

Will You Know an Outcome When You See it? The Holy Grail of Performance Management

Colleen Coop and Bill Ryan

Victoria University of Wellington

Introduction

Without control mechanisms organisational behaviour would “degenerate into a composite of uncoordinated activities that are unlikely to possess the cohesion necessary to allow continued organisational survival” (Berry, Broadbent and Otley, 1995, pg 4). It is widely accepted that measuring purely efficiency- (financial) based dimensions of organisational activity is not appropriate, and measures of effectiveness also lie at the heart of the task of control for organisations. Control in the public sector presents “unique” challenges (Allison, 1982; Behn, 1985; Gregory, 1999). Characteristics unique to the public sector include the absence of markets, the production of goods and services that are not easily able to be priced, and the value-laden expectations of accountability, fairness, openness and honesty as well as a diverse array of stakeholders.

The “New Public Management” (NPM) paradigm based on agency theory and institutional economics, although providing useful ways of measuring some aspects of performance, has fallen short as an encompassing model of control. It does not cater at all well for predicting, managing and controlling complex social goals, and the staff who produce them. While the principal/agent theory works well within a market environment where there is clear definition of roles and accountability, avoidance of conflict between different roles and avoidance of multiple principals and clear *ex ante* specification of outputs/outcomes, it is less applicable to the public sector (OECD, 1999). The demarcation of agents and ability to use contracts to gain accountability is extremely difficult in public organisations that contribute to the social good. Political incentives may conflict with economic or rational incentives for the agency and there are multiple principals resulting in a conflict between different stakeholders. It is these factors which make the current monitoring regime in New Zealand public health systems difficult for the staff that work within in it, and finding a possible alternative to reflect the realities of providing public health services in the 21st century would seem to be an imperative.

For public sector organizations (and arguably private as well) improving performance is related to our understanding of motivators for staff and job design. Multidimensional models provide more flexibility for management of performance and expand our understanding of the forces at play in organizations (Etzioni 1961; Dalton and Lawrence, 1971; Merchant, 1985). Hall (1983) states that in the past we have placed too much stress on the task related dimensions of goal attainment and too little on the social dimension of integration and pattern maintenance. In fact he suggests that we should actually reward the “means”: rather than the “ends”. *If we choose the correct means, such as communicating valid information, trust, free choice in decision making and developing organisational consensus and internal communication to action we would move a long*

way toward achieving positive ends (Hall, 1983; pg 27). However these “means” (open communications, integrity, trust and commitment) are not amenable to formal specification in an accountability document.

It is a given that public services must be accountable. However perspectives on accountability are many and varied (Controller and Auditor General Report, 2002; Cunningham and Harris, 2001). Even in the so-called “profit-motivated” private sector it is becoming apparent that job satisfaction and performance are enhanced in circumstances where heavy reliance on accounting based controls is confined to situations of low environmental complexity (Brownell, 1987). In very high complexity areas, such as health, it is little wonder that accounting based approaches are seen by staff as anathema (Brookfield, 1992). Indeed it is not clear that services provided by public institutions can be assessed against the same principles as those for private organisations. And if they cannot, how can we ensure that our services are as efficient as they can be for the taxpayer who is now demanding more accountability, transparency, choice and service than ever before. This leaves public services in somewhat of a cleft stick – where accountability is demanded, yet the mechanisms to demonstrate this accountability are less than acceptable to those who stand judged.

The difficulties of management control in complex environments was addressed by Hofstede (1981) who proposed a useful typology of models for management control depending on what type of business an organisation is in. He found that traditional approaches to control were not always useful for public or not for profit organisations, using an assessment of whether objectives are unambiguous, outputs are measurable, effects of interventions are unknown and the amount of repetitive activity. When outputs are ambiguous, difficult to measure and assess, and non repetitive, the risk of political interference or environmental change is high. Learning has to occur in these organisations for control to be meaningful. Given the lengthy lead times for the achievement of these goals, and the intervening events and changes in preferences during that time, societies rarely actually reach these outcomes, but move from one set of conditions to another - continually adjusting desired direction and long term preferred outcomes. Cybernetic models of control, as have been favoured over the past decade, would rarely be appropriate given these factors.

