

PAY-FOR-PERFORMANCE IN PRIMARY HEALTH CARE

A comparative study of health policymaking in England and New Zealand

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Abstract

England and New Zealand introduced pay-for-performance schemes in their primary health care systems, with incentives for general practitioners to achieve improved population-based health outcomes, between 2001 and 2007. These schemes were part of health reforms to change the relationship between the state and the medical profession, giving the state increased influence over the quality and allocation of publicly funded health care. Two schemes of differing size, scope and impact were implemented. This research takes a comparative approach to exploring each policymaking process, utilising quasi-natural experimental conditions in these two Westminster governing systems to test the relevance of Kingdon's multi-theoretic Multiple Streams Framework and other theoretical approaches to explain policy variation and change.

The research documented and analysed the agenda-setting, alternative selection and implementation phases in the two policymaking processes and identified the key drivers of policymaking in each case study. A qualitative methodology, based upon documentary analysis and semi-structured interviews with 26 decision-makers, leaders and participants, was used to develop the two case studies, providing rich descriptive details and rare insights into closed policymaking approaches as seen by the participants. From this case study evidence, themes were drawn out and reviewed for consistency with Kingdon's Multiple Streams Framework as it has been interpreted and adapted by Zahariadis. The case study evidence and themes were considered in a framework of comparative analysis where patterns of similarity and difference were established. The utility of Kingdon's Multiple Streams Framework in interpreting the case study evidence was assessed.

This analysis demonstrated that Kingdon's Framework, as interpreted by Zahariadis, had high descriptive power for both case studies but failed to predict the patterns of non-incremental change observed or the importance of institutional factors such as ownership and governance arrangements for public services, interest group structure and historical antecedents seen in the two policymaking processes.

The research finds that the use of bargaining in England and not in New Zealand is the reason for major differences in speed, scope and outcomes of the two pay-for-performance

schemes. Institutional structures in the general practice sub-system are therefore the primary driver of policy change and variation. These acted as enablers of non-incremental change in the English case study, providing incentives for actors individually and collectively to design and rapidly to implement a large-scale pay-for-performance scheme. The institutional features of the general practice sub-system in New Zealand acted as a constraint to the development of a large-scale scheme although non-incremental change was achieved. Phased approaches to implementation in New Zealand were necessary and slowed the delivery of outcomes from the scheme.

With respect to other drivers of policy change and variation, the role of individual actors as policy and institutional entrepreneurs was important in facilitating policy design in each country, with different types of entrepreneurs with different skills being observed at different stages of the process. These entrepreneurs were appointed and working within the bureaucracy to the direction of decision-makers in both countries. England and New Zealand shared ideas about the benefits of New Public Management approaches to public policymaking, including support for pay-for-performance approaches, and there was a shared positive socio-economic climate for increased investment in health services.

The research provides evidence that Westminster governing systems are capable of purposeful and orderly non-incremental health policy change and that Kingdon's Multiple Streams Framework, which theorises policy formation in conditions of ambiguity, needs to be enhanced to improve its relevance for such jurisdictions. Recommendations for its enhancement are made.

Preface and acknowledgements

I have long had a deep sense of connection to England as well as to the country of my birth, New Zealand. I have lived and worked happily in both countries, I have dear friends in each place and I feel a sense of loyalty to both countries. My research reflects this fascination with these two countries and the similarities and differences in their responses to the great policymaking challenges of our times. So it has been a genuine pleasure to spend eight years exploring the way each country approached one of the biggest of these challenges, to achieve improved health outcomes for their citizens. I have been delighted and humbled by the generous support which I have received from the policymakers from both countries involved in this research, whether they were general practitioners or primary health care professionals, civil servants, senior politicians or health researchers, and I thank them most sincerely for this.

My supervisors, Professor Jacqueline Cumming of Victoria University of Wellington and Dr Judith Smith of the Nuffield Trust, London, built another bridge between these two countries for me. They each shared with me their deep knowledge of health policy in New Zealand and England respectively but also helped me to achieve that valuable gift of perspective which comes from comparative study. They are both scholars who have studied and delivered new knowledge through comparative methodology and have consistently provided invaluable advice, support and encouragement to me. I thank them deeply for delivering this over many years.

Both my employers, the Accident Compensation Corporation of New Zealand and, from late 2012, the Institute for Safety Compensation and Recovery Research at Monash University, Melbourne, provided me with study assistance and I am particularly grateful for this and for the understanding of my managers about the personal challenge of working full-time while completing such research. Financial help from Victoria University of Wellington enabled me to travel to England to complete interviews with participants during 2010 and I am most grateful for this. Erin Middleton and Sarah St Vincent Welch provided invaluable help with layout and proofing of the thesis.

Finally, the support and encouragement of my friends in both England and New Zealand, and of my family, was a critical factor in completing this thesis. Their support of my decision to begin the research, their constant interest in progress, and their acceptance that my social life had to be dramatically curtailed for many years while I completed this research, kept me going. This thesis is dedicated to them.

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CHAPTER ONE

INTRODUCTION

The issue

In the years following 2000, the governments of England¹ and New Zealand each implemented major changes to primary health care within their health systems, investing new money and developing policies to achieve improved population-based health outcomes. They each made major changes to the governance and financing arrangements for their general practice services as part of a larger programme of health system reform. The reforms in both countries were designed, amongst other things, to give state funders greater influence over the medical profession's responsibility for quality and allocation of publicly funded health care, increasing the clinical and financial accountability of general practitioners to the state^{1 p.11 2}. Each country introduced a pay-for-performance scheme in their primary health care system as part of this process of policy change. These schemes differed in size, scope and speed of implementation. Consequently the two schemes achieved differing levels of impact upon health outcomes. This provides a strong platform for the comparative study of these two contemporaneous, similar policymaking episodes.²

This research takes a comparative approach to identify the similarities and differences between the policymaking context, processes and the results each country achieved in their pay-for-performance policymaking. The purpose of the research is to gain a thorough understanding of how each country approached their policy problem and to document how the process actually worked in each case and what results were achieved.

¹ This thesis focuses on a comparison of policymaking in England, rather than the United Kingdom, as some elements of difference in policymaking in health exist between the countries of the United Kingdom subsequent to devolution of political responsibility for the NHS to Scotland and Wales in 1998. However, where research which refers to the four countries of the United Kingdom is used in the thesis, the names of United Kingdom or Britain will be used.

² For the purposes of this research, pay-for-performance is taken to include both direct incentives paid to physicians such as general practitioners or their practices or incentives included in a performance-based funding approach which is directed at intermediate provider organisations. Pay-for-performance is defined as 'financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to [monitor] and improve quality and patient safety.'³ Nolte E, and McKee, M. *Caring for people with chronic conditions*. Maidenhead: Open University Press, 2008.

The research also draws out lessons for the practice of public policy development and theories about public policymaking. Policy-orientated approaches in the public policy literature can be grouped into five main theories about drivers of policymaking. These are, respectively, that the influence of institutions, interest groups, rational choice of individuals, ideas and socio-economic factors are the main drivers of policymaking⁴. However, multi-theoretic approaches, which theorise that a mix of these drivers explains policymaking, are thought to have greater utility to explain complex policymaking^{4 p.167}. In this research, the descriptive account of pay-for-performance policymaking in the two case studies is used to test the utility of a particular multi-theoretic approach from the public policy literature; the Multiple Streams Framework, hereafter, the MS Framework, of John Kingdon. Its descriptive and explanatory power to analyse and explain the two policymaking episodes is explored alongside other approaches and the variables they hypothesise to be important in policymaking. This analysis is then used to make suggestions for extending or enhancing the Framework.

The research questions which are considered in this thesis are:

- In what aspects and why did two similar episodes of policy formulation and implementation in two similar jurisdictions follow different processes and have different outcomes?³
- How well do the elements of Kingdon's MS Framework describe and/or explain what happened at each stage of the policymaking process?
- What new relationships between variables can be identified from the analysis which may enhance or extend Kingdon's MS Framework?

The setting

The two countries

This research has taken advantage of 'experimental' conditions which existed between 2001 and 2007 in England and New Zealand, enabling the comparative study of these two

³ Policy formulation is defined as 'setting of objectives and means to achieve them' and policy implementation as 'policy intentions turned into action'. Outcomes are 'action outside the political system produced by public decision-making' 4. John P. *Analysing Public Policy*. London: Cassell, 1998.

contemporaneous, similar policymaking episodes. The two countries share similar political systems and health systems, an earlier similar pattern of health system establishment and a recent history of health system reform, involving the application of New Public Management approaches. These similarities mask some differences. Hill ⁵ warns that although institutions and policies may seem similar, differences in the systems for resourcing and remuneration may mean that their power or significance is varied. A brief description of the comparable features of the two countries, and some key differences, follows.

Political systems

There are significant structural similarities between England and New Zealand. Both have similar majoritarian unitary political systems with adversarial features (in which two parties oppose each other vigorously on matters relating to the state and the general welfare of the people) ⁶. In these systems the central government is ultimately supreme, by contrast with federal states such as the United States in which sub-national units such as states share sovereignty with the central government and have powers which the central government may not unilaterally alter. The United Kingdom (and New Zealand until 1996) has a majoritarian parliament, giving a majority of seats to the party with a plurality of votes in constituencies (a 'first past the post' system). This 'Westminster model' political system in each country gives the Executive high autonomy ⁷⁻⁹. The electoral system in both countries generally delivers strong majority government which empowers a Cabinet to make policy often without constraint by the legislature ¹⁰.

Marmor notes 'the autonomy and authority of government in parliament in the United Kingdom...as well as its position at the apex of a nationalised health service' enabled ideas to be implemented more quickly in that country than in, say, America ^{11 p. 334}. Both England and New Zealand, in the decade up to 1996, were notable for a period of rapid and fundamental policy change, including in their health systems, despite opposition from interest groups and the general public. In New Zealand, this period of reform was followed by major institutional changes which, in 1996, saw the adoption of a mixed-member proportional electoral system and a series of extensions of citizens' rights to create a

‘maverick rather than the pure’ Westminster model ^{12 p.155}, reducing the autonomy and authority of government in parliament through the need to form and manage coalitions of parties to govern. This change affected the implementation of health reforms from 1996-9 ^{13 p.15}. A coalition government also took power in the United Kingdom in 2010.

The two health systems

The national health systems of the two countries are similar and this has led to them often being assessed as being in the same categories of health system typologies ¹⁴⁻¹⁸. Both England and New Zealand have national health services in which comprehensive health services are universally available to all citizens. Established within a decade of each other in 1948 and 1938 respectively, the systems share many features, especially with respect to their publicly owned, financed and provided hospital services. The financing of these two health systems is largely public: in 2000 80.9% of health expenditure in the United Kingdom was public and 78% in New Zealand ^{19 p.268}. In both countries most of this public revenue is generated from taxation, these funds are pooled, centrally managed and allocated prospectively in annual budget appropriations. In this respect they are both national health systems in the OECD 1987 typology ²⁰.

However, the categorisation of the two systems typologically is somewhat misleading with respect to the primary health care sectors of each country. Scott’s comparative study of the health systems of England and New Zealand (Scott’s study covers the whole of the United Kingdom) highlights the role of private provision within an essentially public system and confirms subtle differences between each system: while the United Kingdom’s system is characterized by Scott as ‘mainly public and private providers’, New Zealand’s is described as ‘mixed public and private providers’ ^{16 p.35-36}, implying a greater role for private providers within the New Zealand system. Crampton ^{21 p.203} describes New Zealand’s systems as a ‘dual public/private system for health care, involving largely publicly funded and provided secondary services and largely privately provided primary care services.’

Docteur and Oxley ^{19 p.22} note that the extent of public versus private coverage in a system is indicative of the degree of government control over health spending. The English general

practice system had a publicly-funded and governed form with strong hierarchical features, of a kind which was in theory capable of periodic abrupt and dramatic change ordered from the top, though implementation could be delayed when information necessary to implement it is lacking^{22 p.14}. New Zealand has a complex mix of ownership and governance arrangements in the general practice sub-system as a result of its largely privately provided general practice services. It is assessed as providing minimal opportunities for public influence^{13 22-27}. Crampton suggests that New Zealand policy relating to the funding of general practice services has rarely conformed to organisational principles necessary for efficient and coherent public policy and created intractable problems of financial barriers to general practice services, general practitioner shortages in rural areas and lack of general practitioner accountability^{21 p.205-6}.

Differing mechanisms for accountability in the general practice sub-system

These differences in financing and provision arrangements and mechanisms for accountability in the general practice sub-system in each country have consequences for the overarching health system in each country. The need for more preventive and population-based primary health care is common to both countries. In England there are no concerns about affordability of access to care but other concerns about access to services and quality of services in poorer areas and a concern about levels of responsiveness to patient needs and expectations, particularly waiting times for treatment.

In New Zealand, high patient charges for access to general practice have deterred visits to the doctor when they were needed^{28 29} and policymakers have few levers to encourage general practitioners to keep costs of consultations affordable. There are also problems with provision of general practice services in isolated rural areas with high health needs and with encouraging delivery of preventive health services by general practitioners. In each country different approaches have been taken to resolve these needs and to improve quality of services. Whereas New Zealand typically had a 'stand-off between government and general practitioners'^{21 p.216} and quality initiatives emanated largely from peer-led initiatives generated from within the profession, England developed strong centralised initiatives through its hierarchical system of management of the national health service and close working relationship between the state and the profession. A systematic review of studies

of quality of clinical care in the United Kingdom, Australia and New Zealand in 2001 showed only four studies undertaken in New Zealand and noted the less clearly defined government policy on quality improvement in general practice in comparison with that of the United Kingdom³⁰.

History of approaches to health policy problems

To change the structural and institutional arrangements of a health system requires an effort of significant political will, usually emanating from outside the health arena in rare windows of opportunity^{22 p.11}. The periods of establishment of the national health systems in England and New Zealand are an example of such windows of opportunity and are explored in detail in Chapter Three. The period of reform beginning in the 1990s was also an effort of significant political will, driven by new public management and economic theory¹³³¹. Significant change occurred in these two countries, when health systems were restructured to introduce competitive approaches to enhance efficiency and effectiveness. These reforms met with varied results^{11 13 22 32}. Because each health system has a large publicly-financed share of health expenditure, the governments of each country were able to use their substantial financing role during this recent period of reform to undertake system-wide strategic public policy interventions at that time, assisted by their monopsony powers^{16 p.152}. Implementation of changes did not always follow smoothly, with aspects of the reforms unravelling at this stage in each country^{22 33}.

The parallel nature of the reform pathway between these two countries is often noted in the literature^{16 18 22 31 34 35}. This period of shared public management reform history led to both countries (along with Australia and the United States) being characterised by Pollitt as 'New Public Management-intensive jurisdictions'³¹. New Public Management (NPM) approaches draw on theory which supports public management reforms based upon the introduction of more competition, market-type models and business-like methods within their public sectors but also seeing a large role for private sector forms and techniques in the process of restructuring the public sector, favouring quasi-markets, large-scale contracting out and market-testing, contractual appointments and performance pay for civil servants^{31 p.116}.

Tuohy suggests that health care states such as England and New Zealand have been 'hybridizing' from their original ideal-typical forms or 'increasingly incorporating elements of other models to produce distinctive national hybrids' in order to shift 'lines of accountability in health care decision-making, the flows of information amongst decision-makers and the broad public legitimacy of the health care regime'^{24 p.612}. The increasing power of the state in these relationships has occurred through greater use of information technology which reduces the information asymmetry between state actors and physicians^{36 p.14}. This phase has been called the 'politics of redesign' as states sought new combinations of resources and new coalitions of interest' with the aim to 'optimize the key performance dimensions of equity, cost control and quality'. In particular governments sought to 'control professional power in the interest of ensuring that care of acceptable quality is broadly accessible at reasonable cost'^{23 p.5}.

Divergent steps in their shared history of health reforms have taken place since 1997 in England and 1999 in New Zealand which have led to the two systems beginning to be differentiated in the literature describing typologies of health systems. Docteur and Oxley^{19 p.22, notes 7 & 8 p 74} find that, in respect of the financing and delivery of hospital-based health care, both countries had developed features of a public contract system from 1990 in which, in the usual definition of such a system, public payers contract with health-care providers (the 'purchaser/provider split'). Trials of mechanisms to encourage greater accountability in providers such as fund-holding and pay-for-performance in England and budget holding in New Zealand occurred with general practitioners in the 1990s. While England has continued to strengthen the contractual elements of its health system, from 2001 New Zealand's health system re-introduced more elements of a public integrated system to hospital and health-related services, abandoning the purchaser/provider split introduced in 1993 for hospital services²⁵. The usual definition of a public integrated system is where both purchasing and provision functions are held by the same organisation, usually a government. The change introduced in 2001 in New Zealand is described as being 'from a 'purchaser/provider' market-oriented model introduced in 1993 to the more community-oriented model which is currently in place'^{37 p.1}, though contractual mechanisms were retained and strengthened within primary care.

Political ideology

There is evidence of a partisan pattern of political preferences which has influenced the process of health system reform in each country. In England, health policies based on centralized authority are associated with Labour governments and localised solutions associated with Conservative governments ^{23 p.9}.

In New Zealand there is some evidence that a 'normative ideal of democratic representation' through locally administered health services has become a core value of the Labour Party since 1989, though with ultimate accountability to Ministers ^{38 p.172} whereas National governments are associated with greater willingness to support a private market within general practice and clinical rather than community-based governance structures, involving doctors in decision-making to a greater degree ²⁷. In New Zealand in 1999 the Labour Party actively campaigned against market-based approaches to health care policy ³⁹, distinguishing itself from the policies of the National Party which had since 1993 supported market mechanisms in the delivery of social services ^{13 p.15}.

This partisan approach to health policy should not be overstated, however. There is some continuity of policy direction across different administrations which provides a steady undercurrent, notwithstanding a pattern of policymaking and reversal in New Zealand. Policy ideas developed by a Labour administration have frequently been implemented by a successor National administration and certain concerns about health policy, such as the level of co-payments for general practice services or the earning of disproportionate gains from public funding by medical practitioners, are shared by politicians from both parties ²¹
p.203, 210

The policy instrument: pay-for-performance

Pay-for-performance is the delivery of 'financial incentives that reward providers for achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to [monitor] and improve quality and patient safety'³. The establishment

of national health systems generated financial incentives for governments to regulate the medical profession, bringing them into conflict with doctors who value their professional independence⁴⁰. Both countries implemented a pay-for-performance scheme to exert greater influence over general practitioners as part of policies to achieve greater quality and affordability of and access to primary health care. It is agreed in the academic literature that the way general practitioners are funded has a significant impact on the way they deliver care to patients⁴¹⁻⁴³. There are good theoretical reasons to believe that financial incentives do impact positively on the quality of health care⁴⁴. This is a common strategy in the private sector, having its origins in the managerial approach, which includes 'adoption of performance-related payment systems, introduction of quality and outcomes culture, and generally increased entrepreneurship in the public sector'^{45 p.48}. It is also being utilised by public sector funders to incentivise proactive population-based health care practice^{18 p.141}, but is recognised as being fraught with risks.

The literature warns of many barriers to the successful implementation of financial incentive schemes with general practitioners, not least of which is the opposition of the medical profession. Other barriers include design issues such as setting the size of bonuses or incentives too small or funding incentives from within existing budgets, applying incentives to too small an area of the general practitioner's work, paying for activities rather than results, paying for standards of quality which are already being met rather than for improvements, replacing the intrinsic motive to do a good job for patients with a financial one and reducing the effort in those areas not incentivized. Financial incentive schemes are regarded as having a high risk that they will be gamed or the benefits will be claimed unfairly. Implementation issues include the availability of adequate data on performance, the schemes incurring much more cost than predicted, difficulties in monitoring whether quality improvements have actually occurred and questions over timing of payments, treatment of set up costs for practices and publication of results⁴⁶⁻⁴⁸.

Since 2004, the literature on pay-for-performance in primary health care has burgeoned. An overview by two people involved in the design and subsequent development of research relating to the Quality and Outcomes Framework reports that there are now 20 systematic reviews, and one systematic review of systematic reviews, about whether pay-for-performance improves the quality of healthcare⁴⁹. The authors conclude that the evidence

is clear that pay-for-performance can be effective but the effects can be short term and often not as large as payers wish, depend on the context, and can have unintended consequences. They conclude that it is not whether pay-for-performance should be a component of physician pay, but rather which type of pay-for-performance should be used, and in combination with which other quality improvement interventions.

The analytical approach

The policy-oriented approach

The field of public policy research, and specifically the policy-orientated approach in the public policy literature, asks how public policies are made, from the view point of the actions public decision-makers produce ^{4 p.205}, and specifically why mistakes or successes occur in public policies. John provides a set of overarching analytical questions about the key phenomena for the subject of public policy research ^{4 p.12}: why policy varies between country and sector; why policy changes; which policy was more effective; what were the causes of policy success and failure; and which approach was more democratic and accountable. Most theories of policy change and variation are based upon a presumption about individual behaviour or a belief about a primary driver of policymaking ^{4 50}. John sets out five theory-based approaches, in which the primary driving forces of policy change or variation are believed to be institutions, groups or networks, rational actors, socio-economic factors and ideas respectively. John suggests that these single-driver approaches may lead to partial accounts of policy making processes, concentrating on only parts of the complex processes. He recommends research which is multi-theoretic, or utilises features of more than one approach, such as Kingdon's MS Framework.

Kingdon's MS Framework

The MS Framework is a multi-theoretic approach to understanding policymaking. The MS Framework integrates several elements of theoretical explanation, using important insights from all the approaches ⁵¹. It seeks to explain non-incremental policy change by theorising a continual interplay between ideas, institutions, interests, actors and events in conditions of policy ambiguity ^{4 p.173} rather than a single dominant driver of policy change. Kingdon

describes three streams flowing independently, containing policy problems, policy solutions and political processes respectively. His MS Framework has a theory of political manipulation at its core^{52 p.65}. Kingdon's key insight is the importance of ideas and of human agency (or actors) in coupling opportunities in the three streams to achieve policymaking in an environment of uncertainty or ambiguity^{52 p.65}. Key actors in his Framework, policy entrepreneurs, are motivated to seize chances to influence policymaking and are important in explaining how agendas are set and alternative policy solutions selected. In this way sudden or large-scale change in otherwise incremental processes might occur. Kingdon's theory was a challenge to writers who believed that orderly, incremental, marginal and rational adjustments to policy were the norm. Kingdon's theory has, however, been criticised as being too dependent upon chance and too dismissive of the role of structures, institutions and history upon policymaking⁵³.

Why the research is important

Understanding the health policymaking autonomy and capacity of these two states

The autonomy and capacity of a state to make and implement public policy (or to exercise its 'stewardship' functions)^{54 p.122} is a fundamental characteristic of statehood. 'Autonomy' for a state is defined as 'the ability of government institutions to resist being captured by interest groups and to act fairly as an arbiter of social conflicts.' 'Capacity' refers to the ability of government systems to make and implement policy and 'springs from the expertise, resources and coherence of the machinery of government'^{55 p.81}. Understanding the nature of autonomy and capacity in a particular state and how well it is able to maintain or extend its autonomy or capacity to develop effective public policies may assist it to strengthen these characteristics over time. The purpose of the pay-for-performance policymaking in both countries was to increase state influence over the quality and allocation of publicly funded care by the medical profession. This research will investigate how the 'stewardship' functions of each state were exercised in these two policymaking episodes and will document their results. In a comparative study of general practice financing in New Zealand, England and Australia completed in 2010, the authors concluded

that ‘a powerful profession appears to have succeeded in securing significant autonomy and self determination while receiving public funding in return for relatively little specification or monitoring as to how that funding is used (except in England)’^{56 p.101}. This strongly suggests that there is a deficit in the stewardship capacity for health policymaking in New Zealand by contrast with England. It is important to explore whether this contention remains accurate by testing it through the analysis of the New Zealand and England case studies of policymaking, because this will enable these two states to monitor and develop their health policymaking autonomy or capacity, based on new evidence about their current performance.

The research will also identify how the different contexts within the health system in each country affect its policymaking autonomy and capacity and which of the two countries was most successful in achieving the outcomes sought. The findings from this research may also, therefore, enable each state to consider whether and how to change elements of this context to facilitate its policymaking in future.

Improving the utility of the MS Framework to support policymaking

Policymakers who wish to use evidence and theories in the policymaking literature to guide them in their work depend upon the relevance and accuracy of this literature. By testing and suggesting improvements for the relevance and accuracy of the MS Framework, it may become more useful to policymakers in a greater variety of jurisdictions. Kingdon’s theory was originally developed from evidence drawn from the pluralist processes of United States federal policymaking where well organised interest groups, weak political parties and multiple venues for decision-making create intense ambiguity, resulting in pronounced pressures on policymaking^{52 p.67}. The MS Framework is said to fit less well with Westminster systems with well organised political parties and centralised decision-making (or other European jurisdictions with corporatist consensus-based approaches to decision-making). Though subsequent research and revision has improved the relevance of Kingdon’s MS Framework over time, there is an opportunity to further explore its suitability in the context of two in-depth case studies of Westminster system policymaking processes in this research, to identify gaps in the MS Framework’s relevance for these types of jurisdiction and provide new lessons for policymaking in New Zealand and England.

The MS Framework is focused almost exclusively upon the agenda-setting or policy formulation stage, with limited analysis applied to the processes of policy implementation. It is set out at a relatively high level of description. This research will probe the processes of agenda-setting, alternative policy selection and implementation more deeply, to assist in the testing of the applicability of Kingdon's MS Framework in these phases of policymaking.

Finally, Kingdon's MS Framework emphasises the key role of policy entrepreneurs in bringing together or 'coupling' elements from each stream (problem recognition, policy ideas and politics) where there is policy ambiguity. He defines policy entrepreneurs as having 'a willingness to invest their resources – time, energy, reputation, and sometimes money – in the hope of a future return'^{51 p.122}. Subsequent scholarship has developed an understanding of the role of the policy entrepreneur, how it works and what motivates policy entrepreneurs^{24 57}. The opportunity arises to observe whether policy entrepreneurs are present in these two case studies and whether other types of public entrepreneurs may play important roles in policymaking. This may add to a better understanding of the performance of the entrepreneurial role in policy change.

Methodological approach

This research uses a comparative case study methodology in a most-similar systems design. The research question is why, in two similar political and health systems, did two policy decisions to introduce pay-for-performance in primary health care have such different results, including their process of design, scope and speed of implementation? This requires exploration of similarities between the two countries, as well as key differences, particularly at the level of the general practice sub-system. It will take particular account of differences in resourcing and remuneration (which may mean the power or significance of institutions or policies is varied in that sub-system). The English pay-for-performance scheme is notable for its large size and scope. The literature on health policy reform generally and on pay-for-performance available in 2000 would not have predicted that such a large-scale scheme would have been able to be designed and implemented so readily^{22 p.199 58-61}. The nature of the scheme implemented in England offers a challenge to existing theory that such schemes would usually be resisted by doctors and result in small and incremental change in behaviour of practitioners^{40 59}. The pay-for-performance scheme negotiated in New

Zealand, though non-incremental, was small in size, scope and slow in speed of implementation and designed in an extended consultative process.

The pay-for-performance policymaking in each country will be set out using evidence from documents and interviews with participants which describes each policymaking process in detail. From this descriptive study differences which may be related to differing outcomes will be isolated so that:

‘If we can locate some particular feature in which otherwise very similar nations differ, we are entitled to suggest that it is attributable to one of the few other factors distinguishing them’⁶².

To paraphrase this methodological approach for the purposes of this thesis, if we can locate some particular feature in the pay-for-performance policymaking process in which the otherwise very similar countries of England and New Zealand differ, such as the size and scope of the scheme, we are entitled to suggest that it is attributable to one of the few other factors distinguishing them, such as structural features of financing arrangements for general practice, the role of doctors in the policymaking process or the characteristics of general practice interest groups and look for an explanation - a set of reasons or a theory - which explains the differences in the pay-for-performance policymaking and the other factors of difference between the two countries. Castles calls this to ‘use the anomalous to illuminate the familiar’⁶³.

The logic of enquiry which has been used is that of analytic induction, a ‘specific form of inductive analysis that begins deductively by formulating...hypotheses, and then examines a particular case in depth to determine if the facts of the case support the hypothesis. If it fits, then another case is studied and so forth, in the search for generalizations’⁶⁴. Yin⁶⁵ also sets out the process by which analytic generalization can arise from case studies so that where two or more cases are shown to support the same theory, literal replication or validation may be claimed. Where contrasting results are achieved for predictable reasons, theoretical replication is found.

In this research design the dependent variable is the policy outcome and all other variables including institutional and structural features, network and group structure, rational choice explanations, ideas and socio-economic factors are examined as independent variables.

Outline of the thesis

This research is presented in three parts. The first part sets out the theoretical and methodological frameworks used. Chapter Two provides a review of the key theoretical frameworks used in analysis of the case studies. The policymaking aspect of the research is supported by a description of the five theoretical approaches to policymaking, with a more detailed description of the MS Framework for policy formulation. In Chapter Three a brief review of comparative theory is provided. Then a comparative analysis of the two countries' public policy and health systems is presented. Chapter Four explains the methodology, setting out the qualitative approach to the gathering of evidence and the techniques used for analysis, providing a full description of the process used to complete this research.

In Part Two the two case studies are presented. Chapter Five describes the process of design of the pay-for-performance scheme, the 'Quality and Outcomes Framework' in England. It concludes with a review of several independent evaluative studies of the resulting pay-for-performance scheme and of the outcomes achieved by the scheme. Chapter Six explores the evidence using Kingdon's MS Framework and assesses how well it describes or explains the evidence set out in Chapter Five.

In Chapter Seven, the New Zealand case study is presented with a detailed description of the context and the process for design of the pay-for-performance scheme, the 'Performance Programme.'⁴ It concludes with a review of the small number of independent evaluative studies of the final scheme. Chapter Eight explores the New Zealand evidence using Kingdon's MS Framework and assesses how well it describes or explains the evidence.

In Part Three, Chapter Nine answers the research questions which are set out in this Introduction. This discussion will demonstrate why there are differences in the two health systems today despite significant similarities both at their point of origin and between the

⁴ The Performance Programme was originally known as the Performance Management Programme and changed its name in 2008 when changes to its governance structure were also made.

two countries' political, economic and social systems. This Chapter discusses the impact of the research upon the current literature on theoretical frameworks for health policymaking. Chapter Ten concludes by reviewing the evidence that the research has generated, together with a summary of the contribution the research has made to the literature on health policymaking.

Part One

CHAPTER TWO

THEORETICAL FRAMEWORKS

Introduction

In this Chapter, the theoretical literature which has been used to analyse the public policymaking processes observed in each case study will be set out. In the second section, a detailed assessment of the state of development of a leading multi-theoretic approach for explaining policymaking, the MS Framework, will be presented. The original MS Framework and current critiques and empirical work using the theory are then reviewed.

Analysing public policy

Political science and its sub-discipline of public policy is the discipline within which this research is undertaken. Whereas political science is concerned with the study of politics generally, public policy research studies 'how the machinery of the state and political actors interact to produce public actions'^{4 p.2}. These actions are the result of processes of policy formulation (including agenda-setting and consideration of policy alternatives) and they lead to policy outputs ('a discrete decision or set of decisions that produces or aims to produce a policy outcome') through a process of policy implementation^{4 p.204}. Hence, a policy outcome is an 'action or non-action, occurring outside the political system, intentionally or unintentionally produced by public decision-making'^{4 p.205}⁵. This research is primarily concerned with the processes of policy formulation (or the setting of a policy agenda, the selection of alternatives and design of the chosen policy option) but also

⁵ To clarify the meaning of the terms used in this thesis, the descriptions of the processes of agenda setting, alternative-selection, decision-making and implementation are those used by Kingdon, who draws in turn upon Simon as follows: agenda-setting is 'directing attention', alternative selection is 'discovering or designing possible courses of action' and authoritative choice is 'selecting a particular course of action'. Implementation is 'the implementation of the superiors' decisions'. These definitions are set out on pages 3 and 31 of 51. Kingdon JW. *Agendas, Alternatives, and Public Policies, Update Edition, with an Epilogue on Health Care* 2nd ed. London: Longmans, 2010.

considers the implications for policy implementation and the types of outputs and outcomes achieved by the policy.

These definitions imply that policymaking is a planned, sequential and ultimately cyclical process: problem identification and conceptualisation is followed by the setting of a policymaking agenda, the subsequent process of consideration of alternatives, agreement of the selected option, formal decision-making relating to the detail of the selected alternative and its implementation, then its evaluation and review. However, such a description fails to convey what can be a much more complex process. Sabatier⁵⁰ notes that many complex elements need to be taken into account, including the multiplicity of actors involved, the length of time which is relevant to understanding the particular policy, the need to contextualise it within the sub-system which will influence its development and implementation, the often highly technical subject matter and the role of many subtle influences such as actors' values and motives, resources and power. In summary, Sabatier suggests that understanding the policy process requires' knowledge of the goals and perceptions of hundreds of actors throughout the country involving possibly very technical scientific and legal issues over periods of a decade or more while most of these actors are actively seeking to propagate their specific 'spin' on events^{50 p.4}.

The particular sectoral frame of reference for this research, or the 'field of decision-making concerned with a certain type of public problem'^{4 p.205} is health policy. Kingdon notes that health sector policy making can be characterised as 'being more ideological in content and more partisan in its politics' than policymaking in other sectors^{51 p.250}.

Five explanatory approaches, which seek to explain the causes of rather than simply describing policymaking, policy variation between sectors or countries and policy change, are set out below.

Recent theoretical approaches to the policymaking process

John sets out five theory-based approaches to how policy is made and implemented^{4 p.15-19} which can offer testable hypotheses about why policies differ between policy sectors and countries and why some policies are stable and others change. These approaches

hypothesise that there is a major driver for policymaking: institutions, groups, rational actors, ideas or socio-economic forces, defined in the following ways:

- Institutions or political organisations such as parliament, legal systems and bureaucracies and the rules, norms and strategies they adopt
- Groups and networks whether formal or informal, within and outside political institutions
- Rational choice theory or the preferences and bargaining of individual actors, where their choices are structured by institutional or socio-economic factors
- Ideas about solutions to policy problems
- Socio-economic factors such as cost pressures, and rising consumer expectations.

Institutional approaches

Taking an institutional approach highlights the important role which political organisations, laws and rules play in shaping or constraining policymaking processes. Institutions provide the structure within which individuals and organisations interact and the incentives actors have in making choices about policy^{50 p.309}. Institutions adapt to their political environment and reflect past decisions, state traditions and culture. The New Institutionalists broaden the definition of institutions to include the ‘shared concepts used by humans in repetitive situations organised by rules, norms and strategies’^{4 p.40}.

Differences between political systems can seem to have a significant effect on the way in which policy is made and what policy can be made. For instance, as discussed in the previous Chapter, Westminster systems are generally characterised by stronger party discipline and a more autonomous Executive, especially where they are unitary political systems and majoritarian electoral systems. In these states, such as England and New Zealand (until 1996), there are fewer checks on central government policymaking than in federal systems or in those with separation of powers. Sabatier offers a contrast with the ‘features of American pluralism (multiple venues, majoritarian rule, weak political parties, politicised bureaucracies)’ which create a different policymaking context^{50 p.11}.

Rather than constituting an inertial force, the institutional form of the two-party democracy may facilitate change, especially where the political system is adversarial. Hall suggests that in Britain this dynamic tension gives parties 'a structural interest in product differentiation and incentive to initiate changes' to garner electoral support ^{66 p.24}. The political party provides an institutional channel for new ideas to be translated into policy by coming 'through the legislative process relatively unscathed' ^{66 p.24}.

Immergut has described the comparative advantage of majority parliamentarianism in Sweden which enabled it to introduce health insurance programs in the face of medical opposition more easily than states with more complex political processes and more 'veto points'. This led her to conclude that the medical profession has less impact on health policy than is generally believed and that where it does this is because of opportunities presented by particular political systems rather than differences in medical organisations ^{40 p.413}.

The partisan and adversarial pattern of policymaking in the Westminster system of government is facilitated by its few veto points but also makes it 'difficult to inure any policy framework against subsequent reversal' ^{67 p.12}, providing incentives to politicians to move quickly to both enact and implement policy. However, there is also an incentive for interest groups in such systems to make partisan alliances in the knowledge that the policy could quickly be reversed by the next administration. Politicians need to choose an approach which best guarantees the longevity of their policymaking. Tuohy's model of four types of choices for policy change recognises that the enactment of reforms in Westminster systems is more likely to be 'big-bang' or large scale and fast-paced, fundamentally reshaping relationships and institutional frameworks quickly and in a single comprehensive sweep. It is important for politicians to make 'choices of scale and pace of change [to be] attempted and choices of policy design with footholds for potential allies' ^{23 p.42} to maximise the chance of effective policy change. It should be noted that Tuohy's model of types of change in health systems is referring to non-incremental change in the usual sense of a dramatic shift in policy goals, often accompanied by a shift in the balance of influence across state, medical and private financial actors, the mix of governance mechanisms (hierarchy, markets and peer control), the legitimating ideas about entitlement to health care and the appropriate function of the state as payer, employer or regulator in those systems ^{67 p.11}.

Although institutions may seem similar, differences in rules and regulations at the sub-system level, such as for resourcing and remuneration ⁵ may mean that there are significant differences in the way these institutions provide a structure for individuals and organisations to interact and the incentives actors have in making choices. It is of great interest when similar jurisdictions, such as England and New Zealand, display divergence in patterns of policymaking as this allows exploration of whether the same institutions are producing different outcomes over time or political actors are adjusting their strategies with respect to institutional structures to achieve change. Divergence in similar systems suggests that 'the persistence of cross-national differences despite common challenges and pressures' may relate primarily to differences in intermediate institutions, such as policy networks or corporatist arrangements ^{66 pps.5-6,16-17}.

Group-based approaches

Group or network approaches consider that policy change arises from the interaction of institutional arrangements and groups or networks ^{50 p.298} and that it is collective action or relationships between actors more so than the role of the institution or individual actor which drives policy change. The literature focuses on the nature of the distribution of power amongst groups and whether power is concentrated or shared ^{50 p.303}. 'Group or network' in this research refers to a variety of forms of groups: interest groups and their formal organisations, a wider policy community of specialists including academics, think tank members and analysts from interest groups and looser and broader-based networks formed around issues. Whether groups are fragmented or integrated and whether they have strong neo-corporatised relationships with state decision makers (such as relationships involving closed, shared processes of policy development) or whether access to decision-makers is dispersed amongst groups or less formal issue-based networks is said to make a difference to policy making processes and outcomes ⁵².

Immergut argues against this, finding that although the characteristics of the medical profession as a pressure group with 'insurmountable veto powers' are a key to the relative power they hold, it is really institutional features which block or 'veto' state actors rather than the success of the profession's interest-based policy preferences which count ^{40 p.413}. Dowding, using a health policy example, concurs that the state can 'ride roughshod over any

policy community' to establish a policy framework, though it may rely upon the interest group to elaborate the details of its implementation. He acknowledges that the way in which interest groups respond to policy proposals will be conditioned by previous policy decisions ^{68 p.144}.

Adam suggests that the distribution of power and type of interaction within networks is affected by the national context and that majoritarian unitary democracies have networks where power is concentrated and interaction patterns competitive. Further, the more centralised the state and interest group structures, the greater the likelihood of negotiation of binding agreements between them which usually results in incremental change (or replacement of one policy instrument with another) ^{61 p.139, 145}. Where there is asymmetry between the state and interest groups, either unilateral state action or self-regulatory interest group behaviour is more likely and in an environment such as this there is the greater possibility of more fundamental policy change (or 'serial shifts' which are defined as new ideological paradigms).

Observing patterns of new strategic alliances between state actors and others within Westminster systems, Tuohy asserts that such 'strategic alliances between policy-makers and entrepreneurial actors will be critical to the course of change regardless of scale or pace' of policy change ^{23 p.42}. These alliances can be with national organisations with formal relationships with the state, such as the British Medical Association (BMA) in England, or organisations formed around a particular set of policy preferences with a goal to champion policy change.

The characteristics of the network, such as whether communication between members is facilitated by its structure, whether there is a dense web of connections or more loosely organised interactions and whether relationships within the network have grown trusting over time and facilitate the exchange of ideas may affect the way policy issues are processed. But while networks in a polity, like institutions, may provide the context for policymaking and may either frustrate or facilitate the process, John suggests that they in themselves are not drivers of policy change, but that this lies in components of networks such as the resources, legitimacy and bargaining strategies of actors such as organisations, interest groups or individual leaders within networks ^{4 p.86}.

Rational choice approaches

Rational choice theory takes the approach that the preferences of individual actors are the foundation for political action and inaction ^{4 p.116}. Rational choice methods, including bargaining and game theory, focus upon modelling the expression of individual preferences and choices based upon assumptions about the behaviours which will be observed. The basic theoretical assumption is that individuals act opportunistically in their self interest, maximising their own utility, rather than the interests of others. Rational choice theorists acknowledge that institutions and structures affect actors' choices by determining incentives ^{69 p.54} which constrain some behaviours and encourage others. Dowding lists the four resources which impact upon bargaining: information, legitimate authority, unconditional incentives to alter others' incentive structures and conditional incentives to alter others' incentive structures ^{70 p.143}.

Institutional rational choice theory models the results of actors' preferences and choices and how these are affected by structural variables in institutional arrangements. Ostrom has set out a conceptual map of an 'action arena' composed of actors and an 'action situation' of participants, their roles, allowable actions, potential outcomes and the level of control each participant has over choice, information and the costs and benefits assigned to actions and outcomes. Ostrom suggests that differing structural variables in institutional arrangements within an 'action arena' will produce differing patterns of interactions and outcomes ^{71 p.27}. These can operate at the operational (individual day-to-day decision-making), collective choice (policy decision-making) or constitutional choice levels (who participates in decision-making and by what rules). An assumption of self-interest is not essential to the theory as there is increasing evidence that 'in certain situations people's normative commitments frequently lead them to act in ways that are contrary to their narrowly defined self interest' ^{72 p.101}. People may have limits in their capacity to receive, store, transmit and act upon information and their 'bounded rationality' may cause them to 'satisfice' or achieve some basic level of utility rather than 'maximise' it ^{69 p.52}. Dowding explains that utility maximisation is not necessarily the same as self interest and suggests that the channelling of self-serving behaviour of participants is the key normative policymaking or political task. Even rent-seeking behaviour by interest groups can be socially

optimal^{73 p.455} and 'the recommendation of the careful rational choice scholar is to use its methods to try to reach generalised conclusions about the damaging and beneficial features of different aspects of the modern state.' Other literature acknowledges the role of 'norms of behaviour' such as 'reciprocity' which may limit opportunistic behaviour^{50 p.300}. Self-interest assumptions can be excluded from modelling techniques in this approach, in a process called 'altruistic rational choice.'

Ostrom also identifies the role of entrepreneurial actors as leaders who are 'focused primarily on problem-solving and putting together heterogeneous processes in complementary and effective ways 'as important in solving collective action problems in the public sphere'⁷⁴.

Theorists such as Crouch⁷⁵, Tuohy and Ostrom have used both historical institutionalist and rational choice approaches in combination to explore collective action problems⁶⁷ from an institutional and individual actor perspective. When doing so, historical institutionalists have strongly challenged the strict assumption of utility maximising in rational choice theory^{66 p.7}, regarding institutional structures as reflecting, containing and moderating these expressions of individual utility maximisation. Preference formation including the goals of actors can be shaped by the institutional context and is not to be assumed. 'New ideas can cause groups to rethink their interests...the way in which various policies are 'packaged' can facilitate the formation of certain coalitions and hinder others...leadership can play a key role in this process'^{66 pps.8-9}.

Crouch states that the New Institutionalists have re-established a role for political science in explaining that rational maximising actors are constrained by 'patterns, norms and rules' but warns that actors are not in an 'iron cage of institutions which they cannot change'. He seeks a theory of action which 'retains all the insights of neo-institutionalism concerning the nature of human action, while also being able to account for innovation'. His contribution is 'the institutional entrepreneur', an actor determined to seek change by recombining elements of institutions in unusual ways at opportune moments in order to produce change.^{75 p.3, 19,23-4} Crouch suggests their primary target for change is governance mechanisms. By 'governance' he means not only the formal and explicit mechanisms usually called 'government' but the informal and implicit mechanisms which sustain institutions and

maintain conformity. He also suggests that conditions of institutional heterogeneity facilitate innovation by 'presenting actors with alternative strategies when existing paths seem blocked and by making it possible for them to make new combinations among elements of previous paths'. In empirical applications of this theory, entrepreneurial effort towards 'recombinant governance', which disposes of some kinds of behaviour from the past and retains other forms in new governance compounds, should be sought.

Tuohy has also found that entrepreneurial actors were key to health reforms in England over the period from 1990 to 2010. Entrepreneurial providers, purchasers and NHS policy-makers took advantage of an environment of change to create new organisational roles for general practitioners such as fund-holding. New political allegiances to champion or oppose these were also formed. The combined impact of demonstration effects of entrepreneurial schemes and direct political advocacy drove reform processes forward^{23 p.14} to the extent that significant shifts in influence amongst health providers, especially general practitioners, and within the state hierarchy, especially entrepreneurial managers and central evaluation and monitoring bodies, was able to occur^{23 p.39}.

Tuohy recommends examining variation in the dimensions of political uncertainty and heterogeneity of institutional forms or policy frameworks over time and across nations to help in understanding the variation in degree and kind of institutional entrepreneurialism found, and the power bases from which it may emerge (state authority, private capital or professional expertise)^{67 p.4}.

Ideas

John contends that the role of ideas and their advocacy by actors is a causal factor over and above the effects on policy of political institutions and interests^{4 p.145}. Ideas which become part of political party ideology and characterise partisan politics, especially in adversarial Westminster political systems, may be strong drivers of policy change and structure policy outputs^{27 p.490}. However, John sees ideas and interests as existing in a symbiosis 'which is at the heart of change and stability in public policy'^{4 p.166}.

Socio-economic drivers

Socio-economic approaches, which have been highly influential in explaining public policymaking, are assessed by John as assisting in identifying sets of constraints on action that impact on policy choices ^{4 p.114}, rather than as theorising driving forces of change in their own right.

Multi-theoretic approaches

This leads John to conclude that approaches which may be multi-theoretic and which can explain both constraining forces (institutions and patterns of interest group relationships) and driving forces (ideas and individual actors) have greater explanatory power for public policymaking than single-approach theories. That is, the interplay between ideas and interests amongst actors is the driving force for policy change, structured by the constraining forces of institutions, patterns of interest group or network relationships and socio-economic structures.

John and Sabatier both specifically focus on theories which integrate a number of elements (multi-theoretic in character). Three major multi-theoretic approaches to policy making have been developed: the MS Framework ⁵¹, the Policy Advocacy Coalition Framework ⁷⁶ and the Punctuated Equilibrium Model ⁷⁷. All integrate more than one approach to public policy and synthesise many insights into a coherent framework, and have both elements of explanation and description. The Advocacy Coalition Framework explains policy change by placing emphasis on the policy community as the source of policy change. The Punctuated Equilibrium Framework identifies a pattern in which opponents of contemporary policy settings manage, at intervals, to change policy image and enable policy debate to shift to different venues. The MS Framework considers a wider range of drivers of policy change and variation and is regarded as the closest to 'an adequate theory of public policy' by John. That is the reason for selecting the Multiple Streams Framework for this research. Thurber describes it as 'an interactive model of identifiable forces driving the agenda-setting process' ^{51 p.vii}. It is set out in some detail below. It is the intention of this research into pay-

for-performance policymaking to test the relevance and adequacy of this theory for the selected two case studies.

Kingdon's MS Framework

Kingdon's *Agendas, Alternatives and Public Policies* was first published in 1984 and focused on the processes in public policy agenda-setting, studying the 'list of subjects to which government officials and those around them are paying serious attention' ^{51 p.1-3}. His empirical research was done in the United States. Kingdon challenged the prevailing view that policymaking was usually rational, comprehensive, and followed clear stages and avoided sharp, substantial and sudden patterns of change. He also challenged the prevailing view that planned, top-down policymaking processes could achieve non-incremental change by providing strong evidence of discontinuity and non-incrementalism, especially in the agenda-setting phase. His theory accommodates the notion that at the alternative generation stage, familiar ideas and approaches may be drawn upon but he considers that agenda-setting is more likely to depend upon chance and the receptivity of the climate (which entrepreneurial actors can manipulate) than on existing policy settings.

He developed the MS Framework to describe the dynamics of policy change in conditions of ambiguity, using a theory of political manipulation. He hypothesised that ideas, actors, institutions, socio-economic circumstances and political interests all interact in this process. The most important features he found were the elements of chance and creativity as hypothesised in the Garbage Can Model of Organisational Choice ⁷⁸. These elements strongly reflected the patterns in data he collected in extensive empirical research into policymaking in the transport and health policy arenas over a period of four years, including 247 in-depth but conversational elite interviews with top decision-makers. But there were identifiable patterns within this process. His research led him to conclude that the process of policymaking closely resembled the 'organized anarchy' described by Cohen.

The key features of the MS Framework

Ambiguity, fluid participation and unclear technology

Specifically, three characteristics of the Garbage Can Model borrowed from Cohen are at the core of Kingdon's theory ^{51 p.84}:

- problematic (or ambiguous) preferences, which are 'discovered through action rather than actions being determined by them',
- fluid participation (individuals drifting in and out of decision-making according to the time and effort required) and
- unclear technology (or failure of individuals to understand how the general processes of the organisation really work).

The ambiguity of preferences and fluidity of participation was often exacerbated by temporal constraints and together these circumstances militated, according to his evidence, against rational, measured, incremental policymaking. Instead he often observed dramatic non-incremental policy change. This seemed to be facilitated by opportunistic policy actors he called 'policy entrepreneurs' looking for a window of opportunity or 'policy window'. Policy entrepreneurs are 'people who are willing to invest their resources in pushing their pet proposals or problems, are responsible not only for prompting important people to pay attention, but also for coupling solutions to problems and for coupling both problems and solutions to politics.' Their actions increase the chances of a policy making it to a decision agenda. Out of 23 case studies his subjects found entrepreneurs to be very or somewhat important in 15, and most observers viewed them as 'central figures in the drama' ^{51 p. 180}. Although he concentrates his research upon the first two processes, he describes four processes, using a sequential model of policymaking:

1. The setting of the agenda
2. The specification of alternatives from which a choice is to be made

3. An authoritative choice among those specified alternatives (ie. a vote or presidential decision)
4. The implementation of the decision

The features of ambiguity, fluidity and unclear technology are most noticeable in the agenda-setting phase. His theory covers 'why the agenda is composed as it is at any one point in time and how and why it changes from one time to another.' Kingdon sees the two processes of agenda-setting and specification of alternatives as different and following different processes, with different actors key to each stage ^{51 p.19}.

Agenda-setting

His famous metaphor of the 'policy primeval soup' describes the way in which policy ideas and proposals developed by specialists in a policy community float for selection and are then tested for technical feasibility, fit with dominant values and the current national mood, budgetary workability and the political support or opposition they might experience. He describes three streams flowing independently of one another, each with a life of their own:

- policy problems (or public matters requiring attention)
- policy solutions (proposals for change developed out of knowledge or interest among specialists in that policy field, and often promoted by policy entrepreneurs who try to put ideas on political agendas and keep them there), and
- political processes (such as election results, changes in public opinion).

A process of 'coupling', often achieved by policy entrepreneurs, is defined by Kingdon as critical. The framework sets out the relative importance of various actors at different stages of the policymaking process, as assessed through the field research. This finds the President and elected officials (and their appointed officials) to be of greatest importance in agenda-setting.

Alternative selection

Civil servants and interest groups, including provider groups such as medical professionals, are more important in alternative selection or development of the legislation that is emerging^{51 p.50}. In this phase, policymaking is more likely to be characterised by incremental processes. Interest or provider groups and the nature of the policy community are important. Interest groups are considered to be more likely to constrain or adapt rather than promote policy ideas. Political influence and internal cohesion are resources held by the policy community which are important to the process. These can, if mobilised, have considerable electoral effect. Academics and researchers, while less important than other actors in general, can have a significant influence in policymaking over the longer term. The impact of academic literature on a particular subject in the alternative selection phase is cited by Kingdon. For instance, he found in his research that the influence of literature on market failure in health 'markedly affected the thinking of people in the health policy community', providing the rationale for policy proposals for more market-type mechanisms or more regulation^{51 p.55}. Media actors were considered least important, primarily reporting policy work already under way than having a role in agenda-setting, and perhaps magnifying it. Election-related actors (campaigners, political parties) had similar levels of assessed importance, but significantly more so for health-related issues than the transport case studies showed. Their impact is on agenda-setting. Public opinion was found to have a similar level of impact upon agenda-setting as political parties do in Kingdon's research, being important in six of his 23 case studies.

Decision-making and implementation

Kingdon is not entirely silent on the decision-making or implementation phases of the process, citing the civil servant actors as critical to the implementation phase and acknowledging that this is a process which can generate feedback leading to innovation and further policy change. He cites the longevity and technical expertise of civil servants and their well-developed relationships with other key players, particularly those within interest groups, as being key resources of relevance to this phase of the process^{51 p.31}. To summarise

the process, a policy community of specialists in a particular policy area (bureaucrats, political staff, interest group analysts, academics and researchers) generates proposals and ideas. Depending on what is happening in the political stream and what problems are identified for attention, a window may open briefly for the policy, political and problems streams to come together in an opportunity to place an idea on a 'decision agenda'. The window may open in a policy area because of 'spill-over' from another policy area or from a previous window opening in the same area (and 'establishing a principle'). The advocates for a proposal or idea, who Kingdon calls policy entrepreneurs, must perceive that this window is open and seize the opportunity to move their idea onto this decision agenda or be faced with a long wait for the next similar window to open. In this process, timing and perceptual acuity is critical. Policy entrepreneurs can be in or outside government, seeking 'policies of which they approve, satisfaction from participation, or even personal aggrandizement in the form of job security or career promotion'^{51 p.122}. The incentives which drive this behaviour could be to promote their personal interests or advance their personal values or just because they 'like the game'. The game is to couple solutions to problems at moments of political opportunity. To do so requires the ability to shape and sell the policy idea, building acceptance for it through persuasion in the policy stream and bargaining in the political stream. Supporting the policy through the processes of assessment of technical feasibility, values alignment and hurdles of cost and public and political acceptance requires coalition- and consensus-building and negotiation skills. Factors such as the sense of a national mood, the attitudes of interest groups and the events within the government itself (such as turnover of personnel or indeed a change of administration), will influence the chance of acceptance in the political stream. The personal qualities of the entrepreneur are likely to be personal standing or a claim to be heard, being 'well connected' or highly skilled at negotiation and being persistent, ever vigilant and ready to take advantage of opportunities.

Critiques of Kingdon's MS Framework

Schlager^{79 p.297} describes the MS Framework as attempting to explain why policy-makers adopt some policies and not others, rather than explaining patterns of policy adoptions. She sees the individual as described in the MS Framework as a boundedly rational person interacting in institutional settings characterised by parallel and serial information

processing, 'satisficing' given conditions of uncertainty, complexity and weak selective preferences. Schlager finds that the theory pays less attention to collective processes of individuals coming together to achieve a shared end, instead emphasising the critical role of certain individuals or policy entrepreneurs and the conditions that support broad-based collective action leading to policy change (through coupling activities). It pays very limited attention to collective action or institutional arrangements (pointing to individual entrepreneurs instead) although later work by Zahariadis refines this aspect of the MS Framework to some extent (and this is explored more fully below).

