

University of Southampton Research Repository ePrints Soton

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g.

AUTHOR (year of submission) "Full thesis title", University of Southampton, name of the University School or Department, PhD Thesis, pagination

UNIVERSITY OF SOUTHAMPTON

FACULTY OF BUSINESS AND LAW

School of Management

**Contextual Approach to the Performance Analysis of
Iran's National Accreditation Programme for
Healthcare Organisations**

by

Ebrahim Jaafaripooyan

Thesis for the degree of Doctor of Philosophy

October 2011

*To Safoura, my dear wife,
for her patience, support and affection*

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF BUSINESS AND LAW

SCHOOL OF MANAGEMENT

Doctor of Philosophy

**CONTEXTUAL APPROACH TO THE PERFORMANCE ANALYSIS OF IRAN'S
NATIONAL ACCREDITATION PROGRAMME FOR HEALTHCARE
ORGANIZATIONS**

By Ebrahim Jaafaripooyan

The importance of focusing on performance measurement systems (PMSs) in the public sector has increased following the introduction of new public management (NPM) initiatives, which placed a greater emphasis on organisational accountability and performance measurement. PMSs have always been a key player in ensuring accountability and improvement in the practices of public sector (e.g. healthcare) organisations. Critical features of the health sector have particularly warranted the application of various internal or external PMSs in this area as well as the regular assessment of their own performance. This is crucial in terms of both maintaining their alignment with the initially determined objectives and improving their merits and capabilities to continuously detect the deficiencies and malpractices in healthcare organisations (HCOs).

Iran's national accreditation programme for healthcare organizations (NAPH) has served as the sole element of macro control and regulation in the country's health sector at national level. It has been set up to reflect, operationalise and guarantee the intentions of the government for promoting quality and safety in the local HCOs, mainly hospitals, across the country. Despite the NAPH's importance and vital position in the country's health system and its long-time implementation, the contextual effects of this evaluatory mechanism on the individual hospitals have not been empirically researched in current organizational context; i.e. there is a lack of empirical evidence in the literature on how this macro PMS impacts in practice on the hospitals at local level. Accordingly, this study aims to render a contextual evaluation of the performance of this evaluatory system. A middle-range thinking (MRT) research approach has informed the study. Drawing on this approach, Broadbent and Laughlin's theoretical framework was adopted to both guide the empirical work and help with the analysis and interpretation of the empirical data.

The findings of the study showed that it was mainly the financial benefits rather than the quality improvement merits of the current hospital accreditation and evaluation programme that were apparently the main rationale behind the conformity of the hospitals. Both dysfunctional and beneficial consequences were associated with the NAPH by the hospitals' members. In addition, the hospitals showed different reactions including rejection and gaming as well as absorption to achieve the beneficial gains of the programme. However, they also adopted some requirements of the NAPH exclusively in view of its perceived merits and some other contextual factors. Changes in the hospitals as a result of the programme occurred mostly in the early years following its introduction or modification. This study further provides both theoretical and practical research implications for policy and practice for the improvement of this evaluation mechanism.

LIST OF CONTENTS

ABSTRACT	V
LIST OF CONTENTS.....	VII
LIST OF TABLES	XVII
LIST OF FIGURES	XIX
ACKNOWLEDGEMENTS	XXIII
 Chapter 1 - Introduction	 1
1.1. Overview	1
1.1.1. Statement of the problem	2
1.2. Purpose of the study.....	2
1.3. Theoretical frameworks.....	4
1.4. Significance and contribution of the study	4
1.5. Motivation of the study	6
1.6. The structure of the thesis.....	7
 Chapter 2 - Healthcare Performance Measurement: The Case of Accreditation	 9
2.1. Introduction.....	9
2.2. Performance measurement: Definitions	9
2.2.1. Performance.....	9
2.2.2. Performance measurement	10
2.3. Significance of PM	10
2.4. Performance measurement system	11
2.5. PMSs in the literature.....	12
2.6. Downsides of PM	15
2.7. PM in health care	17
2.7.1. History of PM in health care	19
2.7.2. Difficulties of measuring performance in health care	19
2.7.3. Unintended and dysfunctional effects of PM in health care	20
2.8. PMSs in health care	22
2.8.1. Internal PMSs	22
2.8.1.1. CPC	23
2.8.1.2. BSC	24

2.8.1.3. KBEMS.....	24
2.8.1.4. Surveys.....	25
2.8.1.5. AHP	26
2.8.2. External PMSs.....	28
2.8.2.1. Regulatory inspection	28
2.8.2.2. External (third-party) assessment	29
2.8.3. The EESs: Similarities and Differences	32
2.8.4. Accreditation.....	34
2.8.4.1. History of accreditation	35
2.8.4.2. Accreditation: Definition and Importance	35
2.8.4.3. Accreditation Standards.....	37
2.8.4.4. Accreditation: Purposes and Steps.....	38
2.8.4.5. Approaches to Accreditation	39
2.8.4.6. Accreditation: dysfunctional consequences	41
2.8.4.7. Accreditation, Licensure and Certification	42
2.9. Performance analysis of APs.....	42
2.9.1. Review of existing literature.....	44
2.9.2. Outcome-based approach	46
2.9.2.1. Promoting change	46
2.9.2.2. Organisational impact.....	47
2.9.2.3. Patient satisfaction	47
2.9.2.4. Cost of accreditation.....	47
2.9.2.5. Quality improvement.....	49
2.9.3. Process-based approach	51
2.9.3.1. Accreditation validity and reliability	53
2.9.3.2. Professionals' perspectives	53
2.9.4. Further frameworks and designs for assessing EESs	64
2.9.5. International efforts	66
Chapter 3 - Iranian Hospital Accreditation and Evaluation System	69
3.1. Introduction	69
3.2. The Healthcare system in Iran.....	69
3.2.1. Tertiary level of healthcare delivery- Hospitals.....	72
3.3. Evaluation of hospitals in Iran.....	73
3.3.1. Brief History	73

3.3.2. Accreditation of hospitals	74
3.3.3. Governance of the NAPH	75
3.3.3.1. Macro level	76
3.3.3.2. Micro level	76
3.4.4. Main features of the NAPH.....	78
3.4.5. The standards of the NAPH	78
3.4.6. The evaluation process of the NAPH	80
3.4.7. Modification of the NAPH.....	83
3.4. Literature on Iran's Healthcare Accreditation	85
3.5. The gap in the literature	87
3.5.1. Macro level.....	88
3.5.2. Micro level	91
 Chapter 4 - Philosophical Perspective and Theoretical Frameworks	 93
4.1. Introduction.....	93
4.2. Research approach	93
4.3. Middle Range Thinking (MRT)	97
4.3.1. The limitations of MRT	100
4.3.2. MRT in the literature	100
4.4. Justification for the adoption of MRT	101
4.5. Theoretical models of the study	103
4.5.1. Habermas' theory of societal development.....	103
4.5.2. Broadbent and Laughlin's Model	105
4.5.3. Refinements of Habermas' model of society	106
4.5.3.1. Internal Colonisation (IC).....	108
4.5.3.2. The relevance of IC for the current study.....	110
4.5.4. The model's conceptualisation of organisations	111
4.5.4.1. The utility of the model's conceptualisation	113
4.5.4.2. Practical implications for the study	116
4.5.5. Significance of Broadbent and Laughlin's (2005) framework for the study...	117
4.5.6. Theoretical frameworks in literature	119
4.5.7. Criticisms of the models	120
4.6. Methodological approach to data collection.....	121
4.6.1. Stage one - Formulation of critical theorems	122
4.6.2. Stage two - Process of enlightenment	123

4.6.3. Stage three - Selection of strategies.....	123
Chapter 5 - Research Design and Data Collection and Analysis Methods	125
5.1. Introduction	125
5.2. Research design	125
5.3. Case-study	126
5.3.1. Definitions, features and functions.....	127
5.3.2. Multiple case-study design	128
5.3.3. Typical criticisms of case-study.....	128
5.4. Data collection	129
5.4.1. Data collection practicalities.....	129
5.4.1.1. Access to the sites	129
5.4.1.2. Difficulties of data collection	129
5.4.1.3. Ethical considerations.....	130
5.4.2. Organisational context of the case.....	131
5.4.2.1. Research environment	131
5.4.2.2. The cases for study	132
5.4.2.3. Selection of participants	135
5.4.3. Data collection methods	137
5.4.3.1. Interviews	137
5.4.3.2. Documentary analysis	138
5.4.3.3. Observation	140
5.4.4. Assuring quality of the data.....	140
5.4.4.1. Validity	141
5.4.4.1.1. Triangulation.....	141
5.4.4.1.2. Respondent validation.....	143
5.4.4.1.3. Disconfirmatory evidence	144
5.4.3.2 Reliability.....	144
5.5. Data analysis.....	145
5.5.1. Framework approach	146
Chapter 6 - Assessing the Merits of the NAPH	149
6.1. Introduction	149
6.2. Steering in the country's health sector: Locating the steering medium (institution) and mechanism.....	149

6.2.1. Societal steering institution in Iran's health system	149
6.2.2. Nature of the steering mechanism.....	150
6.3. Theoretical themes on the nature of the NAPH	151
6.3.1. Consultatively-driven	151
6.3.2. Chosen framework	152
6.3.3. Understandable	152
6.3.4. Freedom guaranteeing/reducing	153
6.2.8. Relevancy	154
6.2.9. Position of the NAPH	154
6.4. Empirical themes on the nature of the NAPH	155
6.4.1. Coverage of the measures	156
6.4.2. Focus on structures over processes	157
6.4.3. Biased approach to the hospitals' performance	157
6.4.4. Disproportionate evaluation of the hospitals.....	159
6.4.4.1. Human resources	160
6.4.4.2. Physicians	160
6.4.4.3. Physical structure.....	161
6.4.4.4. Financial problems.....	162
6.4.5. Low sensitivity to the organisational factors	162
6.4.6. Static and repetitive vs. dynamic structure	163
6.4.7. Cross-sectional vs. continuous evaluation	164
6.4.8. Predictability.....	164
6.4.9. Time lag between on-site survey and scoring	165
6.4.10. Judgemental process of evaluation and standards	165
6.4.11. Turning into an informal procedure	166
6.4.12. Limited focus on clinical performance	167
6.4.13. No clear reward and punishment system	168
6.4.14. Surveyors' issues.....	168
6.5. Perceived repercussions of the NAPH for the hospitals	169
6.5.1. Unintended consequences of the NAPH.....	169
6.5.1.1. Tunnel vision.....	169
6.5.1.2. Stress, pressure, anxiety and intimidation	170
6.5.1.3. Disillusionment and reduced staff morale.....	171
6.5.1.4. Distrust in the NAPH	172
6.5.2. Dysfunctional consequences of the NAPH.....	172

6.5.2.1. Gaming and fixation.....	172
6.5.2.2. Rationales behind the gaming	174
6.5.3. Colonising features of the NAPH.....	175
6.5.3.1. Legal coercion	176
6.5.3.2. Resource (financial) dependency.....	177
6.5.3.3. Legitimacy.....	177
6.5.3.4. Reputation	178
6.5.4. The surveyors' views on the rationales of the hospitals	179
6.5.5. Further rationales for hospitals' compliance	179
6.5.5.1. Religious values and altruism.....	180
6.5.5.2. Scientific nature of the standards.....	180
6.6. Beneficial consequences of the NAPH	181
6.6.1. Fresh pair of eyes.....	182
6.6.2. Lever to exert a pressure on the higher authorities	182
6.6.3. Learning process.....	183
6.6.4. Reminder of the rules and regulations	183
6.6.5. Financial support	184
6.6.6. Benchmark and DDS for the hospitals' authorities (and the MoH's policy-makers)	185
6.6.7. Quality improvement	185
6.6.8. Protection mechanism.....	187
Chapter 7 - Reactions and Rationales of the Hospitals towards the NAPH.....	189
7.1. Introduction	189
7.2. The reactions and change processes in the hospitals	189
7.2.1. Real-life steps of the changes in the hospitals	190
7.2.2. Change effects of the NAPH	191
7.2.3. DAs of the hospitals.....	193
7.2.3.1. Internal quality improvement programmes.....	194
7.2.3.1.1. ISO	194
7.2.3.1.2. Self-developed IQIPs	201
7.2.3.2. Hospital committees	202
7.2.4. The effects of the NAPH on the hospitals' DAs and subsystems.....	207
7.2.4.1. Rejection (Rebuttal)	207
7.2.4.2. Absorption (Reorientation)	209

7.2.5. The effects of the NAPH on the ISs of the hospitals	212
7.2.5.1. The ISs of the hospitals	213
7.2.5.2. Submission (Colonisation)	215
7.2.5.2.1. Intra-hospital variations	215
7.2.5.2.2. Inter-hospital variations	218
7.2.5.3. Adoption (Evolution)	220
7.3. Recommendations for improvement in the NAPH	222
 Chapter 8 - Review and Discussion of the Findings	229
8.1. Introduction	229
8.2. Constitutive nature of the NAPH	229
8.2.1. Theoretical interpretation	230
8.2.2. Empirical interpretation	230
8.2.3. Possible justification for the NAPH's constitutive nature	232
8.3. Repercussions of the NAPH	234
8.3.1. Gaming: Dysfunctional effect of the NAPH	235
8.3.1.1. Types of gaming	235
8.3.1.2. Rationales behind gaming	237
8.3.1.3. Theoretical interpretation of the gaming	238
8.3.1.4. Causes of gaming	240
8.3.1.4.1. Legal coercion	240
8.3.1.4.2. Financial dependencies	242
8.3.1.4.3. Legitimacy	244
8.4. Positive grounds for compliance	246
8.4.1. Beneficial consequences	246
8.4.2. Religious values	247
8.4.3. Scientific and technical nature of the requirements	248
8.5. Perspectives on the professionals' position in the HCOs	248
8.6. The NAPH as an external disturbance	249
8.7. Reactions and rationales of the hospitals towards the NAPH	251
8.7.1. The reactions of the hospitals	251
8.7.1.1. Rejection	251
8.7.1.2. Absorption	252
8.7.1.3. Submission	254
8.7.1.4. Adoption	258

8.7.2. The rationales behind the hospitals' reactions	259
8.7.3. The implications of studying the rationales	261
Chapter 9 - Final Considerations: Concluding Discussion, Research Implications and Limitations	263
9.1. Introduction	263
9.2. Concluding discussion	263
9.2.1. The perceived nature of the NAPH	264
9.2.1.1. The significance of feedback.....	265
9.2.1.2. The relevance of Dysfunctional effects	267
9.2.1.3. The role of financial grounds in the hospitals' conformity	269
9.2.2. The importance of religious elements.....	271
9.3. Research implications for theory	272
9.3.1. Limitations of Broadbent and Laughlin's framework.....	277
9.4. Research implications for policy and practice	279
9.4.1. Careful attention to the reactions and rationales of the hospitals	279
9.4.2. Realising the dysfunctional consequences associated with the NAPH	280
9.4.3. Engagement of physicians	280
9.4.5. Learning from changes implications of the NAPH.....	281
9.4.6. Rectifying faulty communication system.....	281
9.5. Limitations of the study	282
9.6. Directions for future research.....	283
9.7. Final remarks	284
Appendices	289
Appendix A: Introductory information on the profile of the country.....	289
Appendix B: Interview Topic Guide.....	291
Appendix C: Participant Information Sheet (PIS).....	295
Appendix D: Consent Form	297
Appendix E: Research sponsor letter	298
Appendix F: Policy Documents	299
1) The MoH's introduction letter to the potential participant organisation (i.e. the UMS)	299
2) MoH's responsibilities.....	300
3) The translation of MoH's letter to the UMSs about the establishment of the hospital evaluation and accreditation system	302

4) The bylaw number 25337/2/S - 21/06/2008 to the hospitals.....	303
5) Strategic plan of one of the hospitals.....	304
6) Policy guidelines of the ISO 9001:2008 in the hospitals	305
7) Hospitals' rules and regulations	305
Appendix G: Tables for the comparison of accreditation with similar PMSs and related concepts.....	306
Appendix H: Performance Measurement Systems	315
Appendix I: Examples of NVivo nodes and further supportive quotations from the analysis.....	320
Reference.....	325

LIST OF TABLES

Table number	Title	Page
2.1	Models of external assessment methods for healthcare organisations	31
2.2	Characteristics of various studies on accreditation across different countries	54
3.1	The distribution of the NAPH's standards and corresponding scores for different categories of the hospitals' activities	77
3.2	The scoring system of the NAPH for hospitals	79
3.3	Quality-oriented indicators of the NAPH	82
5.1	Criteria for choosing different research strategies	123
5.2	Number and type of the hospitals selected for the case studies	130
5.3	Descriptive information of the hospitals under current study	131
5.4	The number of interviews conducted in terms of different hospitals	133
5.5	The number of interviews conducted in terms of different hospitals	133
5.6	List of the documents used for data collection of research	136
7.1	Key examples of the changes in the structural elements of the hospitals over the course of their evaluation by the NAPH	208
7.2	The evaluation grade of the hospitals under study in the last eight years	215
Appendix A		
1	Selected Indicators of Iran's health status	302
Appendix G		
1	A comparison of four main external assessment models	318
2	Definitions of accreditation, licensure and certification	326

LIST OF FIGURES

Figure number	Title	Page
3.1	Organisational Chart of Iran's Healthcare System Organisation	69
3.2	Classification of Hospitals in Iran's Health System	71
3.3	Philosophy of Accreditation	73
3.4	The typical process of hospital evaluation system in Iranian Healthcare System	80
4.1	Four paradigms for the analysis of social theory	92
4.2	Characteristics of alternative schools of thoughts based on Laughlin's assumptions	94
4.3	Contrasting MRT with other research perspectives	96
4.4	Adaptation of the societal development model for Iran's healthcare system	105
4.5	A model of organisations' elements at micro level	109
4.6	Three stages of my data collection methodology in the light of Laughlin's discursive process	121
6.1	Model of research process in qualitative approach	142
7.1	Organisational chart of hospital committees	201
8.1	The relation of the effect of financial incentives on the quality improvement in the hospitals	239
Appendix A		
1	Map of Iran	301
Appendix H		
1	The performance measurement matrix	327
2	Results and determinants framework	327
3	Performance pyramid system	328
4	Balanced scorecard	328
5	Performance prism	329
6	Input, processes, outputs and outcomes framework	330
7	EFQM Excellence Model	330
8	Kanji's Business Excellence Measurement System (KBEMS)	331

PRESENTATIONS AND PUBLICATIONS

PhD Colloquiums

ICAS Research Event, Edinburgh, March 2010

BAA Doctoral Colloquium, Cardiff, April 2010

MCS Doctoral Colloquium, University of Greenwich, September 2010

Conferences

Jaafaripooyan E., Agrizzi D. (March 2009). A bottom-up approach to performance assessment of a national hospital evaluation programme, International Forum on Quality and Safety in Health Care, ICC, Berlin, Germany

Papers

Jaafaripooyan E., Agrizzi D., AkbariHaghigh, F. Healthcare accreditation system: further perspectives on performance measures. International Journal for Quality in Health Care, 2011, Volume 23, Issue 6

ACKNOWLEDGEMENTS

Before everything, I should thank God for giving me the strength and hope not to lose momentum during this long, challenging journey.

Firstly, I am heartily grateful to my supervisors, Dr Dila Agrizzi and Professor Sally Brailsford, whose encouragement, guidance and support from the beginning to the end of my PhD enabled me to stay focused and find my way through, while allowing me to develop my independent research skills alongside.

This study has been financially supported by Iran's Ministry of Health and Medical Education and Tehran University of Medical Sciences. I would like to, secondly, show my gratitude to them and also to the members of Iran's Scientific Representative Office in London who had an important part in facilitating my access to this scholarship during my study.

Thirdly, I offer my regards and blessings to my parents and parents-in-laws who supported us and bore the difficulties of their children being away from them for quite a long time.

My last, but not least, appreciation is for my beloved wife, Safoura, without whom I could hardly accomplish this grave task. She encouraged me when I was disappointed, allayed me when I was anxious... I owe her a feeling of huge thankfulness.

I should also mention that with the oversight of my main supervisor, editorial advice has been sought. No changes of intellectual content were made as a result of this advice.

LIST OF ABBREVIATIONS

ABC	Activity-based costing
ACHS	Australian Council on Healthcare Standards
ACI	Accreditation Canada Institution
ACSQHC	Australian Council for Safety and Quality in Health Care
ALPHA	Agenda for Leadership in Programs for Healthcare Accreditation
AP	Accreditation programme
ASJ	Amenable to substantive justification
BOR	Bed occupancy rate
BSC	Balance score card
CHAS	Centre for Healthcare Accreditation and Supervision
CISE	Committee for Internal Supervision and Evaluation
CQI	Continuous quality improvement
DAs	Design archetypes
DHN	District Healthcare Network
DRG	Diagnostic-related groups
ED	Emergency department
EESs	External evaluation systems
EMRO	Eastern Mediterranean regional office
ERP	Enterprise resource planning
HBs	Health Bases
HCOs	Healthcare organisations
HHs	Health Houses
HOEG	Healthcare organisations evaluation group
HUMS	Hamedan university of medical sciences
IAP	International accreditation programme
IC	Internal colonisation
IQIPs	Internal quality improvement programmes
I.R.I.	Islamic Republic of Iran
ISs	Interpretive schemes
ISQua	International Society for Quality in Health Care
LOS	length of stay

LP	Legitimised through procedure
LSC	limited-surgery clinic
MCSs	Management control systems
MOHME	Ministry of Health and Medical education
MoH	Ministry of Health
MRT	Middle-range thinking
MSC	Management control system
NAPH	National AP for health care organisations
NCQA	National committee on quality assurance
NHS	National health services
NPM	New Public Management
P4P	Pay for performance
PAF	Performance assessment framework
PAHO	Pan American health organization
PBP	Performance-based payment
PhD	Doctor of Philosophy
PHC	Primary health care
PM	Performance measurement
PMM	Performance measurement and management
PMS	Performance measurement system
PPS	Prospective payment systems
QHA	Quality healthcare advice
SEARO	South-East Asia regional office
SWG	Specialised work group
TQM	Total quality management
TSHAS	Trent Small Hospital Accreditation Scheme
UK	United Kingdom
UMSHS	University of medical sciences and health services
UMS	University of medical sciences
USA	United States of America
USAID	United States of America International development

Chapter 1 - Introduction

1.1. Overview

The public sector is argued to be both practically and politically important, given the criticality of its services and the cost of public service provision (Broadbent et al., 2010a). It is distinguished by two main features (Dixit, 2002); First, public sector organisations are responsive and accountable to several groups (i.e. they have different stakeholders with whom they must comply and communicate). Some refer to the public sector as an area with multiple principals and tasks (Propper and Wilson, 2003; Abernethy et al., 2007). Second, these organisations often have various ends to achieve. Accordingly, performance measurement has been overly crucial in this sector, given these particular characteristics. In addition, the inception of New Public Management (NPM) has reinforced the focus on performance measurement and accountability in this area (Hood, 1995; Lapsley, 2009).

Healthcare, as a key player in the public sector, is also seen as specifically distinct in view of such peculiar features as its life-saving activities (Gauld, 2005; Broadbent et al., 2010a) and the information asymmetry between providers and customers (i.e. patients) in this sector (Montagu, 2003). The importance of health care can be more simply highlighted by the fact that practically everyone (or their close associates) in society will need health services. These features partly cast some light on the reasons why the public sector and health care in particular always remain within the purview of governments' duties in most of the developed and developing countries (Broadbent and Guthrie, 1992; 2008) and why the state is always keen to be involved in the regulation of this sector (Walshe, 2003). They further underscore the necessity of applying reliable and continuously reviewed performance measurement and improvement mechanisms in this area to avoid irremediable harm to vulnerable

consumers and undue costs to healthcare organisations (HCOs) operating in this context (McKee and Healy, 2002; Jovanovic, 2005).

In a similar vein, the government is in charge of healthcare services in Iran, as a developing country. According to the Islamic Republic of Iran's (I.R.I.) Constitution, the government is tasked with providing health care for every single individual in the country (I.R.I., 1979a). In order to fulfil this articulated law, the Ministry of Health and Medical Education (MOHME, in short the MoH hereafter) has been established in the country to plan, organise and control the provision and delivery of quality health care to the society (Majlis, 1985). The MoH owns a centralised fabric and applies a national evaluation (accreditation) programme to measure the performance of its HCOs (Sadaghiani and Zare, 2005).

1.1.1. Statement of the problem

This section provides a brief statement of the research problem. A formative evaluation of the implications of Iran's current accreditation programme in the hospitals along with the results of previous scant literature concerning the performance of this programme revealed a fairly comprehensive unhappiness among most members of the hospitals with the performance and functionality of this accreditation programme. This issue was the main trigger for initiating the current research. In fact, it was important to explore why such perceptions (e.g. discontent) existed among a wide range of the hospitals' members towards the NAPH. In addition, the considerably unchanged nature of the NAPH during a long period of time, despite the existing dissatisfaction and the programme's far-reaching effect, was also a reason for choosing this case for further analysis, in addition to the lack of sufficient relevant studies.

1.2. Purpose of the study

Since its introduction in 1997, Iran's national accreditation programme for healthcare organisations (NAPH) has served as an important element of macro control and regulation in the health sector which reflects, operationalises and guarantees the government's intentions for maintaining and improving quality and safety in the

hospitals across the country (MoH, 1997a; I.R.I., 2004). This externally imposed performance measurement system (PMS) - to be discussed in chapter three - evaluates and rates all types of hospitals (i.e. public and private) annually on the basis of their performance (MoH, 1997a). It is developed in a centralised fashion and is the sole evaluatory mechanism of all hospitals in the country.

Despite the NAPH's vital position in the country's healthcare system and its long-time existence, the contextual effects and implications of operationalising this evaluatory mechanism have not been empirically researched in the current organisational context. There is a lack of empirical evidence in the literature as to how this macro PMS impacts in practice on the hospitals at local level; how do the hospitals perceive and react to this control system, and what factors associated with this accreditation programme (AP) might affect the perceptions and reactions of the hospitals' managerial staff towards this evaluatory mechanism? These 'how' and 'what' research questions are invoked by the current study to render a contextual evaluation of the performance of this national evaluatory system.

The scant existing literature on the performance of the NAPH has taken a rationalistic and instrumental approach to the evaluation of this mechanism. This approach is criticised for dismissing the contextual aspects (Modell, 2001). Moreover, these studies have not detected any significant sign of improvement in the hospitals' performance as a result of this accreditation system (e.g. Baghebanian, 2001; Arab et al., 2005). Therefore, this study aims to pursue the following specific objectives in the light of its theoretical frameworks:

1. To examine the perceptions of the hospitals regarding the nature (merits and worth) of the NAPH;
2. To develop an understanding of the contextual (dysfunctional and beneficial) effects of the NAPH on the hospitals;
3. To investigate the reactions of the hospitals towards the NAPH;
4. To explore the rationales underlying the hospitals' reactions;
5. To identify, in a tentative and speculative fashion, ways of improving the accreditation system in the light of insights from the hospitals.

The first two objectives are dealt with in the chapter six and answers to the remainder are included in chapter seven of this thesis. As such, they all are reviewed and discussed in the chapter eight.

1.3. Theoretical frameworks

As will be elaborated in chapter four, this study is informed by a Middle-Range Thinking (MRT) research approach (Laughlin, 2007). The strength of this approach in allowing prior theories to be utilised in a skeletal fashion for investigating the richness of the empirical context (Modell, 2001, Laughlin, 2004) is the main rationale for its usage in this study. Drawing on this approach, Broadbent and Laughlin's (2005) theoretical frameworks are adopted to both guide the empirical investigation and help with the analysis and interpretation of the empirical data. The significance of these frameworks, informed by Habermas's critical theory, lies in their concern with the critical analysis and evaluation of the phenomenon under study (e.g. the NAPH) (Laughlin, 2007).

1.4. Significance and contribution of the study

The relevance of this research can be briefly discussed from the following perspectives. First, most research on the contextual effects of macro PMSs in health care (e.g. the NAPH) has focused on developed countries (e.g. Broadbent et al., 2001; Modell, 2001; Mannion et al., 2005; Agrizzi, 2008; Chang, 2006), leaving developing countries largely unexplored. Chang (2006), for example, studies the hospital managerial responses to the NHS Performance Assessment Framework (PAF). He concludes that the PAF was mostly used for legitimacy-seeking, rather than for rational strategic performance management by the managers of the hospitals. As such, Mannion et al. (2005) found both perceivably positive and negative effects associated with the NHS Star-rating system. Therefore, given the significance of contextual aspects¹ in the design and effectiveness of PMSs (Broadbent and Laughlin, 2009;

¹. Societal and organisational situation in which the PMSs locate and operate (Broadbent & Laughlin, 2009)

Ferreira and Otley, 2009), the studies considering these elements in investigation of PMSs within unexplored countries could further the debate on performance measurement and management (PMM) practices in the public sector. The organisational context of a developing country, addressed by this research, has been largely overlooked by the mainstream performance measurement and improvement literature.

Second, accreditation is argued to be the most ubiquitous PMS used in health care (Heaton, 2000; Shaw, 2000). Whilst it is set up to evaluate HCOs, its performance also needs to be assessed to both maintain its alignment with the initially determined objectives (Smith et al., 2008; Broadbent and Laughlin, 2009) and improve its merits and capabilities to continuously detect the deficiencies and malpractices in HCOs² (Stufflebeam, 2001; Shaw, 2003a). The critical nature of healthcare processes and outcomes, as discussed earlier (Montague, 2003; Gauld, 2005), and the high cost of APs for both those running and being evaluated by these programmes (James and Hunt, 1996; Cerqueira, 2006) reinforce the necessity for assessing their performance. Previous research on the performance and impact of healthcare accreditation shows mixed and inconsistent results (Greenfield and Braithwaite, 2008; Nicklin and Dickson, 2009). Accordingly, there has been an extensive call in healthcare literature for a theoretical-based assessment of such external PMSs to produce rigorous results on their performance (e.g. Mannion et al., 2005; Øvretveit and Gustafson, 2003; Chuang and Inder, 2009; Walshe, 2007; Grol et al., 2007; Greenfield and Braithwaite, 2009). For instance, Walshe (2007, 2009) suggests using theories from the areas with experience in investigating complex social interventions (e.g. education and society) for researching healthcare quality improvement initiatives. Similarly, Laughlin and Broadbent (1996) argue that, given the complexity of the public sector, particularly health care (Scrivens, 2007), the evaluation of accountability mechanisms (e.g. APs) in this sector needs a complex wide-ranging theoretical design. Ferreira and Otley (2009) similarly bring to the fore the importance of using a theoretical approach to scrutinise the impact of PMSs. Adopting relevant theoretical frameworks, the current study seeks to satisfy the abovementioned call.

². This type of evaluation is labelled as meta-evaluation (Scriven, 2009).

Third, this study is one of the first of its kind to investigate the perceived dysfunctional and beneficial consequences of the NAPH for the hospitals, and examines their organisational reactions and underlying rationales in relation to this evaluatory mechanism. In this sense, it addresses a gap in current performance measurement and improvement literature by providing a case-study of Iranian healthcare accreditation system. Moreover, the study endeavours to provide several practical insights for improvement of the current accreditation system. They would be of a high value for authorities in the MoH to tailor this programme to the local and organisational arrangements and complexities, given their roots in the viewpoints and feedback of the hospitals. Since the NAPH is a national and centralised programme, the results of this research could present a reflection of the hospitals' perceptions and reactions towards its implementation and effectiveness to the directorate of this accreditation system.

Fourth, from a theoretical perspective, this study is a modest effort to provide an example of how Broadbent and Laughlin's framework could be extended from their mainly accounting context to analysing the changes and reactions triggered by a healthcare accreditation and evaluation programme (i.e. the NAPH) in the context of a developing country. The study identifies, synthesises and utilises the virtue of these frameworks, originated from Habermas's societal development model, for critically analysing the merits of this evaluation system. As such, it locates the NAPH in a societal context.

1.5. Motivation of the study

The importance of health care in a society (i.e. the part it plays in all stages of people's lives and the dependence of any and each individual on healthcare services³) can never be ignored. I became interested in the topic of performance measurement after realising its vital position in ensuring quality and safe health care, following my rather lengthy involvement in the area of health care and contact with HCOs as student, researcher or practitioner. This is, in the best fashion, encapsulated in the popular adage of 'no measurement, no improvement' (Harbour, 1997, p. 1). On the

³. Health has been even referred to as a hidden wealth in Islamic religious texts.

other hand, there have always been concerns, among both academics and practitioners, about how to enhance the effectiveness and efficiency of evaluation and control mechanisms and how to maximise their intended consequences and minimise their unwanted and dysfunctional effects on their subject organisations. This has been believed to be overly critical in health care, given its peculiar features (Gauld, 2005).

My analysis of the MoH's policies and legislation revealed that the NAPH remained the only control and evaluatory mechanism for evaluating the performance of hospitals in Iran (MoH, 1997a). Particularly, it was understood that the NAPH is an entirely centralised and uniform system for all types of the hospitals, allowing no consideration of local and contextual elements (e.g. the reactions of the hospitals), and its results have a considerable impact on the survivability of the hospitals. In the light of the prominence of this regulatory mechanism in the country's healthcare system, the current study recognised an urgent need to look into its performance and appropriateness from the local hospitals' perspectives. Such an effort is expected to benefit both those who issue the NAPH (the MoH) and those who are assessed (the hospitals) by this programme. The fact that this area of research has not been explored by previous literature also inspired this study. Therefore, the present study is motivated by this opportunity to remedy the shortage of studies concerned with examining the nature of this macro PMS (i.e. the NAPH) by looking into its local and contextual effects from the perspectives of the selected hospitals.

1.6. The structure of the thesis

The remainder of this thesis is organised into eight chapters, each of which is described briefly below.

- **Chapter two - Literature review of performance measurement systems with reference to hospital accreditation system**

This chapter contains three main parts. The first section provides a general description of performance measurement and its different aspects (e.g. its definition and features). The second part revolves around PMSs in health care, concentrating particularly on accreditation as a well-known external performance evaluation system of HCOs. And

lastly, a review of different studies on the performance analysis of APs is conducted in the third part of the chapter.

- **Chapter two - The organisation of the healthcare system and accreditation in Iran**

Chapter two firstly provides some introductory information about the structure of the healthcare system in Iran. The main focus of the chapter, nevertheless, is on the Iranian healthcare accreditation system. Therefore, a detailed account of the structure and various facets of this mechanism are presented.

- **Chapter four - Research paradigm and theoretical and methodological frameworks**

Since this study adopts two theoretical frameworks for undertaking its empirical investigation and analysis, a single chapter of this thesis is devoted to explaining these frameworks. The chapter commences by expounding the philosophical position and research paradigm of the study. Then, it provides a full elucidation of the applied theoretical and methodological frameworks. The reasons for adopting the corresponding paradigm and frameworks are included within this chapter.

- **Chapter five - Research design and methods**

This chapter elaborates on the research design, data collection methods and qualitative data analysis of the study.

- **Chapter six - The assessment of the merits of the NAPH**

This chapter encompasses the first part of the findings resulting from the study's empirical investigation. It contains the relevant results on the assessment of the merits of the NAPH. The dysfunctional and beneficial effects of this programme for the hospitals are also mentioned within this chapter.

- **Chapter seven - The assessment of the reactions and the rationales of the hospitals towards the NAPH**

Chapter seven covers the second part of the results. It includes the reactions and underlying rationales of the hospitals towards Iran's current AP. As such, it encompasses the changes in the various aspects of the hospitals as a result of the

NAPH. Recommendations provided by the hospitals for making improvements in the performance of the NAPH are also presented in this chapter.

- **Chapter eight - Review and discussion of the findings**

This chapter comprises a review and discussion of the main findings presented in chapters six and seven of this study.

- **Chapter nine - Final Considerations; Concluding discussion, implications and limitations**

Finally, this chapter looks at the conclusions of the research including the concluding discussion, key findings and implications for theory and practice. It also provides the direction for future studies and addresses the limitations of the study.

Chapter 2 - Healthcare Performance Measurement: The Case of Accreditation

2.1. Introduction

This chapter includes three main sections. The main purpose of the chapter is to review the existing literature on the performance analysis of APs. However, there is a need initially to provide introductory background information on performance and performance measurement in health care before embarking upon this process. Therefore, the first part is concerned with providing a general description of performance measurement and its different aspects (e.g. its definition, features and real-life examples). The second part gives an explanation of the PMSs in health care sector, concentrating particularly on accreditation as a well-known external performance evaluation system of HCOs and the subject of the current study. A full exposition of this mechanism and its features follow. Finally, the different approaches to the performance analysis of APs and a review of the relevant studies focusing on this mechanism are discussed in the third part of the chapter.

This chapter seeks to provide theoretical support for the concept of performance measurement in health care, helping the researcher develop an understanding of the performance evaluation of APs based on the existing body of the literature.

2.2. Performance measurement: Definitions

2.2.1. Performance

The term ‘performance’ originally emanates from ‘perform’, which denotes fulfilling an obligation or requirement or accomplishing something promised or expected (Dianis and

Cummings, 1998, p. 50). ‘Performance’ is defined as the manner in which something functions (Øvretveit, 1998, p. 151). Robbins and Coulter (2002, p. 554) describe ‘performance’ as ‘the end result of an activity’. As these definitions imply, performance can be linked to both process and outcome. Lohman et al. (2004) believe that performance is usually illustrated and specified by a performance indicator (PI), a variable that expresses, quantitatively or sometimes qualitatively, the effectiveness or efficiency or both of a process or system against a given norm, target or standard. PI might also be called performance metric or measure (Lohman et al., 2004).

2.2.2. Performance measurement

Performance measurement (PM) has recently assumed a renewed importance in a wide range of organisations (Amaratunga and Baldry, 2002). It is been defined simply as the activity of measuring performance using PIs (Lohman et al., 2004). Similarly, Zairi (1994) refers to PM as a group of yardsticks that show organisations how they are performing and motivate them to do better. According to Moullin (2002), the most quoted definition of PM has been provided by Neely et al. (2002, p. xiii) as ‘the process of quantifying the efficiency and effectiveness of past actions’. Nevertheless, he believes this definition might reduce the opportunity for managers to challenge their PM processes. Therefore, he defines PM as ‘evaluating how well organisations are managed and the value they deliver for customers and other stakeholders’ (Moullin, 2007, p. 181). This definition, as Moullin (2007) puts it, could help managers measure the value they deliver to their customers.

2.3. Significance of PM

Assessment of operations, activities, programmes and organisations is a crucial prerequisite for any improvement process. This importance is largely reflected by some popular PM adages, such as ‘what you measure is what you obtain’ (Kaplan and Norton, 1992, p. 71) and ‘what gets measured gets attention’ (Ridgway, 1956). Similarly, Halachmi (2002, p.13) emphasizes that ‘it might be somewhat impossible to understand what is not measurable’ or ‘if something cannot be understood, it cannot be improved’ (Harbour, 1997). Accordingly, in order to make any improvement in the performance and quality of different programmes, organisations and services, the necessity of considering possibilities

and the quality of measuring their performance is undeniable. A wide range of advantages are attributable to PM (to be discussed later). For instance, de Bruijn (2002; 2007) believes that measuring performance can result in more transparency and learning in organisations. Organisations usually measure their performance either systematically and thoroughly or on an ad hoc basis and superficially (Parker, 2000). Whatever is used for assessing or improving performance and quality, such as process re-engineering, Kaizen, activity-based costing (ABC), total quality management (TQM), continuous quality improvement (CQI) etc., one basic goal is shared: to do better and faster with fewer resources (i.e. in terms of people, time or money). Critical for achieving this goal and preceding and enabling most of the abovementioned strategies and models is the ability to measure the performance (Harbour, 1997). PM is envisaged as the central part of the management process (Speckbacher, 2003). It is also associated with promoting accountability, highlighting the strengths and weaknesses and guiding the resource usage of organisations (Kwak et al., 1997).

2.4. Performance measurement system

Performance measurement systems (PMSs) were historically developed for monitoring and maintaining the control processes in organisations (Purbey et al., 2006). As Lohman et al. (2004, p. 268) put it, ‘a *PMS is a framework (procedure, system, software) to execute PM in a consistent and complete way*’. If designed, deployed and implemented diligently, PMSs could ensure that organisations deliver cost-effective and high-quality services and meet the needs of service users (Moullin, 2004). A sound PMS can provide the basis for an organisation to assess how well it is progressing towards its predetermined objectives, help to identify areas of strengths and weaknesses, and decide on future initiatives, with the goal of improving organisational performance (Purbey et al., 2006).

It is argued that PMSs need to do the following: be sensitive to changes in the external and internal environment of an organisation; review and reprioritise internal objectives in terms of the changes; measure performance from a multi and interrelated perspective; be valid, reliable and easy to use and linked to the organisation’s values and strategy to attain its ends (Bititcti et al., 2000; Purbey et al., 2006). Kravchuk and Schuck (2001, p. 350) point to the following principles for designing an effective PMS:

1. Formulating a clear coherent mission;
2. Developing an explicit measurement strategy;
3. Involving key users in the design and development phase;
4. Developing a multiple set of measures for multiple users;
5. Considering the customers throughout the process;
6. Providing each user with sufficient detail;
7. Reviewing and revising the measures periodically.

Different functions have been considered for a PMS pertaining to the nature of organisations being measured (either public or private). A study by Behn (2003) has envisaged plurality of functions for PMSs. For instance, he indicates that public organisations can use performance measures to evaluate, control, budget, motivate, promote, celebrate, learn, and improve their activities and processes. PMSs can help organisations decide what programmes or projects are worth spending their budgets on, or what accomplishments are worthy of attention and celebration. As such, a variety of models and frameworks have been designed and developed for measuring performance in organisations.

2.5. PMSs in the literature

For many years financial measures have lain at the heart of PM in different organisations (Kennerley and Neely, 2002). The failure of these measures to give a valid picture of organisational performance has led to a revolution in measuring performance and the consequent introduction of non-financial measures along with previous measures (Johnson and Kaplan, 1987; Waggoner et al., 1999; Kanji, 2008). As such, frameworks with the balanced inclusion of measures were introduced (Kaplan and Norton, 2005). Different PMSs for measuring performance of an organisation are mentioned in the literature. Some of the important frameworks are briefly explained as follows (they are displayed in the Appendix H):

Balanced performance measurement matrix: Keegan et al. (1989) presented a balanced PM matrix. It categorises the measures into cost or non-cost and internal or external categories (Kennerley and Neely, 2002). It was rather simple and easy to use for measuring performance and encompassed measures ranging from financial to non-financial indicators

(Neely, 2002). A criticism of this framework is that the matrix does not make explicit links between different dimensions of business performance; in practice, this causes the PM to encounter certain complexities and ambiguities (Purbey et al., 2006).

Performance pyramid system: The performance pyramid system (PPS) was originally developed by Judson (1990) and later improved by (Lynch and Cross, 1991). It is useful for describing how objectives are communicated down to subordinates and how measures can permeate various levels in the organisation. This system monitors performance at different levels of organisations. It tries to make clear-cut differences between measures that are related to external stakeholders' interests, e.g. customer satisfaction and quality, and measures that are primarily aimed at elements within the business, such as products and processes (Purbey et al., 2006). The pyramid starts with quality, delivery, cycle time and waste and cost measures at the bottom, customer, innovation and learning and productivity measures at the second level, market and financial measures at the third and visions, missions and CSFs at the top level of the pyramid (see Appendix H). Some criticise that measures related to personnel have not been accommodated in this approach (Bond, 1999). This framework has been found to be difficult to operationalise (Kanji, 2001).

Results and Determinants Framework: This PMS is composed of six dimensions. Two of its measures, namely competitiveness and financial success, are related to the results of organisational strategy. The remaining four (i.e. quality, flexibility, resource utilisation and innovation) are the determinants of the success of these strategies (Fitzgerald et al., 1991).

Balanced scorecard framework: Kaplan and Norton (1992) presented the balanced scorecard (BSC) framework for measuring performance of an organisation. This model considers four main dimensions in measuring organisational performance, namely financial perspective, internal business perspective, innovation and growth perspective and customer perspective (Kaplan and Norton, 1992). However, in terms of its application in different organisations, the nature and number of its dimensions may be changeable and modifiable (Bontis et al., 1999). Kloot and Martin (2000) maintain that Kaplan and Norton (1992) have considered the three dimensions of quality, flexibility and resource utilization in Fitzgerald et al.'s (1991) model as their own internal business processes dimension. They have also appended that Kaplan and Norton's dimensions can yet be classified as results

(financial, customer) and determinants (internal business processes and innovation and learning).

The BSC communicates, i.e. cascades down, organisations' strategic plans via strategic maps in which the cause-and-effect relationships between the different strategic objectives can be visualised (Urrutia and Eriksen, 2005). In this regard, Kloot and Martin (2008) argue that a strong linkage between strategic plans and performance measures can be provided by BSC and RDF. Despite the success of this framework in measuring a multitude of organisations' performance, some criticisms have also emerged in respect to BSC principles. Some believe that BSC is based on false estimations of the cause-and-effect relationship (Norreklit, 2000; Johnson, 2006); furthermore, the four dimensions of the balanced scorecard are rather simplistic and do not take into account some key stakeholders' interests, e.g. competitors, and in some cases they do not comprehensively cover the performance of related organisation (Chen et al., 2006; Papalexandris et al., 2005). Additionally, Bontis et al.(1999) argue that BSC may create circumstances conducive to reifying the knowledge, i.e. treating it like a physical thing. Putting BSC in the group of strategic performance measurement systems (SPMS), Malina and Selto (2001) indicate that most of the approaches taken to SPMS have a problem since they assume a top-down management approach to control. In addition, BSC has said to fall short of attending to informal control systems and organisational context in organisations (Berry et al., 2009). Ittner et al. (2003) indicate that BSC has been used in a different way to that intended by its designers because the involvement of organisations' superiors in the choice of measures and weightings used in performance evaluations has led to a high level of subjectivity and more emphasis on financial measures.

Brown's input, processes, outputs and outcomes framework: This framework is conceptually appealing and useful, as it highlights the difference between input, process, output and outcome measures (Neely et al., 2001). Brown (1996) argues that each stage of this framework is a driver of performance for its next steps. The framework, partly likened to BSC, develops the concept of linking measures through cause-and-effect relationships.

Performance prism: The performance prism is a multi-faceted framework that has been aimed at addressing the shortcomings of its predecessors, such as BSC (Neely et al., 2001). In this sense, the performance prism is arguably a second-generation performance management framework, designed to provide a highly flexible and broad focus on

organisations' performance (Neely, 2002). It consists of five interrelated perspectives: stakeholder satisfaction, strategies, processes, capabilities and stakeholder contributions (Neely et al., 2002).

2.6. Downsides of PM

Despite the aforementioned explanations concerning PM and its functions and advantages for different organisations, some authors have also attributed negative (dysfunctional) effects to this process in organisations (Ashton, 1976). As Kaplan and Norton (1992) put it, PMSs affect the behaviour of measured organisations' management and employees. Ridgway (1956) argues that measuring performance could have motivational, behavioural and dysfunctional consequences for organisations. Within literature, 'dysfunctional' refers to the actions in which subordinates attempt to knowingly manipulate (violate) the elements (rules and procedures) of an established control (PM) system for their own purposes (Jaworski and Young, 1992, p. 18). Hirst (1983) provides some examples of dysfunctional behaviour in organisations such as rigid bureaucratic behaviour, resistance and invalid data reporting. He argues that the incidence of such behaviours could be affected by the perceptions of organisational members of the way the PMSs are used by their superiors. Smith (1995) and de Bruijn (2007) also recognise some unintended and perverse effects of PMSs.

The following negative effects were found to be associated with PM in the literature:

- PM may add to internal bureaucracy in an organisation

Although organisations with a PMS seemed to perform comparatively better, Leeuw (1996) found that they had invested heavily in their procedural and organisational provisions in order to meet the requirements of their PMS.

- PM may stymie innovation in an organisation

Smith (1993) explains that PM may hamper innovation in organisations. According to de Bruijn (2002), innovative organisations usually seek to explore the unknown and accept the risk, sometimes ending up with either different or less impressive results. Conversely, PM is intended to reward the constant reproduction of the existing output (Behn and Kant, 1999), discouraging any inclination to innovation.

- Measurement in a limited scope

Another dysfunction of PM may be the measuring of the performance of organisations based on a special framework or measures which have been chosen purely for this purpose (de Bruijn, 2002). In other words, measurement in this way may miss some other aspects of the organisations' activities, the measuring of which that framework or those measures cannot anticipate. This has also been echoed by Hariharan et al. (2004) who claim that it is overly difficult to measure the performance of healthcare services using a single method. To overcome this problem, they advised multidimensional PMSs or application of more than one PMS.

- Commodification of the public services

Adcroft and Willis (2005) argue that the increased usage of PMSs in the public sector could cause commodification of the services and generate a highly deprofessionalised workforce who are mostly inclined to obey rules instead of values. As such, the basis of decision-making might change and the values become much less important than the rules, regulations and PMSs in organisations. Such outcomes are ascribed largely to the typical managerial and technical features of standard public PMSs and the difficulties in importing management practices from one context to another (e.g. from private into public sector). This trend began and has been reinforced primarily after the introduction of new public management (Hood, 1995).

- Control effect

Goodhart (1984) has stated that any kind of activity is likely to collapse once pressure is placed on it for control purposes. This is mostly because organisational members may change their conduct when they know that the data they produce will be used to control them.

In addition, Argyris (1999) points to some form of tension produced in organisations as a result of their budgetary control by authorities. Unfavourable reactions could be caused by such control.

- Measurement cost

It should be noted that, as Parker (2000) has indicated, overall, measurement needs resources and it must be basically done with the likelihood of making a real impact.

2.7. PM in health care

The measurement of performance has become increasingly important for different stakeholders such as healthcare policy-makers, providers and patients/purchasers in health care (Øvretveit and Al Serouri, 2006; Smith et al., 2008). Growing demands to ensure transparency, accountability and high quality for healthcare services, controlling costs, and reducing variations in rendering (clinical) services have been put forward as the main triggers for this movement (Hilarion et al., 2008). Performance is perceived as a multidimensional concept in healthcare. According to JCAHO: *'Performance in health care is composed of nine definable, measurable, and improvable dimensions; including, efficacy, appropriateness, continuity, safety, efficiency, effectiveness, availability, timeliness, and respect and caring'* (2002, p. 13).

JCAHO (2002, p. 13) has defined PM as; *'Quantifying processes and outcomes, using one or more of those dimensions'*, and a performance measure (indicator) as a *'Variable or quantitative tool that reveals an organisation's performance in relation to a specific process or outcome'* (p. 13).

Accordingly, it would seem justifiable to claim that a comprehensive and reliable assessment could be rendered by a PMS that encompasses and assesses more PMs (indicators). In fact, given the complexity of health systems owning multiple aspects, measuring performance through single measures has proved to be overly difficult (Smith et al., 2008). As such, reliance on single measures (e.g. efficiency) could provide a large amount of information that would still make little sense to users. Therefore, attention in this area has been drawn towards using composite measures, as the forgoing definition indicates (Jacobs et al., 2007; 2006).

PM is receiving widespread attention in the health care sector (Dummer, 2007; Loeb, 2004; Purbey et al., 2006). Davis (1999) and Shaw (2003b) believe that measurement is central to the concept of quality improvement in healthcare. Brignall (1992) has recognised PM as a key agent for change as well as for maintaining and managing the change in HCOs. The following reasons are raised in the literature to justify the necessity of PM in health care (see e.g. Lansky, 1998; Thompson and Harris, 2001; Behn, 2003):

- Helping private and public healthcare purchasers to make wise financial choices and secure good value for money;

- Enabling consumers to make informed decisions about where to seek and receive the best care available;
- Allowing providers access to reliable and valid data for improving the quality of services; and
- Enabling regulators or officials to ensure they meet minimum standards for healthcare provision, holding the organisations accountable, and obtaining meaningful information for making decisions.

PMSs have assumed various functions in healthcare over time, in order to meet the requirements of those stakeholders (Amaratunga and Baldry, 2002; Eddy, 1998; Kanji and Sa, 2003a; Kanji, 2002b; Purbey et al., 2006; Sinclair and Zairi, 1995; Oakland, 1993).

They include the following:

- Highlighting quality problems and identifying areas of strengths and weaknesses which require priority attention;
- Describing the effect of interventions on people or organisations;
- Maintaining attention on changing customer requirements and competitor actions and ensuring customer requirements are met;
- Checking progress towards the established goals and providing standards for comparisons;
- Providing accountability mechanisms;
- Justifying the use of resources and supporting future resource allocation decisions;
- Communicating goals and priorities to lower levels;
- Acting as a motivation tool;
- Providing feedback for driving the improvement effort.

In general, PM provides healthcare systems and the hospitals at their core (Kanji and Sa, 2003) with reliable evidence regarding their existing practices and the values, beliefs, and assumptions of their diverse stakeholders (Lim et al., 1999). These functions enable the

systems to develop a systematic means for identifying shortfalls and improving their future performance (Lim and Tang, 2000).

2.7.1. History of PM in health care

PM is not a new initiative in healthcare and has been in existence for well over a hundred years. A brief historical exploration shows that, by the middle of the 19th century, Florence Nightingale was collecting mortality data and infection rates from the principal hospitals in England during the Crimean War. In the 1860s, she pioneered the systematic collection, analysis and dissemination of comparative hospital outcomes data in order to understand and improve performance (Smith, 2002). However, PM began to emerge as a viable tool for assessing healthcare quality in the early 20th century, when Dr Ernest A. Codman proposed an elaborated procedure for collecting patient records, tracking post-discharge follow-up, identifying the best and worst surgeons based on the actual results of their care, and investigating patient access to the results of various treatments including inter-hospital comparisons (Smith, 2005). Although operationalisation of prior principles was hampered because of many practical, professional and political impediments at the time, those principles at least acted as a trigger for further developments in the PM area. Since then, in the light of recent developments in health care which put large-scale data resources at HCOs' disposal, more attention has been paid to PM in health care (Smith, 2002).

2.7.2. Difficulties of measuring performance in health care

Brignall and Modell (2000) argue that the successful implementation of multidimensional PMSs such as BSC (Kaplan and Norton, 1992) and PPS (Lynch and Cross, 1991) in the public sector, including health care, might prove difficult. Public sector organisations are characterised by multiple stakeholders including complex, heterogeneous and intangible services; they also operate in highly uncertain circumstances, which could make PM challenging (Neely et al., 2000b, Abernethy et al., 2007). West (2001) echoes the differences between HCOs and other organisations, such as business firms and industries, in researching their performance. A significant part of this challenge and difficulty in measuring performance in health care derives from the disparate nature and variable perspectives represented among the key stakeholders in this area (Blank and Valdmanis,

2007). For example, the professional perspective - held by some physicians, nurses, and scientists who are trained to think critically and analytically - is that PM is simply too fraught with problems to be of practical use (Loeb, 2004). According to them, what is being measured in HCOs as performance is usually the easiest (i.e. the cheapest) aspects of care which are often of least importance in improving quality (Loeb, 2004).

Another issue relative to this challenge arises from intangible and long-lasting outcomes of health care, which has made the measurement process to some extent impossible and problematic (de Bruijn, 2002). Despite the fact that there is a preference to measure health outcomes, since people show more concern about them (Eddy, 1998), the results of interventions in this sector usually take a long time to become completely comprehensible. The outcomes can hardly be attributed to the interventions in a tangible way. Eddy (1998) also points to further problems such as probabilistic and low-frequency (hence difficult to measure) healthcare outcomes and inadequate and ineffective information systems in this sector as the important impediments that make PM highly problematic in this area.

Furthermore, PM is seen as a costly endeavour, particularly by those focusing on the operational and financial aspects of health care (Loeb, 2004).

2.7.3. Unintended and dysfunctional effects of PM in health care

As explained in section 2.6 regarding the overall downsides attributed to PM, there are some dysfunctional consequences in relation to PM and PMSs in health care. The following negative effects could be found in the existing literature (see e.g. Bevan, 2006; Bevan and Hood, 2006a; 2006b; Goddard et al., 2000; Mannion et al., 2005; Goddard et al., 2002b; Hannan et al., 1994; Keogh and Kinsman, 2004; O'Neill, 2004; Kelman and Friedman, 2009).

- Gaming: this simply means hitting the target and missing the point, and happens when an organisation adopts a fabrication strategy to meet the requirements of a PMS in that, in some cases, data are manipulated to achieve the related grade or score. Alternatively, it is when the subordinate knowingly selects his activities so as to achieve a more favourable measure (Birnberg et al., 1983). According to Birnberg et al. (1983), the lower the belief in the measurability and analysability of

performance data, the higher the possibility for gaming by those generating this data or are involved in data related activities.

- Tunnel vision: this happens when the HCOs and professionals' time and concentration are directed to achieving the measures of PMSs, while other, even important, clinical priorities not required by those systems are ignored. This might hinder the delivery of good-quality health care as professionals' attention is drawn towards compliance with performance measures rather than to the needs of patients (Werner and Asch, 2007). In fact, attention might be drawn towards what is measurable rather than what is important for patients' health.
- Ossification: this indicates that HCOs mostly focus on routine and specified areas (by PMSs) by providing services in ordinary and conventional ways, rather than trying new methods, to avoid missing their chance of higher rankings. Ossification could hamper innovation in organisations.
- Reluctance of service providers to act on difficult cases: HCOs prefer to focus on easy cases when reporting their performance, particularly if the measures of the PMSs are related to intangible measures (e.g. outcomes). This could increase the chance of a successful performance result for the organisations; nevertheless, they could run the risk of ignoring the complex and critical care delivery results.
- Bullying and intimidation: this could be caused by the pressures of meeting the PMSs' requirements, both by internal managers or external authorities.
- Erosion of public trust: HCOs with low rankings could obviously lose the confidence of the public, because of their low grade and apparent poor performance. Mannion et al. (2005) believe that hostile media and journalistic approaches to medical errors nowadays play an important part in creating such a situation in most developed countries.
- Reduced staff morale: as a result of low ranking and working in a lowly-rated (prestige) organisation, the morale of the organisational members might be reduced.
- Ghettoisation: this points to a situation in which staff are more attracted to highly-rated HCOs and are more reluctant to work in lowly-rated ones.

- Disincentives for improvement: the perception that more resources are being allocated to lowly-rated hospitals by governments might act as a disincentive for highly-rated HCOs to strive for improvement in their services.

2.8. PMSs in health care

Overall, most of the healthcare PMSs originated and developed outside this area in the industrial sector and over time have been adopted into this sector (Ballantine et al., 1998; Brignall and Modell, 2000). As is rightly emphasised by Walshe and Smith (2006), health service leaders have tried to manage their organisations, measure their performance and search for greater efficiency by successful adoption of industrial and commercial models. The arrival of new public management (NPM) has seemingly accelerated this process of infiltration (Hood, 1991; 1995).

Different types and classifications of performance measurement approaches, models and methods for health care have been discussed in the literature. Powell et al. (2009) argue that there has been little uniformity in nomenclature/content of these programmes. Many HCOs have accordingly used a combination of measurement and improvement systems and methods eclectically and variably over time.

Overall, PMSs in health care could be discussed from two main perspectives; internal or external, based on whether they are managed by given organisations or used by an external body to assess the organisations' performance. The intention here is to briefly review these PMSs and their characteristics in health care. This section could guide the study to elaborate on the most applied and suitable PMSs for health care and make the context conducive to the investigation of APs.

2.8.1. Internal PMSs

HCOs may use different strategies and measurement frameworks to assess and improve their internal activities and processes. These systems are mainly developed and conducted or adopted and adapted by the organisations themselves to improve their general performance. Internal measurement systems might also be referred to as management control systems (MCSs) in the literature (e.g. Berry et al., 2009; Otley, 2003; Simons,

2005; Tuomela, 2005). Different types in this group were explained earlier in this chapter (see section 3.5). Critical pathways of care (CPC), BSC (Kaplan and Norton, 1992), Kanji business excellence measurement system (KBEMS) (Kanji, 1998; Kanji, 2002), and analytic hierarchy process (AHP) (Hariharan et al., 2004) are examples of this group⁴ found to be mostly used in health care and they will be discussed here.

2.8.1.1. CPC

CPC is a tool for identifying, evaluating and then modifying processes of care delivery (Johnson, 1997). It represents management plans that display goals for patients and provide a sequence and timing of actions necessary to achieve these goals with an optimal efficiency (Every et al., 2000). Managers have embraced critical pathways as a method to reduce variation in care, decrease resource utilization, and potentially improve healthcare quality. This technique was first developed for use in industry as a tool to identify and manage the rate-limiting steps in production processes (Every et al. 2000). However, it has developed quickly in healthcare and seems to follow a mainly clinical approach for improving quality of processes. Critical pathways are also called ‘tracer methodologies’ in a recent study (Greenfield and Braithwaite, 2009, p.162). They are said to focus on processes, functions and systems that may affect patient care, and examine patients’ trajectory through the health system (Greenfield and Braithwaite, 2009). The following potential benefits are associated with this performance evaluation technique in a healthcare context (Johnson, 1997, p. 7):

- Improved patient outcomes
- Improved consistency in care
- Continuous clinical audit
- Continuous standard/guideline monitoring
- Organisation-wide involvement in a quality improvement process

CPC is nevertheless criticised for not being an evidence-based mechanism, as it is argued that it mostly relies on the use of internal, institution-specific expert knowledge of healthcare professionals (Renholm et al., 2002; Bailey et al., 1998). In addition, Lim et al.

⁴. Other PMSs might be added to this group.

(1999) argue that CPC has, to a large extent, fallen short of addressing the needs of organisations' external customers.

2.8.1.2. BSC

As discussed earlier in this chapter, BSC is of an integrative and multidimensional nature (Kaplan and Norton, 1992; Kaplan, 2001). It has been referred to as a strategic performance PMS in that it links strategy to performance measures and to other systems in organisations, such as human resources, information technology and customer networks, as well as translating strategy into a coherent set of performance measures (Chenhall, 2005; Berry et al., 2009). According to Inamdar et al. (2002, p.179), BSC could provide the following advantages for a HCO:

- It can align organisations with a more market-oriented, customer-focused strategy;
- It is able to facilitate, monitor, and assess the implementation of strategy;
- It may act as a communication and collaboration mechanism;
- It can assign accountability for performance at all levels of organisations;
- It provides continuous feedback on the strategy and promotes adjustments to marketplace and regulatory changes.

Although BSC applications in HCOs have just begun, several studies have described the use and potential benefits of this framework in various healthcare settings (e.g. Abasolo, 2006; Baker and Pink, 1995; Castaneda-Mendez et al., 1998; Chen et al., 2006; Inamdar et al., 2002; Voelker et al., 2001; Pink et al., 2001; Curtright et al., 2000; Stewart and Bestor, 2000). It has been concluded that BSC can be successfully applied in the health sector following the investigation of some important aspects of BSC in nine HCOs which were implementing this framework (Inamdar et al., 2002).

2.8.1.3. KBEMS

KBEMS, like BSC, supports a balanced view of performance measurement but is based on Critical Success Factors (CSFs). CSFs are crucial areas, characteristics, conditions or

variables purported to be the drivers of performance (Leidecker and Bruno, 1984; Hariharan et al., 2004). They can have a significant impact on the successful management of an organisation if properly sustained, maintained or managed. KBEMS is a performance management system based on these factors, using pertinent indices to determine how well different areas of the organisation perform (Kanji and Wallace, 2000). It is *de facto* characterised by its multidisciplinary systems approach, which enables measurement of business excellence from various stakeholders' perspectives (Hassan, 2006). The model is composed of two different frameworks, i.e. Kanji's Business Excellence Model (Kanji, 1998; Kanji, 2002) and Kanji's Business Scorecard (Kanji and Sa, 2002) which are dedicated to the measurement of performance from organisations' internal and external stakeholders' perspective respectively (Kanji and Sa, 2003). Basically this model (see Appendix H) is grounded in TQM and BSC in that it has a systematic approach to organisations, as does TQM, and uses a multidimensional measurement approach, as does BSC (Kanji, 2002). This model has been used in different areas in the public sector including health care (Hassan, 2006).

2.8.1.4. Surveys

This is also another method for conducting performance assessment in the healthcare sector. Rising awareness levels and knowledge among customers have forced HCOs to pay more attention to their views in assessing and improving performance and quality in the process of delivering healthcare services (Kunst and Lemmenc, 2000; Lin and Clausing, 1995). The reliance on customers' views in such a process is called client quality (Øvretveit, 2000). Two main approaches have been more noticeable under this method in health care, namely QFD⁵ and SERVQUAL⁶. They have helped HCOs to consider their customers' needs and expectations as their priorities in developing and assessing their

⁵. Quality function deployment (QFD) started in Japan in 1972 and is used widely by Japanese and Western manufacturing companies to ensure the quality of their products (Lim et al. 1999). QFD is described 'as a procedure or technique for converting the customers' demands into 'quality characteristics' and developing a design quality for the finished product by systematically deploying the relationship between the demands and the characteristics, starting with the quality of each functional component and extending the deployment to the quality of each part and process (Akao, 2004, p.5).

⁶. Service Quality (SERVQUAL) is considered the most popular framework for measuring service quality, founded on the view that the customers' assessment of service quality is paramount (Buttle, 1996; Caruana et al., 2000). Parasuraman et al. (1988) have also defined service quality as 'global judgment, or attitude, relating to the superiority of the service' (p. 16).

performance and services (Zabada et al., 1998; Parasuraman et al., 1994; Akao, 2004). QFD has been extensively applied to health care (e.g. Mazur et al., 1995; Radharamanan and Godoy, 1996; Dijkstra and van der Bij, 2002). SERVQUAL, developed by Parasuraman et al. (1988), has been recognised in the literature as a valuable tool for measuring stakeholders' perceptions and expectations of organisations' services (e.g. Buttle, 1996; Caruana, 2002; Caruana et al., 2000). It has also been widely used in healthcare sectors across different countries (e.g. Babakus and Mangold, 1992; Lam, 1997; Rose et al., 2004; Taner and Antony, 2006). In health care, as Shaw (2003b) has pointed out, standardised surveys of patients and relatives can reliably measure hospital performance against explicit standards. The identification of what is valued by patients and general public and the measurement of specific domains of experience and satisfaction can be mentioned as advantages to be gained from the application of these methods for measuring and assessing healthcare performance. Nevertheless, the main disadvantage of this method is that surveys only provide opinions and cannot always be relied upon. In other words, they may suffer from lack of reliability or validity (Sitzia, 1999). In healthcare in particular, patients may give a relatively superficial overview of the care they receive as a result of their lack of awareness and limited knowledge of treatment processes (Walburg et al., 2006). Standardized, systematic and sound methodology and the use of qualitative methods may make this measurement tool more reliable and valid, as there is some evidence in this case (Bechel et al., 2000; Fremont et al., 2001).

2.8.1.5. AHP

AHP is of a quantitative nature and, like KBEMS, it is grounded in CSFs. It was originally developed by Saaty (1980) in the 1970s as a flexible multi-criteria decision-making procedure. It helps to set priorities and to make the best decision when both qualitative and quantitative aspects of a decision need to be considered (Ahsan and Bartlema, 2004). In addition, it provides a comprehensive and rational framework for structuring a problem, representing and quantifying its elements, relating those elements to overall goals, and evaluating alternative solutions. However, given its functions, AHP is recommended as a valuable tool to measure the process-based performance HCOs. For this purpose, it briefly involves the following steps (Hariharan et al., 2004):

- Identifying CSFs, sub-factors and the way of rating them

- Constructing hierarchical model
- Comparing CSFs and sub-factors in pair-wise mode to derive their importance and assigning weights to the individual ratings
- Deriving the weights of ratings
- Gap analysis by comparing the ratings individually and cumulatively

Hariharan et al. (2004, p. 310) indicate that HCOs would gain the following benefits by using AHP to measure their performance:

- The healthcare service is multi-factorial, the factors are both objective and subjective in nature and measurement of the performance of such a system can be easily modelled using AHP;
- Performance measurement is also a group decision-making process, and AHP allows the same;
- This model enables identification of the deficiencies in specific areas of the organisation;
- It allows a sensitivity analysis to be conducted that may help the organisations' managers to understand the effect of their decisions and prioritise the areas requiring improvement.

There have been many applications of AHP in health care: for instance, an application for monitoring healthcare performance (Ahsan and Bartlema, 2004), and specifically measuring process-based performance of hospitals (Hariharan et al., 2005; Hariharan et al., 2004). Furthermore, this model has been also used for decision-making through patient involvement (Dolan, 2000) and for human resource planning (Kwak et al., 1997).

As such, Powell et al. (2009) have also found initiatives such as Business Process Re-engineering, rapid cycle change, lean thinking and Six Sigma in their review of quality improvement programmes used in health care.

Ibrahim (2002) also identifies PMSs such as performance measurement matrix (Malloch, 1999) and multidimensional performance measurement model (Popovich, 1998) in his study of measurement systems in health care.

Overall, a review of these models shows some strong commonalities among these systems. Although they have different emphases, many share similar underlying objectives and the distinctions between them are sometimes blurred in practice. In addition, given the nature of healthcare, multidimensional and composite measurement systems are more prevalent in this area. However, caution should be attached to an over-reliance on performance measures and indicators. Carter et al. (1995, p.49) argue that performance indicators are mostly ‘tin-openers’ rather than ‘dials’; thus, they only prompt more investigation and, by themselves, provide incomplete pictures of performance.

2.8.2. External PMSs

This group of measurement systems/approaches is mostly executed by external bodies (i.e. government or independent organisations). Health care has been considered a realm of governments and they invest a considerable amount of money in this area in most countries, either directly or indirectly, and in return expect high-quality services from this sector (Smith et al., 2008; Broadbent et al., 2010a). As such, they employ a wide range of mechanisms/programmes to assess and improve the performance and quality in HCOs.

In some cases, governments have used the internal PMSs to develop their own measurement system; for example, NHS Performance Assessment framework (PAF) which was based on a BSC approach (Chang, 2007). Governments might also take advantage of the results of external PMSs run by independent (e.g. JCAHO in the USA and Care Quality Commission⁷ and Monitor⁸ in the England). Two main forms of external measurement approaches include:

- Regulatory inspection
- External (third-party) assessments

2.8.2.1. Regulatory inspection

This method of assessment usually comes in the form of compulsory registration and licensure of HCOs, mostly by governments (Shaw, 2004c). People or organisations can be

⁷. The Care Quality Commission (CQC) is the independent regulator of health and adult social care services.

⁸. Independent regulator of NHS Foundation trusts.

registered or licensed after meeting inspectorates' minimum standards. In fact, these statutory programmes ensure that professional staff or provider organisations have achieved the minimum standards of competence. There are also function-specific inspectorates for public health and safety (e.g. fire, radiation and infection controls). For example, most countries have statutory inspectorates to monitor compliance of HCOs with published licensing regulations. Inspection standards are transparent, have legal authority, induce conformity and address the minimal legal requirements for a HCO to provide care for patients. However, since they are similar to legal regulations in the public domain (Shaw, 2003b) the standards are not easily updated. Moreover, in terms of addressing minimum standards of structure and capacity to protect basic public health and safety, inspection does not *de facto* assess hospital performance, foster innovation or provide information for consumers or providers (Shaw, 2004b).

2.8.2.2. External (third-party) assessment

External review systems/programmes run by third-party organisations are affecting the delivery of health care around the world and the application of these methods is becoming more commonplace worldwide (Shaw, 2003b). This is believed to be mainly because governments, consumers, professionals, managers and third parties are trying, separately, to set up or find reliable schemes to ensure public accountability, transparency, self-regulation, quality improvement and value for money in the services (Shaw, 2001; Smith et al., 2008). Heaton (2000) argues that the following changes and developments have played an important role in pressing health services providers to employ external review systems to bring trust and a measure of comparability to their services and meet the rising demands for accountability from consumers and healthcare funders.

- Rising quality consciousness;
- Separation of providers and purchasers;
- Changes in the way health services are financed; and
- Consumers' growing expectations of better healthcare.

These external evaluation systems (EESs) used in health care have been placed into four main categories by Bohigas and Heaton (2000) (see Table 3.1):

1. Certification by ISO
2. Business excellence award (MBNQA, EFQM)
3. Professional peer review (Visitation/*Vasitatie* in Dutch)
4. Accreditation

Of those, the first two are industry-based and the others are healthcare-based (Shaw, 2004b). These external PMSs are usually voluntary and independent; they link national or international standards to local practices of private or public HCOs, and use explicit standards to combine internal self-assessment with external review by conducting visits, surveys, assessments or audits (Shaw, 2000, 2001). Bohigas et al. (1996) and Bohigas and Heaton (2000) have mentioned three main stages for EESs, consisting of the following:

1. The development of standards; developing, testing and finalising related criteria and standards
2. The selection, training and monitoring of evaluators; all the activities undertaken to prepare reviewers to gather information about the performance and quality of the organisation to be evaluated
3. The evaluation process; what the evaluator performs to give an informed opinion about the quality and the performance of the reviewed organisation

The evaluation process, on its own, encompasses the following phases (Bohigas and Heaton, 2000):

Survey: the primary fact-finding phase which takes the form of a team of professionals visiting the institution and writing a report of their findings. This can be divided into three sub-phases:

- Preparation; all activities carried out by the evaluating body and the organisation to prepare for the survey evaluation, including self-assessment and audit plan
- Survey; the intention is to gather information in order to write the report
- Report; prepared to form a basis for evaluation

Evaluation phase: it is contingent on the survey; that is, the evaluators use the criteria and scores to grade and eventually give an award/certificate to the evaluated organisation. The report may be examined by an individual or a committee that applies explicit rules and implicit judgement when making the decision on whether or not to accredit/certify the

institution. This phase may comprise an evaluation committee, rules for making a decision, a certificate or award, an appeal, and publication of results.

Table 3.1 Models of external assessment methods for healthcare organisations (*Source: developed by the author*)

External Evaluation Systems (EESs)	Description
Accreditation	A public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of the organisation's level of performance in relation to the standards. These programmes, which began with a focus on training, have developed into multi-disciplinary assessments of healthcare functions, organisations and networks. They began in the Anglo-Saxon countries, but spread into Latin America, Africa and South East Asia during the 1990s and onwards.
Peer review (Dutch <i>visitatie</i>):	This uses a collegial approach, usually within a single discipline. It is mostly applied to the assessment and formal accreditation of training programmes, but can be extended to accredit clinical services (Weert, 2000).
The Malcolm Baldrige model for quality management And EFQM	The Baldrige criteria for management systems have devolved from the USA into national and international assessment programs such as those found in Australia and Europe (Nabitz et al., 2000). Healthcare providers who seek voluntary development may assess themselves, or be assessed by others, against explicit performance standards. These were designed for application to service industries, but the revised 1999 European Foundation for Quality Management (EFQM) model identifies specific domains of results applicable to clinical outcome, and patient and staff satisfaction, and offers a transparent framework on which organisational standards may be mapped.
ISO: the International Organisation for Standardization	This system provides standards against which organisations or functions may be certificated by accredited certification bodies or organisations. Although originally designed for the manufacturing industry (e.g. for medicines and medical devices), these standards are now applied to healthcare – in particular, to radiology and laboratory systems – and more generally, to quality systems in hospitals and clinical departments (Sweeney and Heaton, 2000).

Between surveys: this phase involves activities that prevent the evaluated organisations from dropping their standard of performance between surveys, such as agreed quality action plan, an interim visit, unannounced surveys.

Briefly, the evaluation process of the four above-mentioned models share the following common steps (Bohigas, 2000):

- Voluntary initiation by a HCO
- Self-assessment by the organisation
- Agenda or audit plan
- Evaluative on-site visit by trained reviewer or evaluation team
- Written or verbal report
- Evaluation of findings and final award

These elements are, as Bohigas (2000) argues, essential for a structured approach to the external evaluation of HCOs.

2.8.3. The EESs: Similarities and Differences

A number of similarities and differences are mentioned in relation to the foregoing models of EESs (see Appendix G, Table 1). Despite these similarities, the accreditation system has some special characteristics that make it more suitable for external quality evaluation of HCOs. Accreditation is initially originated from health care and has been developed specifically for this sector; therefore, the standards are more specific to HCOs than ISO or EFQM (ACSQHC, 2003b). In addition, having been set up in 1917 as a hospital standardization programme and modified in 1947 for evaluating the competence of HCOs, it has been the longest-established programme in this regard (Shaw, 2000; Heaton, 2000). As such, accreditation has been developed for whole organisation assessment, whereas other models do not cover all parts together; ISO is more related to administrative activities and has been mainly used for individual departments and quality systems (e.g., laboratory and radiology); EFQM covers such areas as clinical results, patient satisfaction, administration, and staff management (Shaw, 2001; Heaton, 2000; Bohigas and Heaton, 2000); and Visitation usually focuses on the individuals' or clinical teams' competencies, i.e. knowledge, skills and attitude (ACSQHC, 2003b). It has traditionally considered

examining the functions and skills of a group of people as a starting point rather than looking at the organisation as a whole (Klazinga, 2000).

In contrast, the revised version of the ISO 9000 series (issued in 2000) is more like EFQM and accreditation and has an increased emphasis on management and organisational development (Heaton, 2000); the strengths of EQFM, as Klazinga (2000) has explained, are its simplicity, fairly low implementation cost and internationally empirical validation. The Visitation has also been expanded to focus on clinical practice, professional development and service quality (ACSQHC, 2003b). Applicability of the ISO system to the health sector has been questioned. Heaton (2000) has argued that ISO 9000's appropriateness for the healthcare sector is not universally accepted. For example, in 1996 a number of German medical associations and insurers criticized certification of hospitals by ISO standards because ISO did not have sufficient emphasis on staff, clinical (or health-related) outcomes and the population impact of health services (Heaton, 2000). Shaw (2003) states that ISO measures hospital performance in terms of compliance with international standards for quality systems, rather than in terms of HCOs' functions and objectives, and its popularity may be mainly due to its international recognition. ISO is mainly suitable for individual departments such as radiology and laboratories, as noted earlier, and few entire hospitals have applied its standards in many countries (Heaton, 2000). Another cited weakness of Visitation is that, unlike the three other models, it does not award any certificate of achievement. As regards accreditation, Heaton (2000) indicates that, with some specialty-specific exceptions, for example clinical and pathology accreditation (CPA) in the UK, accreditation has had a significant uptake in those countries where the EESs are entirely operational. For example, in the UK more than 30% of NHS Trusts and more than 80% of clinical pathology laboratories use accreditation, as compared to around 20% of the Trusts achieving ISO in part (for some functions of healthcare provision) and only around 1% implementing ISO thoroughly. This rate is around 4% of the Trusts for EFQM implementation. Visitation is gradually gaining popularity (Heaton, 2000). In USA, around 80% of hospitals are being evaluated by APs (Walshe and Shortell, 2004). de Walcque et al. (2008) also point to an increase in the number of countries engaging in healthcare accreditation.