Otley (1983) recognises that the presumption that goals exist is an obstacle in transferring cybernetic thinking from hard physical systems in which goals are a given to social systems such as organisations in which goals are not a given. Within the context of transferring cybernetic control to organisations, Willmer (1983) reviews three concerns: a) a lack of well defined objectives tends to create ambiguity and this precludes specification of a clear standard against which to judge performance; b) a divergence of interests contributes to an inability to measure output so that the indicators selected may be imprecise and result in unreliable data; and c) understanding of the relation between objective and output may not be sufficient to allow for adjustment to the internal control variables.

The use of outcomes in the public sector as a method of performance measurement has been problematic (Berry, Broadbent and Otley, 1995; Smith, 1995). Although it is acknowledged that outcomes should be more rational and amenable to measurement so that we can be more accountable for services, measures of performance are difficult to define and difficult to interpret. In the end outcomes measures will be always be predicated on value based judgements of those who hold the political power at the time (Moxley and Manela, 2001; McCracken, McIlwain and Fottler, 2001) and are in fact multi level constructs that require monitoring of change at several different levels and in a number of different systems (McIntyre, Rogers and Heier, 2001). Wilson's (1989) typology which uses combinations of observability of outputs and outcomes as a means of classifying governmental agencies. He links different types of compliance methods (control) to different variations of the observability of outputs and outcomes to create a matrix of typologies of control. The unobservable aspects are not measurable and therefore such organisations must use alternative methods of control other than the results based methodologies. This suggests that universal results based accountability is not appropriate and a framework is needed for those agencies that do not fit into the observable dimensions. Coping organisations (such as public health providers) are agencies in which neither outputs nor outcomes can be readily observed – there may be few or no objective, readily observed measures appropriate for the agency.

Health agencies, who are managing significant long-lived infrastructure, require a long term outcome focus. Thus in practice measuring outcomes in health will mean measuring intermediate indicators towards a long term result. Further to this Cunningham and Harris (2001) have created a contingency model for selection of the most appropriate forms of control within an organisation (Table 1). The compliance (control) systems of government services must differ depending on the extent to which their outputs and outcomes are able to be observed. Sage, Degeling, Coyle, Perkins, Henderson and Kennedy (2001) assessed the views of clinicians and managers in two New Zealand hospitals. Whereas managers tended to support efforts by policy authorities to increase transparency in both the clinical accountability of clinicians and their use of hospital resources, clinicians still tended to oppose these concepts. This may be because output or current controls can actually impede professional behaviours.

The assessment of “professionalism” (of which there is a predominance in the public sector) is characterised by a set of task orientated behaviours with associated social behaviours (Southon and Braithwaite, 1998). Task related behaviours include a high level of expertise, autonomy or the freedom to control the management of each task, commitment to the task, identification with peers, a system of ethics and a means of maintaining standards. Tasks that are characterised by uncertainty and complexity limit the scope for managerial control, since it is the professional rather than the manager which has the ultimate responsibility, and individual organisations have limited influence over practices as these tend to be defined by the profession rather than the organisation. Management of performance is typically not about controlling practice but supporting it (Quinn, Anderson and Finkelstein, 1996). These issues are complex – which raises the question as to whether our current performance controls are multifaceted enough to reflect the complex environment of health.

Table 1 General theoretical profiles of management control systems in governmental organisations.

Configuration Variables	Contingency		Variables	
	Types of Subunits			
	Production	Procedural	Craft	Coping
Output	Measurable	Measurable	Not Measurable	Not Measurable
Outcome	Measurable	Not Measurable	Measurable	Not Measurable
Control System Feature				
Reliance on budgeted input control	High	High	High	High
Reliance on results control	High	Low	High	Low
Reliance on action control	Low	High	Low	Low
Reliance on personnel control	Low	Moderate	High	High

Methodology

Twenty interviews were conducted with fifteen employees of a public health service provider (a urban District Health Board with a large rural component) and five “non-governmental organisation” (NGO) health providers. Staff were from medical, nursing and management groups. Qualitative questions were asked using a semi-structured interview. This data was analysed using the abductive methodology (Ward and Haig, 1997) of grounded theory analysis (Glaser and Strauss, 1967; Haig, 1995; Kinach, 1995; Calloway and Knapp, 1995; Dick, 2000), but focusing more on the approach taken by Glaser whereby the theory is emergent upon the data gathered. Coding and memoing of the interview data produced categories to gather a detailed understanding of the issue under investigation and to uncover propositions, rather than test and verify existing contributions to knowledge. Therefore data collected was qualitative, exploratory and descriptive, asking “what factors are useful in the assessment of organisational performance in a performance improvement framework”.