Mucciaroni ^{53 p.482} finds that Kingdon's MS Framework 'captures much of the complexity, fluidity and unpredictability of agenda-setting and highlights the important role of chance, innovation and human agency in policymaking' but criticises the theory as overly indeterminate because it is specified at too high a level, preventing the development of testable hypotheses. He also suggests that the exclusive focus on situational and temporal factors to the neglect of structural or institutional factors is inappropriate. Because the level of abstraction of the theory creates difficulty in finding testable hypotheses, this reduces its ability to predict the conditions under which agenda change may occur. Mucciaroni suggests the need for 'a classification scheme of problems and solutions that are logically related to political and institutional variables so that middle-level propositions or hypotheses can be derived.' If the theory also ignores or pays too little attention to the unchanging or change-resistant elements of political life as well as the chance occurrences, it may fail to explain all the reasons 'why certain items reach (or fail to reach) the agenda ever or at all.' These are structures and institutions such as political, social or economic factors which set 'taken-for-granted 'rules of the game' as well as having specific organisational forms' ^{53 p.464-466}.

The structural characteristics and decision-making processes of political institutions, which Mucciaroni says are largely resilient to the turnover of individuals, 'help determine whether solutions reach the agenda, if they are blocked from doing so and how they might be modified'. These characteristics include 'pre-existing institutional capacity' that may underpin the efforts of reformers, such as the 'missions' of relevant agencies and their congruence with the reforms or institutional actors such as key leaders who are willing and able to back the reforms.

Mucciaroni sets out differences in Westminster systems or European corporatist systems of decision-making which are more centralised and integrated, the number of participants is limited and their participation is highly structured and predictable. To have utility for these settings, Kingdon's theory must also be able to explain policymaking in these conditions and Mucciaroni suggests its picture of agenda-setting is not so credible in these jurisdictions. John⁴ echoes the criticism that Kingdon's MS Framework is more suited to the United States' political process than to unitary Western European states and needs some correction to be more applicable to these more integrated policymaking systems.

There is a lack of recognition of the importance of historical antecedents and patterns or cycles in Kingdon's work and this reduces its utility. Mucciaroni regards these factors not as determinants of future policy but factors which 'make certain outcomes more likely and others less so'^{53 p.470}. Agenda items may therefore be rooted in past conditions, events and choices or may cluster with other similar items during a particular historical phase. If we can see that items are historically grounded we may see 'how the problems became the way they are and why people came to think of them as problematic' and this requires showing how problems evolved over time, with reference to previous choices and events.

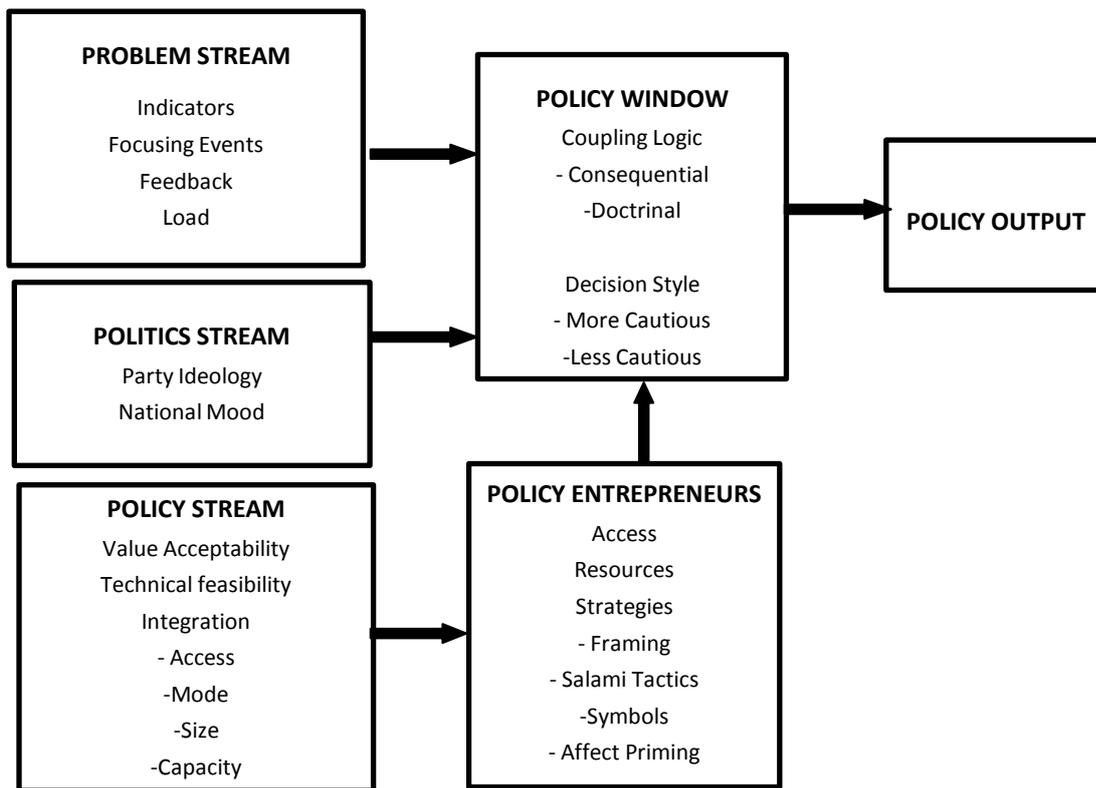
John's primary concern is that the separation of factors affecting policy formulation (agenda-setting and issues-selection) from policy implementation is inappropriate. These processes are almost fused in reality and 'it is the interaction of different types of actors over both policy definition and implementation which is the correct way to conceptualize policy'. He invites Kingdon to 'deconstruct all the key features of the political system, such as the implementation process'^{4 p.176}.

Enhancement of the model by Zahariadis

Zahariadis⁵² has used Kingdon's theory extensively in his own research and has reviewed the critiques of Kingdon's work as well as empirical research conducted using the Framework. He has interpreted and clarified Kingdon's theory. He summarises it as a lens which 'explains how policies are made by national governments under conditions of ambiguity' according to a thesis of political manipulation^{52 p.65}. He has facilitated empirical analysis of cases of policymaking using the theory by setting out the five key structural

elements in model form and adding key features or inputs as sub-elements. The elements are the problem stream, politics stream, policy stream, policy window and policy entrepreneurs. They culminate in a policy output. Together with their sub-elements, some of which Zahariadis postulated as a result of his own research using Kingdon's MS Framework, they are set out together in diagrammatic form below in Figure 1^{52 p.71} and explained further in the following section.

Figure 1: The Multiple Streams Framework



Problems

Problems, according to Kingdon, 'are various conditions that policymakers and citizens want addressed' such as rising medical costs^{50 p.70}. Zahariadis expands upon this to contend that they are discovered through 'indicators' such as the cost of a programme which is used to assess the existence and magnitude of the condition. Indicators may be being monitored routinely or through special studies. Whether conditions become a problem depends on perception and interpretation of any change in that condition shown by the indicator. This will be guided by beliefs and values associated with the condition. A 'focusing event', such as a serious episode of medical harm, may trigger a condition, such as concern about health care service quality, becoming a problem, especially if exacerbated by media attention or the work of policy entrepreneurs. 'Feedback' from programmes is another major source of policy makers finding out about conditions. It could be good feedback which may lead to a programme being replicated ('spill-over') or poor feedback, which may trigger a new policymaking process to change the programme. The 'load', or number of difficult problems faced by an administration, will influence whether a condition gets onto a policy agenda.

Where policy originates in the problem stream it is more likely to be subject to rational policymaking processes in that solutions can be consequential on problem identification. These approaches cannot be assumed but are uncovered through evidence^{52 p.75}.

Politics

'National mood', pressure-group campaigns or attitudes of interest groups to policies, and administrative or legislative turnover are the key elements affecting the politics stream according to Zahariadis. Governments will take soundings of public opinion through polling and may promote or dim the prospects of issues accordingly. They may also be concerned to address concerns expressed by interest groups, especially if a majority of groups feel the same about an issue. When there is political change such as a change of government there is considerable potential for dealing with problems because the new administration may have different ideas from the previous one and be keen to implement them. 'Party ideology', such as items in electoral manifestos, affects how they will deal with each problem.

Policies

Kingdon described a 'soup' of ideas competing to win acceptance in policy communities of bureaucrats, academics and researchers. Zahariadis has deconstructed this high level description by differentiating between two major subjects for analysis, the policy itself and the policy community around it, which he renames the 'network'⁶. Each can be analysed according to aspects of 'technical feasibility' and 'value acceptability', and the network can be analysed according to its level of integration. Only a few ideas are selected for placing on the agenda and this is influenced by their technical feasibility (how easy they are to implement) and their congruence with values of policymakers. However, the type of network of specialists and specifically its level of 'integration' (or linkages amongst participants) is also important to the chances of success in getting items onto the agenda and selected from competing alternatives. This is influenced by the 'size' of the network, the nature of participants' 'mode' of political exchange, the network's degree of 'administrative capacity' and the nature of 'access' to key decision-makers within the network or to those seeking membership of the network from outside it. Briefly, he suggests^{80 pps.73-75} that networks can be examined according to where they sit on a continuum of 'integration' from:

More integrated – smaller in size, having a consensual mode, higher capacity and more restricted access to membership, to

Less integrated – larger in size, have a competitive mode, lower administrative capacity and less restricted access.

Zahariadis further contends that issues and ideas have different trajectories for rising to the top of the soup for selection. Drawing on a typology for the trajectory of alternatives by Durant and Diehl, he suggests that more integrated networks will tend to follow an 'emergent to convergent' pattern in which longer periods of consensus-based debate occurs followed by rapid acceptance and uptake of policy ideas. Less integrated networks will tend to follow a pattern of sudden break-through of ideas, perhaps without attracting much

⁶ Policy community and policy network or network are used interchangeably in this thesis, depending usually on the preferred term used by another researcher when the concept is being discussed in relation to their work. For instance John prefers 'network', Kingdon uses 'policy community' and Zahariadis uses both.

support, followed by gradual steps which soften resistance and move the policy idea towards more broad-based acceptance.

Policy windows

Policy windows, the fleeting ‘opportunities for advocates of proposals to push their pet solutions, or to push attention to their special problems’^{51 p.165}, will present ‘coupling’ opportunities arising, in the terminology of Zahariadis, as a consequence of a ‘compelling event’ or because a ‘doctrinal’ reason exists such as a new administration wishing to make a change in policy. The coupling of problems and solutions depends on the ‘decision-making style’ of the administration in power at the time, with more cautious styles requiring more information.

Policy entrepreneurs

In the MS Framework, policy entrepreneurs are key actors who utilise techniques of political manipulation to gain traction for a policy idea in conditions of ambiguity, enabling non-incremental change. The logic of political manipulation sets this lens apart from others which employ rationality (such as rational choice) or persuasion^{52 p.69}. Driven perhaps by self-interest, a policy entrepreneur’s chance of success is affected by factors found by Zahariadis to include the level of ‘access’ they have to policymakers, the greater the ‘resources’ (time, money and energy) they have at their disposal and their skill at using manipulative ‘strategies’, such as ‘framing’ (or putting the case for the policy with a set of meanings suitable to a particular audience), ‘salami tactics’ (or feeding out the policy ideas bit by bit) to couple the three streams.

This set of structural elements and their sub-elements will provide the criteria for analysis of the two case studies, which are the subject of this research.

Response to Kingdon’s critics

Zahariadis responds to criticism by supporting the multi-theoretic approach, especially the way in which it endorses the role given to ideas as drivers of policymaking processes, its acknowledgement that broader political events can influence policy development within a

small policy community ('spill-over') and the way in which it is able to integrate the roles of both actors and institutions.

He considers that the theory is suitable for application to all stages of the policy formation process, not just agenda-setting. In particular he agrees that the extension of the theory to the implementation phase with appropriate revisions and qualifications and to different polities and venues (such as the sub-national or international domains) is useful. He suggests that research could identify whether there are some types of decisions which are more likely to need garbage cans than others (such as when the issue represents a major challenge to existing values and norms and ambiguity is thereby increased). In general he is a strong supporter of the MS Framework as a device to show how political systems make sense of an ambiguous world.

Zahariadis agrees that Kingdon has underplayed both institutional dynamics and the importance of history in the MS Framework and that these are important sub-elements in the Policy stream. His empirical work has explored these elements of the policymaking process more fully. Zahariadis has developed the MS Framework to provide an explanation of how the structure and characteristics of policy networks (which are called policy communities in Kingdon's MS Framework) influence the trajectory of ideas in the policy stream^{80 p.91} and how long time periods may be relevant. His picture of the dimensions of the network set out earlier – its size, mode of political exchange, capacity and access – identifies what he has found to be important influences on the way in which ideas evolve in the Policy stream. He draws on the policy network theories of Marsh and Rhodes, especially the concept of power-dependence⁸¹, to describe how the mode of exchange or pattern of interaction between participants in the policy network may be quite asymmetrical but 'forces interdependent participants to exchange one resource for another without the ability of any one member to single-handedly impose his or her will on the rest'^{80 p.75}. Network mode can be placed on a continuum. Consensus-based modes have a higher degree of integration of the network and contacts are more frequent and more formalized, characterised by bargaining or 'sounding out' and compromise. Competitive modes have more infrequent and chaotic contacts between participants and adversarial relationships are more likely. In competitive modes, zero-sum approaches are taken in which the consent

of most but not necessarily all participants is gained but subsequent opposition may slow or undermine the policy ideas thus implemented.

Linking his work to that of the historical institutionalists, Zahariadis contends that previous policymaking episodes and their outcomes can be shown to affect contemporary debates and ultimately policy choice by narrowing options and steering debate towards certain clusters of solutions. The 'range of solutions likely to receive a hearing is bounded by history and biased by network structures'^{80 p. 92}. Helpfully he shows this process at work in two European jurisdictions, Britain and Germany, thus extending the use of the Framework beyond the United States into a Westminster-style jurisdiction.

In these case studies, he demonstrates that the more integrated networks are more likely to follow a trajectory of incremental and emergent development of a policy idea or 'rapid propulsion to salience of a persistently softened idea'^{80 p. 73} whereas a less integrated network will display initial 'quantum' changes which evolve into a more gradualist pathway. Size of the network is a factor. Where there are few restrictions to entry, a large and varied membership can develop. Competitive modes of discourse typically dominate large networks and will result in many contending ideas and more adversarial relationships. In this context, the use of zero-sum games by decision-makers to resolve differences between groups is common. By contrast, in a more integrated and usually smaller network with restrictions on access to membership but good access to decision-makers, common interests and a search for unanimity amongst the players places a premium on consensus building, intense bargaining and accommodating amendments to policy. Ideas slowly evolve through these processes to a point where they can rapidly be implemented with widespread support.

The variables of value acceptability and technical feasibility apply to the policy as well as to the policy community. While the policy may in theory be technically feasible it may not actually be feasible to implement it in the policy community because of its structure or capacity or a lack of suitable administrative tools. Such tools could be requisite contractual or financing arrangements or appropriate information management infrastructure. However, Zahariadis has not explored the critique that political institutions and other institutional or structural factors (such as structural characteristics and decision-making

processes of political institutions), which are largely resilient to the turnover of individuals, is a major driver of policy action or inaction.

Empirical work on policy entrepreneurs

Kingdon's MS Framework has inspired much further research on the role of actors such as entrepreneurs in the policymaking process. There is a growing body of writing which describes generic public sector entrepreneurs, policy entrepreneurs and institutional entrepreneurs as key facilitators or leaders of public policy problem-solving processes. Common to the theory is the existence of heterogeneity and uncertainty (or Kingdon's 'ambiguity') in the policymaking environment.

In this literature, much attention has been paid to Kingdon's contention that the driver of policymaking is the policy entrepreneur who couples elements in the three streams when windows of opportunity arise. Mintrom⁸² agrees that the policy entrepreneurship model is beginning to increase understanding of how innovative ideas get articulated on to political and legislative agendas. Drawing heavily on Kingdon he defines policy entrepreneurs as performing three functions:

1. Discovering unfulfilled needs and suggesting innovative means to satisfy them
2. Bearing reputational risks in uncertain situations
3. Resolving collective action problems by assembling and coordinating networks to undertake change^{82 p.422}.

Policy entrepreneurs differ from the activities of advocates within coalitions because they 'seek to change radically current ways of doing things' usually over brief periods of time, and may seek to manipulate institutional arrangements or generate a sense of crisis within a coalition to do so^{82 p.425}. Drawing the findings from the empirical work together he sets out four central elements shared by all policy entrepreneurs to some extent⁸³:

1. Social acuity – making good use of policy networks and understanding and responding to the ideas, motives and concerns of others in a policy context

2. Defining problems – such as presenting evidence to suggest risk of crisis, drawing in others outside the policy area and highlighting failures of current policy
3. Building teams – tight-knit with different knowledge and skills, offering mutual support in pursuit of change
4. Leading by example – such as demonstrating the workability of a policy proposal through pilot projects.

He then offers implications for the work of Lindblom, Kingdon, March and Olsen, Baumgartner and Jones and Sabatier. The empirical work enhances the detail about the role of policy entrepreneurs in Kingdon's MS Framework. Mintrom considers that this is useful for researchers using New Institutional approaches in that it shows how deep knowledge of relevant procedures and local norms within institutions (which he calls 'insider sensibilities') can significantly increase the ability of actors to instigate change. He suggests that further directions for studies include closer studies of the motivation and strategies used by policy entrepreneurs and more study of the interaction between policy entrepreneurs and their specific policy contexts. Mintrom specifically recommends 'cross-national investigations of the means by which popular policy ideas get translated into policy settings in specific jurisdictions' as holding considerable promise for 'insights into the roles played by policy entrepreneurs in promoting policy change and the transnational diffusion of policy innovations'^{83 p.662}. These could include historical studies and contemporary studies.

In a study of policy entrepreneurs in the United States, Oliver and Paul-Shaheen⁸⁴ compared 'relatively comprehensive' policy innovation in a health sector setting in six states, finding considerable variation in policy substance but similarities in process. They studied the factors which made these states receptive to their 'home grown' policy innovations^{84 p.724, p.734}. They concluded that 'skilled and committed leadership' was the shared factor and, importantly that this arose through the collaboration of policy entrepreneurs and prominent 'investors' of political capital. They found that key institutional factors in major reform such as the resources, structure and culture of the health policy community in each state were critical ingredients in the innovation process^{84 p.739}. The study challenges the paradigmatic view of the policy entrepreneur as a 'singular

leader...with a blueprint for action' and finds that innovation was achieved through an 'internal team process' of policy design' melding technical and political analysis. Using a market analogy they describe it as 'not so much the brilliant salesmanship of someone offering a finished product as it is a group assignment for product development...more like internal innovation within a large corporation than market entry by a start-up firm',^{84 p.746}.

Institutional entrepreneurs

The 'institutional' entrepreneur model is a more recent concept in the literature. These are actors who are important in a process of policy change which requires a change in institutional structures or norms and they seek to change institutions rather than policies, looking for opportune moments to innovate and introduce new forms of governance. They are described in the literature as having a primary role of boundary-spanning activities, carrying out public mandates by combining the authority of the state with their specialised knowledge and/or other private resources such as capital or technology^{67 p.3}. Crouch describes the activities of institutional entrepreneurs as 'exploring the transferable, concealed and dormant institutional resources of their societies'^{75 p.157}. In doing so they are helping to forge new institutional arrangements, to 'scale-up innovations' for national utilisation, which, it is suggested by Tuohy, may assist in reconfiguring control over key political and economic resources^{23 67 75}. If their 'endowment' is expertise, they must operate within the norms of a knowledge-based community^{67 p.7}. The risks they take relate to engaging their endowments of knowledge with current political incumbents (which may place them at risk with successor administrations). Crouch emphasises the recombinant features of his model, in which 'an actor becomes dissatisfied with the substantive returns being received from an existing path...has access to an alternative set of practices being used in an adjacent field [and] once the price is paid for transferring these practices in to the first field, the actor can change the path.' He hypothesises that institutional heterogeneity facilitates such innovation by presenting actors with alternative paths ('to carry out this kind of analysis we must have an approach that can perceive two or more, or fragments of several...institutional forms coexisting within one political economy')^{75 p.150}.

Tuohy has taken this concept, relating it to Kingdon's work, in her analysis of health policy case studies, including in Britain, between 1990 and 2010. In these studies, health service

redesign occurred in the context of market-oriented reforms, which focused on the key performance dimensions of equity, cost control and quality. The reforms had both 'favoured and been accelerated by the emergence of institutional entrepreneurs' ^{67 p.2-4}. Institutional fragmentation, heterogeneity (and looseness of coupling of resources in the environment to permit reconfiguration) and political uncertainty (created for instance by periods of major policy change) provided favourable conditions for institutional entrepreneurs. In such conditions, entrepreneurs were able to 'exploit latent...opportunities...to develop new and innovative organisational structures' in the same way Kingdon describes 'softening up' to prepare the ground for acceptance of new policy ideas ^{67 p.5}. She reinforces the elements of risk and recombination as critical to the definition of entrepreneurship. Agents who operate at 'the *interstices* of the public and private sectors' will often have a public mandate but may also be motivated by psychological satisfaction, a social purpose or belief in the inherent value of their product. Careers and reputation are at risk and may be advanced or retarded. Professional standing and influence may be lost or gained. Where, in a health policy environment, entrepreneurs act from a base of professional knowledge they must 'exercise their professional discretion in tension with the objectives of public authorities' ^{67 p.9}.

These patterns of institutional entrepreneurial activity are also seen in the 1993-9 period of reform in New Zealand. The new Independent Practitioners' Associations and other primary care network organisations formed in New Zealand during those years reflect the activities of actors who can be seen to be institutional entrepreneurs who imported ideas from the United States to meet a need for new institutional frameworks within the general practice community. So too are examples of actors who built health organisations with strong community-based governance arrangements and those who helped to establish services by and for Māori and Pacific communities in New Zealand during these years.

Research questions arising from the policymaking literature

Kingdon's MS Framework has been identified as a useful multi-theoretic approach to the analysis of policymaking and has given inspiration to much further research on the role of policy entrepreneurs and other public entrepreneurs. The MS Framework has inspired less

research into the institutional drivers of policymaking and limited research in Westminster-type political systems.

In this research the approach taken will be to describe the process of policymaking in two matched case studies in two Westminster-type political systems and then consider how well Kingdon's MS Framework, as enhanced by Zahariadis' Model of its elements and sub-elements set out in Figure 1, enables these two processes of policymaking to be analysed, with reference to the following specific research questions:

- How well do the elements of Kingdon's MS Framework describe and/or explain what happened at each stage of the policymaking process?
- What new relationships between variables can be identified from the analysis, which may enhance or extend Kingdon's MS Framework?

To consider the second question, the policy outcome will be treated as the dependent variable and other variables including institutions, group structure and resources, ideas, rational actors and socio-economic factors will be considered. Such an approach presents a major challenge in determining the relative influence between the independent variables. It is intended that the strong comparative framework for the research will assist in highlighting a small number of differences between two similar case studies which enable the focusing of analysis upon a small number of variables. This process will be used to signpost opportunities for further research.

Summary

This Chapter has set out the theoretical frameworks in the policymaking literature used in this research and has established the research questions which will be answered. In the next Chapter, the relevant literature on comparative policymaking will be set out. The policy context in the two countries will be set out and compared. This will include a specific analysis of the similarities and differences between the national health systems of England and New Zealand, with a particular focus on institutional features such as financing arrangements and on the relationship between the state and medical interest groups and

policy communities. Issues in the historical development of these two systems which have implications for these differences are described.

CHAPTER THREE

THE COMPARATIVE APPROACH

Introduction

This Chapter briefly reviews writing on comparative approaches to research on policymaking. Then, a section sets out a comparison of England and New Zealand with respect to their current health systems and recent health reforms, with particular reference to the similarities and differences between their general practice services. The history of development of the general practice sub-system of their national health services is also set out in some detail because the history of earlier policymaking and its solutions may affect current contemporary policymaking (as discussed in Chapter Two). Consideration of the way which policy solutions and policy communities evolve over time enables patterns of variation to be studied across time as well as between countries, so strengthening the comparative approach for policy analysis.

Comparative analysis

Freeman ^{32 p.ix} suggests that 'comparative analysis is the closest social science can get to experimentation and the methodological paradigms of 'real' (natural) science' through which theory-building can occur. Hypotheses can be generated and tested where a set of countries are examined to show why A is more like B and less like C, or where A and B are alike in all respects but for one or two variables. Przeworski and Teune set out two common research designs based upon comparative social system analysis: the 'most similar' or 'concomitant variation' strategies and 'most different' strategies ^{85 p.32-33}.

According to the logic of the 'most similar' strategies, if some important differences are found among these otherwise similar countries then 'the number of factors attributed to these differences will be sufficiently small to warrant explanation in terms of those differences alone...Common systemic characteristics are conceived as controlled for and inter-systemic differences are viewed as explanatory variables.' Statements of explanatory

variables can be formulated at the sub-systemic level such as each country's general practice sector.

Marmor identifies three purposes of comparative analysis. First, such analysis can provide the 'gift of perspective' by illuminating or clarifying national arrangements through comparative study, without addressing causal explanation. Secondly, it can generate causal explanations, or an understanding of why policies develop as they do. Thirdly, it can be a quasi-experiment which enables generalisations to be drawn to show 'Why some policies seem promising and doable, promising but impossible or doable but not promising' ^{11 p.339}. Kingdon confirms that his comparative approach 'opens up new areas for theory-building by observing contrasts' ^{51 p.249}.

Despite the value of cross-country comparative analysis of health care systems, researchers agree that this is fraught with risks ^{16 36} because of the diversity of system configuration, the added complexity of the variety of ways in which these functions inter-relate and the evidence of differing performance levels between health systems in different countries.

This research takes an approach to the comparison of these two policymaking episodes which documents the key similarities and differences between the two political and health systems and the general practice sub-systems in each country at a relatively high level to look for possible reasons for the difference in the dependent variable, the policy outcome. In doing so it seeks to establish that the findings are not due to chance. In testing the utility of Kingdon's Framework in these two relatively well matched systems, any similar findings strengthen, through replication, the degree of confidence that these possible reasons for difference are not due to chance.

Another finding which can be tested is the contest between the two approaches: the 'national styles approach', (the view that national styles determine policy outputs) or the alternative view: the 'policy sector approach' (that the nature of the problem is fundamentally connected to the kind of politics and outcomes that emerge) ^{86 p.469}. In an example of the latter, Marmor has utilised the policy sector approach to show that physicians have a unique type of economic power which results in doctors' preferences, regardless of what country they are in, determining the design of payment systems for their services ⁸⁷. Immergut directly challenges this analysis, finding that 'in contrast to scholars

who explain medical influence in terms of the singular characteristics of the medical profession...[it is] the properties of distinct political systems which make them vulnerable to medical influence' ^{40 p.391}. The two case studies which are the subject of this research, will shed light on this debate and may provide some initial findings which lead to further exploration of one or other of these positions.

It is necessary to set out a comparative picture of England and New Zealand, the two countries which provide the case studies for this research, as they are described in the comparative literature.

A comparison of the English and New Zealand general practice sub-systems

Analysts using the OECD typology of health systems ²⁰ have noted that diversities both among and within health systems reduce the utility of its set of ideal types ^{14 16 88}. The OECD model is still useful for paradigmatic cases such as the United Kingdom ^{89 p.74}. However, systems are composed of a number of sectors – public and private, or hospital-based and ambulatory, for example – superimposed one on the other ^{32 p.7}. The general practice sub-systems of England and New Zealand differ substantially though the two countries have national health systems with many other features in common.

General practice services in both countries are delivered by independent medical practitioners but the approach to funding these services differs markedly in the two countries. In England the National Health Service Act of 1946 made consultation costs free to patients at the point of care and all patients were registered with a general practice. General practitioners were, until 2004, directly contracted to provide services and paid from a mixture of capitation, fee-for-service payments, allowances and infrastructural funding in the general practice contract with the National Health Service. In New Zealand the General Medical Services scheme introduced in 1941 provided a universal subsidy for general practitioner services (the patient health benefit), though general practitioners ultimately retained the right to charge patients ^{56 p.27}. There was no contract for service between an individual general practitioner and a public funder for the services delivered to patients under these provisions and patient registers were voluntary and incomplete in New Zealand in 2000.

Funding arrangements in general practice in England

Following the introduction of the National Health Service in 1948, general practitioners were contracted by the state to provide services to their 'list' of patients. In many respects general practitioners had a great deal of freedom about where and how they organised their work and what care they delivered, largely owning their premises. Ham describes a key change to their contractual conditions in 1966 to include reimbursement of expenses of practice staff and opportunities to invest in premises and equipment¹⁰³. The core of the contractual provisions for general practices was an allowance to cover practice expenses, to which weighted capitation funding for patients was added and, in many cases, fees for the delivery of particular services. Though general practitioners were independent contractors to the NHS, they were entirely dependent upon the NHS for the income to maintain themselves and their practices, which included access to pension schemes and other terms and conditions of employment. Further changes occurred with the introduction of the Primary Care Act of 1997 which offered Personal Medical Services contracts to practices on a voluntary basis.

Funding arrangements in general practice in New Zealand

In New Zealand although the Social Security Act of 1938 legislated for a universal tax-payer-funded primary and secondary medical care scheme, including prescriptions, with capitated payments for general practitioners and no provision for private billing of patients for medical care^{21 p.202-3}, this was amended in 1941 to provide a patient health benefit which was essentially a subsidy scheme for general practitioner services. The subsidy for visits to a general practitioner, originally covering about 75 percent of the total fee, dropped to an average of 20-30 percent of the total fee by 1986. The Royal New Zealand College of General Practitioners estimated that prior to the reforms of 2001, the patient health benefit share of the income of general practices was as low as 30 percent⁹⁰ and other public funding took this to 40 percent²⁸. Together with government funding, patient co-payments and private insurance reimbursement of general practices fees, general practice services funding has several small pools. No funder established monopsonistic influence.

Eligibility for the patient health benefit also changed over time. By 2000, the subsidy was no longer universal but targeted for age, income levels and frequency of health service use and only half of New Zealanders were eligible for it ^{21 p.212}. There is much analysis which shows that the New Zealand primary health care sector, as an example of a sub-system with extensive out-of-pocket payments, creates barriers to access for some sectors of the population ^{21 91-93}. Attempts were made by the government at different times to establish limits to the amounts which patients had to pay to see a general practitioner. These included offering higher subsidies for consultations for children in 1985 or, in 1996, seeking to make these free. They included offering higher subsidies for practices willing to collect data and participate in quality assurance programs in 1990 ^{21 p.203}. General practitioner representatives resisted many of these changes and used the courts in New Zealand to challenge government policy initiatives such as a proposal to introduce contracts for funding of general practice services in exchange for higher levels of subsidy ^{94 p.161 13 p.203}. Crampton summarises the key health policy objectives for general practice funding since 1938 as to obtain zero or very low cost universal primary care services, increase service in rural areas, increase primary care use by low income patients, encourage general practitioners to offer health promotion, to lower primary care medical costs and to increase the level of control of patients and communities over provision of primary medical care ^{21 p.206}. However, there were few levers for governments to use with general practitioners to achieve these objectives.

By 1993, the problems of 'fragmented funding, and provision, barriers to access, the mix of primary care subsidies, wrong price signals and unfairness related to user part-charges and lack of consumer choice and control' led to the inclusion, in the Health and Disability Services Act 1993, of a key policy instrument, a contract between the state and general practitioners, which was intended to 'revolutionise the relationship between general practitioners and government...the requirement of all...general practitioners to have a contract with a Regional Health Authority [which] provided levers, for the first time, for government to exert influence over the location and the range and quality of services of general practitioners as well as subsidy levels and control of 'demand-driven' expenditure' through capped budgets ^{21 p.204-5}. These were still incomplete or indirect contractual mechanisms ^{56 p.34} and many general practices continued to receive most of their income

through fee subsidies until 2001. Even after 1993, contracts were negotiated between regional funders and primary care organisations, rather than with general practitioners directly. However, these contracts became more prescriptive over time and included contracts for specific types of services such as budget management of pharmaceutical prescribing, to deal with a perceived problem of over use of some services ^{21 p.11}.

A growing number of new types of primary care provision had been occurring since the 1970s, with a small number of non-profit general practices sponsored by the Department of Health and trade unions. Employing salaried staff under different funding, regulatory and service provisions and typically located in low-income communities, they formed close links to these communities and utilised a team-based approach to delivering primary health care. Approximately 3 per cent of general practitioners worked in these practices ²⁶. After 1993, a number of alternative providers of primary care services, including services run by and for Māori communities, were funded by the new Regional Health Authorities.

Different governance or decision-making models for general practice services

Tuohy has developed a typology of health decision-making systems ²² in which the balance of influence amongst types of actors (the state, private finance and the medical profession) and the mix of instruments of social control (state authority, the market and collegial systems) differ and result in differing opportunity for major policy change. There are three ideal types of decision-making systems: hierarchical corporatist (in which authority flows vertically from the top down), a market-based system (in which authority flows laterally amongst private interests within a market environment) and a system in which professional collegial frameworks guide decision-making. Tuohy shows that the ownership and governance arrangements in England led to a 'hierarchical corporatist' model of decision-making. The bureaucracy and the medical profession, both specialists and general practitioners, established strong hierarchical organisational forms and a track record of partnership to support the interdependent relationship between the state and doctors. In the 1990s it evolved to incorporate features of markets. Applying Tuohy's decision-making model to primary care in New Zealand from 1938, the governance arrangements can be seen to be dominated by the profession, exhibiting a 'professional/collegial' model of decision-making with strong horizontal organisational forms and limited partnerships with

the state. Following the Health and Disability Services Act of 1993, it had evolved to incorporate features of markets, along with new organisational forms suited to the new market opportunities in primary care provision, which arose in response to new public funding opportunities. It settled into a 'market collegial' admixture of decision-making styles. This is explored more fully below.

Shared history of New Public Management-based health reforms during 1990s

Both England and New Zealand developed shared concerns in the 1980s about rising costs of health care. Both countries also identified inequities in both access to high quality health care and in differing life expectancy and health outcomes for different groups within their population. During the early part of this reform period, initial strategies focused on the introduction of general management approaches, tightening budgets and consideration of rationing of access to services, driven primarily by socio-economic forces generating a need for cost containment.

Reform evolved in England and New Zealand in the 1990s by strengthening the hand of third party payers through more active forms of purchasing and the introduction of competition in quasi-markets within health systems^{22 pp. 19, 26 34 54 p13-14}. Public choice theory identified interest-group rent-seeking as a particular policy problem and generated strategies to contain this influence, also called 'producer capture' in New Zealand⁹⁵. Episodes of health policymaking which deliberately excluded the medical profession in order to minimise perceived conflicts of interest in policy development occurred in both countries, such as the 1990 NHS and Community Care Act^{22 p.70} in England and the 1993 Health and Disability Services Act in New Zealand^{21 96}. These active purchasing strategies can be summarised as use of performance measurement, contracting, market-type mechanisms and customer orientation to manage public or publicly funded services. In England the widespread use of performance indicators had commenced from 1983, focused on hospital services and designed to monitor the performance of the new Regional Health Authorities⁶.

In New Zealand this focus was introduced in 1989 with contractual frameworks which specified targets, plans, funding levels and defined obligations of both parties between the

14 Area Health Boards and the Minister of Health^{97 p.281}. Both England and New Zealand implemented bold system-level reforms in which the pace and scope of change within each system has been called ‘big bang’ reform, to reduce inefficiencies in health expenditure and to increase accountability amongst providers for the quality and effectiveness of health care^{22 98 99}. The extent of the convergence, or shared policymaking approaches, in health system reform and neo-liberal social and economic reforms taken by the two countries is often commented upon in the literature^{34 100}. Tuohy comments that in Britain ‘sweeping change in the public politics governing the [health] decision-making system [was] enacted and implemented. More modest versions of the British reforms took place in Sweden and New Zealand’^{22 p.4}. In 2004 the OECD noted that ‘while most countries have focused on the hospital sector, both the United Kingdom and New Zealand have experimented with using primary care doctors as purchasers’^{19 p.57}. Both countries adopted contractual frameworks, in particular budget-holding, as the preferred method to encourage general practitioners to adopt funder goals such as for greater efficiencies, improved coordination or care and improved quality and responsiveness of care. It is in this context that some small-scale local fund-holding, pay-for-performance and budget-holding initiatives began to be trialled in both countries^{99 101}, but in general practice settings which had widely different accountability relationships between state funders and the general practice profession.

New Public Management and general practice

England

From 1991 England had expanded market-type mechanisms within its health system within a fundamentally hierarchical framework of ownership and governance. The English general practice sub-system had a singular picture of ownership and governance for general practice services and the reforms sought to introduce some diversity. Innovative elements and types of delivery to improve the responsiveness of the services for patients and increase local influence in planning and service delivery approaches were introduced. In England a new contract based on capitation was introduced in 1990 (without the consent of the BMA) and included provisions for incentives to deliver immunisation and cervical cytology services as part of population health campaigns. In 1991, fund-holding for general practices over a

certain size was introduced by which practices could hold budgets for secondary care services. By 1997, 50% of the population was covered by fund-holding practices^{16 p 113}. Differences grew between forms of general practice. Fund-holding arrangements, multi-funds (groups of general practice fund-holders that formed independent general practice-led organisations to manage their purchasing), general practice commissioning groups (general practices working together to purchase local health services in collaboration with the local health authority for a defined population) and total purchasing pilots (groups of general practice fund-holders who took responsibility for the total health care purchasing budget for a defined population) co-existed¹⁰².

In 1997, following the National Health Service (Primary Care) Act, a new form of contract, the Personal Medical Services contract was established for general practitioners willing to opt out of the General Medical Services contract. The Act supported the development of primary care organisations, encouraging increased collaboration amongst practices^{103 p.89}. The intention of this new form of contract was to reflect particular local needs and offered individual or groups of practices an opportunity to negotiate novel or site-specific arrangements for provision of primary care to solve a problem of quality deficit, overcome perceived disincentives in the general contract, focus on locally-determined priorities or obtain the additional resources which accompanied Personal Medical Services status¹⁰⁴. Almost 20% of practices held one of these contracts by 2003 covering 30% of patients^{105 p.17}. The pattern of purchasing general practice services in the English system therefore has a more active character and a larger number of practices engaged in innovative approaches to accountability for funding. Evaluations of the Personal Medical Services contract show that it improved quality of care through encouraging an environment of stronger internal leadership and management within practices¹⁰⁴.

The new government elected in 1997 then introduced a more strongly centralized framework of controls, including controls of service quality. Primary Care Groups, which were geographically-based statutory primary care organisations, were formed and developed into Primary Care Trusts with a defined range of functions for service purchasing, development and management.

Tuohy describes an environment in England, resembling developments in New Zealand, in which general practice fund-holding 'galvanised institutional entrepreneurialism to a surprising degree'^{67 p.13-14}. Institutional entrepreneurs took advantage of the opportunity created by rapid change to set in motion a diversity of models. This created allegiances amongst providers to differing forms of contracts and governance arrangements. Particular differences arose between groups of fund-holding practices who favoured the opportunity to reinvest surpluses from the purchasing budgets in their own practices and groups of practices who 'objected on ideological grounds' to features of fund-holding in England such as its non-universal application. Overarching associations representing both movements were formed and became politically active in support of their models. Such divergent ideological camps, each with its own strong alignment with the respective main political parties, had long been a feature of the New Zealand general practice sub-system, in this case divided over preferences for independent private ownership and community-governed models of practice respectively.

New Zealand

In 1993 in New Zealand, New Public Management approaches were introduced into the health system through legislation to establish a public contracted system or 'purchaser/provider split'. In these arrangements, purchasing organisations could use contracts to enhance their influence and leverage over providers within a market-type primary care landscape. This included 'contracting arrangements which specify more accountable relationships between doctors...and funders...to limit autonomy...through the regulation of both payment mechanisms and fee levels'^{106 p.65-7}. Contracts under this legislation were made available on a voluntary basis to general practitioners^{13 p.205}. This encouraged the development of Independent Practitioners' Associations and other primary care network organisations within the primary care sub-system. These were consortia of practices utilising a corporatized structural form to represent them in negotiations with purchasers for new forms of funding such as budget-holding contracts. They were encouraged to pursue novel approaches, both in ownership and governance structures and new funding and quality improvement initiatives. New Māori-based services were also funded during this period, which resulted in 'an explosion in the number of Māori health

providers and...sought to increase Māori involvement in all levels in the health sector ^{13 p.62}. The country had an increasingly diverse set of primary care delivery approaches. A heterogeneous picture of ownership and governance arrangements, including both profit-making and non-profit-making forms, began to develop within general practice services, within a dual system of funding for primary care and hospital based services. By 1999, 15 percent of practices received capitated funding ^{13 p.213}. However, most general practices continued to receive their income as fees-for-service even after the primary health care reforms took effect ^{91 p.8}.

The policymaking process for purchasing primary care services was increasingly decentralised during this period, occurring in diverse ways with pockets of innovation arising through negotiations between regional funders and their local consortia, including Independent Practitioners' Associations.

Table 1: General practice systems: England and New Zealand – key features and changes during reform period

England – pre-1990	New Zealand – pre 1990
Services comprehensive, free at point of use, universal	Services comprehensive, subject to co-payments, universal
Singular governance and ownership structure. All GPs self employed, with individual contracts with NHS, supported by public funding for premises, infrastructure, pension provisions etc. BMA has sole bargaining rights for all GPs	Hybrid forms of ownership and governance: some GPs self employed in privately owned practices, some GPs in non-profit owned practices, small number in special areas employed by state. No contracts for general medical services between GPs and state
Contracts for government funding: <ul style="list-style-type: none"> - Base salary for practice costs - Capitation based on number of patients (50 percent of income) - Fees for certain procedures 	Income from fees-for-service from patients and government subsidies (Patient co-payments and subsidy for targeted patients ('health benefit'))
Gatekeepers to specialist services	Gatekeepers to specialist services

All patients enrol with a GP	Most patients register with a GP – free choice of GP
Public funding by single demand-driven centrally set prospective budget (Department of Health)	Public funding by multiple demand-driven centrally set and administered prospective budgets (Ministry of Health, ACC, other)
1990– 1997	1990 – 1999
More explicit GP contract-for-service	<p>GP funding transferred to contract-based with primary care organisations over time.</p> <p>However, GPs still largely received income on fee-for-service basis.</p> <p>Health purchasing authorities formed to identify local needs and trial new services.</p> <p>Māori and community-oriented services established.</p> <p>Corporate or meso health organisations formed (IPAs and others) to negotiate contracts for services on behalf of individual practices in many areas.</p> <p>A process for reviewing the reasonableness of fee increases introduced.</p>
	Funding for primary and secondary care integrated in regional purchaser budgets
	Increased focus on public health
GP fund-holding for community nursing, outpatient, diagnostics and secondary care services from 1993	Some GP budget management agreements for pharmaceuticals and laboratory testing negotiated between

	regional purchasers and general practice organisations
	'Free' GP care for under-six-year-olds implemented
Competitive internal market for health services encouraged	Competitive public/private market for health services encouraged
	Attempt to define core services
Patient's Charter	Focus on patients' needs/preferences
National, centralized quality initiatives (National Institute for Health and Care Excellence, Commission for Health Improvement)	IPA-initiated Guidelines production Guidelines Group established
Post 1997	Post 1999
PMS contracts available for meeting local needs	
Intermediate organisations of Primary Care Groups assumed commissioning for all secondary services, replacing budget-holding	Intermediate organisations (PHOs) established to commission and manage primary care services Integrated purchaser/provider function for health services established in 21 regions
	Primary care funding moves to capitation basis through contracts between DHBs and PHOs (but GPs still received income on fee for service basis initially)
	GP fees review structure re-established to manage excessive fee increases
	All patients required to enroll in a PHO via a GP

	Expanded amount and basis of entitlement for health benefits
Focus on public health services and importance of prevention and population- based health services	Focus on public health services and importance of prevention and population- based health services

Historical legacies - the development of two national health systems

This section considers the history of national health system establishment and whether there are historical drivers for institutional forms which the two countries now exhibit. The publicly-financed national health systems in England and New Zealand arose in the immediate pre- and post-World War Two period when both countries elected Labour parties with large majorities (this occurred first in New Zealand in 1935 and in 1945 in England), products of ‘extraordinary mobilization of political authority and will’^{22 p.7}. In these decades there was a climate of growing support for collectivist approaches to social and economic challenges. There was also both rising public demand and need for health services. At this time medical professional interests were well organised and sought opportunities to be part of health policy development¹⁰⁷.

The English story

The literature provides several descriptions and analyses of this story of national health service establishment^{22 103 108}. In England, ten years later than in New Zealand, a Labour government was elected with skilled and determined politicians of working class origin and a mandate for major social change, financed on a collectivist basis. It was able to build upon a shared sense, developed over several years by both state actors and health professionals, of the need for a state-sponsored plan for a comprehensive range of health services, to be free at point of use^{22 p.38 108}. Public opinion was supportive of a report by William Beveridge published in 1942 during the Second World War which recommended the establishment of a national health service amongst other widespread reforms to the system of social welfare.

The incoming government proposed a capitated, free and universal service, though initially sought to employ doctors on salaries. The English BMA fought its major battle to avoid implementation of a salaried general practice service. The decision was to engage general practitioners as independent contractors to the Department for Health. But in the process of the larger battle over terms of employment, the Secretary of State, Aneurin Bevan, established the principle that treatment would be free at the point of delivery throughout the health system and that payment would be on a capitation basis rather than fee-for-service. Bevan dealt separately with the interests of general practitioners and specialists during the negotiations. By dividing the profession through offering improved conditions to specialists, the Secretary was able to win agreement to the proposed legislation from the profession overall, carried on the votes of satisfied specialists despite the concerns of general practitioners.

Doctors, as in New Zealand, retained their clinical autonomy, including the right to prescribe medicines and treat as they saw fit. But in England a system of single-payer state-sponsored 'hierarchical corporatism' ensued²², otherwise described as the 'politics of the double bed'¹⁰⁹, in which the bureaucracy and the medical profession, both specialists and general practitioners, established strong organisational forms and a track record of partnership to support the interdependent relationship between the state and doctors. Doctors were formally represented and held effective veto rights at each level of the new hierarchy. Once the legislation was enacted, doctors implemented it readily. A key institutional characteristic of the sub-system was the dependence of all general practitioners on the contract negotiated between their representatives and the Department of Health as their sole source of income. This reinforced and encouraged the development of a close working relationship between the department and the general practice profession. It supported the development of a strongly democratic representative forum for general practitioners which provided the mandate to their bargaining agent, the BMA, to represent them in regular contract negotiations. Over the subsequent fifty years this relationship contributed a strongly centralizing and unifying influence within the general practice profession.

The New Zealand story

The difficult birth of the general practice element of the national health service between 1935 and 1948 is also set out by a number of writers^{94 107 110-116}. While widely understood in New Zealand, it is less well known than the English story outside this country. It is therefore provided here in some additional detail. In 1935, New Zealand's Labour party had been elected in a landslide victory. The idea of a free universal health service, although it had been Labour Party policy since 1919, broke relatively new public policy ground and was not widely socialised amongst political and medical stakeholders at the time. The new government began a three year process of consultation with stakeholders and exploratory research, including seeking advice from the British Medical Association (BMA) in England (which represented New Zealand doctors), to determine how it would be implemented.

The medical profession rapidly emerged as a powerful stakeholder in the policy process. Doctors were, by 1935, amongst the highest paid professionals in the land. On average their salaries were equal only to those of the top civil servants at that time¹¹². Ninety-two percent of doctors were members of the BMA in New Zealand in 1927^{110 p.360} and were at the time organised into regional and provincial Divisions, each with its own executive and standing committee. Business was 'conducted in a painstakingly democratic way, and only in very difficult situations is any Committee of Council given authority to act without approval of the Divisions'¹⁰⁷.

With Labour's election in 1935, and faced with a proposal for a universal capitated tax-payer funded free health care system, doctors resolved to oppose this on a variety of grounds. The profession's objections were primarily directed at the universal character of the scheme and the payment method of capitation. Arguments recorded in Lovell-Smith's history of the dispute¹⁰⁷ included:

- that it was unnecessary to introduce financial support except to the poorest patients

- curative treatment services were operating successfully throughout New Zealand at the time. The greater need was for public health and preventive services and the state should concentrate its effort and resource upon this area of need
- free treatment would result in over use of services by patients
- capitated funding arrangements would place fiscal risk unfairly with doctors
- capitation may encourage doctors to enrol and then under-serve large patient lists
- fear of state control of medical practice and socialized medicine.

Instead, the profession's negotiators, led by Dr Jamieson, proposed a tiered system of benefits, ensuring that the poor who had previously received free treatment at the discretion of the profession could in future be funded by the state, with successively reducing state subsidies of the costs of those patients of better means. Hanson ¹¹¹ considers that the profession was opposed to the scheme not only on economic grounds but from an 'inherent and deep conservatism' and fear of state control of their work. She quotes the leader of negotiations, Dr Jamieson, in his letter to the Minister for Health, Peter Fraser, in 1938: 'We regard with no less apprehension the inevitable danger of infringement of the liberties of the profession as a body...Under the universal system suggested, the tendency would be for the activities of the professional organisations to be merged in greater or lesser degree in the bureaucratic control of the State.'

There were other mechanisms at work too. Fougere contends that the profession had a less hierarchical structure in New Zealand than in England at that time. In New Zealand 'the division of labour within medicine could not and did not advance very far' ^{117 p.79}. Leaders of the profession were more likely to be general practitioners with additional training or specialist practitioners. For instance, three quarters of the Committee selected to negotiate with the government about general practice services were specialist practitioners (general practitioners who also had a specialism in an area of medicine). There were clear interests for specialists on the committee in sustaining their particularly lucrative practice with wealthy patients. This explains to some extent the negotiators' determination to retain fee-for-service and the right to charge a co-payment as part of the policy framework for the new national health service. However, this structural feature did mean that the profession was

unified in a way not seen in England where specialists had separate streams of representation to government. In England, ministers were able to exploit the different interests between these two tiers of medicine, whereas in New Zealand a remarkable degree of unity and unanimity persisted amongst the profession for the long years of dispute with the government, eventually bringing a significant victory by changing the method of payment originally proposed and allowing the right to charge patients additional payments.

The Social Security Bill in early 1938 set out very high level promises for free health care for all and generous remuneration to doctors, based on capitation, not salaried service. Though it was designed by a medical colleague, Dr McMillan, a Labour Member of Parliament, 828 of 913 doctors opposed the proposed legislation. In particular they objected to its universality in a referendum conducted by the BMA (there were 945 doctors in the country at the time). The proposed legislation was publicly announced and formed the basis of the health manifesto for Labour in the general election it faced that year. Labour was re-elected, its share of the vote increasing to 56%. The government implemented the Act in April 1939 regardless of the overwhelming opposition of doctors. The Prime Minister, Michael Savage, was particularly determined to achieve free health care for all, died in 1940. His Minister of Health, Peter Fraser, was known for greater readiness to compromise. Following protracted negotiation, the general practice service provision initially provided, in 1941, for a contract for patients to present to their doctor whereby the doctor could charge his costs to the new Social Security Fund (into which citizens had been contributing a share of their tax payments since 1938). It was based upon a generous capitated payment and allowances for travel and other procedures. The proposed legislation was confined to payment arrangements and made no attempt to limit clinical freedom, making contracts voluntary. General practitioners overwhelmingly boycotted the offers of government contracts for their services and continued to charge patients in full for their services.

By then widespread Friendly Society enrolment by citizens seeking affordable health care had ceased and income for general practitioners, which had been primarily guaranteed by Friendly Society income and rapidly rising, dropped sharply by 1941^{110 p.180} as a result. Patients began sending their invoices for treatment to the government. Faced with declining support and a further election in 1941, the government tabled a further Bill offering, this

time, a very generous fee-for-service payment arrangement, but prohibiting co-payments and effectively making the new arrangements compulsory. This was passed without the support of the BMA. Patients could then claim a refund of their fees from the Ministry. Some doctors commenced the practice of receiving 'token' payments from patients in addition to their basic fee, which was of dubious legality, but endorsed by the Ministry. Incomes soared again, surpassing those of specialists^{107 p.156}. However, the profession had lost its unity on the issue of payment processes and a proliferation of methods of payment existed.

Finally in 1949, following a review of the operation of the service, and shortly before the Labour government faced yet another election, legislation was enacted to settle upon the mechanism of a direct fee-for-service claim on the Social Security Fund by the doctor and the provisions prohibiting co-payments were repealed. This was 'a victory for the medical profession and demonstrated the strength of its bargaining power...[and] effectively sounded the death knell of the free general practitioner service aimed at and legislated for in 1938'^{111 p.124-5}. The implementation of the Social Security Act which established New Zealand's national health system in 1938 resulted in the state's responsibility being 'tempered by compromises between the government of the day and an organised and assertive medical profession'^{34 p.227}.

An historical institutionalist analysis

These two historical episodes can be seen to add support for Immergut's historical institutionalist thesis¹¹⁸ that medical influence can be weakened (or enhanced) by veto points in political systems. Looking at the establishment period of these two national health systems commencing in 1935 and 1945 respectively, in a comparative analysis, the dependent variable can be taken as the resulting ownership and governance arrangements for general practice in each country at the end of that period in 1949. Many independent variables driving policy change at the time can be said to be held constant in these two episodes. These include institutional drivers (the similar political systems and electoral dynamics associated with popular and successful parties representing working people), network factors (the resources and beliefs of the medical interest group, the BMA, in both

countries), ideas (especially the powerful policy ideas expressed in the manifestos of the political parties for social welfare reform and free health care, which captured the support of the electorate in both countries) and the similar socio-economic circumstances supporting social reconstruction, which accompanied the end of a major depression in New Zealand and the war in England.

In both countries, legislation was achieved quickly, sweeping the policy into adoption on the basis of widespread public support despite misgivings of the medical profession. This legislation was implemented successfully in England though the medical profession retained considerable clinical autonomy in their role within the NHS. But the New Zealand administration encountered continuing opposition to the implementation of the legislation by general practitioners. Although some provisions of the legislation were successfully implemented, the intent to implement the core policy of free general practice services failed as a result not only of the sustained boycott of contracts by general practitioners but also the pressure of successive elections (every three years) between 1938 and 1949. In particular, the different electoral prospects faced by the administration in 1941 and 1949 can be seen to be key 'veto points' which then placed pressure on the government to make a series of compromises. Faced with declining political support and needing to resolve concerns about its flagship health policy quickly in 1949, it can be seen that the Labour Party's threat of electoral defeat was at least as significant a driver as the prolonged medical campaign of resistance to the outlawing of co-payments, and drove the series of legislative compromises which resulted in the dual ownership and governance arrangements for general practice in New Zealand. Over time, these would lead to the fundamentally different policy problems and options for policymaking which faced the two countries in the modern case studies.

Summary

This chapter and the preceding chapter have set out

- explanatory models for analyzing policy making and change
- a comparative approach

- an analysis of similarities and differences in the health systems and their public management approach in the two countries
- a comparison of the history of the two countries establishment of their health systems and health system reform efforts of both countries in the 1980s and 1990s

In the chapters which follow, the methodology for the research will be set out, then the process of design of each pay-for-performance policy will be described: who was involved, what was done, how it was done and how the results were implemented. Each case study will be tested against Kingdon's MS Framework for public policymaking. Then an analysis of the fit between the evidence and the theoretical models and explanations will be set out.

