maintaining the association. The accounting controls were also seen by GPs as being consistent with their accountability to their peers and therefore they were not resisted as a managerial intrusion.
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Key words: budgeting; general practice; New Zealand; organizations; boundaries.

1. Introduction

In recent years the structure and management of health care organizations has become a significant issue in many countries. Some authors have suggested that the traditional autonomy of medical professionals has been eroded (see Friedson, 1984) and that health care organizations have become corporatized (Stoeckle and Reiser, 1992). As a consequence of this shift, hospitals have absorbed the values of a market-administration ethos; physicians and nurses are losing their professional ethos and there has been an increase in administrative and accounting control. While much of the literature discussing the corporatization of health care has focused on the USA (Pollitt, 1982; McKinlay and Arches, 1985), literature from Canada (Fried *et al.*, 1987), Sweden (Heidenheimer, 1980; Coombes, 1987), Norway (Riska, 1988), Australia (Willis, 1988) and the UK (Ham et al., 1990) indicate that this is an international trend. Within those countries with a state-funded health service the corporate model has been introduced as a policy to reduce costs and increase efficiency. Hood (1991) called this trend 'New Public Management' and presents reforms in the UK, New Zealand and Australia as examples of corporatization of

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public administration. Given the increasing demands for cost containment without compromising quality of medical care, the role of management accounting technologies has increased (Coombes and Green, 1989), an increase that has also been seen by the medical staff as a threat to their autonomy and values (Dent, 1991).

This paper is made up of three major parts. The first reviews a number of the studies of the use of accounting within health care organizations. A clear theme emerges from these studies of conflict between medical and administrative staff where accounting is presented both as a site for conflict and a tool for gaining power. However, most of these studies have been located in hospitals and it is not clear whether there is the same conflict and resistance to accounting from medical staff who are not located in hospitals. The second section of the paper describes an empirical study of the implementation of management accounting technologies in a General Practitioner (GP) association in New Zealand. The third section discusses this study, utilising the work of Llewellyn (1994) to reflect on why there was little or no resistance to the accounting innovations described.

The research methodology underlying this paper is based on what Laughlin (1995) described as a middle range approach to research. A middle range approach allows a dynamic relationship between theory and empirics. Any theoretical proposition is seen as 'skeletal', providing a language for analysing observed effects. The empirical observations are seen as the flesh; perhaps expanding, perhaps challenging, perhaps modifying the original theoretical model. Any theoretical proposition is therefore seen as being 'in-process' rather than a hypothetico-deductive proposition being tested.

2. Management accounting in health care

While the use of management accounting in health care organizations has received a lot of attention over the last 15 years, it is not a new thing. Wickings *et al.* (1983) reports costing experiments that were conducted as early as 1916 and Lapsley (1994) discussed the systemic use of budgets in the NHS (UK) prior to the 1970s. However, with the growth of corporatism and general public sector reform, interest in accounting in public sector organizations has also grown. Hood (1995) suggested that accounting was central to the shift away from a distinctive public-service management ethos and a shift towards private sector models and practices.

> Accounting was a key element in the new conception of accountability, since it reflected high trust in the market and business methods . . . and low trust in public servants and professionals . . . whose activities therefore needed to be more closely costed and evaluated by accounting techniques. (Hood, 1995, p. 94.)

In his summary of the development of responsibility accounting in the NHS (UK), Lapsley (1994) also argued that the process of corporatization had led to a growth in accounting practices. Nevertheless these practices were decoupled from the key resource decisions which involved the medical staff, maintaining an ambiguity over the financial responsibility of the medical staff and protecting their professional autonomy. However, Griffiths (1983) recommended that doctors be given responsibility for budgets and be provided with information on the resource consequences of their decisions. This recommendation resulted in a series of projects involving forms of budgeting and costing being initiated in UK hospitals. These projects were an

attempt to extend budgetary control systems to 'all spheres of hospital activity, including the medical arena' (Lapsley, 1994, p. 341).

The extension of accounting control to the medical arena set the scene for a confrontation between administrators and doctors. Hunter (1994) argued that the evolution of management in the NHS (UK) had been a struggle between doctors and managers for the control of the health policy agenda and its implications for resource allocations. He presented the management reforms and accounting systems as an attempt to shift the frontier in favour of management. Dent (1991) said that the NHS (UK) was a site of conflict between clinical and administrative staff. He argued that management control strategies were a key area for conflict and competition between doctors and managers, and technology such as management accounting was an important part of securing management power within the organization and reducing the power of medical staff. Coombes (1987) said that the development and implementation of management accounting systems was a focus for conflict between administrators and doctors but that the resistance to accounting control was a perfectly normal response to change rather than some kind of inevitable battle.

Perhaps the conflict associated with accounting controls is a feature of the hospital environment. Most of the accounting literature has focused on the hospital setting and the fact that a significant number of health care professionals operate independently from hospitals, in private practices or in small partnerships, seems to have been ignored. This is remiss, as there is evidence that independent medical practitioners may have different values to those located in hospitals (Meyer and Tucker, 1992). According to Harris (1977) the tension between doctors and administrators is a feature of the internal structure of hospitals. Is it then inevitable that accounting will be perceived as a threat by health care professionals or is the threat actually a feature of the hospital environment?

In countries such as the UK and New Zealand, General Practitioners (GPs) have played an important gate-keeping role in determining who will have access to other medical services (Fougere, 1993). While they were initially ignored in reforms that focused on restructuring hospital services (such as the UK and NZ), some commentators have presented a primary care focused health system as the way forward for the future (Malcolm, 1989). Certainly GPs are now receiving more attention both from governments and in the literature.

There is some evidence that the reform changes have started to impact on the professional autonomy and independence of GPs. Laughlin *et al.* (1992) argued that the changes to the GP contract arising from the National Health Service and Community Care Act 1990 (UK) were a threat to GP autonomy. Calnan and Williams (1995) argued that within the primary care sector managerialism was manifest in the introduction of fundholding. However, how management accounting is implicated in these changes and whether GPs see accounting as the threat to their autonomy remains unclear.

3. Evidence from New Zealand

Research method

This paper presents a case study of the introduction of costs, budgets and variance reports into an Independent Practice Association (IPA) based in Christchurch, New

Zealand. This is particularly interesting because the IPA was explicitly created to manage the contractual relationship or boundary (Llewellyn, 1994) between the local Regional Health Authority (RHA) and the GP practices.

Interviews were conducted over a 27-month period between September 1993 and December 1995 and involved GPs, practice nurses and administrators and were part of a larger evaluation of the New Zealand health reforms. Four practices were interviewed, which all became involved as part of the Pegasus IPA. One of the practices in the case study could be considered large; Practice 1 had over 14,500 people on their regular patient list. Practices 2, 3 and 4 were small to medium with 2000–3000 patients each. The socio-economic location of each practice also varied. Practice 1 and 3 were located in affluent areas, practice 2 was located in a mixed area and practice 4 was located in deprived areas in relation to other parts of the city. There was no attempt to obtain a random or statistical sample of practices, but they were selected to provide a range of different sizes and socio-economic locations.

Interviews were conducted in each practice with medical and support staff and repeat visits were made on a 6-month basis until the end of the project. The research method was based on work of Moustakas (1990), Broadbent and Laughlin (1995) and Rubin and Rubin (1995). Initially the interviews were a formal and somewhat difficult process and the comments provided by interviewees were generally guarded. However, as the study progressed, a measure of trust developed and interviewees were much more willing to volunteer comments. Generally one individual in each practice took on the role of key informant and often provided most of the information. While this may have introduced an element of bias to the study, the notion of key informant or conversational partners (Rubin and Rubin, 1995) is well recognized in the qualitative research literature. On a number of occasions it was possible to attend practice meetings. The interviews and meetings were taped, transcribed by the interviewer and returned to the participants for their comments and amendments.