The interview assessed what the participants 1) perception of currently used and ideal modes of control; 2) how to assess outcomes in a meaningful way and measures which would tell us if the providers were doing a “good job”, and 3) what approaches were required where several different organizations within the public service were working on the same health “outcome” (such as reduction in smoking or reduced infant mortality).

Results

Core themes were repeated in every interview, and were remarkably consistent. Across the four groups of participants sampled there was surprising concordance of views expressed. Respondents were presented with the three types of control methods – budgetary, procedural and personnel. One of the most intriguing aspects of all interviews is that not one respondent believed that the *current* method of control was the same as what they identified as the *ideal* method of control. Table 2 shows the results for the questions regarding current perceived dominant method of control and perceived ideal method of control. The predominant view of each group, alone and then combined, is shown for the perceived current mode of control and the perceived optimal mode of control. Although some (but by no means all) respondents felt that all three types of control were required. The majority of respondents saw budgetary control as the current predominant method of control, and just as clearly the majority saw personnel control as the ideal. This view persisted regardless of whether respondents saw health as a unique industry, although the effect was weakest in the management group where 60% only (as opposed to the other three groups where the choice was unanimous at personnel) believed personnel to be the optimal mode of control, 40% choosing procedural control as their preferred mode of control. Given the emphasis placed on management staff to be responsible for processes within the organisation it is not surprising that a sizable minority saw procedural control as more desirable.

Table 2. Results on Current and Ideal Mode of Control

	Budgetary	Procedural	Personnel
Nursing - Current	√		
Nursing - Ideal			√
Medical -Current	√		
Medical -Ideal			√
Management -Current	√		
Management - Ideal			√
NGOs -Current	√		
NGOs- Ideal			√
Combined -Current	√		
Combined -Ideal			√

Respondents were asked to say what personnel control actually meant to them, and once again a high degree of similarity was evidenced in their answers. It was recommended that staff satisfaction and staff culture be used as a proxy for health outcomes, given the difficulty in obtaining valid indications for outcomes. The view was that staff will be satisfied when they are aware they are providing a good service, and so indirectly this can be used as an outcome measure.

It was reported that the objectives of staff and organisation can be aligned so long as the potential for the “natural conflicts” evoked for humans in times of change were minimised, with effective change management processes and a way to align financial constraints with medical ethics. A useful measure to assess the performance of the organisation was recommended to be the level of staff satisfaction consisting of factors such as a decrease in perceived conflict, increased clinical involvement in service planning and service management, extent of variation in staff views on particular issues. Other indicators suggested were:

- Turnover rates
- Staff satisfaction
- Number of quality projects staff are involved in
- Clinical outcome measures are assessed by staff
- Number of pathways where variability is less than 10%
- Complaints
- Open Communication Measures
- Meeting the strategic goals of the organisation -Job descriptions are aligned to organisation goals and monitored by achievement
- Assessing the culture and morale of staff
- Extent of ability for staff to follow professional body guidelines/best practice guidelines

A strong effect in the data related to the NGO sense that quality was more strongly related to patient “satisfaction” and public assumptions. With respect to satisfaction, this was in relation to not just the effectiveness of an intervention in a pure clinical sense, but also other elements such as participation, extent of communication with patient, getting what the patient actually wanted (as opposed to needed) and whether the provider actually delivered what they said they would deliver in a timely way. As such this concept of satisfaction was a much more robust (and demanding) approach to whether services are of a high quality.

It was observed that at present health provider staff appear to be trapped in a vicious cycle where a culture of blame and retribution after mistakes leads to more and too many controls on staff which creates more paperwork for them, resulting in less time for clinical care and more mistakes. It was reported that many of the controls are not really used, and although radical, possibly if we did away with the compliance demands, freeing up our clinical resource, this would result in more service provided of a higher quality. It was clearly felt that of all the types of monitoring, staff measures were the most useful. Staff measures such as level of teamwork, cohesion, staff satisfaction, and other related measures, aligned with performance appraisals and goals consistent with organisation’s plan, could replace all other controls...*“if the effort went into the right people, with access to training and who were managed in a way that made you feel valued, you wouldn’t need the other two controls (procedural and financial)”* This respondent felt that the system was “undermining itself” in the pursuit of controls and compliance.