Some commentators have considered the following features to be highly influential for the success of accreditation (e.g. Scrivens and Lodge, 1997; Donahue and Vanostenberg, 2000; Heaton, 2000):

- Performing a comprehensive, multidisciplinary assessment of HCOs;
- Suiting the peculiarities of health care (because of originating from this sector);
- Pursuing improvement along with assessment;
- Evaluating by trained and healthcare-oriented surveyors.

Donahue and Vanostenberg (2000) particularly stress that accreditation by employing a systems' approach, quality monitoring, management framework and, finally, a total quality evaluation, could serve as the best tool to facilitate the convergence of the strengths of other quality evaluation models into a common multipurpose model. In other words, they stipulate that APs can provide a comprehensive framework within which quality management from EFQM, quality control from ISO and peer assessment from visitation would be integrated.

In the light of this importance, superiority and suitability of APs for evaluating HCOs, this study intends to focus on this evaluatory mechanism by conducting a theoretical and empirical evaluation and analysis of its performance. To this end, the study has drawn insights from different theoretical and conceptual models (explained in chapter four).

2.8.4. Accreditation

Efforts to find effective mechanisms which both evaluate the performance of HCOs and meet their stakeholders' expectations have never stopped thus far (Roa and Rooney, 1999). Although these functions seem imperative for any assessment framework, there is less agreement as to which evaluation approach can best fulfil them (i.e. meeting expectations of relevant stakeholders such as the providers, regulatory agencies, third parties, and patients). Selecting the right evaluation approach or combination thereof requires a careful analysis and prioritisation of users' needs. In the meantime, there has been a rapid growth, in both developing and developed countries, in the application of quality assessment methods by governments (Montagu, 2003). These methods were expected to improve the quality of services provided by HCOs and bring a measure of accountability and comparability to service standards (Heaton, 2000). In light of its various properties and capabilities, as mentioned earlier, such as ensuring public accountability, increasing

transparency, promoting self-assessment and quality improvement and suiting the peculiarities of health care (Scriven, 1997; Donahue and Vanostenberg, 2000; Shaw, 2001, 2003; Dickson and Nicklin, 2008; Greenfield and Braithwaite, 2009), accreditation could satisfy the stakeholders' preferences and attract the attention of different groups seeking an effective evaluation method. Accreditation has reportedly received more attention than other external assessment mechanisms (Paccioni et al., 2008; Lombarts et al., 2009).

2.8.4.1. History of accreditation

Historically, the first attempts to use accreditation date back to Dr Ernest Codman's efforts in the United States in 1910 that led to the founding of the American College of Surgeons (ACS) in 1913 by Franklin Martin, Codman's colleague, and then the establishing of the Hospital Standardization Programme (HSP) in 1917 (McIntyre et al., 2001; Rawlins, 2001). Thereafter, and following the interest in the standard-based assessment of hospital performance, the ACS joined with other professional associations of doctors and hospitals as corporate members to form the Joint Commission on Accreditation of Hospitals in 1947. During the mid-1960s, accrediting activity was extended to long-term care and since then to other types of healthcare centres. As such, in 1986 its name was changed to the Joint Commission on Accreditation of HCOs (JCAHO). In essence, the Joint Commission has focused its efforts on where most people get their care, i.e. hospitals (Bohigas et al., 1996). The Joint Commission's model, JCAHO, spread first to other English-speaking countries, that is Anglophone countries such as Canada (in 1958) and Australia (1974), and then into Europe (Shaw and Brooks, 1991; Giraud, 2001), Latin America (Arce, 1999), Africa (Whittaker et al., 1998) and South East Asia (Ito et al., 1998; Huang et al., 2000) during the 1990s. In addition to voluntary programmes, mandatory programmes have also recently been adopted in France, Italy and Scotland. At least 28 countries now have an operational AP (WHO, 2003).

2.8.4.2. Accreditation: Definition and Importance

The term 'accreditation', applied to organisations rather than specialty clinical training, reflects the origins of systematic assessment of hospitals against explicit standards (WHO, 2003). Accreditation is defined as follows:

'Initiatives to externally assess hospital against pre-defined explicit published [written] standards in order to encourage continuous improvement of the health care quality' (de Walque et al., 2008, p. i).

Accreditation could be generally considered as an external evaluation system (EES), mechanism, programme or scheme, which assesses the performance of HCOs (mainly hospitals) by investigating their compliance with the pre-established standards aiming at continuous improvement of quality rather than simply maintaining minimal standards (Shaw, 2004; Pomey et al., 2005; Braithwaite et al., 2010). Analysis of the related literature has revealed that accreditation also has the following important features (e.g. WHO, 2003; Shaw, 2004c; Shaw, 2004b; Scrivens and Lodge, 1997; Heaton, 2000; Donahue and Vanostenberg, 2000):

- The longest-established and most widely-known process for the external evaluation of healthcare services;
- A formal process to ensure delivery of safe and quality health care;
- Accreditation standards and processes are devised and developed by healthcare professionals for healthcare services;
- A developmental process using the skills of an external, multidisciplinary and trained team of assessors.

Accreditation *de facto*;

- Is the public recognition of the achievement of accreditation standards by a HCO, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards;
- Is generally voluntary (with the exception of some mandatory programmes, e.g. in France) and available to public and private sectors;
- Is mostly implemented by independent organisations, e.g. JCAHO in the USA;
- Covers a range of healthcare environments from local community-based care through to tertiary-level providers and healthcare systems, but mainly hospitals;
- May have specialised healthcare services as a particular focus;

- Is awarded based on achievement of quality standards and the independent external survey by peers of an organisation's level of performance in relation to the standards.

Central to accreditation are two important features: the principle of external review and the use of standards (Scrivens, 1995a); the survey team evaluates hospitals' degree of compliance with a series of previously-determined standards and, if the compliance is achieved, the hospital receives a certificate of accreditation which is valid for a specific period of time, from one to three years. Zende (2006) argues that accreditation can prove to be a performance management system, because it is able to both improve incrementally the standards of care and provide salient recommendations for enhancing the compliance with standards and consequently improving the HCOs' performance. Furthermore, this programme has proved that it can provide educational guidance for the staff to improve their organisations' performance (Gifford and Garcieri, 2007). Accreditation has tried to incorporate IIP⁹ strategy in its programme. Further elaboration of accreditation reveals the following (Jovanovic, 2005):

- Achieving accreditation standards means ensuring a safe environment, preventing or reducing risk to patients and staff, and helping healthcare providers to identify their own organisations' strengths and weaknesses.
- In a rapidly and daily changing healthcare industry, accreditation standards can be a reliable platform that helps healthcare providers to sustain their system and address quality and safety of healthcare services.
- Considering health care's high level of information asymmetry, an AP can make markets more efficient by allowing payers to better assess what they are paying for.

2.8.4.3. Accreditation Standards

Standards are the core of an accreditation system against which HCOs are assessed. Therefore, choice of standards, their focus and the level at which they are set is crucially important in determining the tone, acceptability and nature of the system (Scrivens, 1997b). The primary objective of these standards is to improve safety, effectiveness, cost

⁹. 'Investors in people' target training and development of staff.

and efficiency for the benefit of the whole community (Scrivens, 1995b). de Walcq et al. (2008) believe that the use of standards could guarantee the systematic reviewing of a complex system and measuring improvements in the processes of delivering health services. Therefore, it is important that the standards are concomitantly reviewed and kept aligned with advances in health care and relevant to the services or organisations under evaluation. This also warrants and reinforces the importance of evaluation of AP. The standards need to be both firm and credible to be applicable to varying health service environments. The credibility of standards used is a significant factor in the credibility of the accreditation process and the willingness of stakeholders, be they consumers, funders, owners, regulators, practitioners or health service providers, to accept an accreditation decision. Unlike minimal standards that are used in licensure, accreditation makes use of optimal but achievable standards (Scrivens, 1995a).

Different accreditation organisations may assume slightly varying approaches to accreditation standards. Examples from three main accreditation bodies, i.e. JCAHO, Accreditation Canada Institution (ACI), and the Australian Council on Health Care Standards (ACHS), are presented below (Scrivens, 1995a):

- ACHS insists on contemporary, professional, surveyable (i.e. a measurable and tangible way of demonstrating compliance), reasonable, consensual and optimal standards.
- ACI believes in optimal but achievable (within the current state of the art) and surveyable standards within the confines of resource constraints. In ACI, standards are reviewed every two years, not annually (rate of revision).
- In JCAHO, standards are reviewed every year for hospitals and every two years for other types of organisation.

2.8.4.4. Accreditation: Purposes and Steps

The main objectives of accreditation are as follows (Nadzam and Loeb, 1998; Rooney and van Ostenberg, 1999; Daucourt and Michel, 2003):

- Evaluating quality and safety of health care;

- Assessing and discerning hospitals' ability to ensure continuous improvement in quality of overall patient care;
- Involving professionals at all stages of the quality initiative;
- Formulating and providing explicit recommendations, education and consultation to HCOs, managers, and health professionals on quality improvement strategies and best practices in health care;
- Providing both internal and external recognition of the quality of care in hospitals;
- Strengthening public confidence in the quality of health care; and
- Reducing health care costs by focusing on increased efficiency and effectiveness of services.

Bohigas and Heaton (2000) have indicated the main steps of accreditation scheme as follows:

- Voluntary initiation by a HCO
- Self-assessment by the organisation (preparation)
- Audit plan (preparation phase for accrediting body)
- On-site visit by trained surveyors
 - Review of documentation
 - Interviews
 - Observation
 - Sampling in clinical departments
- Final report (award)

2.8.4.5. Approaches to Accreditation

Three different approaches to accreditation are mentioned, based on the focus of its standards on structure, process and outcome of HCOs (Zende, 2006). The first approach gives priority to the accreditation of available facilities such as equipment, human resources, physical and space specifications (i.e. hardware) in hospitals. The second approach considers the quality assurance activities (i.e. process indicators) and sets its standards for assessing the processes of care. Accreditation in this case is contingent on meeting some basic indicators of quality and involves ranking based on levels of quality, (i.e. software of hospitals). The third approach relies on customers' charter (i.e. client

quality). It emphasises the fact that health systems should be accessible and acceptable to health care seekers. Therefore, it is basically inclined to using indicators such as providing accurate and relevant information to the users, including information about acceptability, accessibility, accountability and affordability of health services. It stresses the outcome indicators in the accreditation of HCOs. Zende (2006) points out that the most relevant model of accreditation for a health system is the people-centric model. The following pieces of advice are valuable for accreditations' sustainability and viability in the long run (Zende, 2006):

- Emphasis on involvement of stakeholders in the accreditation process right from its inception;
- Assistance with evolution of standards from minimum to evidence-based;
- Attention to activities, aimed at boosting consumers' awareness.

As with these approaches, the general trend is a movement from structure and process towards outcome in accreditation standards. For example, JCAHO has started to change its approach from checking whether HCOs have the capability for producing quality care, reflecting structure and process, to checking whether they provide quality care, concentrating on outcome indicators (Scrivens, 1995a, 1997b). Lack of evidence supporting the assumption that appropriately organised inputs could certainly lead to good outcomes in health care has accelerated the move towards using outcome indicators in accrediting hospitals (Hadley and McGurrin, 1988; Hurst, 1997; Griffith et al., 2002). Bartlett (1993) argues that high capacity (advanced structures) might not guarantee their use for providing good outcomes. According to Griffith et al. (2002), the possible reason why structural and process measures have been mostly utilised for the evaluation of HCOs might be because they are generally more accessible and tangible than outcomes measures. Scrivens (1997b) notes that the impact of an accreditation system seeking to improve quality of care in hospitals would be contained within the outcome measures. de Walcque et al. (2008) recognise outcome measures as determinants of the ultimate impact of an AP. Therefore, attempts to incorporate quality and outcome indicators in accreditation have recently begun. For instance, in the USA since 1997, JCAHO has linked clinical outcomes

indicators to the accreditation process through ORYX¹⁰ (JCAHO, 2005; de Walcque et al., 2008). The ACHS has developed the performance and outcome service (POS) to increase the clinical components and indicators in its new AP, e.g. evaluation and quality improvement programme (Luderus, 1996; Scrivens, 1996).

Even so, Collopy (1995) has reasoned that, if the goal of HCOs is to provide the optimum environment for treating patients, it is appropriate to address the environment in developing an accreditation process, and then move to the assessment of outcomes.

2.8.4.6. Accreditation: dysfunctional consequences

Some of the problems that can be attributed to APs are same as those mentioned earlier for PMSs in general. Some problems have been linked to accreditation schemes in the literature. Despite the high popularity of accreditation in health care and similar areas such as education, some problems might be related to this programme or its ill-conducted activities. For example, Giraud (2001) and de Walcque et al. (2008) have noted that, while accreditation is mainly destined to encourage quality monitoring processes in hospitals, a common fear is that unsatisfactory scores may encourage authorities to close down hospitals. Alternatively, it might disappoint the hospitals and discourage them from attempting to improve their functions. Accreditation, as Walshe and Walsh (2000) note, may not fit well with other quality improvement activities already under way in a HCO. Some believe that accreditation can potentially divert resources from strategies aimed at directly addressing quality and safety concerns (ACSQHC, 2003a) or divert attention from other important concerns of a HCO (e.g. dealing with patients), as argued under tunnel vision (section 2.7.3) (Walshe et al., 2001; Touati and Pomey, 2009). Therefore, it is generally recommended that those designing external review interventions try to prevent or minimise the adverse effects of APs that may arise, as well as maximising and sustaining their positive effects. Over-reliance on value judgement of surveyors in allocating scores to standards in the process of accreditation is another problem that has been noticed in the literature (Scrivens, 1997a; de Walcque et al., 2008).

¹⁰. Introduced in February 1997, The Joint Commission's ORYX initiative integrates outcomes and other performance measurement data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission accredited organisations in their quality improvement efforts (JCAHO, 2005).

2.8.4.7. Accreditation, Licensure and Certification

There has been always some confusion surrounding the terms accreditation, licensure and certification (Shaw, 2004c). Accreditation and certification focus on continuous improvement strategies and achievement of optimal quality standards, unlike licensure which adheres to minimal standards to assure public safety (Rooney and van Ostenberg, 1999). Licensure standards serve to define the quality level required for the safe delivery of patient care or health services, such as drug dispensing by a pharmacy. They also define the capabilities required for a HCO to be entitled to advertise to its public that it is a hospital or health centre. For example, the licensure standards of a particular jurisdiction might require a healthcare facility to provide surgery, radiology testing, pharmacy services, laboratory services and round-the-clock nursing care for patients in order for it to be classified as a hospital. On the other hand, unlike accreditation and certification, which tend to be voluntary forms of external evaluation, licensure is mandatory. When the government grants a license to an organisation, that licence signifies its permission for the organisation to operate and provide care or services to patients. Licensure is always conferred by a governmental entity or its designated agent, such as a licensing or regulatory board (e.g. a state, provincial, or national medical or nursing board), and addresses the minimal legal requirements for a HCO or practitioner to operate or care for its patients (Rooney and van Ostenberg, 1999). Certification is formal recognition of compliance with set standards (e.g. ISO 9000 series for quality systems) validated by external evaluation by an authorized auditor. Shaw (2004a) argues that, although these systems are all being adapted to meet the changing demands for public accountability and clinical effectiveness and improvement in health care, the most rapid development has been in accreditation. See Appendix G (Table 2) for further amplification of these variations of quality control and improvement.

2.9. Performance analysis of APs

EESs in health care including accreditation are being developed and employed largely in response to growing concerns about and interest in the quality of health services (Paccioni et al., 2008). As explained before, given governments' responsibility for improving the quality of health care in most countries, they have used these systems to assess and improve quality in their HCOs (e.g. Annual Health Check in the UK NHS). Similarly, APs

have been used by some governments to fulfil their evaluation intentions (Scrivens, 2002). The development of government-owned accreditation systems (Scrivens, 2002) or adaptation of traditional models of voluntary and independent accreditations to use as a government-sponsored or statutory tool for control and public accountability in health care (Shaw, 2003a; Shaw et al., 2010) has been seen in various countries, such as France (Giraud, 2001) and Iran (Sadaghiani and Zare, 2005). Scrivens (2002) argues that such systems are linked with the regulatory tasks of governments.

Performance analysis of these macro PMSs has been widely addressed in the literature in developed countries. The NHS star-rating system (replaced by Annual Health Check) has been the subject of a number of studies exploring its effects at local hospitals. For example, Mannion et al. (2005) have studied the impact of the NHS star-rating system on acute care trusts (hospitals) in England. Some studies have looked into the dysfunctional effects of this regulatory system in the trusts (e.g. Barker et al. 2004; Jacobs et al. 2006; Bevan and Hood 2006; Kelman and Freidman 2009; Bevan and Hamblin 2009). Chang (2006) and Agrizzi (2008) have adopted a theoretical lens to investigate local effects of the NHS star-rating system by adopting different theoretical perspectives. Chang (2006) looks into the managerial responses to the NHS PAF in the trusts. He concludes that the framework is used for legitimacy-seeking, rather than for rational strategic performance management by the trusts.

Accreditation as a well-known, external and macro PMS in health care has also been widely adopted and used for assessing and improving healthcare quality (Nandraj et al., 2001; Hirose et al., 2003; ACHS, 2008). However, research into its performance and effectiveness is still at an embryonic stage and the empirical evidence base for APs is substantially undeveloped (Braithwaite et al., 2006; Øvretveit, 2003; Greenfield and Braithwaite, 2008a; Greenfield and Braithwaite, 2009; Marie-Pascale et al., 2010). According to de Walcque et al. (2008), despite a large amount of money being spent on hospital accreditation, there is a paucity of evidence about their effectiveness. Walshe and Walsh (2000, p. 17) similarly point out that the rise in 'evidence-based' health care in recent years has warranted a need for rigorous examination of new or existing healthcare interventions and evaluation systems such as accreditation. They claim that adoption and application of these evaluatory programmes should be informed by the findings from such research (Walshe and Walsh, 2000). A large number of studies have called for research into accreditation effectiveness and its impact on quality of HCOs (e.g. Pomey et al., 2004;

Shaw, 2001; Shaw, 2003a; Walshe et al., 2001; Fernandopulle et al., 2003; Mays, 2004; ACHS, 2008; Braithwaite et al., 2006).

2.9.1. Review of existing literature

Previous research on the performance and impact of healthcare accreditation on HCOs has shown mixed and inconsistent results (Greenfield and Braithwaite, 2008; Nicklin and Dickson, 2009). Existing literature abounds with various studies showing either confirmatory (e.g. Devers et al., 2004; Rooney and vanOstenberg, 2004; El-Jardali et al., 2008; Sekimoto et al., 2008) or neutral (e.g. Miller et al., 2005; Salmon et al., 2003; Snyder and Anderson, 2005; DeBritz and Pollak, 2006) evidence regarding the effects of accreditation on HCOs, with no consistent results. Sunol et al. (2009, p. 27) have located the prior literature on the impact and performance of APs in three distinct areas:

- The impact of accreditation on the quality and safety of healthcare delivery, which could include organisational and managerial changes due to accreditation, professional involvement and satisfaction with the accreditation, and changes in organisational culture
- The efficiency of accreditation tools and systems (structure and process) for providing feedback with reliable information both to the accreditation organisations and to all key stakeholders
- The impact on the capacity development of systems

Further analysis of the literature shows that different approaches have been adopted by researchers to look into the performance of APs in health care. Some studies have investigated possible outcomes and impact of these programmes on accredited organisations (e.g. Pomey et al., 2004; Heuer, 2004). A wide range of outcomes have been associated with accreditation in this approach, such as providers' or patients' satisfaction, change and overall improvement in quality. Other studies have tried to analyse APs' performance by looking into their structure and process (i.e. the main components) such as survey or standards (e.g. Greenfield et al., 2008; Greenfield et al., 2009). Scrivens (1996) argues that each of the individual components of accreditation can be scrutinised to see whether they have any effect upon the processes of delivery and outcomes of health care.

These approaches are claimed to make use of two general methodologies, i.e. ‘objective indicator’ and ‘people’s experiences/perceptions’ (Scrivens, 1997a, p.6). The former, which is an outcome-based analysis, requires that tangible measures of success (in the form of performance indicators) be developed or extracted from evaluated organisations. A rationalistic relationship is then envisaged between APs’ functioning and the indicators and quantitatively examined. In other words, any change, improvement and increase in particular qualitative or quantitative indicators of accredited HCOs is investigated and the positive results are attributed to the effectiveness of APs and seen as a confirmatory sign of the programmes’ impact on the organisations. According to the ‘people’s experience or perception’ methodology, the perceptions of different groups such as providers (e.g. nurses, managers) surveyors and patients are elicited regarding the programmes’ overall performance or components (Scrivens, 1997a, p.6). This mode of evaluation allows individuals to suggest their own interpretation of improvements in the quality of service. This methodology has been used by both approaches to performance analysis of APs.

Although the methodologies could be used in complementary fashion, they have their own strengths and weaknesses. The perception approach is accused of being mostly superficial and judgemental (Scrivens, 1997a), whilst criticisms of objective indicator are mostly in connection with difficulties of measuring outcomes in health care. Eddy (1998) points out that measuring outcomes in health care is a complicated process because healthcare outcomes are highly probabilistic. They may not always occur when an intervention, such as accreditation, does the right thing, and they may even occur when it does the wrong thing. As such, conclusions about the results of any intervention (in the form of measurement or improvement) might require a large number of observations and statistical analyses. Another issue concerns the long delays in achieving healthcare outcomes. Control over the outcomes is another challenge indicating that the outcomes in health care may be determined by other factors beyond the control of a given evaluation programme (Eddy, 1998; Kessner and Kalk, 1973). Therefore, impact on healthcare outcomes may not be related merely to the actions of an AP. Another difficulty of using objective indicator, as de Walcque et al. (2008) put it, is that standards of APs are mostly concerned with structure and process-related performance indicators rather than outcome indicators. Moreover, they argue that stakeholders seldom concur on the intended outcomes (de Walcque et al., 2008).

In view of these problems, researchers are inclined to utilise perceptions and experiences of different groups in analyzing the performance of APs. Some studies have tried to overcome these difficulties by using intermediate (outputs) or proxy measures reflecting long-lasting healthcare outcomes such as enhanced compliance of HCOs with external PMSs or patient satisfaction along with or after evaluation by these programmes (e.g. Salmon et al., 2003). The ideal and comprehensive evaluation might result from using a combination of these two methodologies. The following section provides a rather extensive review of existing literature in the light of the aforementioned approaches (outcome and process-based) to the performance analysis of APs, drawing from Braithwaite et al. (2006) and Greenfield and Braithwaite (2009). More details on the studies are presented in the table 3.1.

2.9.2. Outcome-based approach

This type of analysis encompasses differing ways of looking at the effectiveness and impact of APs. For example, some studies have investigated accreditation's effect in promoting change in the reviewed organisations (e.g. Pomey et al., 2004). The effects of APs in organising and ordering the practices of organisations have also been investigated. The cost of accreditation is the subject of another group of studies with regard to effectiveness of accreditation. This group has sought to discover whether this external evaluation system is suitable for assessing the quality of health services by looking into its cost (e.g. Rockwell et al., 1993) and any promotion and enhancement in the quality indicators of accredited organisations (de Walcq et al., 2008). Moreover, some studies have tested an assumed relationship between accreditation and patient satisfaction (e.g. Heuer, 2004; Dickison et al., 2006; Al-Tehewy et al., 2009).

2.9.2.1. Promoting change

Some research demonstrates that preparing for and undergoing accreditation by HCOs may promote change in these organisations (e.g. Duckett, 1983; Scrivens et al., 1995; Pomey et al., 2004; Juul et al., 2005). Duckett (1983) found that accredited hospitals showed significant changes in the organisation of nursing and its physical facilities and safety after undertaking accreditation. Pomey et al. (2004) speak about the changes instigated by the

preparation stage of accreditation which provide a climate conducive to fostering better treatment of patients in hospitals. This was conducted by giving the professionals an opportunity to reflect more on their organisational practices and exchange their views with others. Pomey et al. (2010) also emphasised the role of the accreditation process for the introduction of change in organisations. They indicated that most of the changes happened while organisations were preparing for the accreditation (Pomey et al., 2010).

2.9.2.2. Organisational impact

Research on the organising effects of APs has remained largely unexplored. Sheahan (1999) found that participation in an AP could instigate improvements in the organisation of patient care through the coordination of a patient communication strategy, an evaluation strategy and a quality improvement. Greenfield and Braithwaite (2008) have claimed that the organisational impact of accreditations is fairly unclear.

2.9.2.3. Patient satisfaction

The existing studies could find no relationships between accreditation and patient satisfaction (Greco et al., 2001; Heuer, 2004). For example, an examination of the relationship between 41 New Jersey and Eastern Pennsylvania acute care not-for-profit hospitals' accreditation scores and patient satisfaction ratings revealed no association between them (Heuer, 2004). Similarly, patient-reported measures of quality and satisfaction of both accredited and non-accredited health plans could not be differentiated (Beaulieu and Epstein, 2002). However, Al-Tehewy et al. (2009), who examined the effect of accreditation of the NGO's health units on patients and providers' satisfaction, found a short-term positive effect. What is clear is that there is an urgent need for further research to uncover more evidence regarding accreditation's impact on patient satisfaction.

2.9.2.4. Cost of accreditation

Øvretveit and Gustafson (2003) contend that quality programmes consume more resources than most treatments. Accreditation is not a costless process (James and Hunt, 1996) and a variety of costs are attributed to this evaluation system, such as cost of survey related to

accrediting body, or preparation phase cost of accreditation incurred by accredited organisation (Montague, 2003; de Walcque et al, 2008). Accordingly, another section of the literature, looking at accreditation effectiveness, has scrutinized the financial costs of accreditation for the aspirant accredited organisations (Greenfield and Braithwaite, 2007). Stressing the costs of accreditation, Øvretveit and Ham (2002) state that evaluations should be used effectively, because they take time and money away from other activities of organisations.

Contrasting assessments have been observed in the studies in this regard. Two studies judged the costs too high for an individual organisation and questioned whether accreditation was an appropriate use of resources for high-quality patient care delivery (Rockwell et al., 1993; Fairbrother and Gleeson, 2000). Examining an AP in a developing country, Bukonda et al. (2003) have stated that individual HCOs were partly stifled by the costs of AP. Mihalik et al. (2003), on the contrary, have emphasised that meeting reasonable accreditation standards should be viewed as an substantial investment in maintaining quality and ensuring accountability, although the authors echoed the high costs of accreditation.

Doyle and Doran (2007) sought to identify the cost of operating an acute hospital accreditation scheme (AHAS) in terms of human, financial and physical resources and to undertake a cost-benefit analysis of this scheme. Rooney and Barnes (2001) have also assessed the costs and effectiveness of implementing accreditation in two developing countries, South Africa and Zambia. Their research revealed that, despite this cost, the accreditation can be beneficial in areas such as improved communication, compliance with organisational standards, better leadership and management of the facilities and improved staff and patient safety. Øvretveit and Gustafson (2003) nevertheless indicate that there is a shortage of evidence to show that APs are the best use of resources for improving quality of services. Mays (2004) states his concerns about the high costs incurred by HCOs that undergo accreditation and warns that this might create significant barriers to accreditation for those HCOs serving disadvantaged and under-resourced communities. He argues that accreditation costs must be weighed against the potential benefits to determine feasibility and value.

2.9.2.5. Quality improvement

Quality improvement as an ‘outcome’ is defined as any positive change in measures such as clinical indicators and tangible improvement in healthcare processes as a result of APs, such as low incidence of infection, improved continuity of care, and accuracy of diagnosis (de Walcque et al., 2008). Greenfield and Braithwaite (2007) have described the relationship between quality measures (i.e. outcomes) and accreditation as a complex issue with no apparent direct and clear-cut relationship between them. Griffith et al. (2002) have reported a potential disconnection between JCAHO accreditation and outcome measures. Grasso et al. (2005) expressed similar ideas in connection with accreditation and low rate of medication errors. Beaulieu and Epstein (2002) have noted that, while NCQA¹¹ was positively associated with increased enrolment in the AP and higher accreditation scores, it does not ensure high-quality care or a minimal level of performance. Miller et al. (2005) have arrived at rather similar results in their research investigating the relationship between performance measurement and accreditation. They have demonstrated that, despite high scoring on JCAHO measures, no significant relationship between JCAHO categorical accreditation decisions and quality and safety indicators in the accredited hospitals was detected. Accordingly, they have expressed a need to continuously re-evaluate all measurement tools to ensure that they are providing the public with reliable, consistent information about healthcare quality and safety. As such, Salmon et al. (2003), similar to Snyder and Anderson (2005), have stated that accreditation had little or no effect on clinical indicator performance, in spite of improved compliance of accredited organisations with the standards instigated after accreditation. They have called for additional work to determine whether improvements in the accreditation structure and process standards result in improved outcomes. A weak relationship between accreditation and quality measures was also identified by Hadley and McGurrin (1988), even though the accredited or certified hospitals were more likely to have higher values on specific indicators than hospitals without accreditation. In a more recent study, DeBritz and Pollak (2006) looked into the effect of accreditation of trauma centres on patient outcomes, defined as mortality rate. They found hardly any convincing evidence to support the benefit of trauma accreditation on patient outcomes, apart from a little improvement in survival rate. Similarly, Barker et al.’s (2002) study of medication errors in 36 hospitals comprising

¹¹. National committee on quality assurance

JCAHO accredited hospitals, non-accredited hospitals and skilled nursing facilities, exhibited no significant difference between error rates across those three settings. A research initiative, known as Quest for Quality and Improved Performance (QQIP), with a focus on the quality of health care in the UK and USA, demonstrated mixed results regarding the effects of APs (Sutherland and Leatherman, 2006). It concludes that, despite the evidence of an association between quality of care and accreditation status, there was no evidence of causality between them. The association could therefore be a result of the high-performing organisations choosing to participate in accreditation, rather than accreditation processes leading to better performance or higher-quality health care. As such, the following findings have been achieved by this initiative in relation to accreditation (de Walcqque et al., 2008; Sutherland and Leatherman, 2006; Mays, 2004):

- No correlation between JCAHO scores and alternative, evidence-based measures of healthcare quality and safety
- No difference in the medical error rates between accredited and non-accredited hospitals
- No correlation between patient satisfaction scores and JCAHO survey scores
- No evidence of patient impact, although JCAHO has acted as a key driver in the development of hospitals' patient-safety initiatives
- Disjunction between outcomes measures and JCAHO evaluations

Nonetheless, the literature also abounds with examples supporting the positive impact of accreditation on the quality of accredited organisations (Dearinger et al., 2010). de Walcqque et al. (2008) refer to the experience of the last decade in health care showing that accreditation has been a valuable means of quality improvement dynamics in many hospital settings. Sunol et al. (2009a) argue that those involved in the accreditation projects are likely to believe accreditation can contribute to the improvement of health care and service quality. Chen et al. (2003) found that accredited hospitals performed better than non-accredited hospitals on a range of quality indicators; for example, non-surveyed hospitals had higher mortality rates than surveyed ones, albeit with considerable variation in their performance. Devers et al. (2004) found that a quasi-regulatory organisation (e.g., JCAHO) can be a primary driver for hospitals' patient-safety initiatives. Rooney and van

Ostenberg (2004) stated that patient records defined by accreditation standards have greatly contributed to the improvement and monitoring of quality patient care. They also commented that accreditation could often serve as a comprehensive and powerful tool for quality improvement in cultures and countries with very different systems of healthcare delivery. Simons et al. (2002) found that hospitals owning a trauma programme consistent with accreditation criteria were statistically better than the other centres. El-Jardali et al. (2008) found perceived improvement in the quality of care in hospitals after accreditation and considered the accreditation as a valuable tool for improving quality of care. Hospital accreditation had a significant impact on hospitals' infection control infrastructure and performance (Sekimoto et al., 2008). It has been argued that accreditation could predominantly promote compliance with the published standards in the months prior to the external assessment (Salmon et al., 2003; Piskorz, 2002) and/or increase the number of HCOs interested in taking part in the accreditation scheme (Sutherland and Leatherman, 2006). However, there is little evidence that this high compliance and participation will bring any benefits in terms of clinical process and outcome or quality and safety in the accredited organisations (Sierpiska and Ksykiewicz-Dorota, 2002).

In view of the above-mentioned confusion and alleged failure of accreditation to enhance quality of care, some efforts have been made to improve accreditation's impact. For instance, Scrivens (1997b) argues that, in order to make accreditation more acceptable to HCOs, accreditation systems have to become more relevant to clinical activity. Thus, a handful of accreditation bodies have been introducing, developing, incorporating and monitoring clinical quality indicators in HCOs (Collopy, 2000; Fairbrother and Gleeson, 2000). As a result, some improvements have apparently occurred in care outcomes of these organisations (Collopy, 2000; Collopy et al., 2000; Williams et al., 2005).

2.9.3. Process-based approach

As the analysis of the literature shows, the evidence on accreditation's effectiveness and impact is to a large extent inconsistent and variant in different studies and settings. Therefore, given the difficulty of performance measurement in health care (Eddy, 1998; Loeb, 2004) which might stem from the peculiarities of health care, as explained earlier, the outcome-based approach to the performance analysis of accreditation (i.e. evaluation of accreditation based on its impact on quality care) seems to be a prolonged and somewhat

impractical process. Therefore, the process-based (perception and experience analysis) approach might have relative ascendancy over outcome-related ones for evaluating healthcare accreditation systems in this regard (Scrivens, 1997a). Walshe et al. (2001) also confirm that it is consistently difficult to evaluate EESs by analyzing their impact on target organisations, even though this might seem a fairly reasonable method of testing. Shaw (2003b) indicates that EESs are complex interventions that cannot be easily isolated and measured, and the existing evidence to support these strategies is mostly based on descriptive studies or expert reports. He further comments that ‘endpoints’ of an AP are hard to define and they may change according to the expectations of users and observers (Shaw, 2003a, p. 455). Accordingly, he argues that evaluation of accreditation systems is more difficult than, for example, a clinical technology (Shaw, 2003a).

Øvretveit and Gustafson (2002) point to methodological challenges in measuring outcomes and determining causality between accreditation and possible outcomes. de Walque et al. (2008, p. iii) mention some reasons why this causality has been difficult to demonstrate. They argue that the standards applied by most APs are not associated with outcome-related performance indicators, but with ‘process indicators’. Possible disagreement between the programmes’ stakeholders on the intended outcomes and inconsistency in the definitions of an AP are considered as other possible reasons (Boaden, 2008). Øvretveit and Gustafson (2002) note that, since evaluative interventions are complex, changing and long-term processes, they are difficult to evaluate using experimental methods. Furthermore, they indicate that changing and complex targets and contexts make them difficult to evaluate by conventional medical (quantitative) research evaluation methods. They advise instead quasi-experimental evaluation and social science methods utilising qualitative means and perceptions for evaluation and investigation of these programmes. According to Øvretveit and Gustafson (2002, 2003), the validity of these methods can also be increased by interviewing a cross-section of informants and triangulating data from different sources. Exploratory (qualitative) studies are also favoured for investigation of the relationship between accreditation systems and performance of HCOs (Joly et al., 2007).

In the process-based approach to the assessment of EESs, the focus is directly on the performance of APs without inferring their performance based on their impacts on reviewed organisations. It should be remembered that assuming a clear-cut distinction between these two approaches might be fairly ambitious, yet useful, for the purposes of expounding the impacts of APs. This approach to accreditation performance analysis has

also been seen differently in the literature. The assessment of accreditation validity and reliability and the analysis of different groups' perceptions and attitudes towards these programmes are the two main forms of process-based analysis found in the literature (e.g. Greenfield and Braithwaite, 2008; El-Jardali et al., 2008).

2.9.3.1. Accreditation validity and reliability

Findings from various research concerning accreditation validity are mostly based on anecdotal evidence and are to some extent inconsistent (Greenfield and Braithwaite, 2007; Dickson and Nicklin, 2008). Some studies have deemed accreditation to a credible process for assessing quality of care (e.g. Gillon et al., 2003; Kreig, 1996; Gough and Reynolds, 2000; Hurst, 1997; Dickson and Nicklin, 2008). On the other hand, this validity has been questioned by others and there have been calls for more clarification in monitoring standards and assimilation of outcome measures in the standards (McAlary, 1981; Grasso et al., 2005; Essex, 2000). McAlary (1981) has argued that too much reliance on surveyors' judgements might endanger the validity of accreditation. He advises a movement towards and combination with an outcome evaluation approach to enhance credibility and reliability of the accreditation process. Grasso et al. (2005) have linked validity of an accreditation system to its surveyors' ability to detect medication usage errors. Stressing the importance of reliability for healthcare accreditation, Greenfield et al. (2009) recommend employing a structured report format for evaluation, a detailed training programme with mentoring for new surveyors, and defined surveyor selection criteria to enhance the reliability of AP. In the study by Greenfield et al. (2009, p. 105), stakeholders of the accreditation system identified six interrelated factors including dynamics of accreditation survey, management of surveyor workforce, organisational documentation and survey team conduct that both promoted and challenged simultaneously the reliability of accreditation.

2.9.3.2. Professionals' perspectives

The most common way to examine the performance of APs is said to be based on attitudes and perceptions (Scrivens, 1997a). Many of the studies conducted in this regard are concerned with the application of accreditation in the education sector (e.g. Baker and

Dunn, 2006; Casamassimo and Wilson, 1999; MacFarlane et al., 2003; Reznich and Mavis, 2000). However, health care has also been the subject of a number of studies in which various groups of APs' stakeholders are asked for their perceptions of how an accreditation scheme is functioning or how it should assess HCOs. Table 3.2 outlines a summary of related studies in this regard. As in the table, Hurst (1997) has tried to evaluate Trent Small Hospital Accreditation Scheme (TSHAS) in the UK by surveying and interviewing the programme's managers and surveyors.

The ACHS's accreditation is a pioneering and successful healthcare evaluation scheme established in 1974. This programme has been subject to different evaluations by researchers. Krieg (1996) has examined ACHS's programme with the purpose of investigating its usefulness in assisting any movement towards best practice, its impact on the reviewed HCOs' outcomes and performance, and the benefit of the programme. To this end, he conducted a questionnaire survey of HCOs due for accreditation by ACHS. In another case, Fairbrother and Gleeson (2000) have investigated the attitudes of the senior clinical and managerial staff of a teaching hospital towards ACHS accreditation, in terms of the programme preparation phase, on-site survey and the groups' overall impressions of accreditation. They have utilised the questionnaire as a tool for gathering data.

Another group of studies has tested different groups' opinions concerning the accreditation scheme before and while launching the programme (Bukonda et al., 2003; Nandraj et al., 2001). Nandraj et al. (2001) have elicited the views of a newly established AP's stakeholders (hospital owners and/or administrators, representatives from professional associations, consumer organisations, government officials, insurance companies and health financiers) on the introduction of that scheme and on what form it should take in the future. They have applied a mixed-method research strategy for this purpose. After conducting a questionnaire survey, they have interviewed a selected group of stakeholders to confirm resulted data and increase response rate and validity of results. Another study by Pongpirul et al. (2006) has explored the opinions of hospital staff and accreditation surveyors about selected items of the national hospital accreditation (HA) standards in order to establish crucial issues in the standards, as well as problems and major obstacles to hospitals' implementation of quality improvement (QI) activities. Their research showed that employees were facing many problems with multidisciplinary process-related issues of the accreditation standards, whereas the surveyors' difficulties were mainly in terms of conveying the quality improvement concepts to them. In the most recent study, El-Jardali

et al. (2008) have assessed the perceived impact of accreditation on quality of care through the lens of healthcare professionals, specifically nurses.

Two important points should be made in closing this section. Firstly, the distinction between these two approaches to performance analysis of APs has been heuristic and may not be fully clear-cut in practice. Being inspired by the literature, this research has made such a distinction to obtain more clarification and better explanation. Secondly, it is worth noting that a combination of these two approaches is inevitable and may render even more comprehensive and valid results.

Table 3.2 Characteristics of various studies on APs across different countries (*Adapted from Greenfield and Braithwaite, 2007*)- continued next pages

Author	Year	Country and setting	Purpose	Respondent groups	Study design, collection and analysis	Main results
Pongpirul et al.	2006	Thailand; Hospitals	To explore the opinions of health care professionals (hospital staff) and accreditation surveyors toward selected items in the national hospital accreditation (HA) standards, in order to establish major issues in the standards, as well as problems and major obstacles of hospitals in implementing quality improvement (QI) activities	Hospital staff and accreditation surveyors	A self-administered questionnaire by hospital (different departments) staff (response rate 94.9%) and surveyors of the national AP (response rate of 73.2%). Analysis: descriptive statistics and comparison of views by statistical Spearman's rank correlation test.	Health care professionals have been facing many problems with multidisciplinary process-related issues of the HA standards, whereas surveyors might have had some difficulties in conveying the core QI concepts to them.
Baker, et al.	2004	USA; Health education	To explore the perspectives of selected allied health deans and programme directors regarding the specialised accreditation effectiveness and reform	Allied health programme deans and programme directors	Quantitative study; questionnaire; responses rate 55%; Analysis: sum means; Cronbach's alpha; multivariate analysis; ANOVAs; independent <i>t</i> tests.	Findings affirmed the role of accreditation as an effective system for measuring quality in higher education.

Stoelwinder	2004	Australia; Medical clinicians.	To explore what doctors working in hospitals want from hospital accreditation	Doctors	Qualitative data collected from 12 focus groups in 6 hospitals across Australia involving consultants, registrars and senior medical officers. Total number of participants was 72. Analysis: thematic analysis conducted	Doctors are unaware or sceptical of accreditation; doctors hold concerns about how safety and quality of care should be measured; and doctors perceive themselves to be accountable within a professional framework (self/ patient/colleagues) not to the organisations in which they work.
Grenade and Boldy	2002	Australia; Health professionals	To review the implementation of the accreditation process in Western Australia from the perspective of service providers	Health services providers	In-depth interviews were conducted with thirty participants. Analysis: themes and descriptive analysis presented	The accreditation system is generally supported by service providers
Nandraj et al.	2001	India; Hospital	To elicit the view of stakeholders (hospital owners/ administrators, representatives from professional associations, consumer organisations, government officials, insurance companies and health financiers) on the introduction of accreditation and what form it should take	Hospital owners/ administrators, representatives from professional associations, consumer organisations, government officials, insurance companies and health financiers	A structured questionnaire; An 8% response rate. A sub-sample of 25 (drawn from the 725 hospitals that identified their bed size) – purposively selected to represent broad geographical distribution, ownership and range of size; A semi-structured interview (RR: 76%)	A high level of support for a programme (voluntary, standards based approach, periodic external assessment and quality assurance measures). The biggest obstacle identified was how to finance the programme.

					Analysis: frequency tables and cross tabulations computed; content analysis of qualitative data	
Greco, et al.	2001	Australia; General practices	To survey patient views on standards as part of the AP	Patients	A 27 item questionnaire was completed by over 53,000 patients from 449 general practices. Analysis: percentages and statistical analysis presented.	Patients considered that doctors need to improve interpersonal skills, access, availability and patient information
Gough and Reynolds	2000	UK; Pathology laboratories	To examine laboratories managers' and clinicians' opinions about Clinical Pathology Accreditation (CPA) and whether it had produced any significant benefits to pathology services	Laboratories managers and clinicians	An unsolicited questionnaire (15 items) mailed after accreditation survey, to 145 laboratories (managers and clinicians); 5 point Likert scale and free text questions used; 64 % response rate	Most laboratories felt accreditation by CPA had resulted in better laboratory performance with more documentation and better health and safety training procedures. A significant proportion considered accreditation to be over bureaucratic, inefficient and expensive. A concern that accreditation covered the domains of other regulatory bodies was also expressed
Fairbrother and Gleeson	2000	Australia; Hospital	To examine attitudes of hospital senior clinical and managerial staff to the accreditation (regarding preparation phase, on-site survey and overall impressions of accreditation)	Hospital senior clinical and managerial staff	A case study of a metropolitan teaching hospital. Survey of 20 items, closed and open questions, to all department heads; 44% response rate Analysis: content analysis	Significant levels of negative feedback received; principal concerns related to perceptions that the process is unwieldy and it offers little value in terms of patient care delivery for the resources required

Casamassion and Wilson	1999	USA; Dentistry education	To assess the opinions of programme directors and practitioners about the importance and necessary amounts of experiences required by current accreditation standards for training of paediatric dentists	Dentistry programme directors and practitioner	A 32-item questionnaire was sent to all programme directors of ADA-accredited postdoctoral paediatric dentistry training programmes and to a random sample of 10% of the fellow/active membership of the American Academy of Paediatric Dentistry. An over-all response rate of 56%. Analysis: comparisons using statistical tests.	Practitioners and programme directors agreed on the importance of most experiences and activities required by current accreditation standards.
Scanlon and Hendrix	1998	USA; Purchaser organisations and representatives from other health organisations.	To capture the views of the purchaser representatives who attended a two-day programme, explaining the APs of NCQA and JCAHO	Health care purchaser representatives	Two surveys (N = 20) administered to representatives. First survey at the start of day one and the second at the end of day two. The surveys examined understanding and attitudes to the APs. Analysis: response percentage for questions.	Purchasers have a keen interest in health plan accreditation and rely heavily on accreditation decisions when choosing which plans to offer their beneficiaries. Purchasers also desire to understand the strengths and weaknesses of the accreditation process for their own contracting purposes.
Hurst	1997	UK; Hospital	To examine the characteristics of health care accreditation schemes, in particular the Trent small hospital accreditation scheme (TSHAS) from the	Accreditation manager and surveyors	Data collected through document analysis/ literature review, questionnaires (79% response rate) and	Results confirmed to-date (1997) published understanding of accreditation. The programme is valued by stakeholders, who are also keen to see it

			perspective of the scheme manager and surveyors		interviews Analysis: descriptive and statistical analysis presented	continue to evolve.
Kreig	1996	Australia; Health care organisations	To examine the AP of ACHS focusing on the usefulness of the programme to assist movement towards best practice, its impact on outcomes and performance, the benefit of the programme, and how it could be of greater assistance.	HCOs	Questionnaire survey. A 56% response rate	A large majority of respondents agreed that the AP had been of significant benefit to their organisation. The benefits covered improving communication, commitment to best practice, information available for evaluation activities and quality care activities, improved structure for quality, greater focus on consumers, supporting planned change, and, staff management and development.
Borenstein et al.	2004	USA; Managed care organisations	An analysis that assessed the differences in performance of HCOs with and without quality improvement activities	HCOs	Processes or outcomes from quality activities, identified from 399 organisational self-reports linked to measures in the effectiveness-of-care database of HEDIS Analysis: cross-sectional analysis undertaken (79 activities from 50 organisations, covering 12 measures)	The effects of self-reported quality improvement activities were often small and inconsistent, and in some instances contrary to expectations

Chen, et al.	2003	USA; Hospitals	To examine similarities and differences in health outcomes for accredited and non-accredited hospitals	Hospitals	<p>The study cohort was 134,579 patients from 4,221 hospitals. The association between quality of care, and survival for acute myocardial infarction was examined.</p> <p>Analysis: statistical tests (including chi-square tests, analysis of variance, logic regression and the Cochran-Armitage test), and a disease specific mortality prediction model for elderly patients was used. Risk adjustments were undertaken.</p>	Non-accredited hospitals displayed lower quality than accredited hospitals. However there was considerable variation in performance amongst accredited hospitals.
Salmon, et al.	2003	South Africa; Hospitals	To conduct a prospective randomised control trial of an AP in a developing country	Public hospitals	A random sample of 20 public hospitals stratified by size; ten participated in the AP and ten not as the control group. Data were from the Council for Health Services Accreditation of Southern Africa. Data comprised measures of hospital structure and processes and 8 quality indicators (independently collected). Qualitative and quantitative comparison of data from the two groups was undertaken.	Those hospitals participating in the programme improved their compliance with accreditation standards; non-participating hospitals did not. However, there was no observed improvement on the quality indicators.

Bukonda et al.	2003	Zambia; Hospital	To describe the experience of the development of the Zambian hospital accreditation program	Hospital	Qualitative data from interviews with stakeholders; Review of documents.	Serious resource constraints, both financial and expertise have undermined the ongoing viability of the program
Brasure, et al.	2000	USA; Hospital	To explore why rural hospitals are not participating in the accreditation process	Hospitals	Random sample survey of 299 non-accredited rural hospitals. Mail survey with telephone follow-up. 92% response rate. Analysis: multivariate Probit analysis and predicted marginal probabilities.	The main reason of the rural hospitals for not seeking the accreditation was cost
Casey and Klingner	2000	USA; Health maintenance organisations (HMOs).	To explore why two groups of HMOs that serve rural areas have chosen to apply or not to apply for National Committee for Quality Assurance accreditation, and their future plans regarding accreditation	HMOs	HMOs drawn from 1997 inter study HMO census; identified 182 rural HMOs, 75 accredited and 105 non-accredited; random samples of 21 accredited and 10 non-accredited HMOs; Phone interviews with managers or directors, ratings using a 5 point scale.	Challenges of complying with standards and information requirements identified. Accredited HMOs cited positive benefits of accreditation process; most to reapply.
Bohigas et al.	1998	International level; Surveyors	To explore how different accreditation bodies manage surveyors	Accreditation bodies	Comparative study; Questionnaire	Surveyors around the world share many common features in terms of careers, training, work history and expectations
Verstraete, et	1998	Belgium and	Assessing the attitude of	Laboratory	Multiple choice	A large majority of

al.		Netherlands; medical laboratories.	laboratory personnel towards accreditation	personnel	<p>questionnaires administered to medical technologists in three medical laboratories at varying times after obtaining an accreditation award; two private in Belgium, 29 and 20 responses; one hospital in Netherlands, 28 responses. Follow-up with the first laboratory one year later received 24 responses.</p> <p>Analysis: percentages and comparisons by chi-square analysis.</p>	<p>representatives considered that accreditation increased their workload. Two laboratories did not think accreditation improved the quality of results. A small majority preferred working in an accredited laboratory. Advantages: the improved traceability of work, better knowledge of their activities Disadvantages: increased paperwork, the discrepancies between the accreditation procedures and the reality which directs attention mainly to formalities rather than quality. However, A small majority of the technologists preferred working in an accredited laboratory than in a non accredited one.</p>
Hampel and Hastings	1993	USA; Nursing homes	To evaluate a protocol developed by JCAHO to assess the capability of special care units to provide quality care	Nursing homes	<p>Comparison by testing two separate surveys at two independent sites;</p> <p>Analysis: correlation analysis</p>	The standards used, their intent, and the survey process were considered sound by those who tested the protocol and by those who were evaluated

2.9.4. Further frameworks and designs for assessing EESs

In addition to the foregoing approaches and studies regarding different methods of evaluating EESs, some generic guidelines, suggestions, anecdotal designs, and conceptual models, which are mostly descriptive and grounded in the literature, have been identified in the literature. They were invoked during the different stages of this study to both formulate the research objectives and help enrich the data analysis and interpretation.

1. *Øvretveit and Gustafson* (2002, p. 272) have mentioned the following designs and methods which have been used for assessing EESs. They have argued that these methods may provide decision-makers with workable guidance on how to plan and implement these evaluation programmes.

- Descriptive case design: this design simply describes the EES as implemented, within which there is no attempt to gather data about outcomes.
- Audit design: this is a quick and low-cost evaluation method which usually takes the form of a written statement, such as a protocol, as to what any external programme should do and what it is actually doing. According to *Øvretveit and Gustafson* (2002), audit research of accreditation or other review systems may help managers to develop more cost-effective reviews.
- Prospective before-after designs: this design gathers specific data about the effect of evaluative intervention before and after the intervention.
- Retrospective or concurrent evaluation designs: in this case, a researcher investigates previous theories or empirical research to identify critical success factors and then tests them to find out which are associated with successful and unsuccessful programmes.

2. *Harvey and Wensing* (2003, p. 211) have outlined four types of evaluations for small-scale projects (such as quality assessment or improvement initiatives), including:

- Focused audit studies which monitor impact of the project activities over time. This design mainly centres on a single project and the evaluation is a component of the project quality improvement phase.

- Developmental studies that identify problems and intervene when necessary, and develop hypotheses for testing raised issues. This method mostly functions in a similar manner to action research design.
- Multiple case-studies draw up case reports and comparisons across a number of local projects. Key steps here are as follows:
 - Select individual cases relevant to the issues to be studied.
 - Collect data within individual sites using a range of quantitative and qualitative methods.
 - Analyse the data within individual sites using appropriate quantitative and qualitative methods of analysis- for example, descriptive statistics, and thematic analysis of qualitative data.
 - Compare data analyses across sites to draw more general conclusions and/or generate hypotheses for further testing.
- Process evaluations explain the findings of a bigger research project via in-depth analyses of the project. They also provide important insights into how and why programmes work in practice.

3. *Walshe et al. (2001, p. 368)* have developed an evaluative framework which requires consideration of the following items for assessing and analysing EESs:

- Purpose: objectives of the system for external review
- Organisation: those who undertake the organisation and implementation of the system
- Overall approach: when and how they are initiated - either universally or targeted, voluntary or mandatory
- Methods: homogeneity or heterogeneity of methods
- Results: what is done with the results? How are they used to effect change or improvement?

4. *de Walcque et al. (2008, p. 7)* put forward a conceptual structure grounded in the literature comprising five main building blocks which allow a comprehensive analysis of an AP, including:

- Policy: includes AP's intentions, supporting structure, incentives for stimulating hospitals' participation and coverage
- Governance: comprises stakeholders' participation level in accrediting bodies and their internal organisation
- Methods: composed of accreditation standards, measurement, surveyors' training and recruitment, change management, decision and appeal, and results diffusion
- Funding mechanism and sources: encompasses income and expenses related to AP
- Evaluation: refers to programme evaluation and outcomes, outcome measurement and related key indicators

2.9.5. International efforts

Agenda for Leadership in Programs for Healthcare Accreditation (ALPHA)

At international level efforts have also been made to provide a springboard for accrediting APs and accrediting bodies in health care (Heidemann, 2000). The International Society for Quality in Healthcare (ISQua) established its International Accreditation Programme (IAP), which is called ALPHA, in 1999 (Heidemann, 1999). The ALPHA has been set up to achieve the following main objectives (Heidemann, 1999, p. 275):

- to demonstrate internationally that accreditation is a credible evaluation process;
- to show that external and objective evaluation of a national accreditation organisation is possible and that there is a means of doing this;
- to respond to the growing and ongoing need for an international accreditation forum and organisation through which knowledge and experience about accreditation can be shared; and

- to make standards-based assessment systems more reliable, valid and compatible within and among countries

The tasks for ALPHA were as follow (Shaw, 2004c, p. 38):

- begin harmonization of national programmes
- define principles of standards and programme operation
- evaluate accreditation agencies
- support new programmes
- accredit training programs for training surveyors

ISQua has published a set of generic standards and principles for accrediting the APs and the healthcare standards of different countries at international level (Shaw, 2007; Anonymous, 2007b; 2007a). Its aim has been to provide pertinent guidelines for developing new APs and to assist accreditation systems to be superior to other EESs (Shaw, 2004c).

In summary, this chapter has laid out the general context for PM in health care with a special focus on healthcare accreditation as a widely-used/known macro PMS/MCS in health care sector. Next chapter is to concentrate on the specific context of chosen case for current study. Providing descriptive information, the chapter continues to discuss the related studies and establish the gaps in the overall and specific (in relation to the context under study) literature.

Chapter 3 - Iranian Hospital Accreditation and Evaluation System

3.1. Introduction

In the previous chapter an exposition of performance measurement and various PMSs at a general level was presented. The aim of this chapter is to introduce Iran's national AP for hospitals (at a more specific level), whose performance is examined in this study. Detailed scrutiny of its performance requires a basic understanding of the different aspects of the health system in Iran. Therefore, the first section provides some general information about the Iranian healthcare structure. In the second section, a short history of hospital evaluation and accreditation in Iran is given, including the current AP. Then, the studies conducted on this programme are reviewed in the third section. Following this literature review, the research establishes the gaps in the literature as the final section of this chapter.

This chapter gives useful background information on the different aspects of the NAPH and reports on its modifications over time. It enables a better understanding of the findings of the study upon the impact of the programme on the hospitals. The information given in this chapter is the result of primary data collection and documentary analysis by the researcher.

3.2. The Healthcare system in Iran

Iran¹² is a member state of the Eastern Mediterranean Regional Office (EMRO) of the World Health Organisation (WHO). EMRO includes countries from the Middle East and

¹². Brief introductory information is provided in the Appendix A about the country.

the northeast of Africa, such as Yemen, Lebanon and Morocco¹³. The Iranian healthcare system has been restructured and steadily improved during the past three decades (Mohit, 2000).

The constitution of I.R.I. guarantees all citizens a right of access to health care (I.R.I., 1979b). To this end, the MoH¹⁴, as the ultimate authority of the country's health care, is responsible for the aspects of planning, policy-making, leading, supervising, funding and evaluating the health services and medical education in the country¹⁵ (Mohit, 2000).

However, the executive responsibility has been put on the shoulders of the Universities of Medical Sciences and Health Services (UMSHSs, the UMSs hereafter) at provincial level. These duties include the tasks of providing healthcare services and training the required human resources at all levels of education (Majlis, 1985; 1987; 1988a). While the MoH is essentially concerned with questions of policy-making and financing, the UMSs are responsible for management, organisation and delivery of health services at provincial levels. The UMSs, at least one in each province, play an important role both in medical education and provision of health services. The chancellors of the universities, who are also apparently the deputies of the health minister in their respective province, are the executive directors of the provincial health services and in charge of all hospitals and health centres. Provision of healthcare services in the country at provincial level is undertaken at three levels; primary, secondary and tertiary (Anonymous, 2008). Primary health care, the most accessible services geographically, are provided in rural areas by some basic health centres called Health Houses (HHs) as well as on a limited scale in urban areas, especially in small cities, by Health Bases (HBs), the equivalent of Health Houses in urban areas. These are under the supervision of Rural and Urban Healthcare centres respectively. The secondary level includes the more advanced services and initial access to district hospitals is made possible at this level (Shadpour, 2000). The first and second levels are included in a District Healthcare Network (DHN) and the hospital at this level is the first point of referral from the lower level. The district, in Iran's healthcare system, is the smallest autonomous region and the most natural administrative level promoted by the WHO for healthcare delivery (Mohit, 2000). The DHN provides support

¹³. WHO Member States are grouped into the six regions and each region has a regional office; such as EMRO, SEARO (Regional Office for South-East Asia) and PAHO (Pan American Health Organization).

¹⁴. Since 1985, health and medical education was separated from the country's Higher Education Ministry and merged into the MoH.

¹⁵. A full list of the MoH's tasks is presented in Appendix F.

and supervision for the centres at primary and secondary levels. The services delivered in all the DHNs are called ‘primary health care (PHC)’, which was accepted by the member states of the WHO as the key to achieving the goal of health for all (WHO, 1978). A primary healthcare centre is the basic structural and functional unit of the public health services in developing countries and was established to provide accessible, affordable and available primary health care to people, in accordance with the Alma-Ata Declaration (Tarimo, 1991). As for the importance of district level health care, Tarimo (1991) has indicated that each district covers not only a small enough area that staff are able to understand the major problems and constraints of its socio-economic and health development, but also large enough units for them to develop the technical and managerial skills central to its planning and management. Figure 3.1 displays the organisational layout of all health centres at district level. Tertiary level includes the UMSs and hospitals which provide the most advanced healthcare services in the country. This level is the final referral point of service for lower levels of health service delivery process.

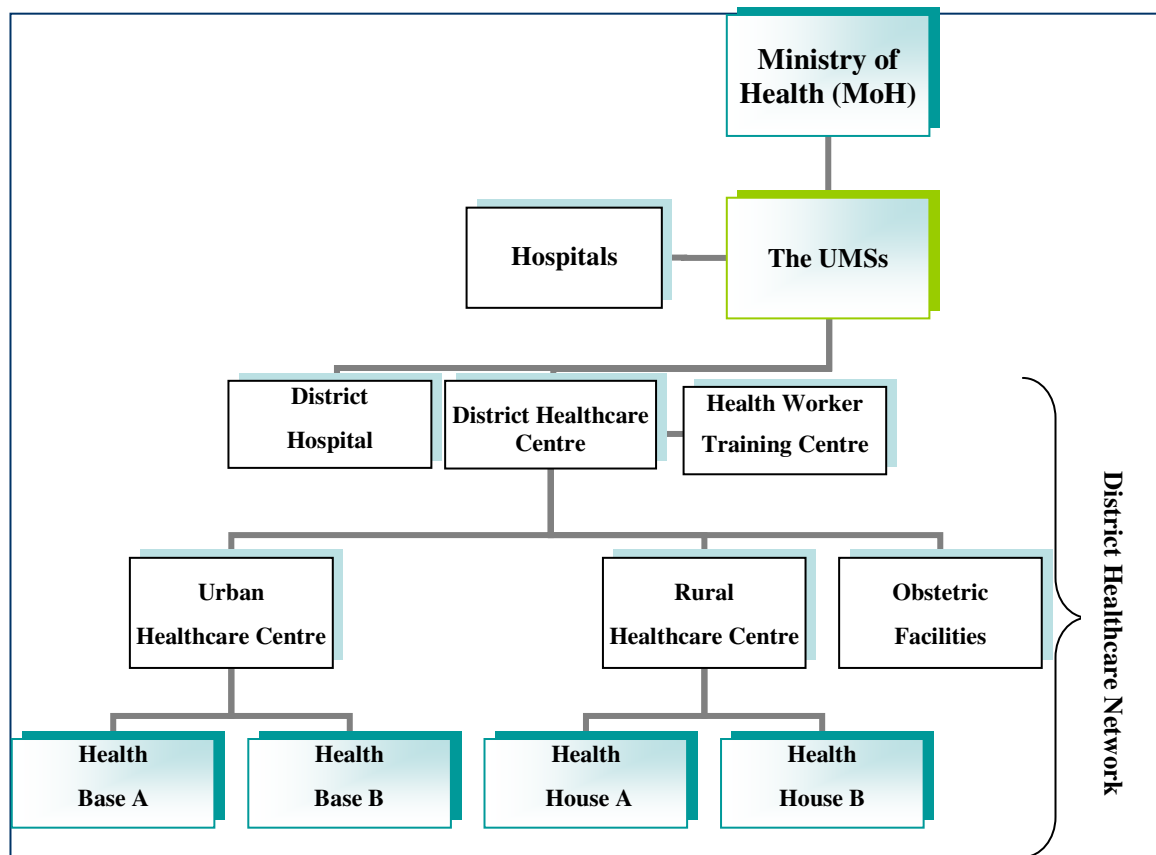


Figure 3.1 Organisational Chart of Iran's Healthcare System Organisation (Source: developed by the author)

3.2.1. Tertiary level of healthcare delivery- Hospitals

General and specialty hospitals are positioned at this level of the healthcare system. These HCOs are the main bodies providing and delivering advanced medical and clinical services in the country, mainly in the cities. There are two main categories of hospitals in the Iranian healthcare system, namely public and private, according to the way they are governed and funded (Figure 3.2). The public hospitals are owned by the government whereas private ones are owned by non-governmental organisations, bodies or individuals. These two categories can be further subdivided into more classes. For example, private hospitals are placed into for-profit and not-for-profit (charity) categories and the public hospitals are subdivided into university and institutional hospitals. Some organisations in Iran such as the Petroleum Ministry, the Military and Welfare organisations have their own hospitals that only serve their staff and their families, although some of them are currently open to the general public, too. The university hospitals are those which are governed and operated under direct control and supervision of the UMSs. These are also divided into two groups: teaching hospitals which provide clinical services and undertake medical training, education and research, and the clinical hospitals that are responsible only for delivering clinical services. The former, unlike the latter, are mostly located in the big cities of the provinces.

The main financial resource of all the hospitals is determined through their income from the services they provide. In addition, the public hospitals are also partly funded by the state through a central budget scheme. The services of the hospitals are priced based on the accreditation grade (explained below) of the hospitals. That is, the hospitals must fulfil a number of regulatory requirements, set by the MoH and checked by the UMSs, to be allowed to charge the highest rate for their (hotel-type) services.

Since the evaluation and accreditation of HCOs in Iran currently only involves the hospitals, despite a later and so far unrealised intention to spread that to other health centres (Sadaghiani and Zare, 2005), this research will concern itself only with the hospitals to maintain its relevancy to the main objective of the research, which is performance analysis of the accreditation and evaluation system of the hospitals. In this research, the hospitals will be mostly referred to as teaching and non-teaching hospitals (NTHs), the hospitals not owned by the UMSs.

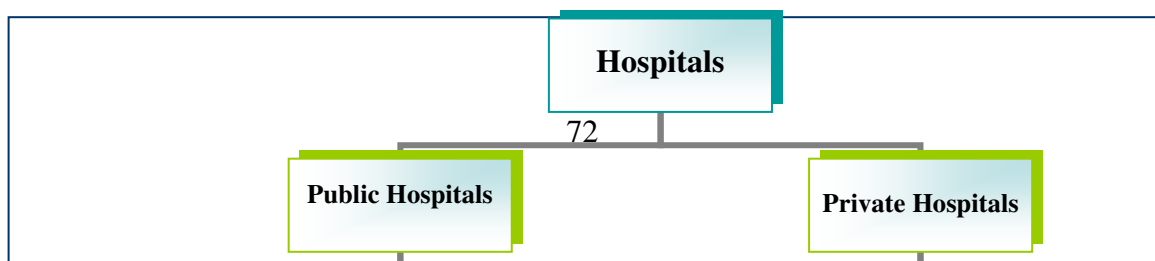


Figure 3.2 Classification of Hospitals in Iran's Health System (*Source: developed by the author*)

3.3. Evaluation of hospitals in Iran

3.3.1. Brief History

The first serious attempts to evaluate the hospitals in Iran could be seen during the institution of the third development plan of the country between the years 1962-1967. The main focus of these efforts was on the evaluation and accreditation of public and private hospitals. The evaluation checklists at the time were allegedly developed on the basis of successful international experiences (Sadaghiani, 1997; Shaw, 2004c). Following attempts to cover all departments of the hospitals such as management, medical and paramedical services, the main focus of these checklists was on nursing activities in view of their importance and volume in hospitals (Srinivasan, 2008). That scheme underwent some important modifications in 1986, especially in regard to the distribution of the scores allocated to the activities of accredited hospitals, even though these changes, as Sadaghiani

and Zare (2005) argue, could not make much improvement in the process of accreditation. Iran's current accreditation system basically started in 1997 and is, in turn, an upgraded version of the year 1986 programme (MoH, 1997a). Prior to year 1997, as indicated by a senior member of the surveyors, only one surveyor assessed all activities of each hospital, but since then the system has been specialised and different surveyors have been deployed to assess different areas of activities in the hospitals.

3.3.2. Accreditation of hospitals

Accreditation in Iran is a compulsory, government-sponsored, state-run initiative similar to a few other countries such as France and Egypt (Giraud, 2001; MoH, 1997a; USAID, 2005). As Scrivens (2002) puts it, government-owned accreditations are growing and are mostly being used to accomplish governments' regulatory tasks in monitoring and evaluating HCOs. Canada is also thinking of making some elements of its AP compulsory (Touati and Pomey, 2009). In developing countries, accreditation is increasingly being used as a tool for government regulation to guarantee quality of care in HCOs (El-Jardali et al., 2008). Shaw (2003a) also points to the adaptation of traditional models of voluntary and independent accreditation to use as a government-sponsored or statutory tool for control and public accountability in health care. de Walcque et al. (2008) show that most APs are embedded in a strong supportive structure by means of legislation and/or government policy. They realised that there is a clear trend of increasing government involvement in hospital accreditation and more programmes are being managed within Ministries of Health or by a separate government agency (de Walcque et al., 2008).

The NAPH might not be referred to as an AP in its conventional sense, given the generic features (i.e. voluntary and independent) of traditional accreditation (Scrivens, 1995a; 1997a). However, in accord with the foregoing discussion on governments' involvements and the relevant features of the NAPH (e.g. conducting an external assessment and ranking the hospitals based on the published standards), it might be considered as an AP. The NAPH has a national standard-setting and local monitoring status (Scrivens, 1996). Awarding of the highest accreditation grade, as Braithwaite et al. (2006) put it, is deemed a valid indicator of high organisational performance and it is central to safety and quality in HCOs.

Overall, Iran's evaluatory programme could be conceptualised as mandated, punitive, quasi-confidential, announced, standard-based, prescriptive and structure-oriented with a minimum requirement, absolute-measurement and multi-level award accreditation system, on the basis of the typology of APs, developed by Joint Commission International and displayed in figure 3.3 (Van Ostenberg, 2005).

Mandated -----	Voluntary
Punitive -----	Improvement-oriented
Cyclical -----	Continuous
Prescriptive -----	Non-prescriptive
Confidential -----	Publicly disclosed
Minimum requirements -----	Cutting edge requirements
Reactive -----	Proactive
Announced -----	Unannounced
Retrospective -----	Prospective
Standards-based -----	Performance measured-based
Process-oriented -----	Outcomes-oriented
Absolute measurement -----	Comparative measurement
One-level award -----	Multi-level award

Figure 3.3 Philosophy of Accreditation- *Source: de Walcqque et al. (2008, p. 6)*

3.3.3. Governance of the NAPH

The governance structure of accreditation and evaluation of the HCOs in Iran can be explained on two levels, that is, macro and micro.

3.3.3.1. Macro level

The MoH is responsible for evaluating and assessing the HCOs, according to the Iranian constitution (Majlis, 1985; 1987). The Centre for Healthcare Accreditation and Supervision (CHAS), itself a division of the MoH's Health Under-secretary, is the main authority for undertaking policy-making, planning and direction of hospital accreditation and evaluation activities in the country. A specific task group within this centre called Healthcare Organisations Evaluation Group (HOEG) deals directly with these activities in the MoH. According to the official documents and formal guidelines (MoH, 1997a, p. 4), the following tasks are conducted at macro level, in the CHAS, in relation to the issuing of hospital accreditation (Moghimi, 2004, p. 6):

1. Policy-making, planning, coordinating accreditation activities in the country;
2. Designing, developing and updating the accreditation standards and checklists;
3. Supervising and monitoring the accreditation operations of the UMSs
4. Final control and approval of accreditation report and awarded certificates sent up from the UMSs;
5. Supporting the UMSs in their hospital evaluation activities (e.g. training programmes for surveyors);
6. Random and unannounced visits of HCOs across the country in the case of unresolved complaints by the HCOs that are not solved at provincial level.

3.3.3.2. Micro level

At micro (local) level, the UMSs are responsible for operationalising and implementing the accreditation and evaluation of hospitals. Except for the capital city, Tehran, where there is more than one UMS and the hospitals are divided among them for evaluation, the hospitals in each province are evaluated by relevant provincial UMS (Raisi, 2006). As the official documents showed, the following hierarchical levels were in place at micro level for evaluating the hospitals:

1. The UMSs' council for evaluation and supervision

2. Treatment deputy of the UMSs
3. Treatment manager of the UMSs
4. HOEGs of the UMSs

Although these hierarchical groups have their own duties in regard to the evaluation of the hospitals, the main tasks of hospital evaluation in context rest on the shoulders of the last group, i.e. the HOEGs at the UMSs. The council is only involved in major policies with regard to the evaluation in the UMSs. As such, coordination with the MoH for approving the accreditation certificates, communication with third-party organisations (e.g. insurance companies), selecting the members of the UMS's HOEG and supporting the evaluation activities at provincial level are expected to be carried out by the authorities at second and third levels.

The HOEGs, including a number of surveyors, annually undertake the surveying of hospitals located in a province under the scope of corresponding UMS. In fact, the HOEGs operationalise the evaluation intentions of the MoH in related hospitals at micro level. They are further supposed to make sure the hospitals stick to the standards over a period of one year before the next evaluation (MoH, 1997a). However, the extent to which this ongoing monitoring of the hospitals by the HOEGs is happening in practice has been contentious and disputed by the hospitals. According to the relevant policy documents for hospital evaluation, the members of a HOEG in the UMSs should be as follows (Moghimi, 2004, p. 8):

- Two consultants from different disciplines such as internal medicine and paediatrics
- Two paramedics including one radiologist and one laboratory technician
- One nurse
- One medical equipment engineer
- One establishment and construction expert
- One administrative and personnel expert
- One financial and budget expert
- Team coordinator
- Healthcare management expert
- Other experts if required

A representative from insurance (purchasing) organisations is also a permanent member of this surveying group.

3.4.4. Main features of the NAPH

Overall, this AP has the following features:

- It is developed and supervised by the MoH, but implemented by the UMSs;
- All types of hospitals are obliged to participate in this programme;
- There is no participation fee for the hospitals;
- It is conducted annually and the rankings (grades) are valid for one year;
- The surveyors are from a varied range of disciplines such as healthcare management, general practice, nursing, and laboratory.
- The hospitals have the right to complain about their accreditation grade

3.4.5. The standards of the NAPH

The apparent aim of the accreditation standards was to establish and ensure the hospitals' ability to deliver quality and safe care (Moghimi, 2004; MoH, 2008). These standards were entirely similar for all types of hospitals (public and private) across the country, as explored earlier (see Figure 3.2). They have been developed at macro level in the MoH and officially dispatched to the UMSs at micro level to be used for the evaluation of the hospitals. The main objective of these standards is, as asserted in the policy documents, 'continuous quality improvement' at all levels of 'general' hospitals' activities (Moghimi, 2004, p. 5). The standards, exhibited in table 3.1, have not changed since the year 1997, apart from the addition of a handful of new qualitative standards (explained later in this chapter) a few years ago, in a bid to make the programme more 'quality-oriented' (MoH, 2004).

Table 3.1 The distribution of the NAPH's standards and corresponding scores for different categories of the hospitals' activities- Adapted from Moghimi (2004, p. 26)

Row	Categories of the standards	Range of the scores	Proportioanal score (%)
1	Religious and humane values	1400- 2000	10.1
2	Management	700- 1600	6.8
3	Medical staff	2160- 3600	17
4	Nursing staff	880- 1600	7.3
5	Other personnel	680- 1200	5.5
6	Estabilishment and physical structure	1100-2000	9.2
7	Safety equipment	480- 600	3.2
8	Non-medical equipment	400- 800	3.5
9	Medical equipment	990- 1800	8.3
10	Patient satisfaction	600- 1000	4.7
11	Information system and medical records	600- 1000	4.7
12	Sanitation and cleanliness	640- 800	4.2
13	Hospital committes	640- 1000	4.8
14	ED	467-1873	6.9
15	Quality indicators	198 - 795	2.96
	Total	11935-21668	100
	Other items*	2000	
* This score can be added equally to the final score for the teaching activities (education and research), ICU and CCU ¹⁶ , other special departments (e.g. Dialysis) and etc. based on the surveyors' judgments.			

As the table displays, overall 16 general domains of activity are covered by the standards of the NAPH. Each domain poses a number of questions and statements in the form of checklists to cover all aspects of the domains (MoH, 1997a). The number of questions might vary slightly in terms of a NTH or teaching hospital. In some cases the MoH has

¹⁶. Intensive Care Unit and Coronary Care Unit

provided guidelines to assist the surveyors to allocate related scores to the activities of the hospitals (e.g. for the quality-oriented indicators). However, in most cases there were no criteria and the surveyors' judgement, observation and interviewing would take the place of the criteria.

3.4.6. The evaluation process of the NAPH

Accreditation of the hospitals is conducted annually and a hospital's next accreditation is expected to take place prior to the expiry of its current accreditation. Alternatively, a hospital might request the evaluation of its activities on a specific date before the next due evaluation. The former procedure was more dominant in the case-study of this research. The hospitals are notified and a date for an on-site survey is arranged.

The process begins with a pre-arranged (announced) site visit by the team of surveyors. The evaluation usually takes no more than one week depending on the size of hospitals and the number of in-patient beds. During the evaluation process the surveyors pertaining to their own specialties investigate different aspects of hospitals' activities including medical equipment, and clinical and paramedical spaces; they interview medical staff (mainly nurses) and sometimes patients, and finally review the related documents.

The evaluation starts with the emergency department (ED) of the hospital. The evaluation of ED is conducted entirely independent of the rest of the hospitals and has important implications for their assessment. That is, if a hospital does not obtain acceptable scores for its ED, the evaluation of the hospital will be suspended until the ED gains a satisfactory score. Furthermore, the overall grade of the hospital can never exceed the grade of its ED (MoH, 1997a). In this situation, the hospital will be given at most three months to rectify the problems and prepare for re-evaluation of its ED. This emphasis on the EDs, given the nature (i.e. vitality) of the activities in this department, is understandable. However, it might also force the hospitals to unwittingly neglect their main activities to obtain higher grades for their EDs' accreditation. Successful evaluation of EDs is a departure point for the evaluation of entire hospitals. At the end of the accreditation visit the surveyors are expected to hold a meeting with managers of the hospital to discuss the problems and to brief them on existing non-compliances with pre-announced standards. The result of the assessment is usually sent to the hospitals within a month of the site visit and, if any

hospital is non-compliant, namely achieving grade 4 (see Table 3.2), it is given three months to improve its deficiencies and solve its identified problems¹⁷.

Table 3.2 The scoring system of the NAPH for hospitals - Source: Moghimi (2004, p. 12)

Score	Grade	Explanation
21669 and more	+1	Excellent
18369 - 21668	1	Good
15869 - 18368	2	Intermediate
13219 - 15868	3	Poor
10869 - 13218	4	Substandard (Non-compliant)
10868 and less	-	Unauthorised ¹⁸

A second visit will be paid to substandard hospitals and a final decision is made after this stage. Those showing no improvement after this time are not allowed to function as a hospital and are downgraded to minor surgery centre/clinic. Different types of decisions (i.e. grades) are taken based on the reviewed performance of the hospitals. Table 3.2 displays the range of scores and corresponding grades granted to the hospitals by the NAPH. The hospitals have one week to complain about the grade they are awarded. The formal grade is then announced by the MoH, through the UMSs, to the hospitals and insurance organisations (see Figure 3.4). The performance grade is intended to give an overview of how a particular hospital is performing in addressing and meeting the quality and safety requirements of the MoH. The rating status of hospitals is used as a threshold for their eligibility to raise their tariffs for hotel-type services (MoH, 1997a). This is the main source of the hospitals' income. Insurance organisations reimburse the hospitals according to their grade in accreditation. The hospitals recognised as 'substandard' by this programme will not be able to provide services for society under their current status. All

¹⁷. During this period the hospital can only charge at 50 percent of the tariffs for a grade 3 hospital.