CHAPTER FOUR

METHODOLOGY

Introduction

In this Chapter the research methods used to undertake this study are described. The processes for management of risks and ensuring rigour are set out.

Subject selection

My curiosity about early reports of the pay-for-performance scheme introduced in England in 2004 led me to the subject of my research. As I investigated the development of the two pay-for-performance schemes, I became particularly interested in assessing how these two cases, on the face of it, seemed to defy well-documented theory that if government policy-makers involved interest groups such as the medical profession in policy development, their work would achieve little meaningful change despite protracted periods of negotiation^{58 59}.

Case study approach

Stake¹¹⁹ sets out three types of case study: the intrinsic case study, chosen for an interest in the particular case; the instrumental case study, chosen because it can provide insight into an issue or redraw a generalisation; and the collective case study, an instrumental study extended to several cases, which are chosen because analysing them will lead to better understanding and perhaps better theorization about a large number of cases. I chose the collective case study approach because there were two well-matched cases available for study which, through comparative analysis, I expected would lead to better understanding of pay-for-performance policymaking.

The comparative analysis undertaken required a process of 'pattern matching' of independent and dependent variables to seek 'literal' replication (the same result in each case) or 'theoretical replication', where contrasting results are achieved for predictable reasons, that is if the same result failed to occur in a second case, due to predictably

different circumstances^{65 p.140}. The pattern matching technique used to demonstrate results was that of rival explanation (or pattern matching for independent variables). In this approach, alternative reasons for the results are sought and the analysis is required to demonstrate which reason predicts the outcome most accurately.

Explanation-building in a multiple-case study seeks to build a general explanation that fits all cases although the cases themselves will vary in their details. This research used an iterative process of explanation building. The study of the English case was undertaken first and revealed the importance of statements or propositions which were then tested against other details in that case (the relative importance of central frameworks for quality and service standards for instance), then against the New Zealand case study. Entertaining plausible or rival explanations and showing how they cannot be supported is an objective of this approach. Castles describes explanation-building as a process whereby 'If we can locate some particular feature in which otherwise very similar nations differ, we are entitled to suggest that it is attributable to one of the few other factors distinguishing them'^{62 p.5}. It is then possible to develop an explanation – a set of reasons or a theory which makes sense of empirically-observed regularities, that is, the similarities or differences revealed. The process of comparison provides a logic by which empirical generalisations which require theoretical examination can be isolated. In choosing the cases, an 'ideal-typical method' has been chosen with a 'most-similar' case for detailed comparison^{36 p.18}.

Sampling

The unit of analysis I chose was the process of policy design of the pay-for-performance component of primary health care policy changes in each country. By this I mean the processes of agenda-setting and alternative selection leading to policy formulation and authoritative decision^{51 p.2-3}. This was a time-limited period of three years in England and five years in New Zealand. However, I also considered evidence relating to the subsequent implementation phase for each policy, the ten-year preceding period of health policy making and the developments relating to each pay-for-performance policy as they occurred over the subsequent period to 2014. This enabled me to utilise information from evaluations of the effects of the two schemes which were published during that period and also to reflect on subsequent changes to the schemes which were made during that period.

I made a deliberate or purposeful rather than random choice of the pay-for-performance policymaking to be studied in order to ensure the maximum theoretical value for the cases studied. Purposeful sampling of information-rich cases was chosen to give the maximum opportunity to study processes, relationships and systems. I felt that depth of understanding through study of two cases would answer more questions than breadth of enquiry. The risks of such an approach, such as a difficulty in ability to generalize from the cases across time and space, and the risk of selection errors, were identified, but I have chosen to trade these for the greater potential for new knowledge to be uncovered from detailed study of both cases. The thickness of description gained for both contexts would, it was hoped, allow readers to make reasoned judgement about the degree of transferability of the findings of these case studies.

In selecting my sample, I had prior knowledge of the nature of variation in policymaking in England and New Zealand from my reading of reports of these two pay-for-performance schemes. I then undertook some parallel literature review and informal discussion with key agents involved in both case studies at an early point in my preparation of this research proposal and identified a range of possible avenues for further study. As set out above, there are risks in this sampling strategy and there needs to be great care to ensure fit between two different contexts (or generalizability). Institutions and policies may seem similar but differences, such as in the system of resourcing and remuneration, may mean their power or significance vary. However, by clearly describing each system I expect to allow readers to be able to assess the comparability of the two cases and to make their own judgements about the degree of fit between the two cases or contexts. Notwithstanding the risk, transferability of findings, which is the hoped for outcome of basic research, depends on comparison and validation from multiple cases.

Logical/scientific paradigm

Having defined what the study is about, the epistemological paradigm I used is a logical/scientific one which sees truth as demonstrable and confirmable through experiment or quasi-experiment. This is the way I acquire knowledge, however it is also the preferred paradigm for the end-users of this research, namely policymakers and the medical

profession. The comparative method employed for the analysis of the qualitative and other data collected for this research within its discipline of social science is well matched with and closely resembles the methodological processes employed within the natural sciences³², enabling rigorous analysis of the qualitative data collected, including perceptions and insights of actors, their behavior, beliefs, values and intentions.

The importance of the data from interviews with actors and the behaviour of individual actors, their beliefs, values and intentions for this research is unquestionable and forms much of the evidence collected. In this instance, to answer the questions which will arise in this study I needed to explore how decisions were made and this involved qualitative research to document actors' perceptions and motivations. Much of the data gathered was subjective, non-quantifiable information:

'Talking to actors and undertaking surveys of key stakeholders...may be the only ways to gather information on the political interests and resources of relevant actors or to gather historical and contextual information'^{55 p.196}.

Qualitative approach

Although the primary data collected and analysed in this research was qualitative, several additional data sources, including documentary evidence, media reports, commentary on and evaluations of the two schemes, information from informants and historical analyses were utilized to strengthen the rigour of the research. Qualitative methodology is better able to capture the perceptions and intentions of participants and to document processes and power relationships between the government policy-makers and the medical profession. It also utilises techniques which allow the researcher to stay open to information arising during the course of the research and to shape its direction. It offered the opportunity for an emergent design which remained flexible even though broad contingencies were planned for, once data collection had started. This is important because although I developed some working hypotheses as the foundation of initial data collection, it was only once the field work commenced that findings and leads began to offer meaning,

and shape the direction of further enquiry. A key limitation of interview data is that they concern what people say not what they actually do or necessarily think. However, I took the approach where possible to strengthen the reliability of the qualitative method by using techniques such as careful recording of interview material and full transcription and constant data triangulation. This involved cross-checking key information from one informant against that from another and checking back with some informants to confirm recorded information (or cross-examination and respondent validation) throughout the period of study.

Rigour and risks

My standard for judging utility of the research is similar to that of the traditional scientific school of research which espouses rigour, validity, reliability and the ability to generalise findings to similar contexts as the core tests of quality ^{120p.104}. There are, however, equivalent tests of the credibility of research or unique tests of rigour which have come to be accepted for qualitative and naturalistic enquiry. Guba and Lincoln ^{120 pp.103-4} set out four tests of rigour for qualitative research: truth value (confidence in the findings); applicability (degree to which one set of findings has applicability in other contexts/other subjects); consistency (would the findings be repeated/is the study design replicable?) and neutrality (are findings independent of bias, motives of the inquirer?) ^{120 p.103-4}. I will take each of these in turn and explain how the research design was constructed to meet these tests.

Truth value

This is essentially demonstrating credibility by minimizing invalidating factors in research design. These include the distortions which may arise through the presence of the researcher in the field work (which may evoke reactive responses from participants) and losing objectivity as a researcher in the field. They also include the presence of bias in either participants or the researcher or simply sloppy data collection. The primary technique I used for managing these risks was structural corroboration, involving triangulation (or use of multiple data sources or measurement processes) and cross-examination (which exposes

the frame of reference or bias in a participant's commentary). I also used techniques for managing elite interviews⁷, drawing on the literature, including Dexter and Fontana, for advice. Having taken these steps, I then tested the credibility of the resulting data and interpretations with the sources to seek their views (member checking). Having taken these steps, I then tested the credibility of the resulting data and interpretations with the sources to seek their views. This involved providing all participants with a copy of the draft description of the policymaking process about which they had been interviewed and seeking confirmation of the accuracy of their recorded contribution and any other comment which they wished to make about accuracy. In the view of Guba and Lincoln, having taken these steps to ensure credibility of data and interpretation, a naturalistic method of enquiry is 'no more open to threats of internal validity than scientific inquiry and perhaps less so'^{120 p.114}.

Applicability

This is defined as confidence that the findings in the research can be equally well applied to another similar setting. The primary foundation of applicability is a high level of internal validity. Having attained this, Guba and Lincoln recommend that the researcher strives for a degree of fit between the context and its working hypothesis and the next context to which the hypothesis is to be applied. I have therefore taken great care to set out the similarities and differences in context, process and outcomes in the two case studies to allow the reader to assess this internal validity for themselves. I have provided the 'thick description' of the naturalistic case study approach so that both contexts can be intimately understood and the degree of compatibility, and thus generalisability, between them assessed by the reader^{120 p.327}.

Consistency

This is the question of replicability, a much more difficult test for naturalistic research to meet. Guba and Lincoln comment that a first principle must be the demonstration of

⁷ I drew on the literature including Dexter, L.A (1997) *Elite and Specialised Interviewing*, Northwestern University Press and Fontana, A and Frey, J (2005) *The Interview in Denzin, N.K and Lincoln, Y The Sage Handbook of Qualitative Research* London Sage

internal validity of the research, however, they also suggest that ‘overlap methods’ (or comparable results from two or more different approaches) may bolster the case for consistency. They also recommend audit of the data and findings by an independent party^{120 p.121}. I made my data and findings available for supervisors to scrutinize in a process of audit to achieve consistency.

Neutrality

Also called ‘objectivity’, it is as difficult a test for scientific as for naturalistic study to meet. No researcher can avoid the subjectivity of his or her approach, as it is his or her individualised approach to the research problem. Provided that the data are factual and confirmable, the responsibility lies with the researcher to ensure that their subjectivity is managed professionally. In considering how to meet this test through my research design I must first of all acknowledge that I am, as the researcher, interviewer and analyst, the key instrument in this research design. It is essential to understand and expose how my own preoccupations, values, existing knowledge and circumstances might influence the process of research and even the findings. It is inevitable that I have had an effect on the subject of my research, primarily through exercising my judgement skills. This is no less a risk for me had I chosen a quantitative approach, though measurement-based analytical techniques are more readily replicable than judgement-based ones. However, I expect my skill, competence and the rigour of the research processes I utilised in this study (their truth value) to be subject to intensely critical review by my peers, especially my supervisors.

Although the focus of my study led me to the choice of qualitative methodological techniques as the primary data gathering strategy, there was a quantitative dimension to the research. Prior to the commencement of interviews I had access to analysis of quantitative evidence set out in the growing evaluative literature on the English pay-for-performance scheme in particular.

The analysis of quantitative data provided a valuable objective measure of the achievements and outcomes of each scheme. New evaluation reports were being published regularly throughout the research and these were closely analysed so that an overview of the achievements and outcomes of each scheme was drawn.

Documentary analysis

Detailed policy documents which described the operation of the Quality and Outcomes Framework and how it should be implemented were available to me from the date of their publication on the internet in 2003/4. Although I repeatedly sought access to policy papers generated by the English Department of Health and by evaluators of the negotiation process used for the General Medical Services contract, both by direct request to authors of the material and through the Freedom of Information Act, I was refused access to these documents. A body of material was made available by members of the negotiating team from the BMA, including PowerPoint presentations, which they used to describe their experience of the negotiations at conferences and tours. I had access to material generated by commentators on the Quality and Outcomes framework (and on the Performance Programme) for conference presentations in New Zealand. I also had material collected by the New Zealand General Practice Leaders Study Tour of England and Scotland in October 2006 which was undertaken to investigate the potential application of the Quality and Outcomes Framework in New Zealand. I obtained access to some media coverage of the impact of the Quality and Outcomes Framework in the English press during my annual visits to England between 2006 and 2012, though this was not a systematic process of media monitoring. I read the reports and took notes of issues and opinion which they contained, in general using this to give me background for the political context in which the results of the scheme were being debated.

In New Zealand I had ready access from 2007 to a variety of government documents not otherwise in the public realm. These included the report of the Referred Services Management Advisory Group from 2007 and the Cabinet paper of 2005 which recommended establishment of the Performance Programme (then called the Performance Management Programme) and background documents such as the reports of the University of Otago Wellington School of Medicine and Health Sciences on the review of the proposed performance indicators for Primary Health Organisations and the final set of recommended indicators of 2004 and 2005. Many documents in the public realm such as the Labour Party Manifesto on Health and the New Zealand Health Strategy and Primary Health Care Strategy publications were also readily available to me. Although there was little coverage of the

Performance Programme in the general media, it was covered regularly in the medical press and I monitored this coverage throughout the period from 2007 to 2010.

Reading and note-taking from this documentary material was undertaken between 2007 and 2009, prior to the conduct of the first interviews following Ethics approval in England and in New Zealand. However, I continued to collect and analyse documentary material relating to the two pay-for-performance schemes and primary health care policy in each country from published and grey literature sources from 2009 to 2014. Material derived from interviews was assessed in the light of the documentary evidence of the process of decision-making, where it was available.

Semi-structured interviews

I undertook in-depth interviews of the key participants or stakeholders in the decision-making and design process in each initiative, utilising a semi-structured, open-ended interview format. This interview technique allowed me to understand the participant's world as he or she saw it and their explanations for what happened and why it happened. The purpose of the study was explained in very neutral and open-ended terms as seeking to answer the question of 'how did the design and implementation of pay-for-performance schemes in England between 2001-3 [or New Zealand between 2001-6]...meet best practice standards of policy design and implementation and if not why not?' The underlying intention I stated was 'to test and verify theory of policy development and develop emergent themes and hypotheses.' I interviewed twelve people connected with the English scheme and fourteen people connected with the New Zealand scheme. I pursued lines of enquiry arising from these interviews through the programme of interviews until saturation of content occurred and nothing new about the key issues was being learned from successive interviews of subjects.

I invited all participants publicly identified by their managing organisations in the design of each scheme to be interviewed. My definition of participation was expressed as 'all persons with responsibility for negotiating the terms and conditions of the Quality and Outcomes Framework (or Performance Programme) on behalf of your organisation.' Where the names of those participants were not in the public domain I requested their managing organisation

to contact and seek agreement from them on my behalf to be interviewed by me. Where the response was positive the organisation provided me with contact details so I could proceed to communicate and make arrangements directly with them. Where participants were publicly identified I wrote directly to them seeking a one hour interview at their chosen venue. I sent out full documentation on the purposes of the research to each person I contacted, detailing possible risks and benefits to them, clear advice about what safeguards I could offer about confidentiality and security of information provided to me and a consent form making explicit their decision about being interviewed by me, being recorded during the interview, processes for using quotes from them and for vetting transcripts of the interview. An opportunity for withdrawal from the study was set out for each person, which could be exercised by them for any reason at any stage up to a given date. Participants whose names were in the public domain were identified by a review of the public documentary records about the design of the scheme, which in many cases sets out the list of participants in these schemes.

Areas identified for exploration with participants in the interviews were:

- their role in the process of policy design and/or implementation
- their perception of the approach taken by the participants to problem definition and problem solving
- their perception of the power dynamic within the process of design – who held it; how was it demonstrated; with what result
- their views about why this dynamic existed
- their perception of who benefitted from the process and why
- what issues caused agreement/disagreement and how was disagreement resolved?
- what pressures affected the process
- their views on how the process affected the result
- what the expectations/concerns of stakeholders about the outcome of the process were

- to what extent did the outcome reflect the expectations/concerns of different stakeholders?

I completed 11 audio-taped interviews and one non-audio-taped interview of participants in the English case study, eight of which were face-to-face and four of which were by telephone. The set of interviews was commenced during a visit to England in September 2009 when five interviews were completed. It continued with a further four interviews during a visit to England in March 2010 and again in March 2011 when three interviews were completed. I made immediate brief notes of my initial impressions of some of these interviews, documenting my major insights about the participant and their role in the policy design process. I then personally transcribed the audio tapes of the interviews shortly after their completion. All participants were offered the opportunity to review the transcripts and this was provided when requested. I completed 14 audio-taped interviews of participants in the New Zealand case study, 13 of which were face-to-face and one by telephone, completed between November 2010 and January 2014. I followed a similar process of capturing immediate impressions and fully transcribing the tapes shortly afterwards.

I used an ethical framework for the study that was strongly protective of the participant's confidentiality, submitting my research proposal to and receiving approval from both the Ethics Committee of Victoria University of Wellington in New Zealand and the National Research Ethics Service in the United Kingdom in 2009. Strategies to ensure reflexivity – self-questioning and self-understanding – were developed by me to support the credibility and transparency of my work. My strategies included extensive use of the language of participants wherever possible. Finally respondent validation, or checking the transcriptions with participants where they requested this, and going back to all participants to check information and interpretation, was used.

Analysis

The data for this research was contained primarily in the transcripts of 26 interviews. Initially each interview transcript was treated as a data set. This data was analysed through

repeated reading and note-taking of themes. This phase of the research delivered the greatest quantity of raw information, traversing matters of trivia to highly significant comments and was the most challenging analytical component of the research. As noted by Patton ⁶⁴, there are no formulas for determining significance and no straightforward tests can be applied for reliability. It is up to the researcher to use the full extent of their intellect to make sense of the data. I read and re-read the transcripts repeatedly and at many different stages of the research, checking for confirmation of interpretation over time and seeking new insights as new themes were uncovered.

The data corpus (or all data collected for a particular case study) was then collected and analysed separately in the first instance. This was undertaken using the process of thematic analysis or identifying, analysing and reporting patterns within the data ^{121 p.79}. I took a realist approach, reporting the experiences, meanings and the reality of participants ^{121 p.81}. I used my judgement to identify themes which were in the data and represented something in relation to the research questions. This was an inductive approach, which built upon themes I had anticipated finding from preliminary analysis of documents. I was looking for a patterned response at some level, including prevalence of themes and strength of themes, according to the role of the participant. Prevalence was judged by frequency of occurrence but there were some instances where a smaller number of participants may have commented upon a theme but deeply or insightfully. To facilitate pattern or theme analysis, a variety of techniques was used. Initially all participant responses were set out in a table to see if there were patterns of similarities and differences, particularly by role (such as 'doctor', or 'politician' or 'civil servant').

By way of an example, the data showed how general practitioners who were engaged in the policy design process saw their role and responsibility differently from that of other respondents, including how they characterized their personal obligations as participants in the process, to whom or what they owed their allegiance and how they reflected this in the nature of their engagement or their contribution to the process. Data which provides answers to these same questions was then similarly identified and coded for academic members of the policy communities, politicians and staff of the government departments engaged in the process.

An important feature of this process was seeking corroborative evidence from all participants for the presence and outcomes of key goals or intentions as expressed by politicians or other state actors. Added to this table was any corroborating evidence from documentary material such as media reports. This enabled comparison of individual and reported records of the process. Finally media commentary on the schemes was collected both from the period during which the negotiations occurred. Each case study was treated holistically and within its own context and justice done to that case before any attempt at case comparison was made. All data, including interview transcripts, documents, records and media reports has been assembled into a comprehensive case record.

In writing the narrative of each case study and as a mechanism to enhance authenticity I sought to create a rich thematic description of the entire data corpus for each case study, using the participants' own words, fully anonymised, and the actual data reported by them and quoting from reported and documentary material, rather than my own constructs for the information in the data. I tried self-consciously to 'get out of the way of the data' as much as possible. This not only assisted me in the evaluation of the evidence, but sets out detailed information for others to assess. Each case study reports in detail an under-researched area, namely health policymaking 'behind the scenes'.

In the next stage, however, that of case comparison, it was my task to compare the two narratives including their contextual, structural and historical considerations which aligned or set the two cases apart (such as electoral system; history of relations between government and medical profession; party political electoral promises; existing system for doctors remuneration etc.) A simple table of these considerations of similarities and differences is included in Chapter Nine.

Having set out what happened in each case as a narrative and compared the two cases, I then used the elements and sub-elements of Kingdon's MS Framework to display the evidence and to assess the extent to which the MS Framework explained and predicted details in each case study. Next I began a process of challenging the utility of the MS Framework and testing the utility of other literature on causes of policy change and variation. I chose the methodological approach to treat the policy outcome as the dependent variable and examine the effect on it of institutions, group structure and

resources, rational choices of actors, socio-economic issues and ideas in my analysis of the case study narratives.

I used analytic induction in a fluid process of moving between theory and data^{64 120} to test the accuracy and predictive validity of the theoretical frameworks and models of policy development and began to formulate new insights into the nature and efficacy of these models¹²². Using these frameworks, interpretation commenced and the process of extraction of meaning, especially as it illuminated aspects of my comparison of the two cases studied was completed. This was a process in which thematic analysis continued in a 'back and forth' mode, and in which reference to the literature became increasingly important. My expectations of the relevance of particular literature changed markedly during the process of thematic analysis and writing up, from one which was focused on Kingdon's MS Framework to one focused on historical institutionalist and rational choice explanations for the two policymaking outcomes. Where, through the research, information emerged which indicated the value of further data gathering or even consideration of the features of other pay-for-performance policymaking processes such as the need for further interviews or even inclusion of other policy design processes, I followed that lead.

This process of qualitative interpretation (elucidating meaning from the data or narrative through subjecting it to my own understanding and perspective) involved searching for causes, consequences and relationships, identifying which things appeared to lead to other things and which processes led to certain outcomes. Establishing cause was guided by the classic rules of temporal precedence (A precedes B); constant conjugation (when A always B) and contiguity of influence (a plausible mechanism links A and B). I clearly qualified these findings as my own tentative interpretation of these patterns in the case studies.

The findings from these phases were then subject to the test of substantive significance. Lacking statistical testing in this methodology, I needed to show that there is solid, coherent and consistent evidence to support any findings (this is where triangulation offers additional strength to findings) and that these findings increase and deepen understanding and are consistent with other knowledge in this field. My supervisors were a primary source of peer review for the validation of this phase of work.

Limitations

There are limitations which apply to this research. Firstly, the research largely reflects the interpretation of events by elites, leaders and entrepreneurs who participated in the policymaking process rather than the views of general practitioners who were not active participants in the policymaking process. Secondly, the events described by participants had taken place at least seven years prior to the interviews for this research so inevitably the passage of time affected the recall of these events by participants. This also gives some time for reflection from a distance.

Some participants who played key roles in the setting of the goals of the policymaking process declined to be interviewed for the case study of the Quality and Outcomes Framework and I was unable to obtain access to documentary evidence relevant to that case study despite making repeated formal requests for this. I was also unable to obtain working papers for the Referred Services Expert Advisory Group in New Zealand. In both cases these additional documentary sources would have enabled more accurate tracing of the minuted decision-making processes in each policymaking episode.

Participants shared with me their understanding of the goals, objectives and conduct of the policymaking process as they interpreted and experienced them. My own judgements about the relative importance of the information I collected added a further interpretive layer. The corroborative processes which I undertook, in particular by offering the opportunity to all participants to read and comment upon the Chapter which described the case study of policymaking in which they were participants were important safeguards against bias and partiality. This process was undertaken by the majority of participants and resulted in minor changes to the text in the description of both case studies.

Summary

In this Chapter the methodology for the conduct of this research has been described. The risks of this methodology and the strategies for managing these have been set out. In the next Chapter, the first case study of the design of the Quality and Outcomes Framework, in England is described, the barriers and enablers of the policymaking process are discussed and commentary of evaluators of the Quality and Outcomes Framework is presented.

Part Two

CHAPTER FIVE

ENGLAND: CONTEXT AND THE QUALITY AND OUTCOMES FRAMEWORK

Introduction

The first case study is set out in this chapter, beginning here with a picture of the context in which the English pay-for-performance policy initiative was commenced, followed by a description of the process of policymaking around pay-for-performance itself. This draws upon an analysis of documentary records, media reports and published commentary on the implementation of the Quality and Outcomes Framework (hereafter referred to as the QOF) and the transcripts of 12 semi-structured interviews with participants in and observers of the design process. Where participants' comments are included in the text, these are usually anonymous but are highlighted through the use of quotation marks. Where a participant has consented to have their comments attributed, names are used.

Next, a set of the major barriers and enablers which affected key goals of the policymaking process is set out as described by participants. These are drawn from clearly-patterned content from interview transcripts, such as their prevalence in records of interviews with participants or the strength and intensity of expression by a small number of participants, or because they were clearly identified with a particular type of participant or type of belief. Finally, the commentary of evaluators of the scheme is presented, providing an independent assessment of its successes and failures.

Background

In the years leading up to their election in 1997, the Labour Party in England set out health policy proposals to improve collaboration between the hospital and primary care sectors and to tie funding of services to best practice as validated by clinical audit (or 'getting patients a better service more quickly')^{123 p.148-9}. They also promised to change features

such as fund-holding that they perceived as encouraging a two-tier system of health care. Half the practices in England had become fund-holding practices (others not wishing to take up or being too small for this new form of local health purchasing arrangement) and these practices were able to obtain better services more quickly for their patients, unlike non-fund holding practices. Following election, the Labour government supported the introduction of new forms of primary care contracts, the Personal Medical Services contracts, established in legislation by the preceding government, which enabled doctors to develop a wider range of primary care services and to respond to local needs-based issues. Labour then implemented a number of primary care health policy initiatives designed to replace competition with collaboration and partnership. It established Primary Care Groups and then Primary Care Trusts. The Groups were general practitioner-led advisory bodies in the first instance, evolving to Trusts which both commissioned care and provided community services. They had a strong population-based and health-promotion-oriented purpose and a clear mandate to ensure good clinical governance of medical practice.

In the three years which followed, the focus of national health policy development was on a strongly centralised set of initiatives to improve standards, to reduce waiting times and to establish targets to reduce health inequalities. Tuohy^{23 p.39} characterises this period as one in which the purchaser/provider split introduced by the previous Conservative government became entrenched and in which the features of a single payer model, with the state as purchaser and auditor and in which providers have greater independence, were enhanced. In this process the role of general practitioners was strengthened in the health system as a whole as were the instruments of collective professional control of medical practice. Her assessment is that contracting rather than rule specification played a much greater role but the dominant role of the state remained little changed.

The NHS Plan 2000

In 2000 the Labour government published its second major policy plan for health services, the NHS Plan¹²⁴. This began the process for the introduction of a new national pay-for-performance programme for general practitioners contracted to the NHS as part of a new General Medical Services contract implemented in 2004. The new and somewhat narrower focus on choice which dominated the NHS Plan was enunciated by the Prime Minister, Rt.

Hon. Tony Blair, as ‘all about trying to introduce systems where the money spent was linked to performance and where the service user was in the driving seat’¹²⁵. New investment had been publicly and dramatically announced by the Prime Minister on 16 January 2000 in an interview on BBC Television’s *Breakfast with Frost*. In that interview he promised to bring expenditure on Britain’s NHS up to the European Union average of 8 per cent of GDP^{126 p.69} from the then levels of 5.7 per cent. However, as a *quid pro quo* for this huge new investment, the Prime Minister also set out five challenges: ‘partnerships, performance, professions, patient care and prevention’¹²⁷. Reforms would include ‘using incentives to kick-start the modernization...to increase the quality of health care and to see the customer driving progress throughout the NHS’^{126 p.44}.

The NHS Plan, while primarily focused on improving access through reducing waiting times and increasing resources and targets for improved service performance, also contained a commitment to reduce health inequalities. The newly elected Labour government had established a Minister for Public Health and commissioned a report on health inequalities. It had announced ‘that it would put reducing health inequalities at the heart of tackling the root causes of ill health to create a fairer society and to reduce the costs associated with ill health’¹²⁸.

The undertaking echoed the commitment in the Spending Review which preceded the publication of the NHS Plan in 2000, to narrow the gap between socio-economic groups and between the most deprived areas and the rest of the country^{128 p.5}. Both documents recognized the central role of primary care and in particular the general practitioner in the identification and management of risks of ill health which underpin differentials in life expectancy.

The Plan clearly shows that the concept of pay-for-performance was central to the policy strategy to improve the quality and effectiveness of primary care services in Britain. To implement the NHS Plan, ‘a complete redesign of the terms and conditions for working in the NHS was required’ according to the newly appointed Junior Minister who was put in charge of negotiation of the new General Medical Services contract at the time, John Hutton (afterwards referred to as the Junior Minister when quoted). The Personal Medical Services contract already provided a model of the type of contract which could be expanded

gradually to cover most general practitioners. This new form of contract paid general practitioners 'on the basis of meeting set quality standards and the particular local needs of their population' ^{124 p.75} and had the following benefits :

- Services could be developed for specific populations such as minority ethnic communities
- Doctors and nurses could be attracted to deprived areas
- Services to patients could be improved.

The benefits were exemplified using a case study of a Personal Medical Services contract in the high-need area of Pennywell, Sunderland, which had resulted in the establishment of a local primary care service offering 'minor operations, drop-in sessions, health promotion, asthma control and breast screening clinics' ^{124 p.76}. This type of contract and a new General Medical Services contract would be amalgamated into a single contractual framework.

A challenge to centralism

The Prime Minister acknowledged the continuity of effort of his reforms with those of the previous government 'breaking down centralized and monolithic structures, about focusing on the developing tastes of consumers, about ending old demarcations in professions...' ^{125 p.262}. Simon Stevens, the health policy adviser to the Prime Minister from 2001, described the method of implementing the reforms as a process of 'constructive discomfort' which was intended to put some pressure on the 'relationship between the British state and medical profession for most of the post war period, with the medical profession taking responsibility for the quality and allocation of publicly-funded care, in return for professional autonomy and the absence of intrusive state regulation' ². In his analysis he identifies three strategies which underpinned the process: providing support for providers, top-down imposition of standards and targets and applying countervailing pressure on providers from strategies such as competition between different suppliers. This set of strategies, where it impacted upon primary care, included enhanced patient choice of provider 'be they public, private or not-for-profit...Private diagnostics and primary care out

of hours services are next.’ It also included aligned provider incentives (‘GP’s new contracts will allow them to earn around a third more, linked to markers of quality’).

The NHS Plan of 2000 had been developed following close and extensive discussion between the Prime Minister, his Ministers and political and academic advisers during 1999 and 2000 ^{125 p.265}. The Plan was also informed by the work of five Modernisation Action Teams which brought together a wide range of clinicians, patients, members of the public, academics and voluntary sector participants in a new process of informing policymaking. The over-arching strategy for NHS reform which drove the Plan included a commitment to spend more money on health care by contrast with the ‘overly effective cost containment since 1948’ ^{2 p.37}. It reflected the need to narrow the gap between expectations of (primarily middle class) tax payers and health system performance (particularly on waiting times for treatment) so that they did not begin to ‘buy their way out and the NHS would spiral down to become a residualist safety net.’ There was recognition that if working conditions and support for health professionals were improved, they could be relied upon to ‘do the right thing’ by patients. Government, acting as proxy for consumers, would set targets and national standards for the quality and outcomes of health services, publicise these, and where necessary intervene to ensure performance improved.

The Prime Minister echoes these expectations for the new contract in his autobiography: ‘We were opening up all the contracts of the professionals for re-negotiation, breaching new ground with the private sector, changing the way the service worked to make it far more user friendly’ ^{125 p.282}. The Prime Minister wanted improved support for providers and plurality of supply. ‘GPs had a complete monopoly. Competition, even in the event of a hopeless service, was literally banned...Health care systems in which there was mixed public/private provision, or which at least demanded some individual commitment and gave some individual choice, did best...surely it must be possible to combine equity and efficiency’ ^{125 p.215, 319}.

The Prime Minister expressed his personal support for pay reform and provider incentives in several forums during 2000 and 2001. He was actively involved in the design of the NHS Plan, describing a period where he and the Secretary of State ‘settled back down to the detail of the NHS Plan. We were having scores of meetings on it, several a week...’ ^{125 p.282}. In

the NHS Plan published in July 2000 it was heralded with the words, 'There will be a big extension of quality based contracts for GPs in general and single-handed practices in particular' ¹²⁷. At his speech to the Labour Party Conference in 2001 the Prime Minister claimed that 'Without reform, more money and pay won't succeed' ^{126 p.69}. The strategy of pay-for-performance was therefore championed at the highest level of the core executive.

A new Executive team

A strongly motivated team of health ministers had been appointed who were determined to make a difference. The Secretary of State for Health appointed in 1999 was a 'modernizer' by contrast to his 'traditionalist' predecessor ¹⁰³ and was, in Blair's words 'fully simpatico with the direction of change' ^{125 p.264}. He is reported by a participant commenting on the set of contract negotiations as being 'hugely driven' to secure additional resources for health and to use these to drive through the vision for health set out in the NHS Plan.

According to a participant, the new team were said to share the belief that to some extent their first term in government had been wasted because of wariness about making substantial change. This team was seen as a high-performing, close-knit group of progressives in the Party, strongly led by the Secretary of State for Health.

Another participant comments: 'It was a time when the Secretary of State for Health was...a very command and control Minister with hands on. It was a time when there was a huge amount of strife in general practice, demands for pay rises, dissatisfaction, a lot of people unhappy with out-of-hours commitment, concerns about quality, managed care creeping over the horizon from the US, quality issues particularly at the lower end of general practice and the failure of the health authorities to performance manage general practitioners and a general mood they needed to.'

The Junior Minister, John Hutton, was a friend and shared 'Newcastle connections' with the Secretary of State ¹²⁹. It was the Junior Minister's task to manage the re-negotiation of three NHS contracts: the General Medical Services Contract, the Consultants Contract and the contract for other NHS staff (called the Agenda for Change). These contract negotiations were seen by him as a key part of the implementation of the NHS strategy as a whole. He reports that 'alongside the general practice negotiations the consultants' negotiations were

going on at the same time...it was very much part of this 'we want to work differently in the NHS' so we...had a complete redesign of the whole contractual terms and conditions for working in the NHS'.

The New General Medical Services contract

The story of the negotiation of the QOF of the new contract is set out below. The focus is on the negotiation of the QOF because this was the part of the contract negotiations which was based on practice-based pay-for-performance processes and is matched to the pay-for-performance component of the policy changes in New Zealand, the Performance Programme. There were many elements within the contract negotiations, such as the initiatives to simplify the funding arrangements for general practice, improve working conditions and recruitment for general practitioners, emphasise teamwork in primary health care, change out-of-hours service requirements and re-distribute core funding for practices according to health needs. These will be referred to where they provide context and insight into why and how the teams from the government side and the BMA negotiated the QOF. Who was involved, what they did and how they did it in the negotiations to establish the Framework will be set out.

The research for this case study has provided a rare opportunity to observe the micro policymaking process which resulted from this strategic policy initiative through the eyes of some of its participants. It is not common to obtain insight into such processes. Marsh, Richards and Smith contend that the culture of present-day policymaking in England is representative rather than participatory, reinforced by a political tradition which they suggest is 'elitist, secretive and closed' ^{100 p.28}, however, in this research, participants have openly shared their insights and their story.

Who was involved

A participant recalls the reaction from 10 Downing Street when, on a day in the middle of the 2001 election campaign, the BMA:

'chose...to give...an ultimatum that said if they didn't get a new GP contract they would contemplate downing tools and stopping serving NHS patients, resigning from

the NHS...[Downing Street] believed...given there was this independent system of pay review bodies that a substantial earnings uplift was legitimate and so one way or another [they would find themselves in a position where they] were likely to have to pay more for GP services. So then the question...was...to use this opportunity to pivot to a ‘something for something’ deal in which rather than simply seeing increased pay [it was possible to] get something in return for it. That was the intellectual genesis of the new contract and the QOF.’

And also that:

‘[The Prime Minister was] in the middle of the election campaign when the BMA put out their statement...and [with a small group of others, the Prime Minister] talked about it: [they] progressed the thought subsequently. Part of [the] thinking as well was that it would make sense to perhaps have more of an arms-length negotiation rather than it being direct between the BMA and the Department of Health and so [it was then] decided...that the negotiations would be fronted by the NHS Confederation - the Employers’ organisation.’

The NHS Confederation is a membership body for organisations that commission and provide NHS services.

The Government team

It was usual practice for Ministers and their departmental officials to conduct the negotiation of terms and conditions for NHS staff directly with the BMA. Although Ministers in this instance decided to out-source the actual negotiations to the NHS Confederation, this was not intended to contract out the decision-making. The BMA was not consulted about this departure from time-honoured practice. They were advised of the decision to use the Confederation as negotiators by the office of the Secretary of State for Health only hours before its announcement at the NHS Confederation Conference in July 2001.

One participant, John Chisholm, Chair of the BMA’s General Practitioners Committee, initially wondered if the decision to outsource the negotiations was, by depriving the BMA

of the direct bargaining relationship with Ministers, 'punishment for the insubordination' of the campaign run by the BMA for better working conditions during the 2001 election. Following the changes in relationships between unions and government during the 1990s, the BMA was one of the last trade unions to have continued access to the highest levels of government. The relationship between the medical profession and the state was one of mutual dependency, described by Klein as the 'politics of the double bed'¹⁰⁹, in which the profession ran the NHS and rationed its scarce resources but was entirely dependent upon the state, as a monopoly employer, for income and resources. The BMA would reasonably have feared that this special relationship was now over for them.

Ministers chose Mr Mike Farrar as the Chairman for the Confederation team of negotiators. Mike Farrar had a successful record in leadership roles in the Department of Health. As head of General Medical Services Primary Care division between 1994 and 2000, he had led much of the major change initiated by the new Labour government in its first term. The formation of Primary Care Groups and Primary Care Trusts were all implemented by his team. He had then returned to front line delivery of health services to take up the role of Chief Executive of a Strategic Health Authority. The Junior Minister thought of this new Chairman as someone who was very strong, experienced and had been in the Department for many years, knew primary care and was trusted for his basic judgement about how these contracts could be renegotiated and his judgement about the mood around the negotiating table.

John Chisholm reports that the BMA 'would have construed that as very good news because [Mike Farrar] was someone who was widely respected by Ministers, by civil servants, by managers and the profession...We got on well with [him] basically because of his palpable honesty really. He was a pleasure to do business with even when he was giving tough messages [and] would focus on the problems not the person.'

The Chairman's first task was to recruit a team and this was announced on 19 September 2001. Dr Tony Snell, a veteran of pay-for-performance in general practice who had led a scheme called the Primary Care Clinical Effectiveness (PRICCE) project in East Kent for over four years, was recruited. His East Kent Chief Executive recommended that he apply to join the team. Mike Farrar confirms:

‘[The team] knew of Dr Snell’s work – it was a factor in selecting him – he came through the process...When he [did] it was the nearest thing...operating to the...vision.’

Others were either well known to the Chairman or were Chief Executives of Primary Care Trusts. The Secretary of State’s goals for the contract had an impact on the selection of members of the Confederation negotiating team. Mike Farrar describes the strategy:

‘The idea was to use the Confederation as a membership organisation to recruit people who wanted to take part in the negotiation...There was a core group and an extended group of advisers...there were one or two people who I suggested should put their names forward, some from scratch, other people I worked with previously and I knew that [they] knew the inside out of primary care very well.’

Most participants felt this decision to outsource the negotiations was cosmetic in essence. The Junior Minister says:

‘I wasn’t in the detailed around-the-table discussions but you know I was practically in the room so this idea that it was at arm’s length...I think very few people saw that as reality. If ever there was a bump in the road they came to me. I was the ultimate court of appeal...the BMA knew the Confederation weren’t the politicians and they came to the politicians when they needed to unblock things, and so did Mike Farrar.’

A thorough and strict selection process included vetting for experience in negotiation by experts in negotiation skills development. These experts also delivered principle-based negotiation training to the team once selected. Dr Snell felt he had been vetted personally by the Secretary of State for Health, recalling being invited to meet with him and being challenged by him strongly on his attitudes to general practice before approving his role in the team. The members of the Confederation team were chosen because of their particular expertise across the range of skills which would be needed for the negotiation.

Participants commented that from the point of view of the BMA, use of the NHS Confederation as intermediary was a watershed in the way the government did business

with the BMA; John Chisholm said this was ‘because the NHS managers with whom [they] were negotiating had a very similar assessment of the problems and solutions...because of their experience of being front-line participants in the health service.’

One participant contended that the role of the Confederation as negotiators made it harder for the government to negotiate their way out of things because the Confederation team was seen as first and foremost health service people and the BMA considered that they were a new set of allies. There was risk of ‘cosiness’ of relationships between the Confederation and BMA during the process. Participants consider that civil servants and Ministers ‘had to stiffen the resolve’ of the negotiating team at times.

The BMA team

The BMA team was formed from members of its General Practitioners Committee, selected by that Committee, together with supporting staff and advisers. The BMA at the time represented 141,000 doctors in the United Kingdom and had and still has a highly democratic structure. The General Practitioners Committee represents the interests of doctors in general practice and acts for all NHS general practitioners whether or not they are members of the BMA. All doctors can vote in or stand for election to the General Practitioners Committee whether or not they are members of the BMA, although the majority on the committee must be members. The BMA and thus the General Practitioners Committee is recognized by the health departments in national negotiations for NHS general practitioners¹³⁰. It has sole bargaining rights for all NHS general practitioners.

The BMA team of doctors included those who had years of experience and training in industrial negotiation between them. The leader of the BMA team had been representing doctors since 1976. In addition, the team had a trade union negotiator and expert advisers including a lawyer, a health economist, a pension expert and actuary and an innovations expert. The team had a limited mandate and was described by a participant as ‘actually very weak in that they are regularly re-elected, their membership is capable of kicking them out...and they put their negotiated positions to votes of all the membership which effectively ties the hands of the negotiators.’ Another thought that tight controls were still kept on some negotiators (‘he was never allowed to attend a meeting alone because it was

feared he would compromise too readily. He had a huge amount of integrity, fairness and a strong value set'). This limited mandate was to place considerable pressure on the negotiators at a later stage of the negotiations and gave members of the BMA a powerful influence upon the course of the negotiations. This created tensions for negotiators. John Chisholm thought:

'It is certainly the case in medical politics that there is a tension between representation and leadership. [In a] representative role you have to bring forward the views of your colleagues as it is them you are representing. And it's them that you are trying to do things for. But also there are issues on which it is important to show leadership and to try to take people with you and to try to argue and persuade.'

Participants observed different approaches: for example some were observed to choose not to 'sell but to tell' without commending a particular proposal or seek to influence membership decisions. One participant suggests 'If you take somebody who has been to university for a bit and is medically qualified you assume they can judge for themselves ... you explain and it is up to them what they do with it.'

Maintaining the support of BMA members during the process was a challenge acknowledged by the Confederation team too. As a participant observed ruefully 'you are still stuck with the mandate-givers.' It was acknowledged by the Confederation team that the BMA negotiators did not have the same level of trust from their mandate-givers that was enjoyed by the Confederation team. At times it seemed to negotiators that a deal had been reached only to have the BMA come back and say their members would not live with it. Although in theory able to say that was the BMA's problem, both the Departmental staff and Confederation negotiators understood that this was hard for the BMA negotiators. There was a vociferous minority within the BMA membership who bitterly opposed the contract. There was an understanding of what would work and what would not work within the BMA - 'the politics of it' - in the Confederation team. Confederation team members went to lengths on one occasion to support the BMA negotiators in presenting the final framework for ratification to the representatives of Local Medical Committees of the BMA.

Papers were late and there was a risk that the debate and therefore the ratification could not go ahead. Mike Farrar recalls that 'I understood this risk and...went to the meeting of the Local Medical Committees and apologized for the Confederation team not having provided the documents on time and hoping that as a result they would not throw out the opportunity to consider and vote on this very important opportunity for a deal.'

Department of Health

In addition to the Confederation and BMA teams, the Departments of Health of England, Scotland, Wales and Northern Ireland appointed a representative each and the four officials had observer status at all meetings of the Plenary (or meeting of the whole negotiating team), although they were very active between meetings checking back with their political and Departmental chiefs about the progress of the discussions.

Representatives of each of the four national Departments of Health also sat at the negotiating table in the sub group of the team which developed the QOF (the Quality Sub Group). All commentators identified the tensions between these Departments of Health as being an ever-present feature in the negotiations. The English Department of Health in particular was seen to seek a more ambitious set of indicators than other stakeholders and to be lobbying for these behind the scenes but faced rejection when the proposed indicators were not for health conditions which met the key criteria of being a primary care intervention which was measurable and made an evidence-based difference to health status.

One participant suggests that even with the contracting-out of the negotiations, the contract 'would never have got...[agreed if it had just been] negotiating with the Department of Health for England...it was possible to put things through because there were four Departments' who could hold differing views. This participant also drew attention to the internal conflicts and debates about priorities between different sections within the English Department of Health which frequently delayed progress on the development of the QOF. In fact, the struggle over the inclusion of targets sought by Ministers resulted in a final version of the QOF which included indicators not supported by the Quality Sub Group but added at the behest of the Departments in the final Plenary sessions. Two indicators to track

practice performance in management of cancer patients exemplify this: to keep a register of all cancer patients and to track the percentage of patients with cancer whose support needs and coordination of treatment requirements are reviewed within six months of diagnosis.

The academic team

During the negotiations the decision was taken to recruit a team of academic advisers to offer independent expert evidence about suitable clinical indicators for the QOF. As advisers their role in the process was intended to establish rigorous standards to test each indicator for suitability. This was a position of considerable influence and as a result came under a critical spotlight. While not members of the teams, these academic advisers were a forceful presence. They evoked different reactions from the other parties. Universally seen as very important to the process, some were sometimes seen by participants as having a relationship which was described by one as 'rather cosy...a bit sub optimal', with the BMA. Some were thought to champion strongly a particular provision rather than neutrally mediating the debate between the parties. Their rigorous tests set high thresholds for governments trying to achieve changes in the framework. This is a pattern which will also be seen in the New Zealand case study where academic advisers were criticised for the time consuming and rigorous nature of their work. As these advisers held the responsibility to actually document the decisions of the Quality Sub Group relating to indicators they were seen to be in an especially powerful position by one participant. However, their role as interlocutors for the evidence-based process of decision-making clearly helped to mediate and submerge the overt interests of any particular party. Without them, it is unlikely that the scope and quantity of indicators which were eventually included in the QOF could have been agreed in such a relatively short time frame. This is more fully explored in the section 'Influence of antecedent policies' below.

General practitioners

Members of different teams had known one another for a number of years in some cases. Most of the participants in the direct negotiations over the QOF were medical professionals (7 of 11 members). Almost all were practising general practitioners for at least a small part of their working week even when the remainder of the week was spent as a medico-

politician or academic. There were connections between members of the team of academic advisers and many of the doctors on the teams through their shared professional backgrounds. With the exception of the politicians, Departmental officials and the Confederation Chair, this was indeed largely a policy design by general practitioners for general practitioners.

What was done

The government agenda

The Junior Minister held overall responsibility for the contract negotiations. He says that 'No. 10 just wanted a deal: a good deal—their top lines intact, this deal shifts more money into primary care and facilitates better work/life balance, addresses health inequalities between different parts of Britain and puts in place payment by results. They wanted all their top line messages and they got them.'

He says this included a need to:

'...shift more of the money into prevention, more public health [and] more resources to be paid to general practitioners on the back of results rather than just per capita. The other big thing we had to address was workforce-related issues ... The theory then was that there was a chronic workforce shortage in primary care that a more generous contract would begin to address. It wasn't just a question of resources – better outcomes, better pay and so on – there was also this work/life balance. Under the old contract a lot of the GPs felt they were being flogged to death almost.'

He recognised that the problems of recruitment and retention within general practice had a serious equity perspective and believed:

'We were chronically under-doctored in many parts of the country. We were also looking very much at this question of equity of provision in primary care. Over 50-60 years what had happened here as in other public health care systems, a lot of the resource had gravitated to the better-off areas. We never had a problem recruiting general practitioners in the home counties, the nicer parts of Britain. But we could

not find a way of getting general practitioners to work in those areas which had the greatest health needs because they couldn't make the sort of money and the work was harder.'

General practitioners fees and allowances regulations were described by Mike Farrar as set out in an 'old Red Book [which] was hugely complex...with massive amounts of money being spent without any sense of what we got back for it in terms of value, patient benefits, health outcomes, information. It was bureaucratic, often fraudulent, paid general practitioners to have high list sizes and promoted entirely reactive general medical care.' This meant that a major transformation was required to meet Ministers' expectations, as shared with Mike Farrar, of a 'move from rewarding inputs to rewarding quality [and] to pay for outcomes rather than paying for time.'

The Junior Minister strongly identified with elements of an agenda for resolving access and quality concerns in the under-doctored areas of Britain. Inequity of health service access and health outcomes were a feature of his constituency in the North West of England. A participant confirms that he saw the Junior Minister as seeking to achieve a 'culture change so the system worked more for patients and less for clinicians in areas such as access times, reflections of patients' expectations in general practice and so on.'

The expectations of No. 10 were, according to a participant, 'what would be the most help to the public to get out of these changes in working relationships? What is wrong at the moment, what needs to be fixed?' Ultimately the outcome of the negotiations can be seen to present a set of clear priorities of No. 10 for responsive services as well as improvements in equity of access and outcomes.

This keenness for responsiveness, to be achieved through increased patient choice, explains the top priority given to negotiating the removal of out-of-hours care from the contract and the transfer of the responsibility for its delivery to Primary Care Trusts (hereafter referred to as PCTs) in England which would need to source it from other private or non-profit providers. This achieved two goals – the top-line requirement of the BMA for improved working conditions for doctors, as they could opt out of the delivery of out of hours care,

and the goal of introducing competition into primary care services through the contracting of these and other services to new entrants to the primary care market.

The priorities for No.10 were seen by participants as linked to the concern to preserve electoral support for a tax-payer funded universal health service. There was a view that the service was 'undersupplying appropriate care, causing long waits for routine surgeries' (Stevens 2004:37) and inviting increasing adverse media commentary which compared the NHS negatively with allegedly better health services available in continental Europe. This gave the government a 'mandate to act as a proxy for the consumer using four powerful new hierarchical levers mostly absent from the previous Conservative government's 1991 health reforms': national standards and targets, inspection and regulation, published performance information and direct intervention in the event of poor performance^{2 p.40}.

The BMA agenda

The BMA wanted a new contract for general practice which would give them their share of the new health funding. Their campaign for a new contract was strongly reinforced by a survey of general practitioners which achieved a response rate of 55 percent. John Chisholm says:

'The national survey of general practice opinion ... in the autumn of 2001...was actually conducted by the Electoral Reform Society...The most obvious thing was that 97 percent of responding general practitioners said too much was being asked of general practitioners...with 28 percent of people contemplating a career change outside general practice...48 percent planning to retire below the age of 60 was evidence of the sort of things we had been saying in previous discussion with the Department of Health.'

Pension reform, the removal of the requirement for out-of-hours work and improved pay were bottom lines for the BMA. They readily agreed that a pay-for-performance mechanism could form a major part of a new contract. One participant believes 'that [the BMA] had agreed to move into this territory [of pay-for-performance] without much fuss because they thought they could shape it in a way that didn't require a major shift of focus for general

practitioners to new areas of work...they saw the contract as an opportunity to get out of work...they were much more interested in the quantum of the cash involved than the fine details of policy and looking to the next ten or fifteen years in public health outcomes.’ This view was not shared by BMA participants.

It was hard for the BMA to resist the strong expectations of the Secretary of State for Health about pay-for-performance. A participant saw him as insistent that ‘there would be no pay rise for work already being done.’ He had a ‘bloody-minded determination for performance pay.’ Others describe the goal as ‘something for something’, meaning to make a significant part of the payment to doctors contingent on quality targets being achieved. It was not easy to negotiate with the Secretary of State. He was also determined to maximize the size of the pay increase which would be attached to quality targets. This created the anxiety that doctors would be seen as being over-paid. A participant thinks ‘the difficulty with [the Quality and Outcomes Framework] was the amount of money which went into [it] was too high. [That] fear has been proven.’

The Junior Minister was equally determined to deliver pay-for-performance but was seen by the participant to be ‘a charming, decent, reasonable man I could easily spend an evening having dinner with’ and ‘a man you could really trade with – not a push-over but a decent bloke.’

BMA leaders already had the idea of rewarding quality. John Chisholm says they thought:

‘There are still issues about unacceptable inequalities in public health terms, in health outcomes terms, but also in the quality of care for individuals and the new contract was part of trying to invest in primary care and also address inequalities in primary care.’

He also says that ‘the national survey (of general practitioners conducted for the BMA in 2001) would have given some comfort to the idea that actually general practitioners did want to see rules for quality...[the team] wouldn’t have been courageous enough to have galloped off in that direction without some kind of mandate.’ However, they would only agree to standards which reflected appropriate clinical performance, not political

imperatives. For instance, it was believed they would resist any access standards which did not have a basis in clinical care even though they might have been asked for by patients. Targets, if they were introduced, would need to be appropriately weighted.

Both parties sought a large scheme. On the government side it was believed that the success of pay-for-performance schemes like the Primary Care Clinical Effectiveness project (PRICCE) in East Kent had demonstrated the effectiveness of rewarding quality and justified a scheme with as many indicators as could be agreed. For the BMA, the larger the scheme, the more money was available to their members. A participant believed that the pre-eminent role for the BMA in its relationship with government would be placed under serious threat if they could not broker a popular and lucrative national deal for their members.

How it was done

Consensus-based

The Junior Minister knew that the Prime Minister also wanted a consensus-based agreement with the BMA. Together with the Secretary of State he kept the Prime Minister informed during the negotiations. He says that they:

‘had regular Health stock takes...Health was a big thing for the Prime Minister and he wanted to know what was going on, so at least 2 or 3 times [the Secretary of State] and I went to No. 10 to brief the PM on the progress with these negotiations and where things were going...yes for sure he wanted this deal, he wanted it and we wanted to be able to say we had reached agreement with the BMA ... it was an important political process to get right.’

The concept of partnership was central to Labour’s NHS Plan, and this is consistent with the belief expressed by Stevens that ‘health professionals want to, and generally will ‘do the right thing’ if properly funded and accorded freedom from external interference’^{2 p.38}.

However, relationships between the BMA and the government had deteriorated in the first term. The Prime Minister recalled that ‘in 1998 the BMA attacked us for the first time’^{125 p.215}. The BMA’s aggressive campaign and ballot for strike action against the government

during the 2001 election provoked the decision to distance Ministers from the negotiations for a new contract.

John Chisholm recalls 'There was I think considerable anger about the tactic and the timing of that ballot. I certainly remember on election night...about 11pm, about an hour after the polls had closed...hearing David Blunkett talking about the election campaign and railing against the BMA's interference.' Despite this provocation, this did not undermine the government's desire for a consensual approach to the negotiation of this contract. The Junior Minister describes how:

'The previous government tried and failed and then imposed an agreement on the BMA. I can quite understand why...[they] might have done that...I was very reluctant to get to that point. I wanted consensus, I wanted agreement that would stand the test of time. An imposed agreement never is going to last the test of time, not in our kind of society where people are in trade unions, there are negotiation processes, they want to be treated properly and respectfully and this is a very well developed vested interest group, the BMA, a very powerful group, so imposed agreement can never survive.'

One of the participants describes the flawed logic of imposed settlements: 'You could do lots of dreadful things...like in the 1990 contract and you could...change the contract without agreement but it ultimately didn't work. People would vote with their feet and those drivers eventually forced [government] to come back and negotiate.' However, the relationship between the BMA and the people heading up primary care in the Department of Health in England, who would usually lead such negotiations, was at the time 'completely broken down' according to Dr Snell. In his view the 'relationships between the BMA and the Department of Health are always up and down and it's about who shouts loudest and who can carry the media.'