The introduction of management accounting practices into the Pegasus IPA provided an opportunity to study whether medical practitioners operating outside of a hospital structure perceived management accounting systems as an intrusion and a threat to their autonomy. The New Zealand health reforms, GP contracts and the development and operation of IPAs are not well represented in secondary sources. When published sources are used, they have been clearly referenced; however, much of the material has been collected from unpublished sources and personal interviews. Attempts have been made to verify the documents and interview comments where possible.

The formation of Independent Practice Associations

The relationship between the State and GPs in New Zealand has never been particularly good and is best represented as a series of skirmishes, generally won by the GPs. In the 1930s the first Labour Government in New Zealand sought to create a tax funded health care system which was free to all citizens. Following a protracted negotiation between general practitioners and the State, a compromise was researched where general practitioners secured high levels of autonomy and relatively little control from the State (Fougere, 1993). General practitioner services were not directly funded by the State, but by a series of fee-for-service subsidies which covered most of their fee. These subsidies were later extended to include the drugs prescribed, the tests used and many other practice costs such as the employment of nurses.

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Throughout the 1950s, 1960s and 1970s there were some attempts to increase the value of the subsidies in line with inflation and increased costs. However, by the late 1980s the subsidies were virtually insignificant and there were serious discussions within the Ministry of Health about scrapping them altogether. This was rejected, as it was felt that cutting the GP subsidy altogether would reduce the access of the poor to medical services. Therefore, in 1990, there was an attempt to alter the subsidy arrangements and place GPs on a contractual relationship with the State. GPs were given an opportunity to sign a formal contract with the Minister of Health which would cap the fees that they could charge patients but would give them higher subsidies for each patient they attended. While a few practitioners chose to take the contracts, seeing immediate financial and access benefits for patients (McPherson, 1990) most were strongly opposed to the contracts, seeing them as a threat to their autonomy and income. Resistance to the contract proposal was clearly expressed by the New Zealand Medical Association (NZMA), which advised its members against accepting the contract and brought an action against the government which questioned the legality of the contract[1] (Tattersfield, 1990). The fact that the Labour Government lost the election in 1990 effectively ended the contract proposal. The proposed contract did not generate any political support from GPs and reinforced the belief that GPs could defeat government policy through collective action.

Upon taking power in December 1990, the National Government announced that they intended to conduct an extensive review of all aspects of social welfare provision, with the intention of increasing targeting and reducing spending (Confidential Cabinet Strategy Committee, CSC [90] 10). In December 1990 they established a taskforce to 'identify and investigate the options for defining the roles of the government, the private sector and individuals in funding, provision and regulation of health services' (Upton, 1991, Annex 1). On the 15 February 1991 the taskforce presented their report to the government. In their report they described four different ways to run a health system, all of which were influenced by the US HMO models; involved some level of competition and a separation between the funder and the provision of health care services. After some discussion the government selected one of the four options and developed it into a policy. The policy paper was released to the public in 1991 (Upton, 1991) and announced that the health care structures would be altered to create an internal market structure. Under the existing institutional arrangements the responsibility for the provision of secondary care (and public health) services was located at a regional level in structures known as Area Health Boards. Upton (1991) announced that the Area Health Boards would be disbanded and reconstituted into separate regional purchasing (Regional Health Authorities) and provider (Crown Health Enterprises) organizations. Under the new structure, health service providers were no longer funded directly by the state, but indirectly through contracts with the RHAs. It was also clear that private and voluntary hospitals could compete for funding with the State owned CHEs.

The RHAs would have a fixed budget, based on the size and characteristics of the population they served. Unlike the Area Health Boards, the RHAs were not elected but were governed by an appointed board, selected to provide 'health, management and business expertise' (Upton, 1991, p. 32).

[1] King v Clark, NZ High Court Auckland, 28 Sep 1990; Thomas J; M1335/90.

As the policy paper (Upton, 1991) focused on the structural arrangements for secondary care and public health, the implications of the changes for general practice were somewhat obscured. One of the few relevant statements was the comment about the integration of health funding.

> The Government plans to integrate the funding for all personal health services — visits to doctors, prescriptions, other community based services, hospital services — and to place the responsibility for managing all this funding with the Regional Health Authorities (RHAs), which will then be in charge of purchasing total health care services for the people in their regions; encourage(ing) better co-ordination in the management of total health care across general practice, other community-based health services and hospital services... (Upton, 1991, p. 41)

From this statement, it was evident that general practitioners were being constructed as independent service providers and were expected to contract with the RHA for patient subsidies they had previously claimed directly from the government. The nature of the contractual agreements was flexible and there was no restriction on the type of agreement a RHA could establish.

Once this structure was proposed, the Minister of Health established a number of different groups to implement the changes. The Health Reforms Directorate was charged with drafting policy and legislation, communicating the reforms to the public and developing the frameworks and structures of the new health care system. One area of particular concern was the proposed contractual arrangements between GPs and the RHAs. As indicated, this area was underdeveloped (perhaps intentionally) in the government policy document (Upton, 1991). Therefore, in 1992, the Health Reforms Directorate commissioned a consulting group to give advice on this area. Curiously enough the New Zealand General Practitioners Association (NZGPA) was also involved in commissioning this work and the recommendations were presented to both bodies (UniServices, 1992). The key recommendation was that primary care providers should organize themselves into collective groups which they called Independent Practice Associations (IPAs).

The concept of the IPA was welcomed by both of the sponsors as it had clear benefits for GPs and for the Health Reforms Directorate. The Directorate saw the IPA as an effective way to transfer risks from the RHAs to the GPs. From a GP perspective, membership of an IPA simplified the process of negotiating contracts and placed them in a stronger negotiating position, it spread the administrative costs of a contractual relationship with the RHA over a large group and provided the protection of a united front. Many of the GPs saw contracts with the RHAs as a threat of interference to their medical autonomy and thought that they would be 'left alone to get on with the job' if they were a part of a group (Marshall, 1992). Currently there are approximately 40 IPAs around the country and over 50% of the GPs in New Zealand are part of these groups (Malcolm and Powell, 1996).

Within the Christchurch area over 90% of the GPs (approximately 200) are part of a collective contract negotiated by the local IPA, Pegasus. The Pegasus Medical Group, one of the largest IPAs in New Zealand, came into existence in March 1993 as an incorporated society. Its published objectives were charitable; to provide quality patient care, to enable local GPs to play a more active role in providing care for their patients and to spend any money they saved on providing additional services for patients (Pegasus Publicity Flyer, Spring 1996). By 1996 Pegasus had made sufficient

savings to be able to offer free services such as hearing tests for children, mammography scanning and smoking cessation schemes.

On the 2 November 1993 the Pegasus Medical Group signed their first contract with the Southern Regional Health Authority who agreed to pay them on a fee-for-services basis while Pegasus agreed to 'co-ordinate and deliver primary health care services in Christchurch'. Pegasus had the right to subcontract the provision of the medical services. Most of the local GPs signed a contract with Pegasus, becoming subcontractors for the provision of primary health services in the area. The contract between Pegasus and individual GPs reproduced the fee-for-service subsidies but it meant that GPs gave up their right to send subsidy claims directly to the RHA.

As with the GP fundholding initiative in the UK, there were different levels of involvement in the IPAs. Most of the GPs who were members of Pegasus were not interested in politics or dealing with the RHA and saw their membership as a way of avoiding change. These GPs would have constituted approximately 70% of the membership. Both Malcolm and Powell (1996) and Jacobs (1997) have suggested that GPs saw the IPAs as a form of protection and a buffer against the uncertainty involved with the contracting arrangements. Approximately 25% of the GPs that joined Pegasus did became actively involved, attending regular meetings and some even became involved in committee and review structures within Pegasus. The more activist GPs argued that they had become involved in Pegasus to:

1. improve the care available for their patients;
2. improve general practice standards; and
3. shift the balance of power from secondary health care to primary care.