¹⁸. These hospitals are not authorised to work as a hospital. They could work as a limited-surgery clinic (LSC).

this shows how crucial this accreditation is for the hospitals in the country. Accordingly, it is vital to study the performance of this AP, since the outcome of the accreditation is overly influential for different groups including mainly patients.

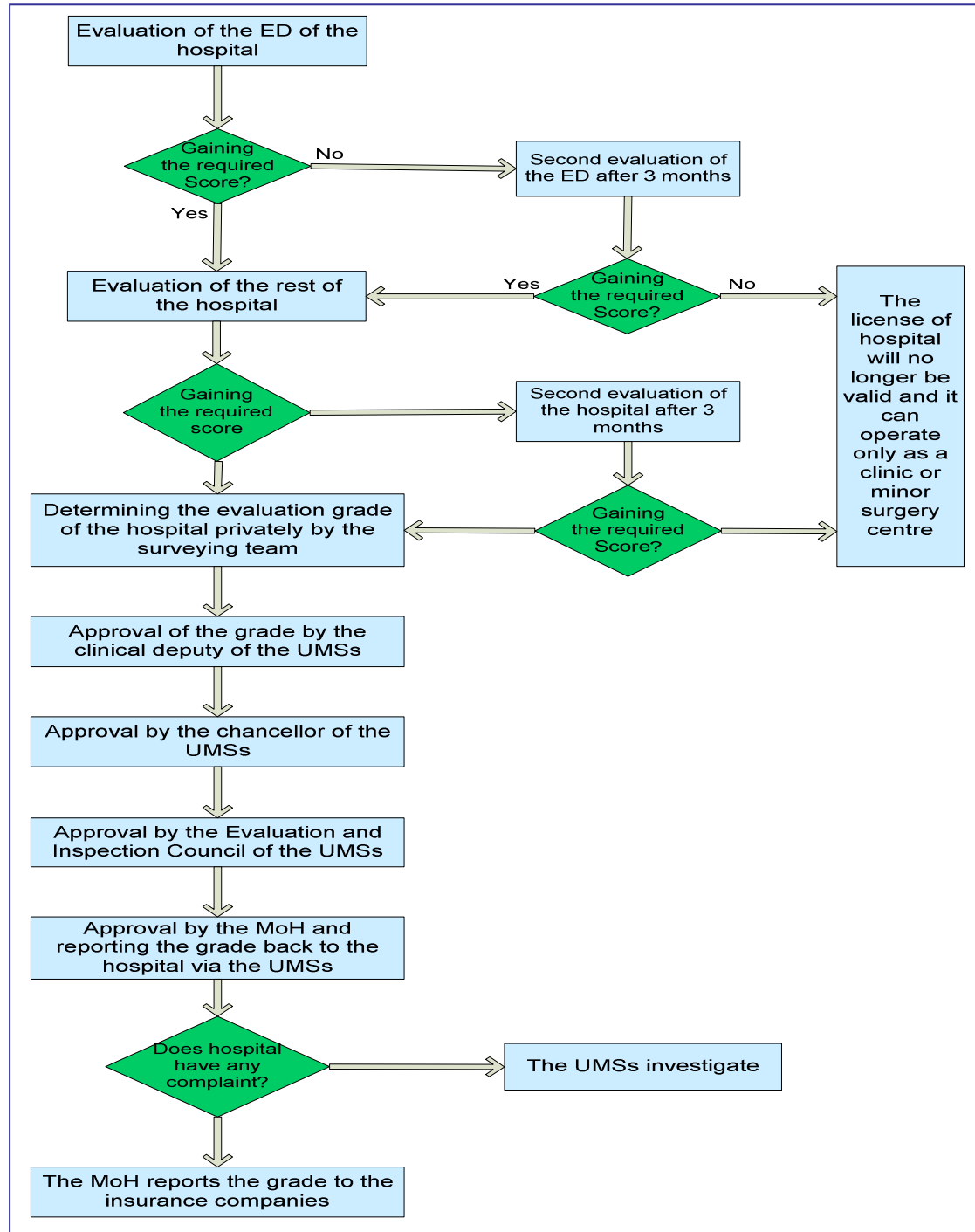


Figure 3.4 The typical process of hospital evaluation system in Iranian Healthcare System-Adapted from (Anonymous, 2004)

3.4.7. Modification of the NAPH

The MoH has instituted the introduction of new standards and made some alterations to the structure of the scoring system and prioritisation of the standards in order to improve the functioning of this evaluatory mechanism (e.g. MoH, 2004; 2006; 2008). The major modifications are explained below.

1. Introduction of quality indicators

The major change in the NAPH was the introduction of a new series of standards from 2004, in order to increase the capability of the programme to focus on and measure quality in the hospitals (MoH, 2004). This effort came after the MoH's stated intention at the inception of the NAPH to replace and update its standards gradually by more quality-oriented standards, something that was not fulfilled until this change (Moghimi, 2004). It is argued by Moghimi (2004) that only five percent of the NAPH standards have been, in practice, related to quality indicators in the hospitals. Therefore, considering the NAPH's defects, a fact recognised by the authorities (Moghimi, 2004), the MoH decided to add a new element to this programme in a bid to increase its capability of measuring and improving quality vis-à-vis quantity in the hospitals (MoH, 2004).

The MoH launched this supplementary programme called the 'Practical instruction for the quality evaluation of hospitals' as a pilot scheme from 2003, and formally and in a compulsory fashion from 2004 (MoH, 2004). As Moghimi (2004) points out, during the pilot phase, which was voluntary for hospitals, there were a few problems such as the hospitals' reluctance to disclose their information and their low awareness about implementing these guidelines. However, overall assessment manifested their tendency to apply this new addition. These guidelines were expected to accomplish three important goals as follows (MoH, 2004, p. 2):

1. To assist with improving quality in hospitals;
2. To provide necessary information for decision-makers (possibility of informed decision-making); and
3. To enhance the level of accountability and regulation of HCOs.

The indicators of this new part, similarly to the main standards of the NAPH, were both concerned with activities of the EDs and whole hospitals. The intention was initially to develop more quality-oriented standards every year (MoH, 2004). However, so far only the indicators demonstrated in table 3.3 have been developed. They are the result of international experience and consultancy with different professional associations (Moghim, 2004).

Table 3.3 Quality-oriented indicators of the NAPH- adapted from MoH (2004)

Scope	Indicators
EDs	<ul style="list-style-type: none"> ▪ The average length of time after which a physician visits the patient when s/he arrives at a ED ▪ The average length of time after which nursing services are delivered to a patient in ED ▪ The rate of customers' satisfaction of services provided in ED
Hospitals	<ul style="list-style-type: none"> ▪ The rate of Nosocomial infections in the hospitals ▪ Safe and sound injections ▪ Necessary assessments before any operation on elective patients ▪ The ratio of C-Section to whole natural births in a hospital ▪ Prescription of prophylactic antibiotics before operation ▪ Sedation of pains caused by scald (burning) and operations

Hospitals are given the relevant forms to record their information in relation to the above indicators during two six-month periods, forwarding them to the surveyors when required. The surveyors will decide and score on the basis of the information provided in the related documents of the hospitals. Although these indicators reflect a positive step towards measuring quality in the hospitals, as is the main mission of this AP, they constitute only a small proportion of the previous standards. They represent only around three per cent of the overall score of the NAPH for a hospital (see Table 3.1).

2. New prioritisation for the areas of evaluation

In addition to the EDs, which had a critical importance from the beginning of the NAPH, as discussed earlier, the evaluation of the areas of Medical Records, Sanitation and Cleanliness, Hospital Committees and Quality Indicators were similarly mandated by the NAPH from 2006 as prerequisites for the evaluation of the whole hospitals (MoH, 2006). The hospitals were required to obtain adequate scores in these four domains, while the EDs had to be evaluated first, before the awarding of a final accreditation grade. ‘The authorities of the NAPH have made these changes to thereby accentuate the importance of these areas to the hospitals (quoted from a surveyor)’. If the scores in any of these areas fall below the acceptable range of score, the hospitals need to improve them and provide the authorities with new confirmation of improvement within six months. Otherwise, their grade will be reduced.

With this alteration, the MoH has shown its intention to induce continuous quality improvement and remind the hospitals of the main areas of importance, as articulated in the policy documents (MoH, 2006).

3. Changes in the grading procedure

In line with this mandate, as of year 2009 those hospitals that obtained a grade lower than grade two (see table 3.2) would be considered and treated by the surveyors as ‘substandard’. The intention of the MoH with this alteration has been to raise the bar for quality improvement in the hospitals and press them for greater efforts to earn higher grades (MoH, 2008).

3.4. Literature on Iran’s Healthcare Accreditation

The NAPH has been the subject of a number of studies inside the country. Some have investigated the programme’s impact on the performance of the reviewed hospitals (e.g. Baghebanian, 2001; Arab et al., 2005). Examining the impacts of the NAPH on the state of performance indicators in a number of teaching hospitals, Arab et al., (2005) could hardly find any significant association between higher grades in accredited hospitals and the

improved outcomes in the hospital performance indicators, such as length of stay (LOS) and bed occupancy rate (BOR).

Another group of studies has conducted comparative research exploring and developing a model for the accreditation of hospitals in Iran (e.g. Amerioun, 2001; Sadaghiani and Zare, 2005; Raisi, 2006). Raisi (2006) has undertaken a comparative study to present a model for formulating an accreditation system in Iran through investigating accreditation systems in a range of selected countries. His study points out that the standards of the NAPH would not have the capability of improving the quality and safety of the hospitals' services, even though the first and foremost objective of accreditation is to ascertain quality and safety of delivered health care (Jovanovic, 2005; Daucourt and Michel, 2003). He further adds that these standards are different from those of the JCAHO (Raisi, 2006).

Some studies have addressed the NAPH's focus on accrediting the hospitals (Amerioun, 2001; Mosadeghrad and Ansarian, 2005). They express that this programme mainly assesses physical structures and processes of a hospital as compared to its outcomes. Recently, the NAPH has started to deal with this problem by introducing some clinical outcome-related standards into its assessment process (MoH, 2004).

Another aspect approached in the literature is concerned with the planning and implementation processes of the NAPH. Some have noted that the programme has mostly a one-sided and centralized approach that is directed only by its governing body (i.e. government) without any representatives from other stakeholder groups (Mosadeghrad and Ansarian, 2005). Moreover, as explained in chapter two, the evaluation checklists are developed directly in the MoH and delivered to the UMSs for implementation (MoH, 1997a). The problem here, as the studies indicate, is that the accreditees have been prevented from playing any part in this programme; this gives rise to their dissatisfaction with and negative attitudes towards this way of evaluating the hospitals (Amerioun, 2001; Jaafariipooyan et al., 2004). Research by Lekakul (2000) has found that the negative attitudes towards the hospital accreditation process by the accreditees could cause difficulties in the implementation process of accreditation.

The credibility of the NAPH's surveyors has been questioned by Jaafariipooyan et al. (2004). The hospitals researched by their study have mostly claimed that the surveyors are not thoroughly familiar with hospitals' activities and practices. This may overshadow the programme's progress in the future. Scrivens (1997a) argues that the success of an AP can

be affected by the credibility of its surveyors. Conducting a questionnaire survey of 53 hospital managers and 30 surveyors in one province, Mosadeghrad and Ansarian (2005) found that the surveyors had more negative attitudes towards the AP than the hospitals' managers. They attributed this to greater awareness among this group of the NAPH's weaknesses. Whatever the reasons for this, such feelings towards the accreditation may damage their willingness to pursue the programme's objectives (Lekakul, 2000). In other words, their role has been viewed as very important for the effective functioning of an AP by some studies; O'Leary (2000) expresses that the contribution of staff in assessing and improving services can enhance their safety and quality, and Scrivens (1997a) has also considered staff members' satisfaction with the programme an influential criterion indicative of its effectiveness.

Amerioun and Khalesi (2007) in a recent study examined the NAPH in terms of its process and possible effect. They surveyed 70 senior managers in the MoH and in Tehran's hospitals asking their views on the system and its possible effects. The conclusion of their study showed that the respondents did not approve of the current grading system and believed that it should be changed (Amerioun and Khalesi, 2007).

In summary, the forgoing studies have concentrated on different aspects of this AP (i.e. the NAPH). They have partly examined the NAPH's impact on hospitals' performance quantitatively, provided practical insights for the NAPH on the basis of a comparative study of a few other countries' APs, and also explored some hospital managers' and surveyors' views on this programme.

3.5. The gap in the literature

The fairly comprehensive review of the related studies, as explained earlier, revealed the following gaps in the literature. These gaps are explained at two levels- i.e. macro (in relation to general agenda of PM and literature about the EESs including APs) and micro level (specifically related to Iran's healthcare context and AP).

3.5.1. Macro level

- A majority of the studies on the performance of macro PMSs/EESs (e.g. accreditation) have been conducted in developed countries and empirical evidence on the programmes of developing countries is to a large degree lacking in the existing literature. Very few studies have focused on the performance analysis of this programme in these countries (e.g. El-Jardali et al., 2008; Al-Tehewy et al., 2009). In addition, most of the existing studies (specifically in developing countries) have assumed a rationalistic (functionalist) approach to the performance of APs. Applying quantitative methods (e.g. surveys), this approach is arguably prone to ignoring contextual aspects and their effects on the programmes' effectiveness which are more likely to be addressed through qualitative and in-depth studies (Modell, 2001; Chang, 2006). Therefore, given the significance of contextual aspects in the effectiveness and implementation of macro PMSs (Broadbent and Laughlin, 2009; Ferreira and Otley, 2009), studies concentrating on the contextual effects of PMSs (i.e. societal and organisational situation in which the PMSs are located and operate) in developing countries could add to the existing knowledge on performance measurement in the public sector.

Broadbent and Laughlin (2009, p. 290) describe the context as '... the nature of an organisation or the part of the organisation which a PMS attempts to control. It also refers to the channels through which the PMS attempts to achieve its aspirations...' The importance of context is widely and variously emphasised in the literature. According to Whetten (1989) empirical observations and investigations are grounded and understood within a context. Modell (2009) argues that there are other factors (e.g. contextual, political and social), besides technical and instrumental aspects, which impinge on the influence of PMSs on organisations that are not addressed by functionalist approaches. Similarly, the effects of contextual factors on the design and implementation of PMSs are acknowledged by different studies (e.g. Bond, 1999; Broadbent and Laughlin, 2009; Abdullatif, 2007). In particular, Laughlin and Broadbent (1996) point out that regulatory systems lacking a focus on contextual aspects such as organisational culture and complexities might not necessarily be effective in controlling organisational practices in health care. Therefore, the organisational context in a developing country, focused on in this research, is one which has been overlooked by the mainstream performance measurement and

improvement literature. The context in this study mainly points to the hospitals under study and the way they are controlled by the NAPH. Therefore, a contextual evaluation of the NAPH is one based on the perspectives of the hospitals and their reactions to the nature and merits of the NAPH. Such an approach to evaluation sides with Laughlin (2007, p. 281), who argues: ‘a meaningful evaluation of external PMSs can only be undertaken by judging their merit, worth and quality in a particular context to which they are targeted.’ In addition, the concept of context in this study also implies the attributes attached to the NAPH which might influence its performance.

- The studies on APs in developing countries are to a large extent based on a simple empiricism and quantitative assumptions, and are not backed by theoretical underpinnings (e.g. El-Jardali et al., 2008; Al Tehewy et al., 2009). This is in the midst of an extensive call in the literature for application of theoretical and societal models in the evaluation and study of macro PMSs/EESs, including accreditation (e.g. Horton, 2004; Mannion et al., 2005; Øvretveit, 2005; Øvretveit and Gustafson, 2003; Chuang and Inder, 2009; Walshe, 2007; Grol et al., 2007; Greenfield and Braithwaite, 2009). These studies have maintained that theoretical models could produce more justifiable and grounded understanding of the PMSs’ effects on their subject organisations. Existing research on APs in health care, as Nicklin and Dickson (2009) have stressed, lacks rigorous and theoretical depth. Walshe (2007; 2009) suggests using theories from the areas more experienced in investigating complex social interventions, such as education and society, for researching healthcare quality improvement. He stresses that the theories could aid an understanding of when, how and why an evaluatory programme works and unpick the complex relationship between context and outcomes of the programmes (Walshe, 2007). Healthcare quality improvement programmes are complex social interventions that can only be properly evaluated if their interconnected context, content, application and outcomes are understood. Øvretveit and Gustafson (2002) indicate that, given their complex, changing nature and their contextual effects, evaluative interventions are difficult to evaluate using experimental methods or conventional medical –quantitative– research evaluation methods. They advocate instead the use of quasi-experimental evaluation and social science methods utilising qualitative means for evaluation and investigation of these programmes. Attree (2006) argues that theories could explain how interventions cause specific outcomes and which conditions/factors are critical in creating an effect. They could also provide

direction for programme improvement (Stufflebeam, 2001). Ferreira and Otley (2009), similarly to Chenhall (2003) and Covaleski et al. (2003), highlight a need for theoretical foundations in researching PMSs and MCSs. Otley (1999) argues that there is a paucity of studies examining PMSs in an integrated and theoretical way. Similar concerns are expressed by Stringer (2007). Hopwood (1983, p. 302) has also accentuated the urgency of theoretically informed studies of both the use and design of PMSs. Such a massive call for application of theoretical assumptions and the paucity of similar studies in developing countries has provided convincing motivation for the current study.

- This study further satisfies a call for research on the dysfunctional and unintended and beneficial effects of PMSs in health care, drawing on systematic and theoretical underpinnings (Oliver, 1991; Goddard et al., 2000; Horton, 2004; Mannion et al., 2005), and also on the attitudes of frontline managers (Modell, 2001).
- The reactions of HCOs towards externally imposed PMSs (i.e. EESs) have not been addressed in developing countries, as in the developed ones (Modell, 2009). These reactions are argued to be influential in looking into the nature of the PMSs (Laughlin, 2007).

In summary, my analysis of the literature showed that there is a paucity of theoretical approaches adopted to evaluate macro PMSs, including healthcare accreditation, and their contextual implications in the context of developing countries. Adopting a theoretical approach to the performance analysis of the NAPH, the current study intends to fill this gap in the literature. The study could be described as an ‘alternative’ approach, in the light of the specific features attributed to this approach by Broadbent and Guthrie (1992, 2008), as follow:

- It accepts the importance of context;
- It seeks to question and understand;
- It embraces a theoretical orientation;
- It moves towards a critical evaluation of processes which are implemented.

This approach takes the context as its primary focus and seeks to examine control mechanisms in the context in which they are introduced. In this sense, as Agrizzi (2003) argues, it perceives that the context can impact on the processes of evaluation and change. As such, it takes a critical view on whether a macro PMS (e.g. accreditation), when introduced and implemented in organisations, inspires them to an improved performance. Therefore, such characteristics make this approach suitable for the intentions of the current research which seeks to focus on the contextual aspects in which the NAPH is implemented in a number of hospitals in Iran.

3.5.2. Micro level

The following gaps could also be discussed with regard to the current accreditation programme in Iran:

- Similar to other developing countries, the studies on the NAPH and its performance inside the country have taken a positivistic approach and used quantitative methods, failing to utilise relevant theoretical frameworks and assumptions in their investigation.
- Very little research (mostly quantitative) has been conducted on the performance of the NAPH, despite its long-time existence in the country (e.g. Baghebanian 2001; Arab et al., 2005; Mosadeghrad and Ansarian, 2005).
- No theoretical and systematic evaluation of NAPH's performance could be found in the related literature.
- Existing scant literature also shows poor evidence of improvement brought about by the NAPH in the hospitals (e.g. Baghebanian 2001, Arab et al., 2005)
- The NAPH has shown little attention to local context, e.g. hospitals' reactions, because it has become a highly centralized evaluation programme in its development (Amerioon, 2001; Sadaghiani and Zare, 2005).
- Most of the studies have considered only hospital managers and surveyors as their target group (e.g. Mosadeghrad and Ansarian, 2005). Jaafaripooyan et al. (2004) have tried to assimilate other hospital personnel and users, yet their study has been conducted quantitatively. This study has considered more diversity in choosing its respondents from the hospitals to obtain rounded and comprehensive perspectives.

Accordingly, this research has adopted a qualitative approach inspired by theoretical grounds and perceptual and attitudinal assumptions (Scrivens, 1997a) for the evaluation of NAPH's performance. Parasuraman et al. (1991) have attributed the inclination to application of perception measures in evaluating quality and performance to the absence and rarity of objective measures in service industries such as health care.

The research has been formulated in a way that addresses the shortcomings identified in preceding studies in relation to this AP. It has utilised some theoretical models, to be discussed in chapter four, which, for the first time in relation to Iran's AP, i.e. NAPH, give a theoretically grounded evaluation of this programme. From a theoretical perspective, this research aims to examine the relationship between a macro PMS and a micro context in a developing country. It intends to investigate the perceived effects of the NAPH (as a macro mechanism) on the hospitals (micro context) and examine the hospitals' reactions and the related underlying rationales for this national PMS. The main objective is to render an evaluation of the performance of Iran's national AP through a focus on its local and contextual effects and provide valuable insights for improving the system.

The theoretical model adopted is expected to give a workable language and guideline for analysis of contextual effects of this national PMS. It is expected to provide a language for exploring the hospitals' interpretations and responses to this steering mechanism.

Chapter 4 - Philosophical Perspective and Theoretical Frameworks

4.1. Introduction

This chapter addresses the study's paradigm, clarifying its ontological and epistemological foundations. It further explains its theoretical and methodological framework for conducting its empirical investigation.

4.2. Research approach

A paradigm has been defined as 'the basic belief system or worldview that guides [research] investigators' [action]...' (Guba and Lincoln, 1994, p. 105). Multiple research paradigms such as positivism and constructivism are argued to exist for exploring reality (Guba and Lincoln, 2008). It is believed that no single truth exists; no single approach can claim to discover absolute truth, and all understanding gained by these approaches is inevitably partial (Laughlin, 2004; Denzin and Lincoln, 2008). Therefore, making choices about suitable research approaches prior to undertaking any empirical research becomes unavoidable. In this regard, Laughlin (2004) speaks of the mutually exclusive nature of research approaches and warns about their simple synthesis (Laughlin, 1995; 2004; 2007). This interpretation was considered as a clear basis for elaborating on the paradigmatic approach of the current study.

Burrell and Morgan (1979) have most notably recommended a seminal framework for understanding and analysing broad streams of social science approaches to empirical research. As shown in figure 4.1, they presented a classification of approaches including four research paradigms for analysis of social theory. The subjective-objective continuum is conceptualised based on four sets of assumptions related to ontology (nature of reality;

external or internal), epistemology (nature of knowledge; tangible or intangible), human nature (role of investigator; passive or active) and methodology (ways to investigate; quantitative or qualitative). The regulation-social change continuum is related to the nature of society and formulated according to the dimension of regulation or radical change. Burrell and Morgan (1979) have posited two different stances for a society; regulation emphasises social order, consensus and solidarity whilst radical change assumes structural conflict, contradiction and emancipation central to a society. Four paradigms are developed on the basis of the foregoing assumptions (see Figure 4.1).

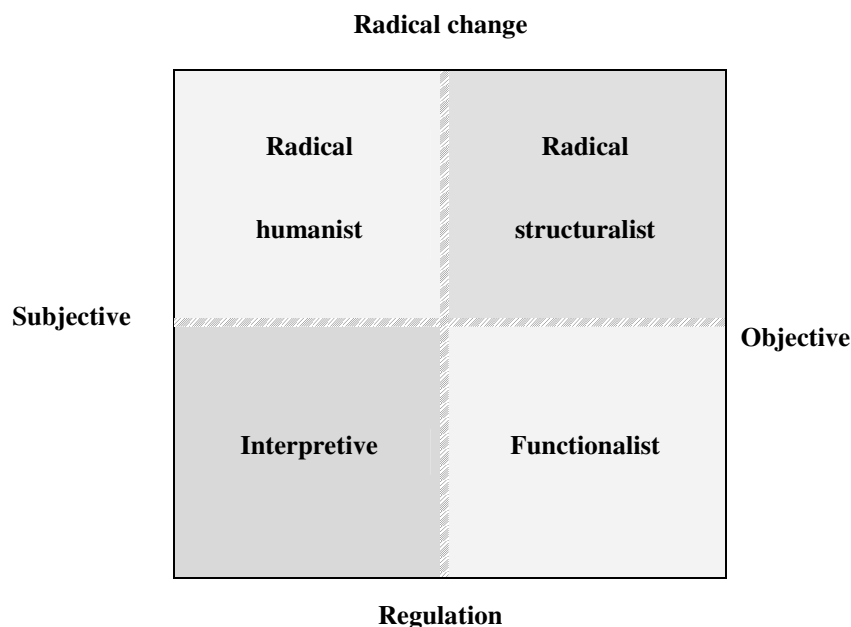


Figure 4.1 Four paradigms for the analysis of social theory- *Adapted from Burrell and Morgan (1979, p. 29)*

Despite being an influential step in understanding research approaches, Burrell and Morgan's framework has been criticised for the incommensurability of its paradigms (Deetz, 1996). Alvesson and Deetz (2000) contend that this classification of the perspectives mostly favours past traditions and its incommensurability discourages the possibility of investigating cross-paradigm similarities and differences. Moreover, this framework has been accused of having a simplistic approach to research methods

(Laughlin, 1995; Willmott, 1993). Laughlin (1995) has further argued that this framework has isolated key domains for change.

Laughlin (1995) has integrated change and the dimensions of Burrell and Morgan's model in three different broad bands, namely 'theory', 'methodology' and 'change', to propose a new typology of research approaches (p. 66). According to Laughlin (2004), choices should be made before starting research. Therefore, choices on the theory could be likened to decisions about ontology and epistemology in Burrell and Morgan's model; choices in relation to methodology signify a position on the nature of methods and role of the observer (i.e. human nature in Burrell and Morgan's model); and finally, choices in relation to the change are concerned with whether the investigation is purposefully geared to achieve change in the phenomenon under investigation, equating to Burrell and Morgan's assumption of regulation/change (Lowe, 2004). Laughlin (1995) considers these three pillars as continuums that varying research approaches could be seen based on their positions on the different points of these continuums (Figure 4.2).

In elaboration of the pillars, by 'theory' Laughlin (1995) means utilisation of prior theories for undertaking empirical research. He ascribes prior theorising to ontological assumptions about the nature of the world in that previous theoretical endeavours can help form our representation of materiality and generality of the world under investigation. In his argument, high levels of prior theorisation are indicative of an assumed material world, which exists distinct from observers' projections and has been well researched through previous studies (Laughlin, 1995). Conversely, low levels assume that the world is not material, but a projection of our mind; hence, generalities are impossible. Therefore, reliance on previous studies is inappropriate and potentially misleading for the details of the present study.

The methodology dimension of Laughlin's model represents a theoretical definition of the means which form the nature of methods for the empirical investigation and which also have implications for the role of the researcher. High levels of theorisation for methods, i.e. quantitative nature, means the researcher has no subjectivity in conducting the research. At the other extreme, the researcher is free to become thoroughly involved (permitted and encouraged, as Laughlin (1995) claims) in the investigation process and there are fewer rules and regulations on how the investigation should proceed.

		Theory choice: levels of prior theorization		
		High	Medium	Low
Methodology choice: level of theoretical nature of methods	High	Positivism (L) Realism (L) Instrumentalism (L) Conventionalism (L)		
	Medium		German Critical Theory (M)	Symbolic Interactionism (L)
	Low	Marxism (H)	Structuralism (L) French Critical Theory (L)	Pragmatism (L) Symbolic Interactionism (L) Ethnomethodology (L)
	Change choice: levels of emphasis given to critique of status quo and need for change (<i>high/medium/low</i>)			

Figure 4.2 Characteristics of alternative schools of thoughts based on Laughlin's assumptions (Source: Laughlin, 2004, p. 273)

The final dimension refers to change. According to Laughlin (1995; 2004), change is concerned with researchers' attitudes in relation to the value of keeping or discarding the current situation as well as views on the necessity of doing something about status quo. According to this dimension, those who believe in high levels of change have the perspective that everything in the current situation should change, even if they are not in a position to engender this change. By contrast, those who have faith in low-level change see

little problem in the status quo. Laughlin indicates that those in the middle of this continuum are strategic in their attitudes to change - open to maintaining certain aspects of current workings, but also open to challenging the status quo.

Figure 4.2 depicts the different schools of thought based on their position on the continuums of theory, methodology and change. For instance, according to this schematic guide, positivism is completely dependent on the prior theories and uses quantitative methods to investigate any phenomenon, while not taking a critical stand on the status quo. Laughlin (1995; 2004; 2007) assumes a mid-point in all three pillars to develop an alternative approach, called 'middle-range thinking' (MRT), for understanding and analysing different aspects of empirical research.

4.3. Middle Range Thinking (MRT)

Middle-range thinking is seen as a third alternative symbolically in the middle in terms of three choices of prior theorisation, theoretical nature of the methods and change (Figure 4.2.). This approach takes some aspects from both high/high and low/low positions, while enjoying a different and less dismissive perspective on critique and change. In his more recent work, Laughlin (2004) also stresses the importance of observing a 'sequence' in approaching an empirical context, which needs to start by clarifying ontological assumptions. Figure 4.3 displays this sequencing through arrow flows highlighting the implications of previous stages on the next steps.

According to Laughlin (1995):

'...MRT recognises a material reality distinct from our interpretations while at the same time does not dismiss the inevitable perceptive bias in models of understanding' (p. 81).

This approach leaves room for researchers' perception in the research process. In line with the MRT, as in figure 4.3, general empirical patterns (i.e. reality) are partial, and not certain or random, and then empirical detail is always important (Laughlin, 2007). Following on this ontological assumption, Laughlin (2004, p. 268) argues that existing generalisations are explained by 'skeletal', rather than 'full' or 'no', theories.

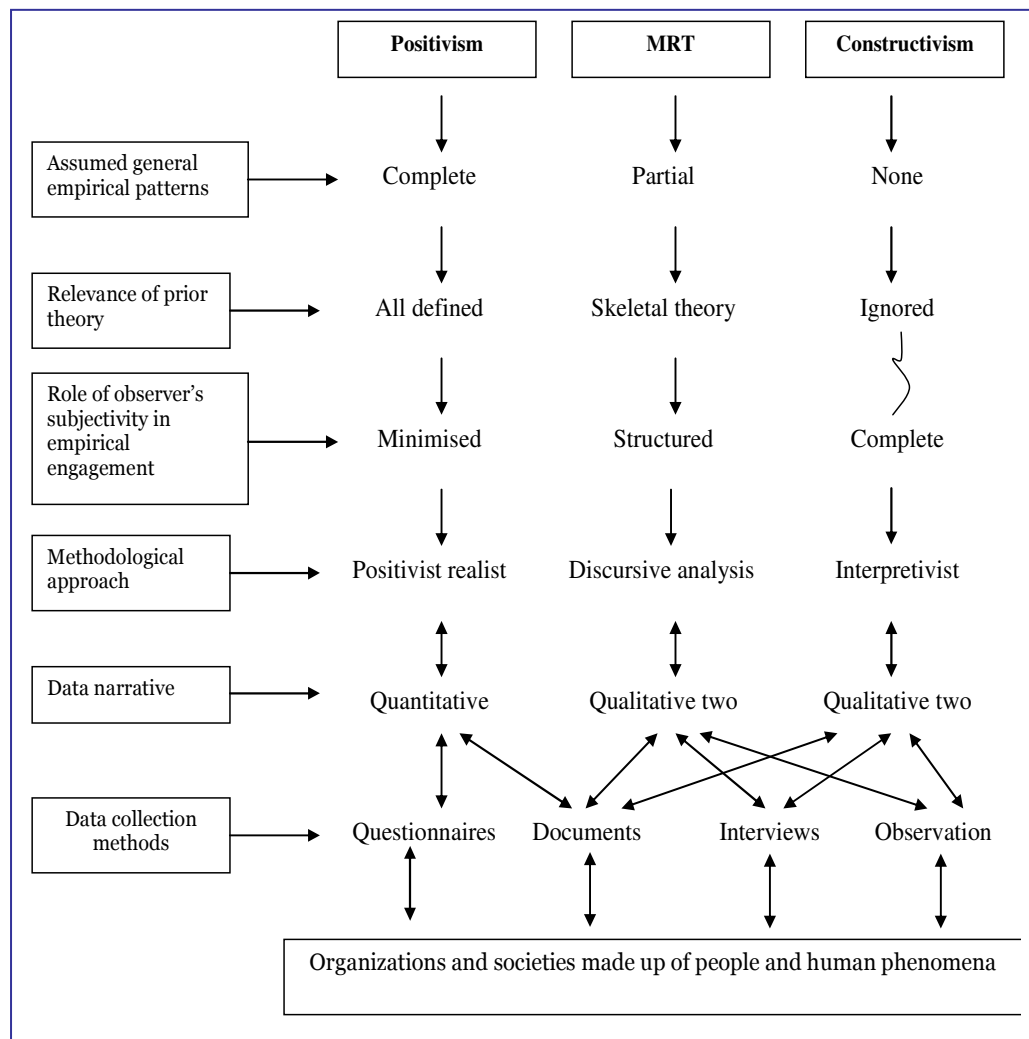


Figure 4.3 Contrasting MRT with other research perspectives (Source: Laughlin, 2007, p. 275)

These ‘skeletal’ theories are not all defined and need the richness of the empirical detail to make them meaningful in particular situations (Laughlin, 2004). In fact, skeletal means there are structures that underlie social situations, but not ones which fully capture the diversity and detail of these situations. The ‘skeleton’ metaphor mostly signifies a picture of an incomplete, albeit reasonably stable, framework that stresses the importance of metaphorical ‘flesh’ as an addition to make definable and noticeable differences in the structure of ultimate ‘whole-being’ (Laughlin, 1995, p. 81). It is incomplete in order to encapsulate the perceptions of researcher and the researched. Skeletal theories are conceptual guides for exploring empirical situations (Laughlin, 2004). The important point

to note is that where the empirical details do not fit the theoretical ‘skeleton’, as Laughlin (2004) puts it, they provide a basis for extending or reforming these skeletal frameworks, although he believes the expansion of the skeleton is not always guaranteed. Given the skeletal structure of theories, empirical detail is of vital significance to complement and enrich them in particular contexts. Just as the skeleton needs flesh to encapsulate the nature of a human being, the ‘skeletal theory’ requires diverse empirical flesh to arrive at meaningful whole beings. To MRT, the empirical detail is as important as the ‘skeletal’ theory which renders the ‘skeletons’ alive and meaningful.

Skeletal theories also have implications for the role of observer (researcher) in empirical engagement. MRT advises a ‘structured’, rather than minimised or complete, subjectivity for the researcher (Laughlin, 2004, p. 273). This is because the skeletal patterns (theories) are unable to capture every aspect of empirical situations, requiring researchers’ subjectivity. ‘Structured’ subjectivity *de facto* specifies precisely what is contained in the engagement process, involving simultaneously the intuitive and imaginative properties of individual researchers. Accordingly, Laughlin (2004, p. 273) emphasises that, in MRT, the ‘fleshing’ out of the ‘skeleton’ is a key purpose of empirical engagement.

As with methodology for conducting empirical work, structured subjectivity provides a meaningful way to draw from skeletal theories to engage with empirical situations (Laughlin, 2007). Different frameworks can be considered, of which Laughlin (2004, 2007) sees those (e.g. discursive analysis) originating from German Critical Theory, which is placed in mid-point positions in the MRT approach (see Figure 4.2.), as the most consistent. Laughlin further explains that:

‘... the intention is to design a methodology which sets “skeletal” rules for processes of discovery which still allows for variety and diversity in observational practice’ (1995, p. 82).

Research methods should be in line with data narratives which are, in turn, informed and guided by the theories and methodology. Given the fact that MRT looks for richness and depth of detail in the empirical context, it is more consistent with qualitative narrative.

As far as change is concerned, Laughlin (2007) argues that the researcher should consider going beyond mere understanding to strategies for policy and practical change in the phenomena under study. A mid-position of MRT on change means that change is not an

inevitable outcome, but MRT requires the undertaking of a separate user-led, but researcher-informed, process to consider change possibilities (Laughlin, 2007).

4.3.1. The limitations of MRT

As growing attention has been paid to ‘middle-range thinking’, some critiques targeting this approach have also appeared in the literature (e.g. Dey, 2002; Lowe, 2001; 2004). Dey (2002) argues that MRT falls short of grounding the theory appropriately in the research and empirical data, because the choice of theory is made beforehand. However, as discussed earlier, despite adopting a prior strict theoretical framework, MRT remains flexible to allow more elaboration of the theory on the basis of empirical data collected, due to its skeletal nature. Therefore, this is seen not as a failure, but as an opportunity to both enrich and critically evaluate the theoretical assumptions in the light of the understanding gained from the related contexts. MRT is also criticised by Lowe (2004) for being mostly dependent on an arbitrarily structured and simplified diagrammatic misrepresentation of different schools of thought, and which has used a rhetorical language to convince readers that MRT and German Critical Theory are superior to other approaches. Nevertheless, Laughlin (1995; 2004), while discussing the nature of other approaches, uses the word ‘choice’ to indicate that there are different research alternatives including MRT. He also advocates making a choice before undertaking empirical research. Laughlin (2004), specifically in response to Lowe (2004), explains that researchers can adopt any of the alternatives outlined in Figure 4.2 provided that they defend their choice of approach and justify its superiority. Trying to distance himself from the conviction that MRT can provide the most meaningful understanding of the empirical world, Laughlin (2004) further stresses that the conceptual patterns in MRT will always be partial and incomplete.

4.3.2. MRT in the literature

Laughlin (2004, p. 270) has made it plain that ‘middle range’ can be used as a ‘third way’ research approach for investigation of events in different settings. Since its introduction in 1995, a wide range of studies have utilised this approach (e.g. Broadbent et al., 2001; Broadbent and Laughlin, 1997a; Modell, 2001; Agrizzi, 2008; Gurd, 2008; Hassan, 2008; Broadbent et al., 2010a). The excellence of this approach in providing a possibility of

discovering the empirical events in an organised way has been repeatedly stated. Parker and Roffey (1997) have indicated that Laughlin (1995) locates major research paradigms and offers a significant vehicle for comparing the theoretical and methodological implications of various theorists. Modell (2001) has adopted Oliver's (1991) institutional theory framework in the context of this approach to examine the responses of senior management and staff specialists to recent reforms in the public healthcare sector in Norway. In the light of MRT, Agrizzi (2008) looks into the organisational effects of performance measures introduced by central government in England to control hospitals. Broadbent et al. (2001) have synthesised two distinctive theories, i.e. Habermas and institutional theories, in the context of the 'middle-range' approach to examine organisational resistance in general medical practice in the UK. Mail et al. (2009) found MRT practical for understanding and explaining accounting change processes in organisations.

In summary, as shown in some of the examples discussed above, a rather wide range of studies has used MRT as a language to approach the phenomena under investigation and examine various events. These authors accepted that this method could provide a sound approach to both properly undertake empirical research and add to the existing knowledge in different strands of research. In fact, the 'skeletal' focus of this approach has the benefit of enabling the empirical data, as the core of research, to inform as well as be informed by theory and vice versa.

4.4. Justification for the adoption of MRT

The current study has relied upon the strengths of the MRT approach to pursue its research objectives. MRT assumes a clear and coherent trend from its ontological assumptions to a detailed choice of data collection methods; thus, it is considered a rigorous and transparent research approach. As elaborated earlier, MRT both preserves the possibility of learning from previous knowledge and other situations throughout the research process from the outset and enjoys engaging in empirical details. This advantage helped this study to draw on prior knowledge (i.e. theories on the evaluation of macro PMSs) as a guiding framework to formulate its approach to the empirical field. Nevertheless, the skeletal nature of the theories does not confine the study, considering the richness of the empirical context, which is an important factor for the study. MRT opens the way for new data to

enrich the skeletal theory (Berry et al., 2009). It allows for a contextual approach to investigation and consideration of empirical variability and diversity of context, while equipping the researcher with an organised and rather structured focus before entering the research field. The latter both prevents possible confusions about the context and helps to take advantage of prior studies and patterns, which can guide the empirical investigation and analysis. The fact that there can be an interactive research process in which theory both informs and is informed by empirical data is a distinctive advantage of MRT, which intrigued the researcher; other approaches fail to achieve this objective.

The particular approach of MRT to change is another workable feature that the current study intends to build upon. MRT advises researchers to go beyond their abstract understanding in conducting research and consider pertinent strategies for policy and practice change in the phenomena under analysis. Although the researcher holds the general view that research should contribute to pure knowledge and literature, he is at the same time largely in favour of a tangible impact of his academic research on relevant practice (Pollitt, 2006; Dumay, 2009). This is much more important in developing countries such as Iran, which are greatly in need of implications from systematic research. Practical implications offered by this research might encourage more cooperative behaviours from the researched, gaining tangible research insights for their organisations (Walburg et al., 2006). MRT, it is argued, allows the building of a bridge between theory and practice (Broadbent et al., 2010b).

Overall, while not holding the view that researchers should adopt a predetermined theoretical framework which produces an overly 'framed' result, and/or believing in a completely subjective world projected from people's minds, the researcher is greatly interested in a partially distinct world which can be understood and changed to some extent. In fact, MRT asserts that there are general patterns 'out there' (theories about macro PMSs and their impacts, as for the current research), but they are skeletal and need to be enriched by data from specific contexts (Iran's health system). The enrichments could either confirm or change (extend) the patterns. This nevertheless is contingent on the nature of the phenomena under study. MRT is used for qualitative studies (Laughlin, 2004); as such, the current study mostly deals with perceptions and attitudes.

Central to the MRT are two important components, theoretical framework and empirical data, which are elaborated in the following sections. They are the tenets of the MRT; the

skeletal frameworks provide a set of theoretical spectacles through which one can interpret the empirical data; in turn, the empirical data enriches the theoretical model.

4.5. Theoretical models of the study

Theoretical models are utilised to provide a language and guidance for fulfilling the research objectives in terms of approaching and analysing the empirical context (Laughlin, 2004). The model used in the current study is developed by Broadbent and Laughlin (2005), which is a recent explanation and combination of the previous theoretical frameworks by Broadbent et al. (1991) and Laughlin (1991). These models are an elaboration and refinement of Jurgen Habermas' (1984; 1987) approach to Critical Theory. The refinements were made to provide a practical language and help operationalise Habermas' theory of societal development, since the original model was complex and far from a practical framework as Broadbent et al. (1991) and Laughlin (1991) clarify. Habermas' Theory¹⁹ has been extensively discussed in the literature and is not addressed here in detail, except for a brief explanation below. This study instead has been largely informed by the practical refinements of Habermas' theory by Broadbent and Laughlin in different stages of their application of this theory, relying on their most recent work in the year 2005 (Broadbent et al., 1991; Laughlin and Broadbent, 1993; Broadbent and Laughlin, 2005).

4.5.1. Habermas' theory of societal development

Habermas has argued that any society has a discursively agreed set of explicit or implicit values, called lifeworld, that comes from an accumulated understanding of and insights into our world (objective), our social relations (inter-subjective) and ourselves (subjective) at a point in time (Davis, 2007). He identifies the lifeworld as a driving force behind society and accentuates the role of human discourse in the nature and evolution of societal development (Broadbent and Laughlin, 2005). As such, tangible systems are formed to express and take forward different aspects of lifeworld value requirements. In complex and

19. Also known as Habermas' Theory of Communicative Action (1984, 1987), it is argued to be his magnum opus. Communicative action is defined as an 'action' motivated by communication aimed at mutual understanding (Davis, 2007).

modern societies, a new intervening element is introduced, called steering²⁰ media, whose specific purpose is to regulate the systems to reflect the shared values so that societal lifeworld is ultimately achieved (Lawrence and Sharma, 2002).

Lifeworld represents a society's values, culture and beliefs based on communicatively-formed (over time) life experiences or taken-for-granted norms that guide people's behaviour, attitudes and thus action. Broadbent and Laughlin (2005) state that lifeworld is a driving force and guide for design of particular systems of action. It is *de facto* the nexus of subjective, intangible and taken-for-granted norms of a society (Broadbent, 2002). As Broadbent (2002) puts it, the lifeworld alludes to the view that the things people do in a society are driven by what they, as a society, see as appropriate in cultural and normative terms. These values may differ at various levels and areas of a society in a sense that there could be multiple lifeworlds in modern societies in relation to disparate areas such as health care (Broadbent et al., 1991). For instance, according to Iran's Constitution and related policies (e.g. its Fourth Plan for Economic, Social and Cultural Development), as far as health care is concerned, the lifeworld is conceived as such values as the eligibility of access to quality health care for all people (I.R.I., 1979a; 2004).

Lifeworld values existing in a specific context might change subject to different factors during a period of time. For instance, given the increasing burden of health care costs, similar to and in the light of the experiences of developed countries, the MoH also started to move towards and take in some principles inspired by New Public Management (NPM) for governing and running its HCOs (Hood, 1995; Lapsley, 2009). For instance, some years ago it initiated the plan of 'Reforming hospitals' economic and managerial structure' which mainly included the items such as performance-based management, outsourcing and privatisation, operational budgeting and applying information systems (MoH, 2005). The hospitals were required to implement these initiatives and report back to the MoH regularly. As the title of this policy implies (i.e. 'economic'), it could be argued that is to a large degree linked with the cost-cutting/managing intentions of the MoH's authorities. In other words, a movement from a conventional devaluation of financial and cost matters towards a clear focus on economic aspects in healthcare delivery could be witnessed within this policy-setting process. In addition and in line with this movement, from several

²⁰. 'Steering' describes a particular approach to control at both societal and organisational level (Broadbent et al., 1991).

years ago the hospitals were mandated to run themselves autonomously, that is, manage their own incomes and expenses and think of generating higher income to cover their own expenditure. The latter could influence the conventional values of the hospitals' members, especially managers, and might instigate the above mentioned movement inside HCOs too. These policies all somehow signify an incremental change in the mentality (lifeworld) of the high-up authorities (of the MoH and generally government) in providing health care, as it has been started to naturally happen in this sector mostly in developing countries, because of growing challenges of population rise and inappropriate use or decrease of resources (Shahhoseini et al., 2011).

Systems are 'expressions of the lifeworld in a functional, definable and objective fashion as organisations' (Broadbent et al., 1991, p. 3). In fact, lifeworld finds its meaning in organisational systems, and the systems are to follow lifeworld concerns (Broadbent et al., 2010a). For instance, in health care, hospitals are the entities that provide services in line with the healthcare values.

Steering media ensure the systems continue to reflect lifeworld demands. They are distinct administrative and structural arrangements which mediate systems and lifeworld (Power and Laughlin, 1996).

4.5.2. Broadbent and Laughlin's Model

Drawing on Habermas' thinking on organisations, Broadbent and Laughlin (2005) recognise the importance of both human agency and structure simultaneously in organisations. They see organisations not as closed systems but rather placed and linked into a wider societal context. They argue that this dynamic relationship provides societally defined purposes for such organisations. Broadbent and Laughlin (2005) further elaborate on the position of organisations as societal entities steered by societal institutions (via their control mechanisms) and believed to have similar elements to those of a society identified by Habermas (i.e. lifeworld). Having such structural elements, it is argued that organisations might show different reactions in response to societal pressures imposed on them (e.g. PMSs such as the NAPH), in terms of the PMSs' effect on their specific elements (Broadbent and Laughlin, 2005). This interpretation by the model provides a conceptual language for evaluating the nature of macro PMSs imposed on micro

organisations and looking into the reactions and changes caused by these PMSs (Broadbent and Laughlin, 1997b; Laughlin, 2007). This model has made some refinements to Habermas' model of societal development to make it more practical for application in current research practices.

4.5.3. Refinements of Habermas' model of society

It has been claimed that Habermas' theory is far away from being a workable framework (Broadbent et al., 1991; Broadbent and Laughlin, 2005) and it needs to be refined and modified to be useful in practice, despite its utility in studying whole societies (Dillard and Smith, 1999). As a refinement, Broadbent et al. (1991) and Power and Laughlin (1996) reshape the abstract societal steering media into tangible institutions and societal systems into actual organisations (Broadbent and Laughlin, 2005). These institutions and organisations are argued to have their own lifeworlds, steering media and systems which are supposed to guide and direct their own behaviour (Laughlin, 2007). The logic behind this refinement, as Broadbent and Laughlin (2005) explain, is that within a society there are certain organisations (e.g. governmental and legal institutions) which are specifically set up to steer, guide and regulate the behaviour of societal organisations. For instance, analysis of the relevant policies and the principles behind the establishment of the MoH shows that it is tasked with planning, policy-making, and organising the healthcare services, and could then be envisaged as a steering institution in the country's health system (Majlis, 1985; 1987; 1988).

The steering institutions are claimed to be largely governmental, because governments usually act as proxies for society in the public sector (Broadbent et al., 2010b). They particularly issue 'steering mechanisms' to operationalise their regulation and steering intentions (Broadbent and Laughlin, 2005). Steering mechanisms are arguably the tangible evidence of steering institutions' lifeworld, which is in turn a mirror of and linked to societal lifeworld (Broadbent, 1992).

Analysis of the policy documents revealed that the NAPH is the main steering mechanism issued by the MoH, given its objectives and functions (MoH, 1997a). It is an important element of macro control in Iran's health system which reflects, operationalises and ensures the government's intentions for improving quality and safety in health care across the country (MoH, 1997a). As Broadbent et al. (2010a) note, these mechanisms could also

act as a channel for transfer of financial resources into organisations under evaluation. They are also said to be the societal equivalent of Simons' (1995, p. 7) 'organisational levers' of control (Broadbent et al., 2010a). Simons (1995) has posited a framework, as explicated in Tuomela (2005, p. 300), for strategic control of organisations; it consists of four levers of control:

- Beliefs systems are used to enhance core values related to business strategy and to inspire the search for new opportunities in line with these values.
- Boundary systems reduce risks by setting limits to strategically undesirable behaviours.
- Diagnostic control systems help to communicate and monitor critical success factors.
- Interactive control systems are used to discuss strategic uncertainties and to learn novel strategic responses to a changing environment.

Broadbent et al. (2010a) argue that it is possible for steering institutions to devolve their steering processes to intermediary institutions, whose exclusive role is to steer organisational systems using their steering mechanisms. In the case of this study, it was understood that the MoH has delegated the tasks of evaluating the HCOs to the 'Centre for Healthcare Accreditation and Supervision'. It is directly responsible for policy-making, developing and monitoring the evaluation of the hospitals (see chapter two for more information).

Steering institutions are distinguished from actual organisations in that they are made up of a range of public, private and voluntary organisations, such as the hospitals in the healthcare system, which are directed and controlled by the institutions to express and reflect societal lifeworld (Broadbent et al., 1991, 2010b). In highly differentiated and modern societies, multiple institutions and organisations may exist with their own lifeworld, steering media and systems with a collective link to societal lifeworld (Broadbent et al., 2001; Broadbent and Laughlin, 2005). This link signifies a 'structural coupling' between lifeworld and those institutions and organisations (Teubner, 1987, p. 26). A simple diagrammatical display of this model is shown in Figure 4.4.

Broadbent et al. (2010a) indicate that the theoretical categorisation of societal steering media and mechanisms is generic and applies across all situations. However, as they argue,

their investigation in the light of specific empirical contexts could show what constitutes actual steering media (institutions) and what mechanisms are used. In line with this debate, Iran's healthcare system and AP are addressed by this study.

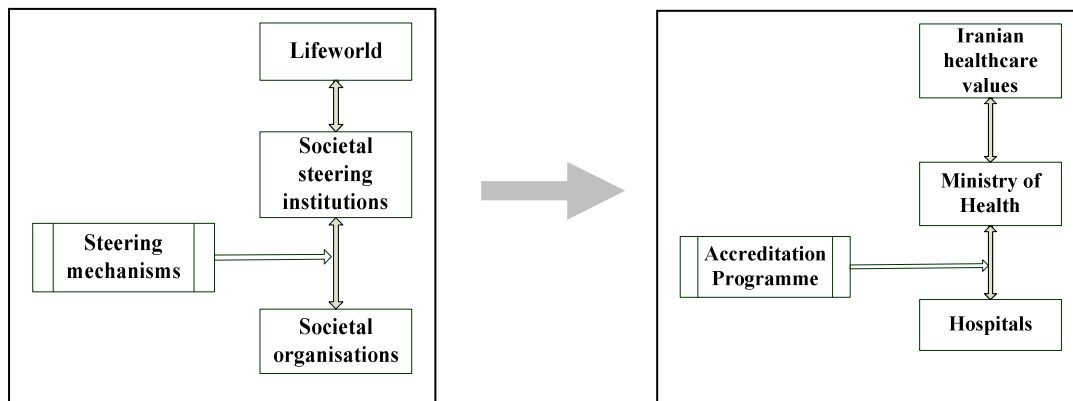


Figure 4.4 Adaptation of the societal development model (Laughlin, 2007, p. 276) for Iran's healthcare system

4.5.3.1. Internal Colonisation (IC)

It has been argued that potential independency of institutions and organisations might lay the groundwork for both steering institutions and organisations to decouple from societal lifeworld requirements (Laughlin, 2007; Broadbent et al., 2010a). In these situations, steering institutions may break out of the societal lifeworld (i.e. follow their own lifeworld) and steer organisations into new domains, which are not locked into the societal lifeworld demands, and impose, instead of reflecting, the societal values (Broadbent and Laughlin, 2005). This is referred to as 'IC' of societal lifeworld (Habermas, 1987, p. 367) or 'disintegration' by Teubner (1987, p. 26) and is argued to generate unintended and dysfunctional effects at different societal and organisational levels (Broadbent and Laughlin, 2005). This interpretation of IC provides a language for developing an understanding of the dysfunctional consequences of IC, if any, produced by the steering mechanism of the NAPH at the subjected hospitals. Organisations might also venture beyond the confines of societal lifeworld requirements through not complying with the requirements of steering mechanisms which are tangible expressions of the lifeworld (Broadbent, 1992; Broadbent et al., 2001). However, in Habermas' thesis, the IC is argued

to mostly occur in relation to the actions of steering institutions and their mechanisms (Broadbent and Laughlin, 2005).

The forgoing decoupling of steering media can be avoided if their steering mechanisms are proved to own specific features (Broadbent et al., 1991; Laughlin, 2007). Firstly, steering mechanisms should be 'regulative' as opposed to 'constitutive', as it is believed that the latter is more likely to cause IC (Broadbent et al., 1991, p. 6). According to White (1988, p. 114), cited in Broadbent et al. (1991), 'regulative rules regulate some pre-existing, on-going activities'. They are chosen, consensual-based frameworks of control and of a consultatively-driven nature, which formalise already established and accepted organisational processes and norms (Broadbent et al., 2010a). Regulative mechanisms are deemed to be 'relevant' (Laughlin and Broadbent, 1993, p. 341) and 'freedom-guaranteeing' (Habermas, 1987, p. 367). Regulation of these mechanisms is accepted by organisations to stay in line with their long-term survival growth and development, and aligned with ownership by key stakeholders (Broadbent et al., 2010a). They moderate organisations' behaviour to reflect existing lifeworld norms and values (Broadbent et al., 1991).

Constitutive mechanisms, on the other hand, constitute new forms of activity (Laughlin and Broadbent, 1993). Interests of stakeholders are far less assured by these mechanisms (Broadbent et al., 2010a). They are accordingly deemed to be 'freedom-reducing' (Habermas, 1987, p. 367) and constitute and direct organisations' behaviour away from accepted norms and guiding lifeworld intentions (Laughlin, 2007). Broadbent et al. (2010a) argue that, whilst there may be situations where 'freedom-reducing' steering is needed, in the majority of situations freedom-guaranteeing steering is the ideal for organisations. As Broadbent et al (1991) have stated these features are both clearly perceptual and locked into particular timeframes.

The steering mechanisms could be either regulative or constitutive or both, contingent on the way and manner in which they are conducted, the time period considered and the level at which the investigation is being undertaken (Broadbent et al., 1991).

A second way of recognising the potential of steering mechanisms to result in internal colonisation as Broadbent et al (1991) cited from Habermas (1987, p. 365) could be identified through this notion that the mechanisms are either 'amenable to substantive justification' (ASJ), or are only 'legitimised through procedure' (LP). The ASJ

mechanisms are argued to be embedded in the societal lifeworld and are then more comprehensible and reflective of ‘informed commonsense’ (Broadbent et al., 1991, p. 7). These mechanisms reinforce the important consensual nature of the regulation (Broadbent et al., 2010a). By contrast, the LP mechanisms are claimed to be far less comprehensible and more questions might be raised about the appropriateness of the official bodies that formulate these mechanisms (Broadbent et al., 1991). According to Habermas (1987), the LP has a colonising potential. Laughlin and Broadbent (1993) maintain that, in the event of internal colonisation, steering mechanisms try to go beyond ASJ, from the perspective of the organisations. Teubner (1987) has referred to this as regulatory dilemma.

Broadbent et al. (2010a, p. 508) use the terms ‘relational and transactional’ for regulative-ASJ and constitutive-LP steering mechanisms respectively. Accordingly, as transactional societal steering mechanisms mostly require ‘defined and prescriptive ends’ achieved by ‘specified means’, relational mechanisms encourage wider stakeholders’ involvement and agreement on ends and means and related regulatory processes (Broadbent et al., 2010a, p. 511).

4.5.3.2. The relevance of IC for the current study

The theoretical concepts of ASJ and LP are put forward for analysis and evaluation of the nature of societal steering mechanisms (e.g. the NAPH). Broadbent et al. (1991) have argued that the analysis of particular societal steering institutions (e.g. the MoH) should be carried out through a specific emphasis on their mechanisms. This focus should be specific and time-related to particular societal steering institutions (Agrizzi, 2003; Davis, 2007). They state that judging the merits of the mechanisms on a societal scale and discerning whether any particular organisation reflects lifeworld demands, based on Habermas’ model, has proved to be difficult and challenging (Broadbent et al., 1991). It is suggested that researchers focus on the organisational participants’ views in judging the constitutive and regulative nature of societal steering mechanisms (Broadbent et al., 1991). The value of their perspective lies in the fact that the organisations include the active participants who are both a part of the whole societal population and are directly subject to steering mechanisms. Therefore, Broadbent and Laughlin (1997b) argue that an evaluation of macro PMSs would be more relevant based on the actual reactions from those most affected by those systems. Similarly, Laughlin (2007) indicates that the reaction of those

micro organisations at which a particular steering mechanism is targeted is a key litmus test for judging whether the mechanism can be seen as regulative and ASJ.

Therefore, this study intends to examine empirically how the externally imposed steering mechanism of the MoH (i.e. NAPH) impacts in practice on the hospitals under its evaluation from the perspectives of the hospitals' participants, in order to evaluate the performance of this AP. This evaluation, as Broadbent et al (1991) have pointed out, considers the extent to which the MoH (a societal steering medium) is attempting to steer the hospitals (societal systems) in a direction which is amenable to the lifeworld of those systems. It is argued that steering media might seek to steer the systems in ways which are not commensurate with their organisational lifeworld (Broadbent et al., 1991). This allows the researcher to investigate whether the NAPH is constitutive and LP or regulative and ASJ. Accordingly, the colonising and beneficial effects of the constitutive and LP or regulative and ASJ respectively could be addressed. The extent to which the lifeworld of the MoH is in agreement with that of the organisations (e.g. hospitals) could be measured by establishing whether steering mechanisms (e.g. the NAPH) are seen as regulative and ASJ by members of the organisations. Constitutive, vis-à-vis regulative, mechanisms are argued to generate the intended behavioural changes in organisations with difficulty, because of resistance from the members of organisations (Broadbent et al., 1991). Therefore, steering mechanisms need to be able to demonstrate that they are regulative and ASJ to be legitimate for the organisation under evaluation (Habermas, 1996, cited in Broadbent et al., 2010a), allowing this research to explore legitimacy-seeking measures and efforts of the NAPH towards the hospitals.

4.5.4. The model's conceptualisation of organisations

Drawing on Habermas' model of society, Broadbent and Laughlin (2005) argue that institutions and organisations, as explained, are in turn at organisational levels composed of functionally definable elements that are microcosms of the elements assumed to constitute society as a whole. They are called interpretive schemes (ISs), design archetypes (DAs) and subsystems at organisational level, equal respectively to lifeworld, steering media and systems at societal level (Broadbent and Laughlin, 2005). According to Laughlin (1991), subsystems contain certain tangible elements about which inter-subjective agreement is possible (e.g. in a hospital: buildings, medical equipment, people

and their behaviours and activities). Furthermore, two less tangible dimensions (i.e. DAs and ISs) give direction, meaning, significance, nature and interconnection to the other more tangible element of subsystems (Figure 4.5). The basic nature of these microcosms is akin to the societal elements (Broadbent and Laughlin, 2005).

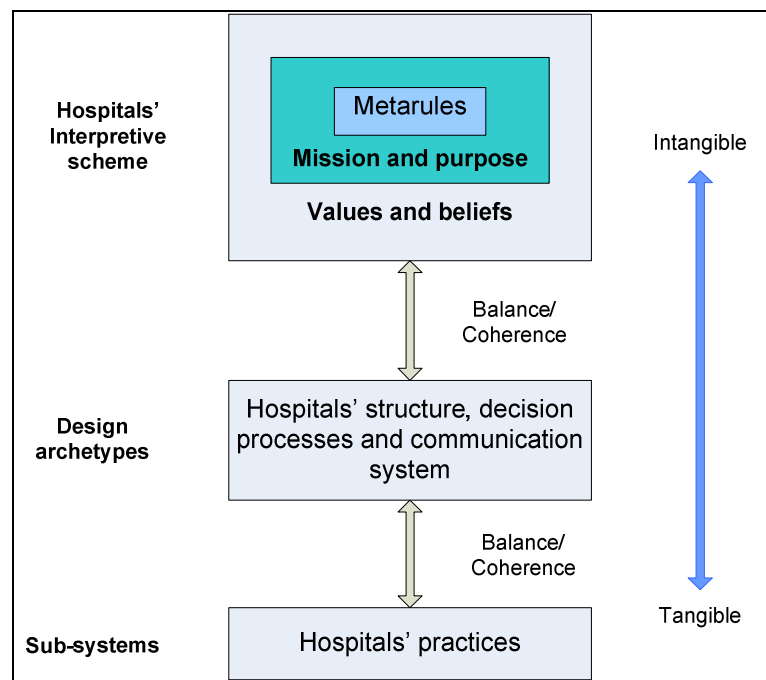


Figure 4.5 A model of organisations' elements at micro level (adapted from Laughlin, 1991, p. 211)

ISs include values and beliefs held by members of organisations, which are grouped by Laughlin (1991) under three main categories (i.e. metarules, mission and purpose, and vision, values and beliefs). Metarules have the highest level of abstraction and underpin and give direction to all lower levels of the ISs (Laughlin, 1991). *They de facto 'form the organisational paradigm which underlies and unnoticeably shapes organisational members' perceptions'* (Broadbent, 1992, p. 345). The ISs are claimed to give an identity and direction to organisations and are given structure and coherence by DAs (Laughlin et al., 1994b).

DAs comprise decision structure, communication and overall management systems of organisations, which seek to control and ensure that organisations' workings, i.e. subsystems, are reflective of their ISs (Laughlin, 1991). They are likened to organisational management control systems (MCSs) by Broadbent et al. (2010a). MCSs also serve to ascertain that organisational members' behaviour is based on pre-established rules and plans (Tuomela, 2005). The following definition of MCSs by Simon accentuates this similarity.

'... the formal, information-based routines and procedures, managers use to maintain or alter patterns in organisational activities' (1991, p. 5).

Subsystems represent the workings and tangible ways in which organisations operate (Laughlin, 1991). They are guided by DAs in ways that are commensurate with values of ISs (Lawrence and Sharma, 2002). These are claimed to be visible hallmarks of organisations, such as buildings, people, activities and services (Laughlin et al., 1994b).

4.5.4.1. The utility of the model's conceptualisation

The overall assumption behind this interpretation of organisations is that an organisation can contain and be represented and viewed through its ISs, DAs and subsystems and, as such, the organisational reactions and changes could be seen as the result of an interaction among these three elements (Laughlin, 1991; Richardson et al., 1996). Broadbent and Laughlin (2005) explain that an ideal situation for organisations could exist when there is a balance among their elements and the DAs monitor the reflection of the ISs by the subsystems. A disturbance (external or internal) could force an organisation to move away from this balance (Broadbent and Laughlin, 1997b), triggering alternative transitions and transformations in organisations (Laughlin, 1991; Pettigrew, 1995). Aside from other disturbances, an improvement initiative (e.g. the NAPH), as Broadbent and Laughlin (2005, p. 16) put it, could also be considered as a disturbance:

'...societal steering [regulatory] mechanisms aimed to "correct" or "mould" organisational behaviour would be an obvious environmental disturbance'.

Therefore, with such an interpretation, also echoed by Gary et al., (1995) and Greenwood et al. (2002), the NAPH, aiming to correct and improve the performance of Iranian hospitals (MoH, 1997a), could be envisaged as an external disturbance to these organisations and might lead to specific reactions (as a result of possible internal changes) from the hospitals, depending on the nature of the disturbance.

In the analysis of the reactions and changes prompted by a disturbance, Laughlin (1991, p. 213) posits possible routes, calling them ‘pathways’ metaphorically, through which the disturbances travel in an organisation. The pathways are not predetermined activity and are not necessarily linear. Broadbent and Laughlin (2005) indicate that the analysis of these pathways could describe the developments in given organisations over time. Therefore, this can provide a skeletal language to categorise organisational reactions/change processes based on the extent of involving or influencing any of the three main organisational elements by the disturbance. Building on a wide range of studies, such as Smith (1982), Levy (1986), Habermas (1987), Greenwood and Hinings (1988) and Laughlin (1991), Broadbent and Laughlin (2005) postulate four possible pathways of change in organisations resulting from the effects of disturbances. They categorised them into two main types of changes, i.e. first and second order. As argued, when the external pressure leads to a change in ISs and is rather long-lasting, it is assumed to be a second-order type (Laughlin, 2007). First-order change may only lead to slight, short-scale changes in DAs or subsystems (Laughlin, 1991; Broadbent and Laughlin, 2005). Broadbent and Laughlin (2005) explain that, due to the dynamic state of ISs, the boundary between first- and second-order changes may be empirically less clear when the change is seen as incremental. However, they maintain that, when the nature of requested attempts for change is contested, the pathways might be more recognisable (Broadbent and Laughlin, 2005).

Two second-order pathways in organisations, according to Laughlin (1991) and Broadbent and Laughlin (2005, p. 16), are ‘colonisation’ and ‘evolution’. The former describes a situation in which an external disturbance is imposed on the structures and systems of organisations’ DAs, aiming to make changes in their ISs. Organisations in this situation are not able to resist the disturbance, leading to their colonisation, i.e. lasting changes in the ISs (Broadbent and Laughlin, 2005). The change could be exerted by a piece of legislation or regulation external to organisations, which has power over DAs and its resources (Broadbent and Laughlin, 2005). This change is not one which, as Broadbent

(1992) argued, would have necessarily been chosen by organisations. Colonisation might also occur through the activities and actions of powerful groups of participants inside organisations (Richardson et al., 1996). The changes in ISs of an organisation by colonisation might even result in a totally new underlying ethos for the organisation as a whole.

The second pathway is 'evolution', which happens when the disturbance is a chosen change and is amenable to substantive justification, thus being less contentious from organisations' perspectives (Laughlin, 2007). Evolution implies that given changes 'facilitate a common organisational vision based on shared values' (Dunphy and Stace, 1988, p. 323), because they are assumed to be accepted by organisational participants freely and with no coercion (Laughlin, 2007). Broadbent and Laughlin (2005) maintain that the external drivers will lead to a process of discourse among organisations' participants. This triggers change in the organisations' ISs, which is made up of their members' values and beliefs, in turn, and will drive change in the organisational DAs and ultimately in subsystems to reflect that change. 'Evolution' is envisaged as a normal and positive type of change process (Broadbent and Laughlin, 1997a, 2005). However, colonisation is argued to be more frequent than the evolution track (Campanale et al., 2010).

The second group of pathways are in relation to first-order change, i.e. rebuttal and reorientation, in organisations (Broadbent and Laughlin, 2005). These types solely affect the DAs (including internal control mechanisms) and subsystems (Laughlin, 1991). Rebuttal involves active boundary control by organisations, preventing the disturbance entering in the first place and leading to a rejection of the disturbance after a temporary alteration of DAs, without any influence on the other two dimensions of organisations, i.e. ISs and subsystem (Laughlin, 2007). As regards reorientation, organisations try to find and create structures to absorb disturbances in a way that avoids and prevents second-order changes from occurring (see e.g. Broadbent and Laughlin, 1998; Broadbent et al., 2001). In fact, as Laughlin (2007, p. 283) articulates, organisations might assume reactive or proactive strategies, e.g. absorption, to prevent their ISs, also called 'sacred core', from being colonised by disturbances. These four change tracks are argued to provide 'a powerful heuristic device for clarifying the nature of any change pathway' (Laughlin, 1991, p. 222).

In practical terms, these change pathways represent the efforts of organisations to meet the requirements of imposed disturbances (Broadbent et al., 2001; Agrizzi, 2008). It has been argued that there can be multiple amalgams of these dynamic change pathways in different situations (Laughlin and Broadbent, 1993). These pathways have formed a theoretical language for exploring empirical situations. Broadbent and Laughlin (2005) explain that the pathways are not predictive and encompassing but, as a skeletal framework, they need empirical data to be meaningful.

4.5.4.2. Practical implications for the study

This theoretical framework is adopted to provide an understanding of the reactions (change implications) by the hospitals in conjunction with their efforts to meet the NAPH's requirements. That is, the pathways of rebuttal, reorientation, colonisation and evolution could be respectively symbolised by the reactions of rejection, absorption, submission and adoption.

Broadbent and Laughlin (2005) have associated the internal shifts and transformations in different elements of organisations with a specific external driver (e.g. the NAPH). This interpretation creates the possibility of investigating the nature of the disturbance through their change effects in the reactions of given organisations. Drawing on this reasoning, the researcher has looked into the performance of the NAPH based on the hospitals' reactions, which also point to its effects on different elements of the hospitals. The aim is to investigate which reaction is mostly displayed by the hospitals in response to the requirements of the NAPH. For instance, Laughlin (2007) points out that the constant presence of the reactions such as rejection and absorption (rebuttal/reorientation pathways) might raise serious questions concerning the merit and worth of the imposed steering mechanisms. Similarly, the evolution pathway is seen as an ideal type of change in organisations as it is the outcome of agreed-upon changes and shifts in ISs of organisations (Broadbent and Laughlin, 2005; Zakus and Skinner, 2008).

4.5.5. Significance of Broadbent and Laughlin's (2005) framework for the study

This model, as mentioned earlier, is a mixture of two theoretical frameworks by Broadbent et al. (1991) and Laughlin (1991). The combination of those models had two main implications for the current study: First, locating the NAPH as a societal steering mechanism in the country's health system to assess its merits from an organisational perspective. Second, identifying their change implications for the hospitals and, as such, the hospitals' reactions. The following advantages, discussed implicitly in this chapter, have inspired the researcher to adopt this framework to look into the performance of the NAPH through the perceptions of the hospitals' members and its impact on the hospitals.

First, the important ascendancy of the Habermasian approach - the underpinning of the model - is that it highlights and advocates an evaluatory and critical stand in the analysis of different phenomena (e.g. societal regulations) in its research worldview (Lawrence, 1999). Such a stance was found to largely satisfy the evaluative intentions of the current research. It further adopts a societal (macro) view in the investigation of organisational issues, without being ignorant of micro aspects. Broadbent and Laughlin (2005) indicate that:

'... this approach sets organisations in a dynamic societal context, whilst maintaining the role and importance of human actors...' (p. 13)

As such, this model locates macro PMSs (e.g. the NAPH) in a wider societal context and interlinks their critical analysis with the responses and reactions of organisations, triggered by the mechanisms, and people's perceptions at micro level (Hassan, 2008). The relevance of considering these reactions and perceptions is, as Hassan (2008) puts it, because (macro governmental) regulatory agencies may make policies and decisions that lack rationality from the perspective of those involved in the original processes. On the other hand, thanks to this model, the re/actions of organisations towards these mechanisms can be measured based on societal perspectives and values. This could help ensure the interests of societies in organisations' actions and reduce the possibility of organisations decoupling from the societal values. As such, the reasons for organisations showing such reactions to societal steering mechanisms could be judged based on the good of the society, and not merely on the organisational grounds. This is overly prominent in the public sector which provides critical services in a society (Broadbent and Guthrie, 2008). This perceived relationship

permits a dynamic connection between societal and organisational levels, which helps this study approach the local level in a theoretically sound way and with a comprehensive focus. Accordingly, this study locates the case of Iran's healthcare accreditation around Habermas' societal development model refined and advocated by Broadbent and Laughlin (Broadbent et al., 1991; Laughlin, 1991; Broadbent and Laughlin, 2005).

Second, the manner in which this model conceptualises institutional pressures toward organisations could be envisaged as another advantage of the Habermasian approach, which is of critical importance for the current study. While the institutional perspective sees organisations under various parallel institutional forces from regulative, normative and cognitive elements (Scott, 2008b), this model renders a different conceptualisation. It conceives the regulative institutional pillar - equated with steering media (and their mechanisms) - to be reflective of institutional normative elements, which is, in turn, likened to the lifeworld in societal context (Broadbent et al., 2001). This interpretation allows the current study to look into the merits of the NAPH as an institutional regulative mechanism, based on its reflection of the societal lifeworld demands (normative elements). Therefore, it gives a relative superiority to Habermas' model over institutional theory, as far as this study is concerned. Moreover, as Hassan (2008) argues, this model's recognition of human actors is not underscored under the institutional theory framework.

Third, the approach of the model to organisations and organisational change processes, as elaborated earlier, provided the researcher with a language to look into the effects of the NAPH at organisational level in the hospitals. From an organisational perspective this model relates the change processes inside organisations specifically to an external driver (i.e. kick/disturbance). This allows the researcher to look at the nature of the driver on the basis of its change implications and respective triggered organisational reactions. The reactions of the hospitals' members towards the NAPH constitute a valuable base for evaluating this mechanism (Laughlin et al., 1994b). This model *de facto* authorises the evaluation of the nature of the NAPH based on the perspectives of those directly affected by this control system. Emphasising the importance of the reactions, Laughlin (2007) argues that a meaningful evaluation of external PMSs can only be undertaken by judging their merit, worth and quality in a particular context to which they are targeted. Furthermore, the model makes researchers identify the ISs, DAs and subsystems of their

organisation (Soin, 1996). Identification of these elements could ease the analysis of the hospitals' functioning and the change effects of the NAPH in these organisations. It also guides the researcher to explore distinctively the NAPH's effects on the hospitals' tangible and intangible elements (i.e. values, their internal PMSs and workings). More importantly, the significance and merits (intended or unwanted) of the changes are distinguishable through the use of this model (Shanikat, 2008).

Therefore, overall, these advantages allow a societally justified and encompassing assessment of the NAPH as a steering mechanism which is set up to monitor the reflection of the societal healthcare values in the country by the hospitals.

4.5.6. Theoretical frameworks in literature

In addition to Habermas' theory, following the refinements by Broadbent and Laughlin of this theory (e.g. Broadbent et al., 1991; Laughlin, 1991; Broadbent and Laughlin, 2005), the derived frameworks have been extensively used in the public sector literature.

Broadbent and Laughlin (1998) applied the change pathways of the model to examine the effects of NPM on GP surgeries and public schools in the UK. They concluded that accounting features associated with NPM showed colonising features towards the two groups, precipitating their resistance. Drawing on the theory, Lawrence (1999) critically analysed the macro issues arising from the reforms in the New Zealand health sector. He found that accounting aspects of the reform were seen as constitutive and legitimised only by procedure and were not introduced to solve healthcare problems, but to reflect market-driven (not health care) ideological commitments. Dillard and Smith (1999) showed that the rural healthcare discourse was heavily affected and colonised by managerialist policies operationalised in the form of Medicare's diagnostic-related groups-prospective payment systems (DRG-PPS). Broadbent et al. (2001) investigate the resistance of GPs in the NHS to institutional pressures, using the assumptions of this theory in conjunction with institutional theory (Scott, 2008).

Lawrence and Sharma (2002) utilised Habermas' critical theory to evaluate the incidence of TQM and BSC implementation in corporate universities in Fiji. Their study showed that, despite the usefulness of these performance measurement and improvement initiatives in promoting efficiency and effectiveness in the universities, their application endangered the very essence of education through commodification of education services. Dillard and

Yuthas (2006) studied the use of Enterprise Resource Planning (ERP) systems in organisations and suggested that they could lead to colonisation of their lifeworld since they are replacing consensual-based systems and activities. Broadbent et al. (2010a) drew on Habermas' notion of 'steering' to analyse the nature of the societal regulatory systems in English Higher Education. They argue that these systems use financing as a key tool for steering the organisations in this area of the public sector.

Although several studies have adopted Habermas' notions, mostly in the light of Broadbent and Laughlin's refinements, they have largely explored the role of accounting and financial reforms in public sector organisations in developed countries such as the UK (Dumay and Guthrie, 2007). Habermas' theory is rarely applied in the developing and under-developed countries, for instance Al-Angari and Sherer (2002) and Hassan (2008). Al-Angari and Sherer (2002) used this model to explore the changes that occurred within auditing firms in Saudi Arabia following the implementation of audit quality review programmes. They reported the signs of different types of changes in the audit firms. Hassan (2008) used the notions of regulative and constitutive steering mechanisms in order to analyse the merits of financial accounting regulations in Egypt transforming towards a market-based economy. He found the regulations showed a constitutive tendency during the period of transformation. No study has applied this theory and its associated models in healthcare systems in developing countries.

4.5.7. Criticisms of the models

Along with the extensive application of these frameworks (i.e. Broadbent et al., 1991; Laughlin, 1991; Broadbent and Laughlin, 2005), as explained, they have also encountered some criticisms in the literature. Given the skeletal nature of the model, as asserted by its developers, these criticisms could be conceived as their limitations.

Some studies have scrutinised the macro societal assumptions of Broadbent and Laughlin's framework. For instance, Hassan (2008) has argued that defining and fully differentiating the lifeworld, steering media and systems is a challenging task in a real situation due to them sliding and overlapping one another. This issue has been also echoed at organisational level with regard to splitting organisations' ISs into meta-rules, mission and beliefs (Soin, 1996).