Many participants agreed that there were problems in the working relationship between the Department of Health and the BMA. Partly this was due to the legacy of previous negotiations. The BMA's history of opposition to governments was feared and their campaign against Kenneth Clarke when he was Secretary of State in 1990, which was seen

as deeply damaging to the Conservative administration, was seen as a salutary lesson by the new Ministers. One participant believed that 'If you have got the general practitioners against you it was seen as a very difficult place to be.'

From the BMA's point of view, officials simply had not listened to evidence that there were serious problems of poor morale in general practice. There had been growing frustration arising from their attempts to present this agenda to the English Department of Health. John Chisholm says:

'There was a sense that the Department was not really wanting to engage with or acknowledge its understanding of the analysis of the BMA. There was a sense for quite a protracted period nothing very much was happening in negotiations. This was between the implementation of [Primary Care Groups] where there had been quite a lot of constructive engagement and really the start of the new contract negotiations.'

This led to the commissioning of the BMA's National Survey of GP Opinion which showed 82 per cent were experiencing excessive work-related stress.

The BMA did not completely trust senior officials in the Department to develop positive relationships with them. Neither did civil servants believe that Ministers entirely trusted them to deliver this new policy. Mike Farrar was seen as one of the few officials who had the trust of and credibility with Ministers. However, a participant close to Ministers confirmed that the decision to contract out the negotiation to the Confederation was less motivated by a lack of faith in the Department than to achieve a bargaining advantage by placing the negotiations at arm's length from the government, thereby defusing the potential for conflict between Ministers and the BMA.

The decision to outsource the negotiations, though successful in its aim to achieve a consensus-based result, later placed the government at some risk. The negotiating team, though pressed to deliver results quickly, had been given minimal infrastructure and financial analysis resources. The BMA team by contrast was very well-supported.

Influence of antecedent policies

The NHS Plan set out the broad framework and objectives for the contract negotiations. The Junior Minister was then trusted to get on with the process by his Secretary of State for Health. A participant observed the relationship between the Ministers as involving the Secretary setting out the vision of what he wanted and leaving it to the Junior Minister to get it done. The first thing to do, according to Mike Farrar, was ‘getting the mandate of...Ministers who said very high level things like moving from rewarding inputs to rewarding quality [and] to pay for outcomes rather than paying for time; a more simple structure (the old Red Book was hugely complex), less bureaucracy and build the issues around recruitment.’

The Secretary of State, who, with his and subsequently the Prime Minister’s health adviser, Simon Stevens, is credited with writing the NHS Plan ^{126 p.71}, was a strong virtual presence during the negotiations. He is referred to frequently in the interviews with participants and is generally portrayed as having a high degree of expectation for the negotiations and uncompromising views about what he would find acceptable. However, he was removed from the process of face-to-face negotiation. He met only occasionally with the Junior Minister and the Prime Minister on the issues during the period of negotiation.

The Junior Minister by contrast had a more visible presence in the process. He established clarity about the negotiating strategy for the team, described as ‘what was wanted, the top and bottom lines.’ This was achieved at an early point through his request for a session with the Chair, Departmental officials and academics from the National Primary Care Research and Development Centre in Manchester. This was a key moment in the design process according to one participant. ‘It established the framework, key issues, absolutes/desirables/not bothereds.’ It fully engaged the Junior Minister. He was given a huge pile of pre-reading by departmental officials who had themselves done much preparatory work for the negotiations. He chaired the meeting but the presentation of the subject matter and management of the debates over issues and strategies was reportedly driven by members of the government negotiating team.

For the negotiators, it was important that they understood exactly what the Junior Minister expected of the negotiations. Mike Farrar reports that he said to the Minister 'early on that if anyone puts a cigarette paper between you and me we are in real trouble. You need to have absolute confidence in me. In the negotiations I would say 'This is saleable to the Minister' (or 'not saleable') and that was in my mind absolutely the case.' The away day consolidated an important partnership between the Chair of the team and a Departmental official. Between them the key ideas and themes which would form the basis of a new contract were identified and driven through. As a result Mike Farrar had

'a clear understanding of what I wanted to do. It was a couple of days where we sat down and thought hard – a process of osmosis more than design – ...shared ideas and thought hard about some of the aspects we had got experience of...I still go by the philosophy that somebody somewhere would have a solution. Our starting point was what was going on in the NHS which had impressed...[that we could] build into this contract...in terms of the ideas and the real form for that, myself and one of the civil servants were probably the two most significant people in terms of the design.'

Several models of quality frameworks were considered. For instance, the Scottish Department of Health and BMA representatives suggested that the initiatives in Scotland (the Scottish Intercollegiate Guideline Network, practice accreditation and SPICE, the Scottish version of NICE) be presented to the team. This resulted in an invitation in 2002 to an academic expert who had during the years of the introduction of those initiatives been Chair of the Royal College of General Practice in Scotland, to attend a meeting to do so. This proved to be a critical turning point in the process and this person was then invited to head a team of academic advisers and to himself act as independent chair or Interlocutor of the design process within the Quality Sub Group. Along with a small team of academics he assisted the Quality Sub Group to agree on the interim framework of indicators for ratification by the membership of the BMA in 2003.

Another model of a quality framework was also considered by the Sub Group. PRICCE was a voluntary quality improvement scheme implemented in East Kent in England to improve chronic disease management in April 1998. People involved in PRICCE later became key to

the development of the QOF. PRICCE offered £3000 in advance to each enrolled general practitioner who could meet the entire set of targets for the clinical care of 13 chronic conditions as demonstrated by post payment audit verification. The money could be used for any purpose. The targets were based on standards developed from published clinical evidence of effectiveness and chosen by a local steering group including members of the Local Medical Committee and the East Kent Medical Audit Advisory Group. A lower set of standards was available for practices in deprived areas.

Practices had to enrol all their general practitioners and also had to upgrade information systems and show participation in audit. In a phased series of uptakes from 1998 nearly 60% of general practitioners were enrolled within two years. No data on pre-project levels of care were collected but the qualitative evaluation collected a rich body of information about the mechanics, strengths and weaknesses of the scheme. The evaluation of PRICCE reports:

‘the main motivation for doctors to take part...was to improve patient care. Many practices invested significantly more than the resources they were given. Key motivators for this were the alignment ... with the doctors’ own professional values and the autonomy given to health professionals in how they achieved the targets ... despite the considerable increase in workload required, involvement in PRICCE was associated with increased morale among primary care staff’^{101 p.3}.

Principle-based negotiation

When negotiations started with the BMA in the autumn of 2001, the benefits of careful preparation were clear. ‘The whole negotiations took nearly three years...but nonetheless the broad outlines of the contract were agreed within about six months in terms of moving towards a practice-based contract allocating resources on the basis of population need and incentivizing quality. Those features of the contract which were absolutely fundamental were agreed quite rapidly,’ reports John Chisholm.

The Confederation team had been through the same type of negotiation training which had for many years been the standard curriculum within the BMA, being principle-based negotiation. This training had been utilized by Confederation managers in the past and for

the BMA it was routine (for some it was the fourth training since first becoming a negotiator), however, for most of the Departmental representatives it was their first experience of these techniques and indeed their first experience of such negotiations. Participants from both sides attest to the difference this training made to the conduct of the negotiations. Mike Farrar says:

‘It was huge...previously with the BMA when neither side were properly trained...it was dreadful – there was banging of tables...they did not quite walk out but nearly. Training meant we took a break and parties regrouped. This was a simple technique but avoided much grandstanding. The great value was we went through the same training programme so used the common language, common techniques. It really was a big boost for us.’

John Chisholm describes principle-based negotiation as follows: ‘Positional bargaining is not quite forbidden but it is not the approach you should use...identifying your objectives, the other side’s objectives in relation to that particular issue, trying to understand their position, trying to decide how far you are prepared to move...in general you are supposed to come at a negotiating issue in an honest way.’

A government participant says: ‘We were trying to strengthen our hand, the way in which we approach the design of the thing was thinking strategically...how we could look at the overarching goals that united us then work through the framework as constructive and consultative as possible.’

A participant describes it thus:

‘It was very different from anything I had done before. It was quite formal. There was calling of time out, which I had not seen before. Sometimes this was quite helpful. I couldn’t always work out what was going on and it allowed us to discuss how to facilitate getting an outcome.’

One of the participants comments that the five Confederation team members, all either Primary Care Trust or Health Authority senior staff, were ‘people who knew how to trade, to

negotiate; they didn't pick these people out of thin air, but because they had the skills which you needed. Nobody could say they sent in some soft hearted pussy cat to negotiate with the BMA.' In the debates in the media after the completion of the negotiations there was much criticism of the weakness of the Confederation team, but participants denied that the BMA were 'genius negotiators dealing with children. No-one who met [some members of the Confederation team] could possibly have come to that conclusion' according to this participant. In fact, Mike Farrar was seen as having exceptional negotiation skills: the participant further comments 'If you look at good negotiators versus bad...[he] had most of those features in the quantities you expect: probing skills, revisiting skills, number of ideas per cubic metre, different ways of getting to yes, trade and bargain versus war and attack, use of humour...negotiation is not about victor and vanquished, it is about trading and coming to a wise agreement.'

There were a number of different levels within the negotiating structure for the contract which involved some people and not others. The Plenary group included some members of both the BMA and Confederation teams and the four Departmental representatives. Most of the work went on in sub-groups. The Plenary group received proposals from smaller working sub-groups, which often included supporting advisers, which were able to focus on the detail of particular issues such as workload and quality. One of these sub-groups was the Quality Sub Group. This held the primary responsibility for negotiating the clinical and quality framework with the two BMA leads on this element. As Mike Farrar describes it:

'Once we had decided we wanted a QOF framework and...put some principles around that, Dr Snell really ran off with the expert group and delivered the detail... they took it away and during the process of negotiation worked up the detail and came back to the main primary group for final agreement and sign off.'

Activities from all sub groups were referred to the six weekly Plenary meetings of the full negotiating teams of the Confederation and the BMA, again with all four Departmental observers present. These Plenary meetings made the final decisions for referral to Ministers. There were fortnightly meetings between a Departmental representative, the Minister and the Confederation team leader.

Participants from all sides of the process acknowledged Mike Farrar's role in facilitating this complex set of negotiations in an almost uniformly positive way. He describes some of these strategies:

'We worked hard and put effort into the social bit...we tried to get people together in the evenings. You can often get agreement in that context which you cannot do around a negotiating table. [Leaders on each side] spoke when...needed...and had a conversation [about] the level of investment right at the beginning – I had high trust at the outset about that...We got on incredibly well...we had the same negotiating skills and currency. We are both reasonable people. [BMA negotiators] did not have the same level of trust from [their] mandate givers...To help them with that I went to their meeting of representatives of Local Medical Committees and was there for three hours...answering any questions they had for me on one occasion.'

Implementation

The Framework could not be implemented without the design of a major new information-gathering software application suitable for installation in every general practice which came to be known as the Quality Management Advisory System ('QMAS'). Having designed an indicator, a participant describes how 'then we had to go on and work out how you would verify it. There was a whole raft of decisions and negotiations over the IT' as the participant recalls.

'You started with the criteria but then you moved on to what are the standards going to be and then what are the exclusion criteria going to be and how are you going to measure it and assess it and have somebody go out and have a look at it. What about the IT...how were you going to deal with confidentiality...there were people suggesting that the patient names should be open to the NHS and the NHS should come in and decide whether the criterion and standards had been met [in a practice]. It was out of that discussion that we had on the one side the practice-based system where you can look at the names and we can search to find which patients, and you have QMAS which can't.'

The data had to be extractable from the databases within general practice. This presented significant practical problems. There were many different suppliers of computer systems for general practice and a small number of practices not computerised. Departmental officials worked with the Connecting for Health IT team over 26 weeks to design a platform to extract the data. There was also the need to ensure that general practices could continue to retain ownership of their information technology but to use software compatible with the new system. Mike Farrar recalls 'These were potential show stoppers but in each case the BMA was persuaded to allow them to proceed because otherwise they would have lost the whole deal' and 'we just crashed through that.' In the event a 'high-trust' system for monitoring and reporting achievements against targets was introduced, along with a provision for independent audit, so that general practices could be funded for their achievements against the QOF.

By February 2003 Mike Farrar was able to write to the BMA Chair summarizing the details of the new contract and attaching the 68-page document 'Investing in General Practice – The New General Medical Services Contract' for his members to consider and vote on. A negotiator recalls 'at the end [the BMA] took it to [the membership] and there was a much more vigorous 'no' campaign [than during earlier membership ballots on the interim framework] but even then 70 percent supported it.' It was accepted in June 2003.

Practices were given a year to prepare for the new Framework. Participation in the Framework was voluntary. In England 99 percent of practices signed up immediately and within a year they were demonstrating an average achievement of 91.3 percent of the 1050 points available.

This section has described the background and context for the design of the QOF, who was involved, what was done and how it was done in the policymaking process, and implementation processes. The next section considers barriers and enablers of the policymaking process as they affected key goals of the process and as they were seen by participants and in evaluations and reviews of the scheme.

Barriers and enablers of the policymaking process

In this section the major barriers and enablers of the policymaking process are set out as described by participants. These were identified from interviews and documentary analysis and affected key goals which can be grouped under four main headings:

- Redistribution of general practice resources
- Balancing funder interests and clinical autonomy
- Shaping patterns of interaction between the state and interest groups
- Solving technical challenges (including choice of indicators, obtaining access to practice data and testing the model)

Redistribution of general practice resources

The pay-for-performance programme was one part of a wider strategy, set out in the NHS Plan, to achieve reductions in health outcome inequalities by increasing access to general practice services and incentivising best practice preventive health care. Achieving leverage for the overarching NHS Plan through the contract was a strong drive for Ministers and their advisers, who sought ‘a power shift to primary care’ according to one participant. Another participant says the focus was on deprived areas: he comments that Ministers ‘had the progressive passions that the poor were getting a very bad service – well that Britain was getting a poor service of which the poor were getting a disproportionately bad service...the drives, the passions for inequalities were...strong.’ A participant explains that ‘the small business model [of general practice] had still left large parts of the country that were often with high needs and a lower numbers of GPs per weighted head of population and poor outcomes...[so the opportunity] to use what would otherwise have been a blanket general practice income in an incentive structure to lever improvement was a strong pro-equity part of the motivation.’

To address these issues required not only the design of the pay-for-performance scheme but also improving the distribution of general practice funding and services according to health needs. In practice, these two goals sometimes affected one another adversely. In

England all NHS patients were registered 'on the list' of a general practice. An element of the contract, namely to replace a multitude of payments designated in the Red Book (the policy guide for payments under the existing General Medical Services contract) into a single and simpler global sum per practice was intended to support a more redistributive allocation of funding and to facilitate, as described by John Chisholm, 'considerable experiments in skill mix and the balance of the practice team between doctors, nurses, nurse practitioners, therapists, pharmacists and so on.'

Mike Farrar recalls developing:

'the idea...[to] wrap up all the things [being paid] in the allowances infrastructure into a single sum which was effectively a weighted capitation meant to recognize the people on the list and what kind of problems they had...[and] the global sum should fund the core business that everybody should deliver...and...this fantastic thing called QOF which effectively brought in about 30 per cent of their income as performance-related.'

In the process of the redesign of the new General Medical Services contract, the goal to redistribute funding was partially frustrated. The national formula for allocation of the global sum payments to practices was designed by an academic advisor, calculated according to practice list size and adjusted for the age and needs of the local population. It was applied to a global sum which had been reduced by 15 per cent by the Department of Health, without advising the negotiating teams, to provide for the payment dependent on achievement against the Framework. In addition the proposed allocations had been modelled on unrepresentative practice data and when presented to the membership of the BMA, in John Chisholm's words, 'there was an absolute bloody riot in the profession and in the General Practitioners Committee in response to that...and a series of demands for change in the detail of the contract.' For many practices their guaranteed income (without payments for quality achievements) would actually go down. This led to the creation of a 'Minimum Practice Income Guarantee' (this is also described in the section on Solving Technical Challenges). However, this is an indicator of the extent of the change which the new General Medical Services contract achieved.' The fact that a large proportion of pay is

dependent on assessing quality and outcomes has incentivised a rapid change that wouldn't have occurred if far less money had been dependent on the QOF,' says John Chisholm

The Junior Minister describes the moment when 'we hit this roadblock...about the distribution which again was a big disappointment for us because we were trying to be a little bit redistributive about where the money for primary care was...we wanted more of it to go to the under-doctored areas and the Minimum Practice Income Guarantee (MPIG) basically stopped it because there were too many losers.' The proposal to transfer money to under-doctored areas was stopped, in the view of the Junior Minister, when it was put to the membership, because 'a process where people had to vote for this deal – they are not going to vote for it: turkeys and Christmas – so we had to scale it back.'

It is on the public record that 'part of the reason for overspending on the Framework is that the department reallocated funding initially assigned to fund the Framework to the global sum (the per capita amount per practice which was not conditional upon performance), in order to fund the Minimum Practice Income Guarantee. It therefore revised its predictions of achievement under the QOF. Following implementation, however, Framework achievements exceeded those revised estimates. The overspend in the first three years was 9.4 percent more than provisioned' (Comptroller and Auditor General 2008).

Related to the equity issue were well documented workforce supply and distribution issues within general practice. A participant confirms that 'the GPs were getting assertive about their request for a new contract...against a backdrop of vacancies or they could demonstrate that it was harder to attract new doctors to go to general practice.' Another comments that 'it was terrible being in general practice in 2002. It was awful, it was haemorrhaging people and at the time the government cared: [Ministers were] worried that this could all go terribly wrong and [they] could lose general practice...we had to put something in place that restored morale and recruitment and if we could do something about implementing chronic disease management to a higher level that would also be very good.' John Chisholm describes the BMA survey which 'was pretty forceful evidence of disaffection, of poor morale.' A commentator confirms that 'much more fundamental [than better quality] was how could we increase the number of GPs because for the previous 10-15 years the number of GPs had hardly risen...and the government recognised that the GPs

‘did most of the work’ and we needed to have more general practice so the contract was about giving us more money to improve recruitment and retention.’

A key element of contract bargaining occurred, therefore, over the right to withdraw from provision of out of hours service and the appropriate sum to be deducted from practice income if the practice opted out of provision of that service. There was criticism of the price agreed for general practitioners to give up the provision of after-hours services. The goal was to find a price which was affordable and would enable the PCTs in England (and Primary Care Organisations in Scotland, Wales and Northern Ireland) to purchase new replacement services. It was, however, a valuable bargaining chip for the state which was negotiated early on and which was too generously traded away according to Dr Snell: ‘Unfortunately the Secretary of State gave away on virtually day one the commitment to have to do after hours and didn’t ask for anything in return, which rather created problems for the negotiating team.’ For Mike Farrar ‘this was pretty positional bargaining, haggling. We needed to make it attractive enough for general practitioners to opt out of after-hours care but also realistic for PCTs to re-provide these services.’ The Junior Minister concludes that ‘the loss of the Saturday surgeries [because of the after-hours settlement] was an error from our point of view.’

Notwithstanding this unforeseen consequence, politicians were determined to get improvements in organisational standards such as measuring patient satisfaction and access times for appointments through the contract. A participant reports ‘Ministers were trying to achieve not just a level of outcome but a culture change so the systems worked more for patients and less for clinicians.’ The focus on non-clinical indicators was a major area of discord and consequently a significant achievement for the Confederation team. They had the advantage that the Royal College of General Practitioners had already developed organisational standards and these formed the major part of the organisational standards in the Framework.

The BMA had mixed views on this: John Chisholm acknowledges:

‘something that [some of us] were very keen on...sadly got quite diluted in later revisions to the QOF; [to] make it quite routine that practices should ask their

patients what they thought of the services they were receiving I thought was a significant achievement.'

Balancing funder interests and clinical autonomy

The key funder interests which the new contract needed to reflect were public health goals, greater patient responsiveness and pay-for-performance approaches to quality improvement. The 'public health agenda was a 'must-have' for Ministers...[a public health issue such as] obesity was a close-fought issue,' according to one participant. Managing the risks of obesity was a cherished target for politicians but sceptically viewed by those charged with finding the evidence-based case for a general practice-based intervention. A participant describes the debates: 'They kept coming up with them...clinical issues like a focus on obesity, cancer, osteoporosis.' This debate included the academic team. The BMA considers that the obesity indicator was imposed on them by the Secretary of State. In their view, they and most of the participants were against inclusion, but they 'could be as against it as they liked', it was going to come in because the government was determined to have it. In the end one of the participants described the final indicator as 'this stupid thing we did which was merely to save government's face.' This is not to say that they could not identify interventions on obesity which were worth doing or that obesity is not important. But they felt that they did not meet the criteria for the QOF which is where a medical intervention delivered in a primary care setting makes a difference. A similar compromise occurred to meet ministerial expectations that there would be a cancer indicator, according to this participant. On the other hand, they felt that osteoporosis was kept out because the government didn't want to pay for it, whereas there was evidence to support an indicator being included in their view.

A commentator agrees that work on the NHS Plan showed how 'poor we were in clinical outcomes compared to other countries. And we were particularly poor in heart disease and cancer...the general issues of primary care not just general practice...the Department of Health's work in these areas around general practice was almost obsessively contractual...' Dr Snell confirms that 'there was a need and a demand to drive up quality particularly around the lower end, the poorer end of general practice and the health inequalities bit.' Another participant confirms that 'the Framework is great...it has helped push up in the

back half of the roughly normal distribution curve...got public health stuff in there up to a point (we are still quite light on the public health stuff)...the main focus was on some of the chronic disease areas...The real benefit from the QOF was the standardisation of the bottom half of the performance spectrum.'

The focus on non-clinical issues was also a major priority. This includes the emphasis on the patient experience and improved access.'Putting patients more in the centre of the process is a huge impact,' confirmed a participant. More generally there was a concern for people who would have difficulty getting to see their general practitioner or who would find that when they wanted to book an appointment they couldn't do so at a time that fitted with the working day. Mike Farrar's 'vision was a better coordinated service if PCTs were responsible. We thought we could get 50 per cent of the previous draw on GP time after hours triaged out by call handling telephonic advice. We felt that we should be using PCTs for multi-disciplinary after hours service...great as an idea, but I feel PCTs have failed to deliver and execute that vision...when they just rolled over contracts,' he said.

A commentator is clear about the conditionality of the agreement and use of 'this opportunity to pivot to a 'something for something' deal.' The concept of a conditional pay settlement was accepted by the BMA. For the Junior Minister, it was an intention for 'more resources to be paid to GPs on the back of results rather than just per capita. The principal defect was we were shovelling lots of cash into primary care but none of it was conditional – none of it depended on certain sorts of outcomes and that was just simply not a sustainable model...I was surprised that was conceded so quickly without any great fuss.' For another there was consistent reiteration of the need for 'something for something.'

This did, however, raise the issue of whether incentives would work too well according to another participant: 'there is ample evidence of a very strong behavioural response by health professionals including primary care doctors to financial incentives...you have got to calibrate them incredibly carefully and the best forum for doing that is probably not a high profile political negotiation between the medical profession and government.'

Shaping patterns of interaction between the state and interest groups

Several new patterns of interaction can be seen to be introduced into this negotiation over general practice terms and conditions in this case study: the new governance role for intermediate organisations, the PCT, as holder of the contract; the explicit consideration of the expectations of patients and their needs for access to general practice services; and principle-based negotiation as a pattern of interaction which was intended to encourage a sharing of goals rather than a contest for victory.

For the first time in the history of contract negotiations between the state and the BMA, this was 'a contract for primary care services between a commissioner and an organisation, the PCT,' with the intent to encourage 'chronic disease management locally' among other objectives, as well as a negotiation over terms and conditions of work for general practitioners. There was potential, through this new governance mechanism of PCTs, for 'the PCT provision side – the community hospitals, the community nurses, social care services' to be part of the effort to improve health outcomes. Reflecting on whether this opportunity was taken up by the PCT, a participant speaking in 2010 believes that the PCTs have 'failed to deliver on the GP side of it.' Primary Care Trusts were able to utilise new forms of contracts such as Alternative Providers of Medical Services (APMS) and Specialist Providers of Medical Services (SPMS) to attract new providers of services and encourage choice, competition and contestability within general practice services.

Another new challenge was how to deal with the different interests of the BMA and patients. This presented a challenge for Labour: the Junior Minister says 'you form a government and take responsibility for public services – when you think about the NHS we have this horrible habit of thinking just about the unions...you always have to think about the patients, the consumer. That's the discipline, it's a tough one – the Tories found it easier than [Labour] for the first few years.'

The extent of the change agenda which re-designed relationships between the state and interests groups in the three years prior to the contract negotiation was emphasised by Mike Farrar: 'We had major change, we created Primary Care Groups, PCTs, introduced Personal Medical Services as a concept, had a big change agenda.' This was the next step, to

‘move from rewarding inputs to rewarding quality, to pay for outcomes rather than paying for time, less bureaucracy and to build the issues of recruitment.’ Another participant believes that ‘the QOF achieved real systemic change not seen since the 90s. Putting patients back into the centre of the process is a huge impact.’ For another it was seen as a broader agenda of which this is merely a sub-part [to] ‘rip it up and start again.’

The changes which made the contract practice-based, with incentives for quality of care and patient-responsiveness, were accepted by all parties: government, civil service and the profession. John Chisholm believes that they recognised that ‘actually GPs do respond to incentives’, and another thought that there was evidence about the 1990 contract and its targets for immunisation and cervical cytology which showed that general practitioners delivered the targets rapidly. Some BMA members were excited about the practice-based nature of the new contract. John Chisholm said: ‘The great move is...the practice is given global allocation of resources which is to some extent linked to patient need...they are judged on the quality and outcomes of care...it was a very big cultural change that not all of general practice has yet adjusted to...fundamentally it is about improving public health and services to patients.’

The negotiation of the contract generally and the QOF in particular had a flavour of consensus and partnership. The Junior Minister ‘wanted consensus...wanted agreement that would stand the test of time...imposed agreement can never survive’ and believed ‘it was an important political process to get right.’ However, tactics were used to strengthen negotiating positions. For another participant part of the strategy was to put some apparent distance between the Minister and the BMA, or ‘a bit of daylight between [the BMA] and the ultimate decision-makers, the politicians’ which would reduce the political traction held by the BMA. Ministers were looking for an equivalent of the BMA negotiators’ position, where, when faced with a hard bargain, they could invoke the democratic process of ratification of their actions by special conferences of their membership (‘who constantly discipline them against making strategic trade-offs or ‘going soft’), and thereby to withhold agreement. This participant believed they ‘were working to find some equivalent...to be able to credibly claim that [the] negotiating mandate was constrained’

There were six meetings over six months in which the Quality Sub Group met formally but one says:

‘the rest of the time you were negotiating with the Departments of Health about what you were going to put in...you are primed, it is stylized. You are negotiating on behalf of the Department but you are saying what you have already negotiated that you CAN say...you would have a primary strategy dictated outside...but the negotiation on the day was a real one. You had to find ways out and you had to duck and weave in order to agree...[and] maybe phone someone who wasn’t in the room to see if you could continue.’

Participants report a clear sense of the competing interests of the BMA on the one hand to minimize the challenge of the new targets and of the politicians, through their Departmental officials, on the other hand to extend the targets to stretch general practice to improved levels of clinical quality. John Chisholm describes the process of negotiation: ‘In terms of the level of challenge, on many indicators the GPC would have been wanting a lower range and the NHS Confederation and the Department of Health would have been wanting a higher range. I don’t expect that occurred in relation to every indicator but that would have been the pattern. So to an extent you did find that there was a bit of positional bargaining however in general one was trying to avoid that. In general, people were starting off in different places and through negotiation and compromise they moved towards each other.’

Mike Farrar says ‘The BMA knew our intention over time was to make it stretchy and we knew they would make this hard.’ An official concurs, describing BMA representatives as saying ‘You can have that much quality or that much quality – have you got that much money or that much money?’ One example of this was heart failure. PRICCE was already using standards around heart failure management that were the latest evidence based ones, however, the BMA refused to support their inclusion in the Framework initially claiming that they were too progressive and too new. The standards have since been added to the QOF but this took over three years to achieve.

Another says:

‘They [the BMA] had some degree of acting as a union but they weren’t totally doing that, they were also interested in patient care and quality and doing what they could get away with and if it was going to be really hard it was going to be costly for someone which was fair enough. I don’t think any one group felt they had won. It was a good negotiation from that point of view.’

The Confederation team were seen by participants as being very keen to do a deal and ‘the Department of Health core civil service team and the political and Ministerial supervision constantly had to stiffen the resolve of the NHS employer negotiators.’ The Confederation team, however, had credibility with the BMA and inspired their trust. Another participant saw it as ‘an approach which says ‘how can we create the right framework to achieve what needs to be done?’ Putting in the Confederation was a strong signal from [Ministers] that they wanted this to work. They recognised the power and authority of GPs as the gateway to service so recognised they needed to have a level of compromise.’ It was an advantage to create a greater sense of employer ownership of the negotiations as the Primary Care Trusts would be the holders of the contracts for primary care services. They also saw it as a chance to divorce this administration from the actions of previous ones and, as another participant saw it, ‘deliver peace with general practice.’

Trust in the Confederation negotiators, based on their personal track record of achieving policy change and personal friendships, meant that the brief from Ministers was general rather than specific. One participant said ‘there was quite a detailed specification drawn up at the time of things [the Department of Health] would like to see in the contract but in the end Ministers said no, they knew [the Chair], they trusted him...it was a bit like having the Department do it but not do it.’ They believed that the Department’s role was to provide analytical support and ensure that political bottom lines were not traded away where they could. ‘We overspent, and we are in the position where it probably hasn’t been terribly flexible around change and it is not quite as well integrated with some of the other stuff going on as we would like to have but overall the evaluation work has been incredibly positive.’

BMA negotiators saw it as 'a watershed in the way the government does business with the BMA.' Dr Snell notes that that 'there was a huge amount of distrust between the BMA, the union and the government negotiators which is why externals were brought in...who didn't carry the baggage that the department had.' He thought that 'They...ran a very thorough and strict selection process for other members of the team...particularly around negotiating skills and experience...[negotiation trainers were] involved in the selection...did the selection and then did the training.' John Chisholm thought they also 'had very similar assessment of the problems and solutions...because of their experience of being front line participants in the health service. And the insights of [the Confederation members] were enormously useful in the negotiations...a testament to the negotiation teams being on the same page in respect of many of the issues that needed to be addressed.' Another said it was a different environment from 1990 – 'it was much calmer and partly that was the [government's] approach to engaging people before they did anything radical. They would propose reform then engage people in how you would do all the detail.'

The negotiation of the indicators in the Quality Sub Group had a flavour of shared purpose for all the parties. It should be noted that participants reported that this was not the flavour of the contemporaneous negotiations between the Department of Health and Consultants which sometimes occurred in adjacent rooms during the same period. These were reportedly stormy with much more adversarial behaviour sometimes observed.

Both parties incurred subsequent criticism for deals done in the negotiation. The BMA and its members were criticised in the media for a significant pay increase for less work. The Junior Minister thought that 'the sympathy the BMA took into the negotiations is no longer there...the pressure is...on the BMA and general practitioners to earn the public's trust again in the sense that they are worth the money.'

Public opinion was mobilised by both parties. When the BMA threatened to strike in the middle of an election campaign this heated up the atmosphere for the negotiations. However, the use of the press was a double-edged sword, exposing the provisions of the contract to public view. As another participant comments 'When I look back to the past and then look at how the GPs are now perceived I see that there is a high profile in the media and the question 'Why aren't they open when I need them?' can now be asked.' The Junior

Minister believes that 'The BMA will never again be able to parade the argument that GPs are fundamentally underpaid...there is no time of day for that argument now.' Another reports that 'The Daily Mail has put the overpayment of doctors in the public domain and haven't said it was reversed' [by subsequent QOF negotiations in later years].

Structures and institutions also added pressure. According to one participant 'The General Practitioners Committee was worried that if agreement couldn't be reached government would impose or default to the Personal Medical Services contract which was locally agreed and this added pressure because if the Personal Medical Services contract was used the General Practitioners Committee would lose its mandate as a nationally representative body.' This is echoed by another participant: [the BMA] 'were quite strongly motivated to get an attractive new contract structure that was different from the Personal Medical Services contract in order to retain their negotiating influence which would have otherwise dissipated quite rapidly. So that was one of the other tools the government had in its negotiating armoury.' Another suggests that 'a lot of this was driven by the BMA scared about the incursions of local contracting.'

The scheme had been thoroughly discussed within the general practice membership of the BMA. One participant says that 'We did two sets of road-shows...they were very cynical and quite angry but in the end we had a vote and the vast majority thought it was OK. There was a very strong no campaign but in the end their votes were not much – they were voting on the interim some way through the negotiations to touch base to see how it would go...'

Solving the technical challenges

Choice of indicators

The use of incentives, according to one participant, 'gave no cause for doubt or political concern...because actually GPs were already subject to a series of incentives...since the 1990 contract the question was are the incentives aligned right and are we getting bangs for the buck...in primary care the focus was very much on chronic disease management.' The scope and speed with which the QOF was designed owes much to the legacy of the 1990

contract and the first term of the Labour government which developed national service frameworks for many of the clinical domains incentivised in the QOF.

The early days of the Quality Sub Group were fraught with tension and conflict as participants began to debate the way in which a set of indicators might be chosen and targets set for achievement in the new contract. However, once its membership had been expanded to include the academic team of expert advisers and the BMA Chair, there was surprisingly little discord between the Confederation and BMA representatives in the Quality Sub Group over the selection of the set of 146 indicators from the literally hundreds collected for consideration by the academic team.

A participant explains:

[The academic team was] asked to become [involved so that it was possible for] both arguments to be put...to synthesise and provide the evidence. So, for example, someone would say 'we really need something on mental health' so the team would take advice, come back with a paper and put forward a view. Either side might use this for their benefit or talk it up...the BMA wanted as little for as much money as possible and the Confederation were driven by departmental rhetoric (especially the English Department).'

One participant says that the experience was arduous: 'You'd get a large volume table when the experts had been through all the schemes they could find and we went through them to find which ones were relevant...It was populated with formative assessments because that was all that was available...the only summative assessment was PRICCE.' As to the atmosphere, this participant says: 'When I was involved in the negotiation it felt like a practice meeting...we thought the patients were going to benefit...we were negotiating this in order to achieve patient benefit. Of all the team that was genuinely what we were trying to do.' Another agrees these were 'discussions rather than negotiations. The government people were very well informed. It was between peers...[with] very much a shared purpose.'

One recalls that working with the Confederation members, 'you had to have read a lot and remembered a huge amount of data and be able to argue the toss about whether this

course of action or that course of action was a high quality intervention and that is something they could do very well.'

The Junior Minister is clear that the BMA 'got the QOF to focus on things that they were by and large already doing.' Another points to the 'steady move from the 1990s onwards to seek to draw back the veil on the variation that exists in quality and performance in the delivery of care...the independent health inspectorate, the move to more clearly delineated clinical guidelines through NICE, the move towards disease-specific standards or frameworks...and the fact that GPs were already subject to a series of incentives.' These developments were supported by 'a whole series of different policy papers and proposals over a course of a number of years' identified by another participant. Indeed, 'to start producing new criteria and standards was virtually impossible...we went with what we had rather than producing new', says another participant. Officials in the Department of Health, according to one participant, knew of 'clearly well defined pay-for-performance schemes in England in the NHS which had clearly worked. People were terribly mindful of the 1990 contract and the development of the Vaccs and Imms [Vaccination and Immunisation] higher and lower target payments and how GPs behaved like an economists dream.' Another participant agrees that 'everything was there – that was how a big scheme was done so quickly.'

This meant that the team could ask: 'What is going on in the NHS which had impressed us and we could build into this contract. We did this search of the territory and things like PRICCE looked like a really strong bet' according to Mike Farrar. There were several models for the team to draw on including a scheme in Nottingham and examples of schemes in Personal Medical Services contracts. This led to the recruitment of members of the team with strong allegiances to these existing models. Mike Farrar says: 'I knew of Dr Snell's work: it was a factor in selecting him' and according to John Chisholm he was 'the person who brought the intellectual energy to that, in effect determined the shape of the QOF.'

The experience of fund-holding was visible in the evidence. Members of the Confederation team in the Quality Sub Group had met and shared their experiences of fund-holding in study groups in the past and this had sparked an interest in how to design a framework which would deliver the necessary quality to underpin such schemes. There was a

developing acceptance by general practitioners, according to John Chisholm 'that some sort of quality assurance of their continued competence to practice was the right thing to do.' Scotland similarly had well developed clinical standards for practices, with professionally-led guidelines development and practice accreditation, initiating data frameworks for recording chronic conditions, says one participant. A commentator confirms that 'It wasn't suddenly something that was plucked out of the air and thrown into a culture that hadn't changed for years. Fund-holding made a lot of us GPs much more aware of our responsibility to patients who are not in front of us.' This in turn had an impact on the BMA, says this participant. 'The BMA were against [fund-holding] and the first wave of fund-holders were delivering government policy against BMA advice. They accepted it when the power equation changed ...the BMA...might be representing a majority of the profession but doesn't tap into the innovators...QOF was easy peasy because government and the BMA were aligned and that was a good thing.'

Obtaining access to data

Data issues were identified and needed to be resolved repeatedly throughout the process of design. Perhaps the most famous data problem, which was discovered on a day which came to be called 'Black Wednesday' by some participants, arose as a consequence of incomplete practice data used to develop the model for allocation of funding to practices. The problem was identified when 'ready reckoner' tests were being done for practices. It is a participant's analysis that:

'The original data was all produced from a computer database of people who were willing to have their data copied so it was skewed to south east practices. It was data which was wrong not the formula.'

Many practices under the formula faced a reduction in their core income. However, MPIG was quickly able to be designed within four days to provide protection from loss of income. Money was provisioned from the total available for the contract. This crisis attracted a high level of collaborative damage control from all the parties to the negotiation. John Chisholm recalls:

‘Within a week of “Black Wednesday” I went to Richmond House for breakfast with both [Ministers] at which effectively they were most helpful and indicated they wanted to do whatever it would take to secure implementation of the contract. They wanted it as much as [the BMA] did and...in the few weeks that followed that up until the ballot on the acceptability of the contract both teams were very committed to securing that the contract could go forward.’

This was probably the worst moment in what the Junior Minister describes as ‘the inevitable bumpy ride...rough patches...unexpected downsides’ of the contract negotiation. He describes how ‘it all went belly up about...MPIG...and [the Secretary of State] rang and said what the...hell is going on.’

Mike Farrar agrees:

‘It put us on the back foot very much. You have situations where a practice has to get twice as many pounds per head but get an equal amount of QOF points. This was particularly a concern for me with its impact on redistribution and the opportunity for the practices in the poorer areas to be supported. However, on an international level the ratio of 2:1 funding for richest as against poorest practices is very good – it is usually 16:1 or some similar large number.’

The money for MPIG was withdrawn from that earmarked for quality payments but by that time the Framework and the price per point had been ratified by the membership of the BMA and could not be renegotiated. Mike Farrar confirms:

‘The only way we could do that [present a feasible total cost of contract] was to moderate our expectation of achievement. So where we had anticipated 850 (of 1050 available points being achieved on average per practice) we then said well ok we will [anticipate] 750 – that made the numbers stack up. If we had realized this earlier we would have had a much wiser negotiation...it caught [us] on the hop and the moral of the story was [we] did not have the finance team in [our] team...and we had come adrift.’

In fact there were several different estimates of likely achievement ranging from 650 by one participant to 750 by the Confederation negotiators of QOF, to the confident expectation of some others of the BMA team that their members would do on average 950.

For the Junior Minister,

‘The biggest thing we got wrong was estimating the risk...we thought that about 70 percent of practices would score the maximum QOF points and it turned out to be 95 percent and that caused a significant amount of financial pressure in the NHS. It was not properly bottomed out...no-one really took hold of that assessment process and ... rigorously tested it. I don’t think the Department did...If we had been told that I’m afraid it is more likely to be 95 percent of practices which will score the top marks I think we might well have thought well hang on this is wrong, this is too generous...Around the country you could see problems in many primary care practices and suddenly under the QOF they all look marvellous.’

Others suggest that they openly advised team members that the targets were highly achievable for well-run practices. But John Chisholm had a different view:

‘I actually thought these [indicators] were tough and would take several years of development to achieve in terms of possibly employing extra nursing staff, training those staff changing the culture to be much more focused on process and outcomes and proactive call and recall. Now in the event...I was proved wrong.’

The media seized on these commentaries as did Opposition politicians and even some politicians within Labour, criticising the failure to set a baseline performance measure of quality before implementing the QOF, so that the true extent of lift in quality could be assessed against the price paid for it. A participant comments that ‘we didn’t have the baseline because the GPs were going to get the money anyway so any improvement, however, easy to achieve the target [was good] – it was navel gazing by the media to talk about the effectiveness of the detail...they want a negative story.’

By contrast, obtaining access to practice-level data to ensure that achievements against targets in the QOF could be tracked and points earned was relatively straightforward.

Mike Farrar describes this process:

‘I negotiated a deal where GPs could retain ownership of their IT but all software had to be compatible. No. 10 advised that they wanted GPs to control their IT. This meant some GPs could opt out of data collection. I thought this could be handled differently. These were potential show stoppers but in each case the BMA was persuaded to allow them to proceed because otherwise they would have lost the whole deal.’

There were data infrastructure challenges for the PCTs in facilitating the complex technical requirements of the QOF. A participant suggests there was variation in the readiness of PCTs to know ‘what was required in terms of background, of education, of computers, policies...you can’t get everyone in on a summative target [such as a target for the percentage of your patients receiving a particular incentivised health action] unless you have a call and recall system so you have to put this in place.’

Testing the model

The literature suggests that pay-for-performance schemes should be trialled to avoid design flaws which might have unintended consequences. The Minister was never invited to consider trialling the contract before implementation and did not request this according to a participant. Mike Farrar comments:

‘Because PRICCE was so relevant we could see how it was going to behave. We also built in a review process so we set up a QOF review team and the principles were that this would be revisited every year...we knew we would have got something wrong...we have to be clever enough not to be stupid and lock ourselves in. So rather than go for piloting it we set in a process [for] an ongoing review.’

John Chisholm concurs for different reasons with the decision not to pilot. ‘Well there is a long history about piloting. One wants evidence-based practice right across the public sector...but on the other hand I identify with the frustration that Ministers and civil servants must sometimes feel and have certainly seen times in the past when the call for piloting is used as a delaying tactic...I think I am more in the camp of...action research rather than the pure research of piloting and rollout and so on.’ And of course ‘general practitioners wanted to see the income fruits of the new contract as soon as possible – so they worked hard! The

negotiations were more protracted than anticipated...There was enormous pressure from general practice about why haven't we got it and we want it now! So the idea that we could then have said that's it, and we are now going to pilot it in the Northern region for a couple of years – we would have been strung up. There was a need to push on and do it.'

There was also pressure on the Confederation negotiating team from the high expectations of Ministers and from the pressure of time. A participant admits that he 'was one of the people pushing the negotiating team to go further, do more, try harder' in an environment where the 'GP magazine [was] whipping up GP grass roots opinion and their ability to recall their negotiators.' This prevented piloting of the points for the QOF to obtain more accurate predictions of achievements. Dr Snell recalls being asked 'at D-Day plus two hours what my feelings were about standards and achievability...I was put on the spot and I came up with a set of figures that turned out to be too low.' As the level of funding (and therefore the value of the points) was not disclosed until after two rounds of BMA membership voting on the principle of the framework had been completed, it was too late to adjust the framework to reduce the risk of overpayment.

However, an approach which sought to ensure against possible negative impacts of these technical difficulties or unintended consequences was the agreement that indicators could be reviewed and replaced or adjusted over the years. A participant explains:

'QOF has evolved as we thought it would. We never thought that QOF was going to be fixed in time but the public health agenda moves on and we will get more ambitious I hope as time moves on...It wasn't going to solve everything over night but getting it entrenched as one of the key foundation stones of the new contract was a very important step forward...we would have probably like to have seen a more immediate change from the QOF than we actually saw so that was a disappointment but that was probably a price worth paying to get the principles established in the first place.'

Mike Farrar confirms: 'Since the original QOF there have been a number of changes – kidney disease introduced after three years. That has been phenomenal in diagnosing about 3% of the population with kidney disease not previously diagnosed because general practitioners weren't incentivised to go out and find it.'

Dr Snell confirms '[The BMA] persuaded us to set a very low minimum [target for achievement] way below what was acceptable but on the understanding that once people had signed it could be increased very rapidly. We probably had a fair negotiation around upper levels.'

Subsequent changes to the QOF are seen by some participants as 'rowing back all over the place...for doing a deal which has given us so much money' and there is a fear that the QOF will become much harder and there will be attempts to introduce things which have nothing to do with general practice and primary care but everything to do with political agendas and aspirations. John Chisholm agrees that 'The government was [in the years after implementation] trying to draw back from the generous settlement that it had got to.'

Others felt the QOF could have been even more flexible. One says:

'It didn't really challenge much people in the top half and...that is what we wanted...we didn't build in enough flexibility through this negotiation process which made it quite static which is a good BMA negotiating ploy...it is built on an annual review only up to a point...there have been changes but most people would say it has been pretty slow and not quite as responsive as we would like it to be.'

The BMA achieved a form of insurance against negative impacts too. One element of the QOF which attracted criticism was the provision that general practitioners could 'exception report' or remove a patient from the denominator for a standard (if patients did not attend for review or if there was a contra-indication for the prescribing of a medicine) and that the upper standard for achievement of targets was 90 percent of patients.

For the BMA, exception reporting was an important provision to win. John Chisholm confirms that 'Indeed one of [the BMA's] lasting concerns was the lack of exception reporting in relation to target payments for immunisation and cervical cytology [in the 1990 contract] because here informed dissent is not allowed...We lost that argument.' However, there was evidence in the literature presented by the expert advisers that this provision could be gamed. General practitioners could seek to maximize their performance against targets by exempting patients inappropriately.

The Framework set the standard for maximum points for achievement of a target when an intervention was used with 90 percent of patients. This seemed to some commentators – and certainly to commentators in the popular and academic media afterwards – to further erode the rigour of the QOF. Mike Farrar says:

‘One of my regrets is the doubling up effect of the exception reporting and the threshold provisions. We were probably over generous about allowing the 10% exception because this allowed practices to give up on the hardest patients. The model was based on PRICCE but in retrospect it would be easier to have said that there were a lower level of points for up to 90 percent and higher points for the last 10 percent, thus encouraging practices to work really hard to get the gains for their resistant patients, but for the same all up costs.’

In fact evaluations demonstrated that this risk of practices giving up on the hardest patients did not occur¹³¹.

The experience with the cervical cytology and childhood immunization targets in earlier incentivised contracts had taught general practitioners that this risk of patient refusal, no matter how convincing the arguments from the general practitioner, still existed. The battle about the upper level has already been described above but Dr Snell further believes that the Department of Health ‘acknowledged the 10 percent was the most difficult to get but...refused to allow extra payment for the most challenging 10 percent [as] it was not very cost effective.’ Another concurs: ‘When we negotiated it we got higher standards than the government eventually agreed. The government reduced them on the basis of cost.’

Some participants were acutely aware of the need to preserve bottom lines in the negotiation and this was not comfortable for them. A participant says ‘We ended up with targets that were less than 100 percent AND exception reporting and we were deeply concerned about how easy the whole thing was...could see the process of negotiating away from the bottom lines going on. Ministers at that time stepped in.’

Evaluations and reviews of the Scheme

In the three years following the implementation of the new contract, Doran reports that having begun the decade in near crisis, by 2009 primary care in the United Kingdom excelled in information technology, access, chronic care management, performance review and patient satisfaction ¹³². The number of general practitioners rose by 15 percent and the vacancy rate fell from 3.1 percent to 0.8 percent though the distribution of general practitioners between affluent and more deprived areas became less equitable as the new general practitioners chose to practice in more affluent areas. Morale as measured by the BMA survey in 2008 showed improvements, though half continued to report low morale.

In 2008 the National Audit Office published 'NHS Pay Modernisation: New Contracts for General Practice Services in England.' The study examined 'the negotiation and implementation of the new General Medical Services contract and how well it was working in practice including the extent to which the new contracting regimes have achieved the benefits intended by the Department' [of Health] ¹³³. This was a comprehensive review which involved surveying 1800 general practitioners and 138 PCTs, interviews and focus groups, visits to surgeries and analysis of data. It summarises the achievements of the contract against a set of objectives for primary care services contained in the Business Case of the Department of Health, which it sets out in its report ^{133 pp.10-11}.

The Audit Office concludes that recruitment and retention and skill mix within general practice had improved though the contract had not increased productivity (i.e. the Department expected returns which had greater benefit than the amount of money put into the new contract). The Office found that it was too early to tell whether quality had improved but found increased flexibility of PCTs to increase the breadth of services for patients. While there had not been a significant increase in patient satisfaction, the Audit Office considered the contract had assisted in the development of an entrepreneurial culture, with PCTs able to contract services to competing private sector providers to meet

local needs. General practitioner satisfaction increased initially with the implementation of the contract but by 2008 had not been maintained.

In a report for the National Institute for Health Research Delivery and Organisation programme published in 2010, McDonald et al find that the QOF achieved accelerated improvements in quality for two of three chronic conditions; however, once targets were reached the improvement in care of these patients slowed, and declined for some conditions not linked to incentives. However, the variation in care quality related to deprivation in general medical practice reduced over time. McDonald concludes that this suggests that QOF has the potential to make a substantial contribution to the reduction of inequalities in the delivery of care related to area deprivation ¹³⁴.

The Final Report of the National Institute for Health Research programme confirmed statistically significant associations between higher levels of achievement on QOF clinical indicators for coronary heart disease, hypertension, congestive heart failure, diabetes and chronic obstructive pulmonary disease and reductions in rates of ambulatory care hospital admissions ^{135 p.121}. In deprived areas, QOF achievement reflecting the performance of general practice was outweighed by wider social determinants of health, leading the evaluators to conclude that insufficient incentives for practices in deprived areas existed to identify and manage patients to prevent admission to hospital. The report hypothesised that exception reporting and targets below 100 percent, taken together, may have undermined the incentives for practices in these areas to actively search out such patients for follow up. It concluded that 'it may prove challenging to shift the focus of general practice from providing medical services to taking responsibility for population health and reducing health inequalities' ^{135 p.20}.

The QOF has been the subject of considerable analysis by researchers in England in addition to official evaluations of the scheme. A wide ranging review of the evaluations conducted since 2004 ⁴⁹ draws out six lessons from the ten years of experience with the QOF. These include the lessons that pay-for-performance is not a 'magic bullet' but needs to be combined with other quality improvement initiatives, aligned with professional values, schemes need to recognise that much clinical practice cannot be measured, reflect the concern of physicians for their reputation, recognise the limitation of single condition

indicators particularly for elderly patients and refrain from attaching too much income to limited areas of practice. One of the associated impacts has been the development of an extensive database of general practice activities which is now available to researchers interested in primary health care questions. One study of the impact of withdrawal of indicators in subsequent iterations of the QOF has found that levels of performance generally remained stable and concluded that health benefits from incentive schemes can potentially be increased by periodically replacing existing indicators with new ones relating to alternative aspects of care. However, the indicators removed remained directly or partly incentivised by other indicators in the QOF and this research is therefore subject to the caveat that full withdrawal of incentives may deliver different results ¹³⁶.

Regarding patient views about QOF, in a study of exception reporting of patients to investigate whether this had been informed dissent, it was found that this was relatively infrequent, suggesting that the incentivised activities were broadly acceptable to patients ¹³⁷. A qualitative study of patients' views of pay for performance who were on disease registers in English practices found few had heard of the QOF. Patients in this survey did not think pay-for-performance was an appropriate tool to promote quality of care but had not noticed any change in their treatment since the introduction of QOF. A minority noticed and expressed appreciation of the questions their general practices were now asking such as about smoking and weight, which were driven by evidence-based prompts in the electronic medical records of patients developed for the implementation of the QOF ¹³⁸.

Another study explored whether the QOF led to the neglect of activities not included in the scheme (based on a longitudinal analysis of 42 activities of which 19 were not included in the scheme). It found that by 2006-7, improvements for 14 incentivised activities were significant, reached a plateau quickly but remained higher than predicted by pre-incentive trends whereas the non-incentivised indicators achievement rates were significantly below those predicted by pre-incentive trends by 2006-7 ¹³⁹.

In 2009 a new way of developing indicators for the QOF was introduced, involving piloting with a testing protocol. A study of the results of this protocol found that there was considerable value for money in pre-testing the implementation issues relating to

acceptability and unintended consequences as well as technical reliability and feasibility of indicators¹⁴⁰.

This growing evaluative literature has enabled the scheme to be monitored and enhanced on an ongoing basis.

Summary

This Chapter has described the context and the process of policymaking which resulted in the implementation of the pay-for-performance programme known as the QOF in England in 2004. It has explored a set of the major barriers and enablers of the policymaking process and concludes with a summary of reviews and evaluations of the pay-for-performance policy making process and its impacts.

The next Chapter will apply Kingdon's MS Framework to this case study and explore how well it describes or explains what happened.

CHAPTER SIX

REVIEWING THEORY AND EVIDENCE: QUALITY AND OUTCOMES FRAMEWORK

Introduction

The previous chapter has described the process of pay-for-performance policymaking in a case study of the design and implementation of the QOF in England between 2001-2004. It has set out barriers and enablers for the policymaking process which can be identified in the data collected in interviews with participants and from documentary analysis. A summary of evaluations and assessments of the outcomes of the policymaking process was provided. This Chapter now applies Kingdon's MS Framework to this case study, with particular regard to the research questions:

- How well do the elements of Kingdon's MS Framework describe and/or explain what happened at each stage of the policymaking process?
- What new relationships between variables can be identified from the analysis which might enhance or extend Kingdon's MS Framework?

Kingdon's MS Framework

To assist in understanding how well Kingdon's MS Framework describes and explains what happened in this policymaking process, this research will use his five key elements of Problem, Politics, Policy, Policy Window and Policy Entrepreneurs, but as enhanced by the sub-elements developed by Zahariadis and set out in his diagram in Figure 1⁵² shown in Chapter Two of this thesis. First, the type of policy change is discussed. Then the evidence is set out in accordance with the elements and sub-elements of the model of a policymaking process. The purpose is to explore whether Kingdon's MS Framework provides a theory which enables complete understanding of this policymaking process and if not, what other drivers of policymaking does the evidence suggest are relevant in helping to explain what happened?

Non-incremental change in conditions of ambiguity, fluid participation and unclear technology?

The first question the MS Framework invites is whether or not this policymaking episode meets Kingdon's predictions about when incremental and non-incremental change occurs and the conditions under which these types of change are likely to occur. The pay-for-performance policymaking process in England was non-incremental change in Kingdon's definition and was achieved in a planned top-down process of policymaking. Although ideas were selected from the policy stream which were already in use (the provisions for incentivising vaccinations and immunisations from the 1990 General Medical Services contract, the Personal Medical Services contract model and an existing pay-for-performance scheme, the PRICCE project), the politicians had clear plans to achieve a major change in the way the NHS worked. Pay-for-performance was identified by them as a key mechanism to achieve this change in the general practice sub-system. The pay-for-performance policy idea appeared quickly on the policy agenda, was widely understood and accepted and was quickly implemented. However, Kingdon's predicted conditions for non-incremental change are less apparent. Instead of ambiguity, there was a clearly set policy goal to introduce pay-for-performance. Instead of fluid participation, the participants at all stages of the policymaking were carefully selected and admitted to a closed and orderly process. Only a small number of aspects of the technology to implement pay-for-performance (relating to data collection) were unclear.

