A HEALTH(Y) IMAGE IN THE POST-MANAGERIALIST AGE

Carolyn Cordery

And

Rachel Bakerville

ABSTRACT

Concomitant with the intensification of private provision of public services, government purchasers are managing third party service providers' performance through accountability demands. As the excesses of New Public Management (NPM) are superseded by a post-NPM ethos, these purchasers are encouraged to soften those demands and 'partner' with providers. However, we argue that post-NPM reforms ignore the role of organisational identity in structuring accountability processes.

Organisational identity can be described through image-laden metaphors. This paper explores how negative and positive organisational metaphors affected government purchasers' demands for accountability from primary health care providers. Notwithstanding standard contractual arrangements, it found that purchasers' demands for accountability vary according to the providers' organisational images. Further, these government purchasers used sense-breaking and negative images to force change in providers' identity.

1.0 Introduction

The rise of managerialism and the purchaser-provider contractual paradigm in government-funded service provision has been thoroughly documented, and its shortcomings aired (for example Broadbent, et al., 1996; Jones & Mellett, 2007; Pallot, 2003). Governments are increasingly dependent on contracts with third-party providers and Jones and Mellett (2007) note that this dependence increases risk awareness. The risk of misalignment between providers' goals and those of the government funder is heightened by relational differences, especially those caused by cultural diversity (Bracci, 2009). To assuage this risk, government purchasers intensify their accountability demands and seek to control providers to ensure that providers' outputs meet expectations (Broadbent, Dietrich, & Laughlin, 1996). These expectations, that competitive contracting will result in cost-savings and quality improvement, have ensured the longevity of managerialism and the contractual paradigm.

In health care, while studies have shown that more cost-effective delivery can occur as a result of competitive contracting (Smith, Preker, Light, & Richard, 2005), there is little support for the proposition that the standard of care improves due to competition. For example, Smith et al.'s (2005) study of mental health care in the USA found that competitive contracting resulted in providers engaging in a 'race to the bottom', thus reducing the quality of health care provided. Further, Anderson and Blegvad's (2006) study of Danish dental care found that competition alone did not result in substantial increases in health sector efficiency or effectiveness, and that monitoring of providers was necessary. These shortcomings of managerialist reforms have led to the reinvention of public governance and emphasis on democratic notions (Pallot, 2003).

The reinvention of governance is especially relevant in health care where the lack of providers reduces the availability of competition; and governments, despite being increasingly responsible for their citizens' health care, fail to meet citizen's expectations (WHO, 2000). This reform to emphasise democracy in government-funded services has also been described as a 'post-NPM environment' (Bhatta, 2003). In this environment, the inference is made that purchaser-provider relationships should be in the form of networks and partnerships. This softening of NPM's face[1] means contractual demands for accountability should also soften to recognise these inter-dependent relationships. While 'Post-NPM' accountability may signal relief, in managerialist accountability demands, this paper suggests that any relief is dependent on the 'appropriateness' of the provider's image.

This paper extends to organisations, the theorisation that an individual's identity forms and re-forms due to accountability demands (for example, Goffman, 1959; Roberts, 1991). While identity can be theorised in different ways (as explained in section 2), we use the organisational concept of image and metaphor. More specifically, the objective of this paper is to evaluate how government purchasers' accountability demands on providers following post-NPM healthcare reforms reflect and re-form organisational image. Image is analysed through the positive and negative metaphors that describe these provider organisations.

The justification for this paper is also derived from studies of "trust, threats and social embeddedness" where the cooperation between entities depends on the good or bad

reputation derived from previous relations and networks within the relevant sector (Blumberg, 2001). The links between organisational accountability and image are developed through the lens of case study based research in primary health care organisations in New Zealand. In that country, relatively new organisations deliver primary health care to citizens under a standard contract with their regionally-based State funder. In analysing how image and accountability interplay, the research found that, notwithstanding standard contractual arrangements, purchasers' demands for accountability vary according to the providers' organisational images. Further, these government purchasers used sense-breaking and negative images to change providers' identities, albeit slowly.

2.0 Organisational identity and image

2.1 Accountability

As expounded by Roberts (1991, 2009) the mirror of accountability reflects an image of an individual's performance. Further, as an account is provided, Goffman (1959) notes that individual identity is defined. Therefore, the process of accountability is described by Roberts (1991, p.358) as follows: "To be held accountable hence sharpens and clarifies our sense of self, and provides focus within the stream of experiencing". This self-absorbing evaluation is extended to organisations by Schweiker (1993) and forms the basis of this paper's analysis.

It is acknowledged that projected images can only ever be partial, limited by language and, suggests Roberts (1991), misrecognition or a misunderstanding that the reflected image actually portrays the whole. This also applies to the reflection of performance. When contracts define acceptable performance, these contractual expectations establish fields of visibility to direct the providers' behaviour and the way they report that behaviour. For example: accounting reports, such as *ex ante* budgets and *ex post* reports, internal controls over processes, render certain activities visible. Schweiker (1993) suggests that reporting on relationships is also part of an organisation's accountability discharge.

The effective discharge of accountability entails the giving of an account and a reaction to that account by those demanding the account (Stewart, 1984). These reactions will include praise and sanction, depending on the report. In order to receive praise, a provider may conceal inaction or inappropriate behaviour by exploiting the partiality of fields of visibility. For example, a provider may be able to perform outside the terms and conditions attaching to the responsibility accepted (as specified in the contract) without sanction (Strathern, 2000).

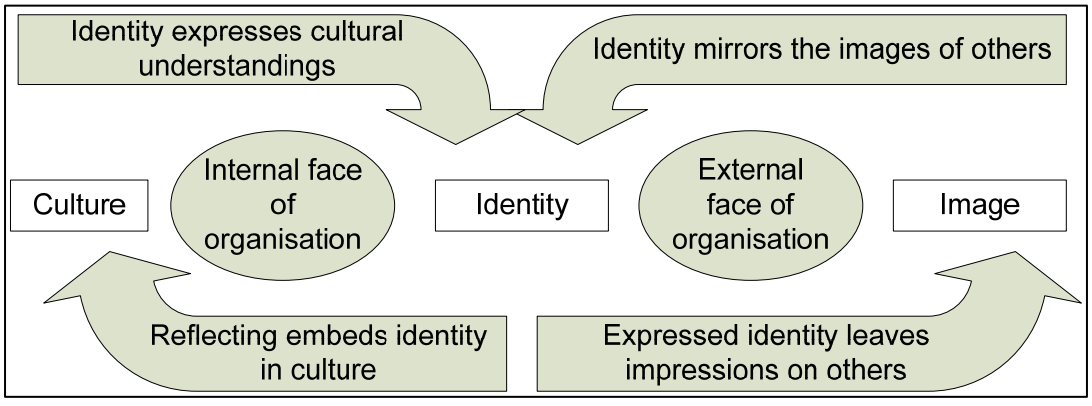
NPM contracting builds on the assumption that organisational accountability reporting can be neutral and yet it can be seen that self-absorbed organisations could drive themselves to garner acceptance or reward by meeting specific performance in the relevant fields of visibility. Kärreman and Alvesson (2004) describe the acts of managing ones identification as a process of sensemaking as well as sensebreaking. The actions of sensemaking and sensebreaking were very useful for the analysis of the data from this study.