There was a clear differentiation in the concepts of outputs and outcomes, and their relative relevance to monitoring. It was felt that long term outcomes, much like utopia, were a highly desirable yet unattainable goal. In fact respondents saw that immediate assessment (discharge or very soon after) was the only valid attribution one could make to a particular health intervention, more in the vein of an output measure, unidimensional and quantitatively assessed. Outcomes, by contrast, were seen as a multifaceted prism, with many aspects depending on the perspective of the patient. Outcomes were seen as qualitatively assessed, and closely aligned to the category of “satisfaction”. Public understanding of an outcome is also strongly influenced by the media take. In answer to the schedule question “what do you think the appropriate dimensions of monitoring should be in an organisation that would indicate if you were doing a good job” one NGO respondent somewhat apologetically cited the media’s take on the organisation or service, acknowledging that the reporting was corrupted but still unable to resist the pull of the perceptions created by them.

In discussing what measures may allow an organisation to know if it has a learning culture that enables the people within it to understand and learn from events better, the measures cited were the same list as above – i.e. staff satisfaction/staff quality measures. It should be noted that these are the same types of assessments as suggested to monitor the entire performance of the organisation. It was reported that alignment of staff to the organisation will occur when the organisation has good retention of staff, is a sought after employer and staff are perceived to be on the cutting edge of research and training, with all staff in ongoing development/training programmes.

Discussion

Healthcare is conceptualised as being “on the edge of chaos” (Plsek and Greenhalgh, 2001; Gauld, 2003). Given the inevitable state of almost “chaos” within which managers must perform, planned management is difficult if not impossible to a certain extent (e.g. Lindberg, Herzog, Maerry and Goldstein, 1998; McDaniel, 1997; Stacey, 1993). Results from the four groups of health provider employees interviewed in this study were remarkably similar in scope. All groups conceived of health services as a “public good” although in the pure economic sense it is not. All groups used “satisfaction” to describe a good outcome. For nurses and medical staff this was their own satisfaction in their work as well as the patient satisfaction. For managers this was satisfaction with the processes used in the delivery of health services and for non District Health Board staff it was satisfaction with the congruence between what the patient was told was going to happen and what did happen (which may have had no relationship to actual clinical efficacy at all). Shared frameworks of meaning represent those ways we all have of perceiving and interacting in our worlds, and which allow society to function. The overall shared meaning of health service provision and its monitoring from the respondents was the need to assess outcomes as far as it is possible, but outcomes in the sense of staff and patient satisfaction.

In public health services performance expectations from the stakeholders are high and the ability to assess outcomes in an unambiguous way is low, but there is assumed to be high goal congruence in that the end result all staff are working towards is better health for the patients. As in health services, when tasks become highly unique, completely integrated or ambiguous for other reasons, it becomes impossible to evaluate the value added by any individual. Whilst current performance management controls are appropriate to control for budget and output performance (or efficiency measures), what about assessing the effectiveness of our organisations in producing desired outcomes? In addition to controlling for efficiency, can we also adopt an additional paradigm of “effectiveness” assessment to monitor public services, in particular complex multifaceted services such as health? Although much work is being done by policy departments on how to assess outcomes and increase organisational developments very little work is conducted on what the staff who ultimately deliver the policy decisions believe should be assessed.

Results from four different types of professional staff in this study clearly show a lack of satisfaction with current approaches. The shared frameworks of meaning have suggested a “public good” approach to the provision of health, and this is extremely ingrained in this culture. Comparative analyses of other countries show that this belief is not as firmly held and many countries see health as like other commodities. The American view of health for example is widely denigrated in our society. However it is a view that is very similar to other Western liberal Anglo-Saxon societies, such as the United Kingdom, and is held by shared framework of **pride** in the health profession – both in the way we think of health professionals and the way they themselves think of their vocation. The main message from the respondents was to select human resource measures as the dominant mode of control, and move from attempts to attribute performance to an individual

organisation (or organisations) where assessment of outcomes, even if possible, may be meaningless. Outcomes as the pure concept of long term improvement in condition that was the focus of a health process were not viewed as useful, because they are so difficult to reliably assess and validly attribute, whereas other dimensions of more immediate or intermediate assessment such as satisfaction or staff morale, were seen as useful.