In the agenda-setting stage, an informal style of decision-making was utilised by the Prime Minister from 1997. It was known in the media as the Prime Minister's 'sofa cabinet' approach to decision-making. This avoided some Cabinet procedures for decision-making which were usually undertaken within British governments. This initial decision to introduce pay-for-performance into the new General Medical Services contract was taken by the Prime Minister in this informal type of process, being made between the Prime Minister, the Secretary of State and the Prime Minister's Adviser on health policy at a discussion between themselves during the election campaign. It was, however, a process to which carefully selected participants were admitted and the description of the process by participants suggests little ambiguity of policy preferences. While the technology of design and implementation debated at that discussion contained some innovative elements, such as

the use of Confederation negotiators instead of civil servants, in most respects the planned approach was one of business as usual for Ministers and their colleagues from the BMA.

The process of alternative selection, as conducted between the government and the BMA, occurred in a closely managed process with rigorously controlled participation and rules of engagements between the negotiating teams. It was based upon a completely unambiguous policy preference for pay-for-performance and had clear and existing technology for implementation (that is, through the new contract for General Medical Services), though strongly contending interests needed to be managed during this phase.

Problem stream

The MS Framework and Zahariadis' Model describe how policymakers come to focus on particular problems to place on the agenda by noting indicators, responding to focusing events and drawing on feedback which, together, create a need for policymaking action to resolve. The model also acknowledges that it is necessary to take into account the load of other policy work under way which may affect capacity to deal with the problem and hence its arrival or priority on an agenda.

The major items in the problems stream that the evidence from the case study shows policymakers observed in 2001 were public concerns about access to and quality of health services (see Politics Stream below for more detail) and general practitioners' concerns about their terms and conditions of work. Quality in this case also means patient responsiveness. Although there was no specific concern that cost (expenditure levels on health services) was a problem, there was a determination to get better value for the planned new investment in health services.

Policymakers in this episode found out about these problems through a combination of electoral, media, policy community and interest group activity. The indicators included polling during the election campaign showing public concerns about the quality of service offered by the NHS, surveys showing 48 percent of general practitioners were planning to retire before the age of 60 and increasing shortages of doctors in areas of socio-economic deprivation, and studies showing increasing variation in the quality of care, especially in areas of socio-economic deprivation. Focusing events included the BMA threat during the

election campaign to go on strike and withdraw their services from NHS work, raising the level of need for a new contract, and exposure of poor health service delivery in media commentary during the election campaign ('Winston's attack [on Labour's handling of the NHS]...was now leading the news...Milburn did well doing the rounds but it was all pretty difficult'^{141 p. 208}). Feedback of a positive kind which encouraged policy-makers to respond to the problems through pay-for-performance approaches was also available through Ministers hearing about and inspecting successful pay-for-performance programmes such as PRICCE. A summative evaluation of this scheme was available and suggested a workable model.

The load of other problems on policy makers' agendas at the time was not a barrier as the Prime Minister wished to concentrate policymaking efforts on domestic agenda items and recognised that these had been neglected in previous term. The government had built high capacity and willingness for bold sweeping domestic policy initiatives.

In Zahariadis' view, policymaking which originates in the problem stream, as this does, will be more likely to lead to a rational approach to policymaking in which the solution is consequential upon the problem identification. This is borne out by the evidence in the case study. A rational top-down approach was followed, consequential to the threat of general practitioners to strike. The Prime Minister and Secretary of State utilised academic advisers to provide ideas and alternative solutions about pay-for-performance extensively as part of the contract negotiations. So the model therefore makes an accurate prediction of this link between the type of problem and the type of policymaking followed in the case study.

Politics Stream

The MS Framework specifies that, in the politics stream, party ideology, national mood and administrative turnover will be the main considerations relating to agenda-setting.

In 2001 party ideology within the Labour Party strongly supported increased investment in the NHS and centralised approaches to the management of public services. A section of the Party championed modernisation of public services. Re-engineering public services to be more responsive to citizens as service consumers was a key policy goal of champions of

'New' Labour ideology. The evidence shows polling of national mood found that health service quality and effectiveness was a key electoral issue for voters. Its electoral salience was heightened by the attention paid to the issue of poor quality of NHS service by the media. The national mood was reflected in highly critical media reports during the election campaign exposing examples of poor quality of health services. Kingdon notes that media are often portrayed as powerful agenda setters^{51 p.57} but his research reveals that they are regarded as having an important impact on the government agenda in only 26 percent of his interviews. Participants confirm that the media was important in this case study. The electoral salience of health policy was a vivid concern to the New Labour politicians and their media advisers. The BMA threat to strike, which created a risk of further immediate pressure on service levels, can be seen as carefully timed for the middle of an election campaign by the BMA so they could put maximum pressure on politicians through the media. Once the decision to negotiate a new contract had been taken, the medical media was attentive to the ongoing negotiation of the new contract, including the influential British Medical Journal. Participants on both sides of the negotiation reflect their ever-present concern about the impact which adverse media coverage may have on their achievement of their policy goals.

The general media had less insight to the process of negotiation during the policy design phase but criticised 'overpayment' of general practitioners after the impact of the scheme was apparent. This had some influence in subsequent negotiations and also impacted upon the public reputation of the BMA and doctors generally. As future negotiations over general practice contracts occur, it will be a matter of interest to see if these perceptions of overpayment will have survived in public opinion and whether, if they have, this will influence the conduct of later negotiations in any way.

The opportunity provided by administrative or legislative turnover was a key factor in creating the need for new policy, particularly in the arena of health policy. The Prime Minister wanted to make more impact upon domestic policy in his second term and was actively seeking ideas and strategies to do so. The election victory with its large majority gave a second five-year term in office. This provided the opportunity for selection of new ministers in the team who were, like the Secretary of State, 'fully simpatico with the direction for change.' Kingdon's MS Framework and Zahariadis' Model rightly anticipates the

importance of administrative turnover for the agenda-setting process. Administrative turnover is an even more important event in adversarial Westminster policymaking environments because of the heightened 'structural interest in product differentiation and incentive to initiate [policy] changes' to garner electoral support^{66 p.24}, the greater level of executive autonomy where there is a large Parliamentary majority and the support of a professional civil service to implement new policy in these environments.

However, the major considerations in the politics stream in this policymaking case study were two-fold. The first was how to deal with an institutional issue about the need to negotiate a new contract for general practitioners. The second was an interest group issue: how to respond to the threat of general practitioners to strike unless they got a new contract. These considerations are not easily categorised in the Zahariadis Model's sub-elements in the politics stream.

Policy stream

The Framework identifies value acceptability and technical feasibility (or the ease with which the chosen policy can be implemented) as they affect two elements in the policy stream: the policy idea and the policy community as important factors in whether a policy gets on the agenda. Zaharaidis' model also specifies the importance of the level of integration of the policy community and its access to decision-makers, mode of decision-making, its size and capacity as key factors in whether policies get onto the agenda. The policy community is seen by Kingdon to include bureaucrats, academics and researchers and Zahariadis expands this to include analysts in think tanks and interest groups and lobby groups.

Policy idea: In the 'soup' of ideas in the policy stream, pay-for-performance for primary health care was clearly present. Members of the health policy community were able to draw on recent research into the effects of pay-for-performance nationally and internationally and within the primary care sector. Academic advisers had ready access to the Prime Minister and the bureaucracy to share the results of their research, including research conducted in other jurisdictions. The chance of its selection was influenced because it had value acceptability to all parties as a way of incentivising changes in quality of health

actions, equalizing access for poorer communities and improving customer responsiveness. Although there was some scepticism, most decision-makers were comfortable with the concept of pay-for-performance. The mechanism for policymaking managed the risks of this policy idea by using principle-based bargaining and relationship-building tactics to soften and manage disputes. This mechanism also engaged the doctors and ensured 'alignment with the doctor's own professional values and the autonomy given to health professionals in how they achieved the targets' through their active participation in the policy design process. Ultimately all general practitioners affected by the negotiations were able to vote on whether it was acceptable and a majority voted in favour.

The policy idea also had technical feasibility. In the case study evidence, existing pay-for-performance schemes provided some successful working models. There were extensive national service frameworks providing evidence-based quality standards and research showing how to successfully incentivise health professional behaviour, and its risks, available to policymakers. There was confidence amongst policymakers of the feasibility of this ambitious policymaking process because of these antecedent policies.

Despite potential show-stopping problems such as the lack of a shared data base to monitor achievements against targets, both parties were willing to overcome these. English general practitioners had a proliferation of practice management systems for patient record keeping and concerns about maintaining confidentiality of patient information like general practitioners in New Zealand. Despite this, the necessary technical infrastructure to support the scheme, the QMAS, was quickly designed and implemented to create a database which was able to draw anonymous information out each day to report on performance against the scheme at the practice level. Linking the scheme to the negotiation of the new general medical services contract provided an incentive for doctors quickly and enthusiastically to implement the changes on a national scale. However, the importance of the collective action of doctors in debating, voting and agreeing to participate in the scheme is arguably more important than the technical process of designing the system. The fact that general practitioners had a unified representative structure to negotiate on their behalf facilitated the rapid negotiation and implementation of the scheme. So these issues of technical feasibility, though significant, were quickly overcome because both parties wanted to achieve the rapid implementation of a large scale scheme.

The evidence indicates that general practitioners supported the idea of pay-for-performance primarily as a vehicle to increase their pay, not in its own right as a policy idea. This means that other drivers for the willingness of general practitioners and the BMA to agree to this policy are likely to be stronger than the idea of pay-for-performance itself. Alternative drivers are discussed in the section 'Importance of rational choice drivers' later in this Chapter.

The policy community: The level of integration of the health policy community concerned with general practice issues can be said to be towards the high end of the continuum in England (defined by Zahariadis as consensus-based, in which there are more frequent and more formalised contacts, characterised by bargaining or sounding out and compromise). The level of formal organisation of the BMA on general practice matters is an example of a highly integrated policy community within the larger health policy community. Within the general practice sub-system there was growing divergence of forms of practice and contracts which were creating a growing heterogeneity of interests and attitudes to particular policies and approaches within this community. However, there was an effective and well-resourced mechanism to coordinate these debates. The representative mechanisms of the BMA and its General Practice Committee, the debating and voting framework for general practitioners and the sole mandate it held to negotiate with government on behalf of all general practitioners in a closed negotiation process gave it a robust structure for coordination of policy debates within the community.

The BMA continued to have very high levels of access to politicians. This Labour government, like earlier Labour governments, sought constructive engagement with interest groups, in semi-corporatist arrangements, and reinstated a strongly consensus-based approach to the policymaking process or a return to the 'politics of the double bed'. Debates about quality and equity of access and other key issues were readily shared through the British Medical Journal and the media.

Within the pay-for-performance policymaking process, collegial and friendship links and shared research interests were reported by many participants who were members of the design team, regardless of which 'side' of the negotiation process they sat on. The evidence suggests that these informal integrating links between individuals facilitated debate,

resolution of conflicts and the building of constructive relationships between all participants. To further build the level of integration of the policymaking design team there was a very careful process of selection of all participants and very restricted access for new members. A high degree of administrative capacity was also provided by both parties to support the policymaking (though not quite enough financial modelling or time was available to the Confederation team to identify and manage some risks).

This sub-element of Zahariadis' Model is therefore a useful and important one for the analysis of this case study.

Policy window

In Zahariadis' Model of the MS Framework he suggests that the characteristics of the policy window can be analysed according to its coupling logic. One type of logic is consequential: the coupling occurs because of a compelling event. Another is doctrinal: it occurs because of a totemic policy position held by a newly-elected administration, for instance. How the coupling proceeds will also reflect whether the decision making style of the administration in power is bold or cautious

The pay-for-performance policymaking had a coupling logic which was consequential on the opportunity which was presented by a long second term in office for the government and the demand to negotiate a new general medical services contract. However, it was also doctrinal in the sense that the government's policy priority for this term was to bring major improvements to general practice services as part of a doctrinal principle of modernization of public services in general. The decision style was bold – indeed the decision to make pay-for-performance the primary element of the new payment arrangements flew in the face of caveats in the literature that there were major risks and challenges in designing and implementing such a pay-for-performance policy mechanism on a large scale without piloting its key features. These opportunities combined to ensure that the Department could couple its readiness for bold non-incremental change with the available policy window. The enthusiasm by both parties to the negotiation for speedy delivery of a contract, combined with this boldness, resulted in some flaws in design and higher than expected costs in the short term.

This type of policy window is not a matter of chance. It appears regularly in adversarial Westminster jurisdictions. The electoral cycle offers a routine opportunity for political parties to review policies and refine manifestos and there are incentives to differentiate policies between political parties. In majoritarian unitary electoral systems, party manifestos of victors can be more assured of immediate implementation and politicians and civil servants can plan this process. The civil service prepares in advance for the post-election rush to implement manifesto commitments and is adept at serving new governments neutrally and efficiently in this process. This reduces the element of unpredictability and chance in policy windows in these systems.

It is important to consider the nature of the governing system, therefore, when analysing the role of policy windows in policymaking.

Policy entrepreneurs

Kingdon and Zahariadis promote the role of actors, particularly policy entrepreneurs, as important drivers of policymaking in conditions of policymaking ambiguity. These actors are able to manipulate events to gain support for their pet policy idea in these conditions. In their view it is this role which facilitates non-incremental change when the conditions are right. As expanded by Zahariadis, the model suggests that the activities of policy entrepreneurs can be analysed according to three criteria: access to decision-makers, resources to influence policymaking and strategies (such as 'framing, salami tactics, affect priming and symbols') to gain support for pet policies.

Other writers have introduced the roles of public entrepreneurs and institutional entrepreneurs to add to policy entrepreneurs. In a generic definition Ostrom calls these actors 'primarily focused on problem-solving and putting heterogeneous processes together in complementary and effective ways'⁷⁴.

The conditions of ambiguity were not found in the pay-for-performance policymaking process. No exogenous policy entrepreneur could be identified during the research. However, the research identified several roles played by key endogenous actors which clearly facilitated this non-incremental policy change. They did not have access or resource

concerns though needed to consider which strategies would best build support for the pay-for-performance policy.

The first of these actors is the Prime Minister during the agenda-setting stage, who seized an opportunity to utilise a preferred policy. The Prime Minister used strategies such as framing to get this item on the government agenda through language used in speeches to his own Party members, many of whom opposed his approach, and appealing directly to the public for support. He framed the issue for the traditional Labour supporters and the unions with the message 'without reform, more money and pay won't succeed' and for the public it was 'the service user in the driver's seat.' The Secretary of State added the mantra of 'something for something' to focus the efforts of the negotiation team and this became a 'symbol' of the rationale for the new contract amongst its designers.

The second is a small group of specially recruited actors who had roles which were developed during the alternative selection stage. These actors undertook activities which resemble descriptions of institutional and policy entrepreneurs respectively as these have been developed in recent writing. These are:

- the Chair of the Confederation team, who is recruited from front line management of health services to build a negotiating team of fellow front line health service managers rather than civil servants. He also recruited academics with general practice experience to mediate the debates over targets for the QOF design between the BMA and Confederation teams. He exhibited the required strategic skills to obtain agreement to the policy within the whole negotiation process of the contract; and
- the leader for the Confederation team on the Quality Sub Group, exhibiting policy entrepreneurial skills, who is recruited from a post implementing a pay-for-performance scheme in a regional health service. He ensured that the key features of the scheme he implemented in East Kent, PRICCE, became the primary model for the QOF through his role as leader of the Confederation team within the forum of the Quality Sub Group. He defended these features in the face of seasoned bargaining techniques of the BMA negotiators.

The empirical work of Mintrom, Roberts, and Oliver adds further descriptions of how entrepreneurs in different settings work. Mintrom⁸² identifies three key attributes of discovering unfulfilled needs and suggesting innovative ways to meet them, bearing reputational risks in uncertain situations and resolving collective action problems by assembling networks to undertake change. These attributes are exemplified in the actions of the leaders of the policymaking process but particularly in the problem-solving approach taken by the Confederation Chair during the negotiations.

Mintrom's concept^{83 p.656} of 'insider sensibilities', or deep knowledge of relevant procedures and the local norms that serve to define acceptable behaviour, is clearly exhibited by the Confederation Chair. He resembles, in Kingdon's terms, 'people who can act as change agents by making connections across disparate groups and engaging with proximate policy-makers.' He conveys a motivation for improving the terms and conditions of doctors as well as the outcomes for patients and disappointment at not being able to do more in these areas. His 'palpable honesty' was acknowledged by other negotiators and he was much admired for his techniques of constructive problem-solving.

Manipulative strategies such as framing, used by the Prime Minister in agenda-setting, are not used here. Salami tactics or tackling the problem in small slices are explicitly rejected. Openness and principle-based bargaining techniques were the primary strategies employed in the policymaking process.

In the Quality Sub Group, the policymaking environment was different. The Chair of the Quality Sub Group was a passionate defender of his ideas and upheld these through the rough and tumble of negotiation at all costs, in Roberts' words like 'the brilliant salesmanship of someone offering a finished product'¹⁴², leading to the respectful acknowledgement of the BMA that the government negotiators were not 'some soft hearted pussy cats.' Other innovations were then developed to manage the risk of negotiation break-down: the Chair of the BMA team joined the group and the Chair of the Confederation team enlisted the services of independent academic interlocutors to settle the process into a balanced and manageable debate, actively using strategies from principled-based negotiation to maintain a constructive environment of problem-solving.

Although these actors do not play the roles of policy entrepreneurs as originally described by Kingdon, they are examples of new forms of endogenous policy and institutional entrepreneur which reflect the needs in the different policymaking rhythms and risks of the Westminster setting.

Entrepreneurial risk-taking

It is intrinsic to the concept of entrepreneurship that risk will be taken in order to obtain greater reward than would be derived through more conventional or routine (and therefore less risky) processes. This concept of risk is at the heart of Kingdon's theory that non-incremental policy change is often only possible when entrepreneurial forces are brought into play. The policy and institutional entrepreneurs identified above took risks characteristic of this entrepreneurial behaviour to a certain extent. Taken at the direction of politicians in one administration, they may render the strategies of the entrepreneur inappropriate for a successor administration. The major risks taken as part of the pay-for-performance design process are explored below:

Public support risk: the risk that some aspects of the negotiation might result in loss of public support. This proved to be accurate. There was commentary in the media that an excessively generous settlement for general practitioners had been reached in the media. The right for general practices to contract out of after-hours services resulted in the wholesale cessation of Saturday morning surgeries, public frustration and the criticism that doctors would now receive much greater pay for reduced hours of work. The Prime Minister himself was confronted by unintended consequences of the new contract when he was advised on live television that it had created an incentive to prevent booking of appointments in advance, thus reducing rather than increasing easy access and responsiveness of services to the general public.

Design risk: the greatest design risk taken was to retain a large share of the income under the new contract as contingent upon performance (to maximise the effect of the incentives in the new contract). As the targets proved to be easy for most practices to reach, this resulted in a better-than-budgeted performance under the

performance-related pay provisions The Auditor General's confirmation that the cost of the scheme was excessive in return for relatively poor productivity gains¹³³, at least in the immediate period following the negotiation, was the consequence.

Explanatory comprehensiveness of Kingdon's MS Framework

To recap, this case study exhibits a non-incremental policymaking process which runs counter to Kingdon's predictions about how non-incremental policymaking occurs. It departs from his predictions because it occurs in a planned top-down way in conditions of great clarity of policy preference. In the agenda-setting phase it has none of the features of ambiguity, fluid participation and unclear technology predicted by Kingdon to create conditions for non-incremental change. No exogenous actor using political manipulation was identified (though endogenous actors with a role to facilitate major change are deliberately recruited by the administration to achieve this result). The pay-for-performance policy in the alternative selection phase was developed in a rational and top-down way but utilising negotiation. Kingdon acknowledges in his further reflections on his original framework that a 'government might generate its own agenda and can be at least somewhat autonomous'^{51 p.230}. Zahariadis confirms that in the problem stream, rational approaches to which are consequential upon the identification of problems can occur. He invites us to specify the conditions under which and the ways in which policymaking works from the top down. This case study shows an example of policymaking in these conditions. In this case study the key conditions were a clear electoral mandate for change, a large parliamentary majority, a bold parliamentary leader with able colleagues and civil servants to assist him, an interest group keen to negotiate a change in their members' conditions and well-studied policy antecedents to provide confidence of the policy idea's feasibility.

There is thus a partial fit between Kingdon's Framework as elaborated by Zahariadis and the complex processes observed in the case study of the design of the QO F. On some large and important predictive theoretical positions, such as the link between chance and non-incremental change, the MS Framework has not been accurate. In many other aspects of the policymaking process there is a strong resonance between the components of the model developed by Zahariadis and the empirical evidence of how this policymaking process unfolded.

Other drivers of policymaking processes

Based on the analysis of the fit between Zahariadis' model of the MS Framework and the description of the policymaking process which has been set out in the preceding pages of this Chapter, there are some major gaps in the way the model captures and encourages us to look for key drivers and features of the policymaking process which were, in the empirical research undertaken for this case study, shown to be critical to the process and outcome of this policymaking episode. These are set out below.

The importance of historical antecedents

The scope and speed with which the QOF was designed clearly owes much to the historical antecedents of the policy. Existing paths, largely arising in the 1990 General Medical Services contract, could be trodden in the design of the new policy. England and Scotland had well developed clinical standards for practices, with professionally-led guidelines development and practice accreditation which were well-accepted by general practitioners.

In Tuohy's terms, these are examples where 'policy-makers continue to cycle through their existing repertoires, shifting the mix of instruments and the balance of influence within the parameters of the established policy framework'^{23 p.5}. Kingdon acknowledges that in the alternative selection phase of policymaking, civil servants may propose policies they have been working on in the past and use a process of 'softening up'^{51 p.214}. He notes that officials will also utilise feedback about existing policies to create new ones but in the alternative selection phase rather than the agenda setting phase. He acknowledges the idea of 'spill-over' or 'establishing a principle'. This captures the phenomenon that a change in another arena of policymaking or a previous experience of policymaking which sets a precedent of some kind will make it easier to achieve the same sort of policymaking in the new arena.

These concepts of 'softening up' and 'spill over' do not capture the importance of the role of historical antecedents, which the evidence shows laid reliable foundations for the policymaking, nor the strong momentum which drove the grand and ambitious scale of the pay-for-performance scheme achieved in the English policymaking episode. There is a case

for including these sub-elements as part of Zahariadis' model to ensure they are considered in policy analysis using the framework.

Institutional and structural features

Kingdon's Framework and Zahariadis' Model are muted or silent on the impact which underpinning institutional features may have on the process of agenda-setting and alternative selection, such as the relative ease with which a Westminster majoritarian and unitary governing system can undertake non-incremental policymaking by contrast with federal systems or those with a separation of powers. An institutional approach to understanding policymaking would look first to these features to explain patterns of policymaking. The ways in which the governing system in England affected the policymaking process differently from Kingdon's predicted patterns have been set out above. These indicate that Westminster governing systems seeking to implement non-incremental policy change can achieve this without having exogenous actors using political manipulation to drive such policy change. This suggests that the Zahariadis Model, if it is to be more applicable to Westminster systems of this type, needs some amendment.

The institutional landscape for a system or sub-system (such as the health system or the general practice sub-system) and the way in which this might structure the relationships between the state and interest group actors has also been shown to be an important factor in a policy design process. Below, the impacts of these institutional features at the general practice sub-system level are set out.

If this institutional approach is taken to this case study of policymaking, it is clear that the general practice sub-system landscape included a singular form of ownership for general practice with:

- A semi-corporatist working relationship between the BMA and the state
- A single payer financing arrangement for general practice
- A single national contract between most general practitioners and the Department
- A centralized structure for health policy making
- A single national representative body for general practice

The analysis of the evidence shows that, together with the policy antecedents, these features enabled a context of bargaining and negotiation - 'something for something' - which greatly facilitated the speed, scale and scope of the policy making on a national basis. The legitimating of a single general practice organisation as representative of general practitioners was crucial to the successful and rapid conduct of the design and implementation process. This also facilitated the design and implementation of the QMAS to resolve information management difficulties.

Importance of rational choice drivers

The case study evidence shows that individual actors were important in the successful design of the pay-for-performance policy, acting in entrepreneurial ways. There are also some clear rational choice drivers which can be identified at the heart of this policymaking process, operating both individually and collectively. The major driver was the prospect of greater rewards. The first example of this is the way general practitioners as a collective chose a guaranteed practice income and improved terms and conditions over retention of absolute clinical autonomy. Secondly individual general practitioners avidly implemented the pay-for-performance programme, which was a voluntary scheme, in their own practices to secure this increased income. Third, the BMA chose to negotiate a lucrative contract mindful of the need to preserve its sole bargaining mandate. All of these drivers were important to achieving the rapid design and implementation of this policymaking process.

It should be noted that other rational choice drivers were present too. These included support for quality indicators of practice and doing what was best for patients. From the economic point of view, 'physicians do not only try to maximise income and minimise workload. Their utility function consists of other non-price elements such as ethical restraints, professional standards which may dilute or even completely remove incentives for physicians to provide ineffective care'^{43 p.191}.

The existence of an institutional framework for bargaining and negotiation enabled the profession to make these choices to trade some clinical autonomy for greater income. So the opportunity for bargaining and negotiation or the use of rational choice drivers was facilitated by the institutional features of this general practice sub-system. Government

negotiators respected and facilitated these institutional processes during the negotiation phase. To anticipate the analysis in the next case study, the New Zealand case study will show a clear difference, having multiple forms of ownership and governance within general practice, multiple general practice organisations and a less integrated policy community, which gave policy-makers fewer institutional features which could be used to facilitate the process of policy design and implementation.

Does the Zahariadis Model encourage consideration of these factors?

The set of sub-elements in the Zahariadis Model does not invite consideration of interest group factors such as the positional advantage conferred on the BMA with its right to hold sole bargaining rights for all general practitioners. Nor does it invite consideration of institutional factors such as the ownership and governance arrangements for health services which gave positional advantage to the state actors in this situation. These factors had a significant influence on the relative strength of different interests and actors in the policy making process. The evidence shows that these two factors in the political stream - the mandate and resources of the BMA and the responsibilities and legal powers of the Department of Health - were vital sub-elements in the policymaking process. The sub-element relating to policy entrepreneurs does not reflect the possibility that these actors may be actively sought out and engaged by state actors to champion particular policies or governance frameworks as part of the policymaking process.

Summary

This Chapter has analysed the fit between the evidence of the design of the QOF and the MS Framework in describing and explaining what happened. It then considered the relevance of other historical, structural and institutional drivers in the policymaking process. In the next Chapter, the case study of the design of the New Zealand Performance Programme is described, the barriers and enablers of the policymaking process are discussed and commentary of evaluators of the Performance Programme is presented.

CHAPTER SEVEN

NEW ZEALAND: CONTEXT AND THE PERFORMANCE PROGRAMME

Introduction

This chapter analyses the context for policymaking and the process of design of the pay-for-performance programme, the Performance Programme (PP), designed in New Zealand at the same time as the QOF was designed in England. This Chapter draws upon an analysis of the New Zealand health policymaking literature, documentary records, published commentary on the implementation of the PP, some media reports and the transcripts of 14 semi-structured interviews with participants in the design process. Where a participant's comments are included in the text, this is stated and quotation marks are used to highlight the comment.

First, the health policymaking context for the New Zealand government in 1999 is set out. Next the process of development of the PP is described. Then, a set of the major barriers and enablers of the policymaking process which affected the goals of policymakers, as described by participants, is described. These are derived from clearly-patterned content from interview transcripts and document analysis, usually reflecting that they were reported by a majority of participants or were expressed with strength and intensity of expression by a smaller number of participants, or because they were clearly identified with a particular type of participant or type of belief. The Chapter concludes with a summary of reviews and evaluations of the pay-for-performance policymaking process and its impacts.

Background

In 1999, New Zealanders elected a majority coalition government led by the New Zealand Labour Party after that party had been nearly a decade out of office. Health services had high electoral salience in New Zealand as they did in England during the election campaign. Laugesen^{96 p.140} contends that health reformers had become 'more attentive to voters' perceptions of reforms and the distribution of costs and benefits' in New Zealand and that

political revisions to reflect public opinion had begun to supplant technocratic blueprints for efficiency or health care professional and provider interests in health policymaking.

Prior to its election victory, the Labour Party had set out a Manifesto dealing with health policy, 'Labour on Health'³⁹. Similar themes to those of the Labour Party elected in 1997 in England were set out in this document. In both countries, politicians were concerned about the gap between the expectations of taxpayers and health system performance. In New Zealand the concern was also to re-establish the 'moral authority' of the national health system³⁹ whereas in England the Prime Minister sought to avoid a situation in which citizens 'would begin to buy their way out and the NHS would spiral down to become a residualist safety net'².

In both countries a revolutionary programme of health reform had been introduced by the previous administrations during the 1990s, which had been largely imposed on an unwilling health sector^{19 p.57}. Each Labour Party promised to distinguish itself from the previous administration by moving away from key features of these reforms, particularly strategies based on the introduction of competition and quasi-markets, towards a system characterised by greater cooperation, improved quality and a greater focus on prevention of chronic health conditions. Like the Labour Party in England, the New Zealand Labour Party's 'core commitments' were 'to focus on patients not profits and to cut waiting times for surgery'^{39 p.2}. But its objectives also addressed some different needs: for 'restoration of a non-commercial system, with the focus on the provision of quality services'; 'full involvement of the representatives of local communities in decisions about ... services in their region'; 'significant improvements in the effectiveness of health services delivery to Māori and Pacific people' and a system in which 'primary and secondary care will be well integrated.'

A non-commercial system

Labour On Health criticised the National government's policy to develop quasi-market systems to improve efficiency and effectiveness in social services, stating that this had caused health services to become 'run down, privatised and commercialized...to the 'overwhelming alienation of the public'^{39 p.2}. Labour on Health also signalled a focus on

population-based and preventive health care, stating that the current system was 'too focused on treatment services at the expense of improving the health of the community.' The document criticised the type of accountability measures which were being monitored in the system, stating that the only accountability measures regularly reported on related to financial rather than health service quality indicators. While promoting the benefits of longer term funding arrangements for health providers, it also stated that only 'organisations which are funded by the state *and have a history of providing a quality service* will have funding arrangements which provide [this] security' ^{39 p.4}. Clinical accountability was to be given the same priority as financial accountability. Quality and effectiveness was to be 'the yardstick by which we measure the quality of the service' ^{39 p.3}.

The overall priority for the public health system as outlined in Labour on Health was to 'raise the health status of New Zealanders and reduce the health status inequalities between different sections of the community' ^{39 pps. 3-4}. The public health goals included reductions in smoking rates, incidence of asthma and diabetes, heart disease and high blood pressure, cancer related mortality, poverty related illnesses such as tuberculosis, meningitis, rickets and cellulitis and targets to increase immunisation rates ^{39 p.5}. The document stated that 'the key to improving the health status of New Zealanders in the long run hinges on public health and public policy measures more than on treatment' but that many of the illnesses 'which are reducing life expectancy and requiring treatment are preventable within existing knowledge' ^{39 p.10}. The commitment was made to set and monitor national population health goals and ring fence funding available for District health boards for population health initiatives.

So clear intentions to encourage, support and measure the delivery of population-based health services and to achieve improvements in the quality of primary health care services were set out in this Manifesto. Addressing the problem of inequitable health outcomes was seen as tractable if existing knowledge could be applied to prevent illnesses more effectively.

Problems of ‘Moral authority’

The promises to restore full involvement of the representatives of local communities were intended to restore the ‘moral authority’^{39 p.2} of the health system. These would provide democratic accountability mechanisms, together with the promise to restore affordable access to primary care so ‘that people’s access to the health system is not restricted by their ability to pay’^{39 p.3}. These problems were not encountered in England to the same extent because in that country general practitioner services were free at the point of care and there was an effective line of accountability from each general practitioner to the Secretary of State for Health and Parliament, through the mechanisms of the General Medical Services contract which bound general practitioners funded through its provisions.

Labour promised to ‘return to a health system which allows people to have a say’^{39 p.2} by making changes in governance and funding arrangements at the regional level and drawing primary care firmly into the ambit of these new systems for public governance of health planning and policymaking. The management of the interface between an integrated primary and secondary care sector would be ‘governed by organisations in which the community and consumers of services have a voice’^{39 p.4}. At the national level, all functions for policy advice, funding, regulation and monitoring and public health services would be returned to the Ministry of Health and direct Ministerial, and therefore parliamentary, control. Elected local representatives would form a majority on re-established District Health Boards, which would also be responsible for primary care. Decision-making would ‘once again be an open and publicly accountable process’³⁹. This was intended to improve the visibility of health services and therefore the accountability of health care providers to citizens generally^{28 143}. It represented the re-introduction of a vertically integrated national health system, drawing all public health policy and funding back under the hierarchical control of the state.

Health needs of Māori and Pacific peoples

The New Zealand Labour Party Manifesto made a commitment to ‘ensuring that low cost quality primary health care services are available in areas of low income and high health need’^{39 p.13, 4} and that ‘significant improvements will be made in the effectiveness of health

service delivery to Māori and Pacific people'. As part of the process of developing the Labour Party manifesto policy, Labour on Health, the Opposition Spokesperson for Health had done much talking about how a new approach to primary health care could be achieved with doctors who were part of her local urban constituency but also those who practised in more isolated and needy communities in New Zealand and with researchers in the health epidemiology, policy and services academic community. The Manifesto promised 'we will ensure that people's access to the health system is not restricted by their ability to pay'³⁹
p.3

New Zealand's semi-commercialised model of primary care delivery had become unaffordable for many New Zealanders. The primary care sector was already highly privatized in both production and consumption⁹⁴ but the changes made in 1993 withdrew subsidy for primary care entirely from most New Zealand adults^{29 p.2 144}. Disparity in health outcomes was a pressing concern to the New Zealand Labour Party. Research had shown that there were 'significant and enduring health disparities relating to both ethnicity and deprivation' including a nine-year gap in life expectancy between Māori and non-Māori New Zealanders and between males living in the most deprived and least deprived geographical areas^{21 145}. The strategies to reduce these disparities outlined in the Manifesto included the use of population-based funding formulae to determine funding levels for personal health services so that funding could be redistributed based on need. Targets for delivery of preventive as well as curative services and the introduction of the requirement for people to enrol on registers for health care were also intended to facilitate delivery of a population-based and preventive approach to delivery of services.

Objectives to reduce disparities between ethnic groups also reflected the major changes which had occurred in the 1990s to establish health services run by and for Māori^{13 p. 75-78} and the growing assertiveness of a Māori worldview in health policy which challenged the dominant ideas at the time and 'were seen as a chance to re-establish a small measure of rangatiratanga' (or self-determination) by Māori over their own health needs and services.

In New Zealand, general practitioners had always been acutely aware of the need to deliver a responsive service to their patients because patients were, along with the state, direct payers of their primary health care services. There was a more genuinely competitive

market for patients in New Zealand in many parts of the country, especially the larger cities, than in England and although the service had attracted some criticism about a character of paternalism and poor cultural responsiveness, nevertheless the key indicators of patient satisfaction, such as availability and length of appointments and satisfaction with the service provided, were relatively high in New Zealand ¹⁴⁶.

Integration of primary and secondary care

Manifesto statements that 'Labour favours moves towards capitation funding for general practitioners' services' and that 'the present fee for service model has not facilitated integration between various parts of the system and has often inhibited better management of the overall health resource' signalled intentions to make major changes to funding arrangements for primary care ^{39 p.12}. In both countries the budgets for primary and secondary health care had been integrated during the 1990s and regional funders had been given the task to contain levels of primary care spending. Contracts for budget management for pharmaceutical prescribing and sometimes laboratory tests (in New Zealand) and fund-holding for hospital services (in England) with primary care organisations had been the preferred way to do so ²¹. However, both incoming Labour Parties had announced their intention to terminate these contracts. The New Zealand Labour Party also proposed to prevent public funding being spent on contracts with for-profit organisations. This signalled a major challenge to the network of existing Independent Practitioners' Associations (IPAs) which had formed in the 1990s to facilitate contracting between general practitioners and regional funders. These were primarily doctor-owned private companies ¹⁴⁷ and most had adopted contracts for referred services budget management offered by regional funders during this period. These contracts had the intention 'to curb growth in referred services expenditure...and typically rewarded reduced expenditure by allowing organisations to keep a proportion of the savings for agreed projects' ^{148 p.16}. Funders had offered two choices of contract:

- Budget management of a fixed allocation of funding for referred services based on historical expenditure. If, through improved quality of referral practice by general practices, savings in expenditure were made, a share of these savings could be retained and spent by the provider on health services or quality improvement

programmes for their practices with the agreement of the funder. If expenditure exceeded the budget excess expenditure was met by the funder. So these contracts were non-risk bearing for the IPAs.

- Budget holding of a fixed allocation (by one organisation only). In the same way as for budget management, the provider was able to retain savings from improved referral practice but under budget holding contracts primary care organisations such as IPAs carried the financial risk of over-expenditure. In this case, however, there were more flexible provisions for the way in which savings could be utilized.

These contracts had delivered savings which funded significant new health service developments by IPAs²⁶ and those other general practice consortia (including some community organisations in rural communities), which adopted them and funded clinical governance initiatives for their members. There were 30 IPAs in 1999, representing over 75 percent of general practitioners¹⁴⁹ and ‘almost all’ had taken on responsibility for budgets for pharmaceutical services with some also having budgets for laboratory services. The level of savings obtained by some large IPAs and the ability for these Associations to determine how to use these savings without consultation with the community was specifically criticised in the Labour Party Manifesto. A participant in this research suggests ‘there was a perception that the budget-holding exercises of the previous...years had resulted in inappropriate and inequitable capture of funding...and IPAs...gained a lot.’

Primary care organisations which formed within the network of community-governed not-for-profit health centres in New Zealand typically did not take up budget management contracts. Evaluation in 1999 indicated that IPAs, who benefited most from these contracts, were those with high historical levels of expenditure on referred services and high utilisation rates serving ‘well-off populations with general practitioner availability well above the national average’¹⁵⁰. Expenditure on referred services had been observed to grow at rates in excess of population needs in some regions where IPAs had formed and there was ‘increasing evidence that the distribution of expenditure on these services follows the ‘inverse care law’ i.e. that ‘the availability of good medical care tends to vary inversely with the need of the population served’”^{148 p.16}. This concern was shared by both the Labour Party and by National politicians: another participant commented that ‘their organisations

have ended up with enormous amounts of money sitting in a bank and even [a spokesperson within the National Party] just goes apoplectic, it is \$80 million because it is not spent on health...and it was utterly up to the Trust [of the IPA] how they decided to spend it.'

A challenge to heterogeneity

The Manifesto announced that any contracting for services with primary care organisations by the new District Health Boards would be with non-profit groups with adequate community or consumer representation. The health reforms initiated in 1993 in New Zealand had led to a proliferation of new types of services, delivery approaches and organisational forms within primary care. The primary care sector was characterised by increasingly heterogeneous organisational and governance forms. While welcoming diversity especially where services had developed to serve high-needs communities and Māori and Pacific populations, the incoming government was keen to see a more planned, coordinated and community-oriented approach, accountable to Ministers, which delivered benefits more consistently and equitably to different communities within New Zealand and which facilitated improved access to and dissemination of information about service delivery¹⁵¹. The British Prime Minister, by contrast, was seeking to encourage heterogeneity within primary care to improve customer responsiveness.

In New Zealand a careful path needed to be trodden between a variety of heterogeneous general practice and primary health care groups and interests as part of the policymaking process. A major new influence within the general practice sector was the network of IPAs which had established clinical governance processes for their member practices during the 1990s, but so too was the new network of other consortia of general practice organisations and Māori and Pacific organisations which had developed to deliver services to their people during the same period.

Organised clinical governance

Unlike in England where quality improvement initiatives within general practice during the 1990s had been established in centrally-driven national programmes, in New Zealand these

were largely developed through regional professionally-led initiatives arising in the IPAs and other similar primary health management organisations. One of the positive consequences of the contracts for budget management and budget-holding had been the development of clinical governance approaches within these organisations, defined as ‘the exercise of collective or organisational accountability for management of clinical performance,’ to improve the quality and resource management of pharmaceutical prescribing and laboratory test referrals amongst their members ¹⁵². These utilised resources gained from budget management of referred services so that variation in prescribing and referrals practice could be minimised and savings maximised. In a study reported in 2002 which sought to quantify medical practice variation in primary care settings, researchers noted that evidence of ‘substantial inter-practitioner variation in patterns of primary care activity has been established for over a decade’ and that the literature tended to explain this by practice and practitioner attributes including professional uncertainty and supplier-induced demand. This study of prescribing and referral behaviour in 10,000 encounters in a representative sample of general practitioners in the Waikato region of New Zealand found considerable variability in medical practice after controlling for case-mix and patient and practitioner attributes and concluded that some 10 percent of this variation was attributable to physician attributes ¹⁵³.

Complementing general practitioner-led peer group networks, the IPAs and similar organisations implemented ‘comprehensive information systems, computerised practice registers...personalised feedback on prescribing behaviour and laboratory use and peer group discussion of guidelines’ ^{149 p.1341} to address this picture of considerable variation in practice. Malcolm et al found that it was largely based on volume rather than price (in which prescribing members prescribe many more drugs but not necessarily more expensive drugs than low cost prescribers). Savings achieved by these arrangements varied between levels of 5-10 percent of referred services budgets ¹⁵⁴. The Manifesto of the New Zealand Labour Party signalled that privately owned companies would no longer be able to obtain funding in this way for these quality improvement initiatives.

Associated with these developments in organised clinical governance had been supportive national initiatives ¹⁵², including the setting up of the National Health Committee and its launch of a national programme of capacity building for quality, including clinical guidelines

development, in the 1990s. This led to the formation of organisations such as the New Zealand Guidelines Group in 1996 and the Clinical Leaders Association of New Zealand in 1998. This Association had a brief to research the learning needs of clinicians and develop programmes to meet these.

IPAs' goals and policies

Key elements of the Labour on Health proposals were a challenge to the aspirations of organisations representing most New Zealand general practitioners. A survey of 30 IPAs conducted in 1998¹⁵⁵ to explore their goals and policies attained a 93 percent response rate and provides a window into the values and approaches which were developing in these organisations. The survey found that, by comparison with an initial survey undertaken in 1994 to establish a baseline, in 1998 these organisations rated 'achieving better health outcomes for your patient' and 'making better use of primary care resources' as the top goals. Their main source of income was budget management contracts. The majority of respondents supported policies to integrate primary and secondary care funding and to move from historical to population needs-based funding but opposed carrying any risk relating to going over allocated budgets. All opposed retaining savings as personal benefits for practitioners. A majority supported integrated, capitated budgets for general medical, nurse practitioner, laboratory and pharmaceutical services if these could be negotiated group by group with funders, but were concerned about the 'compulsory imposition of a capitated general medical services regime' by funders. The respondents rated their achievements over the previous years of establishing an infrastructure, collaboration between members and developing information systems and primary care resource management most highly. Achievement of community involvement was lowest-rated though half thought it to be quite important. The other half thought it slightly or not important. Just over a third had community representatives on their Boards and seven had community advisory boards. They strongly supported initiatives to develop outcome-related performance indicators and developing multi-disciplinary practice teams but less than half supported sharing of information between their group and similar groups. The conclusion of the authors was that IPAs had evolved towards new forms of internal and external

relationships and a new model of clinical governance and were serving more than narrow general practitioner interests ^{155 p.36}.

Community-governed not-for-profit primary care practices

By contrast, community governed not-for-profit primary care practices employed 3% of general practitioners but these worked in multi-disciplinary teams of other health professionals. In comparison with for-profit practices, they served a younger, poorer, largely non-European population, with higher levels of certain types of health issues including asthma, diabetes and skin infections ²⁶. They and their representative organisations had 'long taken a broader population perspective beyond the traditional general practice focus' ^{102 p.17}. Whereas the focus of the IPAs was on engagement with their general practitioner members, the focus of non-profit practices was strongly on engagement with their local community. The values and perspectives of these practices and organisations were better aligned with the proposed changes outlined in the Labour on Health document. In some regions, these practices joined meso-organisations which were not IPAs but offered similar services to them.

Recent policymaking context for primary health care

The health reforms of 1993 had ushered in a new health policymaking approach in New Zealand as well as revolutionary changes to ownership and governance arrangements for health care. This was a top-down, rationalist and technically-driven approach, non-consultative in its process of design and decision-making ³³. Some of the intended changes were hidden behind the provisions of confidentiality associated with the passage of budget and urgent legislation in the House of Representatives in 1993 ³⁸. It is explored from a number of perspectives in academic analysis of policymaking during the 1993-1999 period ¹³. In the arena of health care policymaking the exclusion of the medical profession from the process was a notable feature of the 1993 reforms. Davis and other commentators ²² also note the subsequent unravelling of much of this policy intent during the process of implementation, as both medical and public opposition to the changes built during this phase.

Finlayson³³ describes the attempts to implement one aspect of the 1993 reforms, to integrate the funding and purchasing of primary and secondary health care services and require general practitioners to enter into contracts with newly established Regional Health Authorities for delivery of services to an enrolled population for a capped sum. These contracts were to supersede the existing fee-for-service arrangements for payment^{33 p.168-9}. General practitioners refused to do this as they had done in 1938 and in later attempts to introduce contracts for their services (such as in 1990). The policy was amended, initially temporarily, to permit continued fee-for-service funding. It was in the context of this 'threat to their financial and clinical independence' that the formation of IPAs began to occur, to give general practitioners 'critical mass for negotiating with the Regional Health Authorities.' Only in one Regional Health Authority did substantial take up of capitated funding arrangements occur. In Finlayson's assessment, 'the Regional Health Authorities' ability to counteract the power of the medical profession was impeded by their lack of information and expertise necessary for the negotiation with doctors.' The relationships between the Regional Health Authorities and the IPAs, though initially fractious, settled into more constructive ones over time. Finlayson notes that the Regional Health Authorities 'subsequently succeeded in overcoming general practitioners historical reluctance to contracting with the Government or its agents. This will provide an avenue for more innovative arrangements for paying for primary care in future'^{33 p.170}. Finlayson concludes that key aspects of the 1993 reforms proved impossible to introduce successfully because much of the policy was based on inadequate assumptions about its environment and because implementation was not a 'neutral non-political stage of the policymaking process...rather the whole process has the potential to be highly politicised, especially when key groups have not been involved in the formulation of policy.' Finlayson further contends that the 1993 reforms were poorly designed and conceived and lacked clear and consistent goals even at policy formulation stage and this made it difficult to implement successfully. It was in the context of this pre-history that the incoming Labour government embarked upon its counter-revolutionary changes in health policy in 1999²⁷.

A Ministerial/Civil Service partnership

Once elected in late 1999, the incoming Labour government began to implement its Manifesto commitments immediately to ensure results could be delivered within its three-year term of office. The new Minister of Health and the Director-General of Health met promptly after ministerial appointments were made. These two entered into a strong partnership to implement the reform programme. A participant observed that working with the new Minister, 'it was a very Westminster 'here is what we want to do, can you tell us how we would do it?'...it was what you would expect and it was very very constructive. [The Ministry] would do the work, test it with her, if it needed to go to Cabinet and come back, very supportive, very willing to be driving but to be patient...it was a good partnership, each...doing [their] own roles which meant that we could get some difficult stuff done.'

Researchers in the New Zealand Treasury offered the new government a post-election preparation report on health and disability support services purchasing, addressing the recent experience of purchasing and provision approaches and offering options for possible evolution. In respect of its advice on primary care, this emphasised the need for purchasers to establish a new set of relationships with primary care providers, especially general practitioners, and noted that 'there were few incentives on primary care providers to consider the wider implications of their decisions for the rest of the sector and [that] the delivery of primary care is imperfectly coordinated with other services'³⁵.

This report acknowledged the benefits of contracting with general practitioners which had seen 'movement away from fee-for-service payments towards capitation and modest budget-holding experiments which have reported impressive 'savings' in GP-initiated expenditure on pharmaceuticals and laboratory tests.' It acknowledged the growing bargaining position of IPAs on behalf of general practice and the increasing sophistication of information held about their member general practitioners. It also noted the diversity of primary care organisations including the not-for-profit primary care organisations which were community-owned and controlled which had grown to meet the need for more accessible and affordable primary care services.

The authors noted the growing support amongst IPAs' leaders for capitation for not only laboratory test and pharmaceutical funding but also payments for consultation fees, but recognised that the major barrier to further extension of a budget management role was that New Zealand general practitioners remained 'largely dependent on private fee income and act as private entrepreneurs who can set their own fee rates without any external regulation [so that policy makers will be] extremely reluctant to see them allocated budgets which cover their patients' use of hospital services.'

The report specifically acknowledged the differences in the primary health care systems between the United Kingdom and New Zealand with respect to co-payments and to budget management contracts held by general practice groupings such as IPAs. These differences were seen to dilute the incentives associated with English general practice fund-holding. Although the report recommended that the incoming government considered the option of further development of primary care budget-holding, it recognised that there was conflict between the status of general practitioners as private practitioners operating small businesses and the government's desire for moves towards larger primary care organisations based on enrolled populations, funded via capitation and involving services of a team of primary care professionals. Advice was given that such a development would need to be connected to changes in the way general practitioners were paid ^{35 p.67}. This would also prevent New Zealand policy-makers giving consideration to the large scale changes which occurred in England in 2010 to establish general practitioners as commissioners of hospital and community care for their local communities, in which they became the principal purchasers in the system, combining their professional power with state authority in a dramatic extension of their professional mandate ^{67 pps. 16-19}.

The Government Strategies

The development of two major health strategies, the New Zealand Health Strategy, published in December 2000, and the Primary Health Care Strategy (PHCS), published in February 2001, was undertaken with the assistance of Reference and Expert Advisory Groups to obtain both clinical and community input. These were groups of members with a wide range of interests including older peoples, women, minority ethnic and disability interests as well as funders and practitioners and academics from the different health

sectors¹. There was widespread consultation on each strategy. The New Zealand Health Strategy attracted 466 written submissions and 1500 people attended over 60 meetings to provide feedback^{156 p.33}. This is a higher response rate, at approximately 0.5 percent of the total population, to consultation than was achieved in the United Kingdom (where responses to consultative documents on the health strategy attracted approximately 0.3 percent of the total population). For primary care, a discussion document was issued in 2000 and over 300 written submissions and 54 meetings provided input into the development of the final Strategy.

The New Zealand Health Strategy has as its predominant theme the need to reduce inequalities in health care¹⁵⁶. Governance changes, structural changes in financing arrangements, goals to improve performance on particular conditions and an injection of new money were the chosen mechanisms to achieve this. The Strategy established thirteen population health objectives to reduce the impact of disease and poor lifestyle choices. The inequalities theme was expressed as a more pronounced theme than in the earlier Manifesto, perhaps reflecting the strong voice of Māori advocacy during the design and consultation process.

The Minister herself was seen by a participant as wanting to 'make a real difference to use the structures to deliver in a way that looked at the fence at the top of the cliff rather than the ambulance at the bottom.' The New Zealand Health Strategy acknowledged that primary health care was critical to both improving health and reducing inequalities in health status.

The PHCS which followed, therefore, set out 'a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals and the advantages of funding based on population needs rather than fees-for-service' (King, 2001). Services in future would be organised around a defined group of people, enrolled with a Primary Health Organisation (PHO) as the local structure to achieve this and which involved the community in its governing process. Ambulatory-sensitive admissions (admissions to secondary care which might have been prevented if services had been delivered effectively in the community) were noted as an indicator of the accessibility and effectiveness of primary care

and tracked as from 2000/1 as part of the assessment of the effectiveness of the PHCS¹⁵⁷. Advice from the Treasury researchers to establish new relationships with primary care providers, especially general practitioners, was noted but not heeded.

Links with past disputes over health policy

The development of the two strategies was seen by some participants in this research as part of a continuing struggle between general practitioners and the Labour Party over primary care health policy (which occurred most intensely over issues associated with private billing by general practitioners). The stresses in this relationship between the Party and some general practice organisations was still fresh in the minds of several participants in this research even though these events had occurred over ten years prior to the development of new primary health care policies. On the balance of the evidence, while they are a contextual factor which deterred whole hearted engagement of some sections of the general practice interest groups representing most general practitioners, they are incidental to rather than a driver of the rationale for the PHCS. The Strategy was firmly grounded in the ideas promulgated through the Alma Ata declaration and the research which proposed to put primary care in the driver's seat within national health systems⁴³.

Other participants close to the Minister for Health appointed in 1999, Hon. Annette King, confirm that she personally led the development of the New Zealand Health Strategy and the PHCS, that the Prime Minister left it all to her as Minister of Health and that there was a 'bit of a myth about [the Prime Minister] and Health...but she wasn't [in the role of Minister of Health in the previous Labour government] very long...and [Labour] had a very detailed manifesto in Health. It was all done in Opposition [by Hon. Annette King as Opposition Health spokesperson who was the Health spokesperson for three years].'

Once appointed, the Minister of Health, Hon. Annette King was given authority to implement the Labour on Health manifesto commitments, with Cabinet oversight. She did so, keeping the Prime Minister informed. This sometimes brought her into dispute with Cabinet colleagues and she is credited with winning many battles, for instance over new money for health services and the need to reflect ethnicity in the allocation formula for health spending. A participant suggests that:

‘...I think the only thing [the Prime Minister and she] ever differed on was...[that] there had to be a weighting for Māori and Pacific...but it was right after [public controversy about a positive discrimination strategy] Closing the Gaps...and there was a real reluctance...[the Minister] lost it actually as a straight decision but did it in another way.’

The Ministry of Health did the detailed work in developing the published strategy, based on the principles of the Alma Ata Declaration of 1978 at the International Conference on Primary Health Care. A participant says that ‘the strategy was actually written by the Ministry with [the Minister’s] input and the input of people...who were very aware of how it works [such as] having been a doctor up the East Coast.’

As a model of governance for primary health care, participants felt it was internationally acknowledged to be one of the first thorough-going attempts at implementation of the Alma Ata principles with fidelity: a participant describes it as ‘the zeitgeist on health around the world, the population-based approach.’

Primary Care Sector agendas

The heterogeneous general practice community in New Zealand had a variety of responses to the proposed changes to primary care. In the early months as the New Zealand Health Strategy and the PHCS were being developed, there was interest and support from within the general practice profession generally. But a Chief Executive of a large IPA summarized the reactions of stakeholders in the primary care sector about particular provisions as ‘varying.’ In her view clinicians were excited about the recognition of the importance of primary care but had their strongest focus on patients who walked in the door, feeling a high level of commitment to advocacy for those patients. They did not understand ‘disparity’ in access to health services well. They felt little responsibility for a population-based approach to health. There was a pervasive feeling that they were paid for seeing patients in consultation, not for those outside the practice register or who chose not to visit the practice¹⁵⁸.

While there was strong conceptual support for the goal to reduce health inequalities, this Chief Executive suggests that doctors did not all necessarily believe it to be their

responsibility and they did not like the targeting of health care to a particular group of patients. They felt that all who were ill needed the same level of clinical response. Despite some familiarity with population-based approaches to immunization and screening for some conditions, general practitioners did not feel that they had the expertise to develop health promotion or health education strategies or to utilize population health tools as required by the new PHCS.