2.2 Identity and image

Roberts' (1991, 1996) focuses on individuals' identities when accountability is demanded, but anthropomorphic concepts of identity and accountability can also be applied to organisations. For example, Hatch and Schulz (2002) use an anthropomorphic term to describe identity: that of an organisational face. They suggest that, while an individual possesses a self-image (derived from personal characteristics and experiences), an organisation's internal face is constructed from its culture ('core' values and beliefs held by its members, including its staff) (Empson, 2004; Gioia, Schultz, & Corley, 2000; Hatch & Schultz, 2002). The internal cultural rituals, symbols and stories serve to encode and reconstruct organisational identity through a sensemaking process (Weick, 1995). This identity is projected as an external image that makes statements about the organisation, including its accountability. This reflective process is shown on the left-hand side of Figure 1, where an organisation's culture expresses its identity and in turn embeds that identity. Prior researchers have examined how the internal face of an organisation shapes staff performance and thus accountability of those staff members (for example, Alvesson & Wilmott, 2002; Munro, 2001; Roberts, McNulty, & Stiles, 2005). However, there is little accounting literature that explores an organisation's external face and its accountability; the effect of that face on others, and how those external stakeholders seek to re-form the organisation's identity.

The term 'organisational image' has been used in various ways. For example, in a study of organisational adaptation, Dutton and Dukerich (1991, p.520) state: "organisational members use an organisation's image, which is the way they believe others see the organisation, to gauge how outsiders are judging them". However, Gioia and Thomas (1996) extend the term 'image' beyond organisational actions to include the impressions on others of organisational logos and slogans (brands) which are developed internally. These logos and slogans can become fields of visibility against which an organisation can be held accountable. As such, they augment the selected images portrayed to external stakeholders from internally-developed means of communication such as community meetings, annual reports, and media releases. This reflective process is shown on the right-hand side of Figure 1. The expressions of organisational identity leave sensemaking impressions on external stakeholders. In total, Figure 1 also portrays the manner in which an organisation's identity can be understood from either its internal or external face. The inference in this paper is that the external stakeholders will hold the organisation accountable for that image.

Figure 1: Components of organisational identity



Source: adapted from Hatch and Schulz (2002)

2.3 Image and metaphor

Organisational image is most frequently discussed in the marketing discipline; however recent organisation research has considered the effects of image in health care organisations. For example, Haddow et al. (2007) found that understanding and acknowledging the identity of relational parties was instrumental in the success of a new service. Tensions arose when an NHS 24-hour facility failed to recognise the unique identity of an existing GP cooperative, giving rise to tense relationships between the NHS purchaser and their GP providers. Alternatively, Thompson (2001) and Finan (2002) focused on the design of health organisation's brand images. Crowther (1995) and, more recently, Hudson (2009) noted that different organisations within the NHS market their own brand image in bids for service survival. The NHS itself mobilises image to cement its identity as a 'modern' and 'dependable' provider (McDonald, Waring, & Harrison, 2006).

Terms such as 'modern' and 'dependable' are metaphors[ii] designed to persuade citizens to perceive the NHS as a trustworthy health service provider. Young (2001) suggests that such persuasive metaphors pervade our thought systems, and Walters and Young (2008) contend that metaphors which frame viewpoints perform significant roles within political as well as business discourses. Metaphors represent one thing by referring it to another so that we can experience that thing in terms of the other (Walters & Young, 2008).[iii] Metaphors can also reveal the motivation and underlying values of those who use them, as such they are value-laden, representing choices among competing values (Young, 2001). Similarly to the images they convey, metaphors create fields of visibility.

As seen in Figure 1, Hatch and Schulz (2002) suggest that organisational images held by external stakeholders interact dynamically with the organisation's identity and culture, mirroring and reflecting 'who' the organisation is. By feeding back, and reacting to, that image, external stakeholders can also change organisational behaviour (Dutton & Dukerich, 1991; Dutton, Dukerich, & Harquail, 1994). This may be illustrated by Dutton and Dukerich's (1991) case study of the Port Authority of New York and New Jersey, an organisation that adapted to address its negative image. In the case, the Port Authority's response to homeless people loitering in its bus terminal was initially denial (providing an image of a poor corporate citizen). However, to respond to this poor image, the Port Authority took a lead role in advocating for the homeless, establishing a drop-in centre, and together with other agencies, assisted the homeless in other ways. Dutton and Dukerich (1991) concluded that these actions were 'identity-consistent' as they underpinned the Port Authority's preferred image as a professional and effective organisation. 'Professional' and 'effective' are metaphors by which the Port Authority sought to portray its identity as a transport facilitator.

It is contended that organisational identity is moulded, at least in part, by an organisation's interaction with its myriad stakeholders. Blumberg (2001, p.829) reminds us that "(1) firms are not anonymous actors and (2) they do not operate in isolation from other actors without a history and expectations about the future. Firms are recognisable and have good or bad reputations". Blumberg's (2001) invocation of 'reputation' aligns to the notion of image and identity. Specific stakeholders may be more cognisant of an

organisation's identity than others. In the NPM environment, where the purchaser contracting for goods and services is a significant funder, it becomes a dominant external stakeholder of the provider. As a consequence it seems likely that, through the demands for performance and the fields of visibility selected for accountability, a government purchaser may effect changes in the identity of their contracting providers.

The objective of the research is to evaluate how a government purchaser's accountability demands on providers following post-NPM healthcare reforms reflect and re-form organisational image. While the Hatch and Schulz (2002) schema explains the interplay of organisational identity and image in generating fields of visibility within an organisation, the research reported here extends their theorisation to embrace purchasers' responses to their providers' organisational identities. The research objective was achieved through analysis of four case studies as described below.

3.0 The case study research

3.1 Context of the research

In New Zealand, prior to NPM arrangements in the primary health care arena, the Government subsidised primary health care by part-funding citizens' visits to General Practitioners (GPs). Under a 'fee-for-service' system, GPs were paid a fixed subsidy for each patient visit, with the patient paying the balance of the relevant GP's fee. This funding structure remained largely unchanged from 1941 until the widespread adoption of capitation-based funding (explained further below) in 2002 as a result of the *Primary Health Care Strategy* (Minister of Health, 2001). Despite this relative stability in funding arrangements in the primary health care arena, rapid change had affected the wider health sector as the State introduced market-based practices, including contracting, to improve the performance of the health care sector (McAvoy & Coster, 2005).