The third group within Pegasus had the most influence on the direction and policies of the group. This was a small group of individuals who were fundamental in the formation of the IPA and occupied the key leadership positions. A number of these people were already well known in local circles for other projects they had initiated and for their involvement in medical politics (such as the resistance to the 1990 GP contract). This group regarded the reforms as a challenge and established the IPA as a proactive response to the threat to their autonomy and income.

In 1994 the RHA released a position paper which indicated that restricting GP income was not their primary concern as they predicted that the GP subsidies were growing at a rate of less that 1% per year. However, they did intend to target the pharmaceutical and laboratory costs as they predicted that these costs would grow by 8–9% per year. The total expenditure on pharmaceuticals was also much higher than the expenditure on subsidising GPs fees[2].

In order to cap the pharmaceutical and laboratory test budget the RHA invited Pegasus to enter into two 'fund holding' projects associated with laboratory tests and for pharmaceuticals. Budgets were established on the basis of the 1992/93 spending with a negotiated growth factor to recognize the national average growth in spending. If Pegasus members could spend less than the budget level they would get to retain 70% of the savings to spend on 'improvement of health services'. The RHA retained the right of approval on how any savings were to be spent. Under the initial agreement the RHA carried all of the risk for any overspending.

[2] In 1994 the costs for pharmaceuticals were $140 million while laboratory costs were just over $20 million and GP subsidies just over $30 million.

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The role of accounting

Membership of Pegasus led to the introduction of new forms of visibility and review for GPs, based on accounting measurement. Over a period of 3 years, GPs were made aware of the cost of the consumables they used and were subject to monthly budgetary reports detailing how much they spent on laboratory tests and pharmaceuticals. While many of the GPs thought that the RHA would attempt to control their behaviour, the change initiatives came not from the purchasing authorities but from Pegasus. Initially many of the changes were restricted to a small 'project' group but over time they were extended to the entire membership.

Cost awareness. Once Pegasus signed the 'fund holding' agreement with the RHA, attention was paid to how spending on laboratory tests and pharmaceuticals could be reduced among Pegasus members. Laboratory tests became the first target as they were seen as being an easier area to reduce spending in and less complex than the pharmaceuticals. There were two major laboratories in the Christchurch area that processed tests for GPs. Individual GPs were free to request a wide range of tests from either of the laboratories. The budget holding agreement with the RHA meant that if Pegasus could under-spend on previous years by saving money on laboratory costs, they would get to retain some of the savings to spend on patient care.

The laboratory initiative involved the creation of a number of peer-review groups, which met and discussed test ordering behaviour and individual test usage patterns. Individual GPs were given the opportunity to voluntarily participate in these groups under the leadership of other GPs. The primary emphasis of the project groups was GPs' education and the elimination of unnecessary testing.

As only 40 of the 200 member GPs were involved in the peer-review groups, the focus needed to be extended to create a general cost awareness among all Pegasus members. Research indicates that doctors often have little knowledge of the costs of the test that they order (Long *et al.*, 1983; Fowkes, 1985). However, the provision of cost information can significantly alter the quantity and type of tests they order (Eisenberg and Williams, 1981; Cohen *et al.*, 1982; Hoey *et al.* 1982; Long et al., 1983). This was also found to be true in this case.

The second stage of the laboratory initiative extended the education emphasis to all Pegasus members; making them aware of the costs of the laboratory tests they ordered and encouraging them to order fewer tests. Individual Pegasus members were contacted by the IPA and were asked to reduce their use of laboratories where possible. They were told that savings would be retained by the IPA and used to benefit patients. The laboratories were also contacted by Pegasus and were asked to print the costs of each different test on the order forms, making the financial implications of requesting a particular test obvious to every GP.

> I'm sure the focus on cost of lab results has influenced me quite strongly. Knowing that it costs roughly $20 to do a swab and knowing that a liver function test costs $21–22 makes you think whether it is really necessary. So I would say I've probably reduced. I don't think that I was a high user of those things in the first place but I have reduced them considerably. (Dr S)

The response of the GPs interviewed to this initiative was surprisingly positive. Even the GPs who were reluctant to become actively involved in Pegasus accepted the need to reduce their laboratory testing and welcomed both the educational information about the effectiveness of different kinds of testing and the financial information about the costs of the tests. Within 9 months there was over a 30% drop in laboratory usage and significant financial savings. While the project did save a significant amount of money (over $750,000 by 1995) it was generally seen as an education initiative by the GPs involved.

> The goal was not to save money but to think more carefully and only order tests that were going to give useful information rather than just ticking all the boxes on the lab form without thinking too much. (Dr L)

In 1994 a pharmaceuticals initiative was also launched. Pegasus members were invited to participate in a pharmaceuticals education project, approximately 40 GPs agreed to become involved. The participants were each placed in a peer group, chaired by one GP. The peer groups met on a regular basis so GPs could discuss their use of different pharmaceuticals and compare prescribing behaviour. As most of the available information on pharmaceuticals was documents produced by the pharmaceutical companies the project was seen by the GPs involved as an important source of independent information on the different drugs they used. It also provided GPs an opportunity to learn from other GPs and develop best practise guidelines for themselves.

> The objective is to make us think more about what we are doing. The main incentive has been that if we are careful in what we are doing then any savings that are made will be returned to the Pegasus association, which is indirectly good for us. So I think, particularly with the prescribing, that the small groups that we are running, people have found them very helpful, quite educational. (Dr L)

Following the establishment of the project groups all Pegasus members were sent advice on prescribing behaviour and drug usage. These were also accompanied by more general research documents on particular conditions and preferred treatments.

> The prescribing thing is more educational. More like information on treatments and the medication to use for say urinary tract infections, what the cost is and what people are doing. (Dr S)

Reporting and variance analysis. Up until 1995 all of the Pegasus initiatives were voluntary and GPs could choose whether or not they wanted to be involved. However, during 1995 a monthly reporting process was initiated that involved all of the Pegasus members and created a new level of visibility and control.

> But when you do order a test someone else will know what you have done and you may be asked to explain. (Dr C)

The reporting initiative began because one of the Pegasus leaders had a strong interest in computer technology (described as a computer whiz by another GP). By downloading information from Health Benefits Ltd. he was able to analyse individual GP spending. Initially this was intended to facilitate the peer-review groups associated with the laboratory and the later pharmaceuticals project, however it soon became apparent that the reporting could be extended to include all members.

Health Benefits Ltd. (previously part of the Department of Health) acted as the central clearinghouse for payments to pharmacists and laboratories. Therefore they had accurate information on the prescribing and testing behaviour. All Pegasus members were provided with numbered laboratory test forms and were told that their laboratory usage would be monitored. Individual GPs received a monthly report showing a categorized breakdown of how much they were spending. This was compared to the average spending of other Pegasus GPs. These reports became a regular feature from 1995. As part of their contractual obligations GPs were also required to record an identification number of all of their prescriptions and by 1996 pharmaceutical reports were also introduced and what each GP prescribed was compared to a Pegasus average and to a national average.

The introduction of monthly reporting represented the creation of a new level of visibility for GP prescribing and laboratory usage. However, those involved did not see the changes as a threat to their autonomy, because the changes were initiated by other GPs rather than administrators or the state.

> I think it's a mutual association — it is like an old fashioned guild or collective of like minded people all getting together and saying lets do this well! There is no heavy hand saying that we have got to think like this, or do like that. (Dr E)

> They send out reports on a monthly basis showing your costs compared with other GPs and compared to the number of patients you have seen. It just jogs your mind that tests cost money and so it is quite good. (Dr L)

Those that were interviewed argued that the changes were leading to better medical practice and although saving money was an issue, the most important part was the ability to compare your spending to other GPs.