However, most of the criticisms in the literature have pointed to the organisational change assumptions of the framework. Gray et al. (1995) see this model as rigid and of limited ability for fully explaining the shifting processes of organisational change in practice. Particularly, they maintain that it is silent on recognising a priori disturbances (i.e. occurring in advance of the event) and establishing the legitimate right (or even the need) to colonise. From a different perspective, Skinner et al. (2008, p. 189) indicate that this model 'has a tendency to become a simplistic and compartmentalised representation of complex phenomena' simplifying complex organisational change processes. They point to the failure of this model to address other reactions, including resistance, of organisations in different functional levels of organisations. Broadbent et al. (2001), nevertheless, have up to a point elaborated the ability of this model to attend to the resistance surfacing in organisations.

The model's discussion of inertia and equilibrium in organisations has been also criticised by Zakus and Skinner (2008). They indicate that inertia and equilibrium may not exist in all organisations, as they are continually adapting to minor changes in their internal and external environment. They also maintain that the model fails to notice the strength and impact of external opposing forces on organisational change and varying needs and interests inside changing organisations. As such, its ability is argued to be limited for addressing possible conflicts and their ramifications inside organisations during a change process. Accordingly, this model is criticised for taking a convenient approach to organisational change (Zakus and Skinner, 2008). Finally Gurd (2008), as previously has been reflected by Soin (1996), also shows his concerns about the failure of this model in attending to the role of power in changing processes at social and organisational levels.

4.6. Methodological approach to data collection

In accord with the research approach of this study, i.e. the MRT, besides the theoretical model another vital element is also required to fulfil the objectives of any research - empirical data. This complementary element has been thought to be even more important than the former, since the skeletal theories will not be meaningful unless they are enriched by relevant empirical data. These data might either be in conformity with the assumptions underlying the theories or contradict and, hence, ultimately extend those models (Laughlin, 2004). The theoretical models are not supposed to predict the exact

configuration of empirical contexts; they could rather provide important pointers to and insight into their reinterpretation (Laughlin, 2007). However, as mentioned earlier, ‘empirical surprises’ are still possible, which are *de facto* argued to reshape the conceptual languages where they fail to provide meaningful ‘placeholders’ for the analysis of the empirical data (Broadbent and Laughlin, 2009, p. 293).

In light of the importance of empirical data and in line with the implications of MRT approach, a methodological language was required as a basis for guiding empirical investigation of the study (Broadbent and Laughlin, 1997; Laughlin 2007). Laughlin’s discursive process has provided such a language for this research (Laughlin, 1987; Broadband and Laughlin, 1997; Agrizzi, 2008). This methodology, which is developed from Habermas’ critical theory (Habermas, 1974), outlines a three-stage process for collecting empirical data including formulation of critical theorems, process of enlightenment and selection of change strategies. The involvement of the researcher and the researched varies in different stages of this methodology. It is argued that the stages are not necessarily distinct and might have overlaps with one another (Broadbent and Laughlin, 1997a). These steps are required in order to build an understanding of the empirical data.

4.6.1. Stage one - Formulation of critical theorems

At this stage, the researcher has the prime role in collecting data. Following the collection of related data, they should be subjected to a discourse among researchers to reach a consensual understanding of the subject under study. The quality of this discourse, as Broadbent and Laughlin (1997, p. 628) point out, will be determined through the underlying principle of ‘Habermasian ideal speech situation’ in that each participant has the same right to participate in the discourse and express his/her ideas freely. In this stage, the analysis of the MoH’s relevant documents about hospital evaluation and accreditation as well as the hospitals’ overall profile was conducted. In addition, the interviews with the NAPH’s surveyors and the hospitals’ members regarding the impact of the NAPH on their organisations and also on their mutual reactions were conducted, in the light of the ideal speech principle (Broadbent, 1998). The results were subjected to a discourse between researchers in a sense that there was an equal opportunity for expressing ideas from both sides (Broadbent and Laughlin, 1997a; Baker, 2008). Since there was only one researcher

for this study, this stage was carried out with the participation of the researcher and his supervisor. This stage culminated in the development of the critical theorems from their common understanding on these issues.

4.6.2. Stage two - Process of enlightenment

In this research both the researcher and researched develop some common understanding about the issue under study (Campanale et al., 2010). The theorems from the previous stage were put to the respondents for further discussion and discourse in a similar way to the first stage between the researcher and the researched (i.e. enlightenment). In this stage, the researcher looked for deeper understanding and interaction with the hospitals' members and sought further insights on the impact of the NAPH on the hospitals. Moreover, another aim was to corroborate the data gathered from the first stage. This step was undertaken by re-interviewing some of the respondents of the previous stage.

4.6.3. Stage three - Selection of strategies

In the final stage of this process, as the methodology requires, the researched play the main part (Broadband and Laughlin, 1997). This stage includes a process of suggesting, evaluating and acting upon alternative strategies for change, on the basis of the outcomes from the enlightenment stage (Laughlin, 1987). The overall understandings of the issue under discourse should be given to the respondents based on what action they decide should follow in order to make possible changes to the status quo. According to Broadbent and Laughlin (1997), in this stage there is an intention to challenge the status quo, but it does not necessarily desire change in all situations. The resultant conclusions are intended to raise fundamental questions about the particular issue being investigated. As MRT implies, it is a researcher-informed, researched-led change (Laughlin, 2007). Laughlin (1987) argues that this is the most problematic part of any research project, as it is where the researcher cannot take the lead and does not have control.

In the current study, however, since the participants did not have the authority and power to make any change in the situation of hospital evaluation, the end products of this stage were merely policy recommendations and implications for the improvement in the NAPH. As such, given the position of the researcher, there was no possibility of tracking the

implementation of the suggestions, only the opportunity to propose them as policy implications at the end of this research. Figure 4.6 displays the main steps of the current research in the light of Laughlin's methodology.

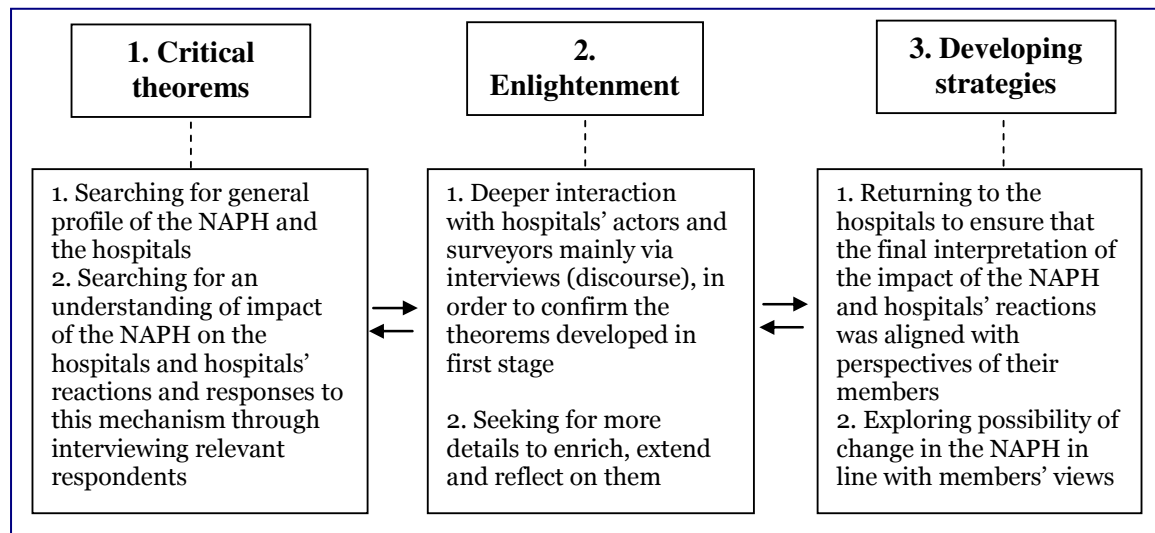


Figure 4.6 Three stages of my data collection methodology in the light of Laughlin's discursive process
(adapted from Laughlin, 1987, p. 488)

The strength of this methodological language is that it gives a possibility (opportunity) and thus motivates organisational actors to acquire a stronger voice in developing their own strategies, while using the knowledge base of researchers (Broadbent and Laughlin, 1997). Despite this strength, it needs more time and high levels of devotion and desire for involvement from both the researchers and the researched. The circumstances of the hospitals (busy sites), the participants' time constraints, and the nature of their activity (dealing with people's lives), created some limitations for fulfilling all stages of the methodology, as explained. Accordingly, the stages, particularly the second and third ones, were mostly integrated and tended to overlap one another.

Chapter 5 - Research Design and Data Collection and Analysis Methods

5.1. Introduction

Following on from chapter four, various aspects of the research design and data collection and analysis methods are explained and discussed in this chapter.

5.2. Research design

In seeking to understand whether and how the NAPH impacts on the hospitals at local level as well as the reactions and responses of the latter to this institutional regulative mechanism, there is a need for a richer understanding of the perceptions of the hospitals' members (Broadbent et al., 1991; Laughlin, 2007). A rich case-study is argued to allow for gaining an understanding and providing pertinent answers to 'how' and 'why' questions about the phenomenon under study (Pettigrew, 1995; Creswell, 2007; Yin, 2008).

Furthermore, due to the complexity and subtleties of the issue targeted, and due to the research's association with intangible perceptions, as Yin (2003) advises, case-study is a suitable research design, which provides an in-depth approach to data collection and analysis. It not only allowed the researcher to examine the tangible organisational aspects of the hospitals, but also provided an understanding of their intangible interpretive schemes (Broadbent, 1992). The adopted theoretical framework (i.e. Broadbent and Laughlin, 2005) also informs case-study research (Hassan, 2010).

Similar views are expressed regarding the study of internal control systems (i.e. design archetypes) by case-study in particular settings in which they are used (Berry et al., 2009;

Arah et al., 2003). The importance of a case-study design is also accentuated for the evaluation of various programmes (Stufflebeam, 2001). Accordingly, this design is selected for operationalising the objectives of the current study.

5.3. Case-study

Case-studies have been extensively used in social research, especially for small-scale studies (Denscombe, 2005). As Creswell (2007) puts it, a case-study tries to understand an issue or a problem using ‘case’ as a specific illustration. It *de facto* involves the extensive study of a phenomenon through one or more cases within a bounded system (i.e. a setting, a context). Yin (2008) indicates that a sound research strategy should be chosen, bearing in mind the following three key factors:

1. type of research question
2. extent of researcher control over events
3. level of focus on contemporary rather than historical events

Building on these questions, he proposes the table 5.1 as a framework for the choice of an appropriate research strategy.

Table 5.1 Criteria for choosing different research strategies - Source: Yin (2008, p.8)

Research Strategy	Form of research question	Control over behavioural events	Focus on contemporary events
Experiment	How, why, who, what, where	Yes	Yes
Survey	How many/much	No	Yes
Case study	How, why	No	Yes/No
History	How, why	No	No
Archival analysis	who, what, where, how many/much	No	Yes

As in the table, experiments can provide an answer to five types of questions, i.e. how, why, who, what and where, provided that there is control over the current event to be investigated. Yin (2008) posits that, when there is no control over events, both histories and case-studies are the preferred strategies (Table 5.1). The focus on contemporary events makes a distinction between case-studies and history strategies as, unlike history, a case-study is able to examine contemporary events. Therefore, in case-studies, ‘how’ or ‘why’ questions are asked about a contemporary set of events over which the researcher has little or no control (Yin, 2008; Denscombe, 2005). However, there may be some situations where more than one research strategy can be relevant. Furthermore, multiple strategies might be considered equally attractive in any given study (Yin, 2008). On this interpretation and given the research questions addressed, the case-study seems to be the most appropriate research strategy for the current study.

5.3.1. Definitions, features and functions

Yin (2008, p. 18) defines the case-study as ‘an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident....’ Creswell (2007, p. 73) similarly considers case-study as an ‘exploration of a bounded system (case) over time through a detailed and in-depth data collection involving multiple sources of data rich in content’. The following features shed further light on the nature of this research design:

- In-depth data collection with multiple rich sources of information
- Contemporary phenomenon study within its real-life (natural) context
- Investigating of interplay between phenomena and contexts
- A holistic focus on subject under study
- Multiple methods for collecting data

Case-study design is argued to have different types, varying based on their different purposes and functions. The following cases were found most often in the literature (Yin, 2003; Collis and Hussey, 2003; Denscombe, 2007; Creswell, 2007):

- *Exploratory case-studies* are used in areas where there are few theories or a deficient body of knowledge; the aim is to guide the development of relevant research questions and hypotheses.

- *Descriptive case-studies* describe the current practice.
- *Explanatory case-studies* use existing theories to explain the causes of events and processes and explore causal relationships.
- *Illustrative case-studies* use a case-study as an illustration of how a particular theory applies in a real-life setting.
- *Experimental case-studies* examine the difficulties of implementing new procedures and techniques in an organisation and evaluating the benefits.

It has been argued that the aforementioned types are not completely delineated and they may be used in combination in different studies (Collis and Hussey, 2003). In the current study, the focus is mostly on explanatory and illustrative case-studies.

5.3.2. Multiple case-study design

A unit of analysis in case-study is the kind of case to which the variables or subjects under study as well as the research problem refer and about which data are collected. It can be an individual, a role, a programme or scheme (such as the NAPH), a small group, an event, a process, an organisation (e.g. a hospital), a community, or even a nation (Collis and Hussey, 2003; Huberman and Miles, 2002; Kumar, 2005). There might be single case or a number of cases (multiple case-study design) in case-study research (Collis and Hussey, 2003; Yin, 2003). Yin (2003, 2008) believes that evidence from multiple cases is often considered more compelling. It can provide more insights and raise the validity of the research (Stake, 1999; Stufflebeam, 2001). This study has adopted a multiple (collective) design to gain more insights and robust understanding of the perceptions of the hospitals towards the current accreditation system of Iran.

5.3.3. Typical criticisms of case-study

Grbich (1999) criticises case-study in a sense that the bounded nature of cases may imply that a case-study approach favours containment and covers small scopes. However, as Yin (2008) puts it, case-study permits the generation of theoretical propositions that might be generalisable to other groups. In fact, in case-study the purpose is mainly to generalise to theoretical propositions not to population (Bassett, 2004; Yin, 2008).

Another criticism of case-studies addresses the point that this design lacks a systematic handling of the data. In response, its advocates indicate the systematic reporting of all evidence by case-study (Yin, 2003).

5.4. Data collection

5.4.1. Data collection practicalities

5.4.1.1. Access to the sites

Prior to collection of the empirical data, the following steps were taken. It was important to clarify them as the ‘research governance aspects’ of this study. For any Iranian student studying abroad and wishing to collect data about health care from inside Iran, there is a ‘Bursary committee’ in the MoH which has to approve the student’s request for this purpose.

In line with this process, the researcher provided the committee with a range of different documents regarding his research along with an introductory letter from his university and supervisor. After a few months, the committee granted its permission and assigned the researcher to the given field, which was Hamedan University of Medical Sciences (HUMS), to collect the data. In the next step, and within the university, the request for data collection was again considered and agreed through a bureaucratic process consisting of two stages. First, the university itself had to give approval and the hospitals needed to endorse the request and issue permission for the interviews to be conducted, at second stage. All these steps took a number of months before the researcher could embark on his empirical work. The researcher spent six months - three continuous and three discontinuous months - collecting data from the empirical field.

5.4.1.2. Difficulties of data collection

The researcher encountered some difficulties during the data collection process. The interviewees were mostly cautious about giving data to someone studying abroad. This problem was to some extent solved by explaining the main objective of this research to interviewees and reassuring them that the data were being collected only for academic

purposes and would be treated anonymously and with full confidentiality and privacy. However, in this regard, a difficulty remained about giving the researcher permission to attend the normal meetings of hospitals' senior managerial members.

Another problem was related to the nature of the research field and interviewees' work. The interviewees were mostly the staff of hospitals and most of the time they were busy with their work and patients. They were less amenable to spending their time on things other than their own affairs. This created some problems for the researcher in terms of finding enough time and right time to interview the staff. However, by pre-booking and arranging the interviews for times when they were free and when it was convenient for them, interviews were, to a large extent, successfully conducted, although most of the interview sessions overran because the staff had to deal with other matters. Moreover, at the beginning of the process, the researcher had to convince people from different hierarchical levels, who would not be directly involved in the data collection, of the benefits this research might bring to their organisation. As such, given the less developed information systems of the hospitals, the availability and accessibility of soft information was highly limited.

5.4.1.3. Ethical considerations

In terms of ethical considerations, certain arrangements were also considered. The hospitals and interviewees were free to withhold their cooperation or opt out of the research despite the tacit order from the MoH indicating that they should cooperate with the researcher. Any of the interviewees could decide not to allocate his/her time for the research and, in a very few cases, some were very busy with their own work and could not cooperate with the researcher. The main reason why most of the hospitals were interested in cooperating was apparently that they were expecting to see changes to the system as a result of this research, and some of them hoped this research would reflect the existing problems to the main authorities and make the situation conducive to positive changes in the system. Therefore, before initiating the data collection, a consent form and a participant information sheet (See Appendices C and D for translated version) were distributed among the potential interviewees. They were given at most one week to decide whether to participate. In addition, at the beginning of each interview their consent was sought.

The participant information sheet included mainly the following information:

- An introduction to the research project;
- The reasons for selecting a particular interviewee;
- Emphasis on their voluntary participation and the right to withdraw at any stage of the study;
- The amount of time the participants would be required to spend on the project;
- The possible benefits of the research for the participants;
- Potential risks involved;
- Confidentiality and ethical procedures.

5.4.2. Organisational context of the case

5.4.2.1. Research environment

As explained in chapter two, hierarchically lower than the MoH which plans, makes policies, funds and directs health care at macro level for the whole country, the UMSs are responsible for managing, delivering and monitoring healthcare services at provincial level. They act as the executive arm of the MoH in different provinces and perform two main dual tasks of delivering quality health care to local areas through their HCOs (including mainly hospitals) and providing medical and healthcare education (Majlis, 1985; 1987). The UMSs hold hospitals and other HCOs to account for their performance by implementing annual evaluation of the hospitals. As such, the UMSs are in turn held to account by the MoH to ensure they are implementing government health policies at provincial level (Majlis, 1988b). In fact, the programme of accreditation is developed in the MoH and is implemented by the UMSs (MoH, 1997a). The research environment chosen for this study was the HUMS which is geographically located in Iran's western province of Hamedan. The related justification for choosing this field and the existing hospitals is given as follows.

5.4.2.1.1. Justification for selecting the HUMS

The most common justification offered for the selection of a particular case is that it is typical (Denscombe, 2007). That is, the particular case is similar in crucial aspects to the others that might have been chosen. With this method, since the case-study is supposed to be similar to most (typical) of the rest, the findings from the case-study are hence likely to apply elsewhere and be transferable to the whole class of cases (Kumar, 2005).

Denscombe (2007) articulates that the convenience factor could come to the fore when deciding on equally suitable alternatives.

The NAPH is a national programme and its accrediting processes and standards and the overall structure of the UMSs (in terms of their hospital evaluation mechanisms and types of the hospitals) were entirely similar in all provinces of the country (MoH, 1997a).

Therefore, all UMSs had similar merits for possible selection as the research environment for the investigation of the programme's impact at this stage, without the need to carry out any similar study in the other provinces. Accordingly, other inclusion criteria were considered as relevant and important (priority) for selecting current UMS, which included the following:

- Familiarity of the researcher with the HUMS and corresponding province;
- The ease of access to the field; and
- Less time and cost associated with collecting data within this university as compared to the others.

These all lead the researcher to the selection of 'HUMS' as the overall research field for the data collection.

5.4.2.2. The cases for study

After selection of the appropriate research field (i.e. HUMS), the second stage was to identify the corresponding hospitals as the cases of study (see Table 5.2). A 'purposive sampling technique' was used at this stage for choosing the hospitals (Yin, 2008). As Ritchie and Lewis (2003) emphasise, qualitative research uses non-probability sampling techniques for selecting the population for its study, within which the units of study are intentionally selected to reflect particular features of groups or organisations within the sampled population.

Since there were different types of hospitals under the HUMS, a multiple case-study design was found to be more relevant for this stage. Yin (2008) believes that a multiple-case design is much stronger than a single-case design. In fact, while qualitative research tends to be based on the intensive study of a relatively small number of cases and the uniqueness of the different empirical cases should be recognised (Denscombe, 2007), the inclusion of more cases is argued to uncover the role of different contextual features in investigation of the phenomena under study (Broadbent and Laughlin, 1997a). Therefore, the researcher sought to deliberately include different types of hospitals (at least one of each type) to capture a more diverse yet complete picture of their members' attitudes towards the NAPH's impact at local level, and maximise the lessons learnt (Larrinaga-González et al., 2001; Creswell, 2003). In addition, this allowed the researcher to obtain contrasting results from the various hospitals. Such a process is called 'theoretical replication' in multiple-case-study design (Yin, 2008, p. 54). Other hospitals, similar to the main cases as far as possible, were also approached to enhance the validity of the data gathered. This is called 'literal replication' (Yin, 2008, p. 54). In practice, given the busy work schedule of those working in the hospitals, choosing more hospitals would expand the range of options and save some time for the researcher, considering his limited access to the field. The data collection process was carried out in the selected research environment until no new data in both similar and contrasting hospitals emerged and data saturation was reached (Strauss and Corbin, 1998). However, it should be noted that such a process would mostly apply to the teaching hospitals, firstly, in view of their majority in the field and, secondly, because of the limited access of the researcher to the other hospitals.

Table 5.2 Number and type of the hospitals selected for the case-studies

Type of hospital	Number of hospitals
Public (teaching)	5
Private	2
Institutional	1
Total	8

The teaching hospitals were advanced and referral HCOs and the hub of the country's healthcare system; they provided the majority of the services in the country.

Notwithstanding their quasi-autonomous status from a financial perspective, they were ultimately owned by the UMSs and the MoH.

The institutional hospital was also ultimately related to the government (Ministry of Welfare and Social Security). Given this link, it was in a stable financial position. Another feature of these hospitals was their fairly standard physical layout, since they were all of a new and purpose-built structure.

The private hospitals were not as advanced as the other two types, as they did not have government support. Instead, they could charge higher tariffs for their services. Given their nature, they had a different mission including both quality improvement and profit-generation. The table 5.3 provides more descriptive details of these hospitals.

Table 5.3 Descriptive information of the hospitals under current study

Row	Hospitals (Pseudonym ²¹)	Nature	Type	Last grade (2009)	Number of active beds	Bed occupancy rate %
1	A	Private	General	4	50	36
2	B	Teaching	Single-specialty	1	110	84
3	C	Teaching	General	1	261	70
4	D	Teaching	General	1	225	73
5	E	Private	General	2	99	38
6	F	Teaching	General	1	382	52
7	G	Clinical ²²	Single-specialty	2	90	65
8	H	Institutional	General	1	116	88

²¹. The name of the hospitals is anonymised on confidentiality grounds.

²². University non-teaching hospital

5.4.2.3. Selection of participants

The final stage before conducting data collection was to choose the main participants for interviews within each hospital. Green and Thorogood (2004) explain that, in qualitative work, there are typically other considerations as compared to quantitative studies, and the sample size mostly depends on the aims of study and elements such as data saturation while the process is ongoing.

For this stage, a purposive sampling technique was applied with the aim of explicitly selecting interviewees who might generate appropriate data (Mack et al., 2005). The main inclusion criterion for this stage was ‘familiarity with and involvement in’ the accreditation and evaluation processes in the hospitals. Analysis and review of the MoH and HUMSs’ formal documents and an informal formative evaluation showed that the senior, middle and junior administrative and clinical managers of each hospital are the most knowledgeable and heavily involved in accreditation of the hospitals. Accordingly, all those occupying such positions from different hierarchical levels in selected hospitals were interviewed for the study. However, a few frontline staff members (including consultants) were also interviewed, where required, in a bid to provide a more balanced and rounded understanding of NAPH’s impact on the hospitals (see Table 5.4). Different factors, such as the complexity of the phenomenon under study, the size of the hospitals based on number of their beds and departments, and the plan to interview people from diverse groups and departments, played an important role in deciding how many staff to interview. Furthermore, in order to corroborate information provided by the hospitals’ interviewees and minimise the potential for bias, it was suggested that data also be gathered from outsiders and cross-checked with relevant documents (Mellahi and Wilkinson, 2004). Accordingly, accreditation surveyors were also interviewed in an effort to increase the validity of the data (Table 5.5).

Table 5.4 The number of interviews conducted in terms of different hospitals

Position/Role	Teaching hospital	Private hospital	Institutional Hospital
Hospital director	1	-	
Hospital manager	3	2	1
Consultant	2	-	-
Matron	5	2	1
Supervisor	2	2	1
Head of Para-Clinic Dept.	10	2	1
Head Nurse (Sister)	4	1	1
Head of ED	5	2	1
Head of Nutrition and Food services	1	1	-
Quality improvement office	4	-	1
Staff	2	-	1
Total	39	12	8

Table 5.5 The number of interviews conducted in terms of different hospitals

Position/Role	Number of interviews
Head surveyor	1
Third party surveyor	1
Surveyor	4
Total	6

5.4.3. Data collection methods

Various methods were utilised under the purview of case-study design in line with theoretical models and the research objectives. Denscombe (2007) indicates that a case-study allows for the use of a variety of methods depending on the circumstances and the specific needs of the situation (strength of case-study design). Even so, it is argued that it relies heavily on qualitative data collection techniques (Jayawickramarajah, 1992). Drawing on this strength of the case-study, a range of formal and informal interviews, documentary analysis and non-participant observation were used to collect the required data. The combination of the qualitative methods allowed the methods to rectify one another's deficiencies. In fact, the flaws of one method could be the strengths of the other method. As the methods imply, only qualitative data were collected for this research, because the intention was to capture people's perceptions and understandings, which include complexity, richness and depth (Burton and Steane, 2004). Moreover, the adopted theoretical model and the methodological language of the study also required mainly qualitative methods including in-depth and semi-structured interviews and documentary analysis (Broadbent and Laughlin, 1997; Broadbent and Laughlin, 2005). The noteworthy point is that the research methods were applied in complementary and corroborative fashion, to both complement one another in addressing all aspects of the data and improve the validity of the data by providing evidence from different perspectives.

5.4.3.1. Interviews

The principal data collection method for this study was semi-structured interview (Creswell, 2007). Interviews are said to be the most commonly-used qualitative techniques in healthcare settings (Pope and Mays, 2006). Tellis (1997) states that this method is one of the important sources of information in case-study design. In the present study, the researcher undertook face-to-face interviews with both the individuals in the hospitals and the accreditation surveyors. Semi-structured interviews were particularly used to elicit their perceptions of the NAPH and uncover their reasons for having a specific reaction and response to this accreditation scheme (Modell, 2001; Oliver, 1991; Chang, 2006). Although these types of interviews were mainly employed for data collection, in practice the in-depth interview was also employed as long as the interviewee could give new data. For example, to understand the intangible interpretive schemes, in-depth interviews with

the members from different levels and positions in the hospitals seemed necessary. In the interview process, interviewees have time to reflect on the issues before other issues are mentioned.

An ‘interview topic guide’ was developed based mainly on the prior theoretical frameworks informing the study (Stufflebeam, 2001) and partly on the review of the related literature (e.g. Mannion et al., 2005). Durocher (2009) points out that using an interview guide as a tool for conducting semi-structured interviews is consistent with MRT approach. The interview guide gives some structure to the interview process, drawing on prior research and theories, yet leaves space for human subjectivity by allowing the observer to focus on the respondent’s experience (Durocher, 2009). The interview topic guide was tried initially with a fellow student and then with a hospital manager from a different research environment than the one selected for this research. The results of this small pilot were then used to modify, logically order and add more questions to the interview guide, allowing the researcher to obtain more focused information. In addition, the guide was to some extent refined during the first few interviews with the participants (See Appendix B for the interview topic guide).

5.4.3.2. Documentary analysis

Analysis of the related documents (Table 5.6) was conducted in order to identify the societal steering institution in the country’s healthcare system and the steering mechanisms of the institution. This method was further used to elaborate on the profile, objectives and descriptions of the MoH’s steering mechanism, i.e. NAPH (chapter two). Two groups of internal (related to hospitals) and external (related to the MoH) documents were studied. Firstly, the policy documents of the MoH in relation to its evaluatory intentions and actions were investigated. As the table shows, more documentation was seen in order to establish the main intention of the MoH for introducing current AP. At local level, in order to identify the ISs and DAs of the hospitals the pertaining documents were analysed.

Table 5.6 List of the documents used for data collection of research

Type	Reviewed documents
External	<p>I.R.I's Constitution</p> <p>Regulations of establishing the MoH</p> <p>The act of the establishments and duties of the MoH</p> <p>National document of healthcare sector development</p> <p>The MoH's Roadmap</p> <p>I.R.I Fourth plan of economic, social, cultural development</p> <p>The instruction of standards and principles of evaluation of the general hospitals</p> <p>The instruction of standards and principles of evaluation of the general hospitals: Emergency department</p> <p>The NAPH' checklists</p> <p>Standard regulations for the assistance, treatment and recovery of accident and emergency patients</p> <p>Practical instruction for the quality evaluation of hospitals</p>
Internal	<p>The guidelines for establishing hospitals</p> <p>Hospital evaluation result checklist</p> <p>Hospital internal review checklists</p> <p>Hospitals' strategic plan</p> <p>Patients' right charter</p> <p>Hospitals' rules and regulations</p> <p>Administrative development guidelines and checklist</p> <p>Hospitals' ISO 9001 standards</p>

Another reason for reviewing documents was to corroborate the information gathered at the interview stage (Tellis, 1997; Yin, 2003). Mellahi et al. (2002) note that, as the interviews generally reveal people's insights rather than presenting deeper realities

relating to the phenomenon under study, the stress is on the confirmatory role of the reviewed documentation.

5.4.3.3. Observation

Observations offer an opportunity to record and analyse behaviour and interactions as they occur, allowing events and actions to be seen through the eyes of the researcher (Ritchie and Lewis, 2003).

Non-participant observation was used to look for the signs and indications of the performance measurement practices in the hospitals. It, for example, allowed the researcher to see whether the accreditation grade is installed in the hospitals. Furthermore, the hospitals' efforts to publicise their regulations and ISO information could be seen through observation inside the hospitals. It also acted as a validating method for the data collected through the interviews. The researcher had the chance to participate once in the evaluation of the hospitals to see in practice the hospitals' reactions to the NAPH's surveyors and their interactions. This was expected to provide further understanding of the participants' actions and substantiate the data collected from the hospitals' personnel in the absence of the surveyors.

5.4.4. Assuring quality of the data

There has always been some contention on the issue of quality (i.e. validity and reliability) of qualitative data and whether it should be measured in the same ways as the positivistic approach and criteria (Bowling and Ebrahim, 2005). Qualitative researchers broadly argue that, because of the different paradigms and traditions of qualitative data, the quality and rigour of qualitative research must be judged on its own terms (Popay et al., 1998; Lincoln and Guba, 1999; Pope and Mays, 2006). Therefore, the focus should be, for example, on credibility and transferability of qualitative data in the investigation of validity and reliability of qualitative data (Pope and Mays, 2006; Ritchie and Lewis, 2003; Denzin and Lincoln, 2005).

5.4.4.1. Validity

The validity of qualitative data is traditionally understood to refer to the 'correctness' or 'precision' of a research reading (Ritchie and Lewis, 2003, p. 273). It is argued that the notion of validity in qualitative research can be problematic, because the truths in this stream of research are socially situated, rejecting a positivist idea of one fixed and essential truth (Green and Thorogood, 2004). As such, Lincoln and Guba (1999) argue that it is not possible for qualitative researchers to prove in any absolute way that they have got it right. However, this does not mean that qualitative researchers can dispense with all considerations of validity. There have been some attempts in the qualitative literature to move away from the concept of validity and to use instead other terms which are more appropriately related to the correctness of qualitative evidence. For example, it is suggested that 'credibility' and 'transferability' translate more appropriately for naturalistic (qualitative) enquiry than internal or external validity (Guba and Lincoln, 1999; Lincoln and Guba, 1999). Glaser and Strauss (1967) referred to the credibility and plausibility of qualitative research data and findings. Triangulation (Seale, 1999; Silverman, 2010), respondent validation (Denscombe, 2007) and disconfirmatory evidence (Green and Thorogood, 2005) are extensively advised for improving validity and proving that the data are likely to be accurate and appropriate and that the qualitative data have been produced and checked in line with good practice. These strategies are used in current study and discussed below.

5.4.4.1.1. *Triangulation*

Triangulation is one of the strategies advised for substantiating the validity of research findings in qualitative research (Pope and Mays, 2006). Denzin (2009, p. 301) points to different types of triangulation for assessing the validity of qualitative data, including the following:

- Data sources triangulation: This refers to the collection and comparison of data from the members of various interest groups (i.e. different stakeholders). This type could vary in terms of time (different time), person and space.
- Method triangulation: This denotes the comparison of the results from two or more different methods of data collection (e.g. interviews and observation)

- Investigator triangulation: This includes using several researchers (e.g. a research team) studying the same phenomenon using the same method (e. g. observation or interviews).
- Theory triangulation: This refers to the strategy used when different investigators with different perspectives (multidisciplinary research team) interpret the same data/results.

In all of the aforementioned categories of triangulation, researchers look for patterns of convergence to develop or corroborate an overall interpretation. Pope and Mays (2006) argue that triangulation is mostly seen as a way of making a study more comprehensive, or of encouraging a more reflexive analysis of the data than as a pure test of validity. Nevertheless, if conducted properly, triangulation can provide contrasting data sources to bolster confidence that the data are ‘on the right lines’ (Denscombe, 2007, p. 297).

Application of triangulation for validating current research data

For validating the qualitative data, this study has utilised the following two categories of triangulation.

1. Data sources triangulation: the data were collected from different groups of respondents to increase the confidence in the data. Hospital staff members from different professions and hierarchical levels and accreditation surveyors were interviewed in order to provide a comprehensive view on the current AP. Moreover, the data was also cross-checked in a few cases with a handful of hospital staff from other UMSs for more confidence (e.g. a hospital manager from another university was interviewed)
2. Method triangulation: interviews, observation and documentary analysis were used for collecting data for the current study. Observation was only used to validate data generated through interviews with the participants.

Consequently, a number of follow-up interviews and further review of related formal documents were conducted to clarify the ambiguities and mismatches among data

collected by these three different methods. Of course, the principal data collection method was semi-structured interviews.

Since the research was conducted by one PhD student, investigator triangulation and theoretical triangulation were not possible.

5.4.4.1.2. Respondent validation

Another strategy to enhance the validity of qualitative research is ‘respondent validation’. This validation method, which is sometimes called member checking, includes a range of techniques in which the investigator’s account is compared with the accounts of those who have been investigated to establish the level of correspondence between the two sets (Pope and Mays, 2006). Similarly, respondent validation implies that the researcher can return to the participants with the data and findings as a means of checking the validity of the findings (Denscombe, 2007). This allows a check on factual accuracy and allows the researcher’s understandings to be confirmed (or amended) by those whose opinions, views or experiences are being studied. Lincoln and Guba (1999) regarded respondent validation as the strongest available check on the credibility of a research project. However, some limitations are attributed to this validation technique. For example, Pope and Mays (2006) have maintained that the account produced by the researcher is designed for a wider audience and might be different from the account of an individual informant because of their different and limited role in the research process. As such, the analysis of the data might take the explanation beyond something that would be immediately recognisable to the respondent (Denscombe, 2007). Bloor (1997) has advised respondent validation as part of a process of error reduction rather than as a straightforward check on validity.

- *How was respondent validation used in the current research?*

Following on from the data collection and primary analysis of data, and in accord with the methodological approach of the study (in its third stage, see figure 4.6), the researcher discussed the initial themes with a few respondents based on their availability for this purpose, in order to check whether they could confirm that the resultant data are in line with their views. This process was complex, since the generated themes were slightly different from the data collected through semi-structured interviews and sometimes not

exclusively related to the person interviewed at this stage. Therefore, the researcher spent some time clarifying this for the respondents.

5.4.4.1.3. Disconfirmatory evidence

Qualitative researchers should look for disconfirming evidence (such as deviant cases) and account for them rather than searching only for the points they want to make (Green and Thorogood, 2005). Popper (1959) in Easterby-Smith et al. (2002) has suggested that researchers should always consider both confirmatory evidence as well as disconfirmatory evidence to resist the temptation of collecting data that solely confirm whatever aim or stance the researcher is pursuing. As indicated earlier, to avoid the temptation of considering only the confirmatory evidence and missing the disconfirmatory evidence, the researcher also interviewed the accreditation surveyors as they belonged to another side of the accreditation process. This was done because the views of the managers in the hospitals might be seen as partial and one-sided (Paton and Mordaunt, 2004).

5.4.3.2 Reliability

Reliability is generally concerned with the replicability of research findings using the same or similar methods (Ritchie and Lewis, 2003). However, in qualitative research, because of the different arguments on reality and the effects of context on the phenomenon under study, it seems hardly applicable in this sense. Instead, those concepts that are felt to have greater resonance with the goals and values of qualitative research have been used; for example, confirmability (Ritchie and Lewis, 2003), consistency (Guba and Lincoln, 2008) or dependability (Marshall and Rossman, 2011) of qualitative findings. Ritchie and Lewis (2003) explain that, to ensure these qualities exist, one should conduct internal checks on the quality of data and their interpretation, and provide information about the whole research process. It has been argued that this could be achieved by conducting an audit trail, i.e. carefully documenting the research process from conception; e.g. who collected and analysed the data and in what ways. The process of analysis and coding can also be described clearly and applied methodically and systematically (Bowling and Ebrahim, 2005; Green and Thorogood, 2004). To address reliability concerns, this study has given a

detailed explanation of the different steps of its data collection and analysis in the current chapter, besides having the data checked by the research supervisor.

5.5. Data analysis

Qualitative data analysis is referred to as the process of bringing order, structure, and interpretation to a mass of collected data (Marshall and Rossman, 2011). Given the nature of qualitative data (i.e. subjective and messy), the analysis process is argued to be difficult and time-consuming (Marshall and Rossman, 2006; Yin, 2008). Unlike the quantitative research process, qualitative data collection and analysis processes are not completely separate and sequential. As Figure 6.1 displays, the following trend can often be seen between data collection and analysis processes in qualitative research.

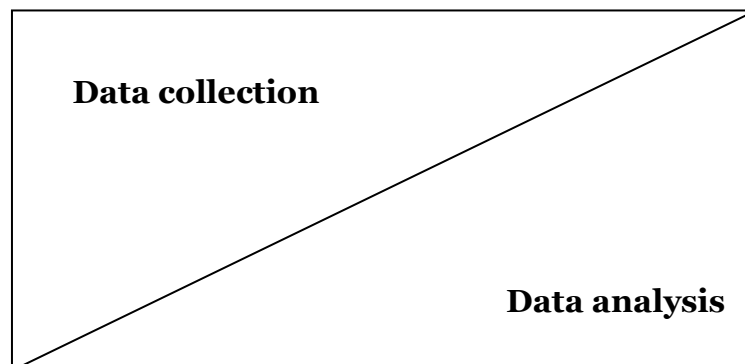


Figure 6.1 Model of research process in qualitative approach (*Pope and Mays, 2006, p. 65*)

In view of this ambiguity and difficulty of qualitative data analysis, Yin (2008) maintains that a general analytic strategy is required to clarify the data used and to define the priorities for the analysis. Pope and Mays (2006) mention three broad analytical approaches for the analysis of qualitative data, including thematic analysis, grounded theory and framework approach. They argue that these approaches range from a broadly inductive approach to a more deductive approach. In line with the MRT which stresses the role of skeletal theories both in collecting and analysing the data (Broadbent and Laughlin, 2009), the framework approach (Pope and Mays, 2006; Ritchie and Lewis, 2003; Adams et

al., 2007) is found to be more suitable for the data analysis of this study. The main reason is that it permits the consideration of previous theories and frameworks, which are vital, according to the MRT, in the analysis of data. The other two approaches seek a more inductive orientation and rarely envisage prior theories in data analysis.

A computerised qualitative data analysis package, i.e. NVivo (version 8), was used in some stages of this approach, to operationalise the framework approach. NVivo is a computer-assisted qualitative data analysis software (CAQDAS), which helped the researcher manage larger amounts of data and reduce the apparent ambiguity attached to the qualitative data analysis (Pope and Mays, 2006). It was used to manage and code interview transcripts and electronic documents. The software also allowed for electronic storage of all transcribed material, and provided methods for coding data and relatively easy data search and retrieval functions. However, the cautious point should be made that CAQDAS could not replace general analytic strategies in the analysis process.

5.5.1. Framework approach

The framework approach was developed by the National Centre for Social Research in the UK (Ritchie and Lewis, 2003). It is seen as a more deductive form of qualitative analysis, which is increasingly being used in healthcare research (Pope and Mays, 2006). It mostly begins the analysis from the aims and objectives already set for the study, whilst being grounded in original accounts and observations of the people studied (i.e. inductive). The framework approach tends to be more explicit and informed by *a priori* reasoning in comparison with thematic analysis and grounded theory (Guba and Lincoln, 1999). It has five main stages, as follows (Pope and Mays, 2006, p. 73):

1. *Familiarisation* starts by reading through transcripts and studying notes and so forth for some time to initially list the key ideas and recurrent themes. Familiarisation might not include entire data sets because of time constraints (Ritchie and Lewis, 2003). A pragmatic selection of the data is advised for this purpose (Pope et al., 2000).

Before this stage, preparation of the data, i.e. transcribing the data during and along with the data collection, translating them from Farsi to the English language, and anonymising the respondents by giving them pseudonyms for the rest of the analysis, was undertaken.

At the beginning of this stage, back-up copies were made of all original materials, given that qualitative data tend to be irreplaceable (Denscombe, 2007). The original copies were stored separately from the back-ups, which were used for the rest of the analysis.

Following the preparation stage, in order to familiarise himself with the data the researcher selected and reviewed a range of transcriptions related to diverse respondents.

2. *Identifying a thematic framework* involves identifying all the key issues, concepts and themes by which the data can be examined and referenced. This could be conducted by drawing on *a priori* assumptions, the aims and objectives of the study and respondents' views or experiences that recur in the data. This is where prior skeletal theories are used for the analysis process in the current study. The thematic framework was used to label the data into manageable chunks for subsequent retrieval and exploration. The thematic framework was developed and refined during subsequent stages.

3. *Indexing*, which is mostly referred to as coding in other qualitative analysis approaches (Guba and Lincoln, 1999), points to applying the thematic framework systematically to an entire data set to identify relevant pieces of the data with different themes and labelling them by both numerical and/or textual codes. In this stage, the themes (the thematic framework) identified and developed in the previous stage were imported to NVivo. During this stage and as the data were being coded, new themes emerged which led to the refinement of the conceptual themes developed in the second stage. The examples of NVivo 'free and tree nodes' are displayed in Appendix I.

4. *Charting* is for more clarification of the analysis and themes by using headings from the thematic framework to create charts of data until they can be easily read across the whole dataset. Charts can be either thematic for each theme across all respondents (cases) or by case for each respondent across all themes as follows:

Thematic chart

	Case 1 (members or hospitals)	Case 2	etc.
Theme			

Case chart

	Theme 1	Theme 2	etc.
Case			

In the current study, the thematic chart was used, because the themes were firstly identified and imported into NVivo. They then were applied to all data gathered from the respondents.

5. *Mapping and interpretation* is the final stage of the framework approach. In this step the charts are used to define concepts, search for patterns, create typologies and find associations between themes with a view to providing explanations for the findings. The research objectives, theoretical assumptions and the themes emerging from the data affect the process of mapping and interpretation. Ritchie and Spencer (1994, p. 186) have indicated that ‘this part of the analytical process is the most difficult to describe’. This stage is reflected in the findings and discussion chapters of this thesis.

Chapter 6 - Assessing the Merits of the NAPH

6.1. Introduction

This chapter includes the empirical findings resulting from the analysis of data collected from selected Iranian hospitals, with regard to the healthcare accreditation of the country. The findings are achieved in the light of the objectives and theoretical models of the study and are meant to render a contextual evaluation of the performance of this programme. The themes are *de facto* derived from the analysis of the transcripts and a review of internal and external documents of the hospitals and the MoH. The most relevant quotes are provided to support the debate, where they help with interpretation. However, more than one respondent made a similar comment in a majority of cases (some quotations are placed in the Appendix I). The chapter will present and discuss the findings related to the examination of the hospitals' perceptions and attitudes towards the merits and contextual effects (unintended, dysfunctional and beneficial) of this NAPH.

6.2. Steering in the country's health sector: Locating the steering medium (institution) and mechanism

6.2.1. Societal steering institution in Iran's health system

As explained in chapter four, according to Broadbent and Laughlin (2005), in any modernised and complex society there are specific bodies called societal steering institutions, which steer and guide societal organisations to reflect societal relevant values, called lifeworld. In practice, the steering mechanisms issued by these institutions operationalise the intentions of these institutions and ensure that the societal organisations reflect societal lifeworld in their activities (Broadbent et al., 1991).

Analysis of the related formal policy documents illustrated that the MoH is the current steering institution designated by the Iranian constitution and government to steer (guide and monitor) the HCOs to reflect the relevant healthcare lifeworld of society (Majlis, 1985; 1987; 1988a). The analysis also revealed that the NAPH is the main steering mechanism (macro PMS) issued by the MoH in the current health system. It monitors, regulates and evaluates the behaviour and performance of the hospitals (i.e. the main societal systems in the current health sector) to make sure they deliver their services in line with the related societal lifeworld for health care. The NAPH represents an important element of the macro control, regulation and evaluation in the country's healthcare system, also called a societal MCS (Broadbent et al. 2010a). It reflects, operationalises and ensures the government's intentions for improving quality and safety in health care across the country (MoH, 1997a).

6.2.2. Nature of the steering mechanism

Broadbent and Laughlin (2005) and Laughlin (2007) have argued that, as discussed in chapter four, the reactions of societal organisations targeted by steering mechanisms and the perceptions of their participants is a key litmus test for judging the nature of the mechanisms and can render valuable information for evaluating the performance of these mechanisms in a specific context. Accordingly, the empirical data to assess the merits and worth (Stufflebeam, 2001; Scriven, 2009) of the NAPH was gathered from selected Iranian hospitals using Broadbent and Laughlin's (1997) three-stage methodological language and in the light of Broadbent and Laughlin's (2005) theoretical model. According to Broadbent et al. (1991) and Broadbent and Laughlin (2005), steering mechanisms externally imposed on organisations (e.g. the NAPH) could be categorised into either of the following two groups, on the basis of their nature.

1. Regulative and amenable to substantive justification (ASJ)
2. Constitutive and legitimised by procedure (LP)

Constitutive and LP, unlike regulative and ASJ, steering mechanisms have specific features which might create serious unintended consequences in subject organisations. They are more likely to impose new values and norms on organisations and reduce their

freedom and independence. Broadbent et al. (2010a) indicate that constitutive mechanisms are not formulated consultatively and with the participation of organisational stakeholders. Conversely, regulative and ASJ evaluatory systems are argued to be the chosen framework of control, consensually-based and relevant to the activities of the target organisations (Lawrence and Sharma, 2002). They are subject to open discussion and questioning, of a consultatively-driven nature and embedded in the internal lifeworld, i.e. ISs, of the organisations (Dillard and Smith, 1999). Moreover, regulative and ASJ steering media are understandable to organisations' members and accepted by them as in line with their long-term survival growth and development (Laughlin, 2007).

6.3. Theoretical themes on the nature of the NAPH

The NAPH: A constitutive and LP or regulative and ASJ mechanism?

Drawing on the aforesaid assumptions and considering the key role of the subject organisations' perspectives in testing the nature of steering mechanisms (Broadbent et al., 1991), the perceptions of the selected hospitals' participants were examined to explore their views on the merits of the NAPH in the light of the adopted theoretical framework. The results are as follow:

6.3.1. Consultatively-driven

Analysis of the data revealed that the NAPH was not developed in a 'consensually-based' fashion. The existing documentation on the initiation of the NAPH, as explained in chapter two, shows that in 1997 the formal guidelines for the evaluation of the hospitals were developed under the Treatment and Medication Undersecretary of the MoH, put once to the convention of the UMSs' Chancellors and their Deputies for Treatment, and sent down to these hospitals to be observed in their practices (Moghimi, 2004; Sadaghiani and Zare, 2005). The UMSs at provincial level monitor the implementation of these standards by the hospitals. Although it was stated by a senior member of the surveyors that the NAPH was piloted at the beginning, no feedback was utilised to tailor the system to the new circumstances at later stages. The members of the hospitals claimed that they had not been asked at any time for their feedback or views at different stages of development, implementation or improvement of the NAPH.

'No feedback is asked from this hospital to improve the NAPH; we reflect the problems though, but nothing has changed based on our views so far. What we say is mostly in an informal way and to the surveyors because there is no formal process in place for asking our feedback.' (Head of ED: Hospital H)

This comment was frequently repeated by an array of different hospital members. The hospitals did not feel, in a way, that their views and feedback were valued by the authorities of the NAPH.

6.3.2. Chosen framework

What was clear from the analysis of the MoH and the hospitals' policy documents was that the NAPH was a compulsory programme and not a chosen evaluation system for the hospitals. Consistently, the analysis of the data demonstrated that most of the interviewees did not perceive the NAPH as a 'chosen framework', but a top-down oversight system. They believed that the NAPH is a basic evaluation system that annually requires them to review their activities and serves as a reminder for a number of static standards.

6.3.3. Understandable

It was claimed by the hospitals' members that some standards of the NAPH, as is indicated in the following comment, were judgmental, too general and vague²³ and not specifically 'understandable' to the hospitals.

'In the case of Nosocomial infection, they insist that we find more cases of the patients with this infection and if we report fewer cases, they will assume that our case-finding system is not working properly, while we think the less should be better.' (Manager: Hospital C)

In addition to the members of the hospitals, this issue was even raised by some members of the surveyors.

'Since the questions of the checklists are too general and somewhat vague, we ourselves try to make them more specific and clear for the hospitals.' (Head Surveyor)

23. It was indicated that, because of this vagueness, the hospitals' authorities needed sometimes to negotiate to justify the surveyors and raise their chance of attaining higher grades.

Similar concerns were shared about the ‘scoring’ method of the NAPH. The hospitals contended that they were not aware of the way the scores are allocated and of the varying importance given to their different practices.

‘Scoring process is not clear for us. It is totally up to the surveyors’ judgements what score to give the hospital. Therefore, we do not know how to perform to get the full score for an activity or process.’ (Member of quality improvement office: Hospital F)

6.3.4. Freedom guaranteeing/reducing

A majority of the members of the hospitals did not think of the NAPH as constraining their ‘freedom’ in their daily activities.

‘I don’t suppose the NAPH limits my freedom and independence, because it is only an annual checking system which stays just for a few days with us in the hospital.’ (Head of ED: Hospital E)

The physicians, as the most powerful and influential group in the hospitals, were mostly unaware of the functionality of the NAPH. It was claimed by the hospitals’ members that the mechanism mostly addressed the structural, not processual, facets of the hospitals. Therefore, it was not directly related to their activities. In addition, they also tended to judge this attribute of the NAPH (i.e. freedom reducing) based on the surveyors’ actions, stating that the process of the evaluation was interactive and proceeded in a friendly and informal mode.

‘Their behaviour is interactive and cooperative and we don’t feel that they (the surveyors) restrain our freedom or discretion.’ (Head of ED: Hospital B)

‘We do not feel they (the surveyors) are constraining our freedom and independence. They even try sometimes to help, but they are just performer of the evaluation and real decision maker about the programme is the MoH.’ (Matron: Hospital C)

Therefore, these views might not be totally reflecting the nature of the whole accreditation system in terms of constraining their independence. For instance, since the hospitals needed to obey the asserted evaluation standards, which they did not have any part in

setting, according to Broadbent and Laughlin (2005) this might be seen as a freedom-restraining feature of this mechanism.

6.2.8. Relevancy

As for ‘relevancy’ of the NAPH’s standards to the hospitals’ activities, the participants apparently approved that the standards were related to the different aspects of their hospitals. However, due to the lack of an updating system for the standards of the NAPH, they perceived them as too old and deficient to assess their current actions. They claimed that if any change was to happen in the activities of their hospitals or a new service was added, it may not have been covered by the current standards. In fact, the initial relevancy could be because APs are originally developed based on healthcare norms, as compared to other external PMSs which are transposed from the industrial sector (Shaw, 2000). They have the advantage of being directly linked with the activities of HCOs. Furthermore, the participants claimed that the activities of the hospitals were not covered by the standards, implying that the NAPH was not a ‘comprehensive’ mechanism.

‘This evaluation system has been without any significant change from the beginning, and any new activity we added to our hospital is not covered by that.’
(Manager: Hospital E)

6.2.9. Position of the NAPH

In terms of the position of the official body performing the evaluations and developing the standards, most of the hospitals, especially NTH²⁴ contested the ‘appropriateness’ of the NAPH’s position for assessing all types of the hospitals. The NTHs especially argued that the surveyors are only the representatives of the MoH and the UMSs and that using similar surveyors for all types of hospitals is biased. This is clear from the following comment by a member of private hospital:

‘We think it is biased, when the university both assesses its own hospitals and others; even if nothing occurs in practice, which I believe there is... other hospitals might feel in this way.’ (Manager: Hospital A)

²⁴. Including institutional and private hospitals in this study (see Figure 3.2, chapter 3).

Members of the teaching (public) hospitals were also aware of and concerned about this situation, for instance:

‘Since the university is beneficiary of teaching hospitals, a bias can happen when its surveyors evaluate hospitals.’ (Head of Para-clinic Dept: Hospital F)

Although the MoH’s interventions are alleged to be in the name of public interest, it might be argued that standard-setting efforts by the MoH are not passing the litmus test of being regulative and ASJ due to its active rejection of a wider stakeholders’ (hospitals) commitment and feedback (Laughlin, 2007).

6.4. Empirical themes on the nature of the NAPH

The following themes also emerged from the data, in conjunction with and as a result of the abovementioned characteristics of the NAPH, in addition to what was explained above on the basis of prior theories and models (i.e. Broadbent and Laughlin’s theoretical framework). These themes reflect further grounds on which the hospitals’ members did not consider the NAPH as rendering a ‘valid assessment’ of the performance of their organisation:

- Coverage of the measures
- Focus on structure rather than process
- Biased approach to the hospitals’ performance
- Disproportionate evaluation of the hospitals
- Low sensitivity to local (organisational) factors
- Static, repetitive vs. dynamic structure
- Cross-sectional vs. continuous evaluation
- Predictability
- Judgemental vs. evidence-based standards
- Time lag between field survey and scoring
- Turning into an informal evaluation process
- No reward and punishment system

- Surveyors' issues

6.4.1. Coverage of the measures

There was a general view among the hospitals' members that the NAPH in its current status did not represent a rounded picture of their hospitals' performance (i.e. a non-representative consideration of different domains). Although the NAPH was meant to assess all the activities of the hospitals, they felt that many areas of their best-performing activities were either undervalued or missed by this grading system. In particular, this was clearly stated by the single-specialty hospitals and the NTHs. Since the standards of the NAPH were static, it might not cover hospitals' new services, initiatives and strengths as indicated by these hospitals. For example, the manager of a single-specialty hospital indicated that:

'This evaluation system has been without any change from its start, and any new activity we added to our hospital is not covered by that.' (Manager: Hospital E)

Some surveyors also believed that this programme is useful for hospitals only to a limited extent.

'I think this programme is only assessing the service quality of hospitals, insofar as it is within the confines of evaluation checklists.' (Head Surveyor)

For example, the evidence from this case-study showed that some managers and hospital decision-makers, since they thought that the NAPH was not giving a comprehensive assessment of their activities, were drawn towards deploying other quality improvement initiatives, such as productivity-enhancing practices, in their hospitals.

'We are initiating productivity measures in this hospital, because we feel the NAPH does not cover some areas which are important and of priority for us.' (Manager: Hospital B)

Pomey et al. (2010) reports a similar tendency among hospitals towards adopting other quality improvement procedures because of routinisation of APs.

6.4.2. Focus on structures over processes

Some hospitals claimed that this programme put more focus on the hospitals' physical and structural aspects and less on processes and outcomes. The following comments are reflective of this issue.

'It (the NAPH) mainly focuses on physical structures and not [...] processes. So those hospitals with good structural appearance, such as advanced teaching hospitals automatically get better evaluation results, irrespective of their outcomes.' (Third party surveyor)

'Checklists are mostly concerned with physical and structural matters and not with hospitals' processes, whilst they both should be covered by the NAPH.' (Matrons: Hospital F and B)

As the documentary analysis of the evaluation checklists showed, they mostly checked the capacity of the hospitals for providing care. It has also been acknowledged by the authorities of the NAPH that the main focus of the NAPH is mostly on the quantitative elements (i.e. physical structures) of the hospitals (Moghimi, 2004). A fairly obvious problem in relation to this issue was that, in a few cases, there was some unused equipment in the hospitals, as mentioned by their members, bought only because of the requirements of the NAPH.

'The surveyors only check the existence of equipment; they have never checked whether we can use it or ...' (Head of Para-clinic Dept.: Hospital F)

In addition, the emphasis on the structural aspects also caused the hospitals' authorities to spend more money on preparing their hospital for the evaluation. Consequently, other high-priority activities could have been ignored or neglected.

6.4.3. Biased approach to the hospitals' performance

This problem was voiced by the all hospitals, albeit largely by the NTHs. As mentioned earlier, varying types of hospitals were addressed by the research (e.g. teaching, private and institutional). The institutional hospital investigated was related to the Welfare and Social Security Ministry and not owned by the UMSs and the MoH. It was on a better

standing in terms of financial position and quality of services as opposed to the other groups of hospitals studied in the whole research, as also stated by the surveyors.

‘Social security hospitals have been good from the beginning; they have better financial situation and organised physical structure, supposedly better service quality.’ (Surveyor)

The findings showed that the institutional hospital was always examining its grade in comparison with that of the teaching hospitals. Consequently, this hospital was expecting to achieve a high grade given its excellence and the structural focus of the NAPH. This hospital had negative perceptions of this evaluation programme overall and believed that, since the surveyors were related to the UMS, they were more lenient with the university hospitals and stricter with them. In addition, they claimed that the score allocated to their activities is not commensurate with the quality of their services in comparison with those of the teaching hospitals. The following comment is expressed by a member of the institutional hospital:

‘Surveyors assess this hospital more strictly than the teaching hospitals. They normally carry a negative view towards this hospital in evaluation process... I know the requirements of the programme are not properly observed in the teaching hospitals, as I have worked there. However, they normally get better grade than us very easily.’ (Head of ED: Hospital H)

‘In my experience, the university hospitals are being assessed by more ignorance as compared to other ones.’ (Manger: Hospital A)

Private hospitals also raised similar issues with respect to the NAPH. The main problem cited by the private hospitals was that they were being assessed by similar standards used for the university hospitals, which were highly advanced and supported by the government. The private hospitals in this study were two small hospitals in contrast to the other two groups. These concerns were reflected in the comments of different members of a private hospital:

‘... I feel they [surveyors] don’t give right score to us, because I don’t think it is fair to compare us with other advanced teaching hospitals and evaluate our work by the same checklists of standards for them.’ (Manager: Hospital E)

‘They compare this hospital with publicly-funded advanced teaching hospitals which is not fair in my idea.’ (Supervisor: Hospital E)

Another important cause of the NTHs' dissatisfaction with the NAPH resulted from not having their representative in the evaluation team of the NAPH. Since the evaluation was performed by the surveyors of the UMSs and the MoH, without any representative from them, the NTHs were always suspicious about the evaluation results of this evaluation system. Bohigas and Asenjo (1995) similarly found that the dual role of accreditor and owner played by the government jeopardised the credibility of the AP.

6.4.4. Disproportionate evaluation of the hospitals

Another issue regarding the evaluation of the hospitals emerging from the interviews was the 'disproportionate requirements' of the NAPH. This means that the hospitals claimed that some requirements of the NAPH exceeded their capabilities and facilities. They argued that the NAPH was asking for improvements and changes that they were unable to accomplish through lack of the prerequisites, which accords with Scrivens' (1993) study. As they commented, the hospitals were evaluated on what they do not own or have control over. This issue could be against the feasibility principle of performance measures (Reiter et al., 2006). As Scrivens (1995a) argues, if set at an optimal level, accreditation standards should be achievable.

'According to our situation and capability as a single-specialty hospital, we really are not able to fulfil completely the requirements of the NAPH ... the standards are for general hospitals ... some equipments or services are not necessary in this hospital but since the NAPH asks for them we must provide and prepare them because of the compulsory nature of the NAPH.' (Manager: Hospital B)

Even the advanced teaching hospitals echoed this view:

'They (the surveyors) do not consider our out-of-hand limitations and capabilities in their evaluation.' (Manager: Hospital B)

'The evaluation is not based on the hospital's capability. We don't think they evaluate what we have or are capable of doing.' (Supervisor: Hospital E)

This problem was more noticeable in relation to the following issues in the hospitals:

6.4.4.1. Human resources

Most of the hospitals, particularly the teaching ones, were complaining about their shortage of staff. They claimed that their current rate of human resources in the hospitals was far below the rate required by the accreditation standards. They stated that the current standards were taken (translated) from developed countries and were not adaptable to their circumstances.

‘We always get lower scores for our human resources, because they are not on a par with the standards and it is not in our hand to adjust that. We always lose points for this problem - it is a big inconsistency for this programme (Emphasis added).’ (Matron: Hospital C)

The allocation of staff to the teaching hospitals, they argued, lay completely with the MoH (given its financial burden and the hospitals’ financial problems, they were unwilling to recruit temporary staff, whom they must pay themselves, to compensate for their shortage.)

6.4.4.2. Physicians

Another inconsistency was related to the activity of physicians in the hospitals. Principally, the hospitals’ consultants are the core of health care in Iran (it is fair to say in all healthcare systems). Their activities accomplish the main mission of the healthcare systems (Flood and Fennell, 1995). However, they are part of a system and need other groups’ cooperation, without which their work might not produce the intended results in delivering quality healthcare services, despite their prominent role.

Most of the interviewees indicated that the quality improvement activities in the hospitals in relation to the consultants did not progress properly because they were reluctant to participate and cooperate in such activities. Pomey et al. (2010) and Touati and Pomey (2009) found similar evidence regarding the low tendency of the physicians to participate in quality improvement programmes (e.g. accreditation).

‘Some problems that they [surveyors] refer to are because of our consultants’ activities (e.g. their attendance in the hospitals or the committee meetings) which are out of our control.’ (Manager: Hospital B)

‘...regarding the attendance time of consultants in the hospitals, because of their power, the time requirements are not fulfilled by them.’ (Third-party surveyor)

As to the standards of the NAPH in relation to the activities of the consultants (MoH, 1997a), it was indicated that the surveyors mostly assessed the hospitals based on the hospitals’ current situation. Therefore, they might experience a loss of points in their score. The hospitals always sought to find an appropriate solution to push the physicians to comply with the requirements of the NAPH.

‘We have problems with the clinicians who don’t comply with the requirements of NAPH (e.g. filling the patients’ record completely). We finally should make them to do that, IF POSSIBLE, because we lose points. I try to do this through senior managers [director] of the hospital.’ (Sister: Hospital E)

The interviews with a few of the physicians also showed that they were either unaware of this programme or saw the NAPH more as a ‘formality’ than a quality improvement mechanism. Because of such perceptions and their tight schedules, it appeared that the NAPH did not have any priority for them.

‘I know there is an evaluation programme, but I am not aware what it does and what its standards are.’ (Consultant: Hospital F)

6.4.4.3. Physical structure

Some of the hospitals, especially the teaching hospitals, were old and built a long time ago; thus, their physical layout and infrastructure were not suitable for a hospital. In such a situation the hospitals lost points in the related aspects for something that was beyond their control. Given the general focus of the NAPH on structural aspects of the hospitals, the losses could be considerable. They argued that the change of the physical structure of the hospitals was beyond their ability and authority.

‘There are some unreasonable demands in current evaluation system, e.g. in relation to the physical layout of the hospitals ...it is not easily changeable, but we must follow the checklists of standards.’ (Head surveyor)

6.4.4.4. Financial problems

The most frequently cited problem was financial problems of the hospitals. Most of the hospitals, except for the institutional hospital to a certain extent, mentioned that they were experiencing financial difficulties. This problem was hampering the hospitals as they prepared themselves for the evaluation by the NAPH.

‘The main obstacle is lack of financial resources, which prevents the hospitals from getting ready for evaluation ...’ (Head of Para-clinic department & Surveyor: Hospital C)

Most of the interviewees believed that financial hardship was the origin of the majority of problems in the hospitals and a known obstacle to furthering quality improvement initiatives.

‘Financial problem is the most important barrier in front of hospitals’ quality improvement initiatives.’ (Sister: Hospital E)

The relating of this problem to the performance of the NAPH was important from this perspective in that the teaching hospitals claimed that the NAPH did not consider their financial ability to meet its requirements, as explained in the following problem.

6.4.5. Low sensitivity to the organisational factors

The standards of this evaluation programme were similar for all types of hospitals (MoH, 1997a). A theme emerging from the interviews was the claim that the NAPH did not recognise the differences among those hospitals based on their ownership (public or private) and scope of activity (general or special and single specialty). That is, it did not have any particular standard specifically for the private or institutional hospitals. These NTHs believed that the NAPH was merely geared towards advanced teaching hospitals (it had specific bonus scores for teaching tasks). Although it was claimed by the surveyors that the checklists for single-specialty and general hospitals were somewhat different, as the interviews revealed, the hospitals did not accept or were not fully aware of this fact (when challenged by the researcher).

'There are identical checklists for all types of hospitals and they are not proportionate with differing type of our hospitals.' (Manager: Hospital E)

As such, the hospitals claimed that the allocation of the scores (extra scores for teaching tasks and special departments) under a similar scoring system could raise the possibility of the teaching hospitals obtaining the higher grades in comparison with the NTHs (see Table 3.1 and Table 3.2, chapter 3). Moreover, the standards' orientation towards physical appearance and structures (Moghimi, 2004) similarly lessened the chances of the small or single-specialty hospitals achieving higher accreditation grades.

The effect of low sensitivity is also clear in the following comments by members of the private and single-specialty hospitals.

'We are forced to have an active operating room in our ED; whilst because of our geographical location [she asserted] we do not have such patients in this hospital and there is a trauma centre in another hospital that patients are always referred to that... it is costly for us to keep it running based on the requirements of the NAPH.' (Head of ED: Hospital E)

'... we are single-specialty hospital and it is difficult to get excellent grade one under this scoring procedure, because of its current allocation system of the scores. ...only a hospital with four main wards²⁵ and other special departments have the chance to get that score.' (Manager: Hospital B)

6.4.6. Static and repetitive vs. dynamic structure

This evaluation programme was stated by the interviewees to be a static assessment system. The standards of the NAPH have not been changed since its introduction in 1997, except for the addition of a small series of new standards few years ago in order to increase the NAPH's focus on quality of services (MoH, 2004).

'The checklists have been static from a long time ago and we are aware of their content.' (Head of Nutrition and Food services: Hospital D)

'Evaluation activities have been routinised in the hospital, because of being repetitive every year.' (Head of ED: Hospital B)

²⁵. Surgery, Paediatrics, Obstetrics and Gynaecology, Internal Medicine

The hospitals were also of the view that the static and repetitive nature of the evaluation process had driven them towards a ‘routinisation’ in their perceptions and reactions in relation to the NAPH, as they conceived of that as a routine checking system. Pomey et al. (2010) similarly found a decrease in the interest of hospitals in participating in APs over a long period.

‘...seeing similar evaluation process every year with same checklists, honestly, I don’t bother to think of that seriously... When preparing for the evaluation, we sometimes even do not try to go and check the checklists of the NAPH ... we have memorised all what they may want and therefore, just change what is important for the evaluation.’ (Matron: Hospital B)

6.4.7. Cross-sectional vs. continuous evaluation

The cross-sectional (rather than continuous and ongoing) nature of the NAPH was another problem related to this evaluation programme, according to the hospitals’ members. It was conducted once a year and there was no formal follow-up until the next evaluation time.

‘The programme is just for a short time. We only see the surveyors for a few days and same again next year. The evaluation seems more like an annual routine check than an assessment and improvement programme.’ (Head of Nutrition and Food services: Hospital D)

Some members believed that the NAPH should be frequently in touch with the hospitals, so that the hospitals, in a way, could feel its presence.

6.4.8. Predictability

The ‘predictability’ of the evaluation system has turned it into a fairly unattractive programme, because the hospitals mostly know what to do, when to prepare for the evaluation and not to worry themselves too much, as the following comments imply.

‘We exactly know the content of the evaluation system. It is similar every year and predictable for us and so does not have any appeal and attraction for us.’ (Sister: Hospital F)

‘This programme (the NAPH) is repetitive and predictable for us. I think the hospitals can fix things to get ready for that.’ (Head of Nutrition and Food services: Hospital D)

6.4.9. Time lag between on-site survey and scoring

Most of the members noted that, since the scoring process is not happening in front of them, the scores are not what they believe they should receive for their abilities and services (lack of credibility for the scoring). They argued that the scoring process was not ‘understandable’ to them. The process was that the surveyors assessed the hospitals by their methods but the scoring was assessed after they had left the hospitals. Therefore the hospitals argued that, were the scoring process to be conducted in the hospitals, they could justify to the surveyors the problems attributed to the hospitals, given the judgemental nature of some standards. In addition, as the following comment shows, the time delay between the day of visit and the hospitals receiving the report was long. Similar evidence is reflected by Scrivens (1993).

‘We forgot the exact problems of the hospital some time because of a long time between assessment and scoring stages. Also, we feel unjustified about the given scores and identified problems.’ (Manager: Hospital H)

6.4.10. Judgemental process of evaluation and standards

The process of evaluation was argued by some interviewees in the hospitals to be judgemental and not evidence-based. They added that some questions in the checklists addressed the processual aspects of the services which needed a long period of monitoring, but since the surveyors were on site for only a short time they gave scores based on their judgement or, at most, by interviewing some of the staff. They explained that the process of scoring was left completely to the discretion and judgement of the surveyors, which could endanger the validity of the accreditation process (McAlary, 1981). The hospitals were claiming that they sometimes did not understand how they had received a certain score for a particular service. This problem was, in turn, somehow a consequence of the judgemental standards.

'As to (evaluation) standards the surveyors might interpret them differently every year. For instance for a case that we even did much better than last year, we scored less than that year because they seem to understand things differently year by year.' (Supervisor: Hospital E)

'Because of judgemental nature of the standards, sometimes surveyors' views are different from each other (e.g. surveyors and head surveyor). Their interpretation of the standards might differ.' (Manager: Hospital B)

The judgemental nature of some of the standards has also caused confusion among some hospitals.

'Some of the standards are completely judgemental and we do not know what to do to get the related score.' (Head of quality office: Hospital D)

Moreover, since the checklists had been left unchanged since their introduction in 1997, some hospitals questioned the credibility of the standards.

'They (surveyors) sometimes assess based on old procedures which are not currently in place in the hospitals, but since the checklists are old and they have not been updated, the surveyors ask about them every time.' (Matron: Hospital F)

'Checklists are not up to date and they are not regularly changed based on the regulations.' (Member of quality office: Hospital F)

Because of this judgemental nature, it was also indicated by some members that the surveyors sometimes had to base their judgement solely on the claims of the hospital staff. Similar evidence was found by Delgoshayi and Tofighi (2005).

6.4.11. Turning into an informal procedure

One of the consequences of being static and repetitive was that hospitals got accustomed to this process. The same surveyors assessed the hospitals for a long time and hence the hospitals also knew them thoroughly and knew how to satisfy them in terms of arranging and meeting requirements or having a discourse with them.

'...in NAPH, it is going informally. We feel the surveyors as our colleagues and customers, because of the same surveyors for years.' (Manager: Hospital B)

Hospitals had in fact got used to these surveyors. This situation worsens when the assessment is mostly based on the judgement of surveyors. Therefore, strong awareness by the hospitals about the mode and methods of evaluation by different surveyors might lay the groundwork for gaming. Since the surveyors also came from a similar context (university) to the members of those hospitals, an informal relationship could develop and unwittingly influence their judgement of the performance of a particular hospital. Also, it was found that some staff members of the hospitals were also members of the surveying team.

‘Because of our shortage of expert we some times use hospital staff as surveyor, though it might not seem right.’ (Head of surveyors)

In this situation and owing to the judgemental nature of the programme the following case could also arise.

‘Because of being judgemental, surveyors sometimes factor their opposition to hospital management team into their assessment process: ... we feel the low score was because the surveyors did not want to give us the right score and we have done our work and it is not our fault. I have heard this as a justification from some managers.’ (Head of quality office: Hospital D)

Raising a similar issue, Scrivens (1993) indicates that different surveyors might notice all aspects of the hospitals whereas, if the same people are used every time, they are unlikely to do so.

6.4.12. Limited focus on clinical performance

The NAPH was said to have an insufficient focus on the clinical aspects of the hospitals’ practices. The members claimed that the mechanism was mostly related to the physical and non-clinical elements, while the key processes of the hospitals were clinically-oriented ones.

‘This system only deals with our equipment and space in this department which are mostly administrative. I think it needs to investigate our activities and processes more.’ (Head nurse: Hospital D)

6.4.13. No clear reward and punishment system

There was no tangible reward or punishment prescribed for the public hospital management team in the event of them not achieving the desired standards of the accreditation system. As such, no obvious reward was set formally for hospitals' managers who obtained high grades, except being permitted to set higher tariffs for their services. In addition, no rewards were anticipated at an individual level for the hospitals' members.

'There are no organised financial incentives for the departments that get higher score. They might get some rewarding leave or overtime hours which are very limited.' (Head of quality improvement office: Hospital D)

Lack of a clear reward and punishment system could remove the incentives for making efforts to achieve a better grade and performance (Custers et al. 2007).

6.4.14. Surveyors' issues

There were also some comments made by the hospitals specifically regarding the skill, experience and familiarity of the surveyors with the hospitals' activities, in addition to what has been mentioned earlier. The following statements were made by most of the interviewees in relation to the surveyors:

- *Surveyors are not quite familiar with hospital: they should be selected from among those with prior hospital work experience.*
- *The surveyors are not trained regularly.*
- *Because of nature of their work, they are somehow caught by 'routines', just doing some assessment without any creativity.*
- *Surveyors do not have enough power to operationalise the improvements in the NAPH, based on the feedback of the hospitals.*
- *The composition of the team and their skill are not comprehensive.*

6.5. Perceived repercussions of the NAPH for the hospitals

The aforementioned problems were, in turn, interrelated with and precipitated separate unwanted consequences in the hospitals in relation to the NAPH. The empirical data showed that the NAPH was unwittingly creating some negative effects in the hospitals. The intensity of these effects nevertheless varied in different hospitals. For instance, some consequences were more obvious in the private hospitals, such as pressure and intimidation. Given the financial climate in these hospitals, the members experienced more severe pressure from their management for obtaining better scores. As such, the level of distrust was higher among the managerial members of the NTHs. These repercussions could be placed and discussed at two following categories. The unintended effects were seen to somehow precipitate the dysfunctional consequences in the hospitals. In addition, the latter was conducted knowingly.

- Unintended effects
- Dysfunctional consequences

6.5.1. Unintended consequences of the NAPH

The following unwanted effects were found to be present among the members of the hospitals because of the NAPH:

- Tunnel vision
- Stress, pressure, anxiety and intimidation
- Disillusionment and reduced staff morale
- Distrust in the NAPH

6.5.1.1. Tunnel vision

The main duty of hospitals is to treat patients and deliver clinical services to the whole of society (Goyal, 2005). This is the first and foremost mission of all hospitals. Given this criticality and urgency of their tasks, hospitals are largely inclined to concentrate on their own work and are resistant to any intrusion that distracts and diverts them from this priority, i.e. tunnel vision (Walshe et al., 2001).

Some members of the hospitals in this research claimed that, since this programme was imposing an extra burden of work on them, it had the potential to cause tunnel vision in the hospitals. The tunnel vision was mostly happening in busy departments such as the EDs (given the nature of their work and their crowded conditions), as mentioned by their members.

'In this ED I am always busy, but I should try to find time to fill the forms of triage (part of the evaluation process) for each patient. We can not leave them for another time because it should be completed at that time. Then, when we have too many patients or those with crucial condition, it might take our time and attention away from the patients. ...I don't know why this information is collected, I only know it is taking too much of my time, even the surveyors acknowledge that filling these forms will need too much time.' (Head of ED: Hospital E)

Nevertheless, in most of the cases, it was mentioned that, since the evaluation was only for a short time and previous arrangements by the hospitals had been made, the staff were able to spare some time for the on-site survey.

'Survey is just for a short time, and it does not normally take much of our time. Furthermore, since we know when they are coming, we put some time for them'. (Head of Para-clinic Dept.: Hospital B)

6.5.1.2. Stress, pressure, anxiety and intimidation

The hospitals under evaluation experienced tension and stress both from the NAPH and inside hospitals from their own management. Over the course of the evaluation, albeit for a short time, they felt stressed because they were experiencing a hectic time due to the cross-sectional approach of the programme and also the evaluation of their performance. In some departments, such as the more clinically-oriented ones and EDs, this stress was more noticeable.

The main source of stress, intimidation and anxiety for the staff, nonetheless, was mostly the pressure exerted by the managers of their hospitals. In particular, staff in the private hospitals expressed more serious concerns about receiving punitive actions from their manager in the event of gaining low scores in the evaluation of their department.

'Stress, tension and workload is high in our ward during the evaluation time.'
(Head of ED: Hospital B)

'We see sometimes pressures in the form of punishment from the hospital management because of getting low score in the evaluation for this department.'
(Sister: Hospital E)

6.5.1.3. Disillusionment and reduced staff morale

Another unintended consequence of the NAPH was disappointment among the staff and a reduction in their morale because of the effects of this evaluation programme. There were different grounds for the hospitals' disappointment with the NAPH, as expressed by the members of the staff. The various perceived problems associated with the NAPH, as explained earlier, constituted the main cause of disappointment among the hospitals' members. For example, the disproportionate evaluation of the NAPH was an important cause of disillusionment for the hospitals. They were dissatisfied because they were being assessed on the basis of matters beyond their control. Some of the NTHs also expressed their disappointment at being assessed by an evaluation team that is related to the UMS and is closer to the teaching hospitals. This desperation is reflected in the comments of a matron (Hospital H):

'I have worked in teaching hospitals before,... we are performing much better than some of them here in this [institutional] hospital, but so what... we hardly get better grades than those university-related hospitals.'