Following a series of reforms in the hospital sector from 1983, a competitive market in publicly-funded hospital services was introduced in 1990. Four Regional Health Authorities were established as purchasers of hospital care services and, in addition to their secondary health care role, they purchased primary health care services from local providers (including GPs) through a central funder, Health Benefits Ltd. Concurrently, the subsidy paid to GPs for patients' visit was reduced, with a corresponding increase in the patient's contribution (Jacobs, 1998). As a response to the changes in purchasing and funding primary health care services, many GPs formed and/or joined organisational groupings and, by 1999, 67 percent of GPs were members of Independent Practitioner Associations (IPAs). Some of these IPAs were intermediaries between Health Benefits Ltd and the GPs, managing in particular the processing of GP funding claims. A number of IPAs also became politically active, representing GPs' views to their Regional Health Authorities.

In 1996 when a National (conservative)-led coalition government was formed, the four Regional Health Authorities were amalgamated into a single Health Funding Authority and the former emphasis on competition in health care delivery was removed. A further change of Government in 1999 (to a Labour-led coalition) reversed the policy of health care centralisation and, in 2000, 21 District Health Boards (DHBs), with local representation, were established to undertake local purchasing of health services (Ashton,

2005; McAvoy & Coster, 2005). This most recent re-organisation which was enunciated in the *Primary Health Care Strategy* (Minister of Health, 2001) and became effective in May 2002, provided a foundation for new structures and funding programmes for primary health care to be established.

A key outcome of this *Strategy* has been increased public funding for primary health care, channelled through new organisations called Primary Health Organisations (PHOs). These are built on the IPA concept in that PHOs act as intermediaries between the DHB primary health care services purchasers on the one hand, and GPs and other primary health care providers on the other. However, their remit is broader than that of the forerunner IPAs as the *Strategy* requires PHOs, *inter alia*, to design and fund the delivery of primary health programmes which will improve their communities' health (Minister of Health, 2001). PHOs are also required to involve local communities in their governance structure and decision-making. This draws on the post-NPM ethos focused on democracy in government-funded service (Pallot, 2003) and thus, on community needs.

Today (in 2010), 80 locally-based PHOs contract with their local DHB to provide primary health care services and they each also contract with appropriate health care providers (GPs, Nurses, and other Health Clinic professionals). Further, DHB contract payments are no longer tied to patient-GP visits on the former 'fee-for-service' basis; instead they are based on a population-based formula called 'capitation' (Minister of Health, 2001). Under this system, DHBs, funded from the 'consolidated fund' (derived from taxes levied on all taxpayers), pay a fixed amount on an annualised basis, based on the number of patients enrolled with the GPs who contract with the relevant PHO, for the PHO to supply primary health care services to its enrolled population. In general, this does not match the relevant health professional's fee per visit, therefore, patients are required to make co-payments when they visit their primary health care provider. The patient perceives only a small change as a result of this funding arrangement as they may continue to visit their same health professional for primary care (albeit at a reduced rate). However, the move from fee-for-service system to capitation makes visible to the purchaser the number of patients enrolled by a PHO's contracted GPs, rather than the number of visits patients make to health services providers, as was previously the case. Further, a performance management programme has been progressively introduced rewarding PHOs for their achievement against key public health goals such as vaccinations, mammograms and cervical cancer checks.

Many of the IPAs developed in the 1990s have sponsored, and many have shareholdings in, PHOs. However, the relationship between IPAs and PHOs are varied. For example, some PHOs are owned by IPAs with the IPA being the sole shareholder, others are owned jointly by an IPA and one or more community trusts, and other PHOs are managed by community-owned trusts without any (former) IPA involvement.

As a consequence of the reforms outlined above, PHOs are expected to encourage power-sharing opportunities with their health professionals and their communities (Minister of Health, 2001). This multi-professional, community-inclusive approach is similar to that adopted in the UK for the delivery of primary health care (Hill, Fraser, & Cotton, 2001) except that, in New Zealand, the government requires all PHOs to be private, not-for-profit organisations rather than public sector organisations as they are in the UK. All

PHOs contract with their DHBs under a standard contract (Ministry of Health, n.d.), which includes the requirement for PHOs to be 'fully and openly accountable'.

3.2 Methodology

As a means of exploring the interplay between organisational image and accountability, four PHOs were approached to constitute case studies. The case study PHOs were selected so as to be geographically spread, cater to populations from different socio-economic conditions, and to represent PHOs with different ownership characteristics (i.e. IPA and community ownership). The four PHOs are shown in Figure 2 based on their ownership structure.

Figure 2: Ownership of case study PHOs

	Predominant IPA ownership	**Minimal IPA ownership**	**No IPA ownership**
Predominant Community ownership		PHO 1 Large, mainly urban	PHO 3 Small and urban
Minimal Community ownership		PHO 4 (2008) Small and rural	
No Community ownership	PHO 4 (2006) PHO 2 Large, mainly urban		

From Figure 2, it may be seen that PHO 2 and PHO 4 were solely owned by IPAs. However, during the research period (2006-2008) the ownership of PHO 4 was partially devolved to community trusts. PHO 1 and PHO 3 were both primarily owned by community although PHO 1 had a strong, but minority, IPA representation at Board level. Analysing the case study PHOs based on their ownership structures facilitates examination of different foci of the PHOs. These structures impact their contracting relationships and their image.

Each case study included analysing of relevant documents of the PHO (for example, its annual reports and performance reports), observation of its community meetings and Annual General Meetings (AGMs) and, between the four PHOs, a total of 37 semi-structured interviews with PHO staff, PHO Board members, DHB staff, and other stakeholders external to the PHO (including media, community representatives, representatives of the relevant Local Authority and interviews from non-governmental health providers). PHOs are an umbrella-type organisation between General Practices and

other health providers on the one hand and DHB funders on the other. As their introduction has brought little perceptible change to the patient-health provider relationship, they remain relatively unknown in the wider population. As a consequence, in each case study PHO, the interviewees selected were informed external stakeholders mainly from health related areas.

The research methodology chosen was an interpretive ethnography to portray events from the view of the actors as much as possible (Erickson, 1984; Patton, 2002). In the case studies, data collection, assessment and analysis formed an iterative process, with ongoing reflection and development (Ahrens & Chapman, 2006). Data reduction involved an open coding of raw data such as recordings of interviews, field notes on site visits and diary notes, recording initial summary themes emphasising contextual information, then reflecting on the data and searching for patterns of meaning (O'Dwyer, 2004). Following this, core codes were developed that included those emanating from the literature and the data. As an iterative project, this research involved previously unrelated codes being merged or related to similar concepts where they overlapped. Also, other codes were extended to deal with the same concepts that may have initially been expressed in different terms. Data interpretation was the third phase of data analysis to extrapolate possible findings to other situations (O'Dwyer, 2004). Through continued data immersion and reviewing the data reductions and data displays, a 'thick' description of the findings is formulated. Events and narratives from the field link to theoretical conversations (Ahrens & Dent, 1998) so that finally, by applying the chosen theoretical lens to interpret the data, a narrative is constructed (O'Dwyer, 2004). As an ethnographic study, the findings are contextually bound.