Participants interviewed for this research saw the PHCS as having many laudable elements but containing a fundamental threat to doctors by what they saw as explicit proposals to augment clinical leadership and clinical governance of their practice with a primary care team-based and community-governed approach. One participant says that 'there were lots of things that made general practitioners very tense. General practitioners associated Labour with being anti-general practitioner. This was never manifested in the composition of groups [in which consultation about the PHCS was conducted], they managed [to conduct consultation with an inclusive approach] well. Everyone you would expect to be there was in the groups I was involved in. [General practitioners] are actually a private business and if you don't build that into your policy you will strike resistance and fail in certain ways.'

As another participant put it:

'It was a turbulent time. Government and the [primary care] groups were in a major conflict around how government funding was rolled out ... [the Prime Minister] had had a low view of GPs.'

This period of policymaking was described by a participant as engendering:

'a major cultural shift with the PHCS and PHOs, and organised general practice was really deeply concerned for the right reasons that what had held them together through the 90s and supported a lot of the innovation they got into such as cell groups, utilization review and feedback, performance improvement activities had been...budget holding...[and] had mobilized general practice...Then when the Primary Health Care Strategy and PHOs came along, all those budget holding and budget management contracts were abandoned as inappropriate in the new environment...they were seen as GP-centric as opposed to primary care-centric;

they were not universal in their coverage – just a few IPAs were delivering services under these contracts and there was idiosyncratic budget setting so it wasn't compatible with the population-based funding formula models of DHBs and the PHO capitation formula.'

For one participant, 'the primary care organisation I was associated with made a decision to exit the market and disappeared.' Other stakeholders within the primary care sector, such as community-governed not-for-profit primary care practices and their umbrella organisations, welcomed the changes.

Top-Down Implementation

Unlike the spontaneous emergence of organisational and governance forms within primary care during the 1990s in New Zealand, the legislation for changes to primary care ownership and governance from 2001 was quickly enacted and implemented by the Ministry of Health and District Health Boards, despite misgivings in parts of the primary health care sector. With implementation of the PHCS, the tentative commitments about capitation, including changes to financing arrangements, in the New Zealand Labour Party Manifesto were strengthened and implemented. District Health Boards received a fully integrated budget for all health care used by people who live in their area for primary, secondary and tertiary services. The opportunity for organisations to form as new intermediate non-profit organisations, PHOs, to be funded on a capitated needs-based formula, was set out. There were clear criteria set down for an organisation to become a PHO.

Research has established that 'a hierarchical mode of governance was in fact implemented quickly, with mechanisms to ensure political accountability to the government'^{159 p.118} through the new District Health Boards (DHBs). The Boards and their staff were strongly influenced by national strategies and targets for improved outcomes and integration of health services. A shift from 'preoccupation with resource management to health outcomes as the 'bottom line' of health service organisations' was delivered through these governance changes¹⁶⁰.

In the PHCS Minimum Requirements for PHOs issued by the Minister in November 2001¹⁶¹ the Minister stated that 'Māori providers, Pacific providers, Independent Practitioners'

Associations and other organisations can all evolve into PHOs.’ The requirements specified that services delivered with public funding must be directed towards improving and maintaining the health of the population as well as first line services to restore people’s health when they are unwell; to involve the communities in their governing processes and show that they are responsive to communities’ priorities and needs; demonstrate that all their providers and practitioners can influence the organisation’s decision-making rather than one group being dominant; and be not-for-profit organisations fully and openly accountable for all public funds they receive. PHOs were required to identify initiatives to improve the health of their enrolled population and work with groups who have poor health or were missing out on services to address their needs.

The Minister of Health’s Foreword to the set of minimum requirements stressed that providers and communities should be able to ‘move at their own pace’ and the document stated that the process for implementing the PHCS ‘is to be an evolutionary one’¹⁶¹. Nevertheless, this set of requirements was incompatible with the ownership and governance arrangements of most existing IPAs and would require them to radically change their mode of operation in order to comply with the requirements and access the new funding for primary care services. For example, the survey of these organisations conducted in 1998¹⁵⁵ had reported that the main source of funding for 14 of 28 respondent organisations was from contracts which were now being terminated by the incoming Labour government. All IPAs would need to become not-for-profit organisations if they wished to become PHOs. Of respondents to the 1998 survey, over half were limited liability companies, four were partnerships and four incorporated societies, with two being non-profit trusts.

While it was voluntary for a general practice to become a member of a PHO, there were considerable financial incentives to do so once new funding for primary care was announced. Only through PHOs could new levels of subsidy be gained. By 2005 there were 77 PHOs covering 3.9 million New Zealanders who had enrolled for their services.

The Independent Practitioners’ Association Council of New Zealand sought to influence the new primary health care funding provisions when these were published for consultation as part of the implementation of the PHCS in 2002. A change was eventually made, which later

became known as Care Plus, in the funding package. Participants in this research who were describing the challenges and benefits of consulting on the development of policy for primary health care said 'we agonised over it, we thought it would be easier without Care Plus...but hang on its got some good benefits...what helped was us being open to it if it's a good idea...rather than [say to its proponents] go away its complicated enough.'

Designing the PP

From the Ministry's point of view, once the structural health reforms were completed, there was both the time and the need for other more operational policy design to strengthen primary care performance to support the goals of the PHCS and to deal with policy issues arising from the reforms themselves.

Who was involved

There was no mention of pay-for-performance in either the New Zealand Health Strategy or the PHCS, though the Health Strategy spoke of setting standards and performance targets and rewarding achievement of these. The introduction and approval of the pay-for-performance policy proposal came through a working group led by a senior civil servant which had been set up to find ways to manage pharmaceutical prescribing and referrals to services more equitably within a population-based funding framework, now that budget management contracts were no longer available. Resembling the technically-driven and rationalist policymaking process developed during the 1990s³³, it was nevertheless a more inclusive one which readily adopted ideas from within the primary health care sector, than the process which was used to develop the health policy proposals implemented in 1993. It is described by a participant:

'The idea came forward that it would be very good to incentivise certain performance measures...grew out of the nexus of communication between the Ministry and the sector...the primary health care sector itself had measures and some of the groupings of general practices had gone quite a long way down the pathway';

and:

‘It was also very much in the interests of the Ministry to find ways to increase the commitment of the new PHOs and their funders to improving the health status of their whole enrolled population, particularly since the new capitated funding arrangements carried with it the risk that practices might just sit there with the additional money and not see the people...So [the Ministry] were wanting to shift the focus from the one to one walk in the door fix the big toe to ‘you have an enrolled population, we want you keeping them healthy, we want measures that are collective and for the PHO to be able to influence’.’

The Ministry of Health had an evolutionary ‘build forward’ approach. There was a willingness to build on what existed, such as the utilisation review and clinical governance systems which IPAs had developed. This participant says that officials were keen to say ‘look [they] had this in place prior, could [they] not use something like this in future, could it not be national.’ Understanding that it was ‘fertile ground – [the sector] had done some of the work’ and that ‘[it was possible] to use some of their ideas, [not] rubbishing the structures that were there, [but to] use them to build into the future’ assisted in the building of acceptance of the changes.

A participant in the design team confirms that ‘key elements such as utilisation review and feedback, comparison of individual utilisation patterns versus that of a wider group [was] what we were trying to preserve. In essence that was the nucleus of the 90s that we were trying to take forward into the next stage, but shifting the focus from ‘pharms’ and ‘labs’ into a population health environment compatible with the PHO model and scalable and reproducible across the whole country.’

Another participant acknowledges ‘the government were trying to say you guys had done some performance stuff and we are keen to try to understand that and put it into this new paradigm – I credit them for that.’

The Referred Services Advisory Group

The Terms of Reference for the Referred Services Advisory Group (RSAG) convened by a senior official of the Ministry of Health in 2001 included provision of advice on suitable ways of funding referred services, how to develop and support clinical governance, suitable performance measures and information needs and other tools ¹⁴⁸.

Many providers serving high needs populations had not participated in the schemes. In fact, there were concerns that their populations were under-serviced. A participant explains a motive as: 'we needed to move away from rewarding savings on historical budgets and instead reward quality and at the same time put much more focus on equity. Under the existing arrangements, the more disadvantaged populations tended to have low levels of 'pharms' and 'labs' spending and were missing out – on drugs and lab tests as well as on the opportunity to benefit from the savings achieved by [other] general practitioners.'

Even those areas where use of referred services was high would over time reduce their capacity to make savings. The RSAG was presented with an opportunity to design 'suitable ways of funding referred services to meet the needs of a defined population.' The new PHCS had required New Zealanders to enrol for primary health care services so that these were delivered to a defined group of people in each PHO ^{1 p.viii}. The RSAG was tasked to advise the Ministry, amongst other things, on 'appropriate incentives for organisations to manage referred services within a predetermined budget' ^{148 p.4}.

The Report of the RSAG demonstrates the dominance of concerns about equity which underpinned the initiatives in primary health care during these years. Its subtitle is 'Building towards equity, quality and better health outcomes.' The opening statement of the Summary states that 'There has been concern for some time that the expenditure on pharmaceutical and laboratory services ('referred services') has not been allocated according to need' ^{148 p.3}. The report establishes as its context the report of the National Health Committee in 2000 which identified that 'achieving better health outcomes for New Zealanders, and reducing wide inequalities in health status, is significantly dependent upon better access to and utilization of primary health care services'¹⁶².

Membership of the RSAG was heavily dominated by academic and funder interests. Of ten members, one was a well-known and influential practicing general practitioner serving a community with a mixture of low and high health needs. He had considerable experience in the study and development of quality frameworks. Four were academics, one of whom had undertaken extensive research into IPA budget-holding schemes as well as research into patterns of prescribing and referral from an equity perspective. There were three District health board staff, an employee of a network of primary health providers and an academic employed by the Royal College of General Practice with experience of analysis of practice-based data and a track record in indicator development. None held a representative mandate, however. They were invited to join the group because of their personal expertise.

The RSAG met on six occasions between October 2001 and August 2002 and delivered its report to the Ministry in October 2002. In this relatively short time frame, the RSAG developed recommendations covering the general approach for funding pharmaceuticals and laboratory tests, an exemplary set of indicators, a payment and information management framework and a clinical governance framework together with an implementation plan.

The Report of the RSAG devoted nearly one third of the body of the report to the issue of inequity and variation in the use of referred services. Up to 2001, funding for primary care services had been 'distributed according to the number of services provided by doctors and the associated prescriptions that are written' whereas the new funding arrangements under the PHCS provided funding to PHOs according to 'a formula that reflects the relative need of their enrolled population, taking account of factors such as age, sex, deprivation level and ethnicity' ^{1 p.14}. The new approach to be taken was to provide 'financial rewards for quality practice, as opposed to financially reward under-spending of a budget based on historic spending levels' ^{148 p.7}. To do so the report stated that a set of nationally consistent quality indicators needed to be developed.

The Report acknowledged the achievements of budget management strategies by IPAs in developing amongst general practitioners a 'sense of collegiality and accountability, greater sensitivity to quality issues, acceptance of the need for evidence-based decision making, exposure to peer review and building a sense of identity within a new and broadly based

organisational framework' ¹⁴⁸. It recognises that clinical leadership, the potential for savings and a commitment to promoting good quality general practice had been the drivers of these achievements. In the new environment the Report noted that it would be necessary to establish needs-based budgets for referred services, a set of nationally consistent quality indicators, quality payments to reward achievements, equity payments to increase levels of under-funded regions and systems for comprehensive information management. The Report envisaged PHOs would develop clinical governance frameworks and would need training and support to build on the approaches 'developed to date by primary care organisations' ^{148 p.9}. Consistent with Treasury advice about the perverse incentives involved ³⁵, it expressed opposition to risk-based budget holding as an appropriate mechanism in the new environment but advocated increased payments to enable PHOs to establish organisational systems and infrastructure to support the new approach.

An exemplary set of 29 indicators was set out in the Report drawing on the work done for a primary care organisation, First Health Ltd, which had been published in the New Zealand Medical Journal in 2002 ¹⁶³. Only some of these relate to referred services. The set contains proposed indicators such as advice to smokers, childhood and older person flu immunizations, blood pressure screening, action plans for asthmatics and diabetes management processes. These resemble the breadth and potential for impact on health outcomes of the QOF in England and are consistent with the most pressing health problems noted in the New Zealand Health Strategy. It is in fact a blueprint for incentivising quality and for improving health outcomes generally. The report notes that the commitment by government to a substantial increase in funding for primary care services justified an increased expectation by funders on improved quality of service.

Recommending that the confirmation of a set of indicators is subject to consultation with sector stakeholders, the report goes on to emphasize the importance of an improved and nationally consistent information database to enable assessment of compliance with quality practice and of the availability of clinical governance systems to support practices in improving quality.

It proposed a funding model which offers up to 2 percent of annual average per capita spending, including on referred services, as a reward for PHOs achieving the maximum

quality score. A period of three years transition from the current historical pattern to a population-based funding formula was recommended. Cabinet ministers were advised of the progress with this work and of the policy intention to reward PHO gains in key health priority areas in October 2002^{164 p.7}.

Consultation with the Primary Care Sector

Prior to the completion of the RSAG's report, as part of the Group's deliberations, a consultative workshop on the proposal to establish a performance management framework for PHOs was held in August 2002. This workshop supported the proposal to take the set of 29 indicators and consult more widely with sector stakeholders.

The next step was to establish a group of providers, professional groups and funders to oversee a consultative, internet-based process for developing a broad set of quality indicators for PHOs, with performance measures and targets. The decision to commence this further process reflected the concern that there were strongly held views about quality improvement within general practice. The full participation of medical practitioners in the decision-making around selection of quality indicators was seen to be essential. A participant recalls that though an evidence-based set of indicators was proposed by the Advisory Group, 'it took three more years to undergo a process of achieving buy-in from the sector...it is undermined and challenged still [in 2007]. [Academics] knew better than to simply present a set of indicators as a *fait accompli* - they would not have been accepted. People...had their own measures in place and they were very attached to them. The general feeling was that indicators were an important tool but that each group of GPs should be able to determine their own set.'

Firstly an internet-based Delphi process was implemented. This was a process to debate and decide upon the indicators. Led by an academic, with an advisory group who were in touch with the academics involved in the design of the QOF in England and who co-published articles with them, the process commenced with commitment from a wide variety of participants. A participant recalls that '30 general practitioners were in the sample who suggested indicators, they did not have to meet but we did a lot of analysis between cycles and if someone wanted to get rid of some indicator the reason was provided and little

graphs were sent out...we looked at the attrition rate as people had to...score it and we used lots of different ways [to monitor and encourage engagement]...the only resistance we had was from people who wanted a more rigorous process.' However, participation levels dropped away. Others suggest the process became undermined by technical problems and absenteeism and that small numbers of participants stayed the course of the process. However, one participant noted that this reduced the visibility of the process to interest groups, saying 'because the PP took so long to become concrete, there was not much interest group involvement.'

Following this process, in September 2003 a Clinical Performance Indicator Advisory Group was established to provide advice on implementation of a set of clinical indicators and had commissioned Otago University's Wellington School of Medicine and Health Sciences to develop an indicator assessment tool and report with recommendations for the process for identifying and deciding upon indicators.

The Project to Implement the Pay-for-Performance Programme

In a parallel process the second stage of the implementation of the RSAG report was to establish another project. Leadership of the process was handed to joint Chairs representing the District Health Boards and the Ministry respectively and their brief was to consider management of referred services within an incentivised framework. The intention was that further planning and implementation would also be jointly managed by funder and policy personnel. These two Chairs developed and obtained approval for a project plan which required a large group of stakeholders to come together to debate and design a PP for primary care. They then convened and jointly chaired this group known as the Referred Services Expert Advisory Group (RSEAG). By contrast with the rationalist and technocratic approach taken in the design phase of this policy making process, the implementation phase was intended to obtain maximum engagement with key funder and provider stakeholders.

During the course of the project, the Clinical Performance Indicator Advisory Group and the RSEAG merged their efforts in a collaborative process to develop the final Performance Management Operational Framework and its initial agreed set of indicators, including referred services performance measures, and formed a Primary Health Organisation

Performance Management Advisory group to advise on and support implementation of the programme ¹⁶⁴.

The Joint Chairs of the RSEAG themselves were carefully chosen. One was a general practitioner and ex-general manager of a primary care network organisation who had been appointed to a senior advisory role in the Ministry of Health to support the implementation of the PHCS. Another was employed in a large District health board, who had also had considerable experience in managing budget holding and budget management contracts during the 1990s. He knew the sector leaders very well and his management experience complemented the clinical experience of the other co-Chair. In fact they had worked together in a Regional Health Authority during the 90s and were instrumental in developing a capitated funding approach for general practice that was widely accepted by providers in their region. In this sense these two policy makers resembled leaders of the English initiative – outsiders to the core civil service who could be considered to have high experience and credibility built in the earlier era of market-oriented funder/profession relationships. These skills and relationships were seen as necessary and useful if they could be carried into the new collaborative, community-oriented era.

When it came to the selection of members for the RSEAG and the design process itself, the Chairs had a clear strategy. As a participant recalls:

‘Basically [they] got everybody inside the tent...chose the stakeholders, the people to get into the tent and they were of course all the troublemakers, all the people with very strong opinions on it plus...moderated that a bit by making sure...[there was] vocal Māori and Pacific presence there.’

Members were primarily chosen for their expertise. They included general practitioners, pathologists, pharmacists, people with an inequalities perspective. Another recalls:

‘People selected were identified on the basis of expertise and experience with actually making something happen in relation to clinical governance, not on the basis of representation of professional groups. That particular approach caused tensions. The reality was most of the people were also members of national groups but [they

were chosen] not because they were representing these but because they were recognized as leaders in this area.'

Within the different interests, a distinction could be made between those with experience of organised general practice – the IPAs – and those general practitioners who were focused on high needs population and equity of provision. A participant from within the first group comments:

'the membership reflected the ideology of the times – quite sensibly the government were trying to say [the sector] have done some performance stuff and we are keen to try to understand that and put it into this new paradigm – I credit them for that thinking but the ideology was more important...it was a state-directed programme.'

Some general practitioner members of the group were reported by participants as later disowning the resulting programme. A participant acknowledges 'At the end of it would I say the College [of General Practice] had a sense of ownership around the programme? – absolutely not for reasons which are quite complex...it is a question of control.'

One participant suggested that representatives of IPAs who had pioneered quality improvement initiatives in the competitive context of the 1990s were uncomfortable and unable to quickly adjust in the new collaborative environment. They had been asserting the ability of IPAs to achieve better results but now all organisations could participate in a national scheme and see if this was true (Personal communication). Another recalls the efforts of the IPAs during the 1990s in quality improvement initiatives, both within their own organisations and in IPA conferences, to share techniques, but noted that some were secretive about processes to achieve quality while boasting about levels of achievement.

Levels of contribution and influence within the RSEAG differed, especially between officials and other group members:

'generally those Ministry people were much more involved in it – it's their day job – whereas the GPs were in an advisory role and would turn up once a month. Those who were living and breathing it day-to-day have a sense of confidence about the way they talk about it, the depth of thought they have put into their suggestions, rightly or wrongly, which tend to become trickier for the people who are the

weekend warrior type...to resist the way some of these things go. There are key individuals in those groups who exercise influence at certain times and there are some who command attention throughout the meetings and those for whom a fraction of the decisions go their way.'

The project team, therefore, included members with many differing interests and resources. The chosen approach was facilitative and sought to engage all members of the team in the production of a shared plan for implementation of the pay-for-performance programme. This was an extremely challenging task.

What was done

The RSEAG met over a nine month period. The generation of papers for debate by the Group and literature reviews was undertaken by the small project team staff, one of whom had previous experience of the implementation of PCTs in England.

A participant says

'there was a set of themes and principles that we got straight out of the PHCS that needed to provide the foundation and it was a real challenge keeping those clinical leaders in the tent...those people had a belief system about IPAs that...had been shaped during the 90s and a lot of those principles and beliefs and values were quite incompatible with the PHCS. What [was attempted] was re-orient the world into the PHCS and [there was] some difficulty keeping everybody in the tent through that process. On the other hand they did recognize the issue and everybody knew we couldn't just reproduce the 90s.'

There was a clear recognition of the problem that the Group had to solve and an agreement that there needed to be a conscious, informed decision about this which had the support of clinical leaders. A participant suggests that 'intermediate organisations are very context-specific. IPAs were a result of the 1990s and the philosophy of the 1990s and the drivers of the health system of the 1990s. They were useful in...generating a collegial network of practices and the better ones did good things around quality...but it was highly variable...the Labour government moved to the next level of saying actually primary care is about

populations and it is about communities and it is as much philosophy as it is anything else ... and it is certainly not just a medical model.'

Clinical leadership in the new environment

The proposed restructuring of the primary health care sub-system led to vigorous debate amongst members about how existing systems and resources for clinical leadership would be affected. There was considerable anxiety voiced amongst leaders of IPAs that their systems and resources for clinical leadership would be imperilled in this new environment and income streams upon which they had come to rely would be closed off. A participant explains:

'Performance improvement activities had been funded through pharmaceutical and in some cases laboratory budget-holding...which allowed them to undertake all these activities that had mobilized general practice and led to a lot of the performance improvement initiatives...these people had been the leaders in the 1990s and had personally led a whole round of innovation and entrepreneurial drive and that needed a home.'

The inequalities agenda

There was also the need to address health inequalities and this was vigorously championed by members with experience of community-based primary care service delivery in regions with high health needs and by Māori and Pacific members. There was a perceived need to remove the wide variation in referred services expenditure which was not explained by patient factors and which pointed instead to inequity of utilisation. A participant says:

'[They] needed to have some transparency around equity in budget setting...take [an IPA with] some of the highest pharmaceutical utilisation in the country - how would you set a "pharms" budget...using a national formula? They would never have any savings...[the IPA] had got to get expenditure down to the national norm.'

An equity focus was also important because the international experience with pay-for-performance is that schemes can aggravate inequalities in the short term.

The focus on quality and equity arose in part because the problem of cost containment which budget management contracts had been set up to solve had been effectively tackled already. That participant continues 'The driver of pharmaceutical budget holding had been growth in pharmaceutical expenditure, but actually Pharmac (New Zealand's central purchaser of pharmaceuticals) had that under control, so why bother? In respect of labs that was the start of the period [when] labs were themselves...moved off fee-for-service and onto fixed contracts meaning they were carrying the volume and price risk.'

This meant that quality improvement had to be the rationale for the project, requiring a fundamental shift in focus. The participant further explains 'At the end of the day [it] was about improving performance in primary health care.' There was also an acceptance that 'all patients are in PHOs, all practices are in PHOs, this has got to be a model which is available for all, not just negotiated idiosyncratically IPA by IPA.'

This in turn raised concerns. Another participant says, 'There are some organisations who feel uneasy about funders wanting to get into performance and quality improvement because it is seen as an area where professional control is fundamental.' There was sympathy for those concerns. '[It was necessary] to understand why people would be concerned...do I want to get into bed with government, how could I protect myself ... mostly they wanted to do well for their patients...[they] had to walk in the shoes [of those organisations] – it is classic change management really.'

How it was done

As one participant describes it, it was like herding cats to come up with indicators that were appropriate, with clinical and financial indicators and a focus on Pacific and Māori and high needs all in place. There were often 20 people in the meetings. One of the Chairs was reported by participants to play a key role in getting the dynamics of the group working well and ensuring the process was based on consensus (Private conversation). Another participant believed the vigour of well managed debate created a more robust policy framework. 'Do you want everybody thinking the same and it being easy or do you want a bunch of people who think differently...but at the end of the day you get a better product...because you have ironed out all the ifs and the buts.'

The Group included Māori and Pacific members who advocated strongly for the needs of their communities. A participant recalls

‘Areas of real dispute included whether or not to make recording ethnicity a condition of entry to the programme, some were won and some didn’t get through. Some got manipulated and changed, so they became ineffective in changing behaviour.’

Another area of dispute was whether to focus on one or two major targets with large health impacts such as smoking ‘which is the biggest preventable cause of death in New Zealand. Why didn’t we choose that first? [we some years later] put a proposal...that we should dump everything except Cardiovascular disease and spend the entire money on CVD as the one thing we should go after...it got a hearing but it didn’t win the day but it did change the balance of payments...it is more valuable.’

Pay-for-performance?

The issue of incentivising performance was not prominent in the debates. One participant recalls ‘I am not sure the government was actually trying to implement pay-for-performance.’ An informant confirms that the use of financial incentives was to strengthen the role of PHO and bring in the general practitioners and nurses for education. Participants felt that the financial incentives were used because there was evidence that they worked but their primary purpose was not to incentivise general practitioners.

It will be seen that this differentiates the New Zealand scheme fundamentally from the English one. In England the locus of impact of the incentives was to be the health actions taken by the individual general practitioner with patients on their register, albeit through a new form of practice-based rather than individual contract. The English scheme required an entirely different set of incentives and processes to be managed both in the process of design and implementation and in its eventual management as a pay-for-performance programme. The locus of impact of the New Zealand scheme was on the actions of PHOs to encourage providers of primary care services in their community to focus on preventive health care. The incentives and processes associated with this scheme operated at the level of PHO policymaking and practice, at some arms-length from the health actions of general

practitioners or from the clinical governance systems which supported quality improvement in general practice. The same incentives for individual general practitioners to engage with policymaking which, it has been seen, animated the negotiations in England were not present to the same extent in the New Zealand policymaking process.

This is further confirmed by the strong principle agreed by all parties that the money went to the PHOs rather than automatically into practice income as it would do in the scheme in England. There was no antecedent policy of incentivising general practitioners directly as there was in England. Even IPAs' budget management savings had to be re-invested in clinical governance systems and health services. In fact, this was also a point of dispute for some participants with experience of the earlier IPA schemes who maintained that income from savings in their schemes was never able to be distributed directly to general practitioners as it was possible to do under the PP. The survey conducted by Malcolm et al in 1998 had reported that IPAs considered 'the retention of savings for personal benefits as both unprofessional and unethical' ¹⁵⁵.

The risk of crowding out other valued behaviours was also a concern to the group, explained by a participant as follows:

'It is small by comparison with QOF because the committee didn't want people to spend all their clinical hours focusing on these indicators some of which might not be relevant. It's a burden for practices to do all this extra activity so why would we get them to do activity which would not necessarily improve health...So [they] were reluctant to add in more.'

Convivial debate

The discussions were seen as convivial – one participant commented that 'there were no stand up rows and walking out' and another felt:

'The dynamics in the group were great...we had about the right amount of people with the right types of views and common agreement that we would debate the hell out of them.'

However, there was a pattern of disengagement by some members with experience of organised general practice from active participation in the debates, both during the process of implementation design and later when the PP was launched.

Sometimes the technical challenges of the task were sufficient to transcend deep-seated differences in interests and priorities. Officials were sometimes surprised at the way in which members of the Group appeared to place the interests of their organisations second to the technical requirements of designing an effective scheme. A participant said:

‘I did a presentation to...the Ministry – it’s another one of those vivid memories where you go to the Ministry and say this is where it is going and its completely wrong and [the official] looked at me and said why on earth would YOU tell me this – if we correct the formula it will get worse for [your PHO]...this attitude about PHO motives persists today.’

Another says:

‘There was intense distrust between the Ministry and general practice – always has been and always will be. They have different goals. The Ministry of Health is a bureaucracy and wants to maintain itself and serve its political masters. General practice is not that animal – it has its own role and different parts have different goals like ensuring the financial viability of doctors or maintaining their power and dominance and access to the money and other socialist parts of general practice see the role to improve the health of the population. General practice in NZ didn’t want to see the closeness of the relationship with the government that exists in the UK.’

The plurality of forms of general practice which had occurred in New Zealand was reflected in these debates. The views of the members associated with IPA contrasted with those from other types of primary health management organisations and non-profit groups with largely salaried staff operating as primary care health centres in areas of high socio-economic need. One participant said that these latter were sometimes ‘conscientious objectors to budget-holding and there were some research individuals who chose to support that view, with research of varying quality about suggesting that it was skewing things, couldn’t possibly work with their population. What they used to say was this will aggravate health

inequalities.’ These organisations were seen to provide the model for practices under the PHCS: another participant suggests ‘the PHCS was largely based on the Health Care Aotearoa model – the union/community owned model of health care’; and another says ‘this is what [they were] trying to achieve out of PHOs...almost a reaction against the IPA-type model...the population focus, community-linked, focus on inequalities was what was in the strategy, not focusing on making a dollar.’

In the design stage, the Chairs worked hard to achieve policy recommendations based on consensus within the group, referring these for decision where necessary to the respective sponsor organisations, the Ministry of Health and the combined District Health Boards. Consensus rather than unanimity was achieved within the group. No attempt was made to achieve formal approval from representative primary health care provider organisations or the general practice leadership in New Zealand, about the recommendations for the scheme. Members of the group were not mandated to nor expected to speak on behalf of their organisations. As has been reported above, some, subsequent to the approval of the framework by Ministers, later disowned elements of it.

The final set of thirteen indicators reflected compromise, pressure of time, ready availability of data and a belief that it was better to ‘build the infrastructure and expectations around measuring something’ which could then evolve. There was also a sense amongst some members that it was an important response to a level of:

‘uncertainty about whether these change programmes would still be encouraged or not – budget holding contracts [had been] cancelled so [people] were thinking are we doing this or are we not and there was a certain level of anxiety believing this was a good thing to do.’

Another said:

‘Nobody said we can’t use an indicator because the evidence wasn’t bullet proof – some of the stuff will never get to the 100 percent answer. It’s going to be evolving so let’s just get on and do something.’

Academic advice

The group utilised a variety of consultative methods and the assistance of the University of Otago Wellington School of Medicine and Health Sciences to complete the selection of a small set of thirteen indicators for the first phase of implementation. The selected indicators had to be the subject of existing data-collection processes so did not always directly correlate with improved health status. This issue of data availability also reflected past disputes between IPAs, which had been seen as reluctant to share information, and other community-governed organisations which were keen to collaborate and share information and strategies to improve services with one another. The divergent approach reflected in the survey of Independent Practitioners' Associations undertaken by Malcolm et al in 1998 which showed that 'only 12 [of 28 respondents] supported sharing of information between IPAs and similar groups'¹⁵⁵. A participant believes 'One of the principles of the [doctors in the 1990s] regime was "we own the data". When you strip away the rhetoric you get "if we own the data we own the system. You can buy it but we will tell you which bits you can buy ... this really illuminates the whole system of PHOs versus IPAs. IPAs own the data but PHOs can say we are the community and it is our data – why shouldn't we share it"'. Another group member recalls that some general practitioners were very concerned about privacy risks and that data relating to some indicators such as mental health conditions and breast screening could become identifiable (Personal communication).

Although there was academic advice about the selection of indicators and target setting methodology, the group modified this advice. The selection process recommended by the academic advisors ('the sieve') was thought to be overly demanding and the proposed use of bands of achievement thought to be unfair where if a PHO was at the top of a band only a tiny amount of reward was payable for getting to the next band (Private conversation). The group adopted a model of continuous lines ('the closer the Primary Health Organisation moves towards its target the greater the proportion of the payment they will receive'⁸) so that no matter what proportion of improvement was achieved, the corresponding funding

⁸ PHO Performance Management Programme Updated Summary Information downloaded on 29th March 2014 from <http://www.health.govt.nz/system/files/documents/pages/phoperfmagmtsummaryinfo.pdf>

for that indicator was paid. The work to design a 'sieve' to select indicators was also lengthy and incomplete at the time that decisions needed to be made on the initial set of indicators. One participant says 'The initial set were a bit of a hotch-potch and not necessarily completely academically validated and weren't necessarily consistent to objectives but it was always intended that that was the starting point. [Leaders] used to say 'don't let the perfect get in the way of the good.'

A first step

The set of indicators which were finally selected for the launch of the PP were of three types: clinical; process indicators (focusing on the ability of the PHO to support population health and quality interventions); and financial indicators of pharmaceutical and laboratory expenditure against benchmarks of indicative budgets weighted for unmet need. The clinical indicators were those which could be drawn from national databases in a pragmatic step to enable the programme to get under way. It was decided that implementation of a second set of provisional indicators would need to be contingent on more work at the practice and PHO level. These were to be focused on chronic disease (including smoking status, statins use, recording of chronic disease and certain data relating to cardiovascular risk, diabetes, urinary tract infection investigation and tests for iron deficiency).

The framework for targets, scoring and rewards was constructed on a PHO baseline performance level. In the first measurement period, to attain full marks those with low levels were expected to achieve more than those whose levels were already at or near the national goal. The clinical indicators constituted 60 percent of the total possible score and financial indicators 30 percent, with 10 percent for process achievements. A double weighting for achievement for high needs populations which could be identified within a PHO total enrolled population was provisioned. The rewards could be used for extending or introducing health programmes, quality initiatives, continuous quality improvement infrastructure, rewarding practices for effort or funding professional development, as agreed between the PHO and the District Health Board.

The indicative budgets for referred services management for each PHO, against which their expenditure performance would be measured, were set taking account of estimated

historical expenditure and utilisation based on age and gender, an allowance for policy changes and an unmet needs adjustment to reflect low historical utilisation in deprived areas. However expenditure would be measured at a practitioner level. If the PHO expenditure was found to be in excess of the target, it would not receive the full score for that measurement period. This made the need to have a strong connection between the PP provisions and clinical governance mechanisms in each PHO critical to the success of the scheme, which was not seen to have been achieved in subsequent evaluations ¹⁶⁵.

At the Minister's request, officials had scoped the options for rewarding PHOs for charging low fees to patients as part of the PP. This was not recommended because of a number of perceived technical and other risks, however, provides further evidence of the continuing search by Labour politicians for ways to discourage co-payments which might create barriers to access to care for people with health needs.

Funder sponsors were pleased with the process of policy design, which was reported to the Minister of Health as an operational framework in 2004 ^{164 p.7}. Funding was approved by Cabinet in July 2004 ^{164 p.2}. The Cabinet Social Development Committee, in August 2004, noted that the Cabinet had invited the Minister of Health to report to the Social Development Committee annually on 'the development of effective accountability measures to ensure that PHO funding is used as intended, including incentives such as performance-based payments and sanctions for PHOs' ¹⁶⁶ and received regular reports on progress thereafter. A final report to the Minister of Health, detailing the 'emergent approach' with a 'good level of sector buy-in,' was completed in May 2005 ^{164 p.16} with recommendations for the implementation of the Programme. In all, the process took a further two years from the completion of the Referred Services Advisory Group report in October 2002 to complete the detailed policy design for decision. Together with the subsequent implementation projects, the whole design process took five years to complete prior to the commencement of the PP and a further two years for implementation.

Implementation

In a second phase of policy implementation, a Primary Health Organisation Performance Management Advisory Group was tasked with the development of an Operational

Framework for the PP in 2004. Feedback on the draft framework for the PP had been sought, as in England, from the primary care sector in a national road show in that year. The set of indicators and the funding framework were approved in July 2005. A new organisational network, District Health Boards New Zealand (or DHBNZ), had formed in 2001 to strengthen coordination between the 21 District Health Boards, offering services including industrial relations, liaison with the Ministry of Health and leadership in regional collaboration. A team within this organisation led the roll out of the new PP with great skill and patience. The approved framework was introduced in two further road shows in 2005 to give details of its operational aspects and to give technical report training to staff of PHOs and District Health Boards about the PP. It is clear from the framework documents that its purpose is to 'improve the health of enrolled populations and reduce inequalities in health outcomes.'⁹

Finally, in 2006, the network of, then, 81 PHOs, were invited voluntarily to take up the PP. Those PHOs wishing to participate had to demonstrate that they had recorded ethnicity for 85 percent of their patient register. They also had to show compliance with the fees agreement in their contract with their District health board. On this basis they could obtain funding in two instalments to establish the PP: an initial sum to assist them to establish the PP and a further payment to accompany an agreed Performance Plan. To obtain this agreement they needed to show that they had complete reporting of general practitioners' information with sufficient data to enable baseline reporting of the performance indicators and compliance with the reporting requirements in their contract with their District Health Board (such as service utilisation reporting and associated Immunisation Reporting). Each District health board was free to add its own funded indicators or to add more funding to a national indicator to reinforce particular local needs. It was expected that all participating PHOs would use their existing clinical governance structures and processes to engage clinicians and achieve improvements. Disbursement of payment would be according to the agreement reached between the PHO and their District Health Board. It was recognised in the Updated Summary Information that 'General practices will be the ones that change and improve clinical practice to achieve against performance indicators. They will be supported

⁹ PHO Performance Management Programme Updated Summary Information downloaded on 29th March 2014 from <http://www.health.govt.nz/system/files/documents/pages/phoperfmagmtsummaryinfo.pdf>

in this by their PHO. General practitioners will receive individualised feedback reports on their pharmaceutical and laboratory utilisation compared to their peers...nationally consistent educational materials tailored to their local needs...[and] other services...which may include clinical facilitators who can discuss utilisation patterns.'

Thus the implementation of the PP was consistent with the approach taken to the PHCS in general: it was seen by one participant as 'a very permissive environment and not in my view micro-managed...there are central controls and accountability but there is an unprecedented opportunity to create your own micro-climate.'

Twenty-nine PHOs participated in the first phase of roll out (a number higher than expected), rising to 42 the following year. The number of participants in 2007 rose to 81 of the then 82 PHOs. Achievement levels against the indicators averaged 81 percent in 2009. Payments were made six-monthly to the PHO based upon performance reported to them in two previous quarterly progress reports. The performance payments so earned are calculated based on \$6 per head of enrolled patient population for each PHO divided by the percentage achievement level. For a PHO with 70,000 enrolled patients and average achievement (81 percent), the annual performance payment would be just over \$330,000. This might have resulted in an annual payment of over \$20,000 per practice (based on an average enrolled population of 5000 per practice).

This was in fact a significant amount of money. A participant recalls 'The Referred Services debate was really crunchy because we knew we had money – all the prior stuff was theoretical but here was money.' However, the size of the potential rewards for practices was not promoted by the Ministry and was a surprise to participants in the governance group of the PP after its roll out. It was not promoted to practices after roll out. Doctors' representatives may well have been misled by this. They were surprised by how much funding was available but not being accessed when they discovered the amounts budgeted for the programme.

Some years later when the governance group for the PP had been extended and included more members from large general practice organisations, a discussion was held about the funding available for the PP. A participant recalls that '[on the group it was] said there was a line item for \$35 million but they didn't expect to spend it because people wouldn't achieve

the targets. In the room GPs suddenly had a quick discussion and said so if we lowered the targets we could get all that money and the Ministry people nearly fell off their chairs. It was a good example of the thinking of different groups.'

Results began to be published in 2008. There had been minimal general media interest in the scheme though regular coverage in NZDoctor.

The decision not to pilot the PP was based on the confidence that several precursor schemes had been trialled and because the scheme was deliberately small and incremental in scope. It was recognised and acknowledged to people that this was something being trialled, it wasn't perfect and there would be improvements. It was a start and the end point was not explicit at the time (Personal communication).

In the next section, the barriers and enablers of the policymaking process are explored. Then a set of evaluations and reviews of the PP are summarised.

Barriers and enablers of the policymaking process

In this section the major barriers and enablers of the policymaking process are set out as described by participants. These were identified from interviews and documentary analysis and affected key goals which can be grouped under five main headings:

- Redistribution of general practice resources
- Balancing funder interests and clinical autonomy
- Shaping patterns of interaction between the state and interest groups
- Solving technical challenges (including choice of indicators, obtaining access to practice data and testing the model)

Redistribution of general practice resources

As in England, the pay-for-performance programme was a part of a larger primary health care strategy. New Zealand's Labour politicians in 1999 sought to implement a 'counter-revolution' to restore universality, hierarchical governance and community engagement in health services²⁷ and resolve inequity of access to primary care services. This inequity had

arisen as a result of a number of factors including historic patterns of distribution of general practitioners, variations in their resource utilisation and increasing levels of patient co-payments for consultations. These problems of universality of access and governance were not so pressing for English policymakers who had a universal system which was free at point of use and also had funding based on capitation and a system for patient enrolment.

The PHCS in New Zealand moved the funding environment from a targeted, fee-for-service arrangement to a universal, capitated environment for general practice, with higher funding levels to reduce co-payments to patients. The governance arrangements to establish District Health Boards and PHOs with capitated, integrated and capped budgets gave new mechanisms for funders to achieve more equitable distribution of general practice funding and services. To support these mechanisms, particularly the introduction of capitation, the state also needed to achieve the enrolment of all New Zealanders with a PHO. The requirement to allocate a unique National Health Index identifier to all patients accompanied this initiative and provided a system for tracking service use and a population denominator for measuring practice and primary health organisation performance.

In practice this meant that PHOs and their general practices then had to be supported to utilise data about their enrolled population and plan resource utilisation in a capitated funding environment. One participant confirms 'we were trying to make sure that at a PHO level there was accountability for an enrolled population...keeping them healthy, we want measures that are collective and for the PHO to be able to influence...members/practices.' Another notes that the decision to attach the PP to the contracts which existed between District Health Boards and PHOs was significant and integrated it fully into the process to ensure implementation of the PHCS. This desire to incentivise the PHOs to achieve targets rather than to reward the general practitioner for improving the quality of practice is in contrast to the QOF which was seen incentivising doctors directly for particular health actions.

In a second strategy to redistribute general practice resources, additional funding in the form of higher subsidies for visits to practices was made available to regions with high socio-economic deprivation. Availability of these higher subsidies was contingent on practices agreeing to limit co-payments to patients. This was a visible policy conflict, both for the

Minister, who sought the elimination of financial barriers to health care, and for the representatives of organised general practice, who continued to cherish the right of practices as private businesses to set their own fees. Descriptions of this battle over fee levels are prominent in participants' recollections of the policymaking process shared in the course of this research. Until it was resolved, by reinstating an earlier fee oversight regime with a fees review committee and independent lay chair, as described by one participant, the roll out of the new higher levels of subsidy for communities with high socio-economic deprivation was thought to be at risk of stalling.

As part of the larger Strategy implementation process, the Ministry recognised that there was value in the improved utilisation management achieved by budget holding contracts. The PP, a national programme offering incentives to continue this focus on utilisation review, 'had the same objective really.' It was recognised there were existing models of organisations getting rewarded for spending below historically high levels and that a national pay-for-performance framework could ensure that this continued. It was recognised that some areas needed to increase spending to reflect historic patterns of under-utilisation of pharmaceuticals and referred services. So the pay-for-performance policy was another mechanism to achieve redistribution of funding based on need rather than on historical patterns of resource utilisation and was focused on 'population not practice.' Another agrees that 'we needed to be much more quality-focused, population-focused rather than just utilisation-focused. Another participant closely engaged with implementation confirms that although the first tranche of indicators was very provider-based, the intent was not to manage the performance of providers. It was always intended to be PHO-based, to strengthen PHOs and emphasise a collaborative environment.

An area of health inequality which particularly concerned the Labour government³⁹ was the need for 'significant improvement...in the effectiveness of health service delivery to Māori and Pacific peoples.' At all stages of the process of design and implementation of this policy making episode, the voices, needs and concerns of Māori and Pacific communities were strongly reflected. Within the RSMAG, the theme that 'Maori, Pacific and low income groups are among those who have been missing out on primary care...' is more strongly expressed than in the Manifesto^{148 p.3}. This was a primary purpose of the PP's counter-balancing initiatives to deter under-servicing. Population-based treatment and screening initiatives

were not core business for general practice and took both time and resources which practices did not believe they had. One participant thought ‘you need to target to improve access. For [some] areas...which needed to reduce their utilisation down to a national norm, within that they needed to increase utilization for some. It required a level of sophistication that was very very challenging and that is why it was absolutely critical to have the [Māori and Pacific voices] in the room as advocates for those populations and the need for clinical leaders to step up to make a difference to health inequalities...[the Māori and Pacific members] were very powerful in that group. They weren’t put off by the need to be outspoken.’

Another participant recalls that ‘the old style fund-holding worked well in some areas but where it didn’t work well was inequalities and this was really in vogue back then. It was part of ‘the new’. Closing the Gaps [in outcomes between European New Zealanders and Māori New Zealanders] was one of the really significant things Labour came out with when it was releasing the strategy so...designing a Referred Services stream that didn’t rely on historic budgets (because that is what promoted the inequality) meant that it drove it down an incentives programme route.’ For some it did not go far enough for fast enough. A participant confirms ‘Areas of real dispute included whether or not to make ethnicity a condition of entry to the programme, some were won, some didn’t get through ... the other thing we kept saying was why should we pay for achievement for the dominant population when there is no problem. Why wouldn’t we...only pay for results for the priority population – which might shift depending on the indicator...we didn’t win that debate.’

One participant subsequently reflected:

‘One thing I feel really positive about is the focus on inequalities across the programme. While that was a principle at the front end at the start of the process there was no detail about how that was going to be achieved. In particular, it was the participation of [a particular member of the group].’

Balancing funder interests and clinical autonomy

Participants describe a conflict between funder interests and clinical autonomy in three major ways during the policymaking process for both the larger PHCS and the PP design:

seeking to influence health actions of general practitioners, the principle of clinically-led quality improvement and fee levels. The first two are focused on here.

In New Zealand the Labour Party policy document Labour on Health included promises that funding arrangements would be focused more on the outcome which is being expected than on specifying exact types of services to be delivered, that quality and effectiveness is the yardstick by which success of a service would be measured and that there would be long term funding for those organisations with a history of providing a quality service. These add up to a strong theme of improving quality to improve health service outcomes^{39 p.3-4} and the PHCS took up this quality agenda, incorporating a section to 'Continuously Improve Quality Using Good Information'^{1 p.24}. This section acknowledged the range of quality tools used by various IPAs and spoke of organisations rewarding and supporting a culture of continuous improvement. However, these are the most general and high level statements. Participants described needing to 'put the meat on the bones' of the Strategy to turn it into policy which could be implemented. A participant who was closely involved in later design stages confirmed that 'a whole mixed bag of people and organisations were raising [their fear of] losing our focus on quality improvement...around pharmaceuticals and labs' and this was the origin of the idea for the PP.

While it was understood that it was 'the natural desire of independent businesses to be independent of government...if government is putting more money in then there has to be a balance between Government being specific about what they are going to get for that money.' It was believed that doctors had firmly held views about things like the patient relationship. This was echoed by a participant who confirmed that uneasiness 'about funders wanting to get into performance and quality improvement...this area is one of the defining characteristics of a profession.' Much discussion focused on 'the boundary between professional issues and funder issues.' Another on the group confirmed that 'the old debate between PHOs and IPAs about who has real control – the community board of governance or the health professionals...was another arm wrestle going on....General practice in New Zealand didn't want to see the closeness of the relationship with the government that exists in the UK. Go back to the Bassett era [a former Labour Minister of Health] and the attempt to control general practice and...they saw it as a victory over the forces of darkness.'

Once the policy design process began, a major and fundamental division occurred over whether the process of design of a quality improvement system should be clinically-led (primarily by general practitioners) or driven by community priorities. A participant, in commenting on who was involved in design of the policy, confirmed that 'it was a big call to have a multi-disciplinary group – part of the issue was that...what you wanted delivered wasn't delivered by general practitioners anyway...there is more to primary health than general practitioners and they didn't like you saying that but it was true ... if we go back to totally doctor-dominated general practice then we have lost all the idea that the PHOs weren't just about going to the doctor.' Implicit in the comment was the recognition that the product of the policy implementation process was not specifically directed at general practitioners but at the wider primary health care professional team.

Many participants were not concerned about the make-up of the group or the role for a broad range of primary care professionals in setting clinical standards as it was consistent with the way in which community-governed not for profit practices, with which they were familiar, operated. For IPA-oriented representatives this was a more fundamental issue of control of a core aspect of professional identity – independence.

There were big debates about who should be at the table. For one participant the issue was simple:

'This was a state-directed programme. I have often reflected that I don't think a single thing [some participants] said...was reflected in the programme that was rolled out...[such as] peer-led, based on feedback and performance data to individuals, the data referenced to colleagues and the group as a whole and using clinical meetings based on the evidence and outlier management visit...a non-judgemental, peer accountability process.'

Amongst some representatives of general practice it was believed that in New Zealand the intent of the PHCS was to replace clinical leadership and governance with community leadership and governance, and an attempt to make 'the union/community owned model of healthcare...the New Zealand health care system model.' The PHCS had not used the words 'general practitioner' and this was seen as ominous by many in the profession. Another participant reports that the Independent Practitioners' Association Council of New Zealand

set itself the role, though it wasn't given a formal mandate by Ministers for this, to 'ensure that there was appropriate general practice governance of the programme and there was appropriate and robust evidence underpinning what was going to be included in the programme.' However, in the initial design, it is acknowledged by another that 'they had a small part in it.'

By contrast with processes in New Zealand, one participant describes how in England 'the Secretary of State [for Health] was on stage talking and he was entirely comfortable with talking about a GP-led system.' One participant contrasted the New Zealand process with the process of contract negotiations in England: 'New Zealand has always been a more socialist society...Internationally there has been a move to genuine primary medical care. New Zealand took that seriously and decided to negotiate without [mandated general practice] representatives. The Treaty of Waitangi meant we always had specific obeisance [to Māori as citizens], which often came through [stakeholder organisations such as] Health Care Aotearoa and representatives of Māori or someone with this interest in the Ministry. We did have a far more democratic...history than the British – [their process of policy making] was much more collusive.'

While these divisions were strongly felt by participants, to some extent participants were talking past one another. Another participant comments that this anxiety about the place of general practitioners in the PHCS was misplaced: 'if you go to the public record and look at speeches of the Minister of Health around the PHCS at the time the vast majority identified general practitioners as absolutely central within primary health care delivery...but secretive competitive commercial models are not compatible with...a more community collaborative multi-disciplinary model.'

Shaping patterns of interaction between the state and interest groups

In the New Zealand case study, most political energy was focused on changes in governance structures including the implementation of the new PHOs. There was great importance given to relationship-building, with widespread consultation and stakeholder engagement over the proposed policy changes.

There was a history of adversarial relationships between some parts of the general practice sector and the Labour Party which had always added to the difficulties faced by Labour governments to build positive working relationships with all parts of the general practice profession. One participant comments that 'I think it goes right back to the first Labour government when they wanted to have socialised medicine...and general practice was an important part of it...and the fight started back then.' By contrast with politicians in England who had 'quite a lot of support at times from the BMA...that was very rare [for a New Zealand politician to] ever get a compliment.' Another dates the lack of trust of some professional leaders of general practice to 'the 1940s since the first attempt to get the Social Welfare Act together post war...but they walked away from it and said no we don't want to be a part of it and the subsidies that were there got smaller and smaller and the rest is history.' Another spoke of 'the stories that rolled around Labour conferences – bad doctors hadn't fallen in with the social security legislation in 1938' and went on to say 'Actually I don't think it served anybody particularly well: we can't change history.'

Like the English policy-makers, much effort in New Zealand was directed at demonstrating a new collaborative approach and seeking win/win solutions to policy dilemmas, but in a context of consultation with stakeholders in primary health care, not negotiation with appointed representatives of general practice. Speaking generally about the whole primary health care changes, one participant comments '[we knew we] had to bring [the general practitioners] along because it wasn't only about what they charged but getting them to think differently about a health team...with health it was a relationship issue...it really was about relationships, first, second and third, and money...[we] used force of personality, partly.' '[If you] looked at what had happened to [previous Labour Ministers]...in the end they would fight...and they would undermine [the Minister]...so [we thought we] had to do it by power of persuasion.'

Many acknowledge the key role played by the Minister, including opponents: one participant says 'she just had the personality to make it work'; another says 'She achieved amazing change within general relatively low noise.' The Minister understood the benefits of a variety of approaches: she reportedly knew that 'telling [general practice] to do things hasn't worked but money has – money talks to them.'

A participant suggests

‘They wanted the money because primary health care was struggling in comparison to someone who was in a specialty. [She] addressed many of their meetings and it was trying to be cooperative, flexible, pleasant whilst having a bottom line and then [she would] reach her rub with them...reach a crunch point and say you are doing it and a fair few of them came along with [her].’

Developing good working relationships at all levels and all phases, especially implementation, were explicitly prioritised. Describing one of the joint Chairs, a participant said it was agreed that ‘we need a really key person who is going to be influential, the status to be able to relate to the sector...from the point of view of persuasion, influence and mana [or respect from colleagues]’.

One participant saw this as a consequence of the unique New Zealand approach to primary care: ‘we don’t operate by command and control so...it is about people and relationships and influence...[the NHS] overall system is command and control...it is a much more strongly medical model than in New Zealand. It is accepted that the doctor will be the leader of the team, whereas, if you said that in New Zealand you would not get out alive.’

Design needed to be managed through individuals because ‘there is not a unified representative structure for general practice...[and within general practice] you certainly have different groups’. One participant, comparing the New Zealand scene with England, found that general practice was ‘slightly fragmented and doesn’t speak with the same political voice that the BMA does.’ Even the leaders of national organisations agreed that there were major divisions between them as well as between the large organisations and some smaller ones ‘who weren’t part of the national thinking.’ Another participant says ‘In those days the College was in bed with the government, the NZMA were working as one and the rural general practice network didn’t count so much really and then you had [large PHOs] and PHONZ [Primary Health Organisations New Zealand]...who had a completely different view of the world...there was always a tension between Health Care Aotearoa, the Māori-led PHOs and the mainstream white pakeha [New Zealand European] organisations.’

There was a view expressed that differences of policy preferences existed between those people considered to be leaders of general practice and the main body of opinion within general practice. It was suggested that leaders were more sensitive to threats to the independence and autonomy of the profession. A participant explains: 'When you are putting in capitation funding there is always the thing that you control it because you set it ...when you are setting up a pot and divvying it up that is fee control. You may reward people a little bit more if they restrict fees, have zero fees...all these things are direct attacks and the leaders tend to be of this ilk: it is regarded as evidence of control and monitoring of professional standards and quality of care something which is the responsibility of the professional body.' A participant recalled a survey of general practitioners conducted by NZDoctor, a fortnightly publication which is delivered free to all full-time general practitioners, showing that the organisation which claimed to be the preferred representative for 'organised general practice' was ranked third of the organisations who speak on behalf of general practice. One participant considers that the New Zealand Medical Association was consultative about the position they should take on policy matters in a way which was not a 'charade' but that generally there has been a lack of representation of general practitioners. Another said there are regional differences: 'there is democracy in different ways at a regional level. In Christchurch it is quite democratic ... they really do engage with their docs on these issues and ask them but in other parts of the country it is not like that at all...leaders will determine what the direction is, then advise.' Another asks 'in a devolved system which is what we are, what is the value of a nationally professional representative organisation versus...local clinicians in local communities getting engaged with their funders to sort their own problems out?'

This meant that it was complex for general practitioners to obtain representation on issues which were of key importance for them, such as fee control. For individual general practitioners themselves there is some evidence that this diversity and disunity was affecting morale. A survey of this was conducted in 2000 attracting a 68% response rate from 658 general practitioners. This found that excessive paperwork, bureaucracy, multiple problem consultations, time pressures and combining work with family life were potent causes of low morale and unhappiness but that morale was higher than in the United Kingdom where these factors were exacerbated by structure, management and

expectations of the NHS¹⁶⁷. While less paperwork and a higher General Medical Subsidy were the preferred solutions of 171 and 153 respondents respectively, a preferred solution of 108 of 448 respondents who suggested solutions was a united and realistic representation for the profession.

The IPAs were a distinct set of interests in the institutional mix. A participant's assessment is that the general practice sector 'became dominated by health sector corporates whose membership was private and that were dealing with very large amounts of public money so the dynamic then changed very considerably...wasn't planned but was in response to government's introduction of contracting and government's desire to organise primary health care in a more systematic way.'

As a participant explained, 'going from a Union Health Care Clinic to a Procure [a large IPA] – two vastly different structures.'