Some members referred to the static mode of the evaluation programme and its inability to improve their quality as another cause of their disappointment with the NAPH. In fact, they did not perceive any improvement in their services because of the NAPH; this disappointed them and reduced their morale, making them reluctant to cooperate with quality improvement initiatives. The participants claimed that the NAPH was mostly looking for the problems and not caring much about the hospitals' strengths, which was another cause of disillusionment among hospital staff.

Overall, since the hospitals saw that they were always assessed by an evaluation programme that was in their view problematic and unresolved over time, and that their feedback was either not requested or ineffective when solicited, the obvious consequence was disappointment and apathy towards this programme.

6.5.1.4. Distrust in the NAPH

All the negative effects associated with the NAPH along with, more importantly, the perceived inability of the programme to improve quality of the hospitals' services seemed to have eroded their members' trust in this programme. The majority perceived the NAPH as a basic checking exercise rather than an improvement system.

6.5.2. Dysfunctional consequences of the NAPH

Another group of perceived repercussions of the NAPH for the hospitals could be referred to as 'dysfunctional effects'. These effects represent those occasions when the hospitals had used some form of ruse to prepare themselves superficially for the evaluation by the NAPH. The 'gaming and fixation' effect was the main dysfunctional effect present in the hospitals.

6.5.2.1. Gaming and fixation

Gaming here refers to the attempts by organisations to conceal their non-conformity with the requirements of a steering mechanism (Oliver, 1991; Bevan and Hood, 2006b).

Gaming is agreed to be the most commonly discussed form of manipulation (Birnberg et al., 1983). The empirical investigation showed that the hospitals were involved in some sort of misrepresentation while making efforts to meet the demands of the current AP. As the following comments show, the characteristics of the gaming were mostly in the form of, for example, putting a piece of equipment in a medical unit just for the period of the on-site survey and removing it after the evaluation.

'We get prepared for the evaluation [by the NAPH] - sometimes superficially. We put some medical equipment such as "infusion pump or incubator" in our ED which we do not use, and we believe they are not necessary... ..we take them away and return them to its previous ward after the evaluation.' (Head of ED: Hospital B)

Alternatively, gaming sometimes involved fabricating the pre-evaluation documents (e.g. those of the EDs) - mostly in private hospitals - since earning the higher grade was more crucial for these hospitals, as their expressions exhibited. The following comments

disclose a developing conflict between the requirements of the NAPH and the interests of these hospitals, which seemed to make the situation conducive to gaming.

'We must prove the average time, after which a physician visits or nursing services are delivered to a patient arriving at the ED, has reduced during a period of six months to get the related evaluation score. In practice, to be honest, this might not always happen in this department because of our shortage of staff. In busy times we bring staff from other departments to keep the waiting times down, but this is not possible in long term.'

[When challenged by the researcher;]

'...although their score is very little, but according to the regulations they must be met.' (Head of ED: Hospital E)

It also emerged that a threat to the hospitals' benefits also partly drove them towards gaming. For example, in the case of a cap on the rate of C-Sections conducted in the hospitals, the private ones seemed to see that policy clashing with their profit-making mission.

'...we have patients who for different reasons such as experiencing less pain and being classy, [...], as I realised, tend to have C-Section in our hospital. They give full consent for the operation. ...we are reluctant to reject their request, because we will lose our patients. But, the requirements do not allow us to stick to the wants of our customers.' (Matron: Hospital E)

Different reasons for gaming emerged in the comments of the members. For example, they mentioned that a particular piece of equipment, required by the NAPH, was not necessary for their department or they could not afford to buy it.

'...they [the surveyors] require expensive and unnecessary equipment that we cannot buy, so we may borrow or take from other departments only for the period of the survey.' (Head of Laboratory: Hospital H)

'In some cases, there is no familiar specialist to work with the required equipment in the hospital, but they [the surveyors] just tick their checklists...' (Matron: Hospital D)

Sometimes the gaming occurred because the hospitals thought they deserved to receive higher scores than those they were given for their services. This reaction was seen in the

institutional hospital because, as mentioned earlier, their members believed they had better circumstances than the teaching hospitals.

The gaming was further seen to be facilitated by the fact that the hospitals knew in advance when they were due to be evaluated by the NAPH, because of the limited number of unannounced evaluation visits; this also reflected by a member of the surveyors.

‘Because the hospitals are aware of the approximate time of the evaluation, they could prepare superficially. I have realised this when I paid an unannounced visit to the hospitals.’ (Third-party surveyor)

‘As the evaluation is pre-planned, I would imagine the occurrence of gaming ...I have seen myself.’ (Matron: Hospital F)

- Departmental gaming

There were some occasions when the staff members tried to hide their non-conformity with the requirements of the NAPH because of their fear of facing punitive actions from their hospital management. This was more noticeable in the private hospitals. They were more concerned with obtaining the financial benefits of a high grade in accreditation, because of their for-profit nature and financial independence. This type of gaming was not a tactical reaction against the NAPH, but a defensive reaction by the staff.

6.5.2.2. Rationales behind the gaming

Both external and internal reasons were seen as being behind this reaction by the hospitals, as discussed above. The external rationale of the hospitals was the ‘perceivably unjustifiable and irrelevant requirements’ of the NAPH from the hospitals’ perspectives. For example, as the previous comments showed, the hospitals did not see buying or using specific medical equipment or preparing documents as influential in their provision of care; instead they saw it as a waste of their time or money. This reaction of the hospitals was also affected by their impressions that the NAPH is not contributing to the quality improvement in their hospitals overall. In fact, the perceived deficiencies associated with the NAPH (explained earlier in this chapter) were purported to have provoked such a perception among the hospitals’ members (especially in the case of the NTHs) towards the

demands of the NAPH. In some cases, the threat to the hospitals' interests by the evaluation requirement also seemed to precipitate the gaming in the (for-profit) hospitals. The internal rationale for the hospitals' gaming was the inability of the hospitals to meet the demands of the NAPH. Different members of the hospitals frequently mentioned that some of the requirements were beyond the ability of their hospitals. This inability was observed in different aspects of the hospitals such as human resources, financial problems and physical structure, as discussed earlier under 'disproportionate evaluation of the NAPH'.

Considering these rationales, the gaming nevertheless took effect only when these rationales were coupled with the attributes associated with the NAPH, which are called 'colonising factors', such as legal coercion (to be discussed below). The following comment by a manager reflects this concern:

'According to our situation and capabilities, as a single-specialty hospital, we really are not able to meet some requirements of the NAPH and only because of its compulsory nature we must comply with them.' (Manager: Hospital B)

6.5.3. Colonising features of the NAPH

A causative situation for the gaming, as stated, was created particularly when the hospitals were not able to overtly reject those requirements of the NAPH which seemed irrational to them. Alternatively, this happened when the hospitals had insufficient means to fulfil the requirements. The reasons why the hospitals perceived the NAPH to be 'irrelevant' were explained earlier under 'analysing the nature of the NAPH'. Further analysis of the empirical data revealed that there were specific attributes associated with the NAPH, referred to here as 'colonising factors', as a result of which the hospitals were drawn to the gaming and fixation (symbolic compliance). The term *colonising* is borrowed from the theoretical concept of 'internal colonisation' which represents a situation where an imposed measurement system or practice (e.g. the NAPH) forces an organisation to reflect values (e.g. gaming) which are not congruent with the societal and organisational values (Broadbent and Laughlin, 2005, p. 11). These factors were thought to somehow contribute to the process of internal colonisation of the hospitals by the NAPH, as evidence from the

empirical data indicated. They are mentioned below based on the degree of their influence on the hospitals' behaviour and reaction towards the NAPH.

1. Legal coercion
2. Resource (financial) dependency
3. Legitimation
4. Reputation

6.5.3.1. Legal coercion

Given the compulsory nature of the NAPH, legal coercion was one of the reasons noted by the hospitals for compliance with the requirements of the NAPH. They did not have any apparent option but to abide by the programme's demands, even if these were not always approved of and accepted by the hospitals. All types of hospitals (i.e. public, private, institutional) were equally required to comply with the NAPH based on the regulations.

'Sometimes they (surveyors) for instance ask for the provision of a new service that is not to the benefit of the hospital, but we must comply with them in any case.'
(Manager: Hospital C)

'We are asked to buy some material or equipment that we don't use too often and as a result of which the hospital incurs costs. But since it is a rule we must obey- e.g. buying a LP set, which is rarely used in this ward.' (Matron: Hospital F)

'It has a few times happened that the surveyors have asked for some documents that we do not think are worth preparing, but it is obligatory and we must draw up, when asked.' (Manager: Hospital C)

Legal coercion was deemed an effective lever at the disposal of the MoH to maintain the hospitals in line with its own aspirations, since its breach could have repercussions for the hospitals.

'Few years ago, the hospitals were advised to change into breast-feeding friendly hospitals, but some of the hospitals did not cooperate well, because of the programme's costs for them. Consequently, the MoH decided to enact the request and make it compulsory for all hospitals and ... BINGO the problem solved!!'
(Manager: Hospital B)

6.5.3.2. Resource (financial) dependency

This factor was also of high importance in driving the hospitals towards gaming. The hospitals were reluctant and unable to resist perceivably irrational requirements of the NAPH, because they were financially dependent on this evaluatory mechanism. In fact, the higher the grade the hospitals received in their accreditation, the higher the tariffs they could charge for their hotel-type services, increasing their income. This money was allegedly the main financial source for the hospitals. Therefore, this kept the hospitals dependant on the NAPH, and even if the NAPH was a voluntary AP, they still had to comply with its requirements, even against their wishes. This rationale of the hospitals for compliance was even echoed by some members of the surveying team.

‘Our motive to comply with this AP is to get high tariffs; because without them it is difficult for us to survive. In fact, they are our main financial source’ (Emphasis added). (Manager: Hospital C)

‘The main motive of hospital for complying with NAPH is to get high tariffs, BECAUSE most of them are suffering from low income.’ (Third-party surveyor)

The views on this attribute varied based on the type of hospital. For example, public hospitals were not as worried as private hospitals, because they were directly related to the MoH and were mostly supported by the government in any situation. Therefore, private hospitals were more concerned about their financial dependence on the NAPH.

6.5.3.3. Legitimacy

Legitimacy here virtually meant ‘authorisation to work as a hospital and provide services in society’. This permission is granted to the hospitals, once they obtain the accreditation grade. Therefore, conformity with the NAPH was expected to bring social legitimacy to the hospitals. As the documentary analysis showed, all hospitals in the country needed to apply for accreditation by the NAPH, and no hospital could operate unless it was accredited by this evaluation programme (MoH, 1997a). This shows that the hospitals gained their legitimacy from the MoH by complying with the requirements of the NAPH.

‘...we need accreditation grade of the NAPH to CARRY ON our work [emphasis added].’ (Manager: Hospital B)

This factor, nevertheless, was not as crucial in practice as it appears, for all the hospitals, but especially for teaching hospitals. Since these hospitals were linked to the MoH, their activity was very unlikely to be stopped by the government, as mentioned by a NTH manager. Investigation of the accreditation results of the last couple of years for the hospitals under study corroborated this argument. The high quality of services provided by all the teaching hospitals because of their advanced equipment and setting was raised as a reason for this record, although it was also doubted by some respondents.

Currently legitimacy is only granted to the hospitals by the state through the NAPH, which is called regulative legitimacy (Scott, 2008b). There were other professional bodies (e.g. in relation to the physicians and nurses working in the hospitals) that conducted very rare supervision of the activities of the specific groups in the hospitals (normative legitimacy). However, these did not influence the accreditation grade of the hospitals. There was no group to regularly advocate patients' rights. In fact these legitimacy concerns were in practice subsumed and reflected by the NAPH.

6.5.3.4. Reputation

Some members of the hospitals mentioned reputation as another rationale that encouraged the hospitals to consider compliance with the NAPH. It was important for the hospitals, as mentioned by a member of staff, to have a higher grade when they were compared to other hospitals. It gave them an internal feeling of content and prestige, she stated. However, there was not a consensus on the factor of reputation as a noticeable rationale from a managerial perspective and the managers did not consider it an effective factor in their decisions to comply with the NAPH. As such, no evidence was found to suggest that reputation encouraged the hospitals to consider gaming.

The private hospitals also, surprisingly, did not see reputation as an influential element in the drive to secure higher grades. The reasons are fairly clear in following comments by the matron of a private hospital:

'I don't see any reputation for this hospital coming out of our accreditation grade. Because the grade is not communicated publicly to patients and they are not aware of our grade. I am not sure patients care about our grade. They don't know about

accreditation of hospitals. ...You can add the fact that there is no competition currently among the hospitals ...'

Despite the fact that, according to regulations of the NAPH, the hospitals are required to display their last grade in the public domain during the year before the next accreditation, my observation did not reveal any sign of this happening in any of the hospitals. Even most of the managers of the hospitals were unaware of this regulation. This might indicate an information communication weakness between the hospitals and the NAPH.

It seemed the hospitals also did not count on the NAPH-related reputation factor as an advantage to attract more patients. The results of a recent study have affirmatively indicated that the accreditation grade did not have any effect on the behaviour of the patients in choosing their hospitals based on the grades (Aryankhesal and Sheldon, 2010). Meanwhile the empirical evidence shows that those PMSs inflicting reputational damage on poorly-performing HCOs are more likely to affect the performance of the HCOs (Hibbard et al., 2003; Bevan and Hamblin, 2009).

6.5.4. The surveyors' views on the rationales of the hospitals

The surveyors also shared slightly similar views with regard to the hospitals' rationales for conforming to the NAPH, which somehow approves and validates the perceptions of the hospitals in this regard. For example, the following comment by the head of surveying team outlines the main rationales of the hospitals from the surveyors' perspectives.

'The reasons that hospitals normally conform to our programme [the NAPH], I think are its compulsory nature, high tariffs and improvement in their service quality, respectively.'

6.5.5. Further rationales for hospitals' compliance

In addition to the above-mentioned grounds (i.e. legal coercion, economic gain, etc.) which constituted the dominant rationales of the hospitals, some other elements were seen to be effective in securing the hospitals' compliance with the NAPH. The perceived beneficial consequences (to be discussed later) of the NAPH formed the main group of these

rationales. In addition, ‘religious and humanitarian values’ were also found to be playing a role in this conformity. These rationales were mostly seen among those in junior hierarchical and frontline levels of the hospitals.

6.5.5.1. Religious values and altruism

Some members of the hospitals, including mostly the frontline staff, also raised religious beliefs and humanitarian values as their grounds and motives for showing compliance with the demands of the NAPH. As observed, they hoped to help patients improve and heal, and any initiative (such as the NAPH) that could assist them for this purpose was valuable from their perspective and worth conforming to.

‘...our motive for complying with the NAPH is helping patients. We hope its [the NAPH] guidelines could help us to do this invaluable task ...’ (Sister: Hospital E)

This might be partly because they were directly dealing and concerned with the care of patients. In addition, there was a set of NAPH’s standards which assessed religious and ethical affairs in the hospitals. It was mentioned by the members that, given the nature of these standards, which were grounded in their religious and humane beliefs, and also considering the impropriety of questioning them, no-one thought of rejecting them, regardless even of colonising factors (e.g. legal coercion) associated with these requirements. The following comments somehow clarify the hospitals’ reactions towards these values.

‘In any situation, we basically observe the religious values.’ (Manager: Hospital D)

‘I do not remember I have seen any problem in respect to meeting the religious values in the hospitals. They also get comparatively high score for these requirements.’ (A member of surveyors)

6.5.5.2. Scientific nature of the standards

It was also claimed by the members of the surveying team that those standards of a more scientific and technical nature were better accepted by the hospitals’ staff. For example, as a surveyor commented, the clinicians did not show any objection to the type of antibiotic

introduced recently for prescription by the consultants in the hospitals (See table 3.3, chapter 3). This was also agreed upon by some members of the hospitals.

‘...yes, we are told some of the recent standards of the NAPH are developed based on scientific evidence by specialist groups. As far as I am aware, our staff members normally show less objection to applying this type of requirements; even though, the manager might sometimes oppose because of their cost.’ (Matron: Hospital G)

6.6. Beneficial consequences of the NAPH

The main intention of introducing the NAPH by the MoH has been to improve the quality of healthcare services in the hospitals across the country and make the hospitals safe places to serve patients in society (Moghimi, 2004; MoH, 1997a; 2008). With reference to anecdotal evidence, the head of the evaluation group of the NAPH in the HUMS maintained that it has made improvements in the hospitals, basing his argument on the fact that more hospitals are currently able to fulfil the standards as compared to the past. For the authorities of the NAPH, the compliance of the hospitals was the main sign of quality improvement; that is, the number of hospitals which obtained accreditation awards (grades) in evaluation by the NAPH was a way of measuring improvement in association with the NAPH. The following comment by a member of the NAPH’s authorities confirms this assumption.

I think this programme has led to an improvement in the hospitals, because since the introduction of the NAPH, each year more hospitals could earn higher grades in their accreditation... under the guidance of the NAPH they learnt how to fulfil the standards.’

In addition to this comment, and regardless of the adverse effects and problems associated with the NAPH, the following perceived beneficial effects also emerged from the interviews with the hospitals’ members in connection with this evaluation mechanism. They seemed also to serve as other rationales for hospitals’ conformity to the NAPH.

- Fresh pair of eyes
- Lever to exert pressure on the authorities
- Learning process

- Reminder of the rules and regulations
- Financial support
- Benchmark and decision support system (DDS) for the hospitals' authorities (and the MoH's policy-makers)
- Quality improvement
- Protection mechanism

Empirical investigation of the data showed that, with reference to these beneficial consequences, the majority of the interviewees gave a positive answer to the question *'will you still participate in the NAPH if it is a voluntary programme?'*

6.6.1. Fresh pair of eyes

One of the important advantages attributed to the NAPH by the hospitals was that this programme helped the hospitals to highlight and prioritise their problems and identify the areas for improvement (Pomey et al., 2010). Since the surveyors were from outside the hospitals and were not routinised by the daily activities of the organisations, they were expected to better identify their defects and faults.

'It is an external control and supervisory mechanism for the hospital which helps us to improve the situation. They are from outside of this organisation and could recognise our problems better than us.' (Manager: Hospital D)

6.6.2. Lever to exert a pressure on the higher authorities

The NAPH served as a lever for some departments in the hospitals to force hospital managers to meet their needs. Heads of some departments used the preparation for evaluation by the NAPH to obtain budgets for buying a necessary piece of equipment, which the managers would otherwise have rejected. For example, the departments asked management to replace the old medical equipment in order to be prepared for the evaluation process.

'We sometimes use the NAPH as a lever for meeting and fulfilling our needs in our department that managers do not accept in normal situations. Managers

accept them easily when we put forward our requests in this way.’ (Head of Nutrition and Food services: Hospital D)

Moreover, some teaching hospitals also used this mechanism to put pressure on the UMS to obtain larger budgets, which might ordinarily take a long time or be impossible due to the bureaucratic processes in place. The importance attached to the NAPH evaluation by the managers and authorities had created this opportunity for the departments and hospitals. Therefore, the higher-ups were inclined to accept the requests from the hospitals in line with the preparation for the NAPH evaluation. Pomey et al. (2010) found similar reactions from the hospitals’ CEOs towards accreditation. They discovered that the accreditation helped the CEOs to accentuate their needs to the authorities.

6.6.3. Learning process

The NAPH was perceived to stimulate learning processes in the hospitals. Current accreditation checklists reflected the basic standards of healthcare practices in different areas for the hospital staff, as raised by the educational supervisor of one of the hospitals. The staff members were found to use the accreditation standards as a reference base for their practices. Moreover, on some occasions the suggestions given by the surveyors to the staff after the evaluation of the hospitals was a source of information for the hospitals.

‘The recommendations given by the surveyors are a driver for knowing about standards and how to try to reach up to that point, specifically for our new staff.’ (Manager: Hospital D)

In this case, the NAPH was deemed a free-of-charge consultation base, specifically for private hospitals, about maintaining the standards in their hospitals. Despite this learning assistance which mostly happened in the initial years of the programme, given the repetitive nature of the NAPH, the hospitals indicated that it had not provided any new insights for them since then (Aryankhesal, 2010).

6.6.4. Reminder of the rules and regulations

This evaluation programme also served as a reminder to the members of the hospitals of standards and regulations. Because of the annual evaluation of the hospitals and necessity of preparation for the evaluation, the standards were repeated annually for the staff.

'We have this evaluation repeating every year. ...it is an annual reminder of standards and regulations for our staff in this hospital.' (Matron: Hospital C)

The accreditation also helped clarify rules by requiring them to be documented and frequently implemented (Touati and Pomey, 2009).

6.6.5. Financial support

This advantage is an ambivalent feature of the NAPH. It might cause gaming inside hospitals, as explained earlier, but also provide, in an ideal situation, financial support for hospitals and their quality improvement efforts (Custers et al., 2007). This was crucial for the hospitals, since they all complained about the financial difficulties they faced. The staff members could also benefit indirectly from a high grade of accreditation in the sense that they could earn more overtime pay and, consequently, a higher income if their hospital gained a higher grade, although this was not consistently reflected by all members of the staff.

'There has not been any change in my salary after our higher grade. The hospital manager promised to give rewards for getting a better grade but it did not happen.' (Para-clinic Dept.: Hospital E)

However, in some hospitals, the departments with highest scores were rewarded, although not financially. In addition, the overall income of the hospital rose sizeably as a result of a higher grade. The accreditation grade is the main prerequisite for the hospitals to set service contracts with third-party organisations (e.g. insurance bodies²⁶).

²⁶. Insurance bodies could also rely on the grades to arrange and regulate their efforts and decisions in their contractual liaisons with the hospitals.

6.6.6. Benchmark and DDS for the hospitals' authorities (and the MoH's policy-makers)

Another benefit mentioned by the hospitals' managers in relation to the NAPH was that this evaluation programme helped them to compare themselves against one another. This is consistent with the results of Scrivens's (1993) study. Given the grade the hospitals were granted by the NAPH, the hospitals could gain an overall picture of their own performance in comparison with other hospitals, especially those with the highest grades.

'We see our grade as a benchmark sometimes to compare ourselves with other hospitals and even with ourselves during the different times.' (Manager: Hospital C)

Even though the grades of the hospitals were not officially published, the managers stated that they were informally aware of the grade of the other hospitals in the same area.

The decision-makers in the MoH also used these grades to increase their knowledge and awareness of the performance and, consequently, the problems of the hospitals, and paid more attention to those with lower grades (as commented by the head of the surveying team). In fact, this uniform evaluatory system allowed the MoH to become informed of the hospitals' capacity and functioning, without having to take notice of specific features of various hospitals. The NAPH also instigated a more structured and systematic collection of data regarding the issues of interest for the MoH and the UMS, such as periodical patient satisfaction or mortality rate of the hospitals.

6.6.7. Quality improvement

The contribution of the NAPH to the quality improvement efforts in the hospitals could be, in the main, recognised through its outputs (i.e. immediate effects). For instance, an obvious way in which the NAPH laid the groundwork for the improvement in the hospitals' services was by triggering the senior members of the hospitals to convene to identify the problems and find pertinent solutions for them. These gatherings happened during the preparation and post-evaluation stages of the NAPH. It was claimed that such meetings facilitated both coordination and communication among the different members and departments of the hospitals (Baskind et al., 2010), even though they were only limited

to the senior members. Scrivens (1993) also found that accreditation was used as a spur by managers to encourage teamwork among their staff in the hospitals.

‘Before the evaluation we hold some meetings including the directors of different departments to identify the problems and find solutions in the hospital in order to get ready for main evaluation.’ (Sister: Hospital E)

A similar study also found that the accreditation triggered the creation of an organisational structure for quality improvement in the hospitals (Pomey et al., 2010).

Similarly, the recommendations sometimes given to the hospitals by the surveyors at the end of the evaluation were another indirect effect by the NAPH to effect quality improvement in the hospitals, as raised in the interviews. The recommendations offered by APs for boosting quality in HCOs are argued to serve to fulfil ‘improvement-and-change’ intentions of these systems in organisations under evaluation (Touati and Pomey, 2009, p. 161). The convening of the management team of the hospitals after the on-site survey to operationalise the requirements of the NAPH was also another way in which the NAPH could contribute to the quality improvement in the hospitals.

In addition, it was claimed by some managers that higher grades served as a motivation and morale booster for their staff to strive to improve their services (Pomey et al., 2010).

‘Earning grade one pushes us to make more efforts, because it raises the expectations from us every year.’ (Manager: Hospital D)

Overall, the major effect of the NAPH in this regard, as touched upon earlier, might be the enhanced compliance of the hospitals over time. It was mentioned both by the members of surveyors and the hospitals’ members that, currently, more hospitals could earn higher grades than in previous years.

‘Currently as a result of this programme [the NAPH] the hospitals are better off in terms of their physical and human resource aspects, as compared to some years ago.’ (Head of Para-clinic Dept.: Hospital C)

Similar evidence could be found in the literature (e.g. Salmon et al., 2003; Snyder and Anderson, 2005), arguing that APs mostly improve the compliance rather than the quality in HCOs under their evaluation.

6.6.8. Protection mechanism

The benefit of this AP could also be seen from a wider societal perspective. Health care is a complex area with vital outcomes which are directly related to the death and life of people (Gauld, 2005) and also to vulnerable costumers as a result of an information asymmetry between providers and patients (Montague, 2003).

Within this situation the NAPH, as an external regulatory mechanism and under the control of the government as the guardian of public interest, was set up to ensure healthcare services are delivered safely and are of a high quality (MoH, 1997a). This was an important task for this AP, owing to the criticality of healthcare outcomes. Therefore, since the NAPH pointed to the hospitals' deviations from the regulations (i.e. the accreditation standards) and warned about the breach of safety rules by the hospitals, it was assumed to be a protection mechanism for society. This effect was raised a few times by the hospital members and surveyors.

'This programme [the NAPH] is useful ultimately for patients. As they are not able to have control on the practices of the hospitals themselves, it monitors safety and quality of the services for them. (Head Surveyor)

Besides the above-mentioned benefits, accreditation gave a holistic view to the managers in that they have to look at the entire hospitals rather than just discrete departments.

Chapter 7 - Reactions and Rationales of the Hospitals towards the NAPH

7.1. Introduction

Following on from chapter six, which presented the first part of the study's finding (i.e. the merits and worth of the NAPH); this chapter explains the different reactions (change effects) of the hospitals to the NAPH and the underlying rationales for their behaviours, as the second and final part of the findings. The final section of this chapter comprises a number of empirical recommendations for improving the performance of the NAPH.

7.2. The reactions and change processes in the hospitals

In the process of analysing the hospitals' reactions to the NAPH and its change effects in the hospitals, the following issues are considered:

First, since the NAPH was a compulsory programme for all types of hospital, none of them could be left unaccredited and, hence, there was no possibility to compare, for example, an accredited with a non-accredited hospital for identification of any change, comparatively, resulting from the NAPH.

Second, all the hospitals had been under the annual evaluation of the NAPH for a fairly long time and, in essence, the hospitals were evaluated by the NAPH immediately after their establishment. Therefore, there was no chance to compare the situation of pre/post-evaluation of the hospitals in order to recognise the change effects triggered by the NAPH.

In addition, the *a priori* state of the NAPH brings to mind the criticism by Gray et al. (1995) of Laughlin's (1991) change framework. They argued that the model fails to identify *a priori* disturbances.

Third, given the fact that the longer a hospital was under evaluation by the NAPH the better it might have been at handling the NAPH's requirements (because of the repetitive standards of the NAPH²⁷), the researcher selected those hospitals that had been under the evaluation of the NAPH for at least five years. This would ensure that all hospitals were fully aware of the standards of the programme. Furthermore, with a similar set of evaluation standards every year, the perceptions of the hospitals' members towards this programme were expected to be relevant (i.e. the variation of the perceptions at different points of time was thought to be low).

Considering these points, the researcher mainly sought evidence of change based on a retrospective approach (Stufflebeam, 2001), relying on the perceived reactions of the hospitals to the requirements of the NAPH. He also looked for the perceived change effects of the NAPH on the different elements of the hospitals. The members were asked whether they had perceived any change in different aspects of their hospitals (with a focus on three main theoretical elements of the model) that had been triggered by (attributed to) this evaluatory mechanism. The changes were *de facto* expected to represent the efforts made (actions taken) by the hospitals to meet (react to) the requirements of the NAPH.

7.2.1. Real-life steps of the changes in the hospitals

The change effects of the NAPH on the hospitals appeared to happen in different stages of their evaluation. The first part of the hospitals' efforts to react to the NAPH occurred during the preparation stage, while they were gearing themselves up for the on-site survey by the NAPH. In this stage, a meeting was held of the directors of different departments of the hospital, chaired by the hospital's manager, after being informed of their forthcoming evaluation.

'We are informed of the approximate date of the on-site survey before expiry of our current grade. Knowing this, we hold a meeting of the directors [the CISE] and within which consider how to prepare for the evaluation.' (Head of Quality Improvement Office: Hospital D)

²⁷. This was also indicated by one member of the NAPH's authorities, because the hospitals could learn how to deal with and meet the requirements over time.

The checklists, which were already placed at the hospitals' disposal by the NAPH during the first evaluation, were the basic framework for the preparation stage. The CISE had the leading role in the preparation sessions. In most of the hospitals under study (especially public advanced hospitals) a quality improvement office (QIO) dealt with the evaluation of the hospitals, along with the hospitals' other quality improvement practices. The head of this office was always the secretary of the CISE. The extent of power devolved to these units differed across the hospitals, depending on both the value given by and the understanding of the hospitals' top management of quality, as mentioned by the head of a QIO.

'Fortunately in this hospital the manager, because of his relevant education, always supports and encourages us to find innovative ways for improving quality.'
(Head of quality improvement office: Hospital B)

The second stage of the evaluation was an on-site visit by the surveyors. During the process of the survey, which lasted for a short time (depending on the size of the hospitals in terms of the number of beds) no change perceptibly took place. In this stage, the hospitals were cross-checked against the evaluation standards by the surveyors through observing, interviewing staff and patients and reviewing the corresponding documentation. The analysis of the data showed that, in this stage, the hospitals concealed their non-conformity by expressing symbolic compliance (i.e. gaming).

Another wave of changes triggered by the NAPH occurred after the on-site assessment of the hospitals, when they were asked by the surveyors to rectify the existing defects in order to earn the required accreditation status (grade). Similarly, in this stage, the CISE also played a key role in communicating the requirements to the all departments. After the on-site evaluations, a list of problems was dispatched to the hospitals, which instigated a convening of the members of the CISE to investigate how to meet the requirements.

7.2.2. Change effects of the NAPH

Broadbent and Laughlin's (2005) theoretical language is invoked to help develop an understanding of the reactions and change processes of the hospitals over the course of their efforts to meet the requirements of the NAPH. The intention has been to draw on this

language to examine the nature of this steering mechanism through its outcome (i.e. triggered perceived changes) in the hospitals. These authors have argued that, when a disturbance such as an external PMS with the aim of change or improvement (e.g. the NAPH) seeks to change organisations, different outcomes and behavioural reactions might emerge. As they have explained, these reactions could be better understood by tracing the processes and routes, calling them ‘pathways’, along which the changes travel through an organisation (Broadbent and Laughlin, 2005, p. 16). These pathways, elaborated in chapter four, are specifically categorised into rebuttal, reorientation, colonisation and evolution (Laughlin, 1991; Broadbent and Laughlin, 2005). The first two signify slight shifts and transitions in organisations’ tangible structures which cause them to either reject or absorb the imposed requirements. By showing these reactions, the organisations maintain their initial status (Larrinaga-González et al., 2001). The latter types, nonetheless, point to deep and lasting changes which transform the organisations’ values, in addition to their tangible aspects. In these circumstances, the organisations might submit to or adopt the requirements, depending on their nature. Therefore, the rejection (rebuttal), absorption (reorientation), submission (colonisation) and adoption (evolution) provided a heuristic language to look into the reactions of the hospitals to the requirements of the NAPH.

Laughlin (2007) has argued that the rebuttal, reorientation and colonisation pathways are of the same nature and function. That is, if a disturbance (driver) cannot be refused (rebuttal), it might be absorbed (reorientation) and finally, under specific circumstances, result in the colonisation of an organisation²⁸. Therefore, as Laughlin (2007) puts it, the constant presence of these pathways could signify that the driver is not in congruence with organisations’ ISs and raise serious questions about the merits and worth of the driver. Such an interpretation has provided the researcher with a theoretical language for assessing the nature of the NAPH. That is, the evidence for this continuum of change (including rebuttal, reorientation and colonisation) from the hospitals might prove that the NAPH has diverged from its preset goals.

The investigation of the hospitals’ reactions to the NAPH has hence been conducted in the light of this model. The analysis of the guidelines of the NAPH (i.e. the checklists of standards; see Table 3.1, chapter 3) illustrated that the majority of the standards are

28. Since not all organisations might pass through these pathways, it is better not to consider them as a continuum, as Larrinaga-González et al. (2001) argue.

directed at the most tangible elements (i.e. subsystems) of the hospitals such as their staff, equipment and physical layout (Haigh and De Graaf, 2009). The development of the hospitals' reactions and the processes of changes were guided through their DAs (to be explained later) and those who had control over these structures. This endorses the argument of Broadbent and Laughlin's (2005) model that organisational DAs play the main role in guiding the external disturbances inside organisations. Modell (2001) also refers to the management team as the main absorber of changes in organisations. The hospital committees including the directors of the main departments (those virtually owning the power of decision-making in the hospitals), were the principal DAs in all the hospitals, and were the forums in which the main decisions on how to react to the NAPH were taken. The committees in fact acted as communication structures to convey the requirements of the NAPH to the hospitals' members (MoH, 1997a). In particular, an internal committee was put in place, in line with the guidelines of the NAPH, to deal with and fulfil the requirements of the NAPH in the hospitals. This committee had a pivotal role in steering the accreditation process in the hospitals. Prior to the accreditation, it asked for reports from other specialist committees regarding the problems in their areas to be considered and dealt with in this committee, for preparing the hospitals.

As the importance of DAs was highlighted in steering the effects of disturbances on organisations, the nature of the hospitals' DAs was analysed to gain an understanding of the impact of the NAPH on the hospitals. Furthermore, the perceptions and reactions of hospitals' managerial teams (who had control over the DAs) were considered towards these DAs.

7.2.3. DAs of the hospitals

DAs in organisations, as explained in chapter four, are intra-organisational management structures, procedures and programmes which seek to control the organisations and ensure that their workings, i.e. subsystems, are in line with their ISs. In this sense, the analysis of the relevant documents of the hospitals and the interviews showed that the following structures and mechanisms were the main DAs applied in the hospitals to control and improve their activities.

- Internal quality improvement programmes (IQIPs)
- Hospital committees

The DAs of the hospitals were not limited to the aforementioned and could further include the accounting and financial arrangements of the hospitals, as indicated by various studies (e.g. Laughlin, 2007). However, since the latter were not directly influenced by the NAPH, they are not considered or explained here.

The core of these DAs was the role of those having control over these structures. They are called ‘specialised work groups’ (SWGs) who, as Broadbent and Laughlin (1998, p. 407) indicate, ‘have a unique position in all organisations,...filter environmental disturbances, ...provide the direction for the full expression of the values or interpretive schemes in the actual and future workings of the organisation.’ In this sense and in relation to the NAPH’s requirements, the current study showed that the hospital managers and the directors of the main departments involved in the hospital committees held such a position in the hospitals. However, in practice the managers had the influential role in these groups.

7.2.3.1. Internal quality improvement programmes

This group of DAs included those procedures that the hospitals had adopted externally or developed internally to control and standardise their activities and processes to improve the quality of their services (i.e. ensure their subsystems were aligned with hospitals’ ISs). Some hospitals had adopted and adapted external quality improvement programmes such as ISO 9000, and others had developed their own IQIPs.

7.2.3.1.1. ISO

ISO was the most common external programme adapted by the hospitals to improve the quality of their services and organise their internal processes and activities. Analysis of the related formal documents showed that the written policy of the ISO in those hospitals encompassed two main goals:

- Increasing patients’ satisfaction
- Reducing waiting times

These goals were written and displayed in crowded parts of the hospitals so as to be noticeable for both staff and patients. The reason for this was to communicate these principles to the whole hospital and create a situation conducive to the implementation of this programme. ISO was adopted voluntarily after recommendation of the HUMS,

specifically by those hospitals that were better placed in terms of physical and financial circumstances. Those hospitals that opted to deploy this programme were also helped financially (i.e. part of its cost) by the HUMS. However, not all hospitals were interested in applying ISO and only three out of eight at the time of data collection had adopted this IQIP. The first impression was that the hospitals did not want to create a headache for themselves and impose extra burdens on their staff. The following explanation was given by the manager of a hospital for not using this programme.

‘ISO is an industry-oriented programme where all processes are certain, while in health care and especially hospitals, our processes are varying and might not be standardised easily. Also the people who are directing ISO activities are from industry themselves and hardly understand the healthcare environment. ...There are other important priorities for our hospital and ISO is not a priority currently for us and our patients. We also do not have basic prerequisites for deploying ISO. I did not want to deploy ISO because I think it is imposing a large burden of work on my personnel and it creates only unnecessary paperwork for them.’ (Manager: Hospital C)

▪ Motives behind ISO

The initial intention of adopting ISO, as it turned out, was not entirely triggered from inside the hospitals and after consultation with the hospitals’ staff. Instead, the managers of the hospitals decided themselves and only asked for their subordinates’ views about ways of operating the ISO.

‘In case of implementing ISO, firstly the senior management (the hospital manager and director) decided to go for that and then we brought that to the other departments’ notice and asked for their participation.’ (Manager: Hospital D)

Motivations for deploying ISO inside the hospitals varied; for instance, it was considered a quality improvement system, a platform to increase the chance of obtaining a higher grade in the accreditation and a way of enhancing their reputation.

‘We want to raise our reputation among other hospitals by implementing ISO. We also intend to get better grade in hospital evaluation by implementing ISO. ... it was also because our hospital was financially in good situation, had receptive

human resource²⁹ and support and encouragement from the UMS for implementing ISO.' (Manager: Hospital B)

However, staff mostly saw reasons other than quality improvement benefits of the ISO for the hospitals, such as reputation of managers and hospitals among their fellow hospitals and recommendations of the UMS. Some also saw the hospitals' management as a paramount factor in adopting this quality improvement programme.

'Although we aim to improve the quality of hospitals' services by ISO, the real driver behind adopting ISO was decision of our manager and there was not any feedback asked from the personnel. It was a complete top-down decision.' (Head of ISO office: Hospital D)

▪ Stages of ISO in the hospitals

The real-life stages of operationalising ISO in the hospitals were as follows:

1. Attendance by the heads of departments and the hospitals' senior staff in the ISO-orientation courses run by an external ISO consultancy body;
2. Identifying and mapping the work processes of hospitals' departments by staff themselves, with the assistance of the hospitals' ISO offices;
3. Developing indicators based on the processes jointly by the departments and ISO office;
4. Setting indicators as ultimate targets to improve the processes over time;
5. Internal and external audits for assessing the degree of achievement to and diversion from the desired indicators.

These steps were taken by all hospitals deploying ISO in the selected research field.

▪ Benefits of the ISO

Perceived benefits of the ISO for the hospitals, according to the comments of the hospitals' members, included:

²⁹. A majority of this hospital's staff members were women. The manager believed that they were less resistant to change.

- Organising and putting the workings of departments in good order, reducing the amount of work done haphazardly or based on staff's personal taste and style, and reducing duplications;
- Stipulating the main policy and procedures of the hospitals for all departments (the policy of the hospital in relation to ISO is communicated to different departments) and staff;
- Helping to improve the circumstances of individual departments by highlighting their obstacles and problems as a requirement of ISO to be noted and solved quickly by the managers;
- Defining job descriptions for staff, clarifying their tasks and setting guidelines for different departments;
- Setting standards and indicators for the hospital's performance;
- Asking for feedback from patients regularly and communicating this to management and the UMS to improve the quality of services;
- Measuring patients' satisfaction after discharge;
- Producing useful statistics for managers' decision-making (a DDS for managers).

These advantages were the immediate effects (outputs) of the implementation of ISO in the hospitals, as reflected by different members of the hospitals. However, their real implications (outcomes) for the quality of the care in the hospitals were not examined and clarified.

▪ Problems with ISO

Apart from the perceived benefits of ISO in the hospitals, staff also pointed to some problems they faced while applying this scheme. They included:

- The obsession of ISO with paperwork which imposed a large burden on staff in addition to their regular tasks;
- Tunnel vision because time spent by staff with patients was reduced;
- Stress and pressure on staff because of heavy workload after implementation of ISO;

- Increasing the expectations, with no tangible effects on the quality of the services, as raised by the matron of a hospital:

‘ISO has given a pretext to our patients to complain more than before about the hospitals’ services. For example, they say the hospital has ISO but it is not delivering pertinent services.’ (Matron: Hospital B)

The reason, as she maintained, was that the improvement in the services of the hospitals as a result of the ISO was not noticeable and tangible for the patients. She claimed that ISO, in its early stages in their hospital, was mostly related to paperwork and did not have objective effects on quality of the services.

- Obstacles to operationalising ISO in the hospitals

Interviews and non-participant observation revealed the following obstacles encountered by the hospitals in their efforts to utilise this quality improvement programme.

1. Cooperation of physicians

The first obstacle mentioned by the personnel was related to the lack of cooperation by the physicians with the ISO.

‘Cooperation of physicians is not enough for full operationalisation of ISO in this hospital.’ (Head of ISO office: Hospital D)

‘Our main problem with ISO is caused in relation to physicians (e.g. their attendance in this department); in ISO we have an indicator for the time period of physicians’ attendance per day in the department. The persistence of this problem reduces our motivation for ISO’. (Head of Para-clinic department: Hospital B)

Since the physicians are the most influential group in hospitals, and their activities lie at the heart of hospitals’ processes (Flood and Fennell, 1995), their disconnection with quality improvement activities might ultimately abort the usefulness of these efforts for the hospitals and quality of services.

2. Financial problems

Money was mentioned as another obstacle to operationalising ISO in the hospitals.

Overall, most of the hospitals were complaining about their financial problems. The staff were anxious about the fact that ISO was requiring them to correct their processes and

create internal arrangements without the necessary financial provision from the management.

‘5Ss was one part of the UMS’s improvement programme in the hospitals which was not successful in this hospital because of the lack of budget.’ (Member of quality improvement office: Hospital F)

3. Physical structure

The faulty and old physical structure of the hospitals was another important problem in furthering ISO initiatives. Some of the hospitals were old and not purpose-built. Therefore, it was difficult for them to meet the all standards of the ISO with regard to space allocation and management of the hospitals.

‘... an important part of the ISO standards is related to our spaces in clinical departments, but you can see, this hospital is old and it is not easy to change its structure. There is neither budget and nor management interest in that.’ (Matron: Hospital D)

4. Lack of experts

A lack of experienced experts who were adept at both health care and ISO was another obstacle to furthering ISO practices in the hospitals.

‘We do not have access to sufficient number of health care and hospital-oriented external consultants for ISO.’ (Head of ISO office: Hospital D)

■ Perceptions of ISO

Staff perceptions of ISO differed largely from their managers in that they were much more critical of ISO than the managers and saw different motives behind the adoption of the ISO, as indicated. This, as findings showed, was mostly because the managers decided to adopt the ISO themselves, without consulting their personnel. For instance, the head of a para-clinic department stated that:

‘We only operationalise the ISO because we are asked to I see that unnecessary for us now, taking our time away from our main duties’. (Hospital D)

As such, the following comments showed that the ISO has been imposed on the hospitals, notwithstanding its success and effectiveness.

‘Though it (the ISO) is a procedure for organising things and improving the process of reporting and presenting hospital activities ...I am not justified about using ISO and don’t believe in that.’ (Head of nutrition and food services: Hospital D)

▪ Impact of the NAPH on ISO

The hospitals initially saw the ISO and NAPH in two rather separate capacities, with different structures and methodology, as reflected below:

‘ISO is completely separate from the NAPH in this hospital. Their requirements and processes are different.’ (Head of ISO office: Hospital D)

The standards of the NAPH were immutable for the hospitals since it was a compulsory external evaluation system; however, as with the ISO, its standards were originated from the hospitals and were more flexible. In addition, ISO was argued to render an evidence-based assessment/improvement of the hospitals’ performance. More differences are reflected in the following comments:

‘The NAPH’s checklists and standards are now as regulations that we cannot exceed or breach, but as to ISO, we ourselves set the indicators inside hospital. Therefore, ISO I assume is better for us because it is more hospital-oriented and relevant to our activities, while the NAPH is quite strict and we cannot change it at all. ISO is more tangible. With ISO we can appropriately identify problems and define solutions for them. ...in ISO, since we should prepare related documents, you can say, it is an evidence-based programme but the NAPH is mostly judgemental. ...and supervision in ISO, unlike the NAPH, is much stricter....’ (Manager: Hospital B)

‘The NAPH does not have indicator, unlike ISO, and just checks current situation. It is only an assessment of the status quo. ... It does not set any target and is a static mechanism....’ (Head of quality improvement office: Hospital D)

These advantages of ISO had made this programme more desirable and helpful for the majority of hospitals than the NAPH, as the above comments show. It was a ‘chosen’ framework by the hospitals’ management, albeit not on an entirely consensual base for all members. Even so, the colonising features associated with the NAPH, explained earlier, were apparently driving the hospitals to make some changes in their ISO to comply with the NAPH. The following comments by the hospitals’ managers underline this impact:

'We try to consult the standards of the NAPH for setting indicators of ISO.'
(Manager: Hospital D)

'We are thinking of setting the indicators of ISO somehow similar to the NAPH's standards to get ready for its evaluation programme. ...even sometimes we show the NAPH's standards as relevant documents for our ISO activities to its inspectors; though they are too general and ISO focuses more on details.'
(Manager: Hospital B)

The hospitals' reasons for manipulating their ISO by virtue of the NAPH varied. The hospitals could not change any thing about the NAPH. Nevertheless, they had to comply with its requirements owing to its compulsory nature and the potential economic gains for their hospital. Moreover, they found the NAPH somewhat lacking in comprehensiveness (not covering all priorities of the hospital) and partly irrelevant to some of their activities (e.g. new developed activities). Accordingly, they tended to incorporate ISO with the NAPH in order to both rectify the deficiencies of NAPH and gear up for the evaluation of the hospital by the NAPH to earn economic gains from higher accreditation grades. This could also save money and time for the hospitals.

7.2.3.1.2. Self-developed IQIPs

Unlike ISO, which was limited to a few hospitals because it had certain prerequisites, most of the hospitals in the study had some sort of internal arrangements for regular assessment of their activities. They were mainly related to clinical and nursing services, since they make up the majority of hospitals' activities (Srinivasan, 2008). These assessments in the hospitals comprised:

- Regular rounds by the hospitals' supervisors;
- Performance report by the different departments and wards to the hospital matrons and managers;
- Self-evaluation by head nurses of their own wards

These evaluations were mostly undertaken based on the standards and checklists which were developed and extracted from the NAPH's checklists.

'We use a set of checklists that are extracted from the standards of the NAPH to evaluate different departments internally and regularly to make them ready for

main evaluation. We started doing these ourselves to improve and keep the quality high.’ (Matron: Hospital C)

They intended to make the hospitals ready for the annual evaluation while assessing their departments internally. This, it could be argued, is causing the hospitals to become unwittingly routinised within the framework of the NAPH and is mandating the hospitals to follow similar aspects of activities (i.e. isomorphism), hence reducing the freedom of the hospitals. This assumption is made regardless of the NAPH’s evaluatory merits and beneficial consequences.

7.2.3.2. Hospital committees

The committees were an important element of the hospitals’ DAs which were set up to monitor the reflection of the hospitals’ ISs in their subsystems (i.e. workings). In accord with Broadbent and Laughlin (2005), they also played a key role in steering the requirements of the NAPH inside the hospitals. There were several committees in each hospital. As specialised entities, they covered all hospitals’ activities and specialties. In view of their nature and tasks, they could also be conceived as influential MCSs facilitating the information flow inside the hospitals. The main goals behind establishing the hospitals’ committees were expressed as follows (MoH, 1997a, p. 55):

- To help the hospitals in their planning, organising and coordinating activities;
- To create an opportunity for all personnel to participate actively in the main decisions of the hospitals;
- To act as an important management assistant and advisor.

The structure and tasks of the committees were originally set on the basis and mandate of the NAPH’s guidelines for the hospitals. Each hospital, as documentary analysis showed, should have twelve committees (see Figure 7.1). The main duties of these committees were as follows (MoH, 1997a):

1. Policy-making and target-setting for hospitals according to the guidelines of the MoH and the UMSs;
2. Planning and devising related strategies and activities for hospitals according to the overall policies and targets;

3. Identifying the hospitals' main obstacles and problems and pertinent respective solutions;
4. Continuous efforts in order to enhance quality of the services and improve the hospitals' performance and customers' satisfaction.

All hospitals were obliged to form these committees; otherwise, they might lose points in their evaluation process, on the basis of the MoH's evaluation regulations (i.e. the NAPH). In fact, a considerable part (i.e. 4.6%) of NAPH's standards was related to the existence and functions of the committees in the hospitals (Moghimi, 2004). The number of these committees might vary on the basis of the hospitals' size and number of beds, yet their associated tasks needed to be fulfilled in all hospitals. In small hospitals committees with similar activities could be merged. The members of each committee were assigned in terms of the nature of their activity; however, a physician, nurse and hospital manager or their representatives were permanent members of all committees.

As mentioned, they had certain types of duties and tasks and tried to identify and investigate different problems in the hospitals and find appropriate solutions for those problems. However, they were arguably not completely operationalised in the hospitals:

'The committees could be focal players in the hospitals if they were operationalised according to their (written) guidelines; however, presently they mean some meetings in the name of committees to show their minutes to NAPH when hospitals are evaluated.' (Member of quality improvement office: Hospital F)

▪ Committee for Internal Supervision and Evaluation (CISE)

All committees were partly involved in handling the requirements of the NAPH so far as their departments were concerned. However, the CISE was the only one directly involved in steering these requirements inside the hospitals.

'We have an internal evaluation committee that identifies and deals with problems. ... It gives feedback about these problems. We use this committee ... to improve the performance of our hospital.' (Manager: Hospital B)

This committee, according to relevant documents, was vital both for internal evaluation of the hospitals and cooperation with the NAPH on behalf of the hospitals. It undertook

various tasks in the hospitals. The main duties of the CISE according to its guidelines were as follows (MoH, 1997a, p. 61):

- Assessing the departments in an un/announced way and preparing evidence-based reports for the NAPH;
- Asking for monthly reports from all departments of the hospitals regarding their workings and possible problems, and looking into them and finding practical solutions;
- Holding monthly meetings and dispatching the proceedings to the higher-ups in the UMSs, and offering them later to the surveyors during evaluation of the hospital;
- *Preparing the hospitals for main evaluations by formal and external bodies such as the NAPH and helping the surveyors, with the aim of continuous quality improvement in hospitals;*
- Developing and checking the job descriptions of different departments based on the current formal regulations and supervising the propriety of their activities.

The members of the CISE included (ibid., p. 62):

- Hospital director
- Teaching/research deputy (in university hospitals)
- Hospital manager
- Matron
- 2-5 physicians (with different specialties)
- Head of accounting department
- A senior nurse
- A member of the laboratory

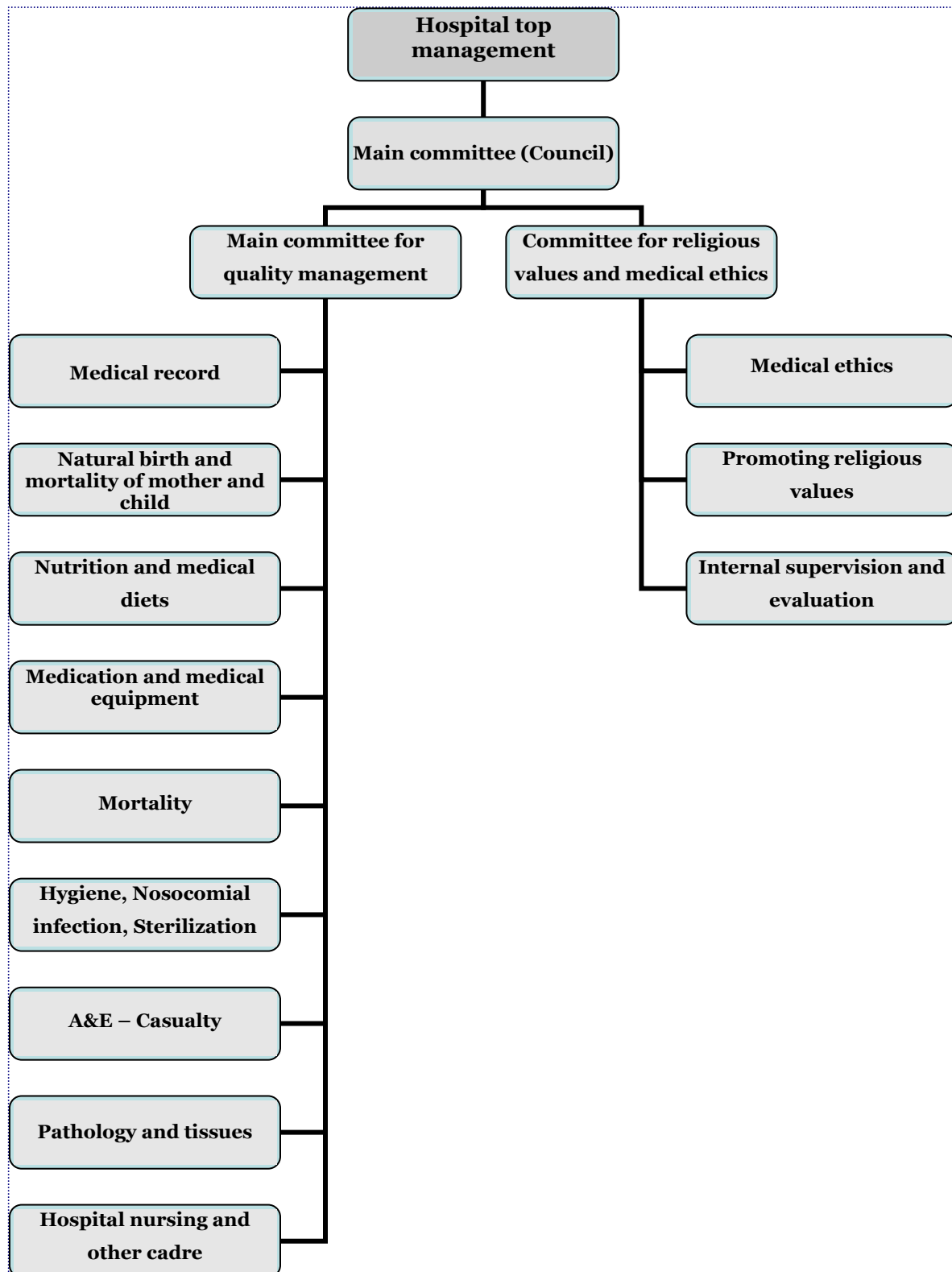


Figure 7.1 Organisational chart of hospital committees – Source: MoH (1997a, p. 57)

In addition to the normal activities of CISE (i.e. investigating the problems of the whole hospital) which was, in turn, in line with long-term preparation of the hospitals, the CISE

specifically conducted a pre-assessment of the hospitals' activities, to prepare them for evaluation by the NAPH. The participants commented that the assessment is mostly done on the basis of the checklists developed within the framework of the NAPH's guidelines.

'We have a committee specifically for "boosting hospital evaluation grade" which tries to prepare the hospital for the main evaluation.' (Manager: Hospital H)

'It [the CISE] uses the checklists (of the NAPH) as its basic framework to perform its activities.' (Manager: Hospital D)

The committee also dealt with the results of the hospital evaluation and tried to rectify the problems after the evaluation to prepare the hospitals for re-evaluation, which happened within three months of the initial evaluation (Moghimi, 2004).

'We deal with the results of the evaluation of hospital in our internal committee [CISE] and in there we decide how to go through this programme and follow-up actions.' (Manager: Hospital D)

▪ Problems with the committees

1. Participation of physicians

Notwithstanding the vital role of the committees in the hospitals as the main DA, there remained some issues about the functionality of these structures in practice. The main problem in relation to the committees, as stated, was linked with the participation of consultants. The physicians were key members of the majority of the committees (MoH, 1997a), but they were absent from the meetings most of the time, as mentioned by other members. As it turned out, the physicians always tried to distance themselves from non-clinical activities of the hospitals, both because of their time constraints and their reluctance. Therefore, the meetings were mostly held without them, as was mentioned by other members of the committees. Given the importance of clinicians in the hospitals, their presence is essential (Flood and Fennell, 1995). Furthermore, they could reject what was decided in the committees, given the strong medical professionalism in HCOs (Abernethy et al., 2007) and their strong position in the hospitals, as was also emphasized by other members.

'The committees are covering everything in the hospital and their guidelines are very comprehensive, but in practice they are not used at their full capacity. ...we have deleted things related to consultants because they do not participate.' (Head of quality improvement office: Hospital D)

2. The effect of the NAPH on the committees

Another issue in regard to the committees and their relationship with the NAPH was the fact that the full guidelines of the committees were set and checked by the NAPH, and any failure and change in this regard could reduce their scores in the assessment. The hospitals were satisfied with the committees' guidelines, as the earlier comments implied. However, the fact that they were not able to alter these committees, as they were keen to obtain the corresponding evaluation score, might allude to the constraining effects of the NAPH on the hospitals' independence. In other words, it was costly for the hospitals to venture into any change in their committees, even though it might appear necessary for their success.

7.2.4. The effects of the NAPH on the hospitals' DAs and subsystems

The relevant reactions and changes in the hospitals as a result of their efforts to meet the demands of the NAPH were identified and discussed in the light of the pathways of Broadbent and Laughlin (2005). The reactions of the hospitals towards these requirements were varied and ranged from rejection, absorption and submission to adoption of the requirements. The classification of these reactions, according to Broadbent and Laughlin's model, is conducted in terms of identifying the hospitals' efforts to change, knowingly or unknowingly, their different tangible or intangible elements (i.e. ISs, DAs and subsystems) in response to the requirements of the NAPH.

The effects of the requirements on the DAs and subsystems of the hospitals imply a type of first-order change in the hospitals. Analysis of the empirical data, focusing especially on the perceptions of the hospitals' managerial teams, uncovered relevant evidence representing the cases of 'rebuttal' and 'reorientation' pathways (i.e. the reactions of rejection and absorption) in the hospitals as a result of their evaluation by the NAPH.

7.2.4.1. Rejection (Rebuttal)

In most of the cases, even if the hospitals found the requirements incompatible with their values, they acceded to them superficially (through gaming) and yet refused to fully operationalise the demands in the later stages. This reaction of the hospitals could reflect a case of rebuttal in the hospitals. Since there was a legal coercion behind the NAPH, the

hospitals were not able to obviously reject the imposed requirements of the NAPH. This might contradict the existence of rebuttal at first glance. However, since the time period of surveying was short and temporary, the hospitals could remove the perceivably unintended changes asked for by the NAPH and resume their previous status. That is, they sometimes prepared the hospital just for the evaluation and, after surveying (and earning a related score), they returned to the previous position (Nicholas, 1999). More examples of this reaction were discussed earlier under ‘gaming’; consider, for instance the following:

‘We get prepared for the evaluation [by the NAPH] - sometimes superficially. We put some medical equipment such as “infusion pump or incubator” in our ED which we do not use, and we believe they are not necessary ...we take them away and return them to its previous ward after the evaluation.’

[When the researcher challenged the respondent about this behaviour]

‘...well ...we are working with the patients and in the hospital. I assume we better can decide...’ (Head of ED: Hospital B)

In fact, the members of the CISE convened and considered whether to comply, albeit symbolically for a short period, with the requirements of the NAPH. However, this did not lead to a permanent change in the workings (subsystems) of the hospitals in later stages. For this reaction, it could be argued that the hospitals were not convinced about the usefulness of these specific requirements for their activities. Therefore, when such perceptions were coupled with the hospitals’ financial difficulty in meeting the requirements, a rebuttal reaction became highly likely.

It was also seen that, in the teaching hospitals, as a hospital manager commented (below), they did not apply (i.e. reject) those requirements that exceeded their capability. Furthermore, since these hospitals were connected to the HUMS, they did not have the required autonomy to meet those requirements.

‘In the case of some requirements, e.g. human resource and physical layout, the surveyors also know, we are not able to fulfil them. In fact, we do not apply them, and they give the score most of the times..., For instance, we always have shortage of nurses and cannot recruit ourselves, but by the permission of the HUMS. We have never been able to meet the requirements of the NAPH for this case.’

[Hospital C]

The analysis showed that the hospitals did not perceive this behavioural reaction (i.e. rebuttal) to be to the detriment of their patients. This was rather because they thought the requested change was not necessary or could not be achieved in the way articulated by the NAPH³⁰. This could be a sign of a clear distinction between the views of the hospitals and those of the evaluatory authorities on perceiving the specific needs of patients and the ways of dealing with them. In line with this assumption, there were situations where members of the hospitals were blaming those outsiders, who had control over the hospitals (e.g. the NAPH), for not being aware of the real needs of the patients and internal circumstances of their hospitals.

'I think those working in regulative areas of the HUMS are not quite aware of our problems and of patients' needs. ...so their evaluation hardly addresses what we think, with our tangible and direct experiences [emphasis added], matters for the patients.' (Matron: Hospital B)

These examples signify some cases of rejection (rebuttal) of the NAPH's demands by the hospitals.

7.2.4.2. Absorption (Reorientation)

This reaction arguably comes to the fore when a driver/disturbance is too strong to be rejected by the targeted organisations (Broadbent and Laughlin, 2005). The findings showed that the NAPH was, in the main, known by the hospitals' members in relation to its effects on the financial status of the hospitals, rather than as a driver for any improvement in the quality of the hospitals' services.

'...as far as I know our departments are trying to prepare themselves just for receiving the higher evaluation score, as the manager is asking from them. I don't suppose it is because of the effect of the evaluation standards on the quality of their services.' (Matron: Hospital B)

Despite the members' dissatisfaction with and lack of belief in the ability of this steering mechanism, there was no possibility of questioning or rebutting the requirements of the

³⁰. This perception was supposedly based on their clinical judgement.

NAPH by the hospitals, because of its colonising features³¹ (e.g. the hospitals' financial dependency on and the legal coercion behind the NAPH). Unlike the rebuttal reaction, the required changes by the NAPH in this stage were far-reaching with long-lasting and critical implications for the hospitals. The hospitals pointed to cases such as the creation of a new ward or committee (i.e. Nosocomial infection committee) or provision of a new service and that their regular reports and proceedings had to be sent back to the higher authorities as required by the NAPH (MoH, 2004). In this situation, the probability of the hospitals refusing them was low.

'We were asked to create an Isolation Unit inside our ED, but this hospital is small and if we would have any patient of that kind, we could use the unit in our main wards. They just act based on their rigid checklists ...while it is costly for us.'
(Manager: Hospital A)

The hospitals hinted at objecting to such requirements of the NAPH; nevertheless, they had to accept and accommodate (i.e. absorb/internalise) them in practice to avoid being downgraded from a hospital to a 'minor surgery centre/clinic' (Gray et al., 1995; Broadbent and Laughlin, 2005). This demotion could bring a change in the hospital's status and goals (i.e. ISs) and, ultimately, create various repercussions for the hospital's financial ability and legitimacy, aside from the perceived damage to its (and its managers') reputation.

This reaction also appeared to generate a feeling of indifference among the hospitals' members towards the NAPH in that, while opposing some requirements of the NAPH, they have yet to comply with this system, which has been unchanged for several years (Laughlin and Broadbent, 1993).

The hospitals' committees (a principal DA), especially the CISE, played a key role in steering the requirements of the NAPH in the hospitals. In fact, those having control over the DAs and called SWGs (Broadbent and Laughlin, 1998) as mentioned before, gathered together and decided and acted on the requested changes. The analysis illustrated that the changes, usually in the preparation or post-survey stages, were firstly considered inside the various committees, depending on their scope and area of activity. The appropriate strategies and tactics were then developed to obtain the accreditation grade. Accordingly,

³¹. The hospitals, nonetheless, had the freedom to appeal against the decision of the surveyors.

they might reject the perceivably unintended requirements, as mentioned in the case of the rebuttal, after a short period of showing symbolic compliance (i.e. gaming) with the on-site survey. However, in this stage, given the nature of the requirements, the tactic assumed by the hospitals was the application of the requirements (i.e. absorption) to avoid demotion of the hospital to a 'substandard' status signifying damage to the legitimacy of the hospital.

The essential change under the reaction of the reorientation took place in the DAs of the hospitals³² (Laughlin et al., 1994a; Gray et al., 1995). These DAs were directly influenced by the requirements imposed by the NAPH. In fact, the DAs of the hospitals were initially developed under the guidelines of the NAPH in order to earn the relevant accreditation status, and the possibility of any non-observance could have a bearing on the hospitals' accreditation grade. Similarly, as mentioned earlier, the empirical investigation revealed that the hospitals were using the principles and instructions of the NAPH to develop and make changes in their own internal PMSs (it was explained earlier that they were changing their ISO and IQIPs according to the guidelines of the NAPH). By doing so, they intended to prepare for the assessment of the NAPH. This, it could be argued, represents a change of reorientation because of a permanent change in their DAs. Similar evidence was reported by Mannion et al. (2005) in that the high-performance hospitals used the star-rating to align their internal performance management and reporting systems with national key targets.

The DAs, as reported by the members, monitored the alterations in the hospitals' workings (subsystems) in line with the NAPH. For instance, the hospitals reported placing required equipment or creating a separate isolation unit in their EDs, as indicated. The table 7.1 has summarised the key changes taking place in both the DAs and subsystems of the hospitals.

³². It should be noted that not all changes in the DAs (especially in the hospital committees), as mentioned by the hospital members, were unwanted (as explained under evolution pathway).

Table 7.1 Key examples of the changes in the structural elements of the hospitals over the course of their evaluation by the NAPH

The structural elements	Changes as a result of the NAPH
Subsystems	<ul style="list-style-type: none"> • Creation of new wards in the hospitals • Introduction of new equipment • Recruitment of new staff • Equipping and mandating the EDs of the hospitals to admit all A&Es • Establishing an Isolation Unit in the EDs • Prescription of new medicines in the hospitals
Design archetypes	<ul style="list-style-type: none"> • Developing the hospitals' committees in the light of the instructions of the NAPH • Creation of an internal evaluation committee (conventions of its members and informing the other departments of the changes requested regularly) • Development of the indicators of the hospitals' ISO programme in accordance with the requirements of the NAPH • Aligning the hospitals' internal control procedures with the guidelines of the NAPH

7.2.5. The effects of the NAPH on the ISs of the hospitals

As explained previously, the direct focus of the NAPH was on the subsystems and DAs of the hospitals. However, the changes in the attitudes and beliefs (i.e. ISs) of the hospitals' members, as a result of the impact of the NAPH on their tangible elements, were also investigated. According to Broadbent and Laughlin (2005), changes in the intangible elements of organisations could lay the groundwork for second-order (deep and lasting) changes, which are called colonisation and evolution. The ISs of the hospitals play the determinant role in understanding this group of changes in the hospitals.

7.2.5.1. The ISs of the hospitals

Given the abstract nature of ISs, it is argued that they are elusive and often difficult to investigate and understand (Laughlin, 1991; Broadbent, 1992; Broadbent et al., 2010b). The analysis of organisational DAs and values held by those controlling the DAs (key/powerful groups in organisations) is believed to be critical for developing an understanding of organisational ISs (Broadbent and Laughlin, 2005). This is because the DAs are arguably the tangible manifestation of organisational ISs (Lawrence and Sharma, 2002; Richardson et al., 1996).

In the case of the hospitals in the current research, as the empirical data showed, the managerial team of the hospitals (the manager and directors of the main departments) qualified as the influential members of the hospitals. They were involved both in setting the hospitals' missions, purposes and DAs and in dealing with hospitals' accreditation. Therefore, they appeared to be the most relevant of the hospitals' members to identify the ISs; hence, their perceptions were examined in order to explain the nature of the hospitals' ISs in relation to the NAPH and understand its effects on the ISs of the hospitals' members.

Exploration of the ISs of the hospitals was conducted using both documentary analysis and interviews with organisational members. The answers to the questions of why (does the hospital exist?), what (does it do?) and how (does it do it?), as pointed out by Tyrrall and Parker (2005), were sought to present a picture of these ISs of organisations. Despite the fact that hospitals are composed of various groups, ranging from clinical to administrative and financial, they are conventionally recognised as organisations with a clinical orientation, with their main focus on the provision of care (Jacobs, 2001). The hospitals in the current study were not seen as exceptions to this argument. Most of the interviewees considered '*serving the society as a hospital*' as the *raison d'être* of their organisation (i.e. metarules)³³. The review of the policy documents of the hospitals (e.g. strategic plan) and interviews showed that the core of their values and mission was '*to deliver the high quality and safe services and increase the satisfaction of their internal and external costumers*'³⁴.

³³. The similarity was dominant at this level. Even the private hospitals highlighted this point at this stage, despite their profit-making purposes.

³⁴. There were other priorities at lower levels, such as staff health, safety and satisfaction, expansion of their services and promoting medical education (in the case of teaching hospitals), as their strategic targets.

This was of central importance to the majority of the hospitals' members³⁵. This was found to be aligned with the healthcare lifeworld at societal level, according to the relevant policy documents of the MoH³⁶ (e.g. MoH, 1997a; I.R.I., 2004). In fact, the lifeworld of the societal steering institution (i.e. the MoH) was supposedly a reflection of the healthcare societal lifeworld (Broadbent et al., 1991; Broadbent et al., 2001). The fact that the main mission of the hospitals was to deliver quality care was repeatedly raised in their discussion. The interviews showed that most of the members recognised the assessment of the hospitals' performance as one of the vital elements for the fulfilment of their mission and purposes.

'I believe our main objective is to improve the quality of our services as much as we can. We really welcome any effort that can help us for this purpose.' (Matron: Hospital B)

They specifically stressed the effect of external evaluation of their performance for the quality improvement in their hospitals.

'We like to be evaluated externally on a regular basis [...] but the current programme [the NAPH] has the problems.' (Head of ED: Hospital C)

This also signals the alignment of hospitals' ISs with the related healthcare lifeworld within which the existence of an external mechanism to assess the hospitals was stipulated (Moghimi, 2004; I.R.I., 2004). These shared views imply that the hospitals' ISs have largely remained unchanged, as a result of the imposition of the NAPH. They still believed in the importance of the external assessment of their performance for their success and survival, despite being under the evaluation of this external mechanism. Notwithstanding this discussion and their emphasis on the importance of external evaluation, there were discrepancies among the hospitals' members as to whether the NAPH could help improve the quality in the hospitals (i.e. in line with their main mission) and hence whether it was worth conforming to. This divergence in the beliefs of the members about the NAPH was recognisable in both intra- and inter-hospital contexts (in the case of the NTHs as compared to the teaching ones), and could be argued as being associated with this AP.

³⁵. In the case of private hospitals, the interests of the shareholders were also mentioned as their strategic target.

³⁶. This was identified only on the basis of the formal documentation.

7.2.5.2. Submission (Colonisation)

In the following section two cases of unintended shifts in the beliefs of the hospitals' members are outlined. They *de facto* represent what is referred to as the colonisation pathway by Broadbent and Laughlin (2005).

7.2.5.2.1. Intra-hospital variations

Although there was an overall dissatisfaction with the NAPH's performance across the hospitals, the detailed analysis of empirical data revealed that the various groups inside the hospitals had somewhat different interpretations of the effectiveness and merits of the NAPH. The main variations were observed between clinical members (mainly physicians) and managers. As explained previously, the perceivably associated defects of the NAPH caused the majority of the hospitals' members to conceive of this MoH-run programme as being incapable of giving a valid evaluation of their performance and boosting the quality of the hospitals. The intensity of these negative feelings was more noticeable among the clinical members of the hospitals. The physicians, a key group of clinical professionals, were the least interested in being involved in the NAPH evaluation discourse of the hospitals, as the analysis showed, and were largely concerned with clinical and teaching tasks in the hospitals. They saw the NAPH as a 'formality' set by the MoH to control the basic standards in the hospitals, signifying the lowest level of belief in the NAPH's merits. This group was accountable only to the directors of the hospitals, who were consultant physicians themselves. The directors were a link between hospitals' physicians and other groups in the hospitals. However, this position in most of the (teaching) hospitals was seen as a nominal role, as the following comments by a hospital manager imply, and the hospital managers were the main executive authority in the hospitals (Sadaghiani, 1998).

'Even though the directors are formally incumbent for the hospital, I've never seen our director even participating in the meetings with the accreditation surveyors. ... I do everything, instead'. [Hospital D]

The directors of the other wards were also consultants; however, in practice their head nurses (sister), and especially the matrons of the hospitals, dealt with the requirements of the NAPH. The head of para-clinic departments were also involved in the NAPH. Their views on the NAPH were mixed, although doubts about the ability of this mechanism were

noticeable in their views, and rationales other than the NAPH's quality improvement ability were raised for their compliance.

The managers representing, apparently, the financial and administrative activities in the hospitals, on the other hand, were generally inclined to be more in favour of (complying with) the requirements of the NAPH, as their expressions implied. It seemed the beneficial effects of the NAPH (discussed earlier, e.g. its financial advantages and as a DDS) were more constructive and in line with the objectives of the managerial groups, as raised in the interviews. In addition, the following comment by a hospital manager also implies this group's preference for complying with the NAPH.

'...in my idea, there needs to be an external programme to ensure hospitals don't get out of control, ... this programme is really helping me as a manager. It is showing me how my different department are operating...' (Manager: Hospital D)

This reaction could be a consequence of their responsibility for entire hospitals. Thus, given their financial (and not clinical) mindset as well as concerns, as my discourse with them revealed, their inclination might seem to some extent justifiable. The fact that the hospital managers were appointed by the 'Financial and Support Deputy' of the UMSS might somehow accentuate their duties and concerns in the hospitals.

A problem nevertheless arose where the NAPH was the main income source of the hospitals. Therefore, the financial dependence of the hospitals on the NAPH forced the managers to be heavily associated with financial matters in approaching the requirements of the NAPH. The managers were thought of as people who only cared for and were always concerned with financial arrangements in the hospitals. For instance, some managers noted that, in the case of physicians' reluctance or opposition to the requirements of the NAPH, they may try to push them, through the hospital director, to adapt to the changes requested by the NAPH, so that the hospital could earn its grade. Their efforts, as stated, might not always be successful in practice, because of the strong professionalism and huge power of the physicians in the hospitals (Abernethy et al., 2007). However, the other members were influenced by the managers, as discussed earlier under 'departmental gaming', and because of their fear of the management (Gray et al., 1995) they showed symbolic compliance, whilst originally believing that quality of care should not be compromised on financial grounds. The latter is a characteristic of health care in that those working in this sector might resist full compliance with regulatory demands,

even sometimes at the expense of losing the receipt of societal resources such as funding (Broadbent et al., 2010a). This non-conformity challenges the classic institutional theorists who claimed organisations always comply with the external regulatory pressures prescribed by law or governments in order to gain economic benefits or legitimacy as a result of this compliance (e.g. Meyer and Rowan, 1977; Scott and Meyer, 1983). This discussion displays a clear discrepancy in the beliefs of these groups (i.e. managers and clinical members) in their response to the NAPH in the hospitals. The clinical members' orientation was more focused on the type of provision that was perceived as appropriate based on the quality norms and rather less on financial matters. This culture could be referred to as clinical culture - vis-à-vis business culture - and is mostly originated from a conventional and traditional focus of HCOs on providing care rather than making profits (Jacobs, 2001). Instead, the managers were more disposed to business culture because of the nature of their work and responsibility. Their orientation further turned out to be reinforced by their fear of the implications of failing to achieve the accreditation status.

'...ultimately if the hospital gets lower grade all the fingers will be pointed at the manager... even much more than the director of the hospital...' (Manager: Hospital B)

This discrepancy was also somehow reflected in the DAs of the hospitals; consider, for example, the managers' decision to deploy ISO in some hospitals as a tool to organise the activities of their hospitals without consulting other groups, as explained earlier. The clinical members, unlike the managers, did not perceive the ISO to be related with the quality of care. This case supports the argument presented by Broadbent (1992) that interpretations by the same DA might vary due to the different orientations of organisational members. The clinical members also had their internal measurement and control systems for evaluating their own activities, such as what was mentioned as the routine clinical rounds. It could be argued that such discrepancies in the views of the different groups in the hospitals had made the adoption of integrated strategies difficult for the hospitals, as happened in the case of ISO. Yet the major problem was that, given the huge power of the managers in the hospitals, the other members' decisions, except for the physicians, could be influenced at the discretion of the managers, as shown by the following comment:

'The compliance with the evaluation depends on our manager's decision.'
(Supervisor: Hospital D)

Therefore, the power of the managers (resulting from their hierarchical position and responsibility, and control over the money) was seen as an influential element in the possible replacement of the members' conventional culture by a business culture in the hospitals' attempts to approach the requirements of the NAPH. This culture was in a way reflected in the discourse of the clinical members, complaining always about the financial problems of their hospitals and having concerns over the financial implications of their decisions. Consistently, the main rationale of the hospitals for compliance with the NAPH was, as indicated before, the economic gain for the hospitals. This could be a tentative sign of 'colonisation' of the societal healthcare lifeworld in that the financial mentality was to some extent promoted in a not-for-profit environment in relation to the effects of the NAPH. Adcroft and Willis (2005) warn of the danger that PMSs might impose compliance with rules and regulations instead of organisations' original values.

7.2.5.2.2. Inter-hospital variations

In addition to the intra-hospital alteration in the members' belief system, a similar type of inter-hospital change was also observed. There was a prevalent view among the members of the NTHs that the NAPH was biased and evaluating their hospitals more strictly, in comparison with the teaching hospitals. It was understood from their comments that the way of governing and executing the NAPH made the NTHs think in this way, reflecting a change in the beliefs of their members as a result of the NAPH's impact on the hospitals. Such views also existed on some occasions among the teaching hospitals, some of whose members claimed that the MoH evaluates the university hospitals generously, because awarding them a low grade would create a financial burden on the MoH itself (Aryankhesal, 2010). Therefore, it was argued that the NAPH always evaluated them leniently *vis-à-vis* the NTHs.