4.0 Case Study Findings

4.1 Expressing an identity as an image

Among other things, the interviewees were asked how important it was for their PHO to possess and project an identity. Although a majority of interviewees from PHO 4 believed it was important for the PHO to have an external image, the image projected was not strong. This relatively new PHO was more interested in establishing itself as a credible provider; indeed, a senior member of the PHO was reluctant to acknowledge that it was necessary for PHO 4 to project any sort of identity. He signified that the PHO had to 'mature' before it could collaborate with other primary health care providers and it was more important for the PHO to continue to be internally-focused. As expressed by this interviewee:

> *We don't want to be involved with anyone else just yet … otherwise it would have just muddied the whole process and structure that we had set up … (PHO representative)*

The focus on internal features of the PHO was confirmed by an interviewee from this PHO's community who noted in respect of the PHO:

> *I find that organisations get isolated and only look internally and there may well be other parts that they don't know anything about that affects them … (Community Representative)*

A media reporter from the region expressed surprise that PHO 4 was not proactive in advising the public items of note through the media. He observed in relation to PHO 4:

> *The Press Releases we get are from the District Health Board. I am surprised because I would have thought it was the PHO's responsibility. I used to live [in another region] and the PHO there was quite proactive. They had to get their message out and tell people about what they were doing. (Community Representative)*

As noted earlier, during the research period (2006-2008), the ownership of PHO 4 was partially devolved from the IPA to the community, and staff changes and a change in office location were indications to the community that the PHO sought an identity independent of its IPA founder. While during this period, the PHO was working on its internal face and lacked the energy to project an external face, its external stakeholders sought an image and (as will be shown later) composed their own from the clues available.

In contrast to PHO 4, although the majority of interviewees from PHO 2 did not believe it is important for the PHO to project an external identity as an image, PHO 2 relied very strongly on its brand, built up over many years as an IPA-based organisation. A senior member of the PHO's Board explained:

> *"The identity of the PHO piggy-backed on the existing reputation of [the IPA]. So Day 0, before Day 1 there was no PHO, there was no brand, Day 2 it was attached to the [IPA] brand and it already could build on that. You know [the IPA] had done publications in the [regional paper] and had all these different things so it was already out there … (PHO Representative)*

PHO 2 incorporated the IPA name in the PHO identity so that patients and the public did not experience brand confusion. Accordingly, in terms of the Hatch and Schulz (2002) schema, it had a strong external face. However, their funder, the DHB, was unhappy about the notion of an IPA brand as this resulted in the PHO focusing on its GPs as providers, rather than the PHO *per se* which was being funded to provide health care. The DHB interviewee noted:

> *We have had several discussions with them around the use of social marketing. It's fine for them to advertise or market healthy lifestyles or that sort of thing, but we are unhappy with them using [DHB] funds for marketing of the IPA as a brand. (DHB Representative)*

A community representative also noted the difficulty with the PHO's adoption of a brand and use of a logo to promote the PHO. This interviewee considered that a brand is a dissonant concept for a PHO and commented:

> *It's not about who does the work, it's about the work being done and that it is of the best possible quality and that is the one thing that really rubs me up the wrong way. You should have enough faith in the knowledge that this is contributing, that you don't really need to have the logo on it to recognise that. (Community Representative)*

These comments point to a recognition that a logo, or projected external face, is merely a partial reflection of the provider's performance, rather than the actual performance. The interviewee was unhappy that the logo was chosen by PHO 2 as its field of visibility.

Unlike the two PHOs with IPA ownership (PHO 2 and PHO 4), interviewees from both PHO 1 and PHO 3 were keen to convey that their PHO has a distinct community identity that could be marketed at a broader political level.

A senior member of the Board of PHO 1 noted:

> *I do believe that people need to understand that we exist so that they understand who is driving the Primary Health Strategy. If the community doesn't understand which one [PHO] they belong to, they may not believe that either the money is being well spent or that it's creeping down to where they might want it to be. (PHO Representative)*

Another senior member of PHO 1 agreed, stating:

> *We are trying to position ourselves as one, being about programmes, but the other is about being a reliable, credible source of information. (PHO Representative)*

PHO 1 attempted to project itself as a reliable, "credible" provider, while an interviewee from PHO 3 signalled that this PHO sought to be recognised for its excellence in health programmes and innovative practices. As a senior member of the Board said:

> *It's really more about waving the flag. From a political point of view, we definitely do need to wave the flag quite a lot. We want to share our belief that [the PHO is] the right way to go … what we've done, how we've achieved it and how this can work for others; to be recognised for doing what we do. (PHO Representative)*

Another senior member of PHO 3 noted that the PHO was keen to make linkages with other organisations outside the PHO in order to achieve those innovations and observed:

> *Knowing them personally means that we can negotiate with them rather than taking a top down approach. We really support the grass roots up and that's what we advocate for and that's what we promote. (PHO Representative)*

PHO 3 and PHO 1 promoted their responsiveness to their communities – an expectation of the *Primary Health Care Strategy* (Minister of Health, 2001) and an alignment with their predominant community ownership. PHO 2 and PHO 4 with minimal or no community ownership, were more internally focused (on GP providers). The difference in orientation between PHO 2 and PHO 4 on the one hand and PHO 1 and PHO 3 on the other, was not only evident from the interviews, it was also shown in PHO 1 and PHO 3 making greater use of community meetings, open AGMs and elections to Board positions to involve the community, than PHO 2 and PHO 4.

4.2 Image conveyed by metaphors

Following the Hatch and Schulz (2002) schema and the analysis of the use of metaphor in section 2, we present metaphors or labels ascribed to PHOs that can serve to clarify a

PHO's external image. A DHB interviewee involved in funding a number of PHOs, including PHO 3, referred to PHOs in which IPAs have a majority ownership as:

> *When you look at … PHOs that have been driven solely out of IPAs, we talk about them as an IPA in drag (laughs). (DHB interviewee)*

Given the historical growth of IPAs as companies with GP shareholders, this interviewee's metaphor of "an IPA in drag"[iv] conveys distaste for PHOs structured as GP-run organisations. Such an image is also incongruent with the *Strategy's* 'ideal' of a PHO being responsive to its community.