Another participant remembers that:

'those big corporates [IPA] – their behaviour was mixed. Quite a lot of it was progressive and pro-system and quite a lot of it was self-interested...basically holding back...[in the face of] government...wanting legitimately to have a say in what goes on in primary care.'

Others said that there were major divisions between them and between the large organisations and some smaller ones 'who weren't part of the national thinking.' A participant found the general practice organisations 'very mixed. Some were really helpful but others were set on frustrating the process. They had firmly held views around things like the patient relationship – 'how dare the government try to get in there!' It wasn't just about the financial impact...[it was said] that one GP leader had said 'This will never happen, PHOs will be gone by next year'.' One participant characterised the successive attempts by governments over the years to make policy as a 'ridiculous dance of 'please do this we are begging you and we will give you a bit of money' and they say 'bugger off'.' Another participant notes that the government position on 'boundaries between legitimate government control and private sector control' has been confused over the years and

subject to debate while the IPA for instance have been much clearer about where those boundaries lay.

Solving the technical challenges

Technical challenges dominated the design of the PP to a greater extent than the policymaking process in England. Problems relating to choice of indicators and obtaining access to data led to a decision to proceed with implementation on an incremental basis.

Choice of indicators

Selecting clinical indicators presented many challenges, despite many methods being utilised to obtain agreement on these. A comprehensive set of 29 indicators was proposed by the RSAG in 2002. However, consultation with the sector through a Clinical Performance Indicator Advisory Group using a Delphi process, as well as enlisting academic advice, failed to achieve agreement on this larger set. A final set of 13 was selected and implemented.

Obtaining access to data

The problems of inadequate centrally-accessible data were frequently mentioned by participants as a barrier to the scheme. A Ministry official confirms that the initial programme was based pragmatically upon data elements that were readily available from central sources, even though those data did not relate to outcomes the Ministry was interested in. This left them open to criticism that the indicators were not relevant. However, a participant, while acknowledging that a number of the indicators were not that meaningful, saw the value in using readily available rather than perfect information and not achieving a national target in step one but setting a baseline and measuring incremental improvement from that baseline. He acknowledged that to move to the stage of more meaningful data would require access to practice management systems and that would raise the questions about 'ownership of clinical information and its accessibility to people outside practice. That is the next major challenge for the health sector.' This was a major issue: it was believed a new database would have taken many years to create (Private conversation). A participant saw general practice claiming to 'own the data' and although

some participants agreed 'you needed real time data', another thought this would lead to government seeking to obtain access to practice data using 'spyware.' Initial data was in fact drawn from systems designed for payment purposes so presented many quality problems to the implementation team.

This differs from the situation in England where policy-makers were able rapidly to design and implement a new computerised database through which all general practices could input their activities, get real time feedback on progress towards targets and their entitlement to payment could be assessed and tracked. This was a deal cut in the negotiation between the parties and facilitated by the national basis on which negotiation and contracting was conducted. By contrast the breadth of the New Zealand scheme was severely curtailed because the choice of targets was limited to those available on the existing national databases to which funders had access. These targets were not those which would ideally have been prioritised for such a programme – they were the only ones with the data available, however. Gauld records the isolated development of information management initiatives, lack of central oversight and difficulty for government to influence these activities in 2002 ¹⁶⁸.

Because of the holding of patient data at the practice level in a variety of different practice management systems, the route to increased clinical accountability in New Zealand lay through the profession. The profession in New Zealand held the information critical to a large and adequately monitored set of targets, though it existed in a variety of largely unconnected databases. In the New Zealand case study the profession can be seen to be using patient data-management systems as a source of power, contending that they owned the data and therefore had a key strategic advantage over the operation of the whole system. One participant believed that they would drive a very hard bargain for access to the data. An effect of this strategy was dramatically to limit the Performance Programme in scope. Without the engagement of the profession as a whole in the negotiation of an agreement to share detailed information about general practice activities on a national basis, the scheme was bound to be a limited one and to have a limited potential impact upon health outcomes.

Testing the model

PHOs were invited to take up the scheme in their own time and way, within certain important parameters. This is in sharp contrast to the large-scale reforms of governance of the health system in 1999-2001 which were revolutionary in character^{25 27}. Scepticism about pay-for-performance but also recognition of the imperfect levers and limited history of effective accountability mechanisms between the state funders and general practice drove this decision to proceed on pay-for-performance policy implementation with caution. A participant says the Ministry believed that 'being able to evolve it rather than a revolution was quite important' and officials wished to evolve it as they could see it working. Another participant reports the Group was keen to 'build a momentum rather than a quick fix...creating a platform on which things could be built and modified over time.' Another acknowledges that the selection of indicators was a 'start here list. We always knew that these were going to change' and a member of the group agreed that 'It is going to be evolving so let's just get on and do something.' A manager involved in implementation, speaking about the decision not to pilot because of previous successful examples of incentive schemes, confirmed that the incremental nature of the policy process was deliberate (Private conversation). As it happened 'getting into the finer details – this has taken literally years' is the view of one participant and 'It is only now we are getting rid of some of the crap indicators.' He acknowledges that 'you build the infrastructure and expectations around measuring something...When you have got that infrastructure and attitude you can supplant whatever indicator you like so there is always a value in moving towards that.'

A number of participants commented upon the anxiety felt about pay-for-performance schemes having unintended consequences ('the amount of money was small because of nervousness...it could be increased over time if it proved to be effective'; it was a 'building towards equity, quality and better outcomes'). Some note that the QOF was being closely watched and 'our people were happier with [small incentive money] because they felt that...there is a risk it will take you down too narrow a pathway.' A participant explains that 'The amount of money was small because of nervousness and doubt about what to measure and incentivise. If you got it wrong and put too much weight on it you could have perverse

outcomes, for example a focus on the things being measured at the expense of other equally important aspects of primary care.’ Another says ‘There was ambivalence...there wasn’t any evidence that it was working or not working – it was too early.’ A participant acknowledged the concerns about possible gaming of the programme. Another recalls anxiety at the Ministry about the large percentage of money which had already gone to general practice from budget management contracts during the 1990s and wanted to make sure this money was more designed to help PHOs to get a structure and focus on quality within primary care (Private conversation). Pay-for-performance could be ‘oversold’ according to one participant, seeing it as ‘one piece of the jig saw but only one piece...what does it take to influence clinical decision-making – the environment in which you work, your contact with peers, focus groups, measurement, reward for measurement. But it isn’t a silver bullet.’

Evaluations and reviews of the PP

At a conference of general practitioners affiliated to IPAs in 2006, held in Auckland a few months after the launch of the PP on January 2006, the QOF of the new General Medical Services contract for English general practitioners was prominently presented and debated in several full conference sessions. A former editor of the BMA journal, the BMJ, a former President of the General Medical Council and other academic commentators were brought to New Zealand to address the conference. By contrast, the New Zealand PP was profiled in a single session, concurrent with several others, by two officials involved in its management. In presenting it, officials stated its purpose to:

- Improve health outcomes
- Reduce disparities
- Encourage clinical governance
- Share good models
- Assist with improvement costs and
- Reward excellence.

The intention of the scheme to protect intrinsic motivation through its very indirect use of financial reward was highlighted. In this feature there was clear contrast with the QOF ¹⁶⁹.

In the same session a senior manager from a large IPA presented an example of an effective outcomes-based payment model trialled in his organisation and took the opportunity to rate the PP against a set of five key characteristics of an effective performance measurement programme, reflecting the disaffection with the scheme felt by IPAs. In his assessment framework it scored 14 of a possible 25 points, failing principally on the criteria of alignment of the incentive with the desired outcome and giving value for all partners. This contending set of perspectives is typical of much of the debate between the public servants administering and the general practitioners delivering the programme in its first few years ¹⁷⁰.

In 2008 the organisation responsible for implementing the PP commissioned an evaluation of the PP which was published in December that year ¹⁶⁵. Evaluators were tasked with finding out how effectively the PP was engaging with PHOs and to what extent it had supported PHOs to make improvements in their practice through affecting their capacity, capability, systems development and implementation of clinical governance. To do so, evaluators selected a cross-section of six PHOs and interviewed managerial and clinical staff of the PHOs and others connected to the Programme, forming six case studies. These case studies were then analysed to assess the PP against dimensions of management and governance, operations and clinical practice. Informants were also asked how relevant they believed the QOF was to the New Zealand PP.

Evaluators found wide PHO variation in population characteristics, size, history and relationship with an IPA, the nature of ownership of practices, whether they integrated into wider networks and human resources challenges such as workforce shortages. These conditions created different contexts for PHOs in implementing the PP.

Although most PHOs saw the PP indicators as offering a narrow but reasonable snapshot of best practice, they tended to qualify this with the view that the indicators are partial or less important indicators of quality practice and risk diversion of effort from other more pressing clinical matters. There was dispute about the fairness of the performance

framework which, using relative measures, can allocate the same performance as either successful or unsuccessful depending on where the target has been set.

Visibility of the PP was found by evaluators to be highest amongst management rather than clinical staff. Correspondingly, many management staff did not know what clinical staff did with the data from the PP when they received it, the processes of clinical leadership and peer support for clinicians being separate from management of the PHO. A variety of funding allocation practices existed, with two of the six PHOs not distributing performance payments and most sharing these between the PHOs and practices. Data exchange and distribution caused a variety of concerns relating to confidence in its quality, the privacy of the data exchange process and timing of reporting periods (feedback of performance under the scheme was delayed by several months after the end of the reporting period). In this relatively small sample of PHOs, general practitioners received reports mainly from their practice manager in a process of administrative feedback rather than peer-led debate and critique of practice.

In assessing the impact of the PP on clinical quality, the evaluators found that PHOs saw it as partially aligned with the recognised drivers of clinician behaviour change and part of the larger set of primary care strategies, supporting these in a low profile way rather than driving practice improvement itself. It reflected achievements rather than incentivised them, and the primary reward was evidence of improved quality, not payment.

This feedback confirms the significant difference in the mode of operation of incentives in the scheme by contrast to the English scheme, targeted as they are in the PP on the actions of primary care organisations rather than the actions of individual general practitioners. The scheme was not able to directly incentivise the health actions of individual general practitioners in the same way as the QOF was able to do in England. The evaluators concluded that the heterogeneity of the PHO and practice landscape and the separation of management and clinical roles provided considerable challenges to the PP's effectiveness. Future success in achieving clinical behaviour change would be dependent upon PHOs obtaining greater leverage with clinicians, the availability of reliable credible and timely data and the role of champions.

The evaluation can be seen as indicating some fundamental flaws in the design of the scheme if it is assessed as an incentive scheme targeted at changing health actions or the day to day decision of general practitioners. Against this criterion it has many shortcomings by comparison with the QOF.

Themes in the evaluation noting the heterogeneity of context, history, ownership and interests amongst PHOs and practices are echoed in the evaluations of the overarching PCHS completed in the same period ^{171 p.30}. A suite of reports was commissioned to evaluate the PHCS by the Ministry of Health, the Accident Compensation Corporation of New Zealand and the Health Research Council and these were completed and published by the Victoria University Health Services Research Centre between 2006 and 2010. The reports focused on four topics of the status and activities of general medical practices, patient fees as a metaphor for different underlying purposes in the Strategy, and the role and functions of PHOs and how these evolved in the years immediately following establishment. While they did not comment specifically on the PP, they are of interest since they offer assessment of the degree to which the goals of the PHCS were seen to be achieved, citing similar barriers to change identified by Martin Jenkins.

Amongst other findings, the reports display the continuing divisions between types of general practices, deriving from their funding and ownership arrangements. For instance, those PHOs which grew out of IPAs tended to give prominence to general practice needs and perspectives more than community-generated ones and were more reluctant to discuss fee levels and patient co-payments with practices than those which grew out of community trusts or similar organisations ¹⁷². There was muted support amongst general practitioners about some of the specific goals of the Strategy such as creating PHO, provision of universal low-cost access and seeking out of patients who do not present for care, and the Care Plus programme for those with chronic illnesses ¹⁷³.

In a report completed by the Health Services Research Centre in 2008 on exploring issues that could contribute to high impact change for service improvement in primary health care, a key theme was the continuing lack of integration of funding streams to enable better alignment with local health needs and priorities, the report noting that 'despite a capitation approach to funding, providers remained in a fee-for-service mind-set, especially in areas

where the patient co-payment remained a significant element of the practice income' ¹⁷⁴

p.15

Evaluation of the PP in 2012

A further evaluation of the PP was undertaken in 2012 ¹⁷⁵. This was a comprehensive review of the strategic vision and purpose of the PP, its impact on service planning and delivery and its information technology systems and impact on data capture. Qualitative and quantitative analyses were completed including in-depth interviews with 11 PHOs and two surveys of practices. An initial survey of staff and stakeholders in nine PHOs attracted 38 responses. Feedback from respondents indicated that there was inadequate information about the programme and a second survey (which included more context for questions) was then sent to the remaining PHOs, received 68 responses. Forty-five percent of responses were from general practitioners, 25 percent from practice nurses and 29 percent from other roles.

The evaluation found that the PP was seen by the sector as a valuable programme, was the only programme that rewards activity on a performance basis and was widely seen as a potential vehicle for future collaborative primary care data development. However, a need for speedier development of indicators and improvements in data integrity and timeliness were expressed. The need for a higher level of incentives to reward efforts to drive results more effectively into high needs populations (who are harder to reach) was expressed ^{175 p.5}.

The evaluation records performance trends for the current set of funded indicators. These had evolved from the initial set, over time, to address more pressing population health targets including ischaemic cardiovascular disease detection and risk assessment, diabetes detection and follow up, influenza vaccinations of older people and immunisations of children under two (all from 2009) and recording of smoking (from 2010) and advice on smoking cessation (from 2011). Performance against all targets had improved at the PHO level. Performance improvement was more rapid for high needs populations and the gap between these and low needs populations had decreased since 2006. By 2012 the PP had become broadened to include indicators for health actions which had higher potential for a positive impact upon population health outcomes and had results which were reflecting greater levels of quality improvement in services for populations with higher needs. These

results mirror the results found for the QOF although in the latter case they were achieved more rapidly.

The evaluation finds there was still mixed support for the PP and rising sector frustration with the low usability and minimal approach to enhancements for data capture and interrogation in practice management systems and the effort required for data collection. Greater transparency and granularity of and access to data was also identified as a major point of dispute, with debates about this causing frustration between stakeholders (such as the Ministry of Health) 'seeking greater utilisation, publication and transparency of activity and others, mainly in the primary sector, extremely reluctant to do so' (ibid. p.24). These problems had been avoided in England with the design and implementation of the QMAS for data capture and reporting.

There were mixed views about whether the PP improved quality of care, with some stakeholders viewing it as setting important clinical governance baselines, others finding it an interference with patient care and others regarding it as 'cookbook' medicine.

The governance group for the PP (which had expanded its membership over time) was regarded as reflecting a variety of sectoral interests rather than providing strong leadership though there was moderate agreement that the advisory committee for the PP had the right clinical experts. At the time nine of 14 members were from primary care, three being practising general practitioners. This had resolved earlier concerns about the 'perceived shortage of clinical leadership...particularly around indicator selection' in the design of the original set of indicators ^{165 p.4}.

Impact on ambulatory-sensitive admissions

It will be seen that in England, evaluators were able to demonstrate a statistically significant association between higher levels of achievement on clinical indicators for coronary heart disease, hypertension, congestive heart failure, diabetes and chronic obstructive pulmonary disease, ^{135 p.121} and measures of population outcomes such as rates of ambulatory care hospital admissions. Although a reduction in ambulatory-sensitive admissions was not specifically a key measure of success and was used more to motivate reform of existing primary health care arrangements in presentations about the proposed PHCS, Cranleigh

Health utilised this measure in their evaluation and were not able to demonstrate this association in New Zealand for the two of three indicators which might have reasonably been expected to have this outcome (cardio vascular disease (CVD) assessment and detection, influenza vaccinations and immunisations). This is possibly because the indicators were too recently introduced (as is the case with CVD) or the number of hospital admissions for influenza small. A statistically significant relationship was found between PP achievements for immunisation of children under two and vaccine-preventable hospital admissions^{175 p.50}. Overall the ambulatory-sensitive hospital admissions for Māori and Pacific Island peoples had remained the same or increased from 2000/1 to 2005/6 although they declined for non-Māori or non-Pacific Island New Zealanders^{157 p.8}.

Review of Performance and Incentive Framework

In 2013 an Expert Advisory Group was convened to recommend a new integrated performance and incentive framework for the health system, which would include primary care. The final report of the Group, published in February 2014, signalled a fundamentally new strategy to address equity, safety, quality, access and cost of services (including unexplained variation of referred services). Comprising nationally-set system-level measures and processes for reporting and assessing performance, the framework proposes to confer levels of achievement and incentives based on performance on PHOs. However, within national targets, detailed quality improvement measures would be developed locally in clinical and consumer-led alliances to reflect local needs. The Performance Programme resources would be re-directed to provide direct incentive payments to practices which achieve performance targets and to up-front allocations of investment to PHOs to support capability and capacity improvement¹⁷⁶. The framework would not in itself modify other policy settings such as funding, co-payments or service coverage, but would substantially re-design the current PP. Such an approach has the potential to incentivise quality improvement at the practice level more directly, with greater potential to influence health actions of general practitioners and other practice staff more directly, providing it does not lose the explicit connection between a health action of a general practitioner and the availability of a reward. This in turn may result in a greater ability for policymakers to

achieve more pronounced associations between the PP and ambulatory sensitive hospital admission outcomes.

Summary

This Chapter has described the context and the process of policymaking which resulted in the implementation of the pay-for-performance programme known as the PP in New Zealand from 2006. It has explored the major barriers and enablers to goals sought by policymakers from the policymaking process and concludes with a summary of reviews and evaluations of the pay-for-performance policymaking process and its impacts.

The next Chapter will apply Kingdon's MS Framework to this case study and explore how well it describes or explains what happened.

CHAPTER EIGHT

REVIEWING THEORY AND EVIDENCE: PERFORMANCE PROGRAMME

Introduction

The previous chapter has described the process of pay-for-performance policymaking in a case study of the design and implementation of the PP in New Zealand between 2001-2007. It has set out barriers and enablers to the key goals sought by policy-makers, from the data collected in interviews with participants and from documentary analysis. A summary of evaluations and assessments of the outcomes of the policymaking process was provided. This Chapter now applies Kingdon's MS Framework to this case study, with particular regard to the research questions:

- How well do the elements of Kingdon's MS Framework describe and/or explain what happened at each stage of the policymaking process?
- What new relationships between variables can be identified from the analysis which might enhance or extend Kingdon's MS Framework?

Kingdon's MS Framework

In the same process set out in Chapter Six, the purpose of this Chapter is to explore the utility of Kingdon's MS Framework, as enhanced by Zahariadis, in explaining the policymaking process in the New Zealand case study. The analysis begins with an assessment of the type of policy change achieved, according to Kingdon's definitions. Then the key themes from the case study evidence are discussed in order of the five key structural elements of Kingdon's MS Framework and the sub-elements as identified by Zahariadis and illustrated in his diagrammatic representation in Figure 1 in Chapter Two.

Non-incremental change in conditions of ambiguity, fluid participation and unclear technology?

Answering the first question about the type of change in Kingdon's MS Framework, the evidence shows that the introduction of the PP more closely matches the definition of non-incremental change than incremental change according to Kingdon, although it takes longer to be implemented than the QO Framework in England. The other conditions which Kingdon suggests will nurture non-incremental change do apply in the New Zealand context at the time. The health sector was an environment of differing, if not exactly ambiguous, policy preferences contending for attention, with considerable fluidity of participation and unclear and inadequate technology for many of the policymaking activities under way at the time. Both committees convened for designing the pay-for-performance programme contained members with a wide variety of views and interests, types of professional expertise and levels of engagement with the policy problem. They were developing policy in an environment of rapidly changing rules and new policy goals. This required much innovation and flexibility in the policymaking process as well as a need to look for existing models which could be quickly adapted for new purposes. Some political uncertainty also existed in 2001 in that the Labour government was half way through its first term of office and had a history of short periods in office. The situation was, according to Kingdon's model, ripe for political manipulation by a policy entrepreneur (or 'loosely coupled')^{67 p.4}.

It is important to note that the pay-for-performance policymaking process was operational policymaking nested within a larger strategic policymaking process, the design and implementation of the PHCS, which was also planned, top-down policymaking, non-incremental, boldly designed and rapidly enacted and implemented by politicians within the politics stream. This overarching reform was intended to achieve a sea change or 'counter-revolution'^{25 27} in the way governance and structural arrangements in the health system, including payment systems for Vote Health funding, worked. Within it, the implementation of the PP followed a different pattern, being subject to extensive consultation and a phased and voluntary process in which many decisions could be taken at the regional level.

In this case study, agenda-setting occurs in a civil servant-led committee. Alternative selection occurs in a new phase of work accomplished through a large committee led by

jointly appointed Chairs with a mix of general practice service delivery management and health services funding and development experience.

Although no policy entrepreneur in the classic Kingdon model is found in the case study (neither is there one readily identifiable in the development of the PHCS overarching policymaking process), it can be argued that actors resembling institutional entrepreneurs were recruited and made a key contribution during the alternative selection stage of policymaking. These have been described earlier as ‘exploring the transferable, concealed and dormant institutional resources of their societies’^{75 p.157} and being effective in environments in which uncertainty exists as well as heterogeneity. This is the more so when there is political uncertainty or the inability to predict political shifts that could change the landscape for new institutional arrangements^{67 p.4}. This is a particular characteristic of the New Zealand health policymaking environment in which fierce partisan positions, short terms of office and relatively frequent changes of administrations differentiate it somewhat from the English health policymaking environment. This is explored below in the section ‘Policy Entrepreneurs’.

Problems stream

This policy making episode arises in the problem stream which, according to Zaharaidis, will be more likely to lead to a rational approach to policymaking. This is borne out by the evidence. During the implementation phase of the larger PHCS (which created its ‘policy window’), the problem arose of how to maintain a quality-oriented approach to pharmaceutical and laboratory services utilisation under the new PHCS structures, capitated funding and principles for equity of access and outcomes. An additional policymaking challenge was how to change inequities in prescribing and funding of these services for poorer communities. A mechanism was needed to redistribute resources and rectify variances in prescribing patterns.

Indicators of the need for a new policy included analysis of prescribing patterns showing unexplained variances and lower levels of resource in poorer communities and data which showed significant variance in life expectancy for some citizens, particularly Māori. Focusing events included an identified need for new policy to manage allocation of pharmaceutical and laboratory testing resources identified in the implementation of the PHCS. Policy

makers had feedback that positive results in changing prescribing patterns from budget management contracts had occurred but also reports that significant public funds had been obtained by IPA through savings achieved in budget management contracts. This was a busy time for primary health care policy so the load created a low priority for this work alongside a major workload of policy issues relating to implementation of the PHCS.

Zahariadis' Model is very useful in the analysis of this process of problem identification and definition.

Politics stream

Kingdon suggests party ideology, national mood and administrative turnover are relevant here, and two of these factors are strongly featured in the evidence. Party ideology which influenced the design included a strong commitment to an accessible, equitable health service, concern over privatisation and profit-making from health care, deep concern over inappropriate and inequitable capture of public funds by IPAs, grievances about the history of relationships with general practitioner representatives and concern over disparity of health outcomes. There was a strong commitment to services appropriate for Māori and Pacific peoples. There was also a preference for a strong patient and community voice in health service design and concern about medical dominance of health policy. The national mood showed no particular public concerns related to this specific issue but growing public concerns about disparate mortality and morbidity rates for New Zealanders of different ethnicity. Administrative or legislative turnover was a key driver incentivising rapid policymaking for Labour, recently elected to a three year term after nine years out of office and governing in a strong coalition. Labour politicians were determined to restore the integrity of a national health service whose establishment was one of the proudest achievements in Party history. But this also acts as a factor incentivising opposition to the policymaking by other interests. The evidence shows that a major feature in this stream was the strong allegiances between particular political parties, their academic advisors and types of general practice organisations. Kingdon suggests that when there is conflict rather than consensus between interest groups, politicians must determine the balance of support and opposition, indicating the price that will be paid for pushing the idea forward .^{51 p.150} This

important calculation is not explicitly included in the sub-elements of the Zahariadis Model of the politics stream.

Policy stream

The value acceptability and technical feasibility of the policy idea and these features as well as the integration of the policy community are all considered by Zahariadis to be important sub-elements in the policy stream.

Policy idea: Pay-for-performance was a controversial idea in the policy stream, attracting some strong negative opinion and academic analysis from some quarters. Improving the quality of general practice was, however, readily accepted as a policy idea. As in England, there were existing budget management and clinical governance initiatives which could be used as templates to develop a national programme for incentivising quality improvement and clinical governance in general practice. But unlike in England these were not nationally consistent or centrally driven, nor underpinned by the new values of equitable redistribution of resources. The existing initiatives formed a heterogeneous collection of regional initiatives and many distributed their savings to privately-owned companies. The policymaking process needed to deliver a nationally consistent framework oriented to equity and population health goals from this heterogeneous mix. There was strong academic interest and support from general practice consortia including the IPAs for continuation of existing approaches (who depended upon it for an income stream). Many participants in the design process had direct experience of such programmes.

Value acceptability included strong state support for population-based and preventive health practices. Officials were open to new contractual approaches, payment methods and other technical approaches to public sector performance management in order to achieve equity goals. But the scepticism about the merits of pay-for-performance within the bureaucracy, academia and the medical profession was enhanced by the fact that its technical feasibility was a major problem. The state had a new mechanism for enrolling patients with a PHO and these organisations were newly established, with differing capacity and capability to develop or influence existing clinical governance systems, few existing national practice or quality frameworks, minimal availability of national data bases suitable

for a performance programme and a regionalised structure for implementation of the policy.

Policy community: The evidence reveals that there were low levels of integration of the general practice policy community, especially on the subject of quality systems and governance arrangements. There were differing levels of access to politicians and civil service decision-makers held by different types of organisations. Access often depended on political allegiances of the organisations. Competitive modes of discourse and adversarial decision-making processes were often used between stakeholders in the policy community and there were variable levels of organisational and administrative capacity amongst organisations. There was a limited history or track record of policymaking partnerships between the general practice profession and state actors. To reiterate, a partisan pattern existed, which broadly saw community-based groups working with Labour and private general practice interests working with the National Party.

Policy window

The policy window included a coupling logic which was consequential on a need arising as part of implementation of the PHCS as well as doctrinal. District Health Boards urgently required a process to assist them to redistribute prescribing and laboratory referral funding more equitably and achieve more equitable use of the funds and the Labour Party had a doctrinal commitment to equitable distribution of resources and services. The decision style was bold for the larger overarching policymaking but very cautious for its implementation and for the policymaking which arose from its implementation.

The set of sub-elements in the Zahariadis Model are useful for analysing these features of the policy stream in this case study.

Policy entrepreneurs

According to Kingdon's MS Framework, conditions were optimal for a policy entrepreneur to emerge and manipulate this policymaking situation. No visible policy entrepreneur was identified in the classic Kingdon sense of 'power brokers who manipulate problematic preferences and unclear technology and exploit the system's fluid participation rates to

push forth their pet solutions' ^{177 p.520}. Civil servants set the agenda for the policy, with advice from academics, as they implemented the manifesto commitments of the Labour government. This process was one which was overseen by traditional Cabinet government processes more clearly than was the policymaking process in England, where the 'sofa cabinet' style of policymaking was practised.

As in England, the issues of access, resources and strategies are not relevant to this case study because the policy making was officially mandated. This case study is an example of strong civil service leadership and management of the policymaking process. Few observed strategies such as framing, affect priming or symbols were used but salami tactics or piece by piece tactics was deliberately employed during the implementation phase to minimise disruption, test the model and build support.

However in the alternative selection phase, entrepreneurial actors were deliberately recruited, fitting the description of institutional entrepreneurs as developed by Crouch ⁷⁵, and these actors help to develop new forms of governance, including clinical governance, for the new PHOs. One of the major policy challenges from these health reforms was to build capacity within primary health care organisations to understand and work within a capitated funding allocation and deliver population-based preventive health care services. Actors who had been involved in their own regional initiatives to introduce capitation funding and quality improvement systems in the 1990s were institutional entrepreneurs, able to draw on their own experiences of innovations in such approaches. Another challenge was how to ensure more equitable access to primary health care services for Māori and Pacific communities more effectively. Actors who could draw on insights and experience from delivering health care in these communities were able to bring this into the debate about priorities for the doctor-patient relationship within primary health care.

General practitioners who had these experiences of working in capitated funding environments or Māori and Pacific communities were particularly important in the debate over the design of the scheme, effectively placing their professional expertise and credibility as clinicians at the service of both funders and their profession. They exhibited attributes of social acuity, team building and leadership by example described in the public entrepreneur literature. Because of the small, incremental, regionalised, low profile and voluntary nature

of the scheme they consequently faced fewer reputational or public support risks than the English policy-makers and the policy design process generally held few political risks. However leaders of the policymaking process recruited from within general practice faced reputational risks such as loss of professional standing and influence within those parts of the professional community which opposed the pay-for-performance policy and its policymaking process and with politicians from opposing parties who did not support a community-led approach to governance of primary health care services. As in England, therefore, the greatest risks faced by the institutional entrepreneurs arose from those which might arise in the event of a change in government and the conditions upon which they had based their strategy

Motivation of entrepreneurs

The case study evidence provides some insight into the motivations and strategies of the institutional entrepreneurs who led the design of the PP in its alternative selection stage. They wished to balance strong personal commitments to reducing inequalities with the desire to reward quality and support clinical governance (having a track record of championing a capitation-based approach to primary health care funding as the most appropriate vehicle to do this). They were very committed to achieving a balanced consultative forum, to build consensus for the features of the PP and to get ownership for the new pay-for-performance policy. They wished to manage or reduce the divisions within the general practice community and reduce the tensions between Labour politicians and some sections of the general practice community. They were strongly committed to broadening the multi-disciplinary approaches to primary care service delivery through team-based and not doctor-dominated practices.

The evidence suggests they were willing to risk professional standing and influence arising from their policymaking activities for the social purpose which animated them, in particular taking forward the inequalities agenda to ensure that Māori and poorer communities had improved access to higher quality primary health care. The same motivation though not the same risk was observed in the civil servants charged with the initial design, who made comments that disadvantaged populations were 'missing out' as a rationale for putting 'much more focus on equity'.

Explanatory comprehensiveness of Kingdon's MS Framework

To recap, non-incremental change, in Kingdon's definition, was achieved in the New Zealand health reforms. The scale and pace of change was determined by the Executive. The case study displays the differences between the two policymaking activities during this period: the overarching health system policy making, which was significant non-incremental change, was rapidly implemented and had closely managed participation and clear technology for implementation (it was straightforward to introduce governance changes such as restoring the District Health Boards for instance); and the pay-for-performance policy making episode which was also non-incremental policy change but has more signs of ambiguity, fluid participation and unclear technology, had a phased, more consultative, regionalised and slower implementation process. This reflected pragmatic realities of policymaking in the general practice sub-system with its multiple forms of governance and ownership of primary care services, many contending interests and few integrating information systems or antecedent quality improvement policies, such as existed in England, which could be built upon. Although conditions were suitable for a classic Kingdon exogenous policy entrepreneur to operate as part of the pay-for-performance policymaking episode (given the ambiguity of preferences and the clear policy window), this did not happen. Endogenous actors with entrepreneurial skills, as in England, were recruited to help develop new decision-making and governance systems to support the new policies designed by civil servants and politicians, assisting in changes of institutions as well as policies to support greater public accountability in general practices.

Other drivers of policymaking processes

Based on the analysis above, there are some major gaps in the way the model captures and encourages us to look for key drivers and features of the policymaking process which were, in the empirical research undertaken for this study, shown to be critical to the process and outcome of the policymaking episode. These are now set out below.

Institutional and structural features

The institutional sub-system for general practice in New Zealand which structured the relationship between the state and interest group actors, as in England, is a critical variable in this policy making episode. The history of health policymaking in New Zealand had led to the following features:

- A heterogeneous set of ownership and governance arrangements for general practice service delivery
- Disengagement between Labour politicians and the largest organisations representing general practitioners
- Multiple payer financing arrangements for general practice so no monopsony
- New arms-length contractual arrangements for primary care funding which needed to be developed by a large number of newly formed primary care organisations
- A re-centralised structure for health policymaking, with preferences for regional implementation
- No representative body for general practice
- A risk of short term administrations, from 1996 needing to form coalitions to govern. Although the governments elected in 1990, 1999 and 2008 in fact each won three successive terms in office, these terms were punctuated by three-yearly elections and, for the Labour Party, three successive terms in office was unusual.

There was a preference amongst politicians for top-down, rationalist and technically-driven approaches for initial policy design and this delivered the initial civil-service-designed, rapidly-developed and comprehensive pay-for-performance proposal. Then a cautious, consultative and stakeholder-oriented approach to alternative selection and policy implementation of the pay-for-performance framework was taken.

This pattern, described by Tuohy as 'big bang' change characteristic of Westminster adversarial systems reflects the different facilitators, barriers and trajectories for policymaking from those seen in governing systems with federal structures or a separation of powers. In the former, policy in needs to be enacted quickly and hard-wired against

subsequent reversal by its rapid casting into law but leaving time for coalitions of beneficiaries, enabled to exercise administrative discretion, to be built around the details of implementation so that these in turn are harder to change by successor administrations. Tuohy suggests that politicians need to make decisions about the scale and pace of change and that politicians in Westminster systems are more likely to choose 'big bang' change which fundamentally reshapes relationships and institutional frameworks quickly and in a single comprehensive sweep. In these conditions, institutional entrepreneurs can assist politicians and civil servants to facilitate the rapid enactment of new institutional frameworks. In governing systems with federal structures or a separation of powers, consensus must be built before legislation is enacted but there is less risk of later policy reversal.^{67 p.12}.

Finlayson's characterisation of the implementation phase in New Zealand as not a 'neutral non-political stage of the policymaking process...especially where key groups have not been involved in the formulation of policy'³³ describes the risks of these dynamics in this country. The evidence shows that the new Labour government had learned from the troubles of the previous administration in the implementation phase for its primary health care policies and sought to minimise these by some more extended use of strategic alliances and stakeholder management strategies, albeit within the terms of an uncompromising policy stance on a community-led governance model.

The structural features of the general practice sub-system and the recent history of failed attempts to implement major health policy change vindicated this cautious approach to implementation of the pay-for-performance policy developed by the RSAG, which slowed and regionalised the process of implementation so that it extended over four more years. Even so the process of alternative selection and implementation was not able to solve key design challenges such as general practitioners' buy-in to a broader and more relevant set of population health targets for the scheme or to develop solutions to the information management deficits which limited the scheme to a small set of targets.

Although the intention of the PP was to establish leverage for the new PHOs to influence and support clinical governance frameworks amongst their general practices, evaluations show that the performance incentives did not always act as drivers of practice change but,

as in England, often reflected existing behaviours. Implementation patterns were as heterogeneous as the environment into which they were introduced. Clinical governance activities in some primary health organisations remained sequestered within the existing peer-led and collegial systems which New Zealand general practitioners had developed over the years. Some PHO management staff had limited knowledge of or involvement in these processes, at least initially. These institutional features, and the barriers which they placed in the way of the design and implementation of a single large national scheme, delayed and limited the achievement of a new focus on population health and preventive practices and any potential for improvements in health outcomes.

Heterogeneity of the institutional landscape

Considering the two case study analyses together, the differences between the impact of a heterogeneous institutional and structural landscape in the general practice sub-system in New Zealand and the more homogenous, centrally coordinated landscape in England become clearer. This makes the nature of the institutional and structural landscape a strong candidate as a driver of difference in the size, scope and speed of policy design.

This heterogeneous environment in New Zealand, with large elements disaffected in some ways from the government's policies for primary health care, meant that the process of alternative selection and implementation of the new policy had to be carefully approached if it was not to falter as had been the case with earlier health policy implementation attempts in the 1990s. It also affected technical feasibility of implementation. A practical consequence of the widespread lack of collaboration or engagement with the new policy was the problem of data adequacy. Existing national databases held information on a small number of activities which could be suitable for development as pay-for-performance targets. Processes designed for the selection of new indicators were unwieldy and time-consuming and participants withdrew from these processes. It was not considered feasible to implement an information management system to support a real time feedback mechanism on practice activity and performance such as the QMAS. A feature of the New Zealand scheme was that the calculation of results and payment of incentives was delayed by 6-12 months after each achievement period. This further deterred general practitioner engagement.

Devolved implementation also slowed the progress of implementation. PHOs were variable in their capacity and capability to implement the PP. Whereas in England implementation occurred at the practice level by practices eager to demonstrate performance and release new income, in New Zealand implementation depended upon the readiness of both District Health Boards and PHOs and the central PP team. These organisations had many other pressing priorities for their resources and attention between 2006-8 (including implementation of major immunization and other population health-related campaigns). Some features such as the variation in amounts of payments for performance and the ease and speed with which practices obtained feedback about their performance under the scheme differed widely. Where these were perceived as unfair or inadequate, practices were less interested in participating in the PP¹⁶⁵. However, devolved implementation permitted the building of local or regional coalitions around the new policy to reflect local conditions, needs and preferences and contributed to its longevity through successive administrations.

Historical antecedents

The evidence shows that historical events, relationships and policies influenced policymaking processes. The history of the genesis of the national health system and the relationship between the Labour Party, in and out of office, and parts of the medical profession in New Zealand is an ever-present theme in the minds of most participants interviewed about the process of policy design. Because of this history, feelings ran high amongst some participants. Opposition politicians were subsequently cultivated by the Independent Practitioners' Association Council to champion different approaches to clinical leadership. The evidence points to some participants deciding to bide their time until a change of government would enable them to exercise greater influence and redress the policy design in their favour.

The existence of antecedents of the quality improvement and budget management schemes developed by general practice consortia including IPAs a decade earlier were critical to facilitating the design of this scheme. Personnel involved in these earlier schemes were heavily involved in designing the new one and utilised their experience from these schemes in their work. Evidence about the need for and effectiveness of such policies in academic

studies of the impacts of the early budget management schemes was used in making the case for and designing the scheme.

Does the Zahariadis Model encourage consideration of these factors?

While the model is very helpful in providing five structural elements which display key features of the policymaking process in New Zealand it does not go far enough to highlight certain elements which have been found to be important influencers of the process. The set of sub-elements in the Zahariadis Model does not invite specifically consideration of interest group strengths, values or political loyalties. It does not invite consideration of underpinning ownership and governance features which may influence or explain these interest group attributes. It does not invite consideration of the type of policymaking which is incentivised by different electoral and governing systems. It does not consider forms of institutional entrepreneurial behaviour which are focused upon the building of new governance or decision-making systems rather than on new policies.

Summary

This Chapter has analysed the fit between the evidence of the design of the PP and the MS Framework in describing and explaining what happened. It then considered the relevance of other historical, structural and institutional drivers in the policymaking process. In the next Chapter, an overarching analysis of the theory and evidence set out in this research is presented, beginning with a summary of key findings, followed by a detailed analysis of how well Kingdon's MS Framework fits the process of policymaking in the two Westminster jurisdictions.

Part Three

CHAPTER NINE

THEORY AND EVIDENCE: DISCUSSION

Introduction

In the previous four chapters, the two case studies of pay-for-performance policymaking have been described, barriers and enablers of the policymaking process discussed and a summary of evaluations and assessments of the outcomes of each policymaking process provided. Then Kingdon's MS Framework was applied to each case study and its utility in describing and explaining each process of policymaking was assessed.

In this Chapter, the research questions are answered:

- In what aspects and why did two similar episodes of policy formulation and implementation in two similar jurisdictions follow different processes and have different outcomes?
- How well do the elements of Kingdon's MS Framework describe and/or explain what happened at each stage of the policymaking process in the two case studies?
- What new relationships between variables can be identified from these analyses which might enhance or extend Kingdon's MS Framework?

This Chapter will focus upon the comparative approach to the case study evidence and seek to draw out findings from the case studies which identify 'particular features in which these otherwise very similar nations differ...[which might be] attributable to one of the few other factors distinguishing them'⁶². Arguments to support the following findings will be set out and discussed:

- The use of bargaining and negotiation processes enabled the large size, scale and speed of design and implementation of the QOF in England and therefore the level of health outcomes attributable to the scheme. It is in this aspect that the two

episodes of policy formulation and implementation in two similar jurisdictions differ most strikingly and it is also because of this feature that the outcomes of each scheme differ.

- Differences in the institutional framework within the general practice sub-system in each country are the primary driver of policy variation. In particular the mandate held by the BMA in England to be sole bargaining agent for general practitioners holding general medical services contracts and the single-payer financing and singular ownership model for general practice services in that country structured the relationships and incentives between state actors and those in the general practice sub-system in a different way from the New Zealand general practice sub-system. The multiple payers and heterogeneous set of interest groups and ownership structures which existed in New Zealand, combined with the absence of any mandated single interest group entity for negotiating general practice public policy and funding matters with state actors, created limiting conditions for pay-for-performance policymaking and reduced incentives collectively and individually for rapid take-up by all general practitioners of the new policy.
- Institutional explanations of policy change are most useful in the two case studies. The ownership and governance structures within the general practice sub-system created a set of supportive conditions and incentives in England and limiting conditions and incentives in New Zealand for the design and implementation of a large-scale pay-for-performance scheme.
- In both countries, actors resembling policy and institutional entrepreneurs assisted the state to scale up local innovations for national utilisation. In England, one of these actors led negotiations based on a pay-for-performance framework they had implemented at a regional level. Another drew academics into the design process, creating an environment 'like a practice meeting' to facilitate the negotiation of targets and indicators between the state and the profession. In New Zealand, actors who had held entrepreneurial roles in the previous decade at the regional level, introducing capitated funding and improving quality of clinical practice and population-based outcomes, now placed this experience at the service of the state. They ensured that voices from Māori and Pacific and low income communities and other primary care professionals were a vocal part of the debates over clinical

priorities within the design process. These actors resemble institutional rather than policy entrepreneurs because they are developing new frameworks which will shift the balance of influence between the state, the medical profession and private financial actors. They are assisting the state to introduce a new mix of governance mechanisms with an increased role for hierarchical forms of influence for state actors.

- There is contrary evidence to Kingdon's prediction that non-incremental change is associated with a policymaking environment of ambiguity of preference, fluidity of participation and unclear technology. In England the pay-for-performance policymaking was non-incremental and occurred in an environment of unambiguous preferences, closed participation and clear technology for implementation.
- Kingdon's MS Framework, as enhanced by Zahariadis, requires further enhancements including explicit consideration of the sub-elements of ownership and governance arrangements of public services (particularly financing arrangements) and of network features of the relevant policy sector in the Politics stream, of the nature and type of policy antecedents in the Policy stream, addition of other types of entrepreneurs, particularly institutional entrepreneurs and the addition of a longitudinal focus by consideration of policy outcomes.
- The need for a synthesised, multi-theoretic approach, utilising multiple drivers, to describe and explain policy change is validated. Kingdon's MS Framework is found to provide an excellent organising tool for diagnostic and prescriptive enquiry but requires a stronger focus upon the importance of institutions, rational choice explanations for how actors' incentives operate individually and collectively and of historical antecedents as factors in policy change and variation. Without taking these additional factors into account, the ability of the MS Framework to display the full complexity of these two processes and to attain greater relevance for policymaking in Westminster jurisdictions is limited.
- There is an evolutionary pattern of policymaking in both case studies. In both England and New Zealand, policymakers are shown to be actively avoiding the risks and pitfalls of earlier similar episodes and learning from mistakes made in the past.

- The two case studies lend support to the theory that policymaking follows national styles rather than sectoral ones.

The two case studies compared

In this section, a table is presented which compares the two policymaking processes according to the five main drivers of policy change and their policy outputs and outcomes. A discussion of the administrative and health outcomes of each case study is then presented in more detail.

Table 2: The two case studies compared: drivers analysis for pay-for-performance policymaking

Driver	England	New Zealand
Institutional	<p>Majoritarian, unitary political system</p> <p>National health system</p> <p>Single payer GP financing (primarily capitation)</p> <p>Single NHS/GP ownership/governance model</p> <p>Strong hierarchical corporatist features of decision-making in GP sub-system</p>	<p>Majoritarian, unitary political system</p> <p>National health system</p> <p>Multiple payer GP financing (primarily fee for service)</p> <p>Multiple GP ownership/governance models</p> <p>Collegial/market features of decision-making in GP sub-system</p>
Networks	<p>Integrated GP policy community</p> <p>Single representative GP body</p> <p>BMA holds mandated bargaining rights</p> <p>BMA has high level of access to state actors</p>	<p>Heterogeneous GP policy community</p> <p>Multiple representative GP bodies</p> <p>No mandated bargaining rights for GPs</p> <p>Partisan patterns of access to state actors</p>

	<p>'Politics of the double bed' history</p> <p>Active well established medico-academic research community</p>	<p>Adversarial history between some GPs and Labour Party</p> <p>Smaller medico-academic research community</p>
Actors	<p>Prime Minister involved in health policy</p> <p>Reforming Secretary of State for Health</p> <p>Executive led policy agenda-setting</p> <p>Civil servants side-lined in policy development</p> <p>Policy design dominated by GPs</p> <p>GP negotiators accountable to GPC/BMA</p> <p>All GPs held vote on final scheme/contract</p> <p>Policy design led by appointed negotiators. Academics mediated policy design process</p> <p>Insider knowledge/ relationship management skills, 'policy entrepreneur' experience of practice-based pay-for-performance scheme used.</p>	<p>Prime Minister involved in health policy</p> <p>Reforming Minister of Health</p> <p>Executive endorsed pay-for-performance policy</p> <p>Civil servants led policy agenda-setting</p> <p>GPs minority in policy design teams</p> <p>No GP accountability framework for policy</p> <p>Community-based and other primary care professionals involved in design</p> <p>Policy design led by appointed leaders to develop new governance mechanisms.</p> <p>Insider knowledge/ relationship management skills and 'institutional entrepreneur' experience of quality improvement in capitated funding environments used</p>

<p>Ideas</p>	<p>NPM-intensive history of public policy</p> <p>Government keen to empower primary care</p> <p>Concerned about health inequalities</p> <p>P for P trialled in several precursor schemes</p> <p>Strong GP support for fund-holding for hospital services</p> <p>GP scepticism about population-based health</p> <p>GP scepticism about customer service</p> <p>Strong commitment to free primary care</p> <p>Supportive of centralised quality standards</p> <p>Majority GP support P for P and monitoring of practice data in exchange for more income</p>	<p>NPM-intensive history of public policy</p> <p>Government keen to empower primary care, community voices and Māori and Pacific communities</p> <p>Concerned about health inequalities</p> <p>P for P trialled in several precursor schemes</p> <p>Strong GP support for budget-holding for referred services</p> <p>GP scepticism about population-based health</p> <p>Strong GP focus on customer service</p> <p>Strong commitment to patient co-payment amongst most GPs</p> <p>Limited exposure to central standards</p> <p>Support for peer-led utilisation review but many GPs opposed to funder access to data</p>
<p>Socio-economic</p>	<p>High predicted burden of chronic conditions</p>	<p>High predicted burden of chronic conditions</p>

	Willing to invest more money in primary care	Willing to invest more money in primary care
Policy output	<p>Voluntary national pay- for- performance scheme</p> <p>146 indicators</p> <p>Clinical/service domains incentivised</p> <p>25-30 percent of income conditional</p> <p>1-yr implementation period</p> <p>Provision for review of indicators</p>	<p>Voluntary national pay-for-performance scheme</p> <p>13 indicators</p> <p>Clinical domains incentivised</p> <p>2 percent of income conditional</p> <p>3-yr implementation period</p> <p>Provision for review of indicators</p>
Policy outcome	<p>95 percent compliance with targets in first year</p> <p>Ambulatory sensitive admissions impact on:</p> <ul style="list-style-type: none"> • Coronary heart disease • Hypertension • Congestive heart failure • Diabetes • COPD <p>Choice of indicators in subsequent years undertaken by National Institute of Clinical Excellence</p> <p>By 2014 reduction to 10 percent of pay conditional on achievement of targets</p>	<p>81 percent compliance with targets in first year</p> <p>Ambulatory sensitive admissions impact on:</p> <ul style="list-style-type: none"> • Vaccination-related admissions <p>Choice of indicators in subsequent years undertaken by governance group with larger number of GPs</p> <p>By 2014 proposal to review scheme, providing quality building grants to PHOs and direct incentives to practices for achievement of targets</p>

What outcomes were achieved by these policymaking processes?

In the two case studies the policy outcomes can be viewed as administrative or health outcomes. Administrative (or stewardship) outcomes describe the ability of the state to better hold general practice to account for its health actions. Health outcomes describe improved health status derived from incentivised changes in general practice-based activities. Both types of outcomes differed in each jurisdiction.

Administrative outcomes

With respect to administrative outcomes, both policymaking episodes delivered enhancements to each government's ability to set priorities, monitor performance and hold to account providers in the general practice sector. In New Zealand the policymaking episode is nested in policymaking which sought to achieve, in Tuohy's terms^{67 p.11}, a large-scale change in the 'balance of interests, mix of institutional forms (governance mechanisms) and the legitimating ideas' about primary health care funding and services through the PHCS. Though more rapid progress towards improved health outcomes through the QOF was made in England than through New Zealand's PP, arguably the greater shift in stewardship capability occurred in the New Zealand policymaking episode, given the very low base from which the state needed to develop improved accountability frameworks for general practice. This broader programme included introduction of contracts for primary health care services, capitated funding allocations, enrolment of patients with PHOs, restoration of universal subsidies and initiatives to redistribute levels of primary care resources according to health need.

English achievements - The introduction of the QOF by England contributed major enhancements to the state's ability to exercise its purchasing functions by incentivising 146 targets for general practitioners to improve population health. Through the QOF policymaking episode, the commissioning function of the state was enhanced to deliver better information systems to record patient health status (through the QMAS) and to monitor what activities were directed, within general practices, to addressing these health needs. The contract was redesigned to place over 25 percent of general practice income at risk if the required activities were not performed, while preserving the core viability of

practice income. These are strong new levers to influence health actions of general practitioners.

There were many features of these commissioning, purchasing and contracting arrangements which were able to be improved¹²⁸. There were clear benefits for primary care in England from the introduction of the QOF and other features of the new General Medical Services contract, which improved the retention of general practitioners and increased its attractiveness as a choice of practice within medicine, at least in the years immediately following implementation of the new contract. However this was at the expense of resources in health services generally, both fiscal and human, as the contract caused over-spending and excessive recruitment in to the general practice sector for some years. Productivity did not increase as a result of the contract, given the higher-than-expected earnings and reduced working hours for general practitioners¹³³.

Evaluations of the overall effect of the English contract show mixed results, with general practices in poorer areas lifting their performance more rapidly than in better-off areas in the first years after implementation of the contract¹³⁴. More general practitioners were attracted to work in all areas increasing service capacity. But needs-adjusted redistribution of funding generally moved at a slower pace than intended and there were many criticisms of the widespread withdrawal of general practices from after-hours services, with those services replaced by new service providers contracted by Primary Care Trusts. Some of these issues have been addressed in subsequent negotiations between the government and the profession. Equity risks relating to access barriers (geographic or service-related such as cultural appropriateness, rather than cost-based) and differential health outcomes remain but evaluators consider that these have been reduced by the QOF.

New Zealand achievements - In New Zealand the small number of targets and the low level of engagement of key general practice leaders in the design process initially delivered a smaller enhancement to administrative ability to monitor and influence general practice. While implementation was well managed within the network of PHOs and especially by the central team managing the PP itself, an 'implementation gap' occurred, with many general practitioners not engaging with the PP initially. However, new national information management systems have developed around the PP, showing the relative performance of

regions in reaching the PP targets. There is no shared national database of practice activity on the QMAS model though there are services which offer sampling of a representative national practice information data set for research purposes. After some years the governance of the PP was restructured to incorporate more representatives from general practice, though this slowed the development of targets and indicators for a time. The number of indicators has remained relatively static though the types of indicators have moved towards those more obviously associated with health status such as cardiovascular disease risk assessment, diabetes detection and follow up and smoking cessation advice. The policy emphasis on population health and inequalities is seen to have receded with the election of a new government in 2008^{17 p.252}. There have been subsequent reductions made in the funds for the PP; total funding falling from \$33 million in 2010 to \$21 million in 2011^{178 179} and there is currently a plan to dismantle the PP in its current form and disperse some of its resources to PHOs for capacity building initiatives relating to quality and a new Integrated Performance and Incentive Framework¹⁷⁶. The funding position of the state within general practice has also eroded as levels of co-payments have increased once again over time. In February 2014 the average fee for an adult to attend a general practice was \$31.93 and for a child over 6 was \$22.70.¹⁰

There are also some shifts in the nature of governance and accountability dynamics between state actors and the profession detected by commentators in the years following the election of a National government in 2008. Greater clinician involvement, or 'sideways' accountability, particularly in the running of hospitals, was advocated by the new Minister of Health in preference to 'downwards' accountability to the community¹⁷. New 'Alliance Agreements' have been put into place between funders and providers which aim to reflect a high trust, low bureaucracy environment with high quality and accountability and which are designed to provide a mechanism for clinical leadership in the development of health services.

Health outcomes

There was high potential for health system impact in incentivising more preventive, population-based activities in primary care in each country. The English scheme

¹⁰ <http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/primary-care-data-and-stats>

implemented a broad range of agreed targets with, potentially, major positive impacts upon health outcomes over time^{180 p.17}. The New Zealand scheme achieved a more limited scheme with few indicators clearly associated with strategic benefits in prevention of chronic disease. These were to be reported publicly at the level of the PHO, based on the analysis of practice data within the PHO.

The case studies report the recent evaluations of each scheme showing the levels of statistically significant associations between the pay-for-performance scheme and measures of health outcomes such as rates of ambulatory care admissions. Although the results are somewhat equivocal, and it should be noted that the reduction of ambulatory sensitive admissions was not an agreed measure of success of these schemes, these show that England achieved gains in five of the key chronic illnesses (coronary heart disease, hypertension, congestive heart failure, diabetes and chronic obstructive pulmonary disease) while New Zealand achieved this solely for vaccination-related admissions^{135 175}.

Studies of the impact of financial incentives on health care rarely report the outcomes of incentive schemes.⁴³ The evaluations of the outcomes of these two schemes provide important feedback for policy-makers about the effectiveness of the two schemes and have enabled this comparative research to include an assessment of not only the process and outputs but also the outcomes of both schemes.

The strength of the comparative case

The comparative approach can give greater methodological assurance that the differences between the two case studies did not occur by chance if it can be shown that, for the purposes of this research, the two countries are alike in all respects but one or two variables. A 'most similar' or 'concomitant variation' strategy^{85 p.32-33} has been used in this research. This most-similar systems case study design, studying matched policymaking processes, has allowed many features to be controlled for, which could be expected to be drivers of policy variation.

According to the logic of the 'most similar' strategies, if some important differences are found among these otherwise similar countries then 'the number of factors attributed to these differences will be sufficiently small to warrant explanation in terms of those

differences alone...Common systemic characteristics are conceived as controlled for and inter-systemic differences are viewed as explanatory variables.' Statements of explanatory variables can be formulated at the sub-systemic level such as each country's general practice sector. Deductive logic is then applied to make the case for these explanatory variables.