> Basically it involves me submitting what I do to other people's scrutiny. Is has made us look at what we do and to question the assumed way of doing things. (Dr E)

> As far as prescribing goes, cost isn't always at the front of my mind. But then it was interesting to see that I was in the cheaper half of the group, I am not an expensive prescriber. The lighter side of the average, which makes you feel good. (Dr R)

One of the GPs interviewed was critical of the monthly reporting system. But that was not because his activities were being monitored, but because the system could not distinguish between what he sent at his practice and what he spent at a special clinic which he operated.

> The reports are useful, but not that much, because they can't seem to separate out what I do in my clinic, which is quite heavy in testing, from what I do here. I am waiting for the next one to come and if they haven't got it right by the next one I will ring up again and complain. (Dr S)

While there was some initial doubt whether the lack of direct financial incentives would provide individual GPs sufficient motivation to change their behaviour, this did not appear to be a problem. Although GPs did not directly benefit, they appeared to value the fact that they did have some control over the funds through the association and that the savings would ultimately benefit their patients.

> It is amazing, apparently I have been saving all of this money on laboratory stuff and prescribing which I wasn't aware of even trying to do and now we get all of these funds back for other things, which is nice. (Dr R)

Beyond the budgets

The UniServices (1992) report suggested that GPs might become funded by the RHAs to purchase secondary service from hospitals and other providers. Malcolm (1993) also presented the development of IPAs in New Zealand as a collective version of the UK fundholding initiatives. However, to date, the Pegasus IPA is not really a purchaser but a provider and is more like community fundholders in the UK rather than standard or total-purchasing fundholders. Pegasus has initiated a few minor projects in an attempt to develop the links between primary and secondary services. An outpatient project was started which involved the gastroenterology and respiratory departments at a local hospital. The objective of this project was to give GPs more control over patients whom they referred to the outpatients services. GPs were also given the ability to specify which consultant their patients saw and the time-frame in which the patient would be seen. The outpatients project did not involve the 'purchasing' of secondary services or holding a budget for patient care. However, a number of the GPs interviewed and other commentators saw fundholding and the purchasing of secondary services as the way forward in the future.

> Well, general practice is moving towards more of a British-type system. Patient registration, capitation fund holding for general practitioners, budget holding contracts for this, that and the other. I am sure that is all on the way. (Dr L)

> Many IPAs are now contemplating taking on budgets for secondary care . . . there is little appreciation that IPAs could be the real solution to the waiting-list problem. Waiting lists have almost disappeared in many GP fund-holding practices in Britain. (Malcolm, 1996)

Discussion

While it has been argued in much of the literature that accounting controls are a threat to GP autonomy, the evidence in this case did not support that conclusion. The GPs that were interviewed saw the introduction of accounting systems as an extension of the medical education process and suggested that the monthly reports made them more aware of their own behaviour, and, as a result, better GPs. The accounting system was not seen as a managerial threat but as one part of the peer review process. Most of the GPs interviewed seemed to be used to peer review and comfortable with a level of scrutiny because it came from other GPs rather than administrators or bureaucrats. When it was suggested that Pegasus could be run by managers, bureaucrats or accountants, this caused some concern.

> Well if a businessman was running Pegasus I wouldn't be very happy. They don't have the same kind of touch on things that a general practitioner has or a doctor has. The same thing happens in the hospital system — I've talked to a number of specialists and they've said that people coming in who aren't medical don't grasp the complexity or don't grasp the philosophy and the philosophy usually is that the patient comes first. Money is a secondary issue. (Dr S)

The fact that the process was controlled by GPs who were concerned with 'protecting the status of GPs', 'improving the quality of medical practise' and 'caring for patients', seemed extremely important. Somehow change initiated by other GPs was not seen as intrusive or as a threat to GP autonomy while change that had been initiated by managers (see Jacobs, 1995) or the earlier attempts by the government to initiate change resulted in vocal resistance. Changes in government drug subsidies have caused at least one GP to stop practising (The Press, 1996). However, to date, Pegasus has made no attempts to force GPs to stop doing anything against their will.

The budgets and cost visibility initiated by Pegasus were seen by GPs as a way to directly benefit their patients. Individual patients would not be deprived because GPs were still free to prescribe the 'best' drugs or the 'best' tests when they thought that it was necessary. However, patients would benefit from any savings GPs made as Pegasus could use the savings to provide additional services. This seemed to provide sufficient motivation for GPs to change their prescribing patterns and laboratory test usage.

To summarize, GPs did not see the new accounting systems as an intrusive managerialsim, as a threat to their autonomy or as a danger to patient welfare. However, these changes were welcomed as part of a GP education and peer review process in the belief that the changes would positively benefit the status of primary care and the health of patients. To understand why the response to accounting in the GP association studied was so different to the response towards accounting described in hospital based studies, it is necessary to reflect on how organizational boundaries are constructed and maintained.

Llewellyn (1994) charts a three-step development of organizational theory. Classical management theory conceptualized organizations as a 'closed system' where a common set of goals were achieved through the principles of internal design. Such organizations were presented as 'detached' and relatively 'impermeable' to environmental influences. Open systems theory recognized the importance of interactions between the organization and society and suggested that the survival of the organization depended upon 'appropriate' relationships with the environment. Boundary maintenance argues that the boundaries between the organization and the environment are not just relationships to be managed, but are what constitutes an organization. Boundaries distinguish between what is and what is not the organization and so, by the process of exclusion and/or inclusion, organizational identity is created and maintained. These boundaries can take many different forms; the physical/productive, financial, psychological, legal and temporal. Llewellyn (1994) suggested that financial accounting is implicated in the process of boundary maintenance and in the management of meaning between the organization and society. Management accounting also plays an important boundary role: this is to act as binding structures, producing and reproducing internal unity within the organization (Llewellyn, 1994, p. 14). By reducing or absorbing uncertainty and by creating history, accounting sustains the image of the organization as an entity. Accounting can also act to create moral order:

> Systems of accountability also embody a moral order: a complex system of reciprocal rights and responsibilities. The practise of accountability institutionalizes the notion of accountability; it institutionalizes the right of some people to hold others to account for their actions. (Roberts and Scapens, 1985, p. 448)

Llewellyn (1994) observed that the costing system of a Japanese manufacturing conglomerate was extended to reduce the autonomy of independent subcontractors and to bind those firms into a managerial relationship of surveillance and control. The accounting system embodied the 'rights' of the management to hold the subcontractors to account.

The nature and operation of the Pegasus IPA contrasts strongly with the typical structure of most hospitals. First, Pegasus was specifically created as a threshold between member GPs and the RHA. Pegasus was intended to create a legitimacy with the authorities and to allow individual GPs to continue running their medical practices unaffected. However, as part of that legitimacy process Pegasus had to be seen to be extending financial control to member GPs. This served two purposes: it satisfied the reformers that wanted to 'transfer risk' from the RHAs to the GPs and it protected GPs from the threat that the local RHA would implement their own systems of control.

Within the Pegasus IPA the accounting systems played an important binding structure. Pegasus did not have clear physical or spatial boundaries. Membership was constituted through a financial/contractual relationship. Therefore the financial and contractual arrangements took on an enhanced importance as it created binding structures for the Pegasus and helped to distinguish between those who were members and those who were not. To refuse to be part of the accounting system was to refuse to be part of Pegasus. 'To be part of an organization is to be subject to that organization's system of accountability', (Roberts and Scapens, 1985, p. 14) therefore to be part of a system of accountability is to be part of an organization.