A senior Board member of PHO 2 expressed surprise about this metaphor being applied to IPA-owned PHOs, such as PHO 2, implying that they control (as well as own) the PHO. This metaphor inferred that the IPA may be prioritising its own company shareholders (i.e. GPs) over the community. He stated:

> *I think that when you look at the ideology that the IPA-run PHOs aren't good … you know the word shareholder almost never comes into our discussion. We see us [the PHO and the IPA] as kind of like this (fingers intertwined), not as us and them. The PHO doesn't say, "We've got to do this because the shareholder wants it." We think, "What do the providers want, what do the people want and need?" That's more the flavour of our discussion than what the shareholder wants. (PHO Representative)*

The interviewee points to organisational misrecognition – an acknowledgement that external stakeholders have an ideology that IPA-run PHOs 'aren't good' but that, to his mind at least, the image was distorted. Yet, the interviewee did not reflect on the PHO's sensegiving that caused the misrecognition.

Notwithstanding this interviewee's protestations to the contrary, a community interviewee from PHO 2 asserted that the wants and needs of the PHO's community were not foremost in the minds of the IPA-owned PHO. This interviewee observed:

> *It's challenging because [PHO2] is the shark! They have all the money and all the practices. (Community Representative)*

Another reason for this skepticism is that the Boards of the IPA-owned PHOs are often heavily populated with GPs, rather than having a mix of health care providers and community as envisaged by the *Primary Health Care Strategy.* Howell (2007, p.2), termed these Boards as having "foxes in the henhouse" as she believed that GPs on PHO Boards were inherently conflicted. Yet, a GP interviewee on the Board of PHO 4 disagreed, saying:

> *I read something recently which was a criticism about Doctors being involved in PHOs: that it's like having foxes in the henhouse. I thought about that analogy long and hard because most of what I do every day involves trust and I have the opportunity, if I was like that, to misuse that trust to maximise my own income from it and I find myself frequently not doing that … That's because of an inner spirit of trying to act for the good, professionalism or whatever it is. In the relationship we have with the DHB, there's no trust. (Provider Representative)*

This is another example of someone internal to the organisation being confused about why there was misrecognition of their organisation's external image.

These images of PHOs as "the shark", and GPs and their IPA body as "foxes in the henhouse" (Howell, 2007), are metaphors that suggest these PHOs have predatory characteristics. GPs were further described as not being able to "play nicely" by a senior member of a PHO who stated:

> *We have an ongoing tension … because General Practice needs to be challenged to play nicely with others[v] and recognise that General Practice is key to a Primary Health Organisation but that, if we are going to do anything about the population's health, it's got to be a bit more than that. (PHO interviewee)*

The use of a picture entitled "teaching elephants to dance" at the AGM, along with this statement, suggests at least mild derision for GPs that need to be taught or coerced in their 'playing' habits. All of these metaphors are potentially disabling PHO images.

In contrast to the metaphors ascribed to PHOs with a majority IPA ownership, the following statements from interviewees from PHO 1 and PHO 3 which have a majority of community ownership convey community-focused images. For example, a DHB interviewee from PHO 1 noted:

> *The role of a PHO is that it is a community-driven organisation that oversees the primary care services of that community … To me, the important thing is whether they are a community-driven organisation. (DHB Representative)*

Another interviewee from this PHO noted that the PHO encouraged community engagement and also coordinates the efforts of other organisations. She explained:

> *I see PHOs as being the key way of engaging the community in being part of looking after their health … I do believe that we are not going to get on top of our health issues until we engage in looking at the broader determinants of health and that to do that, the community needs to be engaged so that they need to have access to information, they need to improve things. So I see the PHO as the vehicle for that community engagement and I see that our function from a service perspective is to link things up. We're fundamentally the coherent coordinator. We're to make the connections, act as the bridge, ensure that our enrolled population has access to the support and services that they need in a way that is logical, reduces fragmentation, reduces duplication, and coherently provides them with the chances at improved health. (PHO Representative)*

Another interviewee summed up the community nature of the PHO as follows:

> *It's good to have something embedded in the community … DHBs are such a juggernaut (Community Representative)*

These interviewees use metaphors reflecting the community orientation of the PHO – "community-driven", "coherent coordinator" and "embedded in the community". These community metaphors accord with the stance of the *Primary Health Care Strategy* (Minister of Health, 2001, p.20) that PHOs are to "take a community development approach to find appropriate solutions for disadvantaged groups". PHO 3 demonstrates its

adoption of this approach by developing its programmes through community consultation. This was described by an interviewee as follows:

> *We spend time finding out what people want and then set it into action once we have really consulted with people … If you really talk about community participation it takes time to do it well and it is not something that can be hurried. I think it is time well-spent to set up something that people truly feel part of, and then when there are issues you can sort it out really easily over time. But if you don't do that consultation first your community will sure as eggs let you know about it (laughs) … You do have to demonstrate that you are doing what you say you are doing. (Provider Representative)*

The PHO's image of being "community-driven" appeared to reflect its internal face or culture. Further, the community-based metaphors ascribed to PHO 1 and PHO 3 are suggestive of the post-NPM principles of networking that underpin the *Primary Health Care Strategy* (Bhatta, 2003; Minister of Health, 2001).

The contrasting metaphors or images associated with the IPA-owned and community-orientated PHOs are presented in Figure 3.

Figure 3: Metaphors ascribed to PHOs with differing ownership structures and orientation

IPA Majority Ownership and internal focus – Negative metaphors	**Community Majority Ownership and community focus – Positive metaphors**
"An IPA in drag"	"Community Development"
"The Shark"	"Coherent Coordinator"
"Needs to be challenged to play nicely with others"	"Embedded in the community"
	"Community-Driven"

4.2 Negative images and accountability

A clear link has been theorised between accountability feedback and identity change in respect of individuals (Goffman, 1959; Roberts, 1991). Dutton and Dukerich (1991) extend this to note that evaluation and feedback on performance changes organisational images and identities. The positive and negative metaphors presented in Figure 3 reflect the differing characteristics of the PHOs concerned. They also elicit different responses from the relevant funding DHBs in terms of the extent and content of data they demand from the PHOs in their search for full and open accountability. These demands appeared to be unrelated to the size or responsibilities of the PHO.

One response of the DHB as funder to negative metaphors was to require increased information. In respect of PHO 2, the DHB had been overtly involved in data-gathering and checking the decisions of PHO 2, so that a compromise was reached. The DHB staff member responsible for the DHB-PHO contract noted:

> *The PHO contract*[vi] *only requires 6 monthly reporting, but we had an arrangement whereby they provided it quarterly because they were accusing us of micro-management. We said, "Fine, we'll leave you alone if we know what's happening, which means greater transparency, which means greater reporting."*

> *… You know [the IPA has] centralised everything to manage themselves. They've set up several companies for all sorts of services and, and now they're saying to us that a lot of the services are unsustainable. But because we've never had access to accounts or knowing what's going on – we can't make a call on that and well: "You be up front with us about what's going on then we may help you, but until you come clean with us, we're not going to engage"… You can see what the tension was. (DHB Representative)*

The trade-off was for the PHO to provide even more frequent reporting than was required, or to make visible the performance of parts of its business that other PHOs did not. Bearing in mind the predator-like metaphors ascribed to PHO 2 both individually and as a type,[vii] which reflected the internal focus of this PHO, it is unsurprising that the DHB required greater reporting. The DHB did not support the PHO image built on the IPA (the brand). The DHB required the PHO to network with other providers, which was slow to occur because the PHO sought to grow the IPA's brand, rather than that of others. In order to effect change, the DHB interviewee noted that the DHB had increased the number of formal meetings between the Chairmen of the DHB and the PHO, between the DHB Management and the PHO Board, and between the DHB Management, the PHO management and the IPA management. The DHB interviewee observed that it was important for the DHB to increase its communication with the PHO's IPA owner as there was a lack of transparency about which organisation (the IPA or the PHO) was responsible for GP performance.