As Wilson (1989) hypothesized, and this study and frameworks generated from it clearly show, coping organisations or cultures must use alternative methods of control than purely outputs/results based ones. Health agencies, which are managing significant long-lived infrastructure requires a long term outcome focus, but measuring outcomes in health will mean measuring intermediate indicators towards a long term result. Long term outcome assessment is too difficult to collect routinely so public agencies need to emphasize immediate and intermediate outcomes, or even internal staff processes, given the difficulty in attribution of ultimate outcomes to provider activity. Results support Cunningham and Harris' (2001) contingency model for selection of the most appropriate forms of control within an organisation, substantiating their thesis that health providers should place high reliance on budgeted input control and personnel control, and low reliance on results and action control. Given that outcomes are seen as complex and made up of many levels or dimensions (and therefore providers and agencies), what does an outcome actually look like and is it possible that staff measures are in fact a more robust and reliable method of assessment of an organisation's outcomes. Two differing approaches to control have been compared by Freeman (2002 – Table 3) and show the paradigm differences that exist.

Health providers' workforce are their most valuable asset. The competencies that are key for the health sector are staff based. In terms of Barney's (1995)¹ VRIO criteria these human resources are extremely valuable, they are rare, as the developing crisis of no medical staff in the rural areas is showing, and they are difficult if not impossible to imitate (due to statutory regulations). If an organization wishes to sustain capability over the long term and sustain this when the external environment changes, the organization must be resource dependent (Campbell-Hunt, 1995). Links between high performing hospitals and staff satisfaction have been documented (Jenkins and Wong, 2001; Sherer, 1997; Valentine 2001; Cumbey and Alexander, 1998; Coile, 2001; Laschinger, Shamian and Thomson, 2001). A hospital that values evidence based practice usually delivers good clinical results and employs satisfied staff (Valentine, 2001). ... *The role of human capital as a potential source of sustainable competitive advantage has recently been the focus of considerable interest in the academic and popular press. The current "terms of art" such as intellectual capital, knowledge work and workers, and high performance work systems (HPWS) all reflect a new interest in people as a source of competitive advantage, rather than a cost to be minimised. By extension, intellectual assets and the organisational systems that attract, develop, and retain them are emerging as significant elements in strategic decision making.* (Becker and Huselid, 1998).

¹ **V**alue in the market; **R**are in comparison with competitors; **I**nimitable by duplication or substitution and **O**rganizational in that the firm organized to foster and sustain the development of these resources with long term commitment and vision with benefits appropriable to the organization.

Havens (2001) and Laschinger, Shamian and Thomson (2001) have revisited the “rediscovered” studies on “magnet” hospitals conducted in the 1980s on the hospitals that had no problems attracting and retaining nursing staff. The so-called “magnet” hospitals had high rates of nurse satisfaction, low job turnover and low nurse vacancy rates even when hospitals in close proximity were experiencing nursing shortages. The nurses believed this resulted in better outcomes and higher quality of care for patients. Magnet hospitals’ nurses reported more overall support for their practice, increased levels of autonomy, control over practice and nurse-physician collaboration. Productive motivated staff are more likely to be found in hospitals with excellent clinical practice and these “empowered”² staff in turn influence the quality of clinical care. The theory therefore is that trust and empowerment will lead to increased nurse satisfaction and affective commitment ultimately ensuring high quality patient care (Irvine, Leatt, Evans and Baker, 1999; Laschinger, Finegan and Shamian, 2001; Sherer, 1997). Thus better clinical outcomes can be achieved through a focus on the quality of the workforce (HealthWAC, 2002) with the “positive performance spiral”. Good organisational practice leads to performance results and this in turn leads to individual behaviours which will lead to good organisational practice – such as satisfaction, high morale, low levels of absenteeism, lateness and stress related illness, high levels of motivation, loyalty, enthusiasm and constructive working relationships between staff.

And if, as the reported research shows, staffing shortages lead to quality problems and medical errors, it therefore appears obvious that increasing staff satisfaction and retention would lead directly (numbers to provide service) and indirectly (attitude and commitment) to improved outcomes (Coile, 2001; Gower, Finlayson and Turnball, 2003). A recently published study has also found that hospital nurse staffing levels affect patient outcomes and nurse retention. The survey conducted by Aiken, Clarke, Sloane, Sochalski and Silber (2002) found that in hospitals with high patient-to-nurse ratios, surgical patients experienced higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses were more likely to experience burnout and job dissatisfaction. The research included a survey of 10, 184 nurses and revealed that for every extra patient per nurse there was a 23% increase in the chances of burnout and a 15% rise in job dissatisfaction. These concepts were also promoted by respondents in this study as important to improving monitoring and quality.