As indicated, systems of accountability also invoke a moral order and give some people the right to hold others to account (Roberts and Scapens, 1985). By accepting the contract negotiated by Pegasus, individual GPs became subject to a system of accountability which gave the Pegasus authorities the right to 'hold them to account'. The introduction of cost information and monthly reports was accepted as a normal extension of this obligation. However, within hospitals accountability is in conflict as dual structures of accountability have emerged (Scott, 1982). Medical staff are required to account to their medical peers for their clinical activities and to the hospital management for their use of resources. Any attempts to extend the management accountability to include clinical activities is naturally going to be seen as a threat to individual autonomy and to the peer or professional accountability structure (Jacobs, 1995; Preston, 1992). This tension is what lies at the heart of clinical resistance to accounting control.

Conclusion

This paper began by describing the interest in management accounting in health care organizations. Most of the studies to date have been focused on hospital settings. This paper presents a study of accounting in a New Zealand GP association and asks the question—do medical professionals who are independent of the hospital system have a different attitude towards accounting systems than those working within hospitals?

A case study of the operation of the Pegasus IPA was presented with particular attention being paid to their use of management accounting. The most curious

feature of this case was the fact that the GPs were willing to accept the new visibility with a loss of some autonomy. The accounting systems were not seen as a managerial threat but as part of a process of peer review and education.

Accounting systems played important boundary functions within the Pegasus association. First, they provided a clear threshold, distinguishing between those who were members and those who were not. Second, the accounting systems served to bind the members together in a common purpose. To be a member of the IPA was to share in the contractual agreement and to be subject to the accounting system. As such, all members 'shared' in the savings that resulted from the laboratory and the prescribing projects, although all savings were spent on patient services.

There is a need for further research into how accounting functions in organizations that are dominated by medical professionals. This paper questions the assumption that accounting is inevitably a threat to medical autonomy. This paper also indicates that accounting can have an important role in creating and defining the organizational boundaries. Therefore the concept of what constitutes an organization must be challenged and extended.

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APPENDIX 2

THE PEGASUS IPA

2.1 THE DEVELOPMENT OF THE IPA

The historical tension between GPs and the State made many GPs reluctant to accept the Section 51 agreements while the overheads and risks associated with developing their own contracts made this option 'too expensive' for most practices. Within the Christchurch area most GPs chose to become part of a collective contract negotiated on their behalf by the local IPA, Pegasus, which allowed them to continue on fee-for-service subsidy arrangements. The Pegasus Medical Group was a large Independent Practice Association (IPA) which came into existence in March 1993 as an incorporated society. Currently about 90% of the local GPs are part of this group. Only GPs were allowed to join Pegasus unlike some other IPAs which were seen as 'primary health groups' rather than GP associations. This did cause some friction with the practice nurses.

> Many of the practice nurses want to join Pegasus but we are not allowed to and I think that is poor. It is putting a bit of ill feeling between the nurses and doctors at the moment. We were working as colleagues and suddenly they have got this big battering ram that we are not allowed to be part of. The problem is that the doctors are looking after their own back at the moment and the practice nurses have come second best (Practice Nurse, Practice Five, March 1995).

All of the other IPAs around the country are significantly smaller than Pegasus. The size, combined with the co-operative attitude of the local RHA has meant that the Christchurch area has effectively become the experimental pilot for the country. While there is a widespread interest in forms of budget holding and capitation, other areas tend to look to Pegasus and the Southern RHA to see how well they work.

> The Southern RHA has taken a pretty hands-off approach in relation to Pegasus. Often Pegasus ends up calling the shots. But it has suited them as the RHA has ended up with money in their pocket too. Because of their

> cohesion Pegasus is leading the way in the country. Everyone else watches and follows them (Dialogue Partner One, June 1996).

Although there was no direct link between the After Hours Collective and Pegasus, many of the people involved were the same. In fact, the office of Pegasus was based at the After Hours Clinic before moving to their own site in 1995. The After Hours Clinic was seen as a successful venture by those involved in creating a sense of co-operation in the local area. Many of the local GPs saw membership in Pegasus as a logical extension of their involvement in the Clinic, which explains the unusually high level of membership.

2.2 REASONS FOR JOINING

In the interviews, GPs outlined two general reasons why they joined Pegasus. First, Pegasus provided some form of protection against the proposed changes:

> I think that Pegasus is a security blanket for a lot of doctors in Christchurch who thought like us — Hell what is going to happen. Pegasus was seen as a group, doing something that anybody could join and be swept up under the skirts (GP, Practice Two, March 1995).

> I am part of Pegasus because I am keen on GPs showing solidarity. This is a way for GPs to act as one rather than being picked off. This is a danger because the government has historically been malevolent, not supporting GPs (GP, Practice Three, November 1993).

Second, GPs felt that they would get a better contract from the RHA as part of an IPA group than as individuals.

> Pegasus have acted as a buffer for the individual GP. They have more clout as a negotiator than does an individual GP (GP, Practice One, October 1993).

> Being part of an IPA means we are less vulnerable than we would be by ourselves. We get the best deal from the RHA and deal with the RHA more effectively (GP, Practice Five, October 1993).

A third reason for getting involved in groups like Pegasus was that this was seen as an effective way for GPs to gain more control over the reform process. The change was seen by many as being unavoidable. From that perspective there was a simple choice, either GPs got involved in the process or they would lose their historical power,

autonomy and control over resources to someone appointed by the State. This view was expressed best in an interview with Dr Tom Marshall published in the New Zealand Doctor. He was one of the key individuals opposing the 1990 contract proposal and was also key in the development of the IPA concept.

> It seems to us that if there is going to be a bureaucracy (accounting for spending in the primary health sector) it was much better for it to be controlled by GPs used to running in a lean way, than any third party (Baker, 1995, p. 17).

2.3 CONTRACTUAL DEVELOPMENTS

On the 2 November 1993 a contract was signed between the Southern Regional Health Authority (SRHA) and the Pegasus Medical Group. The contract was for just over two and a half years and could not be terminated before 1 July 1995. Provision was made for an annual negotiation of fee services and conditions. Strict conditions of commercial sensitivity were placed over all of the information in the contract. The Southern Regional Health Authority agreed to pay Pegasus on a fee-for-services basis, effectively replicating the existing GMS and subsidy fee schedule and Pegasus agreed to "co-ordinate and deliver primary health care services in Christchurch". Pegasus had the right to subcontract the provision of the medical services to whoever they chose. The fund-holding projects represented the only deviation from the fee-for-service basis. Pegasus agreed to accept some level of risk negotiated in a specific agreement for each project, although overall guidelines were established for these risk-sharing arrangements.

- The fund-holding budget was based on historical figures (1992/1993) with a negotiated growth factor added.

- These budgets would not be reduced unless:

    a) The original budget was set too high because of an error

    b) The expenditure of the Pegasus member GPs were higher than the national average.

- The share of the savings from the budget holding will be negotiated for each agreement. In initial agreements where the SRHA is carrying all of the risk the share will be assumed to be 70/30 in Pegasus' favour.

- The savings made by Pegasus will be shared with their members as they agree — these will be spent on the improvement of Health Services and the SRHA retains the right of approval on the expenditure of savings.

- The SRHA is also obliged to invest its share of savings into Primary Health Care in the local area. However, they are prohibited from purchasing services that are in competition with the Pegasus group or its member GPs.

Many GPs were uncomfortable about the contracting consequences of the 1993 Act and were daunted by the size and complexity and 'risks' associated with the Section 51 notices.