An investigation into the accreditation grades of the university (teaching and clinical) hospitals over the course of the last eight years may be able to substantiate this argument (Table 7.2). It was also claimed by some members of the teaching hospitals and the NAPH's surveyors that the leniency is partly due to the teaching tasks of these hospitals. However, teaching hospitals were presumably capable of buying expensive equipment

because of their connection to the government. Given the structural focus of the NAPH, they hence could obtain higher scores for medical equipment. Some managers of the teaching hospitals also noted that the NAPH might delay the evaluation process or ignore those requirements of their hospitals, which they are incapable of fulfilling. This could rarely happen in the case of the NTHs, as they added.

Table 7.2 The evaluation grade of the hospitals under study in the last eight years

Row	Hospital	Nature	2002	2003	2004	2005	2006	2007	2008	2009
1	A	Private	3	3	3	3	3	3	4	4
2	B	Teaching	1	1	1	1	1	1	1	1
3	C	Teaching	1	1	1	1	1	1	1	1
4	D	Teaching	1	1	1	1	1	1	1	1
5	E	Private	2	1	1	1	2	1	1	2
6	F	Teaching ³⁷	-	-	-	-	-	1	1	1
7	G	Clinical ³⁸	2	2	2	2	2	2	2	2
8	H	Institutional	1	1	+1	1	2	1	1	1

The societal lifeworld in relation to the evaluation of the hospitals indicates that there should be a fair evaluation of all hospitals (MoH, 1997a; I.R.I., 2004). Such an impression among the NTHs could allegedly be a sign that the NAPH, as a societal steering mechanism, precipitated the values which are not in line with this lifeworld. In fact, these negative assumptions about the NAPH by these hospitals could signify that the values of these hospitals had been affected by the imposition of the NAPH over time. This might represent a change in the beliefs of the hospitals' members as a result of the NAPH implementation. These changes have as such had their repercussions reflected in the workings of the hospitals. That is, these hospitals were found to be more disposed to symbolic compliance and gaming, which are not consistent with the societal lifeworld.

³⁷. This hospital was established five years ago.

³⁸. This hospital has just been recently taken over by the HUMS.

Therefore, overall, these cases, which illustrated a type of change in the values and beliefs of the hospitals' members over the years as a result of their submission to the NAPH, might to some extent represent the evidence of a colonisation pathway in the hospitals (Broadbent, 1992). In fact, values incompatible with the overall norms (lifeworld) were seen to be expressed in the hospitals in relation to the NAPH, which is an indication of internal colonisation (Broadbent and Laughlin, 2005).

7.2.5.3. Adoption (Evolution)

Broadbent and Laughlin (2005, p. 17) describe 'evolution' as the intended pathway of change in organisations. In accordance with this pathway, the ISs of organisations are transformed through a discursive process among organisational members regarding the required change (Gray et al., 1995). The consensual changes consequently cascade down to the DAs and subsystems of the organisations (Broadbent et al., 2001). The core of the evolution pathway is that the requirements for change should not be imposed on, but agreed upon, by those who are the target of these changes. That is, the change is adopted by the hospitals without the force of legislation and regulation. In this sense, the current accreditation system might seem unlikely to trigger any intended change in the hospitals, given its compulsory nature and non-consensual development process. As elaborated in chapter two, after the initial development of the NAPH in the MoH, the hospitals were served with the evaluation checklists to observe in their hospitals. As such, the UMSs were tasked to annually check the fulfilment of these standards by all hospitals in practice at provincial level.

Notwithstanding the above assumption of this model, there was evidence showing that not all of the requirements of the NAPH were absorbed reluctantly; some were embraced and adapted by the hospitals (Haigh and De Graaf, 2009). The analysis of the data revealed that the hospitals had made some changes in their workings as well as DAs, because of the guidelines of the NAPH, during the years of evaluation (particularly in the early years and stages of introducing this mechanism and its additions, as stated by the members). These changes were claimed to be constructive for their practices and perceived as desirable by the members.

'In the early years of this programme, some standards were new and useful for us. For example, we were asked by the surveyors to use this transition bed for

transferring our patients instead of our old method. It is much more practical and helpful.' (Head of ED: Hospital E)

The main rationale of the hospitals for embracing this change was the merits of these requirements which contrasted with other change pathways. This was when the NAPH was an imposed (compulsory) programme and there had not been any opportunity for the hospitals' members to open a discursive dialogue about its standards (Larrinaga-González et al., 2001). That is, the requirements were not subjected to any kind of discourse among the members of the hospitals.

'Since a few years ago, we are asked to prescribe only the prophylactic antibiotics introduced by the NAPH inside the hospitals. ...I don't feel uneasy about them because we are told they are based on the most recent scientific evidence.'
(Consultant: Hospital F)

This comment highlights an example of the changes made in the hospitals' workings as a result of the requirements of the NAPH. A feature which was seemingly attached to the adopted requirements claimed to be their 'novel, technical and scientific' nature. As it appeared from the analysis, this feature ensured the hospitals' adaptation to these requirements. It could be argued that their scientific and technical nature reduced the room for any contention on the nature of the requirements and decreased the need for a discursive process. Therefore, despite the absence of discourse, the changes were made in the activities of the hospitals, thanks to their particular nature. The scientific base of these requirements (e.g. the specific antibiotics) was explicitly conveyed to the hospitals in the guidelines of the NAPH at the time of their introduction (MoH, 2004). The members of the hospitals were also found to rely on the judgement of their professional associations for the endorsement of the changes inside their hospitals, as shown by the following comment:

'When a specific requirement related to my work is approved by our medical association I am to a large extent convinced...' (Consultant: Hospitals D)

This comment also puts the accent on the apparent superiority of normative institutional elements over regulative ones in their effect on professionals, which should be noted. Another feature which apparently eased the acceptance of some requirements was their religious and ethical nature. The comments of the respondents (as in the one below, also mentioned earlier) showed that the members accepted these requirements with little

challenge, regardless of whether they perceived them as mandatory and beneficial or inefficient for their hospitals.

'In any situation, we basically observe the religious values.' (Manager: Hospital D)

'I do not remember I have seen any problem in respect to meeting the religious values in the hospitals. They also get comparatively high score for these requirements.' (A member of surveyors)

In agreement with Broadbent and Laughlin (2005), the related changes were made in the DAs of the hospitals following the adoption of the changes. For example, the hospitals, as the next comment clarifies, added new members to their committees to monitor the changes in their subsystems.

'After the introduction of "quality-oriented" targets by the MoH in the NAPH, we asked two members of our consultants to attend in our committee of "Medication and Medical Equipment" to assess the prescription and administration of the antibiotics in the hospital.' (Hospital Director: Hospital D)

7.3. Recommendations for improvement in the NAPH

One of the main objectives of this study has been to make a modest, albeit tentative, effort to identify relevant strategies for the improvement of the AP under study. The adopted research approach (i.e. MRT) has this ascendancy over other research paradigms, as explained in chapter four, which allows the researchers to consider a link between research and practice. The third element of this approach (i.e. change) provides a possibility for consideration of a researcher-informed, researched-led change to take place at the end of any research process (Laughlin, 2007).

In the current case-study, however, given the centralised structure of the NAPH, it was observed that there was a shared feeling among the respondents (i.e. the hospitals' members and even surveyors) that they would not be able to change anything, as they did not have the required power and authority. Therefore, rather than change strategies, the suggestions concerning ways to improve the NAPH were provided by the interviewees at the end of each interview (after prompting by the researcher). In addition, some suggestions were also developed in the light of the problems associated with the current

AP. They were also sent back to a few of the respondents to ensure they are grounded in the empirical data.

1. Regular feedback from the hospitals is sought and taken seriously regarding the functioning of the programme

As mentioned earlier, it was widely expressed by the hospitals' members and confirmed by the surveyors that the hospitals always provide feedback on the programme. However, over the years that the NAPH has been running, their views have not been taken into account. This is while the spirit of communicative action (i.e. the base of the frameworks adopted by this study) insists on the consensual nature of the requirements put on organisations (Davis, 2007). As such, the importance of taking the views of those under performance assessment into account has been widely echoed in the literature (e.g. Moullin, 2004; Barker et al., 2004). Specifically, the incorporation of the feedback in different stages of APs is highly stressed (Schyve, 2000) and is receiving growing attention among accreditation agencies (O'Connor et al., 2007).

Given the long-time existence of the NAPH and its perceptibly routinised style, an ongoing review and feedback process could restore motivation to the hospitals and encourage them to take the NAPH more seriously (O'Leary, 2000; Quality Assurance Project, 2005). The following benefits are argued to be achievable through a feedback system (Stoner et al., 1995; Hibbard et al., 2003; Smith et al., 2008):

- The gap between the perceptions of the authorities (directorate) and those of the hospitals in this programme would reduce;
- The problems and the areas for improvement in the accreditation system would be identified;
- The results of accreditation would be easily accepted by the hospitals and they would be more enthusiastic about taking corrective actions;
- More feedback and collaborations from the hospitals might minimise the negative and dysfunctional response to the NAPH;
- Being kept abreast of executives' and hospital managers' views regarding the accreditation's problems would enable the NAPH's directorate to make pertinent policies and decisions based on the realities and status quo;

- The current centralised evaluation system would be set to improve.

2. Update of the standards

It emerged that the repetitive and static nature of the standards over a long period of time had taken the trust of the hospitals' members away from this programme. As the data showed, such a nature has created a mentality among the members that the NAPH is only a superficial supervisory system, not an improvement programme, enabling the MoH to stay abreast of the overall status of the hospitals. The subjective, vague and judgmental nature of the standards was fiercely criticised, with requests for its update and replacement by more objective standards. APs are urged to facilitate progress towards evidence-based and scientific evaluation (Mays, 2004). In addition, Kennerley and Neely (2002) have argued that if not updated, the PMSs are likely to lose their ability to differentiate between poor and good performance over time. A need for regular update of the standards is recently also expressed by the authorities in the MoH with a plan to supplant current evaluation system by an updated accreditation programme in next few years (Anonymous, 2011b).

3. Removing the bias of the accreditation process

Since the NAPH was similar for all types of hospitals, the members of the private and institutional hospitals expressed their dissatisfaction with the system in two ways. First, their hospital was assessed by similar standards used for (advanced) teaching hospitals. Second, they had no representative in either the development or the implementation team of the NAPH. Redressing the latter deficiency could, as Mays (2004) argues, guarantee responsiveness, fairness, credibility and a balanced perspective on the AP.

4. Reorientation towards process and outcome

One of the reasons why the hospitals did not perceive the NAPH to be related to the quality of care was because they did not see its standards focusing on the processes and outcomes of the care. This has also been noticed by the authorities of this programme, who introduced a new set of quality-oriented indicators with focus on the process and outcome of care in 2004, to be continued every year (MoH, 2004). However, this change has not been maintained since then (Sadaghiani and Zare, 2005). These indicators only constituted a tiny percentage of the whole score of the AP. A balanced inclusion of process and

outcome measures is highly advised (Jacobs et al., 2007), along with the structural indicators.

In the current case, the hospitals mostly argued that the NAPH should put more focus on assessing their processes and outcomes and set a licensing procedure for checking their structural aspects (i.e. physical layout, equipment, etc.) in the early years of establishing a hospital and regularly every few (i.e. five) years.

5. Tailoring the evaluation to the current capabilities of the hospitals

As explained under the disproportionate evaluation of the NAPH, the members of the hospitals were complaining that they are assessed based on things over which they have no control (e.g. human resources). Powell et al. (2009) argue that, for a successful implementation of quality improvement programmes, it is critical that organisations also have sufficient means for dealing with their requirements.

Such a situation in the hospitals had created a sense of ‘indifference’ – even, in a few cases, outrage - among the members of the hospitals, since they thought they were being penalised for things for which they were not responsible. This is while, as Powell et al. (2009) put it, the standards should be relevant and actual reflectors of the hospitals’ performance, to be effective.

6. Disclosure of the grades and strengths of the hospitals

There is evidence in the literature that disclosing performance data could improve the quality of care (e.g. Ito and Sugawara, 2005; Hibbard et al., 2005; Fung et al., 2008). Publishing and disseminating the results is considered an important feature for effective PMSs in health care (Hibbard et al., 2003). Although it was part of the regulations of the NAPH that the hospitals should display their grades on notice boards in busy parts of the hospitals, their managers did not seem to be aware of this requirement. One reason that why the authorities did not want to announce the results of the accreditation publicly, as appeared in the interviews with the hospitals’ staff and also was approved by a recent study (Aryankhesal, 2011), was apparently that they did not want to raise the public expectations from the hospitals, especially teaching (public) ones. That is, the public would expect the highest quality from a highest grade hospital.

The majority of the hospitals' members indicated that the NAPH should also highlight their strengths as well as uncover their weaknesses and mistakes. Similar evidence was found by Pomey et al. (2010). The formal communication of the strengths of the hospitals by the NAPH could create an opportunity for other hospitals to identify and emulate those which have received the highest ranking in accreditation. It was realised that the hospitals in the current case were only receiving a simple list of the scores related to their activities without any explanation of their weaknesses or strengths.

7. A clear and formal reward and punishment system for the hospitals in specific relation to the NAPH

Incentives for seeking and maintaining accreditation status are argued to be essential to the viability and success of APs (Mays, 2004). Despite the financial incentives of earning a higher grade for the entire hospitals, the members did not see any sign of tangible change in their situation as a result of their grade. Similarly, Reiter et al. (2006) argue that increased financial incentives for hospitals might not reach those individuals expected to improve their efforts. This injected a sense of apathy among the members about making an effort to improve for this AP, as they indicated. While Harris (1977) argues that, a link between the performance and incentives in HCOs could create a better cooperation between managers and physicians and also better performance of the organisations. As such, the establishment of a punishment mechanism specifically for the managers of those hospitals failing to achieve higher results was indeterminate.

This point regarding the incentives should be clarified in that, while acknowledging the importance of incentives for enhancing the effect of PMSs, it should be argued that they could not supersede the credibility of these mechanisms for the target organisations in the long term.

8. Training programme for the surveyors

Training of the surveyors is strongly recommended by professional organisations in the accreditation area (Shaw, 2004c; 2007). Surveyors are envisaged as the 'eyes, ears and hands' of any APs (Greenfield et al., 2008, p. 1). There were claims by the hospitals' members concerning the incapability and unfamiliarity of the surveyors with the hospitals. Therefore, a detailed, formal training programme for surveyors along with the setting of

surveyor selection criteria could enhance the reliability and acceptability of the NAPH (Greenfield et al., 2009). The training programme could/should also guide the surveyors in detecting gaming in the hospitals (Pickering, 1995).

In addition, given the long-time presence of the surveyors at the same hospitals, as explained before, an informal relationship was created between the hospitals and the surveyors which allegedly influenced their assessment; this aspect should be considered in their training.

9. Combination of the announced and unannounced modes of on-site survey

It emerged from the data that the gaming in the hospitals also occurred because the hospitals were largely (formally or informally) aware of the date when they were to be evaluated. This was expressed by both the surveyors and the members of the hospitals. The best mode of evaluation, as the members advised, was a mixture of announced and unannounced on-site visits. An unannounced visit was also conducted in the current system but it was both very limited and without a relevant score. Thus, it was not taken seriously by the hospitals because it had no effect on the overall grade.

Chapter 8 - Review and Discussion of the Findings

8.1. Introduction

As initially stated in chapter one, this study aimed to evaluate Iran's current hospital evaluation and accreditation system by focusing on its contextual effects in the selected hospitals. The analysis of the data was conducted through the framework approach (as explained in chapter 5). The thematic framework developed under this approach by drawing on prior theoretical models adopted in this research (i.e. Broadbent and Laughlin, 2005) was applied through the NVivo software to all empirical data. All the themes identified through this process were explained in chapters six and seven. In this chapter, the researcher has reflected on the key findings and discussed the results in the light of relevant theoretical frameworks and prior literature.

The findings represented a wide variety of views and perceptions from the hospitals' members on the current accreditation system (i.e. the NAPH) and its impact on these organisations. Despite their variation, a number of common themes and issues have emerged, which are explained in this chapter.

8.2. Constitutive nature of the NAPH

Analysis of the empirical findings revealed that the NAPH was perceived as a constitutive steering mechanism from the organisational perspectives. Theoretical and empirical interpretations behind this nature are presented at the following.

8.2.1. Theoretical interpretation

The features associated with the NAPH, as a societal steering mechanism in the country's healthcare system, indicate that this AP, in accord with Broadbent and Laughlin's (2005) theoretical model, expresses the attributes of a 'constitutive' rather than 'regulative' steering mechanism. Constitutive mechanisms, in the main, are not consultatively-driven but coercive and imposed on the organisations under their purview and evaluation (Lawrence and Sharma, 2002). These attributes of the NAPH were all explained in previous chapters. For example, it was shown that the NAPH was a compulsory evaluation programme imposed on all types of hospitals across the country. The history of the NAPH, discussed in chapter two, shows that the development of its standards has not been achieved through a discursive, consensual-based process among the different stakeholders of this programme. As a result, there was some contention over the standards and the mode of implementation of this AP raised by the hospitals under the evaluation. Despite some inconsistency in the type of attributes (e.g. whether it was a freedom guaranteeing/reducing mechanism), the features of the NAPH seemingly qualify this PMS as a constitutive steering mechanism (Broadbent and Laughlin, 2005), from the perspectives of the hospitals. The constitutive nature of the NAPH was further substantiated by another group of attributes perceivably resulted from this nature, such as the disproportionate evaluation of the hospitals (discussed later under the empirical interpretation).

8.2.2. Empirical interpretation

In connection with the aforementioned - theoretically grounded - attributes of the NAPH (e.g. its non-consensual nature), another group of (empirically drawn) features were also found to be contributing to the constitutive nature of this AP. That is, as a result of these features, the hospitals seemed to perceive that the NAPH is unable to render a 'valid and reliable' evaluation of their performance as a result of these features. Mannion et al. (2005) report similar evidence in their investigation of the perceptions of the hospitals towards the NHS star-rating system. The NHS hospitals questioned different aspects of the current evaluation programme such as its coverage of the measures and sensitivity to local and organisational factors.

Most of the perceived empirical features were linked with the current structure and implementation of the programme. For instance, the static and repetitive status of the standards without any updating as well as their focus on structures vis-à-vis processes and outcomes were frequently questioned. Evaluation standards (i.e. the measures based on which PMSs assess the performance of HCOs) are the core of APs (Scrivens, 1997b). While existing well-established programmes such as JCAHO issue a regular update of the standards, those of the NAPH have been unchanged since its inception. In JCAHO, the standards are reviewed every year for hospitals, and ACI reviews its standards every two years (Shaw, 2004c; Nicklin and Dickson, 2009). The standards' dominant focus on the structure (physical appearance) of the hospitals concurs with Shaw (2003a) that, in developing countries, the emphasis is on facilities and environmental aspects of HCOs, given their tangible and measurable nature. This has also been echoed in relation to accreditation systems in other countries. For instance, although the well-known programmes such as JCAHO and NCQA in the USA and TSHAS³⁹ in the UK have realised the importance of outcome measures, they have also been criticised for their excessive concentration on the structure and process measures (Hurst, 1997; Griffith et al., 2002; Beaulieu et al., 2003). Both anecdotal and empirical literature (elaborated in chapter three) has underlined the significance of outcome measures as the determinant of ultimate impact of APs on HCOs (e.g. Jacobs et al., 2007; de Walcque et al., 2008). Similar stress on patient-related outcome indicators has been reflected by Zende (2006) and El-Jardali et al. (2008). A more balanced approach, nevertheless, seemed to involve the inclusion of all aspects of structure, process, outcome and stakeholders in the assessment of healthcare quality (Øvretveit, 1998; Donabedian, 2005).

The low sensitivity of the NAPH to the organisational factors of the hospitals was also argued by the members. The MoH has been seeking to conduct an equitable evaluation, by applying a uniform AP (MoH, 1997a). However, the hospitals did not express the same perceptions of this intention of the NAPH, as the findings revealed. In fact, the careful consideration of local circumstances of HCOs is argued to be crucial in developing tailored quality improvement models (Powell et al., 2009), and merits further exploration as regards the NAPH, given the varying geographical, cultural, etc. factors in Iran. Moreover,

³⁹. Trent Small Hospitals Accreditation Scheme, now known as QHA (Quality Healthcare Advice) Trent

PMSs could be more effective in improving clinical outcomes when they are owned by professions and also attend to the context the systems operate (Goddard et al., 2002b).

The hospitals also had concerns over the NAPH's limited coverage of the hospitals' activities. A number of dangers are associated with incomprehensive coverage of PMSs of organisations' activities. There might be a risk that the organisational efforts and attention are only drawn to the aspects covered by the measurement systems, leaving the other activities unattended (Ganz et al., 2007). Consequently, these limited measures are considered as representative of the performance of the entire hospitals and the evaluation of those aspects which are vital for the functioning of the hospitals might be ignored and excluded (Bevan and Hood, 2006b). Furthermore, the hospitals could be driven to concentrate more on those activities that were measurable but presumably not in need of quality improvement, from their perspective (Smith, 1995; Brennan, 1998). Consistently, some of the hospitals echoed that their newly developed activities - seemingly important to them - were not covered by the NAPH. Accordingly, advocating the application of a multi-method approach, Hariharan et al. (2004) argue that measuring the performance of healthcare services is overly difficult using just a single method given the complexity of healthcare. Similarly, the analysis showed that the hospitals in this study, as indicated in chapter six, were trying to adopt complementary quality measurement and improvement methods to compensate for the inability of this evaluation programme to cover all their practices.

8.2.3. Possible justification for the NAPH's constitutive nature

The constitutive nature of the NAPH might be argued as somehow congruent with the circumstances dominant in the area of health care. Given the criticality of the outcomes (Gauld, 2005) and information asymmetry between providers and consumers in health care (Montagu, 2003), governments are seen as the main stewards of public interest in this sector (Broadbent et al., 2010a). They are hence more amenable to dominating and regulating the organisations involved in this sensitive area. The term 'regulation' - an inseparable task of governments - which is defined as a 'sustained and focused control exercised by a public agency over activities which are valued by a community' (Walshe, 2002, p. 967) also reflects both the criticality of health care and the role of governments in this public good (Broadbent and Guthrie, 2008). This is why the government-owned

accreditation systems (e.g. the NAPH) are increasingly being developed and used to fulfil these regulatory intentions (Scrivens, 2002), as governments always reserve the right to regulate this area. As such, the MoH, as the official representative of the government in the healthcare sector, played a key role in supervising and controlling the hospitals' activities by setting up the NAPH, without giving serious consideration to the perspectives of those under its evaluation, as the findings revealed. This might be seen as an explanation of why the standards are set in the MoH and the hospitals were only served with the evaluation checklists to observe in their practices (Sadaghiani and Zare, 2005).

However, there is an extensive body of literature which has criticised such a centralised approach and strongly highlighted the effects of the views and feedback of those under the evaluation of PMSs (e.g. the NAPH) in their success. Goddard et al. (2002b) strongly advocate the development of the PMSs consensually and through those whose behaviour affects or is influenced by the measures of the systems (Murray and Evans, 2003). Barker et al. (2004) argue that the mechanisms for judging the delivery of a service must have the confidence of those being judged. Loeb (2004), Walburg et al. (2006) and Zende (2006) underline the importance of the contribution and cooperation of those under evaluation in the process of performance measurement. Similarly, Kravchuk and Schack (1996) and Moullin (2004) suggest that, in developing and operationalising performance measurement and improvement practices, it is vital that the feedback and values of different stakeholders are considered. A possible reason might be that, ultimately, such organisations and people will be applying the requirements of the PMSs and ensuring their success. Moreover, the unintended effects of forgoing the feedback are also to some degree reflected in the literature. Loeb (2004) warns that the lack of attention to this issue could run the risk of evoking considerable anxiety and frustration, which concurs with the findings of this study (explained under 'unintended consequences'). Similarly, O'Leary (2000) explains that performance measures perceived as irrelevant, unrealistic or unfair by the accredittees, as in the current study, would be more counterproductive than useful in assessing the performance of HCOs. Scrivens (1997a) also underscores the importance of organisational satisfaction with APs in assessing their effectiveness. As such, from a theoretical perspective, Laughlin (2007) argues that the rejection of stakeholders' views and commitments, as explained, could drive a steering mechanism (e.g. the NAPH) away from being 'regulative and ASJ'.

8.3. Repercussions of the NAPH

PMSs are argued to also precipitate dysfunctional effects in the targeted organisations, besides their desired results (Smith, 1995; de Bruijn, 2002; 2007). The extent of the unintended effects generated by quality improvement initiatives have been worrying for the policy-makers (Ganz et al., 2007). Birnberg et al. (1983) identify several categories of dysfunctional behaviours in organisations triggered by MCSs and PMSs, including; smoothing, biasing, focusing, gaming, filtering and illegal acts. They argue that not always these behaviours could be dysfunctional, but *de facto* their potential for generating dysfunctional effects is greater than beneficial.

The NHS has been the subject of various studies underlining these effects in the literature (e.g. Bevan, 2006; Bevan and Hood, 2006a; Bevan and Hood, 2006b; Goddard et al., 2000; Kelman and Friedman, 2009). Consistent with the existing literature, the current case-study also found evidence of unwanted effects in connection with the NAPH in the hospitals. They arguably occurred mostly because of the constitutive nature and the associated attributes (e.g. non-consensual base) of the NAPH. The way in which these unintended and dysfunctional effects were found to be developing in the hospitals could be likened to a domino effect. For instance, the constitutive attributes such as the perceived partial attitude of the NAPH towards the NTHs seemed to prompt the feeling that it conducts a biased performance evaluation of the hospitals. This perception (or, e.g., the static nature of the NAPH) in turn caused the unintended effects such as anxiety, outrage and disillusionment among the members of the hospitals, because of their permanence.

These results of the study regarding unwanted effects of the NAPH are supported by Walshe et al. (2001), arguing that external review systems, such as accreditation, may divert attention from other important concerns of a HCO (e.g. dealing with patients). They also side with Mannion et al. (2005) on their emphasis on similar unintended effects caused by national PMSs in HCOs. Moreover, the study also identifies further unwanted effects such as the hospitals' distrust of the current AP. No evidence was, nonetheless, found of Mannion et al.'s (2005) ghettoisation, in that staff could be attracted by higher-grade hospitals. Since the hospitals did not have the authority to recruit new staff independently, such an effect did not appear in the hospitals. Moreover, the results might to some extent contradict the study by Mays (2004) who dismissed unintended and adverse effects on service providers by APs. This contrast might be somewhat justified by their

different contextual factors including the difference between the patterns of programmes (i.e. voluntary/compulsory); furthermore, the context in which they are operating should be recognised.

8.3.1. Gaming: Dysfunctional effect of the NAPH

8.3.1.1. Types of gaming

Gaming was the main perceived dysfunction found to be caused by the NAPH in the hospitals. The majority of the cases of gaming found in the hospitals were in the form of fabrication and data falsification (Kelman and Friedman, 2009; Bevan and Hamblin, 2009). Aworski and Young (1992, p. 19) similarly point to ‘strategic information manipulation’ in which subordinates alter the natural flow of information and report only those aspects of an information set that is in their best interest.

The findings presented evidence of symbolic compliance (concealing non-conformity) with the NAPH’s requirements by the hospitals. This gaming was mostly seen in structural forms: for example, not abiding by the requirements of the NAPH to buy or use specific pieces of medical equipment in their practices or in a specific ward or unit. The high frequency (existence) of this form of gaming may have been specifically due to the NAPH’s dominant focus on the structural aspects (e.g. medical and non-medical equipment) of the hospitals (Moghimi, 2004) and hence the high cost of their procurement for the hospitals.

The gaming also took the form of preparing spurious documents related to the ‘quality-oriented’ guidelines of the NAPH (e.g. for the evaluation of the patients’ waiting times in the EDs). This instruction introduced a few numerical target-based indicators for assessing the performance of the hospitals (see section 3.4.7, chapter 3).

In addition, there were also cases of hospitals deploying their nurses and physicians from other wards in their EDs to meet their performance targets in this department, mostly at the busiest times for the EDs. These efforts to some extent represent another type of gaming which is called ‘effort substitution’ and alludes to an un/conscious decision to exclude other performance measures or use resources for measurable elements, mostly because the latter are considered by the PMSs (Kelman and Friedman, 2009, p. 922). A similar argument is posed by ACSQHC (2003a) in that accreditation could potentially divert the

hospitals' resources from strategies aimed at directly addressing quality and safety concerns. Casalino (1999) refers to a tendency (among managers) to spend time and money ensuring their hospitals score highly on measures used by accrediting bodies and not on those which benefit the patients. With the persistence of this gaming, there is a danger that the members of hospitals will begin to equate high quality simply with high scores in quality measures (Casalino, 1999).

The findings revealed that the gaming was more noticeable in relation to the EDs of the hospitals and also to the newly-introduced 'quality-oriented' indicators. Given the crucial nature of the services provided in the EDs, the MoH has put too much emphasis on the performance of these departments (MoH, 1997b; 1997c). Therefore, their successful accreditation status was considered a prerequisite for the evaluation of whole hospitals, according to the guidelines of the NAPH (MoH, 1997a, Moghimi, 2004). Unless they are able to obtain an accreditation grade, the hospitals will not be qualified for accreditation. Accordingly, the hospitals have to pay more attention to their EDs. Apparently this special attention was one reason why the EDs were unsurprisingly seen to be in a better position in terms of their physical layout and appearance in comparison with the hospitals as a whole. However, this issue, as indicated in chapter six, was also to some extent a cause of discontent in the hospitals. For example, some complained that this isomorphism-oriented policy of the MoH was imposing a high cost on them, despite their low rate of emergency admissions. Moreover, they argued that the real merits of their hospital could be overshadowed by the status of their EDs. The quality-oriented indicators had also recently been given a high priority by the NAPH in that the hospitals could not in any case ignore them (MoH, 2006), despite the fact that they contributed only a small proportion of the hospitals' score (see the sections 3.4.5. and 3.4.7, chapter 3). The target-based nature of these indicators also facilitated the extent of the gaming in relation to these indicators. This is in line with the existing literature that gaming is largely attributed to target-based measurement systems, such as those in the NHS (Bevan and Hood, 2006a; 2006b; Bevan, 2006; Hood, 2006; 2007). Therefore, overall the hospitals seemed to show more concern with their EDs and the quality indicators, which seemingly led them towards gaming.

The extent of gaming also varied between teaching hospitals and the NTHs, with more cases in the latter. It was thought that the teaching hospitals did not take the NAPH as seriously as the NTHs, as the findings showed, since they were government-owned organisations. This concurs with Bevan and Hamblin (2009) that an important reason for

the extensive gaming in the NHS in relation to its star-rating system was because the hospitals have taken the system very seriously.

8.3.1.2. Rationales behind gaming

Various elements, both extrinsic and intrinsic to the hospitals, seemingly prompted gaming (i.e. symbolic compliance) by the hospitals. The effects of these factors were found to be interrelated in creating such reactions by the hospitals and were intensified in relation to one another.

The main rationale appeared to be the inability of the hospitals to meet the requirements of the NAPH. Greenwood and Hinings (1996, p. 1032) have referred to this as the ‘capacity for action’ and accentuated its importance in organisations’ conformity with institutional requirements. As the requirements of the NAPH exceeded the capability of the hospitals and were found to be disproportionate, the hospitals were drawn towards gaming (symbolic compliance) to avoid losing their accreditation status. The expectations set by the NAPH for some major aspects of the hospitals such as physical layout and structure and the standards of human resources did not perceivably match the current status of the hospitals. As such, the financial problems of the hospitals and non-cooperative attitudes of internal groups (i.e. physicians) reduced their ability to meet the requirements. The fact that any considerable modification to their structural aspects (i.e. human resources and physical layout) was beyond their control and should be supported and funded centrally by the higher authorities has drawn teaching hospitals towards concealing their non-conformity with these requirements.

The clear focus of the NAPH’s standards on the structures vis-à-vis processes and outcomes of the hospitals appeared to aggravate their problem of complying with the evaluation requirements. The structural factors relating to the capacity and establishment of the hospitals were costly for the hospitals to fulfil.

Another reason for the gaming was that the hospitals perceived some aspects of the NAPH’s requirements (as indicated in chapter six) to be irrelevant to their processes of service delivery and not effective in providing quality care. For instance, as mentioned, some medical equipment was removed and the documents were not properly prepared, because the members did not perceive (and could not justify) them as a priority for their hospital. The constitutive features of the NAPH apparently reinforced such perceptions

among the members of the hospitals (Broadbent et al., 1991). Since the NAPH was developed on a non-consensual base and no feedback was sought from the hospitals on accommodating and updating the system, this perspective may have been inevitable. The perceived lack of sensitivity of NAPH's standards to organisational factors of the NTHs and the biased approach of the NAPH to the evaluation of these hospitals and their permanence had further created a situation conducive to gaming by these hospitals. Overall, these features had created an impression of the 'perceived incapability' of the NAPH to improve the quality in the hospitals.

In fact, the main intention behind establishing the NAPH has been to promote the quality of services rendered by the hospitals (Moghimi, 2004; MoH, 2008). However, the NAPH was, in the main, recognised by the hospitals as a routine checking system and a means to earn more money. The ability of the NAPH to improve quality was hardly mentioned in their discourse (Laughlin et al., 1994a). Similar results were found by Aryankhesal and Sheldon (2010) regarding the GPs' attitudes about the perceived inability of the NAPH to impact on the quality of the hospitals. This finding is also in accord with the previous studies on performance of the NAPH (e.g. Baghebanian, 2001; Arab et al., 2005; Raisi, 2006). Relevant literature on a wider scale, as explained in chapter three, provides mixed results. Some support the effect of accreditation on quality (e.g. Chen et al., 2003; Devers et al., 2004; Sunol et al., 2009) while others did not show any evidence of this improvement (e.g. Beaulieu and Epstein, 2002; Miller et al., 2005; Snyder and Anderson, 2005).

Given such perceptions, the natural reluctance of the members to spend their resources (e.g. time, money) on preparing for this programme seemed unavoidable and they hence felt justified for exhibiting symbolic compliance, as they needed the evaluation score. However, given the external (e.g. the legal coercion) and internal (from their managers) pressures the avoidance seemed impractical.

8.3.1.3. Theoretical interpretation of the gaming

Gaming is argued to lower the organisational performance and diminish the quality of services because of the inappropriate decisions taken by those involved (Kelman and Friedman, 2009). Although this study was not able to establish the direct adverse effects of these dysfunctions (i.e. the gaming) on the patients and on the quality of care, it did

conceptualise the possibility of the occurrence of such malfunctions in the hospitals as a result of the NAPH. In addition, as the facial expressions of the interviewees (particularly managers) showed during the discourse with the researcher, they were reluctant to disclose the gaming, due to it being unacceptable or a sign of hospitals violating the rules and requirements of the NAPH. Therefore, it is possible that not all the forms of gaming were disclosed to the researcher.

From a theoretical perspective (i.e. the Habermasian model adopted), the gaming represents those efforts and reactions by organisational systems (i.e. the hospitals) that are not apparently aligned with the societal healthcare lifeworld (Broadbent et al., 2001). Therefore, the foregoing malfunctions were labelled as gaming, by judging based on the requirements of the NAPH, which is the tangible manifestation of societal lifeworld in an ideal fashion (Broadbent, 1992; Broadbent et al., 2001). However, as the word 'ideal' conveys, a regulative mechanism is expected to reflect the lifeworld values (Broadbent et al., 1991), whilst the NAPH tended to feature constitutive attributes. The perceived rationales for the gaming indicated by the members also implied that they perceived the NAPH as not contributing to quality improvement practices in the hospitals. Such perceptions seemingly represent the situation predicted by Broadbent et al. (2001) where, from organisations' perspectives, steering mechanisms (i.e. the NAPH) have moved away from expressing the societal lifeworld, whereas the organisations (i.e. the hospitals) remained in concert with the related lifeworld. Basing this assumption on the perceptions of the hospitals might seem partial and one-sided, as the hospitals might naturally criticise this external PMS imposed on them (Mannion et al., 2005). However, the perceived constitutive qualities of the NAPH arguably increase the propriety of such an assumption in relation to this AP. Although the views of the authorities of the NAPH might contradict this finding, the hospitals are arguably in a better position to decide on the provision of quality services, in view of their direct involvement and contact with patients (Berwick, 2008). Scott (2009) found that clinician/patient-driven quality improvement practices showed stronger evidence of efficacy than manager/policy-maker-driven practices. As such, according to Casey (2010), valid performance measures are formulated based on the recommendations of frontline people. Therefore, the hospitals' perceptions of the nature of the NAPH seemed justifiable. This is also in accord with Laughlin (2007), who based a meaningful evaluation of external PMSs on the perceptions of the organisations under evaluation. Theoretically, these organisational (hospital) members are seen as the active

members of a society and capable of judging the merits of societal steering mechanisms – e.g. the NAPH (Broadbent et al., 1991). They are *de facto* both members of society and also directly affected by the mechanism.

As the above debate might imply, there could be seen a discrepancy in the perceptions of the hospitals' members and the authorities of the NAPH towards the ways of delivering and evaluating hospital services. This is also indicated by Jaworski and Young (1992) that the lack of goal congruency and information asymmetry between subordinates and their superiors could trigger dysfunctional behaviours among the former.

8.3.1.4. Causes of gaming

While the occurrence of gaming in the hospitals was the result of different elements, discussed above, the main causes of this phenomenon were found to be the attributes associated with the NAPH, which mainly included legal coercion, financial dependency and legitimisation. That is, the existence of these elements, when coupled with the abovementioned rationales of the hospitals, created a situation conducive to gaming in these organisations. They were the main reasons for hospitals' compliance with the NAPH, in accord with the findings of Pomey et al. (2010). However, unlike their study, which found different rationales in relation to various hospitals, the rationales of the compliance in the current research were observed in all the hospitals, albeit with varying levels of intensity in the different hospitals (e.g. teaching and NTHs). These elements were found to weaken the opportunity and ability of the hospitals to question and resist the very nature of this imposed steering mechanism (Dillard and Smith, 1999; Brennan, 1998). Oliver (1991) similarly attributes the same features to imposed institutional pressures requiring unreserved compliance from organisations.

8.3.1.4.1. Legal coercion

In the public sector, governments are believed to have a coercive power (i.e. legal mandate) over local organisations such as hospitals (Brignall and Modell, 2000; Modell, 2001). Habermas (1996, cited in Broadbent and Laughlin, 2005) emphasises the power and effect of law in steering organisations in the public sector. As such, the power of law

to command a wide-ranging compliance from organisations has been recognised by institutional studies (Scott, 2008b).

The imposition of the NAPH on hospitals, as its compulsory nature implies, was found to be an important cause of gaming (symbolic compliance) in the hospitals. The hospitals' inability or reluctance to comply with the NAPH, in the face of legal force behind this evaluation programme, drew the hospitals towards gaming. The findings uncovered various occasions when the hospitals were forced to show conformity merely because of their legal obligation to the NAPH's requirements. As documentary analysis revealed (MoH, 2004), the legal force behind the NAPH had created a situation conducive to coercive isomorphism, by forcing the hospitals towards a set of uniform rules and standards (Hassan, 2005).

Similar evidence has highlighted the effect of law and regulations on the reaction of organisations in the public sector, as follows. Regulative elements (including law) are recognised as fast-moving institutions (Roland, 2004) and hence easy to manipulate, which are highly likely to cause gaming and decoupling (Scott, 2008a). Modell (2002) found that the coercively imposed cost allocation techniques by governmental bodies encountered implementation problems. In addition, as Broadbent et al. (2010a) point out, the imposed regulatory mechanisms, leaving no choice for organisations, are more likely to precipitate resistance and gaming in organisations. As to accreditation, as the majority of existing programmes are of voluntary status (de Walcq et al., 2008), the literature is lacking evidence on the adverse effects associated with their compulsory nature.

The above discussion could be challenged by the necessity of governments' regulatory role in health care, given the critical importance of the services provided in this area and the prevention of possible malfunctions (Barnum and Kutzin, 1993; Gauld, 2005).

Nonetheless, the PMSs employed by the governments, as Broadbent et al. (1991) and Broadbent and Laughlin (2005) maintain, ought to have regulative attributes (e.g. consensually-based) if they are to have intended, rather than dysfunctional, effects on the organisations under their evaluation. The key factor is that the process of developing a PMS should undergo a discursive process (i.e. with mutual understanding) in Habermasian language. The importance of this point is that, as Broadbent et al. (2010a) put it, to an extent even PMSs could be compulsory, provided that their mandatory status is justified and agreed upon by the stakeholders (mainly the organisations under evaluation).

8.3.1.4.2. *Financial dependencies*

Another key factor which seemed to play an important part in causing gaming was the hospitals' financial dependency on the NAPH (and ultimately on the government). Davis et al. (2009) also found financial incentives overly influential in hospitals' participation in accreditation. The importance and effect of financial resources for HCOs are extensively recognised in the literature (Custers et al., 2007), and their positive effects on the achievement of organisational goals is echoed by various studies (e.g. Locke and Latham, 2002; Custers et al., 2007). Organisations are argued to show different responses and reactions towards the determinants of their requisite resources, given their critical importance for them (Reiter et al., 2006). The concept of pay for performance (P4P), introduced in the USA, encapsulates the implications of financial incentives for organisations' performance (Duckett et al., 2008). As such, it is argued that performance-based payment (PBP) is increasingly applied more in developing countries (Eldridge and Palmer, 2009).

According to resource dependence literature, organisations are more likely to comply with those on whom they are dependent for their resources (Pfeffer and Salancik, 2003). Broadbent et al. (2010b) similarly contend that the actions of the recipient organisations could be conditioned by the providers of their funds and resources.

Despite the impact of financial incentives on the promotion of quality care, unintended effects have also been attributed to this initiative in the literature (Goldman, 2006; Smith et al., 2008) which are specifically discussed here. For instance, it is argued that PMSs backed by high-powered incentives for their success and failure are highly likely to result in gaming (Bevan and Hamblin, 2009). This is similarly echoed in relation to health care by Smith (1995). In the current case-study, the hospitals under study were directly dependent on the NAPH for their financial resources, as the role of strong incentives for seeking and maintaining accreditation by HCOs is clarified (Mays, 2004). This dependence was more crucial because of the hospitals' perceived financial problems. Therefore, when the circumstances of non-compliance materialised (i.e. they were not able/willing to meet the requirements of the NAPH), while recognising the importance of obtaining higher grades for their (financial) survivability, they were highly likely to be drawn towards superficial preparation (i.e. gaming).

Alternatively, the effectiveness of financial incentives in improving performance is said to be low if the requirements appear unacceptable to organisations (Kelman and Friedman, 2009). Consistently, the evidence from this case-study showed that the unacceptability of the NAPH's requirements to the members led to gaming (not improvement), since the hospitals needed the financial support.

Some dysfunctional effects have been associated with the use of financial incentives. Although the introduction of these spurs was initially intended to trigger performance improvements in organisations (Ferreira and Otley, 2009), Locke and Latham (2002) argue that they might also somehow damage performance. That is, when organisations receive lower ratings, their goal commitment and performance decline as a result of poor financial status and reduced staff morale (Mannion et al., 2005; Bevan and Hamblin, 2009). A similar pitfall could be predicted for the NAPH in this sense (i.e. providing financial incentives for higher grades). When the hospitals earned lower grades, their financial situation automatically worsened, indicated as a punitive effect of APs (Davis et al., 2009). This could create a vicious cycle (Figure 8.1) in that a poor financial status might jeopardise quality improvement efforts in the hospitals and, accordingly, a low grade might follow. Since, according to the quality improvement officer of one hospital, the quality-related practices were perceived as second-class activities by the hospital authorities, there was a high possibility that a lower income for the hospitals leads to a reduction in the rate of investment in quality improvement. Consistent with this discussion, it was stated by some members (e.g. a member of a quality improvement office of one hospital) that the main reason for the abandonment of quality improvement efforts in the hospitals was the lack of financial support. This is echoed by Broadbent et al. (2010a) as the limiting power of the money, meaning that its shortage might influence the reflection of the lifeworld demands by organisations.

No evidence of reduced morale was, nevertheless, found as a result of the NAPH in the hospitals. One reason might be that there was no tangible link between the accreditation grade of the hospitals and changes in the financial status of individuals in the hospitals.

Another issue associated with financial incentives is their possible effect of diverting the hospitals from unmeasured practices to ones that would help them obtain the money, discussed earlier as tunnel vision (Custers et al., 2007; Bevan and Hamblin, 2009).

Moreover, the use of financial grounds for regulatory purposes is also questioned from a different perspective by Habermas (1987). He has argued (cited in Broadbent et al., 2010a) that using money as the focus in regulating organisations might run the risk of non-compliance by the recipients (i.e. the hospitals). That is, the recipient organisations could use the money for purposes other than reflecting societal lifeworld values, as requested by steering media. Dodd (1994) has expressed similar concerns about the reuse of money by organisations. Therefore, while the money's strength in enabling the change efforts should be also acknowledged (Broadbent et al., 2010b), the problem with the reuse of the financial resources might nullify this advantage in the hospitals, because of their mentality towards quality, as mentioned.

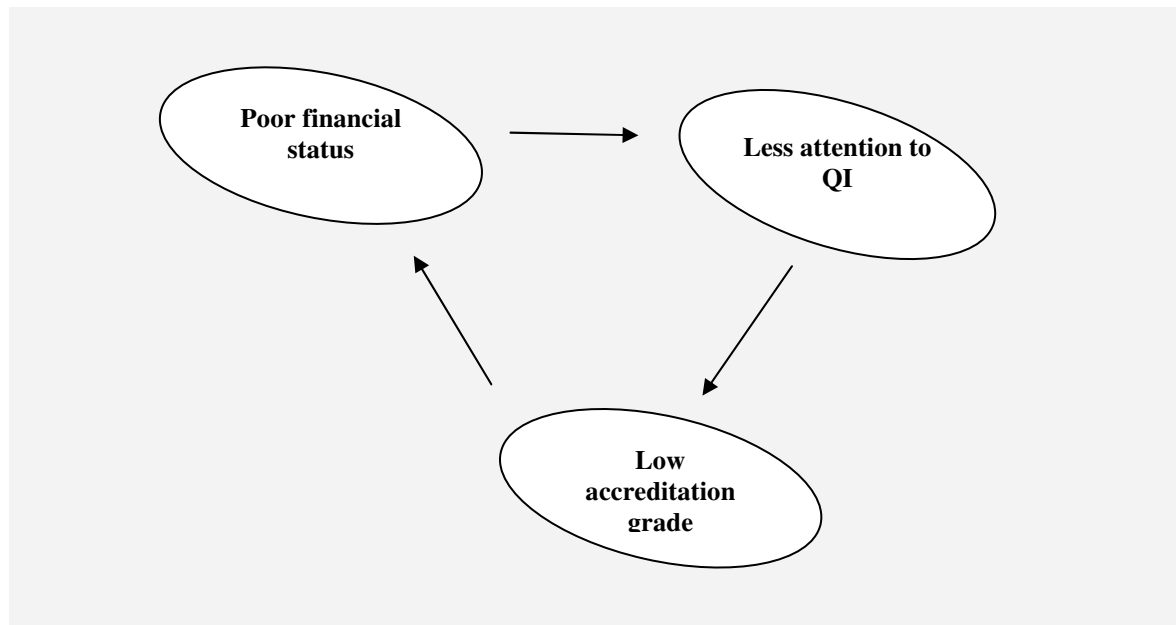


Figure 8.1 The relation of the effect of financial incentives on the quality improvement (QI) in the hospitals

These unwanted consequences might be a reason for Mays' (2004) recommendation that the financial incentives should be gradually phased out over time to evade adverse effects associated with short-term shifts in resources by organisations.

8.3.1.4.3. Legitimacy

The rationale of legitimisation, in the sense that public sector organisations might show compliance with the imposed institutional pressures to earn legitimacy, has been widely

discussed in the literature (e.g. Oliver, 1991; Chang, 2006). Ruef and Scott (1998) even place more importance on legitimacy in health care. They argue that, since the outcomes are often uncertain and difficult to assess in health care, the source of legitimacy could play a prominent role in enhancing public trust in HCOs. Legitimacy is defined according to Suchman (1995, p. 574) as ‘... a generalized perception or assumption that the actions of an entity (i.e. a hospital) are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs’. In Habermasian language, legitimacy is ideally obtained through compliance with the societal steering mechanisms that are supposed to be a manifestation of the societal lifeworld (Broadbent et al., 2001).

In the health system of the country the government was the guardian of the public interest in society. It has thus set up the NAPH, as a supposedly tangible manifestation of public norms and values in health care, to ensure the hospitals’ actions are within socially constructed norms (i.e. legitimised). However, whether the NAPH represented the public interests in health care remained in doubt, as the findings implied. The hospitals sought this legitimacy through complying with the requirements and earning an accreditation grade (see table 3.2, chapter three). Legitimacy here meant ‘the authorisation of the hospitals to provide quality services to the society as a hospital’. The efforts of the hospitals to avoid being downgraded to a ‘minor surgery centre/clinic’ (MoH, 1997a) underscore the importance of legitimacy for the hospitals. However, since the process of demoting a hospital to a clinic was a fairly lengthy and rare procedure, even more unlikely in the case of teaching hospitals, as the findings exhibited, the sensitivity of this factor in driving the hospitals towards gaming was lower in comparison with the previous factors, despite its apparent importance.

The NAPH was the main source of legitimacy for the hospitals; this is considered regulative legitimacy (Scott, 2008b). Other types of legitimacy (i.e. normative and cultural-cognitive legitimacy) were not apparent in the context. In fact, all three types were integrated in the regulative legitimacy represented by the NAPH. Therefore, Habermas’s interpretation of the legitimacy was found to be more suitable for the investigation of the legitimacy-seeking behaviour of the hospitals, because he recognises the regulative legitimacy (steering mechanism) as a manifestation of the normative legitimacy - i.e. lifeworld (Broadbent, 1992; Broadbent et al., 2001).

In summary, these three factors remove the possibility of ignoring the compliance, despite the perceived inability of this evaluatory mechanism to achieve quality improvement and that of the hospitals to meet its requirements. This finding is consistent with Chang (2006) on contradicting Oliver's (1991) assumption that local organisations' managers would be reluctant to conform to those requirements that are incompatible with the goals of their organisations. However, the results showed that, despite this perceived incongruence, other rationales forced the hospital managers to consider complying (either properly or symbolically) with the requirements of the NAPH.

8.4. Positive grounds for compliance

Apart from the above-mentioned elements which had the potential to drive the hospitals towards gaming, other factors were also found to play a part in stimulating and convincing the hospitals' members to consider (non-symbolic) compliance with the NAPH, without causing gaming. They included 'beneficial consequences' of the NAPH, the effects of 'religious values and altruism' and 'technical nature of the NAPH's requirements'. They were mostly seen among the frontline members who were more concerned with the care of patients.

8.4.1. Beneficial consequences

The dominant rationales for the hospitals' conformity with the NAPH were those explained as 'colonising features' of the NAPH. However, the perceived benefits of the NAPH were also said to be effective in encouraging the hospitals to comply with this AP. Although the existence of both positive and adverse effects associated with the NAPH might seem contradictory, steering mechanisms are argued to exhibit the characteristics of both regulative and constitutive mechanisms (Dillard and Smith, 1999; Broadbent et al., 2010a). These dual features of the NAPH are supported by the findings of Mannion et al. (2005), pointing to some perceived benefits of the NHS Star-rating system, despite its downsides. For example, they found that the poorly-performing trusts used the ratings to guide the development of their new performance management and reporting systems or as a mechanism for transmitting important priorities from central government (Mannion et al., 2005). These consequences were also supported by existing literature. For instance, the role of APs in identifying the problems of the hospitals was also found by Pomey et al.

(2010). As such, the NAPH also encouraged the coordination and communication in the hospitals during the stage of preparation for the survey and for making the corrective actions (Pomey et al., 2004).

8.4.2. Religious values

The effect of religious values and altruism was also seen to encourage compliance with the NAPH among the hospitals' members in the sense that it could assist them to accelerate and improve the process of curing the patients. Traditionally, there has been a religious and humane facet attached to curing patients (George, 2003). This was, to some extent, the case in the context of the current research (MoH, 1997b). The members tended to comply with the NAPH on the grounds that it could improve the quality of care and consequently accelerate the treatment of their patients, which seemed religiously rewarding for them. Given the religious context of the country, it was usually advised that the related actions be justified from a religious perspective and be in harmony with religious teachings. As such, a number of spiritual precepts regarding healing and helping patients to recover were displayed on the hospitals' notice boards and could be seen in the different instructions (e.g. MoH, 1997a, 1997b). These efforts were understood as very rewarding and motivational for the hospitals' practices. Moreover, more than nine per cent of the entire set of the NAPH standards was related to the observation of 'religious and ethical values' by the hospitals (see table 3.1 chapter 3). With this in mind, such a rationale might not seem surprising. This debate is generally consistent with Jayasinghe and Soobaroyen (2009) whose study found religious spirit as an integral and important part of accountability in non-western societies.

As the findings showed, this rationale was mostly raised by those in direct contact with patients (e.g. head nurses). Similar evidence is reflected in the literature by Hamblin (2008, p. 292), emphasising the importance of 'altruism' as a reason why healthcare providers might consider reacting to PMSs' demands. Aryankhesal (2010, p. 265) similarly found that some head nurses in the hospitals raised 'the increased patient satisfaction' as their incentive for obtaining a good accreditation grade. Furthermore, the religious values were also found to have another effect on the compliance of the hospitals. The findings showed that the reaction of the hospitals' members towards religious-related standards tended to be largely passive, i.e. receptive. They manifested less objection to and criticism of these standards. The high scores by the hospitals for this item also provided a confirmatory sign

for this assumption (stated by the surveyors). Furthermore, the high proportion of the total score allocated by the authorities to these values could signal their critical importance for the government. The reason, as expressed, was the spiritual nature of these values as well as the government's sensitivity about them. A theoretical justification for this compliance might be the alignment of these values with the religious orientation of the hospitals' members. It might be called goal congruency (Oliver, 1991), or structural coupling between the ISs of the hospitals' members and related societal lifeworld in Habermasian language (Broadbent et al., 1991).

8.4.3. Scientific and technical nature of the requirements

The scientific and technical nature of some standards of the NAPH also apparently reduced the extent of the resistance in relation to which the hospitals gamed. As it appeared, some standards were developed based on scientific and up-to-date evidence; when communicated to the hospitals, these standards boosted their compliance and triggered positive attitudes and reactions towards those requirements. Similar evidence by Hassan (2008) showed that technical boost in the knowledge of organisational members triggered by specific requirements facilitated their adoption by the organisations. The hospitals were informed about the process of the development of the standards and of their basis in scientific evidence. These reactions were mostly associated with the recent modifications in the standards of the NAPH and the addition of a new set of 'quality-oriented' standards (MoH, 2004). The majority were developed based on scientific evidence and had a purely technical content, as their guidelines explicitly asserted. They were related to practices such as prescription of specific medicine for patients.

8.5. Perspectives on the professionals' position in the HCOs

A wide range of studies has highlighted the critical role and importance of professionals in the healthcare area. For example, Abernethy et al. (2007) point to the existence of multiple points of power and decision-making in HCOs. Campanale et al. (2010) argue that management and decision-making processes in hospitals are strongly influenced by professionals and their autonomy. Mintzberg (1979, cited in Aidemark and Funck, 2009) maintains that the traditional and administrative forms of control, such as budget, are

ineffective for controlling the work of professionals in healthcare, since they might not be able to represent the complexity in their tasks. Accordingly, Abernethy and Stoelwinder (1990) and Touati and Pomey (2009) indicate that professionals will accept a standard-based system (e.g. accreditation) if they agree upon and if it originates from their expertise. Funck (2010) stresses on the significance of professional values and norms for control of HCOs as opposed to performance measurements focusing on controlling behaviour or output.

This case-study also found that the physicians were known as an influential group in the hospitals by the managers and other departments, and their non-cooperative behaviour was considered a noticeable cause of low efficiency of internal MCSs (i.e. DAs) in the hospitals. Consistent with Pomey et al. (2010), this study also found that the physicians were failing to comply with the requirements of the NAPH. In fact, the NAPH was interpreted by the clinicians as an administrative rather than a clinical improvement initiative which should be operationalised by administrative members, concurring with the studies such as Abernethy and Stoelwinder (1990) and Pomey et al. (2010) in this sense. Such a perception by the physicians might be a sign that they mostly showed an inertial response to the NAPH (Larrinaga-González et al., 2001).

8.6. The NAPH as an external disturbance

In the existing literature (e.g. Laughlin, 1991; Broadbent and Laughlin, 1998; Broadbent et al., 2001; Broadbent and Laughlin, 2005; Broadbent and Laughlin, 2010a), the word disturbance implies that the requested change or requirement is not considered as desirable for the subject organisation. It is argued that the external PMSs, aiming to correct and improve the activities of organisations, could also be considered as a disturbance (Gray et al., 1995; Greenwood et al., 2002). This is largely, as Laughlin (1991) and Broadbent and Laughlin (2005) note, because organisations are naturally predisposed to inertia. On this reasoning, this section elaborates on the perceived features of the NAPH as an external PMS, rendering this evaluatory mechanism as a ‘disturbance’ for the hospitals (Laughlin, 1991, p. 209).

Most of the studies utilising the regulative and constitutive concepts (Broadbent et al., 1991; Broadbent and Laughlin, 2005) have focused on the incompatibility of transposed

societal steering mechanisms with the values of targeted areas (e.g. education or health) or organisations. Relying on such a rationale, they have recognised the mechanisms as constitutive (see e.g. Lawrence, 1999; Lawrence and Sharma, 2002; Dillard and Yuthas, 2006). In accordance with the language of communicative action⁴⁰ (Habermas, 1984, 1987), which is the origin of the adopted theoretical models (i.e. Broadbent and Laughlin, 2005), the main determinants of a regulative (vis-à-vis constitutive) mechanism are virtually the principal features such as being consensually-based, chosen, and understandable to those under its evaluation, as discussed in chapter five (Broadbent et al., 1991; Broadbent et al., 2010a; Broadbent et al., 2010b). As such, Broadbent (1998) makes plain that agreement on and acceptance of the mechanisms by stakeholders are essential for a regulative mechanism in the light of communicative action. As argued, insofar as a steering mechanism such as the NAPH is developed or adopted based on these features of communicative action (Broadbent et al., 2010a), it is more likely to represent a regulative mechanism. Broadbent et al. (2010a) affirmatively stress that if a compulsory (imposed) mechanism, potentially constitutive, is agreed upon and chosen to be mandatory by its stakeholders, it could be assumed to be a regulative mechanism. This statement emphasises the importance of these key features for judging the merits of societal steering mechanisms. Broadbent et al. (2001) further predict the possibility of diversion of steering mechanisms from the lifeworld.

APs (e.g. the NAPH), unlike other quality measurement and improvement systems such as TQM, ISO and EFQM, are formulated inside health care (Shaw, 2000). However, as the findings from the current case-study showed, the mode by which the NAPH had been developed and implemented did perceivably qualify this steering mechanism as a constitutive mechanism. The NAPH did not apparently have the features of a regulative mechanism. In fact, the shortage of related characteristics and specific defects associated with them (see 6.4, chapter 6) was a substantive factor which caused this mechanism to appear as a disturbance to the hospitals. The NAPH also had a different set of requirements (Table 3.1, chapter two). Consequently, given their nature, the varying reactions and rationales could have been anticipated from the hospitals.

⁴⁰. Communicative action is defined as an action motivated by communication aimed at mutual understanding (David, 2007).

8.7. Reactions and rationales of the hospitals towards the NAPH

The reliance on the reactions representing the changes in the hospitals was another alternative pursued by this study to assess the performance of the NAPH. As elucidated in chapter four, different reactions (e.g. rejection) *de facto* represented the various changes in three main elements of the hospitals (i.e. ISs, DAs and subsystems) while they attempted to meet the requirements of the NAPH. The changes triggered by APs in HCOs are evidenced in the literature (Nicklin and Barton, 2007; Pichoir-Drew, 2005; Pomey et al., 2004; Pomey et al., 2010; Braithwaite et al., 2010; Sunol et al., 2009b). A majority of these studies are, nonetheless, conducted in developed countries (e.g. mainly in Canada). They have not further uncovered the effects of these programmes separately on the hospitals' values, internal PMSs and workings, as this study was allowed to do in the light of its adopted theoretical framework. However, the findings of this research are consistent with these studies in that the changes instigated by APs mostly happen in preparation and also post-accreditation stages as a result of remedial recommendations offered by the programmes (Pomey et al., 2010; Braithwaite et al., 2010). The reactions and underlying rationales are, in turn, discussed below.

8.7.1. The reactions of the hospitals

The reactions of the hospitals to the NAPH took different forms, as explained in chapter six. Obviously there was no possibility of the hospitals ignoring the requirements of the NAPH, implying that the inertia could not be seen in the context (Larrinaga-González et al., 2001).

8.7.1.1. Rejection

The rejection of the requirements was to some extent present among the hospitals, despite the fact that the NAPH was a compulsory regulatory mechanism. This reaction by the hospitals took place after the on-site survey, seemingly due to the lack of a comprehensive unannounced visit by the surveyors (Aryankhesal, 2010). This also concurs with Nicholas (1999) who argued that HCOs might only comply with standards at the time of the accreditation survey. Pickering (1995) has similarly acknowledged the inability of APs to detect wilful fraud by hospitals. Although the rejection of the requirements happened in

accord with Broadbent and Laughlin (2005), it did not happen in an explicit way, but through gaming (i.e. showing symbolic compliance). This was because, as Gray et al. (1995) also argue, the hospitals could not afford to directly rebut the NAPH's requirements. This reaction is further in agreement with Scott (2008a) who recognises the possibility that a regulative institutional element (i.e. backed by law) might give rise to non-conformity by organisations. In contrast, it contradicts the perspectives of classic institutional theorists, predicting mere compliance towards regulative institutional pressures (e.g. Selznick, 1949; Meyer and Rowan, 1977, cited in Scott, 2008a). The gaming that occurred in the hospitals, as explained before, was seen as a reaction by the hospitals to the NAPH. The occurrence of gaming is not recognised in the model of Broadbent and Laughlin (2005) during the rebuttal reaction. The hospitals could reject some requirements after a period of symbolic compliance (i.e. gaming) during the on-site survey, unlike the compulsory nature (strength and forcefulness) of the NAPH (Richardson et al., 1996).

The findings also revealed that the hospitals showed different reactions to the various requirements, owing to the wide range of the NAPH's requirements for the hospitals (see table 3.1, chapter 3). Unlike what has been argued by Laughlin (1991), the reaction of rejection did not turn into the absorption; rather, these reactions existed alongside each other depending on the nature of the requirements (i.e. some requirements were rejected and some absorbed). In addition, the changes under this reaction took place in both DAs and subsystems, not just in the DAs as Broadbent and Laughlin (2005) predict. In fact, only the changes occurring in the subsystems were declined while the changes in the DAs remained untouched (see section 7.2.4.1). In view of these features, the given reaction did not match either of Laughlin's and might be placed somewhere between the rebuttal and reorientation pathways of Laughlin (1991), in terms of the changes in the hospitals' different aspects.

8.7.1.2. Absorption

The dominant reaction was, nevertheless, the absorption (i.e. reorientation) of the perceivably unwanted requirements of the NAPH (Larrinaga-González et al., 2001). The fact that the most frequently raised reason by the hospitals for compliance with the NAPH was perceivably its economic gains could to a large extent confirm the existence of this

reaction in the hospitals (Agrizzi, 2008). This reaction *de facto* implies that the respective requirements were not perceived as desirable by the hospitals, yet were absorbed reluctantly to avoid the possible resultant punitive consequences for the hospitals in the event of rejection. A refusal to implement the requirements by any given hospital could result in the hospital being branded as substandard, which would have major financial and non-financial implications (i.e. legitimacy issues) for the hospitals, such as a change in their status (becoming a clinic) as well as in their income. In fact, it seemed the value of the rejection, as claimed, was a great deal less than absorption for the hospitals in relation to the requirements in this stage and, by containing the requirements, the hospitals' survivability could be assured (Larrinaga-González et al., 2001).

While this finding concurs with Laughlin (1991) and Broadbent and Laughlin (2005) emphasising that safeguarding their status (i.e. legitimacy with public and government) led to the absorption of the unwanted demands, it also identifies other rationales (e.g. financial grounds), because of which the hospitals decided to internalise the requirements. In fact, as the findings revealed, the effect of financial gains was more prominent in showing such a reaction by the hospitals as it seemed more tangible and influential in the hospitals' daily activities, given their financial problems. In this sense (i.e. the compliance of organisations with external pressures to earn economic benefit and legitimacy), this finding is further in line with institutional theory literature (e.g. Scott and Meyer, 1983; Oliver, 1991; Chang, 2006). Besides those rationales, the impossibility of refusing the requirements (i.e. the transition towards reorientation) also stemmed from the nature of some of the NAPH's demands, which could not be rejected. That is, the findings indicated that they were extensive, critical and highly-monitored demands. As Laughlin (1991, p. 218) similarly emphasises: '...ideally the disturbance [the unwanted requirements of the NAPH] should be rebutted but, to the extent that it is impossible, the next best thing is to internalise ...'

The changes in this stage involved both the DAs and subsystems of the hospitals (Dumay and Guthrie, 2007). The findings showed that the hospital committees were developed under the requirements of the NAPH to diffuse the requirements across the workings of all departments; *inter alia*, a bespoke committee for evaluation and supervisory activities in the hospitals was specifically created in relation to the NAPH. Similar studies found the absorption of the imposed changes by the GP practices in the NHS (e.g. Broadbent and Laughlin, 1998; Broadbent et al., 2001). Nonetheless, in the current study the hospitals

tried to absorb the unwanted changes for a different reason than those of GP practices, which was, in the main, the incompatibility with their professional values.

A distinction could be made between the absorption reaction in the current study and one suggested by Laughlin (1991) and Broadbent and Laughlin (2005). Similar to their argument, the findings showed that the hospitals absorbed, reluctantly, the unwanted requirements, when they were not able to reject them. However, the difference lies in that, according to their statement, the requirements are absorbed until their repercussions for the core values of organisations are restrained. Conversely, in the case of the current study, the absorption was assumed because the hospitals tended to benefit from the advantages (e.g. economic gain and legitimacy) resulting from this reaction (Gray et al., 1995), as the rejection of the requirements could endanger their survivability as a hospital (i.e. legitimacy with the government). In fact, the absorption of those requirements was not perceived as damaging to the core values of the hospitals, as the findings showed (section 7.2.4.2), and there emerged no fear of any change in their general identity and ethos caused by the absorption.

8.7.1.3. Submission

Another response to the environmental disturbance is argued to be submission (colonisation) in that the given organisation completely surrenders to the values exerted by the disturbance. That is, following the changes in subsystems and DAs (tangible and quasi-tangible elements), the intangible parts of organisations will also be transformed (Broadbent and Laughlin, 2005). This reaction is assumed to be highly likely in response to an imposed disturbance (Laughlin, 1991). It embodies shifts in the ISs (e.g. values, beliefs) of organisational members and brings a new ethos and identity to the given organisation (Laughlin et al., 1994b).

Evidence from the current study showed that the main values and mission of the hospitals remained largely unchanged. At the highest levels of the hospitals' ISs, namely, metarules (Broadbent, 1992), the clinical dominance (conventional culture of HCOs) was preserved and the hospitals were still recognised generally as places for the provision of quality care. However, at lower levels of the ISs (Richardson et al., 1996), despite their belief in the importance of the external assessment of their hospital, they manifested different attitudes and rationales for their conformity to the NAPH, as an external quality improvement

programme. They believed it was not the capability and merits of the NAPH (as reflected in the ISs of the MoH) but rather its financial benefits (alternatively, the fear of losing them), legal coercion and the members' fear of their managers that drove the hospitals towards compliance with the NAPH (Gray et al., 1995; Larrinaga-González et al., 2001). That is, the hospitals conceived the NAPH as a financial element rather than a performance assessment and improvement programme. The financial problems of the hospitals and their financial dependence on the NAPH seemingly facilitated and assisted with the formation of this mentality among the hospitals' members.

In fact, the hospitals' main rationale for absorbing the unwanted requirements of the NAPH (i.e. grasping the financial gain) gradually created an environment oriented towards business culture (Dillard and Smith, 1999), particularly when it had the managers' strong backing. Such culture was essentially against the overall ISs of the hospitals. The managers were the main incumbents and key decision-makers (Pettersen and Solstad, 2007)⁴¹ who had to ensure the requirements of the NAPH were met. Accordingly, when this responsibility was coupled with their administrative power and financial responsibility for the hospitals as well as with the beneficial consequences of the NAPH, a tendency to press the subordinates towards compliance (submission) became highly likely among the hospital managers. The strong power of the managers in instituting such alteration and deciding on the occurrence of the changes in the hospitals was recognisable (Greenwood and Hinings, 1996; Richardson et al., 1996). The key role of strong groups inside organisations in increasing the rate of changes is similarly also highlighted by various studies (e.g. Dumay and Guthrie, 2007; Gurd, 2008). These shifts in the attitudes of the members following the absorption of the requirements and under the influence of the managers is consistent with Laughlin (1991) and Broadbent and Laughlin (2005).

The NAPH was also seen as a biased means of quality improvement by the hospitals. This impression, largely seen at inter-hospital level among the NTHs, was also against the ISs of the MoH (MoH, 1997a).

These issues were found to be out of line with the values (i.e. the ISs of the MoH) behind the establishment of the NAPH (i.e. quality improvement), according to the existing

41. Key decision-makers are described as 'those who exercise the power to decide on the use of resources and the performance of services' (Pettersen and Solstad, 2007, p. 135)

documentation (Moghimi, 2004, MoH, 2004, 2008). Therefore, the aforementioned cases show that the hospitals have developed different internal attitudes and beliefs from those expected by the steering institution (i.e. MoH) towards this AP. These values might allude to some shifts in the attitudes of the hospitals' members as a result of their evaluation by the NAPH over time. Relevant examples regarding these shifts were provided previously (see e.g. sections 6.4.3 and 6.5.3.2). However, as the findings suggested, the overall ethos of the hospitals was found to be fairly unchanged (i.e. their changed beliefs had not apparently affected the hospitals' metarules and overall purposes). Therefore, the change could not be conceived as a second-order colonisation pathway in the sense of Broadbent and Laughlin (2005)'s model. Two possible justifications might be put forward for this assumption:

First, the NAPH was grounded in the same values as the hospitals. As explained previously, the NAPH - as an AP - was developed in line with the overall features and guidelines of the healthcare system⁴² (Shaw, 2000). The core of mission and targets set out originally for the NAPH (i.e. quality improvement) were aligned with the goals and values of the hospitals (MoH, 1997a). The NAPH was not meant to import new values into the hospitals. However, the way it was operationalised (developed and implemented) along with its features was not welcomed by the hospitals and they perceived that the NAPH was not able to improve quality. Accordingly, it could be argued that the main elements of its requirements were not chosen and embraced, but rejected or absorbed.

The second factor was thought to be the presence of the physicians in the hospitals, who traditionally have the potential to create an 'occupation imperialism' (Laughlin et al., 1994b, p. 122) and strong professionalism (Abernethy et al., 2007) in the hospitals. They were the most powerful group and the least influenced by the NAPH and the hospital managers, as the findings revealed. They seemed to act as an anchor for the hospitals, keeping their original values intact.

To sum up, given the above discussions, the following insights could be provided into the argument presented by the model of Broadbent and Laughlin (2005) regarding the colonisation change pathway (i.e. submission reaction) in the light of evidence from the current study:

⁴². Unlike other mechanisms such as TQM and BSC which are originated from the industrial sector.

Firstly, despite the transitions in the beliefs and attitudes of the members, the hospitals' ISs did not change into the completely different ones and there was no shift of the ISs in the sense Broadbent and Laughlin (2005) argue. Therefore, the changes could not be labelled as morphogenetic (Broadbent and Laughlin, 2005). They could instead, as pointed out by Gray et al. (1995), be morphostatic colonisation. Affirmatively, Levy (1986), Larrinaga-González et al. (2001) and Tyrrall and Parker (2005) dismiss the idea that the changes in the beliefs (the lowest level of the ISs) of the organisational members could lead to a morphogenetic change.

Secondly, unlike Broadbent and Laughlin's (2005) colonisation pathway which arguably follows a change in the DAs and subsystems of organisations, the evidence from this study shows that the shifts in the attitudes of the hospitals' members towards the NAPH were not affected and caused exclusively by its change effects on the hospitals' DAs and workings (Gurd, 2008). They were instead formed, as Gray et al. (1995) also put it, by the people's feelings and perceptions towards the features of this accreditation mechanism. For example, the perceptions of the NTHs of the biased evaluation of the NAPH or the members' compliance through fear of their managers were influential in their changed values. The fact that the NAPH was a mechanism which was developed centrally and which ignored their feedback persistently (i.e. constitutive features) seemed to contribute, to a large degree, to the formation of such thoughts among the members.

Thirdly, the issue of perceived fragmentation observed in the beliefs and cultural level (Broadbent, 1992) of the different groups in the hospitals is not reflected by Laughlin (1991) and Broadbent and Laughlin (2005). They have predicted shared values at all levels of the ISs. This discrepancy could also be compatible with the fact that hospitals are professionalised organisations composed of various groups with different culture-orientations and interests (Anderson and McDaniel Jr, 2000; Riley et al., 2009). In fact, the members' reaction and response to the NAPH was determined by their values and beliefs (Zakus and Skinner, 2008). However, the integration at the hospitals' metarule might be because it forms the hospitals' overall picture at organisational level, which is beyond the individual orientations and interests of the members. In addition, the mission and values of the public hospitals were found to be largely formulated under the influence of the MoH and the HUMS (Tyrrall and Parker, 2005). As for the private hospitals, it seemed they needed to at least display such an image, albeit symbolically, to receive authorisation from the government.

8.7.1.4. Adoption

This pathway represents the situation in which organisations embrace the change requirements (Haigh and De Graaf, 2009). While the NAPH was an imposed mechanism, the evidence from the study showed that the hospitals adopted some parts of its requirements and benefited from their effects. The nature of the hospitals' rationales for adopting the requirements was an important indicator for distinguishing this reaction from the absorption and submission (Larrinaga-González et al., 2001). The findings illustrated that the application of the requirements, as far as the adoption reaction was concerned, proceeded entirely because of the merits of the requirements, as perceived by the members at the time of their application. In contrast, in the case of other reactions such reasons as the financial benefits of the NAPH took priority for the hospitals. In fact, the beliefs and reasons behind the reactions of the hospitals to the requirements were crucial. That is, the reaction may have been a result of the hospitals' fear of losing their legitimacy or financial benefits (as in the case of reorientation and colonisation) or their belief in the requirements' ability to improve their practices through adding to their knowledge or because they were in line with their values, as seen in the current study (as to the evolution).

A noticeable feature (i.e. newness and scientific nature) was attached to the requirements presented for adoption. Diverging from the argument of Broadbent and Laughlin (2005), this reaction (i.e. evolution pathway) was developed in the hospitals without any discursive process among the hospitals' members (Gray et al. 1995). A boost in the knowledge level of the members as a result of the requirements seemed to facilitate the members' acceptance of them. The scientific content somehow improved the level of the members' knowledge, which could be envisaged as an allusion to some (intended) alterations in the members' ISs (Hassan, 2008); this is consistent with the evolution pathway of Broadbent and Laughlin (2005).

In addition, the requirements relating to the religious and ethical values were found to be adopted, as such, without undergoing any discursive process. The findings reported that a majority of the hospitals' members did not conceive that they could or should challenge these requirements, regardless of the legal force behind them. Indeed, the spiritual and humane nature of the requirements was claimed as the main rationale for their adoption. The hospitals did not perceive these sorts of requirements as undesirable and, as such, their

rationale for compliance with them was found to be positive. As explained earlier in section 8.4.2., the spiritual nature of these demands seems to be compatible with the religious context of the country.

As explained before, the NAPH was a programme imposed on the hospitals and no free discourse was possible on whether to accept or reject its requirements. Therefore, the change tracks resulting from these requirements which were accepted (welcomed) and thought to be for the good of the hospitals seem to be different from the evolution pathway of Broadbent and Laughlin (2005). They instead side more with the pathway of ‘positive inner colonisation’ by Laughlin (1987, p. 485) or ‘forced evolution’ by Dunphy and Stace (1988, cited in Tyrrall and Parker, 2005, p. 510). Laughlin (1987, 1991) has argued that, in the latter situation, the colonising challenges are welcomed or deemed to be for the good of the organisations. Therefore, it could be alleged that the evolution pathway, as in the sense of Broadbent and Laughlin (2005), has not occurred in the hospitals for a number of reasons. First, there was no free discourse in the hospitals about the requirements, as explained. Second, the embraced changes did not involve every part and the member of the hospitals. In fact, hospitals normally include a range of professionals with different areas of expertises and orientations (Pomey et al., 2010). Therefore, a discursive process among all of their members might be a challenging task, as Zakus and Skinner (2008) also point to the failure of Broadbent and Laughlin’s framework in attending to different needs and interests inside organisations. As such, achieving an organisation-wide consensus might seem practically difficult in such organisations. Therefore, the evolution pathway found in the current study might be labelled a morphostatic type of evolution pathway (Gray et al., 1995).

8.7.2. The rationales behind the hospitals’ reactions

The reactions of the hospitals, as discussed in previous chapters, represented different change implications inside the hospitals. Overall, along with the constitutive features of the NAPH such as the failure to be a consultatively-driven (i.e. persistent ignorance of the hospitals’ feedback) and consensually-based evaluatory mechanism, some dissatisfaction surfaced with this external PMS among the majority of the hospitals’ members. This accordingly gave rise to the reactions such as rejection and absorption or dysfunctional consequences (e.g. gaming), as explained. With the various groups working in hospitals

with different orientations and interests (Pomey et al., 2010), the varying rationales for the reactions might be inevitable. The reasons the hospitals react in such ways are discussed briefly as follows.

- *The rebuttal reaction*

The main reason why the hospitals manifested the reaction of rejection was the fact that the members did not perceive the specific requirements as a priority for their hospitals. In fact, the basis of such a perception was partly the clinical judgement of the members (e.g. heads of EDs) in that they did not believe that their non-conformity would reduce the quality of the care or damage their patients. In addition, this reaction was also reinforced by the managers, because of the inability of their hospitals in terms of their financial and human resources (intra-organisational factors) to fulfil those requirements (Greenwood and Hinings, 1996). They acted as a deterrent factor which made conformity with the (justified) requirements of NAPH a complicated matter. This incompetence was a further rationale for rejection itself. The findings identified the situations in which the (teaching) hospitals rejected some requirements only because they were not able to meet them. The findings showed that there was a feeling of apathy among these hospitals toward meeting the requirements.