In a framework suggested by John,^{4 p.89} this research has treated the policy outcome as the dependent variable and included all other variables in the analysis, including those relating to institutions, rational choice explanations, group structure and resources, socio-economic drivers and ideas. It is contended here that the comparative analysis of the New Zealand and English governing systems and their overarching national health systems demonstrates extensive common systemic characteristics. These are therefore controlled for and the inter-systemic differences – namely the general practice institutional features (financing arrangements and ownership and governance structures as well as the relative strength of general practitioner representative associations) which permitted bargaining in one case study - are the explanatory variables.

Similarities which are relevant to the case studies

The case for the common systemic characteristics includes the contemporaneous and synchronous era of health reform commencing in the late 1990s which provided a similar window of opportunity in England and New Zealand in the sense that Kingdon defines such windows. The policy context and goals, including the pay-for-performance policy as designed in the alternative selection phase in New Zealand, were very similar. Regarding context, at that time, both new governments held large popular mandates to seek improvements to their health systems. In both New Zealand and England this window opened at the same time with the election of a new administration in New Zealand and re-election of the government in England. These two governments shared similar ideas and constellations of interest and had similar political agendas, including on health matters. The Minister of Health for New Zealand and the Junior Minister for Health in England met regularly to compare notes and hold discussions about health policy during the time period in which the case studies are set. The case studies reveal remarkable similarities between the two countries in many respects:

- timing – occurring contemporaneously at the end of a period of neo-liberal government
- ideology - initiated by social democratic governments with a strong public mandate for investment in health services
- setting - in similar Westminster model parliamentary systems (though New Zealand had introduced proportional representation, the Labour/Alliance government of 1999 had a large majority)
- similar health reform history - both governments faced a change-weary community of health stakeholders who had succeeded in the past in opposing the implementation of legislation, so were equally cautious about the proposed nature and extent of health policy change
- a broad current of public opinion supported improvements in health service delivery
- both pay-for-performance policies had strong continuity with policies from the previous era, especially general practice fund-holding and budget management
- both are nested within larger health policy reform efforts
- the medical profession were highly influential in each country
- good reasons (relating to efficiency, equity and cost-containment) to justify implementing greater accountability within general practice for the delivery of medical services
- new money was available.

So the policy-makers in each country therefore faced many similar conditions as they embarked upon a process to change accountability frameworks for general practice provision. Pollitt suggests that the history of nationally established performance indicators in England from 1983, facilitated by structural and institutional features, supported readiness for further reform and explains its broad pattern^{181 p.15}. He therefore anticipated similar patterns in other majoritarian, centralized states such as New Zealand, and in the arena of health care.

The same goals for primary health care underpinned the purpose of the two policy pay-for-performance initiatives. These include intentions to:

- incentivise general practice-based health actions which prevent or improve the management of chronic health conditions
- shift resources to under-doctored or under-serviced areas
- encourage new approaches to workforce utilisation
- maintain the momentum for greater accountability of health providers to funders created by the health reforms of the 1990s
- avoid open conflict or imposition of settlements on unwilling parties
- avoid the risks of pay-for-performance policies by building-in of provisions for review and refinement of targets, mechanisms and funding levels over time.

Both countries built on existing New Public Management-generated policies post 2000 in a way described by Pollit as a 'logic of escalation'¹⁸¹ or a dynamic in which an initial tendency for 'a few simple measures to become a more comprehensive package' exists. Career civil servants in both countries carried these approaches from one administration to the next and in New Zealand were the primary agenda-setters of the pay for performance policy.

Differences which are relevant to the case studies

These are:

- use of bargaining and negotiation mechanism for developing the pay-for-performance policy
- institutional/structural framework for general practice sub-system
- history of relationships between the state and general practice interest group

The framework for sole bargaining rights in England is a product of history and of the singular ownership and governance structures within the general practice sub-system in that country. It has given rise to a more integrated general practice interest group in England and creates the opportunity and incentive for general practitioners to exercise their bargaining power collectively, through a single democratic representative channel. It is reasonable to conclude that the bargaining framework is an artefact of the institutional and structural arrangements for general practice services, particularly the financing

arrangements, in England. Similar institutional and financing arrangements were originally legislated for in New Zealand at the time of health system establishment but then diverged markedly over time to produce a multi-payer and heterogeneous context for policymaking without a legitimated bargaining agent. In England the single payer/single contract arrangement had been uninterrupted since 1948 and has encouraged the development of a single point of interface for the general practice profession with the state, the BMA.

This leads to the conclusion that the response of each government to the conditions in its general practice sub-system was in fact a rational approach which accorded with the instruments of governance and influence available to them. Whereas in England more direct forms of incentives, focused on the unit of the general practice itself, could be bargained for nationally and achieved more rapidly, in New Zealand a population-based approach to improving primary health care needed to be developed first within its new community-governed PHOs.

Utility of MS Framework

Kingdon's MS Framework primarily provides an explanation for non-incremental policy change in a set of circumstances of problematic preferences, fluid participation and unclear technology. It emphasises the role of human agency or actors (the policy entrepreneur) in cutting through this lack of clarity and seizing the chance to offer manageable solutions to decision-makers⁷⁹. This section compares the utility of this model for both case studies. Its ability to predict and explain the two policymaking processes is assessed.

Incremental or non-incremental change?

The analysis has shown that the English case study exhibits non-incremental change without the expected features of ambiguity, fluidity of participation and unclear technology. By contrast the New Zealand case study exhibits much of this ambiguity, fluidity of participation and unclear technology. It delivers change which meets Kingdon's definition of non-incremental change but is smaller in size, scope and speed of implementation.

What is non-incremental change?

To recap, Kingdon's own definition of non-incremental change is that a policy idea reaches the agenda and dominates it in a visibly significant way over a four-year period. In England the pay-for-performance idea became the centrepiece of a new financing arrangement for general practice within a period of two years from the focusing event of the BMA ballot of general practitioners about resignation from the NHS, held during the election campaign in 2001. Most participants confirmed that pay-for-performance ('something for something') was a pervasive concept which was understood and accepted by participants throughout the rapid process of policymaking.

The New Zealand PP is also an example of Kingdon's definition of non-incremental change even though it had low visibility amongst general practitioners and comprised only 2% of the budgeted funding for primary care services. It was quickly developed and reported to Cabinet. Decision-makers then took a consultative and phased approach, with funding approved in July 2004 but implementation occurring in 2006. This process of design took twice as long to design and implement as the QOF. However, the policy achieved an important change in the level of knowledge about and potential influence over the activities of general practitioners which the state now holds, through a central monitoring body and the network of local PHOs and District Health Boards.

Ambiguity, fluidity and unclear technology?

To recap, the three characteristics of the Garbage Can Model borrowed by Kingdon from Cohen^{51 p.84} are problematic (or ambiguous) preferences, which are 'discovered through action rather than actions being determined by them', fluid participation (individuals drifting in and out of decision-making according to the time and effort required) and unclear technology (or failure of individuals to understand how the general processes of the organisation really work). In Kingdon's original research, the ambiguity of preferences and fluidity of participation was often exacerbated by temporal constraints and together these circumstances militated, according to his evidence, against rational measured incremental policymaking. Instead, he often observed dramatic non-incremental policy change,

facilitated by exogenous manipulative policy entrepreneurs influencing agenda-setting processes.

Against the criteria of ambiguity, fluidity and unclear technology, the English and New Zealand case studies deliver contradictory findings. In England where non-incremental change occurred there is planned top-down policymaking featuring clarity of preferences, closed participation and clear technology for implementation. The evidence shows that these features of ambiguity, fluidity and unclear technology do apply to the New Zealand case study, which also delivers non-incremental change, but with a step-by-step process of implementation.

The two case studies reinforce the conclusion that policymaking in Westminster systems can be planned, top-down and non-incremental in purposeful and orderly rather than chance-dominated circumstances, that political leaders do indeed make decisions about the scale and pace of change and these strategies reflect the political and institutional settings in which they operate^{23 p.38}. This leads to a question about the importance of the entrepreneurial role itself and Kingdon's theory of political manipulation. The case studies show that it was not at the agenda-setting phase that these actors were important. During this phase in Westminster systems, political parties and Ministers dominate. At the subsequent stages of alternative selection and implementation, however, other actors including civil servants and entrepreneurial actors play a much more significant role.

Importance of policy entrepreneurs

In both case studies, the exogenous manipulative policy entrepreneur is not found but actors with a variety of entrepreneurial skills are seen in the evidence to be enlisted by governments to bring disparate ideas together to explore common ground and to conciliate different interests. Policy change in each case study was facilitated by individual actors exhibiting entrepreneurial skills as described in the MS Framework literature. However, this evidence does not add up to a theory of political manipulation at the agenda-setting phase. These actors are most relevant in the alternative selection phase though were acting according to the directions of Ministers.

There are two main types of policy entrepreneurs which have been established in the literature following Kingdon: the opportunistic 'brilliant salesman' with a predetermined policy idea and the facilitator of the 'internal team process' of policy design. A third kind, the 'institutional' entrepreneur, is a more recent concept in the literature. These actors seek to change institutions rather than policies, looking for opportune moments to innovate and introduce new forms of governance. The risks they take include, for instance, engaging their endowments of knowledge with current political incumbents (which may place them at risk with successor administrations or deliver them greater benefits). Two examples of entrepreneurial actors who were particularly important for the design of the pay-for-policy-framework in each case study are the Chair of the Quality Sub Group in the English case study (a 'policy entrepreneur') and the Co-Chair of the Referred Services Expert Advisory Group appointed by the Ministry of Health in the New Zealand case study (who resembles an 'institutional entrepreneur'). In New Zealand this Co-Chair had experience of the implementation of quality improvement schemes within capitated funding environments in a regional primary care network organisation. With the assistance of his colleagues, he was able to bring this experience into the heart of the national policymaking process, spanning boundaries between general practice and funding organisations to champion quality improvement schemes within capitated funding models. He also drew in influencers from Māori, Pacific and disadvantaged communities and other primary care professionals into the policy design process. Both these actors were general practitioners, each having a particular passion for quality improvement in medical practice and had extensive experience of relevant policymaking in another adjacent arena which they were able and willing to transfer into national policymaking processes. In this sense they can be seen to have 'laid the ground work for the next major episode of change' ^{67 p.36}.

However, a distinctive model of public entrepreneur is also offered by the Chair of the Confederation team in England who established a new negotiating team to facilitate the building of a closer strategic alliance with the BMA through very challenging times. Participants for the research in England confirm that he utilised qualities of social acuity, problem definition, team building and leading by example, such as are identified by Mintrom ⁸³. He maintained the support of his mandate-givers despite the peaks and troughs of the policy design process and the pressure of the political dynamics of both the BMA and

government administrative processes. He was noted for his active problem-solving skills and stakeholder relationship management. The freshness of this approach, in contrast to remembered and more traditional adversarial negotiating styles, is remarked upon and endorsed by all participants.

These actors can be seen as entrepreneurial because they ‘gamble that certain resources can be combined now to yield greater value at some uncertain future state than they do in their current use’^{24 p.614}. They assisted state funders to enter into clinical debates with general practitioners, without directly challenging the professional autonomy of general practitioners, enabling the state to influence the use of health resources by these medical professionals. They carried out this public mandate, encouraging change within the primary care service landscape, by combining the authority of the state with their specialised knowledge^{67 p.3} and their previous experience of such innovations at the regional level.

So in summary, actors utilising entrepreneurial skills were important to the successful conduct of policymaking in both of these case studies, though it cannot be said that these policies would not have been implemented without these entrepreneurs. Their contribution is made not in agenda-setting but in the alternative selection and implementation phases.

Poor fit with Westminster jurisdictions

Some of these findings undermine the utility of Kingdon’s MS Framework for majoritarian, unitary Westminster systems, as they do not seem to conform with his predictions and therefore reduce confidence in the generalisability of his theory to these systems. Critics of Kingdon’s MS Framework emphasise their concerns about the serendipitous elements of the framework and its lack of attention to collective approaches of individuals coming together to achieve a shared end, its United States-centricity, the dependence in the theory upon opportunistic policy entrepreneurs as policy enablers to the exclusion of institutional or structural drivers or constraints upon policy change and its lack of recognition of the importance of historical antecedents. This research supports this wide-ranging critique. In particular, many elements of Mucciaroni’s critique as they relate to the under-theorising of institutional factors⁵³ are upheld.

Both case studies show non-serendipitous planned top-down policymaking: each government was able to introduce its preferred type of pay-for-performance policy (and its overarching reforms of health services) in a planned way, in the way it preferred and at the speed it preferred, taking careful account of the institutional arrangements in each jurisdiction. This research offers support to the consensus in the literature, almost a truism, that policymaking has characteristics of greater autonomy in majoritarian unitary Westminster political systems, at least at the agenda-setting stage. The features of these political systems facilitate the management of top-down policymaking processes, which usually commence within political parties prior to an election and are implemented by an apolitical and experienced civil service immediately after an election. Incoming governments can make major changes, at least initially, in the face of opposition from some interest groups. The particular risks faced by policy-makers in Westminster jurisdictions are the difficulties in managing the implementation stage of policymaking and the risk that policies will be often overturned at the next change of administration.

Identifying other drivers of policy variation and change

Accepting that these two processes of policymaking in these two jurisdictions conform only partly with Kingdon's MS Framework, this section now considers what particular features of these policymaking processes seem to explain the nature of policy change in each case and the variation between the two cases. A mix of institutional and rational choice approaches best explains what happened and why. To isolate these, the key differences revealed in the two case studies are now set out.

Opportunity for bargaining and negotiation

The most important aspect in which the two episodes of policymaking differ is the use of formal bargaining and negotiation processes in England and their absence in New Zealand. Because this bargaining approach encouraged the development of a larger scheme and achieved higher levels of engagement from general practitioners, it is also responsible for the difference in health outcomes attributable to the schemes in each case study.

England

Bargaining processes used in England occurred in several key aspects of the policy design: the setting out of the initial principle that more pay would be conditional upon performance; the bargaining over the scheme itself including types of domains, health actions suitable to be included, the nature of the indicators, the targets themselves and features of thresholds and exemptions within the scheme; and on the share of income dependent on performance. The government took many steps to ensure that the risk of self-interest and opportunism inherent in bargaining and the risk of gaming of pay-for-performance schemes was managed. Rules were set around the bargaining and negotiation approach to temper it through principle-based negotiation strategies. Employers knowledgeable about health service delivery, rather than civil servants distant from the realities of the front line of health service delivery, were used as state negotiators, reducing the information asymmetry which characterises debates about medical practice between funders and clinicians. Within the Quality Sub Group, moderation of debates on clinical best practice by independent academic interlocutors was a key innovation by the Confederation team to ensure even-handed consideration of the merits and value of targets and to speed up processes which had become unconstructively disputatious.

All participants agree that there was something palpably different and more constructive about the process of negotiation of this particular contract than had been experienced in previous years. Participants in both parties described how they, themselves, and others strove for a constructive negotiation which balanced socially optimal outcomes with improved terms and conditions for general practitioners. Participants describe explicit attempts to improve the levels of shared goals and mutual trust in the negotiation process through principle-based bargaining over levels achieved in previous negotiations. This provides some evidence that lessons have been learned by governments from past experience and there is an increase in their skills to manage the risks of self-interest and opportunism of the parties in such bargaining situations.

The fact that the QOF was part of the pay negotiation for general practices was a factor in its size and the speed of its implementation and comprehensiveness of take up. The BMA and its members were impatient for an improvement in their terms and conditions of work

and ready to concede increased oversight of the quality of their clinical practice to achieve a substantial lift in pay. This agreement was achieved through regular reporting back to the membership and formal processes of stage-by-stage voting, allowing members to participate directly in decisions about these new terms and conditions. General practitioners as members of the BMA were therefore well prepared for change arising from the settlement and thus for the implementation of the QOF itself.

Although there was division within the membership about the scheme, it was able to be adopted by a majority vote of the membership. This process achieved a high degree of awareness of and engagement with the scheme amongst general practitioners and consequently it delivered more improved health outcomes more speedily.

The greater-than-expected cost of the new General Medical Services contract, as well as its speedy implementation, is a by-product of the strong incentives and drivers within the pay negotiation process at the heart of the new contract. Some fierce interest-based bargaining is certainly uncovered in the English case study evidence despite the attempts to minimise it through principle-based bargaining. This drove the generous out-of-hours settlement which, when the reduction of weekend surgery hours was apparent, had immediate negative repercussions for politicians. Within the QOF negotiation there was also some positional bargaining on the degree of challenge of the targets, with one side wanting these to be 'for work already being done' and the other wanting 'to make it stretchy' but for several participants, comments such as it 'felt like a practice meeting', which is a consensus-based process, were most common.

New Zealand

In New Zealand there was no existing framework for the interests of general practitioners to be formally bargained for or negotiated through a nationally representative forum. There was some use of bargaining-like tactics by Ministers and policymaking officials as part of the overarching PHCS implementation; for instance the availability of the highest levels of new general practice fee subsidies for regions with high socio-economic need level were made conditional upon certain actions such as general practices keeping patient co-payments at an agreed level. This required the development of a process for fees review which was

negotiated between individual leaders of general practice and the Minister of Health. Some informal 'bargaining' occurred between members of the RSEAG who competed with one another to install aspects of their preferred policies in the design of the pay-for-performance scheme (such as the requirement to collect ethnicity information as a condition of participation or whether high-performing PHOs should be able to obtain greater rewards through the scheme). But there was no requirement to finally achieve consensus. General practitioners closely associated with IPAs felt that this was, in the end, a zero-sum game of winners and losers which was seen by some participants as a 'state-directed program'. This conforms with Zahariadis' description of competitive networks which 'appease certain critics...and...blatantly disregard the grievances of others' ^{80 p.81}. The result of this approach was disengagement and some bitterness about the process felt by some leaders of general practice and a reluctance to champion the scheme amongst their peers. It also reinforced the lack of a willingness by some general practice leaders to champion a project to develop a national database of practice performance in New Zealand whereas the need for this was supported in England. If a database had been developed in New Zealand, this might have extended the range of indicators and therefore the value of the scheme to general practices and sped up processes of feedback to general practitioners themselves about their practice. In New Zealand the lack of timely feedback about performance exacerbated the low levels of engagement in its implementation. This contributed to the lower and slower levels of achievement of attributable health outcome gains (although the scheme was deliberately designed to be small and incremental because of caution about the mechanism of pay-for-performance).

It is impossible to know whether, in New Zealand, a mechanism for bargaining might have enabled resolution of the arguments over clinical leadership of the process and adequate access to patient treatment data. However, these issues were successfully resolved in England.

What theories best explain this evidence?

The major differences in the two case studies arise from institutional differences. Although the overarching health institutions and policies in these two case studies may seem to be similar, differences in the systems for resourcing and remuneration of general practice

services created a unique combination of institutional, rational choice and network drivers in each country which affected each policymaking process and the power of each state to strengthen its influence over providers of these services.

In England these include the mechanism of the General Medical Services contract and also the relationship between the association representing the interests of general practitioners, the BMA, and the state. Both of these features enabled the state to increase its leverage over the individual general practitioner's clinical behaviour through negotiating a conditional pay settlement. In this institutional framework bargaining was a rule of the game and general practitioners could negotiate a reduction in autonomy for a more valued improvement in their terms and conditions of work.

The policy makers were able to build the pay-for-performance framework of the QOF on a substantial body of existing central guidelines and national service frameworks introduced by the new government after 1997 which were accepted by the medical profession and were in widespread use.

Given the high level of political determination for a large share of new investment to be conditional upon performance and the desire of the BMA to negotiate as generous a contract for its members as possible, the incentives for both parties were aligned in support of the design of a large pay-for-performance scheme. The mechanisms for its negotiation through collective bargaining were ready to hand. The incentives for individual general practitioners to adopt the new policy were similarly strong. They had little choice but to engage with the contract negotiation process if they wished to influence their terms and conditions of pay. They had to implement the pay-for-performance scheme if they wished to increase their income.

In New Zealand, the state was able to implement new mechanisms to give it greater ability to influence health care providers by legislating for a new contractual relationship with general practitioners, requiring the introduction of patient registers and creating a governance framework through PHOs which were, in theory, led by community representatives. But the state still had relatively little leverage over the individual general practitioner's behaviour. In this institutional framework there was no opportunity for bargaining between the state and the general practice profession. General practitioners did

not have to implement the pay-for-performance scheme if they wished to increase their income, especially since the scheme was dependent upon PHOs and practices locally negotiating terms for general practitioners which did not always provide for rewards to be paid directly to practices. Where this was the case there was less incentive for practices to implement the pay-for-performance scheme.

New Zealand had very few existing central quality guidelines to build on and it was difficult to obtain clinical agreement on suitable targets for the pay-for-performance scheme. Because New Zealand policymakers were sceptical about pay-for-performance and individual general practitioners did not need pay-for-performance to increase their income, the incentives for both parties were against the design of a large scheme.

Theories which combine institutional and rational actor approaches^{22-24 75} emphasise the role of individual actors in health policymaking. In both the case studies for this research, actors from within the general practice profession are seen to be taking an innovative approach to designing new governance mechanisms for clinical practice, enabling funders and patient representatives to be included in debates over clinical practice which were usually conducted within the profession. These actors undoubtedly facilitated the policymaking process. There are significant differences in the general practice networks in each country. In general terms the English network can be described as having greater unity, fewer and stronger structural forms, a more consensual mode which facilitated communication between members, higher capacity and more restricted access to membership, and guaranteed access to decision-makers. Such networks, in Zahariadis' terms, have a trajectory of incremental and emergent development of a policy idea or 'rapid propulsion to salience of a persistently softened idea'^{80 p.73}. The New Zealand network is at the other end of the continuum with considerable heterogeneity, multiple, loosely organised structures, more competitive modes which retarded communication between members, lower administrative capacity and less restricted access to membership, and had patchy access to decision-makers. In such networks a more 'quantum' pattern of initial change may occur but then a more gradualist pathway towards unified adoption will be observed. Each country displays a different trajectory. The English sub-system displays 'rapid propulsion' to pay-for-performance after a period of 'softening up' in the fund-holding era. The New Zealand sub-system displays initial quantum change in take up of local

budget management contracts but then gradual progress towards adoption of a national pay-for-performance scheme.

The history of relationships between the government and the interest groups also exerted influence and provided important context for the policymaking differently in each case. In England the 'politics of the double bed' had been reinstated by the Labour government in 1997. In such a working relationship the 'logic of exchange stresses common interests and a search for unanimity'^{80 p.74}. In New Zealand the relationship is identified as 'a fundamentally conflicted one'^{91 p.33} in the evaluation of the primary health care reforms, which also identified that 'the government had no formal contractual means for meeting some of its objectives [and that] trust is a key informal arrangement in this type of environment - so if it is missing...a vital component of the informal institutional arrangements is also missing'^{91 p.36}.

Two drivers of change and variation had relatively similar effects in both case studies.

Socio-economic factors - Both countries were in a period of strong economic growth and politicians had resolved to invest more resources in health care. So both schemes were able to be funded from new appropriations rather than making retention of existing levels of funding conditional upon new quality standards. This is undoubtedly an important feature which encouraged the design of both schemes. It can be assumed that the process of scheme design would have been more challenging and controversial in both countries if it had sought to make the use of existing income for general practitioners conditional upon new quality standards.

However, the evidence shows that policymakers in both countries were driven by concerns about significant socio-economic risks and pressures in the future if chronic health conditions were not better managed through population-based approaches to health outcomes.

Ideas - Consistent with the view that 'purchasing systems are still very much path dependent – that is today's choices are limited by what has gone before'^{45 p.45}, the content of the new policy in each case study draws heavily on existing models or familiar systems and that these in turn were based on New Public Management ideas.

The evidence shows that the Ministers in both jurisdictions supported the idea of pay-for-performance within general practice and championed its use. Civil servants and general practitioners in both jurisdictions had mixed views, some believing strongly in its merits and seeking actively to implement it and others concerned about its risks or morally opposed to it. Participants reported that this mixture of attitudes to the idea of pay-for-performance was widespread. There was a greater degree of scepticism for the idea reflected in the New Zealand policy, policymakers choosing an incremental approach deliberately to minimise risk.

Together with the similar existing and predicted socio-economic environment shared by the two countries, the importance of the idea of pay-for-performance is a factor which, broadly speaking, affects both case studies equally. The evidence also illustrates the tenacity of politically partisan ideological preferences over time. In New Zealand these were very explicit and included the championing by the incoming Labour government of primary health care team approaches over general practice leadership approaches and community-governed services over clinically-led services. Starke has assessed the 25-year period of health reform in New Zealand as being driven by multi-causal factors but dominated by the tendency, when a moment of political opportunity presents itself, to turn to ideas already in the primeval policy soup but importantly, those that accord closely with partisan or party ideology²⁷. In New Zealand's case this results in a pattern of reform and counter-reform in health policy. The establishment, abolition and re-instatement of regional health boards, initiated by successive governments, is a good example of this pattern. This pattern of reform and counter-reform is made more vivid by the shorter electoral term for administrations in New Zealand (three years as opposed to five years in England).

Implications for Kingdon's MS Framework

It is not possible to make sense of the two case studies without taking into account the institutional, rational choice and network factors which impinged so strongly on both policymaking processes described in this research. Kingdon's multi-theoretic approach, as

enhanced by Zahariadis, does not encourage sufficient consideration of these factors, particularly institutional ones. It emphasises chance and individual actors as policy entrepreneurs in agenda-setting and these are factors which did not ultimately drive change or explain variation in these two policymaking episodes. The MS Framework under-emphasises the role played by members of policy communities organised collectively as interest groups within the politics stream (including political parties). The MS Framework also focuses upon single events of policy agenda-setting and adoption and their outputs, rather than seeing policymaking processes in a longitudinal context, which is especially important in Westminster systems where policies can be short-lived or long-lived depending upon policy-makers' choice of process. Neither does the MS Framework consider policy outcomes, in this way neglecting opportunities to observe policy evolution over time.

Taken together, these shortcomings under-theorise aspects of the policy change and variation observed in the case studies and do not accurately predict the circumstances under which purposeful and orderly policymaking can occur or how policymaking occurs in settings of goal and policy clarity.

Enhancing the MS Framework

This section considers how the analysis of this case study evidence can assist in developing policy-oriented approaches in the field of health policymaking research. The case studies have shown that institutional, rational actor and interest group or network approaches are all necessary in understanding what happened and why and, potentially, how to manage policymaking more effectively in each jurisdiction in this health sub-system in future. If the model of Kingdon's MS Framework as set out by Zahariadis were adapted to include new sub-elements of the policymaking process in addition to those originally found by Kingdon and Zahariadis to be important, this would increase its utility, especially for Westminster jurisdictions and for future policymaking generally. These enhancements are proposed as sub-elements capturing network and institutional variables to be added to Zahariadis' model:

Interest group structure and resources - The MS Framework Model as Zahariadis has enhanced it subsumes interest or pressure group views about policies within its sub-

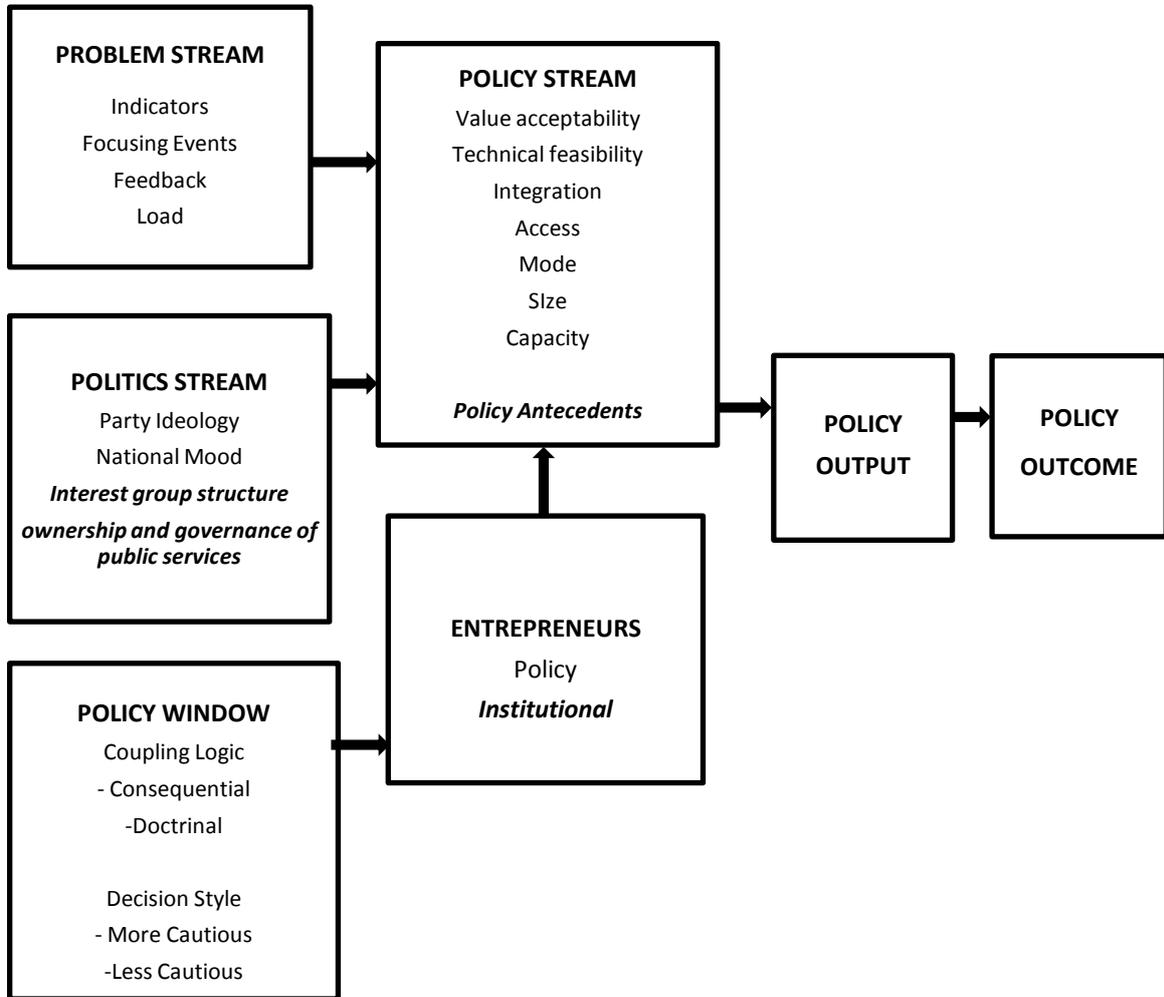
element of 'national mood' in the Politics stream (though the value acceptability of ideas to interest groups is regarded as important in the Policy stream). These interest group factors loom large in the two case studies in its 'politics' stream and are key elements for policymaking in Westminster jurisdictions. National mood is often a separate influence from that of pressure groups or interest groups, with quite different interests. This is particularly the case in health policymaking where professional interests are powerful and resourceful and consumer or public concerns typically more muted and sometimes in opposition to medical power and interests. It is suggested that the sub-element of Interest group structure is added as a separate sub-element in the Politics stream of the model so that there is encouragement to analysts to consider the degree of power (concentrated or shared) and access to decision makers (high or low) held by interest groups if they are involved in policymaking.

The form of ownership and governance of public services (in particular the form pertaining to the system or sub-system related to the policy making) may also be a key factor in policymaking. If consideration of this is encouraged within the Politics stream, it would enable an assessment of the degree of autonomy the state, through its elected representatives, has to develop policy. This would not only enable options such as bargaining approaches to be assessed for feasibility in the policymaking process and also enable consideration of which types of entrepreneur in which institutional positions may best be able to facilitate policy making. More broadly it would invite questions about whether party ideology is important in agenda-setting. If so it will elevate consideration by policy-makers of windows of opportunity arising from administrative turnover. In such an environment, greater consideration would be given to doctrinally-driven policy ideas arising through political parties. These changes would strengthen the relevance of the theory to a wider range of jurisdictions. It is suggested that this is added as a sub-element to the Politics stream.

Schlager also recommends that Kingdon's MS Framework is amended to incorporate institutional structure within the politics stream ^{79 p.306}. This would in turn lead to consideration of whether institutional entrepreneurs are observed in any policymaking process. Different types of entrepreneurs should be envisaged in the model.

Antecedent policies or the policymaking history are an important feature of the two case studies and the literature suggests they are likely to be so in other policymaking situations. Kingdon acknowledges their importance in his written work. The presence or absence of antecedent policies as a sub-element of the Policy stream is suggested as an enhancement to the model. In addition, consideration of its outcome is an element which is absent from Kingdon's policy making framework as elaborated by Zahariadis. While the policy output is a focus in Zahariadis' model, it is incomplete without consideration of the variable of the policy outcome. Analysis of the outcome of a policymaking process would assist successive policy makers to make judgements about the costs and benefits of different approaches. It would inform subsequent cycles of policymaking, of which there may be many, repeated over many decades, as this case study has shown. Outcomes will not be able to be known and understood at the time of policymaking but the desired outcome should be documented and achievements measured to provide a full picture of the policymaking process. This research has made a case for inclusion of a new variable in the model – that of policy outcome - which would enhance or extend Kingdon's MS Framework for policy analysis. Together these sub-elements reflect the key institutional factors which are under-represented in the model. It could be enhanced as shown in Figure 2 below.

Figure 2: The MS Framework: Proposed additions



Relevance for related empirical work

The evidence offers support to Freeman's contention that it is the politics which determines policy and that national styles are the drivers of policy outcomes rather than the alternative view: that the nature of the problem is fundamentally connected to the kind of politics and outcomes that emerge (or that policy determines the politics). In a similar vein, Glaser in his classic comparative study of methods for paying doctors suggests that 'the adoption of a particular payment mechanism results from 'national tradition and political manoeuvres'⁶⁰ p.25 in which doctors' 'powerful clinical traditions' and their 'concern with prosperity and independence' make the medical market 'an exception to the simple rule that monopsonists can use their bargaining power to obtain advantageous procedures and minimum prices.' The differences in policies adopted in identical sectors in each case study tend to indicate that it is the politics of the sector, not the sector itself which is the independent variable in policy choice.

The case studies offer partial theoretical replication of research by Pollitt which seeks to explain why pay-for-performance is 'a prominent part of NHS management, along with a proliferation of regulatory instruments'^{182 p.4}. Pollitt offers a 'nested' explanation that the institutional features of a centralised majoritarian political system and tax-funded single payer financial structures have enabled a long period of development of a coherent and standardised system of pay-for-performance, initially within the hospital sector. This has led to training of users and building of trust. He specifically predicts this will also be the case in a majoritarian centralised system such as New Zealand. The case of New Zealand's general practice sector is in a sense the exception which offers some proof of the rule. New Zealand has not had centralised management of general practice funding and performance, nor single payer contractual funding arrangements in this sector during the period. It also lost its majoritarian political status in 1996 though for most of the period of review of the development of the English performance indicator system it had this feature. So the development of pay-for-performance has been late and tentative in the general practice sector because two key variables are different from the situation in the NHS in England: the interest group systems (pluralist) and financing structures (multi-payer and private providers) which affect general practice.

The two case studies also add evidence which is of relevance to other research by Pollitt⁶. In his study of drivers of performance improvement/increased accountability approaches for professionals in health care he suggests that the operation of majoritarian and adversarial political systems is closely associated with the development of performance improvement systems as exhibited in England. He suggests that New Zealand as a similar political system should be studied to validate this finding. He found that different political systems such as in the Netherlands did not develop performance improvement systems as quickly or as willingly and identified the political system as the key driver of a preference for performance improvement approaches. In fact the New Zealand case study provides an example of slow and unwilling development of performance improvement in its general practice services *despite* its majoritarian and adversarial political system. This offers support to the idea that it is the nature of the decision-making approaches and institutional features such as financing structures within a particular policy sector or sub-system which seems to be *more* important than the nature of the overarching political system. While the overarching systems are different in New Zealand and the Netherlands, each sub-system has features in the relevant policy communities which impede speedy consensus building and policy change.

Recommendations for enhancement of typologies of health systems

Typologies for health systems, health system reforms and political systems and public management approaches usually group the United Kingdom and New Zealand together. This research has shown that the sub-system differences between the general practice sectors in each country were profound and affected the ability of the state in each case to make system wide changes and improve equity. These differences were not readily exposed in the typologies available at the time. Indeed, the typologies may give a false sense of similarity and deter or distract researchers from the exploration of points of difference which may turn out to be critical. In the case of health system typologies, although there was some acknowledgement of differing levels of private financing in the two systems, these differences were not presented in a way which was particularly useful for either English or

New Zealand policymakers, or those from other countries, to understand how this might affect the operation of each system or the process of change to systems.

Taking health system typologies as an example, some new indicators of difference between outwardly similar systems could be considered for addition and have been important factors in assisting this research and its analysis:

- New indicators by sector such as
 - the degree of monopsony by sector
 - number of funders by sector
 - modes of governance overall and by sector
 - modes of decision-making overall and by sector
 - structure of policy community by sector.

- Differences for existing indicators at the sub-system or sectoral level (in financing or stewardship approaches for instance) such as;
 - the proportion of out-of-pocket payments for medical services by sector
 - the type of physician payment by sector
 - the proportions of public/private finance by sector

Where these can be identified and incorporated into typologies, the comparative and explanatory power of the typology would be greatly enhanced. Typologies encourage variable-driven explanations which have ‘an automaticity that largely removes human agency from view...leaving a huge unexplained residual’^{50 p.274}. The task of identifying these indicators will itself focus attention on a larger range of mechanisms in each health system. Where these features could be mapped against the performance or outcomes of health systems generally, which *Health 2000*⁵⁴ sought somewhat controversially to do, this would give impetus to efforts to analyse drivers of difference and isolate key variables which are associated with improved health outcomes.

In the first section of this Chapter, the research questions set out in the Introduction are answered, with reference to the literature on drivers of the policymaking process and

comparative approaches to such study and to the evidence obtained in two case studies of contemporaneous pay-for-performance policymaking in similar jurisdictions. A set of findings has been presented and the arguments which support these findings have been explored in depth, taking a comparative approach. In the next section, ideas for the use of these findings in the New Zealand policymaking context are set out.

Summing up: research findings and looking forward

This research has studied pay-for-performance health policymaking in two countries in 2001 when pay-for-performance schemes in national health systems were relatively untried. With the passage of time, much new research about pay-for-performance has been completed and has drawn upon the experience of the QOF development in England. Researchers have commented that the research question today is not whether to use pay-for-performance but how best to incorporate it in financing arrangements for general practice services⁴⁹, bearing in mind Saltman's warning that 'the experience of one country with payment systems and financial incentives cannot easily be reproduced in another country - even if there is a high degree of cultural and institutional similarities'^{43 p. 195}. Given the passage of time there can also be an assessment of whether improved population-based health outcomes have been achieved by the initiatives in both countries.

As a final contribution from this research, some next steps are proposed for consideration by policymakers in these two countries which might improve their ability to achieve population-based health outcomes through primary health care services.

The first comment relates to the opportunity for a stronger collaboration between the two countries which are the subject of this research on health policy. Despite the different results and the differences in the general practice sub-system in each country (which have grown in recent years with the decision to implement general practice-based commissioning in England) there remain many similarities in the institutional, structural and cultural features of the two health systems. There are well developed linkages between England and New Zealand for policy making dialogue in both the political and the policy streams. In developments since 2004, English policymakers have made step by step improvements in their pay-for-performance scheme, including removing the design of the QOF from the collective bargaining environment. England has recently decided to reduce the component of income which is dependent upon it within the General Medical Services contract. Taking all these factors into consideration, there is much benefit to be gained from continuing a strong and collaborative dialogue over future developments of pay-for-performance policymaking in the two countries.

The second set of comments is directed at policymaking in New Zealand. As was the case in the policymaking for the Primary Health Care Strategy in 1999, New Zealand policy-makers can choose the appropriate scale and pace of change to reflect the nature of the window of opportunity for such change. Some ideas for future research and policy development, set out in two alternative scenarios of incremental or non-incremental styles of policymaking, are offered below:

Incremental style: New Zealand policymakers could support the evolution of both its current general practice institutional forms and interest group structures towards different types of political exchange over time, building on the achievements described in this research and setting a stronger institutional context for the building of trust and collaboration within this sub-system. This would entail, for instance, developing a more consensual and receptive institutional context for the introduction of improved accountability frameworks. Steps to take to provide for the development of such a framework might include:

- Mandating a single national representative body for general practice, perhaps consisting of a forum of representatives from the various segments of the general practice professional community. Such a body would have unrestricted access to government decision-makers regarding policymaking which affected general practice, utilising principle-based bargaining and negotiation processes. This could be expected to lead to the slow building of greater mutual trust, between general practitioners and the representative body and between that body and the state, through repeated examples of consensus-based policymaking that was seen to balance the interest of both parties.
- Supporting the enhancement of policy community resources for primary health care (including general practice) to inform policy ideas and develop information and knowledge infrastructure based on evidence. This could include investment of adequate resources to build a comprehensive shared database for primary care service delivery on the model of the QMAS and rapid development of an evidence base, shared national service frameworks and quality standards and targets on the model of the domains developed within the QOF.

- Negotiating greater alignment between both interest groups and policy specialists and the two major political parties on key aspects of population-based health policy. A bi-partisan agreement to support the key elements of agreed infrastructure-building steps over a ten-year period, avoiding the regular cycle of policy windows at election time which can bring policy reversals, could be a first step towards achieving longer periods of time for policy changes to embed.
- extending the engagement with an international policy community, particularly of countries with similar governing systems, to support these developments. A more extensive network and community of practice in this field of knowledge, which draws on other policy community resources, would enhance the resources of the New Zealand policy community for general practice and primary care policymaking.

Non-incremental style: Policymakers could commence further reforms of the ownership and governance frameworks for general practice services by negotiating with the profession for the implementation of major structural change (such as a single payer financing arrangement within general practice). Costly in terms of meeting the full and reasonable costs of general practice services through public funding, a business case for such investment could perhaps be built based on potential improvements in metrics such as reductions in the health care costs of chronic conditions and reduction in ambulatory sensitive admissions which would arise from improved access to high quality general practice services. Introduction of a broader-based pay-for-performance scheme has demonstrated in England the potential to deliver savings arising from anticipated reductions in ambulatory sensitive admissions to more costly hospital-based care.

Another comparative case

Canada offers an example of a jurisdiction which successfully achieved a major policy change in general practice governance when it introduced a single payer framework late in the development of its health system. Canada shares a Westminster-style adversarial political system though with a federal structure. Its universal comprehensive government-sponsored medical care insurance scheme was legislated for in 1966 and finally fully implemented in 1971^{22 p.93-95}. With respect to both constitutional structure and timing,

Canada does not offer so close a match to the New Zealand case study as England does, except for a key feature.

During implementation, and in a replay of the accommodation reached between the state and medical profession in New Zealand in 1948, several Canadian provinces allowed doctors to 'extra-bill' patients in exchange for accepting the state as the sole funder of medical and hospital services. The practice was not extensively adopted, with only 10 percent of physicians utilising it. The amount was estimated to constitute only 1.3 percent of total physician billings, unlike the widespread use of co-payments in New Zealand. However, concern about financial barriers to care arose during the 1980s in Canada as it did in New Zealand. Symbolically important to the medical profession as a cherished hallmark of private medical practice, the practice of extra-billing was nevertheless outlawed in 1984 in Canada as a result of a campaign by a Liberal government with declining popularity, seeking the 'product differentiation' typical in an adversarial electoral system. This campaign promise to end extra-billing was seized upon and joined by the opposition party for its own electoral advantage. All provinces had to comply with the proscribing of extra-billing and provincial battles were then fought to implement the legislation, the most protracted being in Ontario where a bitter strike ensued. In the event the profession has preserved considerable clinical autonomy but surrendered some entrepreneurial autonomy to the state in its role of funder.

A non-incremental change of this nature in New Zealand would require bi-partisan political support based on public interest principles. It may take many years to design and implement in a constructive way, drawing on the experience and advice of governments and general practice organisations in England (and Scotland) and Canada to give a complete picture of the costs and benefits for both parties to the arrangements. It would also be an appropriate environment for the activities of institutional entrepreneurs to be recruited by the state. New institutional arrangements would be the key output of such policymaking. New collaborative working relationships between the state and general practitioners and improved population health would be the sought-after outcomes.

In both scenarios, skilful engagement by the state of entrepreneurial actors with a particular brief to pursue continuing institutional innovation is likely to be a facilitating factor in the speed, nature and extent of policymaking change.

The third set of comments relates to policymaking in the English general practice sub-system. This has followed a further cycle of reform began in 2010, which gave general practitioners, in consortias, greater powers as commissioners of hospital and community services⁶⁷, and has therefore diverged in some important ways from the shared path hitherto followed with New Zealand. However, a more heterogeneous environment for general practice now exists in England and in this regard, New Zealand policymakers may have some relevant experience to offer their English colleagues about the challenges of health policymaking under conditions of heterogeneity.

CHAPTER TEN

CONCLUSION

The aim of this research was to identify what enabled or impeded two Westminster states to increase incentives for improved population-based health outcomes in the general practice sub-system of their health system, taking a policy-oriented approach. An opportunity presented by a quasi-natural experiment in these two countries has been utilised to explore, understand and develop generalisations from empirical data collected in two case studies of the design of a pay-for-performance scheme. The research has applied theories of policy change and variation and a rigorous comparative analysis in seeking to answer the research questions:

- In what aspects and why did two similar episodes of policy formulation and implementation in two similar jurisdictions follow different processes and have different outcomes?
- How well do the elements of Kingdon's MS Framework describe and/or explain what happened at each stage of the policymaking process?
- What new relationships between variables can be identified from the analysis which may enhance or extend Kingdon's MS Framework?

The research has utilised qualitative methods to gather evidence in 26 elite interviews and has analysed documentary evidence in the two countries to build thick descriptive case studies of each episode of pay-for-performance policymaking. The exploration of the process of policymaking in England has opened a window on 'private negotiations between tight networks'^{100 p.196} and rare views of public policymaking in that country. The comparative approach considered the policy goal and policy instrument, timing, governing systems, type of health system, history of health sector reform and general practice sub-system institutional and network features in each country. This process has established that many explanatory variables can be considered to be controlled for in the analysis of findings. A 'most similar' case study methodology has been used and the inter-systemic differences have been viewed as independent explanatory variables. The policy output and

outcome and nature of policy change achieved (incremental or non-incremental) has been used as the dependent variable.

Specifically, the research has provided an in-depth study of the process of agenda-setting and alternative selection, with some focus upon implementation processes, in the two pay-for-performance policymaking case studies. Limitations affecting the research include that it has captured, predominantly, the views of elites, leaders and entrepreneurs some years after the events in which they participated, that documentary evidence and access to some policymakers was not able to be obtained, and that the process of interpretation of evidence is inevitably mediated by the researcher's judgement. The research should be read and the findings assessed in the context of these limitations. However, a process of careful corroboration and triangulation of evidence was followed to minimise these risks and limitations and this is described more fully in Chapter Four.

The key finding of this research is that key institutional enablers assisted England to engage general practitioners successfully in policymaking. This created a context for rational choice drivers to lead to policymaking which increased the influence of the state over general practice activities. While New Zealand has taken important steps towards achieving its policymaking goals, its institutional features within the general practice sector acted as constraints on pay-for-performance policymaking. These differences include the multiple forms of ownership and governance of general practice services, the systems for resourcing and remuneration, multiplicity of interest groups and low levels of integration of the policy community in the general practice sector in New Zealand. These differences, especially in the systems for resourcing and remuneration, reduced the power of politicians to achieve a significant shift in their influence over general practice services. This in turn affects the ability of the state to exercise effective stewardship over all the public investment in its health system. In the New Zealand case study there is evidence that the degree of genuine engagement with a large segment of the general practice sector in the policymaking process was low. Without such engagement, the risk of lack of adoption of the policy and the delivery of its benefits by that section of general practitioners was high. With greater engagement, the opportunity to design a larger pay-for-performance scheme with greater influence on health inequalities might have been achieved. However, new forms of governance have been developed, with the assistance of entrepreneurial actors, which

recombine successful mechanisms from adjacent areas including IPAs and community-led primary health care services and Māori and Pacific institutional approaches to equity-based service delivery.

Both case studies shows that non-incremental change in primary care health policy can be achieved by governments wanting to improve health outcomes for citizens and that general practitioners can be incentivised to take a population-based approach to their work. However, politicians need to carefully assess the scale, pace, and scope of change of such change in light of the institutional features of their general practice sub-system.

The utility of Kingdon's MS Framework in describing and explaining these two episodes of policymaking in Westminster jurisdictions has been explored to establish whether this multi-theoretic approach or other single-driver approaches in the policymaking literature are more helpful in achieving an understanding of what happened and why and how this knowledge may be useful to policymakers in future. The patterns of change found in the research run counter to those predicted in Kingdon's MS Framework for the conditions associated with non-incremental change. However, the research has found that Kingdon's multi-theoretic approach has great value in enabling a systemic approach to be taken to the analysis of each policymaking episode, demonstrating the interactivity of streams, elements and sub-elements and acknowledging human agency. Kingdon's MS Framework captures the complexity of the policymaking in the two case studies better than a single approach would have done. It confirms that Kingdon's work has been helpfully enhanced by the work of Zahariadis, which has deconstructed elements of agenda-setting and alternative selection processes, setting these out in an analytical framework and extending it to reflect on network factors such as the effects of policy community integration on the type of policy change.

The entrepreneurs in the two case studies were appointed by state actors, to assist with activities in the alternative selection and implementation stages. They used their social acuity, problem definition and problem-solving skills, team-building and leadership skills to facilitate the design of these two schemes. The role of entrepreneurs during these phases was one of continual problem-solving and team management within a clearly-set political agenda. The value of entrepreneurs with 'insider sensibilities', who can command trust and

respect in key stakeholders, is demonstrated in both case studies. Actors resembling both policy and institutional entrepreneurs are observed, with the latter actively seeking out new governance mechanisms from adjacent institutional areas to recombine in new modes of governance about clinical practice for this general practice sector.

However, the research has confirmed the critiques in the literature that the MS Framework continues to underestimate the importance of institutional features in policymaking in Westminster jurisdictions. The research has found that these jurisdictions permit more purposeful and orderly policymaking while still achieving non-incremental change. This research suggests enhancements to the MS Framework to heighten its consideration of institutional and network-based factors. Further, the suggestion is made that outcomes of policymaking as well as outputs are considered in the Framework so that it is able to show what has and has not worked, and why, providing improved guidance for future policymaking.

This research has found that additional insights from the New Institutionalists, institutional rational choice and network literature enabled fuller exploration of the policymaking processes observed in the two case studies. In future, application of both institutional and rational choice methods and approaches may be helpful to explore policymaking.

The research has also highlighted the high degree of continuity of policies and processes between apparently different eras of health system reform. Both case studies demonstrate the closeness of connection between policies instituted in the era of market-based reform in each country and those adopted in the subsequent era. Pay-for-performance is such a policy and its small-scale application to general practice funding in the 1990s created the foundation for much larger scale national utilisation of this policy in both countries after the turn of the century. This continuity is reinforced through the continued involvement of individual policy-makers whose activities span successive eras.

The research makes a contribution to the literature on typologies for health systems and health system decision-making. In particular, it has provided empirical evidence which contributes to the literature challenging the utility of the whole-system level approach and the tendency for over-simplification generally in these typologies. The research has highlighted the risks of masking or submerging important sub-systemic features. Although

these two countries are often placed in the same categories in typologies of health systems and public management systems, the evidence has shown that there are considerable differences between these countries' general practice sub-systems and their relationship with state funders. The research has shown that these differences affected the ability of state funders to undertake strategic public policy interventions within their health systems.

It is a recommendation arising from this research that models of health systems need to allow for sub-systemic variation more explicitly. The implications of these submerged sub-system features have been evidenced through the exploration of their affect on health system stewardship in each country.

Despite differences in the scope and effectiveness of the pay-for-performance policies achieved in each jurisdiction, both states are shown to have held and exercised considerable powers to design and drive through health system reform of a wide-ranging kind in planned top-down processes. They both sought to use non-confrontational methods of engagement with key interest groups where possible, in order to distinguish themselves from attempts of previous administrations to impose unwanted change.

How states can achieve major change to improve health outcomes for citizens is part of their challenge of health system stewardship. That has been the underlying theme of this research. Both governments held high hopes, on behalf of citizens, for system-wide health reform when they came into office. Through the detailed examination of these reform efforts, it is hoped that there is a greater understanding about how these policy changes were achieved and why these pay-for-performance policies varied between the two countries. Through such studies it may be easier for future governments to improve their policymaking processes and through this, their ability to fulfil their hopes for improved health outcomes for citizens.

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INTERVIEW QUESTIONNAIRE

Victoria University of Wellington

Health Services Research Centre, School of Government

Implementing Pay-for-Performance in primary health care

In-depth Interviews

July 2007

Name:

Job:

Organisation:

Date of interview:

Location of interview:

Interviewer:

This PhD research study is seeking to improve our understanding of how the design and implementation of two financial incentives schemes for general practitioners in 2004, one in England and one in New Zealand, measured up to current theory on best practice in the design and implementation of health policy, what this had to do with the level of success or failure to date, why this happened and how current theory could be changed to reflect these findings if necessary. The research will assist public policy makers to improve the design and implementation of similar initiatives in the future and enhance the likelihood that future initiatives will be more successful.

The interview is completely confidential in nature, and in our reporting, we will ensure that all findings are anonymised with nothing being able to be tracked back to an individual. A report of the findings of this research will be made available to all who are interviewed as part of this review, in advance of any publication of research findings in a PhD thesis or in other academic or professional publications.

Before proceeding with the interview, I would welcome any questions that you have about this research and this interview.

I would like to make a tape recording of this interview, as well as taking contemporaneous notes. The tape recording and notes will be stored securely in line with Victoria University of Wellington/University of Birmingham data protection procedures and only I and my PhD

supervisor will have access to the data. Are you prepared to give consent to the recording of the interview?

Name.....

I confirm that I give consent to the recording of this interview:

Signature.....

Date.....

1. Could you give me an overview of your role in the design and/or implementation of the Quality and Outcomes Framework (QOF) in England between 2001-3/Performance Programme (PP) in New Zealand primary care between 2001-5?

Prompt for why chosen for this role ie: what skills, influence, experience, information held which were relevant to the process and how were they used/not used

2. Thinking back to that process, what in your view was the QOF/PP intended to achieve?

3. Do you understand there to have been a research or theoretical framework which undergirded the proposed scheme and if so what was it?

Prompt for use of evidence-based policy; role of advisors; how team operated; roles of participants; process for making decisions/resolving debates

4. What do you understand to have been the policy advice/situation analysis process which informed programme design or implementation planning? Who was involved in that? How did they go about this?

Prompt for influences such as use of previous experience, expectations of politicians; availability of resources of time, expertise and money

5. Who was responsible for deciding on these aspects of policy design and implementation planning? Why them? How did they approach this task?

Prompt for which issues caused debate and how this was resolved; ability to subject decision making to critique; who held which sorts of roles in the process of decision-making

6. Who in your view had a stake in these decisions and how were these various interests reflected in the design or implementation planning?

Prompt for how interests were declared or identified; how they influenced the final shape of design or implementation

7. What do you believe is working as expected or not working as expected? What challenges and barriers emerged and how were these responded to?

8.

What changed from the original design, why and who approved this? Is change continuing and how and by whom is this being decided?

Prompt for who the key stakeholders for each set of interests/issues were and how they influenced/are influencing the outcome of the process

9. What elements of the scheme, the process of its design and implementation do you believe are relevant for similar initiatives to improve quality through financial use of pay for performance ie; are not situational to this scheme? What can policy managers/academics learn from this experience?

10. What other comments do you have about the process of design and or implementation of this scheme and its results? Who else should I speak to about the design and implementation of the scheme?