> The Pegasus group has now contracted with the RHA. All of our claims are now sent to the Pegasus group. The executive have got some radical ideas about what they want to do with any savings made. On the 1 July the Government decentralised the health funding. GPs fell under Section 51 of the Health and Disabilities Act. This was very detailed and all GPs became a party to this. Pegasus restated the S51 material in 16 pages. Those who signed the Pegasus contract did not have to try and comply with Section 51. This was a strong incentive to sign with the Pegasus group. Both Pegasus and the medical association (NZMA) analysed Section 51 and made reports. They negotiated with the Government and removed some of the more obnoxious clauses (GP, Practice One, October 1993).

By contrast the collective contract offered by Pegasus was seen as being a lot simpler and much less of a threat for individual GPs and GP practices. Signing the collective contract was also a condition for continued membership as part of Pegasus. Effectively GPs gave up their right to send subsidy claims to the RHA and became a subcontractor to Pegasus for the provision of primary health services. From the GP's perspective the contract offered to them by Pegasus rolled over the historical funding levels but removed them directly from the influence of the State and the RHA.

> What people want is mastery over their own destiny and to protect their autonomy. Strangely enough the managed care path of Pegasus involvement

> has secured more autonomy that those who stuck with the Section 51 agreements. Those people are more controlled and subject to the whim of RHA middle managers (Dialogue Partner One, June 1995).

The major fear on the part of GPs was that the contracts with the RHA would place restrictions over the GMS and thus effectively cap practice income. However, documents released by the SRHA in September 1994 indicated that the GMS was not the major area of concern. There was only 1% annual growth in the GMS charges in the Southern Region but Ministry of Health forecasts showed an 8-9% annual growth in pharmaceuticals and laboratory tests. Therefore, these areas were highlighted by the SRHA as an important target and led to Pegasus' involvement in notional budget holding for laboratory tests and for pharmaceuticals. A number of other projects were also initiated on immunisation, maternity services, primary care nursing and better integration with hospital outpatient services. As yet there has been no move to place Pegasus member GPs on capitated funding and the de-emphasis of GMS indicates that this may not be the key issue.

Within Pegasus three different groups emerged: first, the rank-and-file members who are happy to let someone else deal with the contracts and the politics so they are free to 'get on with being a GP'. For these people Pegasus has guaranteed maintenance of the status-quo fee-for-service arrangements and continued access to the same services and resources. GPs in this group only have a limited involvement in the Pegasus activities and projects and tend to see membership as a way to avoid change. This approach was taken by the doctors at Practice 3 and 4.

The second group consists of those actively involved in attending the Pegasus meetings and in being part of the projects underway. Pegasus provided these people a way for them to be actively involved in improving the standards of General Practice. For them Pegasus has been an active change agent, but this was change that the GPs had chosen to become a part of. Some of the doctors from Practice 1 and Practice 4 chose to take this more active stance.

The third group is the core of about seven GPs who are the leadership of the Pegasus IPA. One GP described these people as the 'next mountain to climb brigade', similar

to the first wave budget holders in the UK; middle aged and looking for a challenge. These people are highly committed to Pegasus and have become the driving force of the change process. None of these people were willing to be interviewed for this study.

> What has made the difference in Christchurch is the core of smart/driven people who are dedicated to making things better and see this as a way to get rewarded for their skills (Dialogue Partner Two, June 1995).

These GPs are seen by others as the movers and shakers in the city. They have had previous involvement in medical politics, are experienced in dealing with the public and are very experienced in the use of computer technology. Because these people are respected as GPs in the local area their leadership has been widely accepted by the other member GPs. Many of these individuals already held a level of legitimacy from initiating and generating GP support for a co-operative After Hours Surgery. GPs interviewed felt that one of the most positive features of Pegasus was that it was being run by other GPs rather than from a group of civil servants or businessmen.

(Interview transcript, GP Practice Three, June 1995)

Q If you had, say, an accountant who is in there on the Pegasus executive that would be different?

A Well if a businessman had political sway in the area I wouldn't be very happy.

Q Because they are not necessarily doing what is good for general practice?

A They don't have the same kind of touch on things that a general practitioner has or a doctor has. The same thing happens in the hospital system, I've talked to a number of specialists and they've said that people coming in who aren't medical don't grasp the complexity or don't grasp the philosophy and the philosophy usually is that the patient comes first. Money is a secondary issue.

While membership at the most basic level did lead to a few administration changes, the changes introduced through Pegasus were mainly voluntary. GPs who were reluctant to be involved found it reasonably easy to pass-off the new administrative responsibilities to the practice manager/receptionists or to the practice nurses. Practices were required to direct their claims through Pegasus rather than to HBL. Collection of patient records and sending the claims to the correct authority was

generally dealt with by the receptionists / practice managers. Therefore this had little or no effect on the GPs.

2.4 GP VISIBILITY

Pegasus introduced a process of claim audit for all of their members. The process involved the selection of a number of practices to review. One week of GMS claims were selected and letters were written to all patients that visited the practice in that week. Patients were then asked if they were seen by the GP on that day. GPs interviewed suggested that if their patients received a letter they would probably ring up the practice to check. Because of this they felt that the validity of the audit process was questionable. While claim audit did have some direct influence of GP behaviour, the major effects were on the practice managers and practice nurses. As already indicated, the practice managers / receptionists were primarily responsible for recording patient details and sending in subsidy claims. Within some practices the claim audit process has led to a review of practice nurse activity to ensure that the patient had seen a doctor and therefore the subsidy claim was valid. One practice has started charging patients directly for the nurses' services rather than claiming the subsidy (Practice One).

Combined with the claim audit was a general sense of visibility or review. As part of the contractual obligations GPs were required to record an identification number of all of their claims. One doctor suggested that Pegasus was collecting data on everyone's prescriptions. This was corroborated in another interview where one of the Pegasus officers was using computer technology to download prescribing data from the HBL database in Wanganui. This, together with the laboratory data, gave Pegasus the ability to analyse, pinpoint and to monitor individual prescribing, laboratory use and subsidy claims if they so desired. GP feedback on monthly lab expenditure became a regular feature in 1995. They also proposed to produce similar reports for prescribing in 1996.

> But when you do order a test someone else will know what you have done and you may be asked to explain.

> I think that there is a desire in Pegasus to be very scrupulous in the way they do GMS and things, like the claim, and have regulations or audits set in place to make sure that happens. Doctors by-and-large are an honest group but . . . I think we all suspected that certain doctors in Christchurch had a rather liberal approach in their GMS claims. That was all very well when it was coming out of some bottomless pit, but now it is coming out of someone else's slice of the Pegasus cake (GP, Practice Two, March 1995).

From the GP perspective the major impact of the Pegasus group has been in the area of 'fundholding' or more correctly special projects. The special projects had direct effects on the wider group who have chosen to take an active role within Pegasus, including a number of the GPs under study and indirect effects on many of the more passive members. The three primary areas for attention were laboratory tests, pharmaceutical usage and outpatient management.

2.5 SPECIAL PROJECTS

2.5.1 Laboratory

Pegasus negotiated a contract with the RHA providing a form of budgetholding for laboratory tests. If the Pegasus group could prove that they saved money on laboratory costs they would get to retain some of the savings to spend on patient care. All Pegasus members were sent a letter asking them to think carefully about laboratory tests ordered and that any savings made would come back for the group to spend on primary care. Members were also invited to join a pilot group which paid particular attention to their laboratory usage. About 30-40 of the Pegasus members responded to this invitation and attended a number of educational meetings on the topic. They were also split into smaller peer-review groups to discuss test ordering behaviour. Those involved maintained that the goal was not to save money but to think more carefully and only order tests that were going to give useful information. The laboratories were also asked to print on the order forms the costs of each different test. The letter from Pegasus, the provision of cost information and detailed monthly reports on what each GP spent led to quite dramatic results. Although the project had only been going for 9 months there was a 30% decrease in laboratory usage in the Canterbury area and a net saving of over one million dollars. The

interesting factor was that the savings were not just generated by the GPs involved in the pilot group but from most of the Pegasus members.