- *The reorientation reaction*

There were different reasons for the hospitals being dragged towards absorbing the perceivably unwanted requirements. The apparent reason for absorbing the unwanted requirements was because the hospitals could not reject them, given their nature (e.g. the strength and forcefulness). However, the underlying rationale for such a reaction, as realised, was the tendency of the hospitals to earn economic gains as well as sustaining their survivability and legitimacy to remain as hospitals (Gray et al., 1995). In addition, some beneficial consequences of the NAPH were also influential in the hospitals' reaction (e.g. 'being a lever to exert pressure on the higher-up authorities' to consider the problems of the hospitals or allocate higher fixed budgets), as discussed before (see section 6.6.2, chapter 6). This rationale showed that, while the hospitals were not able to reject the NAPH's requirements, they tried to take the greatest advantage from absorbing the requirements. They applied the requirements reluctantly, until they could earn other benefits.

- *The submission reaction*

The main rationale behind the submission of the hospitals to the requirements of the NAPH, similarly to the absorption reaction, was their overall fear of losing its benefits (e.g. legitimacy and financial gains). However, as discussed earlier, when such fear was fuelled by the pressure from the hospital managers to comply with the NAPH, the principal factor in effecting changes in the beliefs of the hospitals' members materialised.

- *The adoption reaction*

Although the merits of the NAPH were not prominently mentioned as a reason for non-symbolic compliance by the hospitals with this mechanism, evidence was found of some requirements which were embraced by the hospitals. The rationales of the hospitals' reaction to this group of requirements appeared to be different from other reactions, as the findings illustrate. Two main features of these requirements which were influential in their adoption included their technical (scientific) and religious natures. The beneficial effects of the NAPH could also be considered as further rationales for the adoption reaction of the hospitals.

8.7.3. The implications of studying the rationales

The study of the grounds underlying the reactions of the hospitals to the NAPH was important in the sense that they could guide the researcher towards the contextual aspects associated with the NAPH which prompt these specific reactions. They could further clarify whether the conformity of the hospitals to the NAPH has been exclusively because of its quality improvement capabilities. This is of critical importance, since quality measurement and improvement have been the main preset objectives of the NAPH, according to the relevant policy documents (Moghimi, 2004; MoH, 1997a; 2008). Therefore, the rationales could help judge the merits and performance of the NAPH based on the views of the hospitals' members, arguably the group whose perspectives are the most reliable for assessing the programme's effectiveness (Barker et al., 2004, Laughlin 2007, Casey, 2010).

The most notable rationale of the hospitals according to the empirical findings was 'increased tariffs for the hospitals' services' as a result of the accreditation award. This was more crucial because of the hospitals' financial dependence on the HUMS and ultimately on the MoH. Findings overall showed that the rationale of 'economic gains' was

more important than other rationales for the hospitals, which seemed unsurprising, given the hospitals' frequent references to the 'financial issues' as their foremost problem.

Even though the legal coercion and financial benefits were set by the authorities to encourage the hospitals to comply with the NAPH (MoH, 1997a; Majlis, 1987), these rationales were not to be the main drivers behind the hospitals' compliance with the NAPH as the societal lifeworld indicates; reflected in the policy documents of societal steering medium and mechanisms (i.e. the MoH and NAPH). Instead, the quality improvement power of the NAPH has been set to be the main reason for the hospitals to comply, while it was not seen to be as effective as other grounds in practice. In fact, considering the importance order of the rationales in the hospitals' compliance, the occurrence of gaming could be predictable, since the hospitals were keen to achieve the financial benefits. Therefore, this insight could be a clear indication to the policy-makers to revisit the effectiveness of this AP and consider ways to minimise the repercussions of the NAPH.

Hamblin (2008) points out that an intelligent design of measurement schemes could discourage perverse responses by organisations. According to the results of this study, the main feature which apparently needs to be considered for the intelligent design of the NAPH is the frequent consideration of the hospitals' feedback in different stages of the initiation, development and improvement of this accreditation programme. The findings revealed that the permanent ignorance of their feedback as well as the unchanged status of the NAPH over the years seemed to be the root cause of most unintended and dysfunctional behaviours on behalf of the hospitals in relation to the NAPH.

In addition, the authorities could recognise the real merits of the NAPH and strengthen the positive and beneficial effects of the NAPH under the hospitals' critical eye.

In summary, as discussed earlier, the rationales were extensive and interrelated. They varied among different groups of staff. For instance, (senior) managerial people were mostly inclined towards economic gains as their rationale for compliance, which seemed natural because of their responsibilities, while clinical and frontline staff members were largely in favour of quality improvement as their motives, as explained earlier. Despite their own motive, the clinical people also thought that the main rationale of hospitals' managers was the financial benefits of the NAPH for the hospitals.

Chapter 9 - Final Considerations: Concluding Discussion, Research Implications and Limitations

9.1. Introduction

This final chapter aims to present an overview of the main issues addressed in this study. Accordingly, it firstly outlines the steps taken in the study and highlights and reflects on its key findings in order for illuminating its contribution to the literature in concluding discussion. Then, the theoretical insights and implications are explained in the light of the study's empirical investigation and theoretical frameworks. Next, the policy implications are explained and suggested for the improvement of the current accreditation system. Thereafter, the limitations of the study and the research avenues for further research are outlined followed, by final consideration of the research.

9.2. Concluding discussion

This study has sought to develop an understanding of the micro effects of macro performance control and evaluation mechanisms (i.e. MCSs/PMSs), based on the evidence from the critically-known area of health care and rarely-explored context of a developing country. It is a problem-oriented study (see chapter one) whose main motivation has been to explore and analyse the perceptions and reactions of local hospitals towards the implications of Iran's national accreditation programme, identified as a 'macro steering mechanism' in the light of Broadbent and Laughlin's (2005) refinement of Habermas's model of societal development. This is to show how local organisations (e.g. the hospitals) react to the actions of the macro steering mechanisms (e.g. the NAPH) seeking to control and evaluate their performance on behalf of societal steering institutions (e.g. the MoH).

The steps taken in this study commenced by conducting an extensive literature review upon the measurement of performance in the public sector (particularly, health care). This process culminated in the identification of a gap in the literature regarding a shortage of studies on the performance measurement in the healthcare area in developing and underdeveloped countries. Any effort to fill such a gap could be argued to be justifiable given the importance of contextual factors. In fact, this research intended to contribute to the wider literature of performance measurement and management (PMSs/MCSs) in developing countries considering their contextual distinctiveness and shortage of similar studies. Iran, as a developing country, was selected in the next step and the NAPH, a national and sole PMS in the country's health system, was chosen to be the subject of the study. This selection was mostly because of its crucial position in the country's health system, a lack of related studies on its performance and its perceived deficiencies, according to the researcher's primary investigation and the existing scant literature.

Then, the philosophical perspective of the study and appropriate theoretical frameworks to address the phenomenon under study were clarified. Following decision on the research design and data collection methods in the light of the adopted theoretical frameworks, the data collection stage began, taking around six months. The data analysis was undertaken next, followed by the final stage which was to set out the results and discuss their theoretical and practical implications.

Overall, several key issues emerged from analysing the empirical findings of the study (see chapters six and seven) of which those with deeper significance are explained underneath to clarify the contribution of the current study to the public performance measurement and management control literature.

9.2.1. The perceived nature of the NAPH

As elucidated in chapter six, the theoretical notions of 'constitutive and regulative' (Lawrence and Sharma, 2002; Broadbent and Laughlin, 2005) were invoked to judge the merits of the NAPH on the basis of the perceptions of the selected hospitals' members and the relevant policy documents. The evidence from the empirical investigation of this programme suggests that the NAPH is increasingly perceived by the hospitals to display the characteristics of a constitutive mechanism legitimised only through legal and financial procedure (Broadbent et al., 2010a). In fact, it was also understood that the NAPH's ends

and ways of evaluating the hospitals (means) have not been in practice set through the consensus of its stakeholders (Broadbent and Laughlin, 2009).

Both theoretical and empirical evidence was accordingly found in support of the constitutive nature of the NAPH (see chapter 6, sections 6.3 and 6.4). For example, the hospitals did not envisage the NAPH as their chosen programme and, further, they attributed a range of structural and functional deficiencies to this evaluatory system. As such, the current accreditation programme did not seem to be able to command a wide-ranging consensus towards its performance inside the hospitals. The hospitals perceive the NAPH not as a system which is developed through a consensual process, but a top-down system with no consideration of hospital reactions and complexities. Such a PMS is argued to lack a legitimate right, power and authority to direct the behaviour of organisations, in the sense of the communicative action principles (Broadbent and Laughlin, 2009). In addition, this perception of the hospital members towards the NAPH, had created the mentality that this PMS could not generate an intended change in the hospitals, which should follow after a wide range of communications among the stakeholders leading to a unanimous consensus to conduct specific actions such as performance measurement (Habermas, 1984; 1987; cited in Broadbent and Laughlin, 2005; Davis, 2007). As such, as indicated earlier, the members also referred to a number of problems such as its biased approach to evaluation of the hospitals, in relation to the NAPH, which as revealed, were seemingly caused by its non-consensual nature.

At the following sections, three main implications of the foregoing nature of the NAPH are explained, which are thought to have new insights for the literature.

9.2.1.1. The significance of feedback

A key effort to operationalise the theoretical principle of ‘communicative action’ is to consider frequent feedback from those under evaluation in the different stages of development and modification of a PMS (Moullin, 2004; Barker et al., 2004; Laughlin, 2007; Baker, 2008). Despite the bottom-up feedback from the hospitals and the UMSs’ surveyors regarding the performance and functionality of the NAPH; from the perspectives of the hospitals’ members, it has not changed since its inception and the perceived problems have mostly remained thus far; except for recent limited modifications to its structure and standards. It was stated by both the hospitals’ members and the surveyors

that their feedback has not been in practice considered by the authorities to modify the NAPH. Some reasons could be given by this research for such behaviour from the authorities:

As also emerged in the interviews, since the hospitals were associated with different organisations such as the MoH and various insurance organisations, it appeared to be challenging for all of them to gather, ponder, and discourse (i.e. the basis of communicative action) on common evaluation methods and standards for assessing the hospitals' performance. For instance, there have been always some related and even state-commissioned studies (e.g. Sadaghiani and Zare, 2005) offering the establishment of an independent organisation including all stakeholders for the NAPH. However, these ideas have never put into practice given the existing practicalities and there still remains a conflict of interests among the NAPH surveyors, hospitals, the surveyors of insurance organisations and even the directorates towards the evaluation of the hospitals. It could be understood from this situation that various expectations of stakeholders could be one of the challenges for operationalising communicative action and reaching a consensual agreement through discourse process (Broadbent and Laughlin, 1997; Laughlin, 2004).

The CHAS, governing body inside the MoH, as the main entity in charge of the NAPH seemed to be lacking sufficient expert (expertise) and information system infrastructure to conduct and coordinate comprehensive research projects on developing and modifying this evaluation programme (also stated by one of its members). There was a few staff working in the CHAS mostly busy with administrative tasks of, for instance, communicating with the UMSs' evaluation offices and investigating the complaints, as found out. Therefore, it seems that the authorities are not able to fulfil the expectations of the hospitals in relation to the performance/functionality of the NAPH, given their own limited resources and capabilities.

Therefore, it might be argued that given the abovementioned barriers and shortage of appropriate resources, the authorities were not willing to raise the hospitals' expectations of the NAPH by considering their regular feedback, as similarly echoed by Aryankhesal (2010). This could be subject of further investigation.

Ignorance of feedback from subordinate organisations, which is against the principles of communicative action, might be to some extent justifiable, where requirements are

imposed on organisations under evaluation in a specific context, because they are thought to be for the good of whole society (Broadbent et al, 1991; Broadbent and Laughlin, 2005). Thus, the organizations are urged to change, although against their participants' wishes (Agrizzi, 2003). Given the sensitivity of healthcare services (Gauld, 2005), it might be considered such an area within which some requirements could be imposed on the hospitals with not certainly considering their perspectives. However, this study argues that this imposition could be defensible only in the case of inspection, which ensures the implementation of basic health and safety standards in the hospitals (Shaw, 2003b) with no need for the contribution and cooperation from those inside the hospitals. In the case of quality improvement programmes, such as the NAPH, which the participation and feedback of subordinate organisations are highly recommended for the success of the programmes (Moullin, 2004; Barker et al., 2004; Laughlin, 2007) such ignorance might have no explanation. Therefore, overlooking the tenets of communicative action might not be justified in the case of the NAPH.

In summary, the aforementioned points try to highlight this fact that the implementation of 'communicative action' process in any context demands some requirements without which it might be futile. Such conditions (e.g. the willingness of all stakeholders, especially those with more power, to discourse and their sufficient capabilities) seemed to be less likely to be practical in the context under study. In fact, 'communicative action' achieved through 'ideal speech situation' (Broadbent and Laughlin, 1997, p. 628; Broadbent, 1998), apparently was found to be to some extent 'idealistic' currently for given context as a developing country as the findings implied (e.g. the fairly long period of ignoring the hospitals' feedback), because of abovementioned practicalities.

9.2.1.2. The relevance of Dysfunctional effects

Given the overall constitutive nature of the NAPH, it was highly likely to precipitate dysfunctional and unwanted consequences in the hospitals. From the adopted theoretical perspective, these behaviours represent those efforts and reactions by the hospitals that were not apparently aligned with (i.e. decoupled/disintegrated from) the societal healthcare lifeworld (Teubner, 1987; Broadbent et al., 2001; Broadbent and Laughlin, 2005). In an ideal fashion, it is argued that this lifeworld is tangibly manifested by steering institutions

(i.e. the MoH) and consequently their steering mechanisms (i.e. the NAPH) (Broadbent et al., 2001; Broadbent et al, 2010a). Therefore, the dysfunctional behaviours such as gaming emerged when the requirements of the NAPH, the tangible manifestation of the country's healthcare lifeworld, were violated by the hospitals.

However, as the word 'ideal' indicates, a regulative, and not constitutive, steering mechanism, which is developed based on communicative action, is expected to reflect/manifest the lifeworld values (Broadbent et al., 2010a), whilst the NAPH tended to feature constitutive attributes. Therefore, the gaming occurred could not certainly be labelled as dysfunctional, as the hospitals gamed, because they believed the NAPH is not expressing the societal healthcare lifeworld.

The perceived rationales for the gaming indicated by the hospitals (chapter six, section 6.5.2.) also implied that they perceived the NAPH as not contributing to quality improvement practices in the hospitals, which was consistent with exiting literature (e.g. Raisi, 2006; Aryankhesal, 2010). Such perceptions seemingly represent the situation predicted by Broadbent et al. (2001) and Broadbent et al. (2010a) where, from the hospitals' perspectives, the NAPH has moved away from expressing the healthcare societal lifeworld (e.g. quality promotion), whereas they themselves have remained in concert with the related lifeworld. Although the authorities of the NAPH might contradict this finding, in the light of current evidence (e.g. Berwick, 2008; Scott, 2009; Casey, 2010), it could be said that the hospitals are arguably in a better position to decide on the provision of quality services, in view of their direct involvement and contact with patients and given that valid performance measures are formulated based on the recommendations of frontline people.

PMSs are all discussed to precipitate some degree of dysfunctional effects along with their beneficial outcomes (Ridgway, 1956; Ashton, 1976; de Bruijn, 2007; Ganz et al., 2007).

The key point with regard to dysfunctional behaviours is to explore and analyse the rationales behind such behaviours in order to both assess the nature of dysfunctional behaviours and alleviate their adverse effects to organisations. Although these behaviours might not be always detrimental to organisations, their potential for generating dysfunctional is argued to be greater than beneficial effects (Birnberg et al., 1983).

Organisational members might, for instance, game to increase their individual or organisational benefits (Jaworski and Young, 1992). Alternatively, they might be dragged

towards this conduct because of incongruence and inconsistency between their objectives and those of the imposed MCSs/PMSs. The latter case was seen mostly in this study in that the majority of hospital members did not perceive that the NAPH is able to improve the quality of health care in the hospitals.

In fact, two main rationales of the hospitals for gaming, namely, ‘inability to fulfil the NAPH’s requirements’ and ‘discrepancy between the hospitals’ expectations and the requirements of the NAPH’ have somehow their roots in ignoring the feedback of the hospitals’ members by the NAPH over the years of implementing this system.

As the above debate, especially the rationales behind the hospitals’ dysfunctional behaviours, could suggest, the results of the study indicated that the gaming observed in the majority of hospitals could not be labelled as ‘detrimental’ or ‘dysfunctional’ since they *de facto* gamed to relieve (in response to) the perceived deficiencies of the evaluation system to these organisations. This result mostly disagrees with mainstream literature on gaming and dysfunctional behaviours (e.g. Birnberg et al., 1983; Smith, 1995; Bevan and Hood, 2006a; Kelman and Freidman, 2009), which predominantly recognise these actions/reactions disadvantageous to subject organisations.

9.2.1.3. The role of financial grounds in the hospitals’ conformity

As discussed in chapter eight (section 8.3.1.4.), several factors were identified behind conformity of the hospitals towards accreditation programme. The findings revealed that the main rationale for conformity of the hospitals towards the NAPH was ‘financial grounds’. As emerged, the perceived deficiencies associated with the NAPH which were largely persistent for a fairly long period, have gradually lessened the trust and belief of the hospitals’ members in the quality improvement merits of this system. Nevertheless, they were not able to clearly disobey its requirements, because of its economic gains and compulsory nature.

In fact, a financial incentive was attached to the accreditation system by the MoH to encourage the hospitals to comply with the requirements of the NAPH. However, as asserted in the related policy documents, this spur was not supposed to serve as the main rationale for the hospitals’ compliance with the requirements, but the quality improvement

merits of the NAPH (Moghimi, 2004). While in reality, as the findings indicated, majority of the hospitals' members referred to financial benefits as their rationale for conformity.

Some contextual elements linked to the hospitals appeared to be highly influential in development of such a mentality (i.e. money-oriented micro lifeworld/interpretive schemes) inside these organisations (Broadbent and Laughlin, 2005, Broadbent et al., 2010b). The relative autonomy of the hospitals, which was mostly associated with financial aspects of the hospitals (Ghafari, 2009; Anonymous, 2011a) made these bodies, especially their authorities, to always be concerned with their financial arrangements. Such a situation was apparently aggravated considering the power of the managers in these organisations as the main incumbents who were liable to press the hospitals' members to conform to the NAPH's requirements. In addition, the perceived financial problems of the hospitals which were clear in their discourse and were repeated many times seemed to contribute to the formulation of such perceptions in these organisations.

Therefore, despite other factors such as legal coercion and perceived advantages (see sections 8.3.1.4. and 8.4.), the main factor stimulating the conformity was found to be financial grounds attached to the NAPH, as repeatedly raised in the interviews. As such, because of the effectiveness of financial grounds, and not quality improvement merits, the 'absorption' reaction was perceivably more dominant in the hospitals towards the requirements of the NAPH as opposed to 'adoption' (section 8.7).

This finding indicates that solely setting financial incentives might not certainly guarantee organisations' (non-symbolic) conformity towards a PMS, but initially there should be a consensus on the merits of the PMS (Laughlin, 2007; Kelman and Friedman, 2009). Only in that case, these incentives might encourage organisational compliance. In fact, financial incentives should serve as facilitator rather than enabler of the conformity.

This study identifies two distinctive roles for 'financial incentives' that are 'enabler' and 'facilitator', of them the latter should be considered for financial incentives. It also argues that those applying such encouragements for increasing the possibility of compliance to given PMSs should be cautious of assuming the 'enabler role' by this incentive. Otherwise, it is likely that subject organisations might take any action (e.g. gaming) to obtain the monetary gains, as in the case of present case study.

Some studies (e.g. Mays, 2004) have even taken a more extreme position in regard to financial incentives and argued that they should be gradually phased out over time to

evade adverse effects associated with reuse of money (Habermas, 1987; cited in Broadbent et al., 2010; Dodd, 1994), as was the case in current study (section 8.3.1.4.2), by organisations. For example, an important side effect associated with the financial incentives in current study was their limiting effects on the internal PMSs (DAs) of the hospitals. That is, the hospitals were drawn to align their internal measurement systems with the NAPH, despite their lack of belief in its merits, in order to achieve the financial benefits (section 7.2.4.).

9.2.2. The importance of religious elements

Given the emphasis of the current research on ‘contextual factors’ in the effectiveness of PMSs/MCSs, a key contextual aspect emerged in present study was ‘the effect of religious elements’ on the hospitals’ perceptions and reactions towards the NAPH. By and large this is consistent with the fact that, traditionally, there has been always a religious and humane facet attached to health care, especially treating patients (George, 2003).

This factor might be equated with ‘altruism’ in general literature. For instance, Hamblin (2008) emphasises on the importance of ‘altruism’ as a reason why healthcare providers might consider reacting positively to PMSs’ demands. However, unlike the humane activities which are of a personal nature and believed to be mostly unrelated to religion in western societies, the altruistic grounds seen in this research context seemed to be under the influence and guidance and as a part of religious values (i.e. with a religious nature). This situation did not sound unusual given the religious context and ruling system of the country (i.e. Islamic Republic). Jayasinghe and Soobaroyen (2009) also similarly found religious spirit as an integral and important part of accountability in non-western societies.

Given the religious context of the country, it is usually advised that the related actions be justified from a religious perspective and be in harmony with religious teachings. In health care, a number of spiritual precepts regarding healing and helping patients to recover were displayed on the hospitals’ notice boards and, more importantly, could be seen in the different instructions of hospital evaluation (e.g. in their introduction section) (e.g. MoH, 1997a, 1997b). These efforts were understood as very rewarding and motivational for the hospitals’ practices. As such, approximately ten per cent of the hospital evaluation standards of the NAPH were directly related to religious aspects in the hospitals.

In fact, this contextual aspect somehow facilitated the acceptance of current PMS by some groups (especially frontline staff) in the hospitals. That is, they were more amenable to conform to the NAPH's requirements, because of religious reasons and being spiritually rewarding. The evidence that the hospitals agreed easily to the religious requirements was approved by both the surveyors and hospital members. In addition, the higher scores of the hospitals in these standards also was a confirmatory sign of this assumption.

The known effect of religious values in the easier/better acceptance of accreditation requirements, from the theoretical perspective, signifies the alignment (structural coupling) of micro lifeworld (ISs) of the hospitals' members with overall societal (i.e. religious) lifeworld dominant in the country (society). Consistently, 'the increased patient satisfaction' was also seen as an incentive important for some hospital members for compliance with the NAPH (Aryankhesal, 2011, p. 265).

Highlighting such a key finding, this case-study strongly concurs with studies such as Modell (2009) and Broadbent and Laughlin (2009) in emphasising the effect of contextual factors on the overall design, implementation and effectiveness of PMSs/MCSs. As such, it is one of the first studies recognising clearly the effect of religious elements on the functionality of PMSs/MCSs. Therefore, as a practical insight, it should be stated that careful consideration of contextual elements could provide invaluable insights for developing effective PMSs/MCSs.

9.3. Research implications for theory

This work has drawn on Broadbent and Laughlin (2005) to approach the performance analysis of Iranian hospital accreditation and evaluation system. The application of their model for the investigation of the NAPH proved helpful in locating this steering mechanism in a societal context, examining its merits from an organisational perspective, and ultimately analysing its change implications (i.e. various changes as a result of the NAPH) in different elements of the hospitals following their reactions towards this PMS. Notwithstanding this fact, as the empirical investigation uncovered some issues surfaced out of line with the theoretical assumptions suggested by this model, which are the base of developments and extension of Broadbent and Laughlin's model, in the light of current research findings.

To remind us from chapter four (section 4.5.4) and clarify the suggested developments, Broadbent and Laughlin (2005) propose four change pathways of rebuttal, reorientation, colonisation and evolution which might develop in organisations subject to external steering (performance measurement) mechanisms. This study equates these pathways with the reactions of rejection, absorption, submission and adoption, respectively, in view of their nature, shown by the organisations towards steering mechanisms. All these four reactions were observed, though at varying scales, in the hospitals under study in response to the effects of the NAPH, in consistent with the adopted model. However, the following differences emerged in the context of current study illuminating the theoretical contributions of the research:

First, although occurrence of the rejection in the hospitals was in accord with Broadbent and Laughlin's (2005) model, it did not happen in an explicit way, as their model assumes, but through gaming (i.e. showing symbolic compliance). This was because, as Gray et al. (1995) also argue, the hospitals could not afford to directly rebut the NAPH's requirements. The incidence of any type of gaming is not recognised by their model during the rebuttal reaction. In fact, the hospitals could reject some requirements after a period of symbolic compliance (i.e. gaming) during their on-site evaluation survey, unlike the compulsory nature (strength and forcefulness) of the NAPH. This point concurs with Nicholas (1999) who argued that HCOs might only comply with standards at the time of the accreditation survey. This reaction by the hospitals after the on-site survey took place seemingly due to the lack of comprehensive unannounced and follow-up visits by the surveyors as also echoed by Aryankhesal (2010).

The findings showed that the alterations in the different elements of the hospitals induced by the NAPH's requirements during the rebuttal pathway (rejection), involved both the hospitals' DAs and subsystems and not just the DAs, as claimed by Broadbent and Laughlin (2005). In fact, both rejection and absorption of the demands were found to be contemporaneous in the hospitals, contradicting their assumption that there should be a transition from rejection to absorption as a result of external disturbances. This situation was seemingly created because of the nature of the NAPH's requirements, of which some were refused and some absorbed simultaneously.

Second, consistent with similar studies (e.g. Larrinaga-González et al., 2001; Agrizzi, 2008), 'absorption' was the most dominant reaction exhibited by the hospitals towards the requirements of the NAPH. As the findings indicated, the hospitals absorbed the unwanted requirements, not only to safeguard their status as a hospital, as argued by Broadbent and Laughlin (2005), but, more importantly, to obtain the financial gains resulting from the conformity to the NAPH's requirements. Given the impact of these financial benefits on the survivability of the hospitals, they were found to be pre-eminent among the hospitals' rationales for compliance. Therefore, in addition to 'forcefulness of the requirements', this study also identified 'financial benefits' as another rationale for internalising (absorbing) the perceivably unwanted requirements by subject organisations. The absorption was assumed because the hospitals tended to benefit from the advantages (e.g. economic gain) resulting from this reaction (Gray et al., 1995), and not because they perceived such a reaction to be damaging to their core values, as Broadbent and Laughlin (2005) have stated.

This behavior from the (especially public) hospitals could be argued that was possibly because they were to a large extent certain that the MoH will not close down them as this could mean an extra cost to the government and a blunder for the government itself. As such, some contextual factors such as 'uneven distribution of hospital beds' in the country (Aryankhesal, 2010) have left no option for the MoH to give up on accurate implementation of the NAPH. In other words, in some regions because of the existence of only one hospital, even in the case of their poor performance the MoH could not close the hospital because of its societal legitimacy. Therefore, the hospitals were not concerned about the closure; instead, they were keen to grasp the financial advantages resulted from this opportunity.

Third, the only intended change pathway indicated by Broadbent and Laughlin (2005) is 'evolution' in which the organisations adopt requirements of external PMSs/MCSs. The key prerequisite for this reaction is the operationalisation of a comprehensive discursive process by all stakeholders on the requirements which leads to their adoption (Broadbent and Laughlin, 1997; Laughlin, 2004; Haigh and De Graaf, 2009).

The results displayed that despite the NAPH's compulsory nature, some of its requirements were embraced, and not absorbed, by the hospitals. The nature of the

hospitals' rationales for adopting the requirements was an important indicator for distinguishing this reaction from those of absorption and submission (Larrinaga-González et al., 2001). That is, the hospitals have applied these requirements exclusively because of their merits, as emerged in the interviews; whilst in case of other requirements, which were mostly absorbed; other rationales such as a fear of losing financial benefits played the main part.

Key fact concerning these groups of requirements was that their adoption by the hospitals was not followed by them being subject to any free discourse among hospitals' members, which is a key prerequisite of the evolution pathway in the sense of Broadbent and Laughlin's (2005) framework. This process revealed an important differentiation between the findings of current study and the assumptions of the model. Further analysis of the empirical data revealed that two distinctive contextual features were connected with the adopted requirements: Their newness and scientific nature as well as religious nature

The novelty and scientific nature which boosted the knowledge of the hospital members, was a key feature associated with these types of requirements. Seemingly, a boost in the knowledge level of the members as a result of the requirements facilitated their acceptance by the hospitals' members. In fact, majority of these requirements were newly developed (updated) and explicitly based on new evidence of knowledge. In addition, the hospitals members were informed of the process of their development (MoH, 2004) and the requirements also had the approval of the members' professional associations. The findings showed that the enhancement in the level of the members' knowledge and their awareness of the development process of these requirements apparently resulted in some (intended) alterations in the members' ISs (Hassan, 2008), which made the situation conducive to the acceptance of those requirements by the hospitals.

Similarly, in the case of the religious requirements of the NAPH, the hospitals embraced them without discursive process. The (spiritual) nature of these requirements seemed be the main reason for their adoption. In fact, the majority of the hospitals' members did not conceive that they could or should challenge the religious requirements, regardless of the legal force behind them. In fact, the spiritual nature of these demands seems to be compatible with the religious context of the country and consequently, the attitudes of the hospitals' members.

The evidence from this study suggest that these two characteristics (i.e. the knowledge-enhancing and religious nature of the requirements), forwent a need for discursive process, which is a crucial part of evolution pathway, on the adoption of these requirements by the hospitals. That is, the hospitals' members accepted such requirements without challenging them and expecting their consensus to be sought. This finding has not been raised by (seems new to) Broadbent and Laughlin's (2005) model.

Fourth, any variation in the ISs of organisational members is considered as second-order change (i.e. colonisation and evolution) by Broadbent and Laughlin (2005). However, notwithstanding the shifts in the ISs of the hospitals' members as a result of the NAPH's effects, these changes could not be envisaged as second-order, because the overall identity of the hospitals remained unchanged. That is, some changes in the values and perceptions of the hospitals members towards the NAPH could be noticed (section 7.2.5.). However, they still strongly believed in the role of the hospitals as an entity for providing quality health care. Therefore, the evidence from this study on these shifts is more in sympathy with Gray et al. (1995); this is called morphostatic, rather than morphogenetic, colonisation. The rationales of the members for conformity with the external requirements of the NAPH were assumed as a sign for the type of alterations in the beliefs of the members (Gray et al., 1995).

Fifth, the order asserted by Broadbent and Laughlin's model for the change in DAs, subsystems and ISs were to some extent contradicted in this study. There was evidence that some alterations in the ISs of the hospitals in the colonisation pathway happened regardless of (without) any shift in their DAs and subsystems. The attitudes of the members towards the NAPH were changed in relation to the NAPH's overall structure (e.g. unfair combination of the surveyors) or features (its financial and legal attributes) instead.

In addition to the above theoretical insights, the following consistency was seen between the result of current study and those of existing literature concerning the Broadbent and Laughlin's (2005) model:

1. The power of the hospital managers in pressing the hospitals' members to conform to the NAPH was recognised. The role of organisational participants who might facilitate the transition from absorption (reorientation pathway) to submission (colonisation pathway) in organisations is somewhat recognised by Broadbent and Laughlin (2005). However, as Soin (1996) and Gurd (2008) have also emphasised, they fail to elaborate on the importance of this power in their theoretical framework. This power was found to be overly influential in increasing the absorption reaction in the hospitals as the managers exerted on the other members of their organisation.
2. The possibility of fragmentation in the ISs of the hospitals' members, which is not acknowledged by Laughlin (1991), was observed in the current study. There were discrepancies in the beliefs of the members towards the NAPH. Accordingly, this study endorses the research results of Broadbent (1992), Soin (1996) and Agrizzi (2003).

9.3.1. Limitations of Broadbent and Laughlin's framework

The strengths of the adopted models (i.e. Broadbent et al., 1991; Laughlin, 1991; Broadbent and Laughlin, 2005) were discussed in chapter four of this thesis (section 4.5.5). The frameworks allowed the evaluation of the NAPH from the hospitals' perspectives, and to conceive of the hospitals as organisations composed of distinct structural elements, which permitted the investigation of the NAPH's effects on their different elements. Despite the aforesaid advantages, while Broadbent and Laughlin (2005) and Laughlin (2007) speak about the utility of relying on the perceptions of organisational members for judging the merits of the societal steering mechanisms (e.g. the NAPH), their model arguably fails to address some possibilities which are explicated here as the limitations and practicalities of applying these models in the light of insights from current study.

- ◆ The discrepancies among the beliefs and attitudes of different organisational members, because of their nature of work and different knowledge level of the phenomenon under study (e.g. the NAPH) might complicate the achievement of a conclusive and consensual evaluation of the steering media and their mechanisms, which is overly crucial according to this model. This framework assumes a more societal and macro approach to organisations; therefore, it pays little attention to differences at individual levels.

- ◆ Merely utilising the perceptions of the organisational (e.g. hospital) members to evaluate a societal steering mechanism (i.e. the NAPH), as in this model, seems to ignore the possibility of decoupling the hospitals from societal values (i.e. lifeworld) and focuses mostly on the deviation of steering mechanisms. According to their model, the merits of the steering mechanisms are examined by drawing on the perceptions and reactions of the organisational members. Given the existence and importance of safety issues in the area of health care as stressed by Barach and Berwick (2003) and Hutchinson et al. (2006), the authorities might retain a legitimate right to allow less freedom in the specific practices of the hospitals. This situation, which is also referred to by Gray et al. (1995) as the right to colonise by steering media, was not recognised by Broadbent and Laughlin's framework.
- ◆ Identifying the ISs of the hospitals and distinguishing their different levels (i.e. splitting them into metarules and beliefs) was a fairly complex task, given their intangible nature. For example, consideration of the hospitals' members, physically, as subsystems and their attitudes and beliefs as ISs, as by Broadbent and Laughlin (2005), might be challenging. The researcher relied largely on the documentation to identify the ISs of the hospitals.
- ◆ The situation for change predicted by Broadbent and Laughlin (2005) seems to be somehow simplistic and idealistic. The linear and continuum-base trend for organisations' change was not fully endorsed by the current study. Evidence shows that change pathways may happen in parallel and/or at different rates. For example, both rebuttal and reorientations pathways were simultaneously observed in the hospitals. In addition, organisations' DAs as the mere point of their exposure to the environment were not supported, because the hospitals' views (constituting their ISs) seemed to be changing under the influence of external pressures.
- ◆ The evidence from this study revealed that the change pathways presented by Broadbent and Laughlin's model did not apparently represent the changes requested by an impetus composed of a range of requirements. Different pathways were de facto triggered in the hospitals at the same time because of the various requirements of the NAPH.

9.4. Research implications for policy and practice

Drawing on the findings of this study, the following implications could be provided for practice and policy-making in relation to Iran's current healthcare accreditation system; in addition to the recommendations supplied in chapter seven (section 7.3.):

9.4.1. Careful attention to the reactions and rationales of the hospitals

The reactions of the hospitals towards the NAPH could generate insightful implications for its improvement.

The existence of the rejection reaction despite the compulsory nature of the NAPH could convey two points: First, as the rationales of the hospitals for this reaction imply, unless the hospitals are content with the merits of the requirements and their internal capacity and ability are adjusted to meet the demands, they will scarcely show intended conformity to the NAPH just because of its mandatory nature. Second, an appropriate mechanism is chosen simultaneously to prevent the possibility of rejection by conducting unannounced on-site and follow-up surveys of the hospitals and integrating their scores in the main score of the hospitals.

Financial incentives for the conformity of the hospitals to the NAPH were found to be influential, albeit to a large extent superficially, because of the hospitals' financial problems and, thus, their dependency on this programme. As the absorption reaction was the most common reaction of the hospitals and these incentives constituted the main rationale for this reaction, some doubt could be cast on the quality improvement merits of the NAPH and proper use of this incentive. This insight could provide a crucial warning for the authorities to consider reorienting the approach of the NAPH.

In addition, since financial benefits were allocated on an organisational basis, the hospital members, particularly those in the frontline, were not found to be individually encouraged by these incentives. Therefore, a procedure should be developed to make those groups take more advantage of these incentives and be clearly encouraged.

9.4.2. Realising the dysfunctional consequences associated with the NAPH

Most PMSs are often have some sort of unwanted consequences along with their dominant intended effects in organisations (Goddard et al., 2002b; 2002a). The dysfunctional effects of the NAPH, unexplored prior to present research, provide first-class information about the real-life effects of the NAPH on the hospitals for the policy-makers. They could guide the authorities directly to the root causes of the programme's problems and contribute to identification of pertinent corrective solutions.

As indicated in chapter six, it was stated (mostly by the authorities of the NAPH) that more hospitals could currently obtain a high evaluation grade, implying that the NAPH has made an impact on the quality of the hospitals. However, this assumption might be contradicted in a couple of aspects. First, the gaming identified in the hospitals by this case-study means the compliance could be superficial. Second, as the rationales underlying the hospitals' reactions (i.e. the absorption of the requirements) indicated, the hospitals' conformity was largely propelled by the financial benefits, and not by the quality improvement capacity, of the NAPH. Therefore, sole reliance on the results of this programme for judging the quality of services might seem fairly simplistic.

9.4.3. Engagement of physicians

The physicians, as frequently noted, are the most influential and powerful group in the hospitals in Iran's healthcare system, as is the case almost globally (Flood and Fennell, 1995). A specific justification for this situation could be the fact that they have the most senior positions in the overall governance structure of the health sector in the country (i.e. in the MoH). Regardless of this, the criticality of their job at organisational level in the HCOs was also recognisable (Abernethy et al., 2007). Moreover, there were problems mentioned by the hospitals' members that arose specifically because of the physicians' non-cooperative behaviour (see chapter 6).

Involvement of this group in the hospital evaluation might enhance their cooperation and consequently raise the success rate of this programme (Powell et al., 2009). This process could be operationalised in two modes: First, by developing more related standards of the NAPH to the clinical processes and practices of this group, as they were somehow lacking in the current system; second, by increasing their evaluation-related knowledge, skills and,

more importantly, incentives, which make physicians more appreciative of the values of quality management and performance measurement in the hospitals (Jacobs et al., 2007). The participation of professionals, as argued, could ease the implementation of intended changes recommended by quality improvement programmes in the HCOs (Weiner et al., 2006). In addition, given their strong value system, Abernethy and Stoelwinder (1995) indicate that their involvement could promote self-control in hospitals, where administrative and formal control mechanisms might seem impractical and bound to fail.

Given the importance of this involvement, some advise to include raising the awareness as to the necessity of professionals' participation in quality improvement practices of HCOs as a part of their education and training (Kips and Rademakers, 2010).

9.4.5. Learning from changes implications of the NAPH

It was explained in chapter seven that most of the changes occurring as a result of the NAPH in the hospitals took place in the early years of the NAPH or when new standards were added (section 7.2.1). Their novelty and learning insights for the hospitals appeared to be the main reasons for these changes. Years after the inception of the NAPH, since the standards were static and repetitive with no updates or innovations for the hospitals, the intended changes of this programme have dwindled. Therefore, the standards should be updated regularly and enriched scientifically (evidence-based) to enable this programme to make positive changes.

As explained in chapter three, the MoH has made some modifications, extensions in fact, to the structure of this evaluatory mechanism, which explicitly indicates that the authorities have also realised the deficiencies of the current programme and its failure to encourage quality improvement in the hospitals (Moghimi, 2004). However, despite this being a positive step, they have not attentively addressed existing defects of the NAPH, which is highly required, if the authorities intend to enhance the effectiveness of this evaluation system.

9.4.6. Rectifying faulty communication system

The hospitals' awareness of the NAPH was also found to be suffering from some difficulties. Despite the fact that this programme had been in effect for a fairly long time,

there were some important cases where the hospitals did not have the correct information about their regulations. For example, it was mandatory for the hospitals to display their last grade in a few busy places inside the hospitals in the public domain. However, even the managers of the hospitals, when asked, were not definitely aware of this imperative regulation.

Another case was related to the use of different checklists of standards for the evaluation of single-specialty and general hospitals. While the researcher could never obtain the checklists for single-specialty hospitals, the members of these hospitals were also unaware of this important difference.

Since the first prerequisite for fulfilling the requirements is to be fully aware of them, reinforcing the informative side of the NAPH also needs to be heeded by the authorities of this evaluatory mechanism.

9.5. Limitations of the study

This study also labours under some limitations, as with any other research. It adopted a case-study design, and hence a small-scale one, and explored the impact of the NAPH over a relatively short timescale. It demonstrates only the views and perceptions of those who participated in this study. Since qualitative research requires an in-depth, longitudinal study to capture the richness inherent in an empirical context, the limited time and access constraints of the researcher in the field may have endangered the required quality of the collected data.

In addition, although the members of the survey teams in the HUMS were also included in the target group of this study, its focus was largely on a local level (i.e. the views of hospitals' members), and it was unable to triangulate their views with those from the directorate of the NAPH in the MoH on the phenomena reported. Therefore, this possibility remains that the canvassed perspectives provide a slightly one-sided picture of the NAPH's performance.

The study strived to include at least one example from all the types of hospital currently working in the country, to provide a fairly complete range of their views towards the NAPH. However, as a case-study, this research has only covered the hospitals from one

province. Therefore, given its qualitative and perceptual nature, the findings should be generalised cautiously to the whole country or other similar contexts.

The evaluation results of this study of the NAPH's performance are based on the hospitals' perceptions and judgements and the researcher was not in a position to establish the technical and practical effect of this programme on the practices of the hospitals themselves. Furthermore, the evaluation of the NAPH was based on the perceptions of the selected interviewees. Although they are the most relevant part of a big society in relation to the NAPH, their views towards the NAPH could not be taken with certainty as those of the whole society.

9.6. Directions for future research

The following avenues can be identified and recommended for further research in the related and similar areas:

- Similar case-studies in other provinces of the country, considering the differences in the size and the advancement level of the hospitals, might provide confirmatory or contradictory evidence for this research. As such, this could cautiously be also applied to other developing countries with similar accreditation arrangements.
- The current research only focused on the views of the hospitals' members and the university surveyors, as the direct stakeholders of the NAPH, in order to judge its performance. The next step could be to consider the perspectives of indirect stakeholders such as patients and third-party organisations for assessing the performance of the programme. The latter was not covered by current research because of its time and access limitations.
- Application of a mixed-method research approach might provide more extensive results in this regard. A survey could investigate the whole range of hospitals' reactions to the NAPH using a statistically sound sample from the whole country (quantitative part), followed by a multiple case-study for exploring the hospitals' rationales for exhibiting such reactions (qualitative part). The results in this case could be easily generalisable.

- A prospective longitudinal case-study in a single hospital might provide more profound and in-depth understanding of the change processes caused by this AP in the hospitals, utilising Broadbent and Laughlin's (2005) model of change. Given the time and access constraints of the current study, an internally-based (i.e. inside country) study is expected to be able to carry out such a research project.
- The current study could be replicated for examining the performance of accreditation programme in education sector or for evaluating similar PMSs in other sectors.
- Investigation of the reactions of the hospitals towards the NAPH could also be explored through other perspectives. Given its focus on the performance of AP as a regulative institutional element, the current study did not involve other institutional factors (normative and cognitive) external to the hospitals which might have an effect on their reactions to this programme. Hospitals operate in a society and are accountable to their patients (cognitive). They also include various specialised groups which are *per se* related to their own professional associations (normative). Adopting an institutional perspective might be helpful in addressing these elements and their influence on formation of hospitals' reactions to the external regulative pressures.
- Different quantitative studies could also be hypothesised in relation to the impact of this programme on the hospitals. For example, future studies could try to examine the relationship between the hospitals' accreditation grade, their ownership (teaching or private) and nature (general or single specialty) and their reactions to the NAPH.

9.7. Final remarks

Selection of the certain research paradigm (i.e. MRT) and theoretical frameworks for this study all were intended to allow and assist the research to fulfil its main goal which is a contextual assessment of Iranian national hospital evaluation and accreditation system. In fact, the main focus of this case study has been on the effects of 'contextual factors' on the impact of this macro PMS/MCSs on their subject organisations (Broadbent and Laughlin, 2009). The MRT research approach and Broadbent and Laughlin's (2005) model (elaborated in the chapter four) provided a workable language to operationalise this intention in view of their attention to empirical complexities and the hospitals' reactions

and perceptions (Laughlin, 2007; Berry et al., 2009). This study could be assumed as a modest effort to offer an example of how Broadbent and Laughlin's (2005) framework could be extended from their mainly accounting context to analysing the changes and reactions prompted by a healthcare accreditation and evaluation programme (i.e. the NAPH) in a developing country.

Regardless of the real merits of the NAPH as a quality assessment and improvement programme, it was clearly noticeable that the hospitals have lost to a large degree their trust in the virtues of this programme. They did not have a compelling motivation to make efforts to improve themselves in line with the requirements of this programme. This fact that the hospitals viewed the NAPH as basically unchanged since its introduction has also instilled this mentality to the hospitals that the MoH has been unsuccessful in pursuing quality improvement inside these organisations. Another substantive point which seemed relatively discouraging for the hospitals was the persistent ignorance of their feedback by the authorities. This failure has seemingly diminished any enthusiasm or caring for the success of the programme inside the hospitals.

Therefore, the MoH should first focus on changing the mindset (interpretive schemes) developed in the hospitals towards this programme, as changes in the attitudes and beliefs are assumed to be the first step in making an intended change in any organisation (Broadbent and Laughlin, 2005). It could be also acknowledged that, given the critical circumstances of health care, the existence of the NAPH as a governmental tool is justifiable in order to regulate this area of the public sector and have a positive impact on the hospitals, provided that its current features change considerably and the feedback of the hospitals are included regularly. As current evidence shows that a consensually-based AP could catalyse quality improvement, enhance accountability and improve the credibility of accredited organisations (Halverson et al., 1998).

Another noteworthy point is that, although the NAPH was not perceived as an appealing mechanism from the hospitals' perspective, as evidence from this case-study showed, the managerial members still agreed that they were happy to be evaluated by the current system, when they were asked. Even though the beneficial effects of the NAPH influenced their answers somewhat, the main reason appeared to be the point made by some members implying that 'having a poorly-performing evaluation system is much better than having nothing'. Apparently, since they could not imagine any situation other than the NAPH,

they still approved of this programme. In addition, their incumbency of the hospitals and also the free subscription of the programme were thought to be effective.

It might be also argued that it is natural for the hospitals under the evaluation of this mechanism to be critical of its nature (Mannion et al, 2005). As such, the authorities of the NAPH might contradict what has been said by the hospitals because they regard them as partial and one-sided. In response, it should be clarified that, in addition to the inclusion of the surveyors' views by the study, who were themselves a part of the NAPH; the important point is whether the hospitals have belief in the ability and intention of the NAPH to effect improvement. This is because they are assumed to be the main players in health care who satisfy the wishes of the MoH in providing quality care and are directly involved in delivering the services (Berwick, 2008; Casey, 2010). Accordingly, their distrust in the capability of the NAPH might give rise to the development of dysfunctional consequences (e.g. gaming) and hinder the whole process of quality improvement by the programme. A primary signal for judging the merits of an evaluatory mechanism is arguably that whether it is able to command a wide-ranging consensual support among those being regulated (Laughlin, 2007).

Overall, given the all above discussions and explanations, the following contributions to the literature were briefly made by this study, in addition to its theoretical contributions (see section 9.3.):

First, the study found that the tenet of 'communicative action' needs a number of prerequisites to be practical in any organisation and context, which they might not be always available. For example, health care is an area that because of its sensitive (life-attached) services (Gauld, 2005; Broadbent et al., 2010a), governments might dismiss various aspects of this guideline (e.g. ignoring the local organisations' feedback), as in the current case. However, acknowledging such an action in the case of inspection of basic health and safety standards in HCOs, the study stresses on the importance of applying communicative action for the success of quality improvement programmes such as the NAPH.

Second, it could establish that dysfunctional behaviours on behalf of organisations should not be always envisaged as detrimental. This study argues that the rationales and reasons behind such behaviours are crucial for assessing their nature. In addition, the possibility of

appraising the organisational rationales (interpretive schemes) in comparison with the societal lifeworld also proves to be a key indicator for ascertaining their essence.

Third, the study identifies two distinctive roles for ‘financial incentives’, attached to PMSs/MCS (i.e. ‘enabler’ and ‘facilitator’). It suggests that this group of encouragement tools should serve as facilitator rather than enabler to ensure their effects, because as the former, financial incentives might precipitate dysfunctional and unintended effects in organisations. That is, it should be the merits of the PMSs that attract given organisations’ conformity at the first place and not improvement of their financial status. Therefore those applying such incentives for increasing the possibility of compliance with given PMSs/MCSs should be cautious of assuming the ‘enabler role’ by this mechanism. Otherwise, it is likely that subject organisations take any action (e.g. gaming) to obtain the monetary (economic) gains, as in the case of present case study.

Fourth, the importance of contextual aspects was approved by present case study. As one of the first efforts, this study brought to the fore the element of ‘religious values’ as an influential contextual factor in facilitating the impact and implementation of the PMSs/MCSs, in the public sector performance measurement literature.

As the final thought, it should be clarified that, despite the dysfunctional effects of the NAPH, this study does not discredit all the merits of the NAPH, since it was not in a position to establish the following issues:

First, the exact impact of this programme, as Kelman and Freidman (2009) argue, could be judged when a comparison between an organisation under its evaluation and one with no evaluation is made, which was impossible in the current case.

Second, the compulsory nature of the NAPH, according to Habermas (1987, cited in Dillard and Smith, 1999) might be justified if the costs to the hospitals result in an overall benefit for the larger society. This means that, even though this programme was not effective from the selected hospitals’ viewpoint, it might practically (and not based on what is asserted in the related policy documents) still satisfy the intentions of the MoH. Future studies could cast more light on this claim.

Appendices

Appendix A: Introductory information on the profile of the country

Islamic Republic of Iran (I.R.I.), the sixteenth largest country of the world and the second largest one in the Middle East, is bordered by the Caspian Sea, Armenia, Azerbaijan and Turkmenistan in the north; Persian Gulf and Gulf of Oman in the south; Iraq, Turkey in the west; and Afghanistan and Pakistan in the east (Figure 2.1). This relatively vast country is located in both the northern and eastern hemispheres of Asia in a recognized geographical region of the south-western Asia called the Middle East.



Figure 1- Map of Iran - Source (Anonymous, 2007d)

The area it covers is 1,648,194 square kilometers and, topographically, it has a diverse landscape and climate; over half of the area is mountainous; a quarter is desert, and only less than one fourth is habitable land. Iran has administratively divided into 30 provinces, 336 districts, 676 cities and over 66,000 villages. According to the last national census of year 2006 (Anonymous, 2007c), the population of the country is approximately 70,472,846, of which 68.4% live in the urban and 31.6% in the rural areas. From this population women constitute 49.1% and men 50.9%. Tehran, capital of Iran, accounts for about 19% of this population by itself, that is, 13,413,000.

The official language of the country is Farsi (Persian) and religion is Islam with a majority of Shiites (89%). Some of the Iran's healthcare indicators have been illustrated in the table 2.1.

Table 1- Selected Indicators of Iran's health status- Source: WHO (2006)

Indicator	Rate (2006)
Life expectancy at birth (years)	71
Child mortality under 5 years (per 1000)	35
Total health expenditure per capita (\$)	788
Total health expenditure as % of GDP	7.8
Population annual growth rate %	1.6
General government expenditure on health as a percentage of total expenditure on health	55.6
Private expenditure on health as percentage of total expenditure on health	44.4

Appendix B: Interview Topic Guide

(English version)

[The sentences in Italic are further explanation and not part of the questions]

Introduction

(Icebreaking stage)

[In the day of interview] Thank you for meeting me today. *[The researcher once again checked whether the respondents were still happy to participate in the research and emphasised the following points to them]:*

- I would like to record the interviews, if it is okay *[Showing the voice recorder]*. That would help me remember more accurately what we talk about today. It also means I don't have to make loads of notes whilst we are talking. *[Reassuring them]* the recordings will be confidential and used only for research purposes and I won't be playing the recordings back to anyone else, only I will hear them *[they were also provided with participation information sheet (PIS) and consent form few days before than interview takes place (see Appendix C for PIS version)]*.
- I will anonymise all the materials and no real name of you or your hospital will appear in the context of my research.
- We can stop whenever you like. Please just let me know and we can finish the session.

[Either of verbal or written consent was sought from the participants (see the Appendix D for the written version of consent form)]

Interview with hospital staff

(Including mostly senior and mid-level positions)

A) Assessing the awareness *(all respondents)*

1. Are you familiar with the current AP (*i.e. the NAPH*)? Where did you get the information from?
2. How (from where?) and when do you get access to the evaluation checklists?
3. Are you aware of the way the checklists have been developed?

4. Is the on-site survey a pre-arranged or unannounced process for you?
5. Do you prepare your hospital (department) for the survey? If yes, how?

B) Main body of the guide (*all respondents*)

1. How do you overall perceive this AP?
2. What do you think of the main intentions of this programme?
3. Do you think the NAPH is generally leading to any improvement in the services' quality in this hospital?
4. Is your feedback considered in any stage of the development, implementation or improvement of this programme and its standards by the MoH (*i.e. consultatively driven*)?
5. Do you think the standards of the NAPH are relevant to your daily activities in the hospital?
6. Are the standards comprehensible to you?
7. Do you feel the NAPH is constraining your normal freedom of practice?
8. What do you think about the current governance (the UMSs) of the NAPH?
9. What do you think about the combination of the surveying team?
10. Do the surveyors provide you with advices for improvements in the hospitals?
11. What unintended and dysfunctional effects (*e.g. tunnel vision, intimidation, gaming, misrepresentation, etc.*) would you associate with this programme?
12. What benefits (*e.g. quality improvement, financial support, learning, etc.*) would you attribute to this programme?
13. On what grounds you base your assumptions about the merits of this system?
14. What do you think are the main reasons of the hospital for conforming to the NAPH (*e.g. compulsory nature, economic gains, etc. of the NAPH*)?
15. What is your personal motivation for compliance with the requirements of the NAPH (*e.g. its reputational effects, helping patients, financial incentives, competition with other hospitals, etc.*)?
16. Have you tried to ignore or reject the requirements of the NAPH? If yes, how? Why?
17. How much obtaining a higher grade is important for you? Why?

18. Can you identify any tangible benefit for yourself as a result of a higher accreditation grade for your hospital? (*Mid-level and junior staff*)
19. What features of the NAPH will make you to adopt its requirements freely?
20. Have you noticed any conflict between the requirements of the NAPH and your individual or organisational values? If yes, how do you react?
21. How do you resolve the possible conflicts between the requirements of the NAPH and values of different groups in the hospital? (*Senior managers*)
22. What, do you think, are the main goal, mission, vision and values of the hospitals?
23. Do you have strategic planning (SP) in your hospital? (*Senior managers*)
24. How do you develop your SP (bottom-up or top-down)?
25. Can you identify any change different elements of your (department) hospital resulted from this AP? How do you react if the changes are undesirable from your perspective?
26. Have your values ever changed as a result of the requirements of the programmes?
27. What type of internal PMSs do you use in this hospital? How are they developed or adopted? (*Senior managers*)
28. How do you perceive these PMSs? (*Mid-level and junior staff*)
29. How does the NAPH impact (support or overlap) on these PMSs? (*High and mid-level staff*)

C) Seeking for the respondents' suggestions for improvement (*All staff*)

1. Do the surveyors provide you with advices for improvements in the hospitals?
2. What recommendation can you provide for improving the programme? What facets of the NAPH need to be improved? How?
3. Do you still participate in the NAPH, if it was a voluntary programme?

D) Interview with the surveyors:

1. Do you send the evaluation checklists to the hospitals? If yes, when?
2. Do you inform the hospitals of the date and time of the on-site survey?
3. Do you ask for the feedback of the hospitals during the evaluation of the hospitals?

4. What methods do you use for the assessment of the hospitals (*interview, observation, etc.*)?
5. Do you have the authority to make any change in the checklists or procedure of the evaluation of the hospitals?
6. Do you pay any unannounced visit to the hospitals, apart from the main survey?
7. Are you involved in developing the evaluation standards of the NAPH with the MoH? Is your feedback asked for any modification or improvement of the NAPH?
8. Have the standards of the NAPH changed since its introduction?
9. What do you think are the hospitals reasons for compliance with the requirements of the NAPH?
10. What types of requirements are more accepted/rejected overall?
11. Are the hospitals able to complain about the results of the evaluation?

D) Closing the interview

The researcher:

- *Thanked the respondents*
- *Provided his contact details to the respondent for any possible questions*
- *Sought their approval to contact them again to chase up any queries and validate their interpretation of the information provided, and also check the summary of key points raised in the interview*

Appendix C: Participant Information Sheet (PIS)

(English version)

Study Title:

Contextual approach to the performance analysis of Iran's national AP for healthcare organisations

Researcher:

Ebrahim Jaafaripooyan

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

Given the importance of healthcare accreditation system for ensuring the quality and safety of health care, there has been an extensive call for the assessment of this external evaluatory system in the literature. This study as such aims to analyse the performance of Iran's national healthcare AP using selected theoretical models. It seeks to enhance our understanding of what impacts this national AP has on local hospitals and how the hospitals react to this evaluation system.

Why have I been chosen?

Hospitals' senior administrative and clinical staff are the most involved and knowledgeable people in the hospitals towards this AP whom seem to be suitable for this research.

What will happen to me if I take part?

This study will probably take around five/six months and you will be involved in a few face-to-face or telephone interviews conducted by researcher. A short introductory session will include explanation of the plan of the interviews and ask about the extent of your involvement in the accreditation of your hospital. At most two follow-up interviews will be undertaken to understand the interaction of the AP with your hospital. Each interview will last about 45 minutes.

Are there any benefits in my taking part?

There is no tangible benefit for your participation; however a report including the results of this research could be finally given to your hospital, if requested, to help improve your hospital advantage of this evaluation process. Moreover, the experience of participating in the research process might be useful for you.

Are there any risks involved?

There is no risk involved in this research process for you (even in the case of a lengthening the interview time, it can be carried on at your convenience).

Will my participation be confidential?

The gathered data will be kept strictly confidential. Your name and your hospital name will be immediately coded and anonymised when each interview is transcribed. Your ID will not be mentioned in the interview by other participants. The audio recordings, if you agree, will be kept only with the researcher in the password protected computers and will be destroyed in compliance with the Data Protection Act and University of Southampton policy, after the end of current research. Only the researcher will have the access to data collected during the course of the research.

What happens if I change my mind?

You are completely free to withdraw yourself from the participants of this study whenever you want without your legal rights are affected.

What happens if something goes wrong?

In the case of any concern you can contact either of the following numbers:

University of Hamedan Hospital Evaluation office:

(0098)- 08112524940

School of Management, University of Southampton:

0044-2380598979

Where can I get more information?

Contact details:

Ebrahim Jaafaripooyan

University of Hamedan

Hamedan

Tel: xxxx

Mob: xxx

Appendix D: Consent Form

(English Version)

Study title: Contextual approach to the performance analysis of Iran's national AP for healthcare organisations

Researcher name: Ebrahim Jaafaripooyan

Please initial the box (es) if you agree with the statement(s):

I have read and understood the information sheet and have had the opportunity to ask questions about the study

☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study

☐

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected

☐

Name of participant (print name).....

Signature of participant.....

Name of Researcher (print name)

Signature of Researcher.....

Date.....

Appendix E: Research sponsor letter



Mr Ebrahim Jaafariipooyan
School of Management
PG Office
University of Southampton
University Road
Highfield
Southampton
SO17 1BJ

RGO Ref: 7138

21 April 2010

Dear Mr Jaafariipooyan

Project Title Performance analysis of Iran's national accreditation programme for healthcare organisations

This is to confirm the University of Southampton is prepared to act as Research Sponsor for this study, and the work detailed in the protocol/study outline will be covered by the University of Southampton insurance programme.

As the sponsor's representative for the University this office is tasked with:

1. Ensuring the researcher has obtained the necessary approvals for the study
2. Monitoring the conduct of the study
3. Registering and resolving any complaints arising from the study

As the researcher you are responsible for the conduct of the study and you are expected to:

1. Ensure the study is conducted as described in the protocol/study outline approved by this office
2. Advise this office of any change to the protocol, methodology, study documents, research team, participant numbers or start/end date of the study
3. Report to this office as soon as possible any concern, complaint or adverse event arising from the study

Failure to do any of the above may invalidate the insurance agreement and/or affect sponsorship of your study i.e. suspension or even withdrawal.

On receipt of this letter you may commence your research but please be aware other approvals may be required by the host organisation if your research takes place outside the University. It is your responsibility to check with the host organisation and obtain the appropriate approvals before recruitment is underway in that location.

May I take this opportunity to wish you every success for your research.

Yours sincerely

A handwritten signature in blue ink, appearing to read "L. Dale", with a long horizontal flourish extending to the right.

Dr Lindy Dalen
Research Governance Manager

Tel: 023 8059 5058
email: rgoinfo@soton.ac.uk

Corporate Services, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44 (0) 23 8059 4684 Fax: +44 (0) 23 8059 5781 www.southampton.ac.uk

Appendix F: Policy Documents

(English version)

1) The MoH's introduction letter to the potential participant organisation (i.e. the UMS)

(English version)

22.July.2010	Islamic Republic of Iran Ministry of Health and Medical Education
<p>Dear Dr. A.</p> <p>Chancellor of the HUMS,</p> <p>Hereby Mr. Ebrahim Jaafaripooyan, our sponsored PhD student in the University of Southampton, the UK, is introduced for conducting his empirical research. Please facilitate his access to your hospitals for this purpose. Data will be collected via interviews, questionnaires, or observation. I appreciate any help you/your organisation can give him. Please feel free to contact the MoH if there is any help we can give you in this issue.</p> <p>Kind regards,</p> <p>Dr. X Y</p> <p>The Head of MoH's Education Services</p>	

2) MoH's responsibilities

(Majlis, 1988a)

(Continued in the next page)

- | | |
|----|---|
| 1 | To develop and establish policies and plans for training necessary manpower for research, health services and medicine, social welfare and social security |
| 2 | To provide public health and promote it through the implementation of health programmes, especially in the fields of environmental health, prevention of diseases, family and schools health, public health education, occupational health with emphasis on primary healthcare, and maternal and child health with cooperation of relevant agencies |
| 3 | To create a coordinated system of health and medical education and expand integrated healthcare networks |
| 4 | To define the required fields and levels of research and implement training programmes for medical manpower in order to achieving self-sufficiency |
| 5 | To conduct basic and applied research in all medical disciplines and fields and create and expand medical research institutions and units and supervise and coordinate research programmes and medical research institutes |
| 6 | To plan an appropriate and equitable distribution of manpower and other facilities (medical education and health care facilities) with an emphasis on primary health plans and priority of the deprived regions |
| 7 | To provide facilities for public enjoyment of healthcare by establishing and expanding public health centres, improving their standard, and of cooperating with charities, private sector, and different medical insurance companies |
| 8 | To finance through public funds, premiums, special revenues and public aid |
| 9 | To provide the necessary services to the remediable physical, mental, or social handicaps |
| 10 | To encourage the individuals and private institutions to support children under school age, elderly people and families, orphans, non-remediable physical, mental, and social handicaps and to provide such supports for the non-urgent |

cases by public institutions

- 11 To define the necessary standards for:
 - Health services, medication and rehabilitation
 - Food, hygienic, cosmetic, laboratory, medical equipments
 - Health and safety of involving institution in the above service
- 12 To issue, extend or cancel the license of:
 - Medical, pharmaceutical, and welfare Institutions and workshops of food and drinking, and health and cosmetic products
 - Production of medicine and biological materials, food and drinking, health, and cosmetic products, and laboratory and rehabilitation equipment and instruments
- 13 To monitor and control the quality of paragraph "B" of section 12 and define the necessary regulations for the cases mentioned in the paragraph "A" and "B" of section 12
- 14 To license the medical and medical related occupations
- 15 To define the principles of pricing the diagnostic and therapeutic, pharmaceutical, and social welfare services and charges in the public and non-public sectors and determine the tuition fees of informal training programmes
- 16 To define the principles of assessing, monitoring and controlling of healthcare institutions and to implement them
- 17 To define the criteria of importation, manufacture, storage, issuance, use and disposal of raw materials of biological medicines, food and drinking, health, cosmetic, pharmaceutical products and laboratory and medical rehabilitation equipment and instruments and to evaluate, supervise and control these criteria
- 18 To conduct research on traditional medicine and studies in the field of herbal medicines and to deliver proper education in the fields above and establish the appropriate centres for traditional medicine

3) The translation of MoH's letter to the UMSs about the establishment of the hospital evaluation and accreditation system

17.08.1997 Index no: 5234	Islamic Republic of Iran Ministry of Health and Medical Education
<p>Dear Medical University/School Chancellor</p> <p>In line with strengthening the values in all medical affairs and in accordance with Article 8 of the Act of establishing the MoH and Article 1 of the MoH's organisation and duties Act, enclosed "The instruction of standards and principles of evaluation of the general hospitals" is presented. These regulations are obligatory for all general hospitals including public, military, police, private and charity. The instruction should be provided to all hospitals, to obtain the necessary preparation for evaluation based on the criteria of these standards. All general hospitals should be evaluated based on these standards from 21.03.1998. Supervising and monitoring the implementation of the standards will be performed by the UMSs. All hospitals would be required, while studying the standards carefully and educating the relevant personnel, to facilitate achieving these standards by 21.03.1998.</p> <p>The Medicine and Treatment Deputy in the Ministry will be responsible for coordinating the implementation of the guidelines and delivering the practical evaluation forms.</p> <p>Signed by Dr Alireza Marandi The Minister of Health and Medical Education</p>	

4) The bylaw number 25337/2/S - 21/06/2008 to the hospitals

(English version)

<p>Islamic Republic of Iran K. University of Medical Sciences</p>
<p>To all hospitals,</p> <p>Given the fact that the main goal behind the evaluation of the hospitals is ‘to improve the quality of their services’, in line with this bylaw (21 June 2008-25337/2/S) of Ministry of Health and Medical Education, hereafter grade two will be considered as the lowest grade. Those hospitals that receive lower than this grade will be recognised as ‘substandard’ and consequently unauthorised to work.</p> <p>Kind regards,</p> <p>Dr. X Y</p> <p>Treatment and Clinical Deputy of the KUMS</p>

5) Strategic plan of one of the hospitals

(As an example)

Mission

The 'hospital H' has been established to facilitate public access to clinical and diagnostic services, help patients recover and prevent disease-related physical and mental disabilities. It is determined to accomplish its mission through delivering extensive quality health services and enhancing patients' satisfaction. We always see ourselves committed to the society, our customers and staff and government and try to satisfy their demands and include their feedback and participation.

Vision

We are aiming to be the best among the provincial hospitals in terms of abiding by quality standards as well as quality and diversity of our services in next five years. We aspire to apply the most efficient and cost-effective medical procedures and use highly qualified human resources in our hospital so that our staff take pride in their work for this centre.

Values

- Our staff are the most valuable assets of the hospital and their empowerment to have enough autonomy and authority in their decision making and work is the main goal of this hospital.
- Observance of Islamic values and reverence for human being is of a high priority for us.
- We always support and welcome staff participation and involvement and know that a sign for the hospital's maturity.
- Continuous quality improvement has been and is our permanent belief.
- Customer-oriented services are always in line with our mission.
- Proper management of the resources is crucial for the hospital's financial stability.

Objectives

1. Operationalising and furthering the economic and managerial reform of hospital structure (including, performance-based payment, preventive maintenance, operational budgeting, outsourcing of supportive services, information systems)
2. Instituting, developing and completing clinical and Para-clinical departments
3. Standardising the technical and medical equipment
4. Provision of quality services to the patients
5. Systematising the crisis management in the hospital
6. Improving the education and training of the staff and students
7. Standardising the physical layout of the departments
8. Facilitating the service provision through delivering supportive services

6) Policy guidelines of the ISO 9001:2008 in the hospitals

1. Observance of ethical and humane values and principles
2. Human resources development through ongoing training, motivation, participation and conducive work environment
3. Improving the productivity through optimal use of all available resources (human, information, financial and physical)
4. Continuous review and enhancement of processes and practices in order for internal and external customers
5. Application of scientific management and change and modification of the hospital's managerial and economic structure
6. Responsiveness to and appropriate informative strategies for customers

7) Hospitals' rules and regulations

1. A need for full cooperation of patients and their companions with medical team
2. Trust in physicians and hospital staff and allowing them to deal with the work on priority
3. Adherence to patient visit schedule
4. Keeping the hospitals as a quiet place
5. Attention to Health and safety and hygienic principles by patients and visitors
6. Handing all the relevant documents to the medical team as soon as possible
7. Observance of Islamic values and patients' privacy
8. Full payments of all hospitals' cost because of their financial autonomy
9. Expectations of the hospitals are commensurate with their capability
10. cooperation with the student given the teaching nature of the hospitals

Appendix G: Tables for the comparison of accreditation with similar PMSs and related concepts

Table 1- A comparison of four main external assessment models (Shaw, 2000; 2003b; 2004a; 2004c; Bohigas et al., 1996; Bohigas and Heaton, 2000; Donahue and VanOstenberg, 2000; Nabitz et al., 2000)

Continued in next pages

<div>Models</div> <div>Features</div>	EFQM	ISO	Visitation	Accreditation
Origin and first applications of the systems	<p>Europe, 1988</p> <p>Initiated by the European Commission and 14 European multi-national organizations</p> <p>Re-launched in 1999 as the Excellence Model</p>	<p>UK, 1947</p> <p>As a British standard for quality management systems</p> <p>Designed for defence engineering and manufacturing industries</p>	<p>The Netherlands, 1992</p> <p>Implemented by Dutch Medical Association as a peer review for registration of members and speciality medical training</p>	<p>USA, 1917</p> <p>Set up first by American college of surgeon as a mechanism for recognition of training posts in surgery</p> <p>Then as Hospital Standardization Programme (HSP)</p>
	<p>- Inspired by Baldrige award (MBNQA), it has followed the Donabedian performance</p>	<p>- ISO proliferation is due to rising enthusiasm for an internationally</p>	<p>- External peer review programme</p>	<p>- Healthcare-based (ie, originally initiated from</p>

<p>Important Features</p>	<p>measurement framework (structure, process, outcome)</p> <ul style="list-style-type: none"> - Some countries (eg, Scandinavia) have introduced their own national awards based on the EFQM - It can be used both as a self-assessment tool and external review - Provide a graphic conceptual framework - Covers areas such as clinical results, patient satisfaction, administration, and staff management - It focuses on organizational development and continuous improvement more than the others. 	<p>recognized healthcare quality standard</p> <ul style="list-style-type: none"> - More suitable for individual departments and quality systems (eg, laboratory and radiology) - More related to administrative procedures rather than to clinical results - Not intended for organizational development - A revised version of ISO is moving closer to the EFQM and Accreditation - ISO appropriateness for healthcare sector is not universally accepted. - Focusing on how the 	<ul style="list-style-type: none"> - Firmly grounded in medical profession - Improving performance by focusing on the quality of individuals' and clinical teams' performance - Directs its attention to the appropriateness of service delivery provided by the medical practitioners - Focus on clinical practice, professional development, and service quality 	<p>health care)</p> <ul style="list-style-type: none"> - Developed primarily for whole organization - Reflects the origins of systematic assessment of hospital against explicit standards - assesses based on a interdisciplinary approach
----------------------------------	--	---	--	--

		institution's stated objectives are achieved, rather than how the institution as a whole meets the needs of its patient.		
Evaluator terminology	Assessor	Auditor or Lead assessor	Visitor	Surveyor
Site visit	Assessment	Audit	Visit	Survey
Basis	Industry-based		Healthcare-based	
Public disclosure	It can be known for public (it is usually used for professional prestige)	It can be known for public (it is used for professional prestige)	Report are not available for public (strictly confidential)	Public can be aware of the result most of the time
Standards	Pre-established sets of expectations, stated as standards or evaluation criteria			
Focus of standards	Management systems	Quality systems	Professional performance	Health service delivery
Participation	Voluntary			Voluntary (exceptionally compulsory in some countries ⁴³) or in some cases both ⁴⁴ modes

⁴³. France, Scotland, Iran

⁴⁴. Italy

Evaluation team⁴⁵			Mostly clinical and often uni-disciplinary	Multi-disciplinary team of health professionals (including at least a senior executive physician, nurse and hospital administrator)
Evaluation team selection criteria	Some academics and quality professionals; or Mainly experienced managers	<ul style="list-style-type: none"> - Knowledge and experience of quality management; - Understanding of certification schemes - Relevant healthcare qualifications including medical, nursing and management; and seniority in health care sector. <p>General criteria such as:</p> <ul style="list-style-type: none"> - Maturity, judgement and understanding, analytical skills and management capabilities. <p>Specifically:</p> <ul style="list-style-type: none"> - At least four years fulltime appropriate 	A registered specialist with at least 5 years experience and Independent of the clinical staff being surveyed;	<ul style="list-style-type: none"> - Experience in the healthcare sector within the defined professions of doctor, nurse and an administrator or chief executive with a minimum period of experience in senior managerial positions. <p>Some example requirements of main accreditation bodies;</p> <ul style="list-style-type: none"> -Holding a master degree in JCAHO; - Being employed in an accredited institution in CCHSA; - Knowledge of national

⁴⁵. All four models use trained team for evaluating the quality of service. The size of this team usually depends on the size, nature and complexity of the healthcare organization being surveyed

		<p>practical work place experience;</p> <ul style="list-style-type: none"> - At least two years in quality assurance activities; <p>At least 20 days and four audits as a trainee auditor</p>		<p>healthcare system, good interpersonal skills and commitment in ACHS</p> <ul style="list-style-type: none"> - Knowledge and experience in continuous quality improvement in NZCHS
Training		<ul style="list-style-type: none"> - ISO requires training and assessing by externally recognized training bodies and selection is contingent on having certification from those bodies (eg, International Register of Certificated Auditors-IRCA); - According to IRCA, owning certain academic qualifications and experience in working quality and audit environment are requirement of certification. - And , passing around 40 hrs IRCA-approved courses: - Content: procedures 	<ul style="list-style-type: none"> - One day training; - <p>Content: procedures, attitudes, and techniques</p> <ul style="list-style-type: none"> - Monitored in first visit with specific personal feedback 	<ul style="list-style-type: none"> - Training at the beginning of their surveyor career (2-4 days of initial training. JCAHO, exceptionally requires 15 days of orientation and training); - Ongoing training updates thereafter, between 1 and 5 days per year; - Participatory methodologies; - The content of training are: standards knowledge, survey processes, communication, interviewing, and report writing

		<p>related to the audit of facilities, in the way of role-play, lectures, and some time a live audit.</p> <p>Auditors' qualifications are judged by a panel (consisting of internal, and external customers and third parties audit member)</p> <p>- Selection process is under general guidelines of ISO 10011.</p>		
Self-assessment ⁴⁶	<p>Healthcare institution is asked to provide data about activities generally derived from their self-assessment. This information must be closely aligned with EFQM nine award assessment criteria⁴⁷</p>	<p>The client institution is encouraged to show evidence of self preparation in some of the following ways:</p> <ul style="list-style-type: none"> ▪ Documentation ▪ Internal audits ▪ Management review 	<p>Clinical departments are asked a self-assessment questionnaire prior to the visit, addressing the organizational aspects of professional performance, giving an opportunity to select and discuss key</p>	<p>- Some APs use the institution's self-evaluation guide to the surveyors</p> <p>- The organization may be asked to state or grade its compliance to a set of explicit standards; the</p>

⁴⁶. "A comprehensive, systematic and regular review of an organization's activities and results, which allows the organization to discern clearly its strengths and areas in which improvements can be made and culminate in planned improvement actions that are then monitored for progress" (Bohigas and Heaton, 2000, p. 233). All models suggest the institutions to undertake a self-assessment, albeit in different ways.