In this study the overwhelming majority of respondents identified that monitoring of outcomes must be carried out within a paradigm of “public good” not “private commodity”. And the assessment of public good, as it is very difficult to define as it exists on so many levels, should be assessed from staff variables – i.e. personnel control. There is now ample literature emerging on the links between staff satisfaction and quality outputs to validate these findings. But can performance management be achieved when based on a framework which favours learning within a humanistic, vocation-based public good and satisfaction paradigm, while still meeting the demands of legislation and

² “Empowerment” as a concept can be described as intrinsic motivation with meaning (fit between the requirements of a work role and a person’s beliefs, values and behaviours) competence (belief in one’s capability to perform work activities), self determination and impact (degree to which a person can influence strategic decisions).

Governmental expectations. In this study staff of provider organisations were surveyed, and so it is perhaps not surprising that the dominant ideal mode of control or improvement should be towards assessment of staff issues. However as Lipsky (1980) noted the street level bureaucrat “interacts directly with citizens in the course of their jobs and (who) have substantial discretion in the execution of their work”...and these people have significant power not normally recognised. At the end of the day it is in fact staff who deliver health services, who have the power to subvert any strategic objective by the way that the goals are implemented (or not as the case may be). Freeman (2002) has described the difference between “accountability” and “improvement” paradigms of performance management. The results from this study would suggest that in New Zealand the middle ground between these approaches has yet to be reached.

Table 3. Differences between accountability and improvement approaches to indicator systems (from Freeman, 2002).

	Assurance/Accountability	Improvement
Emphasis	Verification and assurance. Measurement oriented	Learning to promote continual improvement. Change oriented
Rationale	Provide external accountability and renew legitimacy	Promote change and improvement in care quality
Culture	Comparisons in order to make summative judgements on care quality. League tables, blame and shame	Comparisons to have a formative emphasis to learn from differences between providers and encourage improvement. Informal benchmarking to promote discussion and change
Precision Required	High precision. Use of statistics to identify “real” differences	Lower precision
Epistemology	Empirical. Statistical validity and reliability important	Interpretative. Use of other data sources and local information to provide context

The concepts that emerge as a result of the findings in this case study are not new. However what does not seem to have been adequately recognised is the relationship between work satisfaction and quality outcomes. Furthermore, as learning and development is a key people management function undertaken by all public agencies we need to be much smarter about the investment that is made in this resource. We need to focus on assessing dimensions such as how many hours of training per year are typically received by employees, what proportion of training efforts are devoted to skill enhancement, and what proportion of the workforce is regularly administered attitude surveys (Becker and Huselid, 1998). A recent study in the Australian public sector (Wyse, Huey and Lewis, 2002) concluded that the total cost of learning and development in the public sector was unknown yet it is the most important thing to assist organisations to effectively achieve their goals. The overall conclusions were that learning and development needs to be firmly and clearly aligned with corporate goals and supported by meaningful performance indicators for management and reporting purposes. Organisations need to be able to measure the investment in learning and development, and demonstrate the effectiveness of that investment in “outcomes” of the organisation.

The research aimed to address whether the appropriate controls are in place to manage the performance of the public health sector providers in New Zealand. We should place more emphasis on staff measures within a framework of performance improvement, focusing on the views of the staff who work within the services. To be meaningful this must be done within a policy and legislative framework that enables this approach. The 21st century is a time of increasing complexity, uncertainty and discontinuity which will demand new forms of governance and management ...technocratic solutions to policy problems, rationality and linearity in policy design are now seen as inappropriate (Ryan, 2002). Public management in the 21st century must be highly contingent in nature, underwritten by a framework of constant evaluation and “action science”. This “emergent” character is the hallmark of the learning paradigm and undermines formalised notions of “performance” in Westminster derived systems where ex-ante specifications of goals and objectives is the political promise given to voters and against which they are judged at the next election. The stakes are therefore very high, and the incentives for a learning paradigm weak. Keeping a balance between financial escalations in health and cost and fiscal probity; and public drives for accountability with staff commitment to a “leaning no blame culture” are key and immense challenges.