As noted above, an interviewee referred to GPs in IPA-owned PHOs as "needing to be challenged to play nicely with others". Reflecting such concerns, the DHB contracting with PHO 2 sought to determine whether the PHO was assessing its community's demands appropriately. It also encroached into the domain of PHO 2 by trying to develop further its own relationship with community in respect of primary health care. This led to considerable strife in the DHB-PHO relationship, escalating the number of meetings between the DHB's and PHO's management and governors, resulting in further DHB directives. The consequence of the inward focus of PHO2 and the resulting negative images which resulted was suspicion and increased demands for performance reporting. These demands did not focus on clinical issues but were designed to make the PHO reduce its brand/image marketing and, through expanded reporting, to increase its transparency.

The role of the IPA in PHO 4 (especially before it moved to include community ownership) was also a problem for its DHB. The DHB interviewee noted:

> *I find that the IPA doesn't like to let go. We have contracts that are separate with the PHOs and the person I deal with over the [IPA] agreement will suddenly jump into a discussion around some PHO agreements and that is not for their discussion. (DHB Representative)*

A senior PHO member observed that the DHB had not supported the establishment of an IPA-owned PHO and had sought to withhold funding for patients in the area.

The DHB interviewee recounted past issues where they felt that the IPA employee had not been communicating their concerns to the PHO sufficiently, or appropriately. The

requirement to have weekly meetings with the DHB and the taking of formal minutes at those meetings was deemed unusual. The DHB interviewee explained:

> *We have had issues in the past with things not being communicated well to the PHO's Board. [The IPA staff member] is meant to be the main link but I don't know whether he is passing that on appropriately … We have kept those meetings weekly. We take minutes now that he should be circulating to the [PHO] so that they know … what we've said and what he said … I don't think the [PHO's Board is] getting enough information. (DHB Representative)*

Further, despite PHO 4 being eligible for performance payments under the Performance Management Programme, its DHB was withholding the funding until PHO 4 had demonstrated it would use the funds 'wisely'. This was indicative of the DHB using sensebreaking to strong-arm the PHO into a new identity. Another indication was the statement made by a senior DHB staff member about this PHO. An interviewee recounted:

> *The [DHB's] Funding and Planning Manager got up to the Chairman of [a PHO] in a meeting the other day and told him that if he didn't do it his [the Planning Manager's] way, he would make sure his PHO 'withered and died'. (PHO Representative)*

Apparently, if the new identity did not emerge, the DHB was prepared to dispense with the PHO.

When asked if the introduction of greater community 'ownership' into the PHO and a change of employer for the PHO manager would make a difference, the DHB interviewee responded:

> *I think it shows that they are growing … They do need to understand that we do need to have that transparency around the spending of the dollar … to see what evidence they have that they are spending the money appropriately and how they are benefiting the community … I think the changes will be good, we'll just have to wait and see. (DHB Representative)*

Attitudinal change reflecting negative images appeared to be slow to occur, however a DHB staff member noted that they could not cancel the PHO contract because:

> *You're obliged to be a mentor and be supportive because it's a health environment … because if thousands of people didn't have health care suddenly, it would be a big disaster, and a political disaster. (DHB Representative)*

Accordingly, it could be suggested that the threat to cause a PHO to 'wither and die' is empty, but made to effect change in the provider's performance and its identity which reflected the reporting of that performance.

4.3 Positive images and accountability

The DHBs' demands for PHO accountability reporting by the PHOs that were described as "community-driven", "coherent coordinator", "embedded in the community" and being involved in "community development" was entirely different in nature to those to

which negative metaphors were attributed. Their demands appeared to be less process driven and there appeared to be more openness between the parties. For example, in addition to its regular 6-monthly reporting, PHO 1 provided its DHB with a copy of its annual report before it was printed so that the DHB could provide feedback on its content. According to interviewees from PHO 1 – who identified it as a "coherent coordinator" – the PHO believed its transparency generated a good relationship with the DHB. As an illustration of this 'good relationship', an interviewee explained that, although the PHO's reports to the DHB are sometimes late:

> *The DHB is not uncomfortable I think, because we report consistently and constantly out of the reporting cycle. Because of our view about openness, they gets copies of every status report we do on Health Promotion … and Services to Improve Access, so [the DHB] is always actually in the loop … At any time they can have financial stuff because our Board papers as far as we're concerned are open. And all of our financials go into our Board papers each month. (PHO Representative)*

This openness was also reflected in the relationship of PHO 3 with its DHB. A senior member of PHO 3 also commented that the DHB had made changes to its demands for accountability reporting to accommodate the PHO's processes and data needs. A Board member interviewed from this PHO noted:

> *I think probably where I would see the PHO heading is one where they have a relationship [with the DHB] in the spirit of collaboration and best practice … You are talking about highly skilled professionals and dedicated community. (Provider Representative)*

These PHOs developed images that were congruent with the community focus from the post-NPM reforms brought by the *Primary Health Care Strategy* (Minister of Health, 2001).

5.0 Discussion and Conclusion

The objective of this paper was to evaluate how a government purchaser's accountability demands on providers following post-NPM healthcare reforms reflect and re-form organisational image. In order to do that, this paper has analysed the primary health care contracting relationships following post-NPM reforms in New Zealand. An ethnographic methodology was used in four case studies.

Specifically, this paper highlights the metaphors used in describing the providers' organisational identity. It was found that these metaphors could be categorised as being either positive or negative. Walters and Young (2008) argue that such metaphors perform significant roles in our business discourses as they express viewpoints about organisations. The schema from Hatch and Schulz (2002) is useful to observe how these metaphors, or the image of the organisations, both leaves impressions on others and also feeds back to the organisational identity to mirror the images others hold.