2.5.2 Pharmaceuticals

A similar contract was negotiated between Pegasus and the RHA to cover pharmaceuticals. This project started in December 1994. Pegasus members were invited by letter to attend a meeting on the project. About 40 GPs expressed an interest. They were broken down into four smaller groups, each chaired by a GP facilitator and with a pharmacist involved. The groups meet once a month to discuss their prescribing behaviour and to provide a 'peer review' forum. Data on individual GP prescribing was provided by Pegasus to the GP facilitators to provoke discussion and to 'get the GPs thinking about their prescribing'. Three specific groups of drugs have be targeted as representing a significant chunk of the pharmaceutical budget: antibiotics, asthma drugs and gastroenterological anti-ulcer drugs. There is also a significant educational component of this project. Pegasus ran regular 'educational' meetings for those involved addressing the nature and benefits of available drugs.

Although the Pegasus prescribing project did not directly reward GPs who prescribed more economically, the fact that Pegasus retained control over any savings made was a powerful incentive.

(Interview transcript, GP Practice One, March 1995)

Q: Last interview you mentioned the PreMeC prescribing analysis and said that it was very good but that there were no real incentives to change your practice. Has this project started to give you incentives to change?

A: Yes, definitely! Basically, it is the fact that the Pegasus group has got a contract with the RHA so we get to retain control of some of the savings made. That is the incentive and it is quite powerful. Without that you are only doing it for the good of the general person, it is a bit vague.

GPs involved in the project did get paid $100 an hour for the time involved in attending meetings and in peer review meetings. These payments and the costs of administering the project were met by a direct Government grant. On the 19 August 1994 the Government announced a $20 million funding package to assist with the

development of new health services. Currently only a small proportion of this fund has been taken up, however Pegasus was one group that did apply for a grant to run and administer the pharmaceutical project and, to date, they have been given the largest grant of anyone who applied.

2.5.3 Outpatients

The outpatient project involves the gastroenterology and respiratory departments at the local hospital. GPs who are involved in this project had far more control over what happened to their patients. The GP could specify which consultant their patients saw and the time-frame in which the patient should be seen.

The other projects, immunisation, maternity services and primary care nursing, are far smaller in scale, concerned more with the reorganisation of service rather than saving funds. However, the immunisation project caused a strong reaction among practice nurse staff. This was because the management and provision of immunisation services was conducted by practice nurses and the Pegasus project was seen as impinging on their work responsibilities.

2.6 SAVINGS

At the Pegasus AGM in 1995 it was announced that there were already significant savings from the projects, particularly from the laboratory budget holding. After running costs there was over $750,000 in the bank and this was not just from the project group but from right across the board.

The existence of savings opened the question of what it was going to be spent on. Because of the contract between Pegasus and the RHA it is necessary that any savings be spent on 'the improvement of Health Services'. The SRHA also retained the right of approval on the expenditure of savings. An initial suggestion was the creation and funding of a Chair of General Practice at the local medical school. Although there was strong support for this proposal there was some resistance from the RHA who were concerned that such a use of funds would not "relate directly to patient welfare".

There was also some tension between Pegasus and the University over who would control the funds[1].

Two other suggestions were also put forward. First, that they fund a gastroscopy service that GPs could have open access too. Second, that a terminally ill benefit be established, which will fully subsidise the cost of GP visits to people who are terminally ill where GPs are caring for them in the patient's own home.

> When you have a terminal patient it often means you are visiting 2, 3 or 4 times a week and as the situation stands at the moment, either we don't charge them or the bill gets very high very quickly, so there is a proposal to put in a benefit. Pegasus funds are to be spent on that to enable good care and a fair reimbursement for us (GP, Practice One, June 1995).

To date Pegasus has announced free Mammography screening to prevent breast cancer (NZ Doctor 10 Nov 1995, p. 5) and a "special needs benefit for patients with terminal illness". This looked very much like the terminally ill fund proposed earlier. The New Zealand Doctor article also described free hearing checks for children under five, free urea breath testing and a hardship fund.

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1 This chair was established in 1996.

APPENDIX 3

THE PREFERRED MEDICINES CENTRE (PREMEC)

3.1 INTRODUCTION

This appendix describes the development and operation of the Preferred Medicines Centre (PreMeC). PreMeC was a collective GP response to the 1991/1993 reforms. However, this was not a response to the change in funding but to the increased concern about the costs of GP prescribing and the associated threat of Government control of GP prescribing.

3.2 THE DEVELOPMENT OF PREMEC

PreMeC was a non-profit incorporated society established in 1991 by General Practitioners and pharmacists to educate GP prescribing behaviour. It began in 1988 as a research project set up in the Nelson area to study whether an analysis of actual GP prescribing patterns could be used to improve the quality of prescribing. The outcome was that the Nelson area had approximately 25% lower dollar value in their prescribing without, apparently, affecting the health of patients. The then Minister of Health got interested in the project and set up a national entity attached to the Wellington School of Medicine and funded by the Ministry of Health. In 1993 this organisation became an incorporated society known an PreMeC and the responsibility for funding was delegated from the Ministry to the individual RHAs.

Essentially PreMeC represented the medical profession's response to resource restrictions and an attempt to focus the process on the 'practice of better medicine' rather than the cutting of costs. One of the doctors involved in establishing PreMeC outlined three reasons why they took the initiative in the area of prescription analysis and pharmacist facilitation services:

- It would pre-empt a restrictive drug list being produced by non-GPs.
- It would prove that the medical profession could 'manage their own house'.
- GP practice would improve as GPs worked with a small number of drugs they knew well.

(Interview PreMeC Founder, August 1994).

The official mission statement was:

> The Preferred Medicines Centre exists to promote and enhance pharmaceutical management and prescribing efficiency, based on principles of efficacy, safety and economy, taking account of data from primary health care providers and consumers (PreMeC Annual Report July 1993-June 1994, p. 1).

In 1995 PreMeC was independent from the Ministry of Health and the RHAs but was principally funded by the RHAs. Individual GPs register to become part of PreMeC's prescription analysis programme. In 1995 86% of GPs nationally had joined. PreMeC's had two major activities, the GP prescription analysis programme and pharmacist facilitation services. For prescription analysis, PreMeC obtained and analysed the prescribing data from the HBL computer in Wanganui. Individual prescribing behaviour was reported to each GP along with comparative group averages. PreMeC employed part-time pharmacist facilitators around the country who then met with individual GPs to discuss their prescribing behaviour as detailed in the reports. Over half of all New Zealand GPs had been involved in this process.

PreMeC also employed a number of full time pharmacist facilitators. These were mainly in the North Island and tended to be attached to particular IPA groups. The full time facilitators established an ongoing process of education for member GPs and assisted in the development of therapeutic / best practice guidelines.

Other PreMeC activities included research into prescribing trends, the publication of educational bulletins, which were distributed to all GPs and pharmacists on topics relating to prescribing and an interactive case study programme. In each case study GPs were sent a hypothetical case to analyse. The results from all the different GPs were

collated and sent to top GPs and specialists for their comments. A summary was provided to all interested GPs. The object of the case studies was to identify and quantify practitioner and regional variation and to generate a consensus about what constitutes best medical practice. A survey of the use made by GPs of the case studies conducted by PreMeC found that 38% of practices used the case studies as a basis for peer review.