We cannot remove ourselves from the requirements to be able to prove that public servants are acting with probity, ethics and due diligence. We live in a contradictory world, which both 21st century public management and parliamentary practice must reflect. Can learning and accountability be held in balance against the forces of adversarial politics amplified by unbalanced media content? To possibly go some way to developing such a balance I make the following four recommendations with respect to performance improvement assessment in New Zealand public health providers:

1. Encourage research to establish a clearer understanding of the relationship between staff variables and health outcomes.
2. Create the balance by strong emphasis on two, balanced, types of control - strong financial *input* controls, with strong reliance on personnel *output* control.
3. Encourage permanence. Given the complexities of measuring performance of health provider organisations it seems that one of the imperatives is to develop a multi party accord to mitigate against the effects of repeated sector restructuring which has a hugely detrimental effect on capacity.
4. Accountability Frameworks and Legislation. The effect of compliance and regulation on staff is currently devastating to morale. As Ryan (2002) suggests, contingent 21st century public management may benefit more from “rough and ready” internal evaluation that is managerially useful, than highly specified, external evaluation which is resource and capability challenging. Health care being at the edge of chaos requires multiple approaches and an evolutionary direction.

References

- Aiken L.H., Clarke S.P., Sloane D.M., Sochalski J. and Silber J.H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*, 23, 1987-93.
- Allison G.T. (1982) Public and Private Management: Are they alike in all unimportant respects? In Lane F.S. (ed) Current issues in Public Administration. New York: St Martins Press.
- Barney J. (1995) Looking inside for competitive advantage. *Academy of Management Executive*, 9, 49-61
- Becker B.E. and Huselid M.A. (1998) High Performance Work Systems and Firm Performance: A synthesis of research and managerial implications. *Research in Personnel and Human Resources Management*, 16, 53-101.
- Behn R.D. (1995) The Big Questions of Public Management. *Public Administration Review*, 55,313-323.
- Berry A.J., Broadbent J. and Otley D. (1995) Accounting Systems and Control. In A.J. Berry J. Broadbent and D. Otley (eds) Management Control: Theories, Issues and Practices. London: MacMillan
- Brownell P. (1987) The role of accounting information, environment and management control in multinational organisations. *Accounting and Finance*, 27, 1-16
- Calloway L.J. and Knapp C.A. (1995) Using Grounded Theory to Interpret Interviews. <http://csis.pace.edu/~knapp/AIS95.htm>
- Campbell-Hunt C. (1995) Perspectives on sustainability. *New Zealand Strategic Management, Winter*, 16-27
- Coile R.C. (2001) Magnet hospitals use culture, not wages, to solve nursing shortage. *Journal of HealthCare Management*, 46, 224-227.
- Controller and Auditor-General (2002) Reporting Public Sector Performance.
- Cumbey D.A. and Alexander J.W. (1998) The relationship of job satisfaction with organisational variables in public health nursing. *JONA*, 28, 39-46.
- Cunningham G.M. and Harris J.E. (2001). A heuristic framework for accountability of governmental subunits. *Public Management Review*, 3, 145-165.

Dalton G.W. and Lawrence P.R. (1971) Motivation and Control in Organisations. Homewood, Ill: Irwin.

Dick B. (2000) Grounded Theory: A Thumbnail Sketch. <http://www.scu.edu.au/schools/gcm/ar/arp/grounded.html>

Etzioni A. (1961) A Comparative Analysis of Complex Organisations. New York: Free Press

Freeman T. (2002) Using performance indicators to improve health care quality in the public sector. *Health Services Management Research*, 15, 126-137.

Gauld R. (2003) Continuity amid Chaos. University of Otago Press: Dunedin

Glaser B.G. and Strauss A.L. (1967) The Discovery of Grounded Theory. Chicago: Aldine.

Gower S., Finlayson M. and Turnbull J. (2003). Hospital restructuring: The impact on nursing. In Continuity amid Chaos. University of Otago Press: Dunedin

Gregory R. (1995) The peculiar tasks of public management: toward conceptual discrimination. *Australian Journal of Public Administration*, 52, 27-33.

Gregory R.J. (1999) Social Capital Theory and administrative reform: maintaining ethical probity in public services. *Public Administration Review*, 59, 63-75.

Haig B.D. (1995) Grounded Theory as Scientific Method. http://www.ed.uiuc.edu/EPS/PES-yearbook/95_docs/haig.html

Handler A., Issel M. and Turnock B. (2001) A conceptual framework to measure performance of the public health system. *American Journal of Public Health*, 91, 1235-1239.

Havens D.S. (2001) Comparing nursing infrastructure and outcomes: ANCC magnet and nonmagnet CNEs report. *Nursing Economics*, 19, 258-267.