The metaphors in these cases were linked to the notion of fields of visibility which Starthern (2000) uses to express how organisations can report on specific performance as a reflection of their identity (i.e. their image), without revealing their internal face entirely (their culture). By drawing on Roberts (1991) and Schweiker (1993) these case studies have shown that the projected images of these organisations affect the accountability demanded of the PHOs. The image has an affect on the DHB purchaser and, in the case of negative metaphors the DHBs attempt to reconfigure the external face of the PHOs. Specifically, this research found that PHOs with a majority IPA ownership generated negative images that were reflected in the value-laden predatory or derogatory metaphors used to describe them. The findings of Hatch and Schulz (2002) suggest that this is a natural outcome of the expression of the PHO's identity.

In line with the extension of Hatch and Schulz (2002), the DHB funders' reaction to these PHOs' identities was to use sensebreaking to require the PHOs concerned to be more transparent. This included demands by the DHBs for more reporting than was required by contract and more frequent meetings that were formalised by minutes and action points. Further, this resulted in the PHOs accusing DHBs of 'micro-managing' them, and of DHBs threatening to cut off PHOs' funding until they conformed with the preferred image.

The DHBs were concerned that the PHOs with negative images (i.e. PHO 2 and PHO 4) did not focus on their communities – the preferred field of visibility expounded by the *Primary Health Care Strategy*. The interviewees from PHO 2 and PHO 4 seemed unable (or unwilling) to comprehend the images their PHOs generated. When pressed on specific communication strategies, such as why the PHO's AGMs were not open to the public, or whether they would consider greater community involvement on the PHO's Board, interviewees from these IPA-owned PHOs noted that their PHO operated within its DHB-PHO contract. Thus, these interviewees signalled a reluctance to change.

In contrast, the PHOs with a majority community ownership (i.e. PHO 1 and PHO 3) generated positive images based around their focus on their community – images which accord with the *Primary Health Care Strategy* and governance reforms (Pallot, 2003). Representatives from these PHOs noted that their respective DHB funders were 'relaxed', and had attempted to make 'the reporting load a little bit easier'. Interviewees from these PHOs signalled that their PHO took its images seriously – wanting to be recognised as reliable, credible and innovative. Greater openness and trust was evident in the relationships of these PHOs with their DHBs, leading towards the networked partnerships that are indicative of a post-NPM environment (Bhatta, 2003).

Schweiker (1993) suggests that the iterative process of accountability requires organisations to be accountable not only for performance and reporting, but also for its accountability relationships and the anticipated responses to its accounts. Accordingly, it could be suggested that the way for PHOs to develop a 'balanced' partnership with their DHB funder is to move away from IPA ownership towards community ownerships to reflect the DHBs' accountability responses. PHO 4 attempted this devolution; however, the reaction of the relevant DHB was cautious – it sought to 'wait and see' before reducing its close oversight of this PHO's activities. The DHB had firm ideas of its ideal PHO and its readiness to use sensebreaking (or strong-arm) tactics showed a forcefulness that is not in line with post-NPM networks and relationships.

The development of networks and partnerships in a post-NPM ethos appears to provide a window where relationships focused on similar goals (in this example, improved community health) can take place. A post-NPM ethos provides a counter to the hierarchical demands of accountability in the contractual managerialist paradigm. However, while all of the PHOs in this research met clinical performance guidelines, for those with visibly ugly characteristics (described by negative metaphors) the reforms did not break down in prior hierarchical accountability demands as the post-NPM reforms would suggest. Indeed, these organisations experienced increased accountability demands and the government funder used sensebreaking to force the PHO to change its image. Alternatively, for the PHOs generating positive metaphors, these post-NPM reforms led to sensegiving and sensemaking opportunities, and the 'accountability load' was a little lighter, more open and collaborative.

Thus it appears that although the softening of managerialism's face could lead purchasers away from previous hierarchical demands of accountability, the post-NPM reforms in these case studies have not lived up to this aim. Instead, signs are that this paradigm has developed a new homogenisation placing the responsibility firmly on the provider (as accountor) to be responsible for its image and the reaction of external stakeholders to that image.

Bhatta (2003) and Pallot (2003) welcomed reforms that would soften accountability and provide space for democracy. The lesson from these case studies is that 'softening' can occur only when providers project an external face reflecting positive images to their government purchasers. Negative organisational metaphors are likely to cause the purchaser to exercise sensebreaking. This results in the purchaser tightening the demands for accountability and ignoring the opportunity for democracy. Ultimately the funded organisation is responsible for its visible image, the relationships it generates and the accountability it engenders.

References:

Ahrens, T., & Chapman, C. S. (2006). Doing qualitative field research in management accounting: positioning data to contribute to theory. *Accounting, Organizations and Society, 31*(8), 819-841.

Ahrens, T., & Dent, J. F. (1998). Accounting and organizations: realizing the richness of field research. *Journal of Management Accounting Research, 10*, 1-39.

Alvesson, M., & Wilmott, H. (2002). Identity regulation as organizational control: producing the appropriate individual. *Journal of Management Studies, 39*(5), 619-644.

Anderson, L. B., & Blegvad, M. (2006). Does ownership matter for the delivery of professionalized public services? Cost-efficiency and effectiveness in private and public dental care for children in Denmark. *Public Administration, 84*(1), 147-164.

Armenic, J. H., & Craig, R., J. (2000). The rhetoric of teaching financial accounting on the corporate web: a critical review of content and metaphor in IBM's internet webpageguide to understanding financials. *Critical Perspectives on Accounting, 11*(3), 259-287.

Ashton, T. (2005). Recent developments in the funding and organisation of the New Zealand health system. *Australia and New Zealand Health Policy, 2*(9).

Bhatta, G. (2003). Post-NPM Themes in Public Sector Governance. In 17, State Services Commission, Wellington.

Blumberg, B. F. (2001). Cooperation contracts between embedded firms. *Organization Studies, 22*(5), 825-852.

Bracci, E. (2009). Autonomy, responsibility and accountability in the Italian school system *Critical Perspectives on Accounting, 20*(3), 293-312

Broadbent, J., Dietrich, M., & Laughlin, R. (1996). The development of principal-agent, contracting and accountability relationships in the public sector: conceptual and cultural problems. *Critical Perspectives on Accounting, 7*, 259-284.

Craig, R., J., & Armenic, J. H. (2004). Enron discourse: the rhetoric of a resilient capitalism. *Critical Perspectives on Accounting, 15*(6-7), 813-852.

Crowther, C. (1995). NHS Trust marketing: a survival guide. *Journal of Marketing Practice, 1*(2), 57.

Dutton, J. E., & Dukerich, J. M. (1991). Keeping an eye on the mirror: image and identity in organizational adaptation. *Academy of Management Journal, 34*(3), 517-554.

Dutton, J. E., Dukerich, J. M., & Harquail, C. V. (1994). Organizational images and member identification. *Administrative Science Quarterly, 39*(2), 239-263.

Empson, L. (2004). Organizational identity change: managerial regulation and member identification in an accounting firm acquisition. *Accounting, Organizations and Society, 29*, 759-781.