3.3 INFLUENCE OF PREMEC

Although PreMeC claimed to have a significant effect on GP prescribing behaviour and, in some cases, generated significant savings, maintaining ongoing support from the RHAs appeared to pose difficulties. According to the manager their educational approach is not always understood or well supported by the RHAs which "only understand financial incentives and carrots like money-in-the-pocket or new equipment for the practices". (Interview PreMeC Manager, August 1994)

The information provided by PreMeC was seen to actively complement a peer-review arrangements within the practices studied and to provide useful educational material. Most of the GPs interviewed had been involved in a PreMeC prescription analysis and discussed their prescribing behaviour with one of the PreMeC pharmacists. Many of the GPs also actively participated in the hypothetical case studies. One of the GPs commented that the process was interesting but was already aware of his prescribing and was reluctant to prescribe more expensive drugs unless there were clear medical benefits.

> Sometimes I get pressured by the patients (and the salesmen) to prescribe the more expensive drugs. I would generally prefer to prescribe a cheaper drug if it is as effective (GP, Practice Three, May 1994).

One of the other GPs who was involved in the prescription analysis programme also commented that the exercise was informative but a bit pointless because there was little real incentive to change what he was doing.

> They conduct prescription analysis which is interesting but has little impact on my prescribing behaviour. Prescription analysis provides details of a GP's prescribing costs over a four week time period and a comparison to the prescribing levels of

> other GPs. But there is no incentive to be a more economic prescriber. Maybe if we had a budget for pharmaceuticals it would make a difference, but currently I can see no reason why I should not give my patients the best available (GP, Practice One, May 1994).

Within the Northern Region full-time Pharmacist Facilitator positions were established attached to particular IPAs. These pharmacists developed ongoing relationships with GPs and groups of GPs, assisting them to develop their own 'therapeutic guidelines'.

3.4 FUTURE OF PREMEC

By the beginning of 1995 there were indications that some of the RHAs (particularly Southern) were reluctant to provide ongoing financial support for PreMeC. In the Christchurch area Pegasus picked up the focus on prescription analysis and improving GP prescribing behaviour. Pegasus developed the technological access to monitor individual GP prescribing and to run their own prescription analysis systems providing monthly reports to all member doctors and a wide range of additional 'educational' material.

APPENDIX 4

SCHOOL GRANTS

4.1 INTRODUCTION

This appendix describes the three different school-funding grants and how these changed under the New Zealand education reforms.

4.2 OPERATIONAL GRANT

Under the pre-reform structure most of the funding for primary schools went to the local education boards who had the discretion to allocate funds on the basis of need. A significant amount of the direct funding for secondary schools went to either the Secondary Schools' Council or the Department of Education and what did go directly to the school was pre-allocated along set budget lines.

The direct funding of school operations began in 1989 and a national formula was established to determine how much each school would receive. A slight re-adjustment was made to the formula in 1990, increasing the total allocation of funds by 1%. The operations grant consisted of two major components, a base or fixed component to help smaller schools which did not have many students and a 'per pupil' rate which was set at four different levels to reflect the respective costs of different educational levels.

Operational grants remained unchanged until 1994 when the government announced an additional $20 million increase. The stated objective of this increase was to recognise:

> The additional requirements of implementing the new curriculum and the qualifications initiatives (NZQA) applying to senior secondary students (Ministry of Education Circular 1994/25).

At the same time there was a re-adjustment of the allocation formula, resulting in a drop in the fixed base grant and increase in the per pupil rates. This effectively meant that large schools received more and smaller schools received less.

From May 1993 the direct funding increased to include the "salary grant for management". Under the existing staffing formula schools were entitled to a certain number of senior positions known as PRs or positions of responsibility. The grant covered all teachers designated as principal, associate principal, deputy principal, assistant principal, senior master, senior mistress and heads of department (PR3 and PR4). (Education Amendment Act 1992, Sec 91E)

The move to direct funding has been a central policy in the reform process (Taskforce to Review Education Administration, 1988, p. 49). The most significant impact of this policy was the direct financial responsibility expected from the school.

4.3 STAFFING GRANT

Like the operating grant, school staffing entitlements were based on the student roll. At the end of each year the Ministry told each school their guaranteed minimum staffing for the next year based on the expected roll. If there was a significant drop in the expected roll, the school would lose a number of teaching staff.

Prior to 1990 the numbers of teaching positions available nationally and the scales of entitlement were published in the Education (Salaries and Staffing) Regulations 1957. The entitlements under the 1957 Regulations were maintained under the Education Act 1989 Sec 91 (C). The Education Amendment 1990 Sec 22 (C) adjusted the 1989 Act and gave the Secretary of the Ministry of Education the ability to vary the number of teachers employed nationally and the formula to determine school entitlements.

In 1991 there was a national adjustment of school staffing entitlements in what came to be known as "the mother of all budgets". The formula for non-contact teacher hours was adjusted resulting in a loss of approximately 300 Secondary teaching positions around the country. The effect on Primary Schools wasn't significant.

In 1992 Section 91 of the 1989 Education Act was repealed under the Education Amendment Act Sec 91 (M) and the Governor-General was given the power to alter staffing and entitlement through the Orders in Council. Orders in Council have legislative status and therefore eliminated the vulnerability of the Ministry of Education to challenge. After 1993, Orders came out annually detailing the staff entitlements for the next year. Under the Orders, staffing levels and staffing entitlements remained constant until the beginning of 1996.

In November 1994 the government established a Ministerial Reference Group (MRG) to develop a model for school resource entitlement. A central part of that process was their review of the existing school staff entitlements. In March 1995 the MRG released the new staffing levels. The MRG recommendations did not appear to affect the secondary schools as significantly as the primary schools. There was an improvement in the staffing allocations for the senior school with year 11 going from 1:25 to 1:23 and years 12 and 13 from 1:20 to 1:18 and 1:17 respectively. It was only the secondary schools with over 600 total students or a large senior school that consistently benefited. However, there were some real changes for the primary schools. The larger primary schools (over 100) received additional teaching staff while the smaller ones (below 100) tended to lose staff.

Combined with the MRG adjustment to the staffing ratios was another effort to encourage schools to take responsibility for the payment of teaching salaries. While bulk funding of teachers' salaries was clearly envisioned in the Picot Report (1988) this was not implemented, generally because of strong teacher resistance. In order to 'ease in the implementation' the government introduced a 3-year trial of bulk funding. The MRG reviewed this trial and recommended that 'direct funding' of teachers' salaries be introduced as an option. This option was resisted by the teaching unions represented on the MRG and by individual teachers and some principals interviewed.

4.4 SPECIAL GRANTS

A number of schools are entitled to additional or special funding. The most significant of these grants was called the Equity Fund. This grant was provided to

schools that had students with 'cultural and social learning disadvantages'. In 1994 the Equity Fund was reviewed by the Ministry of Education and renamed Targeted Funding for Educational Achievement (TFEA). Previously schools had qualified for funding by writing to the Ministry and making a case for the needs of their school. Staff at the Ministry argued that allocation of the TFEA funds should be based on the needs of the area not the persuasiveness of the principal. A number of factors were selected by the Ministry of Education that related to poor socio-economic status and consequential lower educational achievement. Schools were placed in one of ten different bands based on the socio-economic data for their local area. Funding grants were made to schools in the bottom three bands, staggered so those who were classified in the bottom band got the most.

In 1995 the Ministerial Resource Group proposed a new form of funding called the Secondary Tertiary Alignment Resource (STAR). A pool of $15 million was made available for State secondary schools to purchase or provide their students tertiary level programmes which have higher costs than conventional programmes. This was a joint move by the Ministry of Education and the New Zealand Qualifications Authority.

APPENDIX FIVE

NEW ZEALAND GOVERNMENTS 1978-1996

Year Elected	Party	Prime Minister
1978	National	Robert Muldoon
1981	National	Robert Muldoon
1984	Labour	David Lange
1987	Labour	David Lange / Geoff Palmer
1990	National	Jim Bolger
1993	National	Jim Bolger
1996	National / NZ First	Jim Bolger