Health Workforce Advisory Committee (2002) The New Zealand Health Workforce: Framing Future Directions Discussion Document. Health Advisory Workforce Committee: Wellington.

Hofstede G. (1981) Management Control of Public and Not-for-Profit Activities. *Accounting, Organisations and Society*, 6, 193-211.

Irvine D., Leatt P., Evans M.G. and Baker R.G. (1999) Measurement of Staff Empowerment within Health Service Organisations. *Journal of Nursing Measurement*, 7, 79-95.

Jenkins K. and Wong D (2001) A survey of professional satisfaction among Canadian anaesthesiologists. *Canadian Journal of Anaesthesia*, 48, 637-45

Kinach B.M. (1995) Grounded Theory as Scientific Method: Haig-Inspired Reflections on Educational Research Methodology. http://www.ed.uiuc.edu/EPS/PES-yearbook/95_docs/kinach.html

Laschinger H.K., Finegan J. and Shamian J. (2001) The impact of workplace empowerment, organisational trust on staff nurses' work satisfaction and organisational commitment. *HealthCare Management Review*, 26, 7-23.

Laschinger H.K., Shamian J. and Thomson D. (2001) Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care and work satisfaction. *Nursing Economics*, 19, 209-219.

Lindberg C., Herzog A., Merry M. and Goldstein J. (1998). Life at the Edge of Chaos. *The Physician Executive*, Jan-Feb, 6-20.

Lipsky M. (1980) Street Level Bureaucracy: Dilemmas of the individual in public services. Russel Sage Foundation.

McCracken M. J., McIlwain T.F., and Fottler M.D. (2001) Measuring organisational performance in the hospital industry: An exploratory comparison of objective and subjective methods. *Health Services Management Research*, 14, 211-221.

McDaniel R.R. (1997) Strategic Leadership: A View from Quantum and Chaos Theories. *Health Care Management Review*, 22, 21-37.

Merchant K.A. (1985) Control in Business Organisations. Cambridge, MA: Ballinger

Moxley D.P. and Manela R.W. (2001) Expanding the conceptual basis of outcomes and their use in the human services. *Families in Society*, 82, 569-577.

OECD (1999) Performance Contracting: Lessons from performance contracting case studies. Paris: OECD.

Otley D. (1983) Concepts of control: The Contribution of Cybernetics and Systems to Management Control, in T. Lowe and J.L.J. Machin (eds) New Perspective in Management Control. New York: St. Martin's Press.

Plsek P.E. and Greenhalgh (2001) The Challenge of complexity in health care. *BMJ*, 323, 625-628.

Quinn J.B., Anderson P. and Finkelstein S. (1996) Managing professional intellect : making the most of the best. *Harvard Business Review*, 74, 7

Ryan B. (2002) Death by Evaluation? Reflections on Monitoring and Evaluation in Australia and New Zealand. Personal Communication.

Sage D.J., Degeling P., Coyle B., Perkins R.J., Henderson S. and Kennedy J. (2001). Hospital reform strategies: Professional subculture attitudes and beliefs of clinicians and managers in two New Zealand hospital groups. *Health Manager*, 8, 9-13.

Sherer J.L (1997) The human side of change. *HealthCare Executive*, 12, 8-14.

Smith P. (1995) Performance Indicators and Control in the Public Sector. In Berry A.J. Broadbent J. and D. Otley (eds) Management Control: Theories, Issues and Practices. London: MacMillan.

Southon G. and Braithwaite J. (1998) The End of Professionalism? *Social Science and Medicine*, 46, 23-28.

Stacey R. (1993). Strategy as Order Emerging From Chaos. *Long Range Planning*, 26, 10-17.

Valentine N.M. (2001) Quality measures essential to the transformation of the veterans' health administration: implication for nurse as co-creators of change. *Nursing Administration Quarterly*, 15, 48-59.

Ward T. and Haig B. (1997) Abductive Reasoning and Clinical Assessment. *Australian Psychologist*, 32, 93-100.

Willmer M.A. P. (1983) The Contribution of the Cybernetic Approach to Management Control In T. Lowe and J.L.J. Machin (eds) New Perspective in Management Control. New York: St. Martin's Press.

Wilson J.Q. (1989) Bureaucracy: What governments do and why they do it. New York: Basic Books.

Wyse A., Huey A. and Lewis M. (2002) Management of Learning and Development in the Australian Public Service. Commonwealth of Australia Audit Report, <http://www.anao.gov.au/Website.nsf/Publications>.