Erickson, F. (1984). What makes school ethnography "ethnographic"? *Anthropology and Education Quarterly* (15910), 51-66.

Finan, N. (2002). Visual literacy in images used for medical education and health promotion. *Journal of Visual Communication in Medicine, 25*(1), 16-23.

Gioia, D. A., Schultz, M., & Corley, K. G. (2000). Organizational identity, image, and adaptive instability. *Academy of Management. The Academy of Management Review, 25*(1), 63.

Gioia, D. A., & Thomas, J. B. (1996). Identity, image, and issue interpretation: sensemaking during strategic change in academia. *Administrative Science Quarterly, 41*(3), 370.

Goffman, E. (1959). *The Presentation of Self in Everyday Life.* Garden City, N.Y.: Doubleday.

Haddow, G., O'Donnell, C. A., & Heaney, D. (2007). Stakeholder perspectives on new ways of delivering unscheduled health care: the role of ownership and organizational identity. *Journal of Evaluation in Clinical Practice, 13*, 179-185.

Hatch, M. J., & Schultz, M. (2002). The dynamics of organizational identity. *Human Relations, 55*(8), 989.

Hill, W. Y., Fraser, I., & Cotton, P. (2001). Of Patients' interests and accountability: reflecting on some dilemmas in social audit of primary health care. *Critical Perspectives on Accounting, 12*, 453-469.

Howell, B. (2007). Governments, governance and trust. *Forum, 8*, 1-4.

Hudson, R. (2009). Brand strategy for acute NHS trusts. *Journal of Communication in Healthcare, 2*(1), 20-33.

Jacobs, K. (1998). *The Impact of Accounting Led Reform in the New Zealand Public Sector: an empirical study of schools and GP practices.* Unpublished PhD, University of Edinburgh, Edinburgh.

Jones, M. J., & Mellett, H. (2007). Determinants of changes in accounting practices: Accounting and the UK Health Service *Critical Perspectives on Accounting, 18*(1), 91-121.

Karreman, D., & Alvesson, M. (2004). Cages in Tandem: Management Control, Social Identity, and Identification in a Knowledge-Intensive Firm. *Organization, 11*(1), 149-175.

McAvoy, B. R., & Coster, G. D. (2005). General practice and the New Zealand health reforms - lessons for Australia? *Australia and New Zealand Health Policy, 2*(26).

McDonald, R., Waring, J., & Harrison, S. (2006). At the Cutting Edge? Modernization and Nostaligia in a Hospital Operating Theatre Department. *Sociology, 40*(6), 1097-1115.

McGoun, E. G., Bettner, M. S., & Coyne, M. P. (2007a). Money n' motion—Born to be wild. *Critical Perspectives on Accounting, 18*(3), 343-361.

McGoun, E. G., Bettner, M. S., & Coyne, M. P. (2007b). Walt's Street and Wall Street: Theming, Theater, and Experience in Finance. *Critical Perspectives on Accounting, 18*(2), 213-230.

Minister of Health (2001). *The Primary Health Care Strategy*. Wellington: Ministry of Health.

Ministry of Health (n.d.). *Primary Health Organisation Agreement Version 17*. Wellington: Ministry of Health.

Munro, R. (2001). Calling for accounts: numbers, monsters and membership. *The Sociological Review, 49*(4), 473-493.

O'Dwyer, B. (2004). Qualitative data analysis: illuminating a process for transforming a 'messy' but 'attractive' 'nuisance' In C. Humphrey & B. Lee (Eds.), *The Real-life Guide to Accounting Research: A Behind-the-scenes View of Using Qualitative Research Methods* (pp. 391-407). Amsterdam: Elsevier.

Pallot, J. (2003). A Wider Accountability? The Audit Office and New Zealand's Bureaucratic Revolution. *Critical Perspectives on Accounting, 14*(1-2), 133-155.

Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks, CA: Sage Publications Inc.

Roberts, J. (1991). The possibilities of accountability. *Accounting, Organizations and Society, 16*(4), 355-368.

Roberts, J. (1996). From discipline to dialogue: individualizing and socializing forms of accountability. In R. Munro & J. Mouritsen (Eds.), *Accountability: Power, Ethos and the Technologies of Managing* (pp. 40-61). London: International Thomson Business Press.

Roberts, J. (2009). No one is perfect: The limits of transparency and an ethic for 'intelligent' accountability. *Accounting, Organizations and Society, forthcoming*.

Roberts, J., McNulty, T., & Stiles, P. (2005). Beyond Agency conceptions of the work of the Non-Executive Director: creating accountability in the Boardroom. *British Journal of Management, 16*, S5-S26.

Schweiker, W. (1993). Accounting for ourselves: accounting practice and the discourse of ethics. *Accounting, Organizations and Society, 18*(2/3), 231-252.

Smith, P. C., Preker, A. S., Light, D. W., & Richard, S. (2005). Role of Markets and Competition. In J. Figueras, R. Robinson & E. Jakubowski (Eds.), *Purchasing to Improve Health Systems Performance* (pp. 102-121). Maidenhead, England: Open University Press.

Stewart, J. D. (1984). The Role of Information in Public Accountability. In A. G. Hopwood & C. R. Tomkins (Eds.), *Issues in Public Sector Accounting* (pp. 13-34). Oxford: Philip Allan Publishers Ltd.

Strathern, M. (2000). The tyranny of transparency. *British Educational Research Journal, 26*(3), 309-321.

Thompson, G. (2001). The design of a corporate identity for a department of medical illustration: a case study. *Journal of Visual Communication in Medicine, 24*(2), 60-63.

Walters, M., & Young, J. J. (2008). Metaphors and accounting for stock options. *Critical Perspectives on Accounting, 19*(5), 833.

Weick, K. E. (1995). *Sensemaking in Organizations*. Thousand Oaks, CA: Sage Publications.

WHO (2000). *The World Health Report 2000: Health Systems: Improving Performance*. Geneva: World Health Organization.

Young, J. J. (2001). Risk(ing) metaphors. *Critical Perspectives on Accounting, 12*(5), 607-625.

[i] Bhatta (2003, p.10) describes it as "that gooey stuff known as values/ethos".

[ii] Here we use the dictionary definition of metaphor: a figure of speech in which a name or descriptive term is transferred to an object to which it is not properly applicable.

[iii] For example, Armenic and Craig(2000), Craig and Armenic (2004) and McGoun et al. (2007a, 2007b) provide examples of discussions of accounting as metaphor. This article instead considers metaphors for organisations.

[iv] Chambers Dictionary describes "in drag" as the wearing of transvestite clothing.

[v] The 'others' include community representatives, NGOs that deliver health services, and other providers that contribute within the primary health care system.

[vi] As noted, the PHO contract is a standard contract (Ministry of Health, n.d.).

[vii] Specifically "the shark" and "IPA in drag".