⁴⁷. Leadership, Policy and strategy, People, Partnership and resources, Processes, Customer Results, People results, Society results, Key performance results (Nabitz, 2000)

		<ul style="list-style-type: none"> Pre-audit by and external body <p>This should include information on general features and resources of the institution, a copy of the institution's quality manual, and general information on the quality systems</p>	quality issues	surveyors then verify those results and comment on the differences
Agenda/Audit plan	Mainly identify the objectives, scope and duration of evaluation			
Survey		<p>Audit encompass;</p> <ul style="list-style-type: none"> Interviews Examination of documentation and activities Observation 	<p>Peer reviews also include;</p> <ul style="list-style-type: none"> Documentation Observations Structured and non-structured interviews 	<p>Elements used in accreditation surveys usually include:</p> <ul style="list-style-type: none"> Review of documentation Interviews Sample of medical records and other types of record Visits-observations
Survey report content	The report provides a list of strengths and areas for improvement under each criterion addressed in the application.	Audit report comprises the details included in audit plan; documentation against which the assessment was made; observations of non-conformities; and audit	The report consists of a description of clinical department, positive and negative findings and recommendations with suggestions for improvement	Accrediting bodies' report demonstrates compliance and non-compliance with standards. It usually contains a text summary as well as numerical

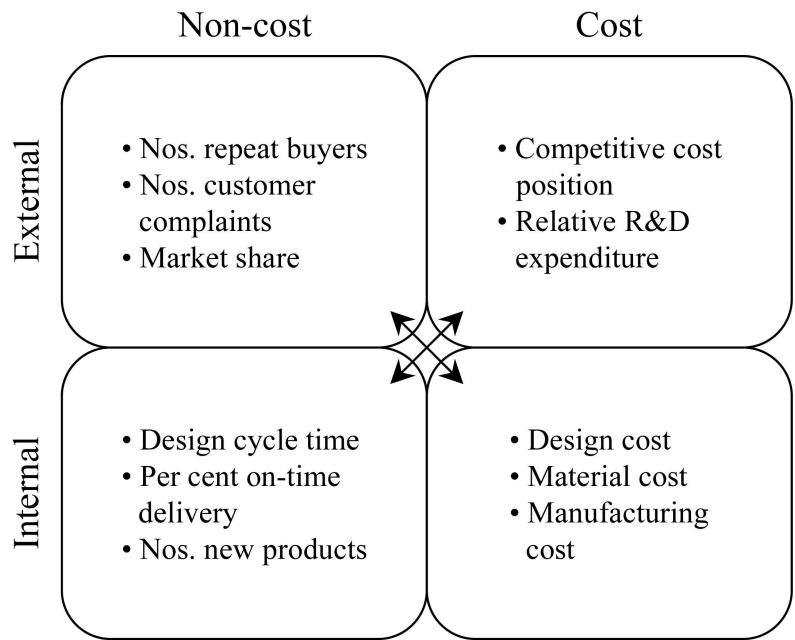
		team's judgement of the level of compliance		grading with appropriate comment, measured against the standards.
Grading of standards	EFQM assessors use a defined scoring process to allocate points to each assessment criteria.	ISO non-compliance is graded minor or major, according to its impact on the quality of the final product or process	In <i>visitatie</i> , consensus within the team is the first criterion for each formal conclusion or recommendation made. The second criterion is that judgement must be based on more than one argument mentioned in the report, and thirdly, a balance in positive conclusions and recommendations for improvement is necessary.	Grading systems vary from accreditor to accreditor and may be numerical (eg, 1-5) or descriptive (eg, minimal, partial, substantial or non-compliance). Accreditees may even be asked to grade themselves, the surveyors checking these grades during the survey and commenting in cases of divergences
Report writing		Report is prepared by the team under the direction of the lead auditor	Report is written up by someone from main evaluation centre	Accrediting bodies may use client managers or analysts employed to write report based on the surveyors notes and observations
External evaluation result and span	Award -	Certificate – 3 years	No award - 5 years	Accreditation – 3 years

Table 2- Definitions of accreditation, licensure and certification- Adapted from Roa and Rooney (1999)

Process	Issuing organisation	Object of evaluation	Components/Requirements	Standards
Accreditation (voluntary)	Recognized tools, usually an NGO	Organization	Compliance with published standards, on-site evaluation compliance not required by law and/or regulations	Set at a maximum achievable level to stimulate improvement over time
Licensure (compulsory)	Governmental authority	Individual	Regulations to ensure minimum standards, exam, or proof of education/competence	Set at a minimum level to ensure an environment with minimum risk to health and safety
		organization	Regulations to ensure minimum standards, on-site inspection	
Certification (voluntary)	Authorized body, either government or NGO	Individual	Evaluation of predetermined requirements, additional education/training, demonstrated competence in specialty area	Set by national professional or specialty boards
		Organization or component	Demonstration that the organization has additional services, technology, or capacity	Industry standards (e.g. ISO 9000 standards) evaluate conformance to design specifications

Appendix H: Performance Measurement Systems

Figure 1- The performance measurement matrix



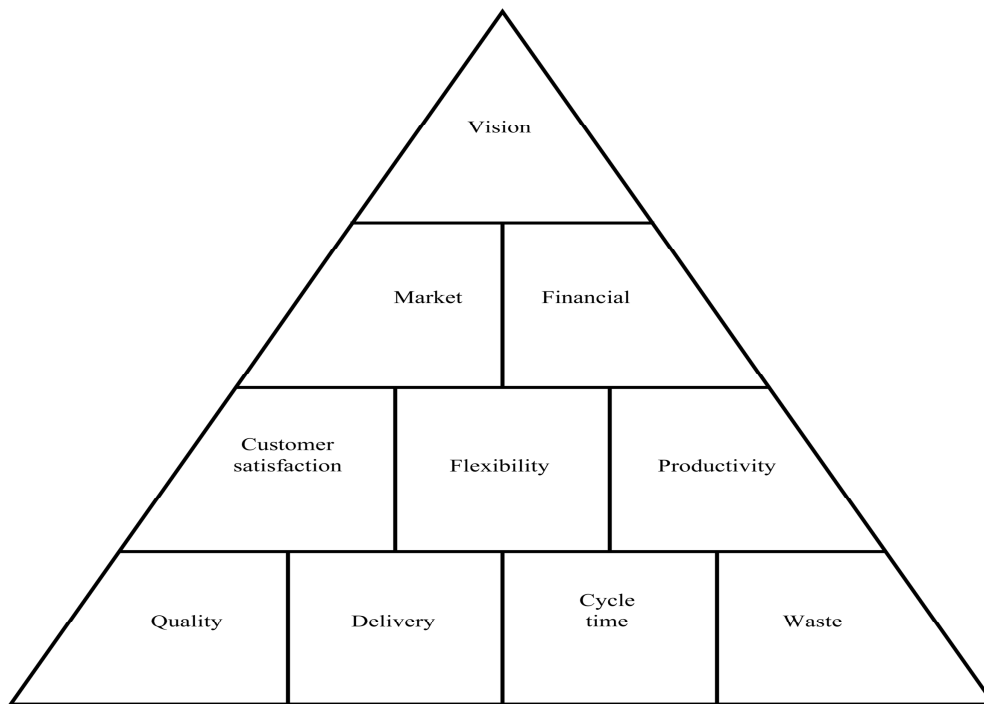
Source: Keegan *et al.*, 1989

Figure 2- Results and determinants framework

Results	Financial performance
	Competitiveness
Determinants	Quality
	Flexibility
	Resource utilisation
	Innovation

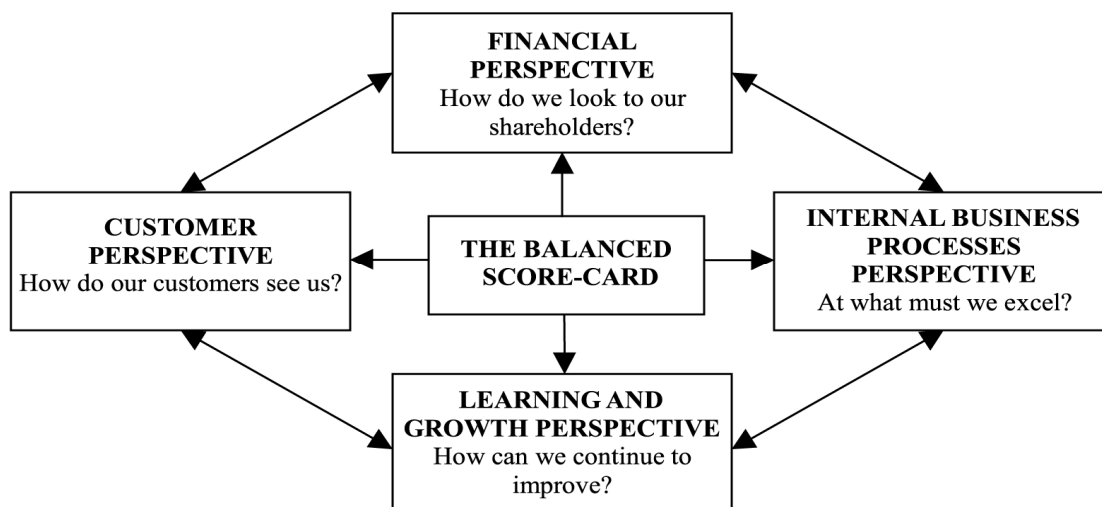
Source: Fitzgerald *et al.*, 1991

Figure 3- Performance pyramid system



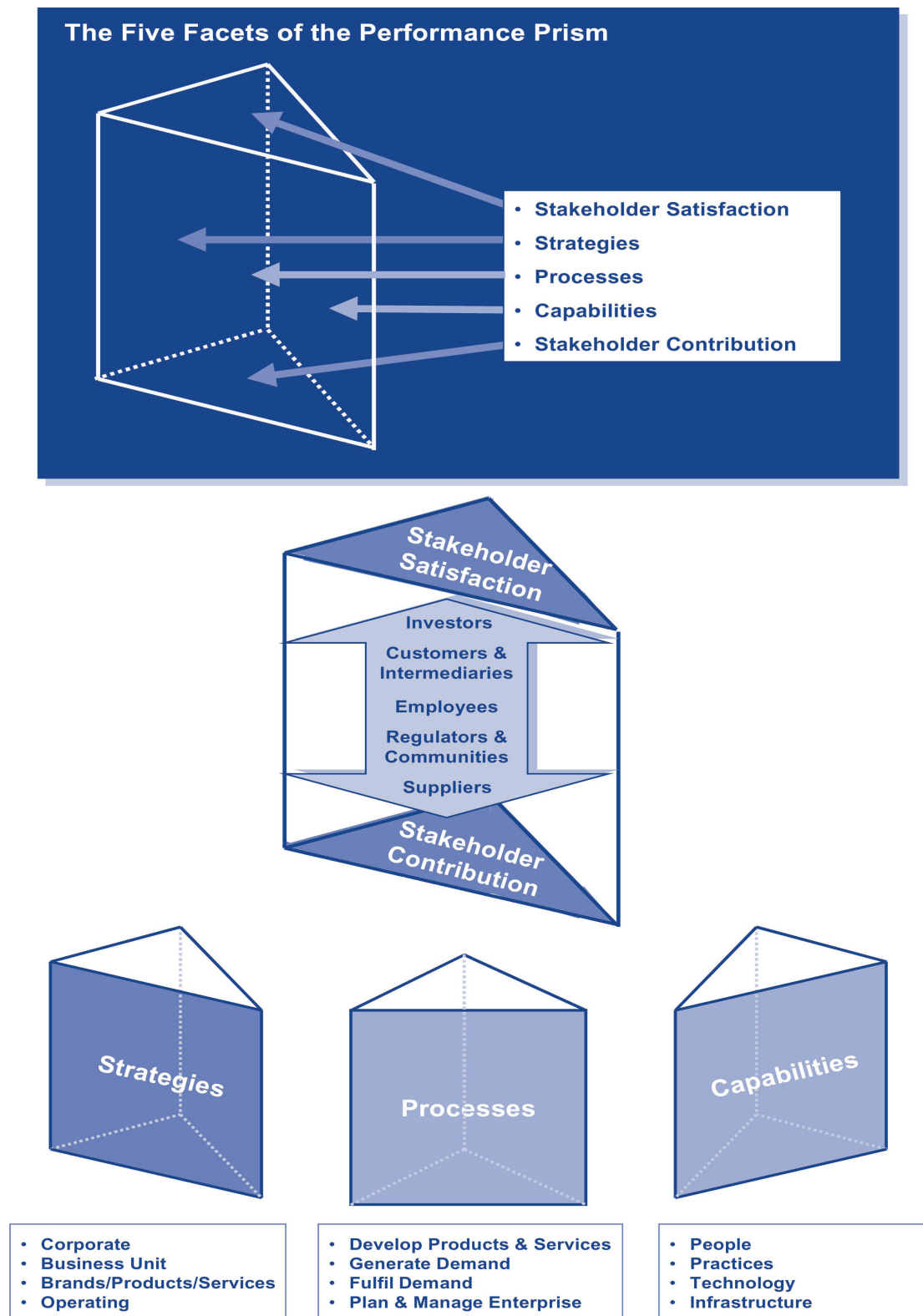
Source: Lynch and Cross, 1991

Figure 4- Balance scorecard



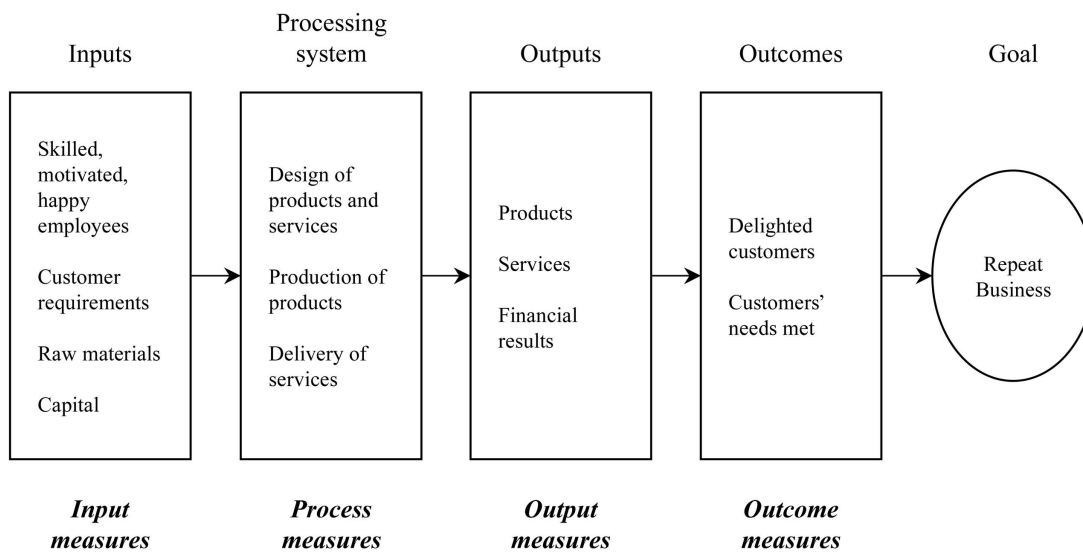
Source: Kaplan and Norton, 1992

Figure 5- Performance prism



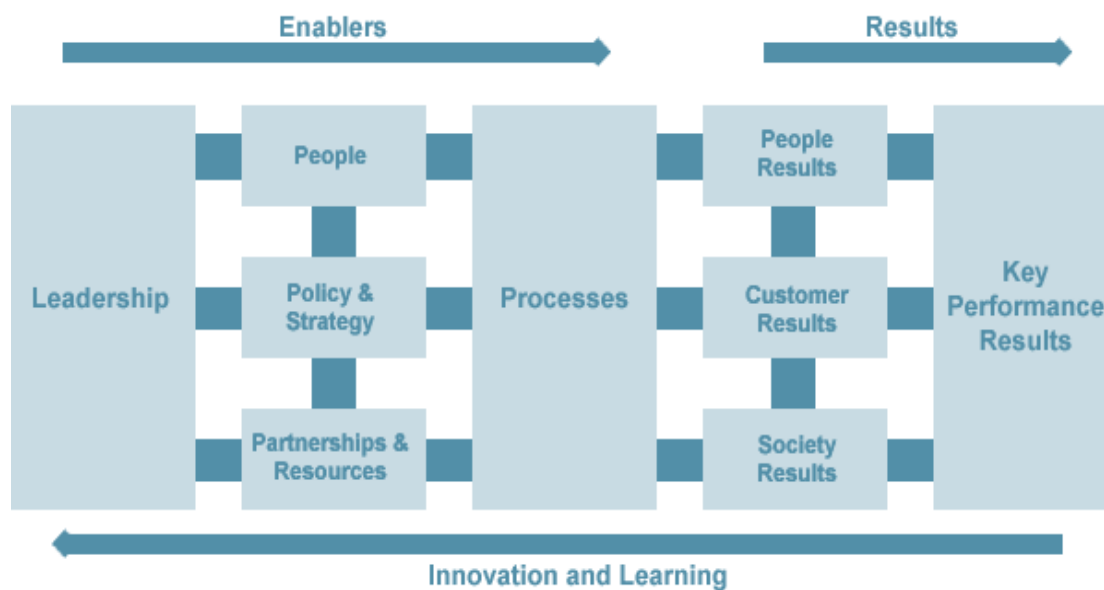
Source: Neely et al (2001)

Figure 6- Input, processes, outputs and outcomes framework



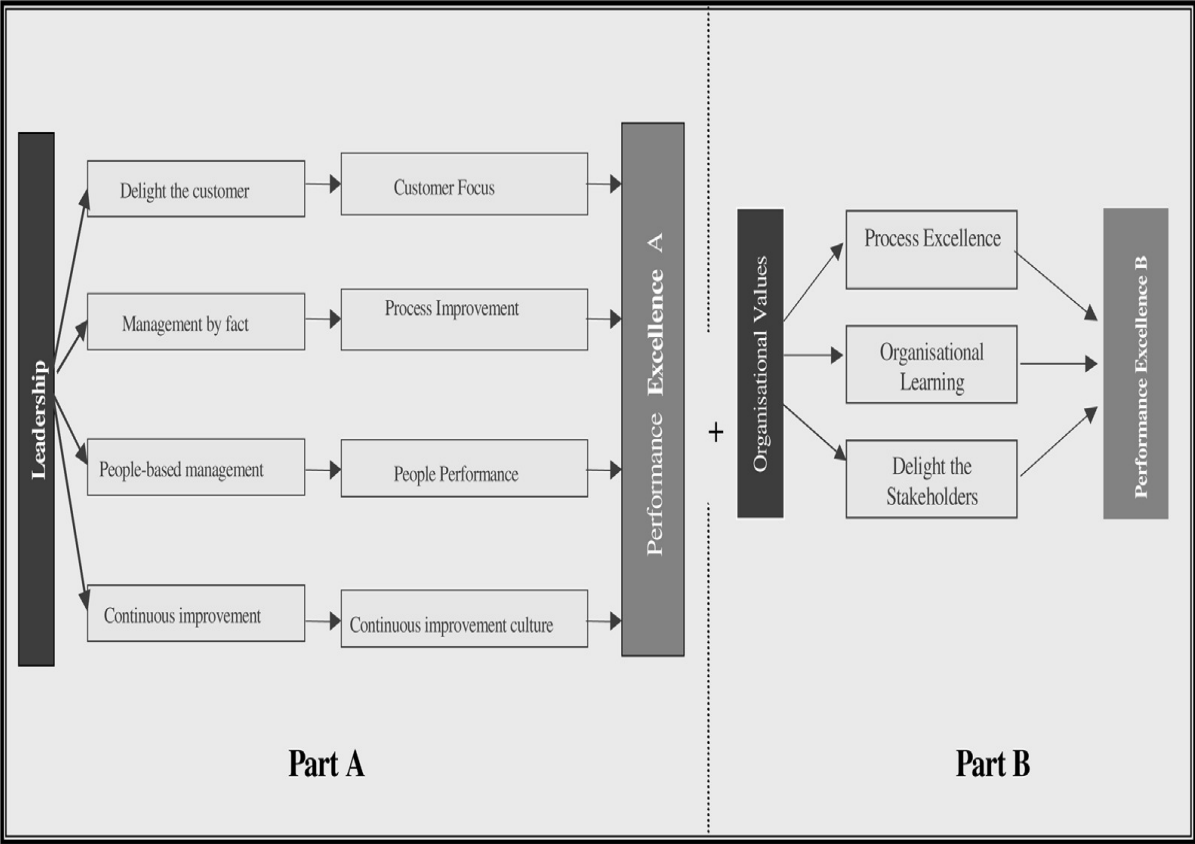
Source: Brown, 1996

Figure 7- EFQM Excellence Model



Source: Nabtiz et al. (2000)

























Figure 8- Kanji's Business Excellence Measurement System (KBEMS)




































Source: Kanji & Sa, 2003.

Appendix I: Examples of NVivo nodes and further supportive quotations from the analysis



















Free Nodes

	Name	Sources	Reference	Created On	Created B
	Benefits	 21	34	2009/11/06 10:33 ق.ط	E
	Overall Perceptions	19	33	2009/11/06 10:26 ق.ط	E
	Internal PMS (MCA)	7	12	2009/11/06 10:29 ق.ط	E
	Problems and Negative effects	30	96	2009/11/06 10:35 ق.ط	E
	Medical Universities	2	2	2009/11/06 12:07 ب.ط	E
	Surveyers' Side	4	26	2009/11/06 12:26 ب.ط	E
	Objective	4	4	2009/11/06 12:30 ب.ط	E
	Evaluation Merits	9	13	2009/11/09 04:20 ب.ط	E
	Chosen framework	3	4	2009/11/10 11:29 ق.ط	E
	Consultatively driven	12	12	2009/11/10 11:30 ق.ط	E
	Formalization of norms	0	0	2009/11/10 11:31 ق.ط	E
	Relevant	5	6	2009/11/10 11:48 ق.ط	E
	Freedom guaranteeing	1	1	2009/11/10 11:49 ق.ط	E
	Freedom reducing	2	2	2009/11/10 11:52 ق.ط	E
	Understandable	3	5	2009/11/10 12:57 ب.ط	E
	Consensual support	12	12	2009/11/10 12:58 ب.ط	E
	Embedded	2	2	2009/11/10 01:04 ب.ط	E
	Informed commonsense	0	0	2009/11/10 01:05 ب.ط	E
	Appropriateness	6	9	2009/11/10 01:06 ب.ط	E
	Intrepretive schemes	10	39	2009/11/10 01:13 ب.ط	E
	Design archetypes	20	61	2009/11/10 01:14 ب.ط	E
	Social Legitimacy	1	1	2009/11/10 02:28 ب.ط	E
	Economic gain	20	21	2009/11/10 02:33 ب.ط	E
	Dependence	5	6	2009/11/10 02:42 ب.ط	E
	Discretionary constraints	12	16	2009/11/10 03:20 ب.ط	E
	Legal coercion	24	39	2009/11/10 03:21 ب.ط	E
	Colonization	17	36	2009/11/10 04:51 ب.ط	E
	Evolution	12	15	2009/11/10 04:54 ب.ط	E
	Rebuttal	3	3	2009/11/10 04:59 ب.ط	E
	Reorientation	2	2	2009/11/10 05:01 ب.ط	E
	Evaluation Time	11	12	2009/11/23 04:39 ب.ط	E
	Contradiction and Inconsistency	17	36	2009/11/23 04:44 ب.ط	E
	History	3	3	2009/11/23 04:47 ب.ط	E
	Training about NAPH	3	6	2009/11/23 04:51 ب.ط	E
	Rewarding Score of NAPH	4	5	2009/11/23 04:55 ب.ط	E
	Stages and Methods of NAPH	4	4	2009/11/23 04:57 ب.ط	E
	Unannounced evaluation	2	4	2009/11/23 04:59 ب.ط	E
	Complaints from NAPH	3	4	2009/11/23 05:02 ب.ط	E
	Resisting NAPH	8	8	2009/11/23 05:03 ب.ط	E
	Update in NAPH	3	3	2009/11/23 05:08 ب.ط	E
	Hospitals' reaction to NAPH	3	4	2009/11/23 05:09 ب.ط	E
	Hospitals	5	8	2009/11/23 05:12 ب.ط	E
	Bias in NAPH	9	14	2009/11/23 05:17 ب.ط	E
	Gaming	13	16	2009/11/23 05:22 ب.ط	E
	Feedback	22	27	2009/11/23 05:23 ب.ط	E

Free Nodes

	Name	Sources	Reference	Created On	Created
	Evaluation standards	16	18	2009/11/23 05:44 ب.ظ	E
	General points	11	23	2009/11/23 05:52 ب.ظ	E
	Grading	2	8	2009/11/23 05:56 ب.ظ	E
	Third party evalution	8	13	2009/11/23 05:59 ب.ظ	E
	Recommendation	21	38	2009/11/23 06:15 ب.ظ	E
	SP	2	10	2009/11/23 06:44 ب.ظ	E
	Checklists (Recommendations)	1	1	2009/11/23 07:00 ب.ظ	E
	Checklists (weaknesses)	12	21	2009/11/23 07:02 ب.ظ	E
	Profile of PH	4	10	2009/11/23 07:23 ب.ظ	E
	Preparation	14	18	2009/11/23 07:40 ب.ظ	E
	Conflict of interests	9	9	2009/11/23 07:54 ب.ظ	E
	Evaluation team	4	5	2009/11/24 04:49 ب.ظ	E
	Professionals	3	6	2009/11/24 05:07 ب.ظ	E
	Hospital Informal perceptions	15	39	2009/11/24 05:17 ب.ظ	E
	Evaluation process	11	12	2009/11/24 05:20 ب.ظ	E
	Research Contribution	2	2	2009/11/24 05:21 ب.ظ	E
	Problems (for quality improvment)	14	42	2009/11/24 05:48 ب.ظ	E
	Surveyors (problems)	6	13	2009/11/24 05:54 ب.ظ	E
	Surveyors (recommendations)	3	6	2009/11/24 07:13 ب.ظ	E
	Other PMS	6	17	2009/11/24 07:46 ب.ظ	E
	My thoughts	13	19	2009/11/25 12:30 ق.ظ	J
	Colonizing effect	9	15	2009/11/25 12:35 ب.ظ	E
	Reputation	1	1	2009/11/25 05:29 ب.ظ	E
	ISO	10	30	2009/11/26 05:51 ب.ظ	E
	Autonomous hospital	1	1	2009/11/26 08:13 ب.ظ	E
	Perceptions to Design Archetypes	2	9	2009/11/27 05:01 ب.ظ	E
	Surveyors (Evaluation)	1	1	2009/11/27 06:08 ب.ظ	E
	Tunnel vision	2	2	2009/11/28 12:11 ب.ظ	J
	Compliance motive	1	2	2009/11/28 06:28 ب.ظ	J
	Incentives	2	2	2009/11/30 05:03 ب.ظ	E
	ISO(Benefits)	1	1	2009/12/01 12:46 ب.ظ	E
	ISO(Problems)	1	2	2009/12/01 12:47 ب.ظ	E
	ISO(Motives)	1	1	2009/12/01 12:47 ب.ظ	E

Tree Nodes

	Name	Sources	References	Created On
[-]	 Regulative and constitutive mechanism	0	0	2009/11/30 05:23
	 Consensual support	12	12	2009/11/30 05:23
	 Consultatively driven	12	12	2009/11/30 05:23
	 Appropriateness	6	9	2009/11/30 05:23
	 Understandable	3	5	2009/11/30 05:23
	 Embedded	2	2	2009/11/30 05:23
	 Freedom guaranteeing	1	1	2009/11/30 05:23
	 Formalization of norms	0	0	2009/11/30 05:23
	 Informed commonsense	0	0	2009/11/30 05:23
[-]	 Colonising factors of the NAPH	0	0	2009/11/30 05:25
	 Legal coercion	18	28	2009/11/30 05:25
	 Economic gain	20	21	2009/11/30 05:25
	 Social Legitimacy	1	1	2009/11/30 05:25
	 Reputation	1	1	2009/11/30 05:25
[-]	 Design Archetypes of the hospitals	0	0	2009/12/01 11:32
	 Design archetypes	20	61	2009/12/01 11:32
	 ISO	10	30	2009/12/01 11:32
	 Internal PMS (MCA)	6	11	2009/12/01 11:32

Supportive quotations

Static

'We might not take that serious because it is static and is done in a short time.' (Sister: Hospital F)

'It is a static and repetitive evaluation programme.' (Third party surveyor)

Focus on structures

'This evaluation programme normally does not assess processes, but mostly the structures ...' (Head Surveyor)

Biased evaluation

'Standards are good in theory but hospitals do not have enough means to fulfil them as requested.' (Matron: Hospital G)

Gaming

'...they [the surveyors] for instance ask for the provision of a new service that it is not to the benefit of this hospital from cost perspective.' (Manager: Hospital C)

'We are asked to buy some material or equipment that we don't use them too often, as a result of which the hospital incurs costs. ...for example, buying an LP set, which is rarely used in this ward.' (Matron: Hospital F)

'...this hospital deserves more, but the surveyors are not recognising us properly; then we may sometimes try to prepare the hospital in a way to get a higher grade.' (Manager: Hospital H)

Gaming rationales:

'We are sometimes asked to do some thing like ...buying new equipments, but since it is not a priority for the hospital...' (Head of ED: Hospital F)

'The [perceivably] irrational requirements of the NAPH when is coupled with our shortage of financial resources drive us to prepare superficially the hospital for the evaluation. We need its score.' (Manager: Hospital H)

Legal coercion

'Our motive to compliance is compulsory nature of the NAPH'
(Manager: Hospital B)

'High tariffs are the main motive of this hospital, as far as I know, for the compliance with the NAPH, although apparent reason is the compulsory nature of the programme (the NAPH).' (Member of quality improvement office: Hospital F)

ISO

'We adopted ISO to improve the quality of our services ... preparing us for evaluation by the NAPH.' (Manager: Hospital D)

'ISO can bring reputation and class to our hospital and...' (Head of Para -clinic Dept.: Hospital B)

'We are trying to align our ISO indicators with the NAPH's evaluation checklists; in order to both perform a self-assessment before its evaluation and raise the chance of getting high score.' (Manager: Hospital H)

Self-developed IQIPs

'Internal evaluation is based on some checklists extracted from the main standards to prepare and perform a self-evaluation of the hospital.' (Matron: Hospital D)

Hospital committees

'... We form a temporary committee [the CISE] to prepare the hospital for main evaluation. This committee gathers the head of different departments and hold some meetings and justify them for preparation for the evaluation. It also gives the checklists of NAPH to the departments to get prepared for evaluation.' (Manager: Hospital H)

Reference

- ABASOLO, A. F. 2006. New Measure of Hospital Maintenance: Balanced Scorecard. *Journal of Health Management*, 8, 139-143.
- ABDULLATIF, A. A. 2007. Towards the better performance of hospital systems in the Easter Mediterranean. *International Hospital Federation Reference Book*. IHF.
- ABERNETHY, M. A., CHUA, W. F., GRAFTON, J. & MAHAMA, H. 2007. Accounting and Control in Health Care: Behavioural, Organisational, Sociological and Critical Perspectives. In: CHAPMAN, C. S., HOPWOOD, A. G. & SHIELDS, M., D. (eds.) *Handbook of Management Accounting Research*. Oxford: Elsevier.
- ACHS 2008. Annual Report 2007-2008. Sydney: Australian Council on Healthcare Standards.
- ACSQHC 2003a. Standard setting and accreditation literature review and report. In: DEPARTMENT OF HEALTH AND AGEING (ed.). Sydney.
- ACSQHC 2003b. Standard setting and accreditation system in health care: consultation paper. In: DEPARTMENT OF HEALTH AND AGEING (ed.).
- ADAMS, J., KHAN, H., RAESIDE, D. & WHITE, D. 2007. *Research Methods for Graduate Business and Social Science Students*, London, SAGE.
- ADCROFT, A. & WILLIS, R. 2005. The (un) intended outcome of public sector performance measurement. *International Journal of Public Sector Management*, 18, 386-400.
- AGRIZZI, D. 2003. *Steering the UK NHS: Costing information in a NHS Trust*. PhD Thesis. University of London, Royal Holloway.
- AGRIZZI, D. 2008. Assessing English hospitals: contradiction and conflict. *Journal of Accounting & Organizational Change*, 4, 222-242.
- AHSAN, M. K. & BARTLEMA, J. 2004. Monitoring healthcare performance by analytic hierarchy process: a developing-country perspective. *International Transactions in Operational Research*, 11, 465-478.
- AKAO, Y. 2004. *Quality function deployment: integrating customer requirements into product design*, New York, Productivity Press.
- AL-ANGARI, H. & SHERER, M. 2002. The implementation of quality review programmes on audit firms in Saudi Arabia: an illustration of change processes in a transitional economy. *Journal of King Abdolaziz University: Economics & Adminstration*, 16, 21-36.
- AL-TEHEWY, M., SALEM, B., HABIL, I. & EL OKDA, S. 2009. Evaluation of accreditation programme in non-governmental organizations' health units in Egypt: short-term outcomes. *International Journal for Quality in Health Care*, 21, 183-189.
- ALVESSON, M. & DEETZ, S. 2000. *Doing critical management research*, London, SAGE.
- AMARATUNGA, D. & BALDRY, D. 2002. Moving from performance measurement to performance management. *Facilities*, 20, 217-223.
- AMERIOUN, A. 2001. *Comparative study of public and private hospitals' evaluation mechanism in theory and practice in Tehran and proposing a model*. PhD Thesis, Tehran Open University.
- AMERIOUN, A. & KHALESI, N. 2007. The method of hospital grading from the MoH and Tehran hospital senior managers. *Health Management*, 9, 39-44.

- ANDERSON, R. & MCDANIEL JR, R. 2000. Managing health care organizations: where professionalism meets complexity science. *Health Care Management Review*, 25, 83-92.
- ANONYMOUS. 2004. *Schematic diagram of the hospital evaluation process in Iran* [Online]. Tehran: Iran University of Medical Sciences and Health Services. Available: http://www.iums.ac.ir/page.php?slct_pg_id=2610&sid=18&slc_lang=fa [Accessed 16th July 2009].
- ANONYMOUS 2007a. International accreditation standards for healthcare external evaluation organizations, 3rd ed. Melbourne: International Society for Quality in Health Care.
- ANONYMOUS 2007b. International principles for healthcare standards: A framework of requirements for standards, 3rd ed. Melbourne: International society for quality in health care.
- ANONYMOUS. 2007c. *The last national statistics of Iranian population* [Online]. Tehran. Available: <http://www.aftabnews.ir/vdcc0xqe.2bqsi8laa2.html> [Accessed 20th July 2007].
- ANONYMOUS. 2007d. *Map of Iran* [Online]. Available: www.iranmap.com [Accessed 17th April 2009].
- ANONYMOUS. 2008. *Healthcare Networks* [Online]. Tabriz: Tabriz University of Medical Sciences and Health Services. Available: <http://www.tbzmed.ac.ir/DHN/network.htm> [Accessed 13th May 2008].
- ANONYMOUS. 2011a. *Hospital autonomy: An unconsidered plan imposed on the hospitals* [Online]. Tehran. Available: <http://www.salamatnews.ir/viewNews.aspx?ID=28578&cat=1> [Accessed 28/02/2011].
- ANONYMOUS. 2011b. *Hospital evaluation based on the new series of the checklists of standards* [Online]. Tehran. Available: <http://salamatnews.com/ViewNews.aspx?ID=31879&cat=12> [Accessed 20/08/2011].
- ARAB, M., POORREZA, A., ZAREI, H. & RAVANGARD, R. 2005. Is there any relation between hospital grade and performance? *Management and Information in Health and Treatment*, 2, 1-7.
- ARAH, O. A., KLAZINGA, N. S., DELNOIJ, D. M. J., ASBROEK, A. H. A. T. & CUSTERS, T. 2003. Conceptual frameworks for health systems performance: a quest for effectiveness, quality, and improvement. *International Journal for Quality in Health Care*, 15, 377-398.
- ARCE, H. E. 1999. Report. Accreditation: the Argentine experience in the Latin American region. *International Journal for Quality in Health Care*, 11, 425-428.
- ARGYRIS, C. 1999. *On organizational learning*; 2nd ed., Oxford, Blackwell Publishing.
- ARYANKHESAL, A. 2010. *The Iranian hospital grading system and its influence on stakeholders' behaviour*. PhD Thesis, University of York.
- ARYANKHESAL, A. & SHELDON, T. 2010. Effect of the Iranian hospital grading system on patients' and general practitioners' behaviour: an examination of awareness, belief and choice. *Health Services Management Research*, 23, 139-144.
- ASHTON, R. H. 1976. Deviation-amplifying feedback and unintended consequences of management accounting systems. *Accounting, Organizations and Society*, 1, 289-300.
- ATTREE, M. 2006. Evaluating healthcare education: Issues and methods. *Nurse education today*, 26, 640-646.

- AZZONE, G., MASELLA, C. & BERTELE, U. 1991. Design of performance measures for time-based companies. *International Journal of Operations & Production Management*, 11, 77-85.
- BABAKUS, E. & MANGOLD, W. G. 1992. Adapting the SERVQUAL scale to hospital services: an empirical investigation. *Health Services Research*, 26, 767-86.
- BAGHEBANIAN, A. 2001. *Investigating the relationship between Shiraz public and private hospitals' performance and their accreditation ranking*. MSc Dissertation, Tehran University of Medical Sciences.
- BAILEY, D., LITAKER, D. & MION, L. 1998. Developing better critical paths in healthcare: Combining 'best practice' and the quantitative approach. *Journal of Nursing Administration*, 28, 21-26.
- BAKER, C. R. 2008. A Habermasian Approach to the Analysis of Globalisation Processes. *International Journal of Social Inquiry*, 1, 89-112.
- BAKER, G. R. & PINK, G. H. 1995. A balanced scorecard for Canadian hospitals. *Healthc Manage Forum*, 8, 7-21.
- BAKER, S. & DUNN, D. 2006. Accreditation: The Hallmark of Educational Quality. *Radiologic Technology*, 78, 123-130.
- BALLANTINE, J., BRIGNALL, S. & MODELL, S. 1998. Performance measurement and management in public health services: a comparison of U.K. and Swedish practice. *Management Accounting Research*, 9, 71-94.
- BARACH, P. & BERWICK, D. M. 2003. Patient Safety and the Reliability of Health Care Systems. *Annals of Internal Medicine*, 138, 997-998.
- BARKER, K. N., FLYNN, E. A., PEPPER, G. A., BATES, D. W. & MIKEAL, R. L. 2002. Medication errors observed in 36 health care facilities. *Archives of Internal Medicine*, 162, 1897-903.
- BARKER, R. M., PEARCE, M. S. & IRVING, M. 2004. Star wars, NHS style. *BMJ*, 329, 107-109.
- BARNUM, H. & KUTZIN, J. 1993. *Public hospitals in developing countries: resource use, cost, financing*, Baltimore, Johns Hopkins University Press.
- BARTLETT, H. 1993. *Nursing homes for elderly people: questions of quality and policy*, Chur, Switzerland, Harwood Academic Publishers.
- BASKIND, R., KORDOWICZ, M. & CHAPLIN, R. 2010. How does an accreditation programme drive improvement on acute inpatient mental health wards? An exploration of members' views. *Journal of Mental Health*, 19, 405-411.
- BASSETT, C. 2004. *Qualitative research in health care*, London, Whurr.
- BEAULIEU, N. D. & EPSTEIN, A. M. 2002. National Committee on Quality Assurance health-plan accreditation: predictors, correlates of performance, and market impact. *Medical Care*, 40, 325-37.
- BECHEL, D., MYERS, W. A. & SMITH, D. G. 2000. Does Patient-Centered Care Pay Off? *Joint Commission Journal on Quality and Patient Safety*, 26, 400-409.
- BEHN, R. D. 2003. Why Measure Performance? Different Purposes Require Different Measures Performance. *Public Administration Review*, 63, 586-606.
- BEHN, R. D. & KANT, P. A. 1999. Strategies for Avoiding the Pitfalls of Performance Contracting. *Public Productivity & Management Review*, 22, 470-489.
- BERRY, A., COAD, A., HARRIS, E., OTLEY, D. & STRINGER, C. 2009. Emerging themes in management control: A review of recent literature. *The British Accounting Review*, 41, 2-20.
- BERWICK, D. M. 2008. The science of improvement. *JAMA*, 299, 1182-1184.
- BEVAN, G. 2006. Setting Targets for Health Care Performance: Lessons from a Case Study of the English NHS. *National Institute Economic Review*, 197, 67-79.

- BEVAN, G. & HAMBLIN, R. 2009. Hitting and missing targets by ambulance services for emergency calls: effects of different systems of performance measurement within the UK. *Journal of the Royal Statistical Society: Series A (Statistics in Society)*, 172, 161-190.
- BEVAN, G. & HOOD, C. 2006a. Have targets improved performance in the English NHS? *BMJ*, 332, 419-422.
- BEVAN, G. & HOOD, C. 2006b. What's measured is what matters: targets and gaming in the English public health care system. *Public Administration*, 84, 517-538.
- BIRNBERG, J. G., TUROPOLEC, L. & YOUNG, S. M. 1983. The organizational context of accounting. *Accounting, Organizations and Society*, 8, 111-129.
- BITITCTI, U. S., TURNER, T. & BEGEMANN, C. 2000. Dynamics of performance measurement, systems. *International Journal of Operations & Production Management*, 20, 692-704.
- BLANK, J. L. T. & VALDMANIS, V. (eds.) 2007. *Evaluating Hospital Policy and Performance: Contributions from Hospital Policy and Productivity Research*, Oxford: JAI Press Inc.
- BLOOR, M. 1997. Techniques of validation in qualitative research: a critical commentary. *Context and method in qualitative research*, 37-50.
- BOADEN, R. 2008. *Quality Improvement: theory and practice in healthcare*, London, NHS Institute for Innovation and Improvement.
- BOHIGAS, L. & ASENJO, M. A. 1995. Hospital accreditation in Catalunya: an assessment of the performance in quality of hospitals. *The International Journal of Health Planning and Management*, 10, 201-208.
- BOHIGAS, L. & HEATON, C. 2000. Methods for external evaluation of health care institutions. *International Journal for Quality in Health Care*, 12, 231-238.
- BOHIGAS, L., SMITH, D., BROOKS, T., DONAHUE, T., HEIDEMANN, E., DONALDSON, B. & SHAW, C. 1996. Accreditation Programmes for Hospitals: Funding and Operation. *International Journal for Quality in Health Care*, 8, 583-589.
- BOND, T. C. 1999. The role of performance measurement in continuous improvement. *International Journal of Productions and Operations*, 19, 1318-34.
- BONTIS, N., DRAGONETTI, N. C., JACOBSEN, K. & ROOS, G. 1999. A review of the tools available to measure and manage intangible resources. *European Management Journal*, 17, 391-402.
- BOWLING, A. & EBRAHIM, S. 2005. *Handbook of health research methods: investigation, measurement and analysis*, Maidenhead, Berkshire, UK, Open University Press.
- BRAITHWAITE, J., GREENFIELD, D., WESTBROOK, J., PAWSEY, M., WESTBROOK, M., GIBBERD, R., NAYLOR, J., NATHAN, S., ROBINSON, M. & RUNCIMAN, B. 2010. Health service accreditation as a predictor of clinical and organisational performance: a blinded, random, stratified study. *Quality and Safety in Health Care*, 19, 14-21.
- BRAITHWAITE, J., WESTBROOK, J., PAWSEY, M., GREENFIELD, D., NAYLOR, J., IEDEMA, R., RUNCIMAN, B., REDMAN, S., JORM, C., ROBINSON, M., NATHAN, S. & GIBBERD, R. 2006. A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social-organisational design for researching health sector accreditation. *BMC Health Services Research*, 6, 113-123.
- BRENNAN, T. 1998. The role of regulation in quality improvement. *Milbank Quarterly*, 76, 709-731.

- BRIGNALL, S. 1992. Performance measurement systems as change agents: a case for further research. *Warwick Business School Research Papers, No.72*. Warwick: Warwick Business School Research Bureau.
- BRIGNALL, S. & MODELL, S. 2000. An institutional perspective on performance measurement and management in the 'new public sector'. *Management Accounting Research*, 11, 281-306.
- BROADBENT, J. 1998. The gendered nature of 'accounting logic': Pointers to an accounting that encompasses multiple values. *Critical Perspectives on Accounting*, 9, 267-297.
- BROADBENT, J. 2002. Critical accounting research: a view from England. *Critical Perspectives on Accounting*, 13, 433-449.
- BROADBENT, J., GALLOP, C. & LAUGHLIN, R. 2010a. Analysing societal regulatory control systems with specific reference to higher education in England. *Accounting, Auditing & Accountability Journal*, 23, 506-531.
- BROADBENT, J. & GUTHRIE, J. 1992. Changes in the public sector: a review of recent 'alternative' accounting research. *Accounting, Auditing and Accountability Journal*, 5, 3-31.
- BROADBENT, J. & GUTHRIE, J. 2008. Public sector to public services: 20 years of "contextual" accounting research. *Accounting, Auditing & Accountability Journal*, 21, 129-169.
- BROADBENT, J., JACOBS, K. & LAUGHLIN, R. 2001. Organisational resistance strategies to unwanted accounting and finance changes. *Accounting, Auditing & Accountability Journal*, 14, 565-586.
- BROADBENT, J. & LAUGHLIN, R. 1997a. Developing empirical research: an example informed by a Habermasian approach. *Accounting, Auditing & Accountability Journal*, 10, 622-648.
- BROADBENT, J. & LAUGHLIN, R. 1997b. Evaluating the 'New Public Management' Reforms in the UK: A Constitutional Possibility. *Public Administration*, 75, 487-507.
- BROADBENT, J. & LAUGHLIN, R. 1998. Resisting the "new public management": absorption and absorbing groups in schools and GP practices in the UK. *Accounting, Auditing & Accountability Journal*, 11, 403-435.
- BROADBENT, J. & LAUGHLIN, R. 2005. Organisational and accounting change: theoretical and empirical reflections and thoughts on a future research agenda. *Journal of Accounting & Organisational Change*, 1, 7-26.
- BROADBENT, J. & LAUGHLIN, R. 2009. Performance management systems: A conceptual model. *Management Accounting Research*, 20, 283-295.
- BROADBENT, J., LAUGHLIN, R. & ALWANI-STARR, G. 2010b. Steering for Sustainability. *Public Management Review*, 12, 461-473.
- BROADBENT, J., LAUGHLIN, R. & READ, S. 1991. Recent financial and administrative changes in the NHS: a critical theory analysis. *Critical Perspectives on Accounting*, 2, 1-29.
- BROWN, M. G. 1996. *Keeping Score: Using the Right Metrics to Drive World-Class Performance*, New York, Quality Resources.
- BUKONDA, N., TAVROW, P., ABDALLAH, H., HOFFNER, K. & TEMBO, J. 2003. Implementing a national hospital accreditation program: the Zambian experience. *International Journal for Quality in Health Care*, 14, 7-16.
- BURRELL, G. & MORGAN, G. 1979. *Sociological Paradigms and Organisational Analysis*, London, Heinemann.
- BURTON, S. & STEANE, P. 2004. *Surviving your thesis*, London, Routledge.

- BUTTLE, F. 1996. SERVQUAL: review, critique, research agenda. *European Journal of Marketing*, 30, 8-32.
- CAMPANALE, C., CINQUINI, L. & TENUCCI, A. 2010. Do Management Accounting Systems Influence Organizational Change or Vice-Versa? Evidence from a Case of Constructive Research in the Healthcare Sector, Working paper. SSRN.
- CARTER, N., KLEIN, R. & DAY, P. 1995. *How organisations measure success: The use of performance indicators in government*, Routledge London.
- CARUANA, A. 2002. Service loyalty: The effects of service quality and the mediating role of customer satisfaction. *European Journal of Marketing*, 36, 811-828.
- CARUANA, A., EWING, M. T. & RAMASESHAN, B. 2000. Assessment of the Three-Column Format SERVQUAL: An Experimental Approach. *Journal of Business Research*, 49, 57-65.
- CASALINO, L. 1999. The unintended consequences of measuring quality on the quality of medical care. *New England journal of medicine*, 341, 1147-1150.
- CASAMASSIMO, P. S. & WILSON, S. 1999. Opinions of practitioners and program directors concerning accreditation standards for postdoctoral pediatric dentistry training programs. *Pediatric Dentistry*, 21, 354-8.
- CASEY, D. E. 2010. Performance Measurement 2.0: Time to Raise the Bar. *American Journal of Medical Quality*, 25, 246-248.
- CASTANEDA-MENDEZ, K., MANGAN, K. & LAVERY, A. M. 1998. The role and application of the balanced scorecard in healthcare quality management. *Journal of Healthcare Quality Assurance*, 20, 10-3.
- CERQUEIRA, M. 2006. A literature review on the benefits, challenges and trends in accreditation as a quality assurance system. British Columbia: Ministry of Children and Family Development.
- CHANG, L. 2006. Managerial Responses to Externally Imposed Performance Measurement in the NHS: An Institutional Theory Perspective. *Financial Accountability & Management*, 22, 63-85.
- CHANG, L. 2007. The NHS performance assessment framework as a balanced scorecard approach: Limitations and implications. *International Journal of Public Sector Management*, 20, 101-117.
- CHEN, J., RATHORE, S., RADFORD, M. & KRUMHOLZ, H. 2003. JCAHO Accreditation and Quality of Care for Acute Myocardial Infarction. *Health Affairs*, 22, 243-254.
- CHEN, X. Y., YAMAUCHI, K., KATO, K., NISHIMURA, A. & ITO, K. 2006. Using the balanced scorecard to measure Chinese and Japanese hospital performance. *International Journal of Health Care Quality Assurance*, 19, 339-50.
- CHENHALL, R. 2005. Integrative strategic performance measurement systems, strategic alignment of manufacturing, learning and strategic outcomes: an exploratory study. *Accounting, Organizations and Society*, 30, 395-422.
- CHUANG, S. & INDER, K. 2009. An effectiveness analysis of healthcare systems using a systems theoretic approach. *BMC Health Services Research*, 9, 195-205.
- COLLIS, J. & HUSSEY, R. 2003. *Business research: a practical guide for undergraduate and postgraduate students*, Basinstoke, Hampshire, UK, Palgrave Macmillan
- COLLOPY, B., T. 1995. Extending facility accreditation to the evaluation of care: The Australian experience. *International Journal of Health Planning and Management*, 10, 223-229.
- COLLOPY, B. T. 2000. Clinical indicators in accreditation: an effective stimulus to improve patient care. *International Journal for Quality in Health Care*, 12, 211-216.

- COLLOPY, B. T., WILLIAMS, J., RODGERS, L., CAMPBELL, J., JENNER, N. & ANDREWS, N. 2000. The ACHS Care Evaluation Program: a decade of achievement. *Journal of Quality in Clinical Practice*, 20, 36 - 41.
- CRESWELL, J. W. 2003. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, Thousand Oaks, SAGE.
- CRESWELL, J. W. 2007. *Qualitative inquiry & research design: choosing among five approaches*, 2nd ed., Thousand Oaks, SAGE.
- CURTRIGHT, J. W., STOLP-SMITH, S. C. & EDELL, E. S. 2000. Strategic performance management: development of a performance measurement system at the Mayo Clinic. *Journal of Healthcare Management*, 45, 58-68.
- CUSTERS, T., KLAZINGA, N. & BROWN, A. 2007. Increasing performance of health care services within economic constraints: working towards improved incentive structures. *Zeitschrift für ärztliche Fortbildung und Qualität im Gesundheitswesen*, 101, 381-388.
- DAUCOURT, V. & MICHEL, P. 2003. Results of the first 100 accreditation procedures in France. *International Journal for Quality in Health Care*, 15, 463-471.
- DAVIS, M. V., CANNON, M. M., CORSO, L., LENAWEY, D. & BAKER, E. L. 2009. Incentives to Encourage Participation in the National Public Health Accreditation Model: A Systematic Investigation. *American Journal of Public Health*, 99, 1705-1711.
- DAVIS, N. 2007. A review of Habermasian research in Accounting, Working Paper. Charles Sturt University.
- DAVIS, R. M. 1999. Measuring the performance of public health agencies. *BMJ*, 318, 889-890.
- DE BRUIJN, H. 2002. Performance measurement in the public sector: strategies to cope with the risks of performance measurement. *International Journal of Public Sector Management*, 15, 578-594.
- DE BRUIJN, J. A. 2007. *Managing Performance in the Public Sector*, Oxon, the UK, Routledge.
- DE WALCQUE, C., SEUNTJENS, B., VERMEYEN, K., PEETERS, G. & VINCK, I. 2008. Comparative study of hospital accreditation programs in Europe. Health Services Research (HSR). *KCE reports*. Brussels: Belgian Health Care Knowledge Centre (KCE).
- DEARINGER, A. T., RIDDELL, M., SCUTCHFIELD, F. D., INGRAM, R., HOWARD, A. & COOPER, S. 2010. Improving Knowledge of Public Health Accreditation Through a Group Vetting Session of a Practice-Based Research Network. *Journal of Public Health Management and Practice*, 16, 134-139
10.1097/PHH.0b013e3181c6b69d.
- DEBRITZ, J. N. & POLLAK, A. N. 2006. The impact of trauma centre accreditation on patient outcome. *Injury*, 37, 1166-1171.
- DEETZ, S. 1996. Describing differences in approaches to organization science: Rethinking Burrell and Morgan and their legacy. *Organization science*, 7, 191-207.
- DELGOSHAYI, B. & TOFIGHI, S. 2005. Comparing hospitals standards with ISO's principles and delivering a suitable model for developing hospitals standards. *Quarterly Journal of Lorestan University of Medical Sciences*, 23, 19-26.
- DENSCOMBE, M. 2007. *The good research guide: for small-scale social research projects*, Maidenhead, England, Open University Press.
- DENZIN, N. 2009. *The Research Act: A theoretical introduction to sociological methods*, New Jersey, Rutgers.

- DENZIN, N. & LINCOLN, Y. 2008. *The landscape of qualitative research: Theories and issues*, 3rd ed., Thousand Oaks, CA, SAGE.
- DEVERS, K. J., PHAM, H. H. & LIU, G. 2004. What Is Driving Hospitals' Patient-Safety Efforts? *Health Affairs*, 23, 103-115.
- DIANIS, N. L. & CUMMINGS, C. 1998. An interdisciplinary approach to process performance improvement. *Journal of Nursing Care Quality*, 12, 49-59.
- DICKISON, P., HOSTLER, D., PLATT, T. E. & WANG, H. E. 2006. Program accreditation effect on paramedic credentialing examination success rate. *Prehospital Emergency Care*, 10, 224-8.
- DICKSON, S. & NICKLIN, W. 2008. The Value and Impact of Accreditation in Healthcare: A Review of the Literature Accreditation Canada (<http://www.isquaresearch.com/ResearchList.aspx>).
- DIJKSTRA, L. & VAN DER BIJ, H. 2002. Quality function deployment in healthcare. *International Journal of Quality and Reliability Management*, 19, 67-89.
- DILLARD, J. & SMITH, H. 1999. The Effect of the Prospective Payment System On Rural Health Care. *Accounting Forum*, 23, 327-358.
- DILLARD, J. & YUTHAS, K. 2006. Enterprise resource planning systems and communicative action. *Critical Perspectives on Accounting*, 17, 202-223.
- DIXIT, A. 2002. Incentives and Organizations in the Public Sector: An Interpretative Review. *The Journal of Human Resources*, 37, 696-727.
- DODD, N. 1994. *The sociology of money: economics, reason & contemporary society*, New York, Continuum International Publication Group.
- DOLAN, J. G. 2000. Involving patients in decisions regarding preventive health interventions using the analytic hierarchy process. *Health Expectations*, 3, 37-45.
- DONABEDIAN, A. 2005. Evaluating the Quality of Medical Care. *The Milbank Quarterly*, 83, 691-729.
- DONAHUE, K. T. & VANOSTENBERG, P. 2000. Joint Commission International accreditation: relationship to four models of evaluation. *International Journal for Quality in Health Care*, 12, 243-246.
- DOYLE, G. & DORAN, J. 2007. The Cost of Implementing Hospital Accreditation - What are the benefits? : Irish Health Services Accreditation Board & University College Dublin.
- DUCKETT, S. 1983. Changing hospitals: the role of hospital accreditation. *Social Science & Medicine*, 17, 1573-1579.
- DUCKETT, S., DANIELS, S., KAMP, M., STOCKWELL, A., WALKER, G. & WARD, M. 2008. Pay for performance in Australia: Queensland's new Clinical Practice Improvement Payment. *Journal of Health Services Research Policy*, 13, 174-177.
- DUMAY, J. 2009. Reflective discourse about intellectual capital: research and practice. *Journal of Intellectual Capital*, 10, 489-503.
- DUMAY, J. & GUTHRIE, J. 2007. Disturbance and implementation of IC practice: a public sector organisation perspective. *Journal of Human Resource Costing & Accounting*, 11, 104-121.
- DUMMER, J. 2007. Health care performance and accountability. *International Journal of Health Care Quality Assurance*, 20, 34-39.
- DUNPHY, D. & STACE, D. 1988. Transformational and coercive strategies for planned organizational change: beyond the OD model. *Organization Studies*, 9, 317-34.
- DUROCHER, S. 2009. The future of interpretive accounting research. *Management*, 6, 137-159.
- EASTERBY-SMITH, M., THORPE, R. & LOWE, A. 2002. *Management research: An introduction*, London, SAGE.

- EDDY, D. M. 1998. Performance measurement: problems and solutions. *Health Affairs*, 17, 7-25.
- EL-JARDALI, F., JAMAL, D., DIMASSI, H., AMMAR, W. & TCHAGHCHAGHIAN, V. 2008. The impact of hospital accreditation on quality of care: perception of Lebanese nurses. *International Journal for Quality in Health Care*, 20, 363-371.
- ELDRIDGE, C. & PALMER, N. 2009. Performance-based payment: some reflections on the discourse, evidence and unanswered questions. *Health Policy and Planning*, 24, 160-166.
- ESSEX, C. 2000. Baubles are a waste of time. *BMJ*, 321, 905.
- EVERY, N. R., HOCHMAN, J., BECKER, R., KOPECKY, S. & CANNON, C. P. 2000. Critical Pathways : A Review. *Circulation*, 101, 461-465.
- FAIRBROTHER, G. & GLEESON, M. 2000. EQUiP accreditation: feedback from a Sydney teaching hospital. *Australian Health Review*, 23, 200 - 203.
- FERNANDOPULLE, R., FERRIS, T., EPSTEIN, A., MCNEIL, B., NEWHOUSE, J., PISANO, G. & BLUMENTHAL, D. 2003. A research agenda for bridging the 'quality chasm'. *Health Affairs*, 22, 178-190.
- FERREIRA, A. & OTLEY, D. 2009. The design and use of performance management systems: An extended framework for analysis. *Management Accounting Research*, 20, 263-282.
- FITZGERALD, L., JOHNSTON, R., BRIGNALL, T. J., SIVESTRO, R. & VOSS, C. 1991. *Performance Measurement in Service Businesses*, London, CIMA.
- FLOOD, A. & FENNELL, M. 1995. Through the lenses of organizational sociology: the role of organizational theory and research in conceptualizing and examining our health care system. *Journal of health and social behavior*, 35, 154-169.
- FREMONT, A. M., CLEARY, P. D., LEE, H. J., ROWE, R. M., JACOBSON, N. B. & AYANIAN, J. Z. 2001. Patient-centered Processes of Care and Long-term Outcomes of Myocardial Infarction. *Journal of General Internal Medicine*, 16, 800-808.
- FUNCK, E. K. 2010. The Role of Performance Measurements in Professional Organisations: a Study of the Health Care Setting. 8th International Management Control Research Conference, 8-10th September. Greenwich University, London.
- FUNG, C. H., LIM, Y. W., MATTKE, S., DAMBERG, C. & SHEKELLE, P. G. 2008. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of internal medicine*, 148, 111-123.
- GANZ, D., WENGER, N., ROTH, C., KAMBERG, C., CHANG, J., MACLEAN, C., YOUNG, R., SOLOMON, D., HIGASHI, T. & MIN, L. 2007. The effect of a quality improvement initiative on the quality of other aspects of health care: The law of unintended consequences? *Medical Care*, 45, 8-18.
- GAULD, R. 2005. *Comparative health policy in the Asia-Pacific*, Maidenhead, Berkshire, UK, Open University Press.
- GEORGE, A. 2003. Accountability in health services: transforming relationships and contexts. *Indian Institute of Management, Bangalore & Harvard Center for Population and Development Studies Working Paper Series*.
- GHAFARI, M. 2009. *Hospital autonomy; a suicidal plan* [Online]. Tehran. Available: <http://www.hamshahrionline.ir/news-68905.aspx> [Accessed 12/03/2010].
- GIFFORD, D. R. & GARCIERI, D. L. 2007. *Hospital Information for the Public: How does the accreditation process work?* [Online]. Available: <http://www.health.ri.gov/hsr/facilities/hospitals/process.php> [Accessed 16th August 2007].

- GILLON, M., BUETOW, S., WELLINGHAM, J. & TALBOYS, S. 2003. A practical approach to quality improvement: the experience of the RNZCGP practice standards validation field trial. *The New Zealand Medical Journal*, 116, U682.
- GIRAUD, A. 2001. Accreditation and the quality movement in France. *Quality and Safety in Health Care*, 10 (2), 111-116.
- GODDARD, M., DAVIES, H., DAWSON, D., MANNION, R. & MCINNES, F. 2002a. Clinical performance measurement: part 1—getting the best out of it. *Journal of the Royal Society of Medicine*, 95, 508-510.
- GODDARD, M., DAVIES, H., DAWSON, D., MANNION, R. & MCINNES, F. 2002b. Clinical performance measurement: part 2—avoiding the pitfalls. *Journal of the Royal Society of Medicine*, 95, 549-551.
- GODDARD, M., MANNION, R. & SMITH, P. 2000. Enhancing performance in health care: a theoretical perspective on agency and the role of information. *Health Economics*, 9, 95-107.
- GOLDMAN, R. 2006. Payment for Performance: In Sickness and in Health. For Better or for Worse? *Blood purification*, 24, 28-32.
- GOODHART, C. 1984. *Monetary theory and practice: the UK experience*, London, Palgrave Macmillan.
- GOUGH, L. A. & REYNOLDS, T. M. 2000. Is Clinical Pathology Accreditation worth it? A survey of CPA-accredited laboratories. *British Journal of Clinical Governance*, 5, 195-201.
- GOYAL, R. C. 2005. *Hospital Administration and Human Resource Management*, 4th ed., New Dehli, Prentice Hall.
- GRASSO, B. C., ROTHSCILD, J. M., JORDAN, C. W. & JAYARAM, G. 2005. What is the measure of a safe hospital? Medication errors missed by risk management, clinical staff, and surveyors. *Journal of Psychiatric Practice*, 11, 268-73.
- GRAY, R., WALTERS, D., BEBBINGTON, J. & THOMPSON, I. 1995. The greening of enterprise: an exploration of the (non) role of environmental accounting and environmental accountants in organizational change. *Critical Perspectives on Accounting*, 6, 211-239.
- GRBICH, C. 1999. *Qualitative research in health: An introduction*, SAGE.
- GRECO, M., SWEENEY, K., BROWNLEA, A. & MCGOVERN, J. 2001. The practice accreditation and improvement survey (PAIS). What patients think. *Australian Family Physician*, 30, 1096-100.
- GREEN, J. & THOROGOOD, N. 2004. *Qualitative methods for health research*, Sage.
- GREENFIELD, D. & BRAITHWAITE, J. 2007. Health Sector Accreditation Research Literature Review and Selected Citations. *A Review of Health Sector Accreditation Research Literature*. Sydney: Centre for Clinical Governance Research in Health, Faculty of Medicine, University of New South Wales
- GREENFIELD, D. & BRAITHWAITE, J. 2008. Health sector accreditation research: a systematic review. *International Journal for Quality in Health Care*, 20, 172-183.
- GREENFIELD, D. & BRAITHWAITE, J. 2009. Developing the evidence base for accreditation of healthcare organisations: a call for transparency and innovation. *Quality and Safety in Health Care*, 18, 162-163.
- GREENFIELD, D., BRAITHWAITE, J. & PAWSEY, M. 2008. Health care accreditation surveyor styles typology. *International Journal of Health Care Quality Assurance*, 21, 435-443.
- GREENFIELD, D., PAWSEY, M., NAYLOR, J. & BRAITHWAITE, J. 2009. Are accreditation surveys reliable? *International Journal of Health Care Quality Assurance*, 22, 105-16.

- GREENWOOD, R. & HININGS, C. 1988. Organizational Design Types, Tracks and the Dynamics of Strategic Change. *Organization Studies*, 9, 293-316.
- GREENWOOD, R. & HININGS, C. R. 1996. Understanding Radical Organizational Change: Bringing together the Old and the New Institutionalism. *The Academy of Management Review*, 21, 1022-1054.
- GREENWOOD, R., SUDDABY, R. & HININGS, C. 2002. Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal*, 45, 58-80.
- GRIFFITH, J., KNUTZEN, S. & ALEXANDER, J. 2002. Structural versus outcomes measures in hospitals: A comparison of Joint Commission and Medicare outcomes scores in hospitals. *Quality Management in Health Care*, 10, 29-38.
- GRIFFITH, J. & WHITE, K. 2007. *The well-managed healthcare organization*, 6th ed., Chicago, Health Administration Press Chicago.
- GROL, R., BOSCH, M., HULSCHER, M., ECCLES, M. & WENSING, M. 2007. Planning and studying improvement in patient care: the use of theoretical perspectives. *Milbank Quarterly*, 85, 93-138.
- GUBA, E. & LINCOLN, Y. 1994. Competing paradigms in qualitative research. In: DENZIN, N. K. & LINCOLN, Y. S. (eds.) *Handbook of qualitative research*. Thousand Oaks, CA: SAGE.
- GUBA, E. & LINCOLN, Y. 1999. Naturalistic and rationalistic enquiry. In: KEEVES, J. & LAKOMSKI, G. (eds.) *Issues in educational research*. Oxford: Pergamon.
- GUBA, E. & LINCOLN, Y. 2008. Paradigmatic controversies, contradictions and emerging confluences. In: DENZIN, N. K. & LINCOLN, Y. S. (eds.) *The landscape of qualitative research: theories and issues*. Thousand Oaks, CA: SAGE.
- GURD, B. 2008. Structuration and middle-range theory--A case study of accounting during organizational change from different theoretical perspectives. *Critical Perspectives on Accounting*, 19, 523-543.
- HABERMAS, J. 1974. *Theory and Practice*, translated by J. Viertel, London, Heinemann.
- HABERMAS, J. 1984. *The Theory of Communicative Action Volume 1: Reason and Rationalisation of Society*, McCarthy, T. (transl.), London, Heinemann.
- HABERMAS, J. 1987. *The Theory of Communicative Action Volume 2: Reason and Rationalisation of Society*, McCarthy, T. (transl.), London, Heinemann.
- HABERMAS, J. 1996. *Between facts and norms*, Cambridge, Mit Press, Mass.
- HADLEY, T. R. & MCGURRIN, M. C. 1988. Accreditation, Certification, and the Quality of Care in State Hospitals. *Hospital Community Psychiatry*, 39, 739-742.
- HAIGH, M. & DE GRAAF, F. 2009. The implications of reform-oriented investment for regulation and governance. *Critical Perspectives on Accounting*, 20, 399-417.
- HALACHMI, A. 2002. Performance measurement: a look at some possible dysfunctions. *Work Study*, 51, 230-239.
- HALVERSON, P. K., NICOLA, R. M. & BAKER, E. L. 1998. Performance measurement and accreditation of public health organizations: a call to action. *Journal of Public Health Management and Practice*, 4, 5-7.
- HAMBLIN, R. 2008. Regulation, measurements and incentives. The experience in the US and UK: does context matter? *The Journal of the Royal Society for the Promotion of Health*, 128, 291-298.
- HANNAN, E., KILBURN JR, H., RACZ, M., SHIELDS, E. & CHASSIN, M. 1994. Improving the outcomes of coronary artery bypass surgery in New York State. *JAMA*, 271, 761.
- HARBOUR, J. L. 1997. *The Basics of Performance Measurement*, New York, Productivity Press-Technology & Industrial Arts.

- HARIHARAN, S., DEY, P. K., CHEN, D. R., MOSELEY, H. S. L. & KUMAR, A. Y. 2005. Application of Analytic hierarchy process for measuring and comparing the global performance of intensive care units. *Journal of Critical Care*, 20, 117-124.
- HARIHARAN, S., DEY, P. K., MOSELEY, H. S. L., KUMAR, A. Y. & GORA, J. 2004. A new tool for measurement of process-based performance of multi-specialty tertiary care hospitals. *International Journal of Health Care Quality Assurance*, 17, 302-312.
- HARRIS, J. E. 1977. The internal organization of hospitals: some economic implications. *The Bell Journal of Economics*, 8, 467-482.
- HARVEY, G. & WENSING, M. 2003. Methods for evaluation of small scale quality improvement projects. *Quality and Safety in Health Care*, 12, 210-214.
- HASSAN, D. 2006. *Measuring quality performance in health care: The effect of Joint Commission International standards on quality performance*. PhD Thesis, Walden University.
- HASSAN, M. 2005. Management accounting and organizational change: an institutional perspective. *Journal of accounting and organizational change*, 1, 125-140.
- HASSAN, M. 2008. Financial accounting regulations and organizational change: a Habermasian perspective. *Journal of Accounting & Organizational Change*, 4, 289-317.
- HASSAN, M. 2010. Understanding the behavioural aspects of costing systems in public health organisations. *International Journal of Behavioural Accounting and Finance*, 1, 207-223.
- HEATON, C. 2000. External peer review in Europe: an overview from the ExPeRT Project. *International Journal for Quality in Health Care*, 12, 177-182.
- HEIDEMANN, E. 1999. Editorial. The ALPHA program. *International Journal for Quality in Health Care*, 11, 275-277.
- HEIDEMANN, E. G. 2000. Moving to global standards for accreditation processes: the ExPeRT Project in a larger context. *International Journal for Quality in Health Care*, 12, 227-230.
- HEUER, A. J. 2004. Hospital accreditation and patient satisfaction: testing the relationship. *Journal for healthcare quality*, 26, 46-51.
- HIBBARD, J., STOCKARD, J. & TUSLER, M. 2003. Does publicizing hospital performance stimulate quality improvement efforts? *Health Affairs*, 22, 84-94.
- HIBBARD, J., STOCKARD, J. & TUSLER, M. 2005. Hospital performance reports: impact on quality, market share, and reputation. *Health Affairs*, 24, 1150-1160.
- HILARION, P., SUñOL, R., GROENE, O., VALLEJO, P., HERRERA, E. & SAURA, R. M. 2008. Making performance indicators work: The experience of using consensus indicators for external assessment of health and social services at regional level in Spain. *Health Policy*, 90, 94-103.
- HIROSE, M., IMANAKA, Y., ISHIZAKI, T. & EVANS, E. 2003. How can we improve the quality of health care in Japan?: Learning form JCQHC hospital accreditation. *Health Policy*, 66, 29-49.
- HIRST, M. K. 1983. Reliance on accounting performance measures, task uncertainty, and dysfunctional behavior: some extensions. *Journal of Accounting Research*, 21, 596-605.
- HOOD, C. 1991. A public management for all seasons? *Public Administration*, 69, 3-19.
- HOOD, C. 1995. The "new public management" in the 1980s: variations on a theme. *Accounting Organisations and Society*, 20, 93-93.
- HOOD, C. 2006. Gaming in targetworld: the targets approach to managing British public services. *Public Administration Review*, 66, 515-521.

- HOOD, C. 2007. Public service management by numbers: Why does it vary? Where has it come from? What are the gaps and the puzzles? *Public Money & Management*, 27, 95-102.
- HORTON, R. 2004. Why is Ian Kennedy's Healthcare Commission damaging NHS care? *The Lancet*, 364, 401-402.
- HUANG, P., HSU, Y. H. E., KAI-YUAN, T. & HSUEH, Y. S. 2000. Can European external peer review techniques be introduced and adopted into Taiwan's hospital accreditation System? *International Journal for Quality in Health Care*, 12, 251-254.
- HUBERMAN, A. & MILES, M. 2002. *The qualitative researcher's companion*, London, SAGE.
- HURST, K. 1997. The nature and value of small and community hospital accreditation. *International Journal of Health Care Quality Assurance* 10, 94-106.
- HUTCHINSON, A., COOPER, K. L., DEAN, J. E., MCINTOSH, A., PATTERSON, M., STRIDE, C. B., LAURENCE, B. E. & SMITH, C. M. 2006. Use of a safety climate questionnaire in UK health care: factor structure, reliability and usability. *Quality and Safety in Health Care*, 15, 347-353.
- I.R.I. 1979a. The Constitution of Islamic Republic of Iran: Article 29. Tehran: Islamic Cultural and Relations Organisation; Department of Translation and Publication.
- I.R.I. 1979b. The Constitution of the Islamic Republic of Iran. Tehran: Islamic Cultural and Relations Organisation; Department of Translation and Publication.
- I.R.I. 2004. I.R.I.'s fourth plan for economic, social and cultural development: Article 88. Tehran, Iran: Planning and management organization.
- IBRAHIM, A. 2002. *An integrated performance measurment system of health care services: An empirical study of public and private hospitals in Malaysia*. PhD Thesis, University of Strathclyde.
- INAMDAR, N., KAPLAN, R. S. & BOWER, M. 2002. Applying the balanced scorecard in healthcare provider organizations. *Journal of Healthcare Management*, 47, 179-95; discussion 195-6.
- ITO, H., IWASAKI, S., NAKANO, Y., IMANAKA, Y., KAWAKITA, H. & GUNJI, A. 1998. Direction of quality improvement activities of health care organizations in Japan. *International Journal for Quality in Health Care*, 10, 361-3.
- ITO, H. & SUGAWARA, H. 2005. Relationship between accreditation scores and the public disclosure of accreditation reports: a cross sectional study. *Quality and Safety in Health Care*, 14, 87-92.
- ITTNER, C., LARCKER, D. & MEYER, M. 2003. Subjectivity and the weighting of performance measures: Evidence from a balanced scorecard. *Accounting Review*, 725-758.
- JAAFARIPOOYAN, E., AKBARIHAGHIGHI, F. & MAHMOODI, M. 2004. Gap Analysis of Performance Measurement System in the Hamedan Hospitals (in Farsi). *Tehran Medical University Journal of Public Health*, 3, 43-52
- JACOBS, R. 2001. Alternative methods to examine hospital efficiency: data envelopment analysis and stochastic frontier analysis. *Health Care Management Science*, 4, 103-115.
- JACOBS, R., GODDARD, M. & SMITH, P. C. 2006. Public Services: Are composite measures a robust reflection of performance in the public sector: Research paper. Centre for Health Economics, University of York.

- JACOBS, R., GODDARD, M. & SMITH, P. C. 2007. Composite performance measures in the public sector: Policy Discussion Briefing. Centre for Health Economics, University of York.
- JAMES, M. & HUNT, K. 1996. Accreditation at what cost? *Journal of Management in Medicine*, 10, 49-56.
- JAWORSKI, B. J. & YOUNG, S. M. 1992. Dysfunctional behavior and management control: An empirical study of marketing managers. *Accounting, Organizations and Society*, 17, 17-35.
- JAYASINGHE, K. & SOOBAROYEN, T. 2009. Religious “spirit” and peoples' perceptions of accountability in Hindu and Buddhist religious organizations. *Accounting, Auditing & Accountability Journal*, 22, 997-1028.
- JAYAWICKRAMARAJAH, P. 1992. How to evaluate educational programmes in the health professions. *Medical Teacher*, 14, 159-166.
- JCAHO 2002. *Tools for Performance Measurement in Health Care: Quick Reference Guide*, Washington, Joint Commission Resources.
- JCAHO 2005. *Comprehensive Accreditation Manual for Hospitals (CAMH)*, Oakbrook Terrace, Joint Commission Resources.
- JOHNSON, H. & KAPLAN, R. 1987. *Relevance lost: The rise and fall of management accounting*, Boston, Harvard Business School Press.
- JOHNSON, M. 2006. Steps toward an automated scorecard system. *Healthcare Financial Management*, 60, 84-90.
- JOHNSON, S. 1997. *Pathways of care*, Oxford, Wiley-Blackwell.
- JOHNSTON, S., DAHROUGE, S. & HOGG, W. 2008. Gauging to gain: Primary care performance measurement. *Canadian Family Physician*, 54, 1215-1217.
- JOLY, B. M., POLYAK, G., DAVIS, M. V., BREWSTER, J., TREMAIN, B., RAEVSKY, C. & BEITSCH, L. M. 2007. Linking accreditation and public health outcomes: a logic model approach. *J Public Health Manag Pract*, 13, 349-56.
- JOVANOVIC, B. 2005. Hospital accreditation as method for assessing quality in healthcare. *Oncology*, 13, 156-7.
- JUDSON, A. S. 1990. *Making Strategy Happen: Transforming Plans into Reality*, London, Basil Blackwell.
- JUUL, A. B., GLUUD, C., WETTERSLEV, J., CALLESEN, T., JENSEN, G. & KOFOED-ENEVOLDSEN, A. 2005. The effects of a randomised multi-centre trial and international accreditation on availability and quality of clinical guidelines. *International Journal of Health Care Quality Assurance*, 18, 321-8.
- KANJI, G. 2001. Forces of excellence in Kanji's business excellence model. *Total Quality Management & Business Excellence*, 12, 259-272.
- KANJI, G. 2008. Performance Excellence: Path to Integrated Management and Sustainable Success. *Corporate Sustainability as a Challenge for Comprehensive Management* [Online], 2.
- KANJI, G. & SA, P. M. 2002. Kanji's Business Scorecard. *Total Quality Management & Business Excellence*, 13, 13-27.
- KANJI, G. & SA, P. M. 2003. Sustaining healthcare excellence through performance measurement. *Total Quality Management & Business Excellence*, 14, 269-289.
- KANJI, G. & WALLACE, W. 2000. Business excellence through customer satisfaction. *Total Quality Management & Business Excellence*, 11, 979-998.
- KANJI, G. K. 1998. Measurement of business excellence. *Total Quality Management & Business Excellence*, 9, 633-643.
- KANJI, G. K. 2002. *Measuring business excellence*, London, Routledge.

- KAPLAN, R. & NORTON, D. 2005. The Balanced Scorecard: Measures that Drive Performance. *HARVARD BUSINESS REVIEW*, 83, 172.
- KAPLAN, R. S. 2001. Strategic Performance Measurement and Management in Nonprofit Organizations. *Nonprofit Management and Leadership*, 11, 353-370.
- KAPLAN, R. S. & NORTON, D. P. 1992. The balanced scorecard: measures that drive Performance. *Harvard Business Review*, January/February, 71-9.
- KEEGAN, D. P., EILER, R. G. & JONES, C. P. 1989. Are your performance measures obsolete? *Management Accounting*, June, 45-50.
- KELMAN, S. & FRIEDMAN, J. N. 2009. Performance Improvement and Performance Dysfunction: An Empirical Examination of Distortionary Impacts of the Emergency Room Wait-Time Target in the English National Health Service. *Journal of Public Administration Research and Theory*, 19, 917-946.
- KENNERLEY, M. & NEELY, A. 2002. Performance measurement frameworks: a review. In: NEELY, A. (ed.) *Business performance measurement: Theory and practice*. Cambridge: Cambridge university press.
- KEOGH, B. & KINSMAN, R. 2004. *Fifth National Adult Cardiac Surgical Database Report 2003: Improving outcomes for patients*, London, The Society of Cardiothoracic Surgeons of Great Britain and Ireland.
- KESSNER, D. & KALK, C. 1973. *A strategy for evaluating health services*, Washington, National Academy of Sciences.
- KIPS, J. C. & RADEMAKERS, F. 2010. Hospital accreditation from the perspective of a Belgian Academic Medical Centre. *Building Quality in Health Care*, 4, 21-24.
- KLAZINGA, N. 2000. Re-engineering trust: the adoption and adaption of four models for external quality assurance of health care services in western European health care systems. *International Journal for Quality in Health Care*, 12, 183-189.
- KRAVCHUK, R. S. & SCHACK, R. W. 1996. Designing Effective Performance-Measurement Systems under the Government Performance and Results Act of 1993. *Public Administration Review*, 56, 348-58.
- KREIG, T. 1996. An Evaluation of the ACHS Accreditation Program: Its Effects on the Achievement of Best Practice. Sydney: University of Technology.
- KUMAR, R. 2005. *Research Methodology: A Step-by-Step Guide for Beginners*, 2nd ed., London, SAGE.
- KUNST, P. & LEMMINC, J. 2000. Quality management and business performance in hospitals: a search for success parameters. *Total Quality Management*, 11, 1123-1133.
- KWAK, N. K., MCCARTHY, K. J. & PARKER, G. E. 1997. A Human Resource Planning Model for Hospital/Medical Technologists: An Analytic Hierarchy Process Approach. *Journal of Medical Systems*, 21, 173-187.
- LAM, S. S. K. 1997. SERVQUAL: A tool for measuring patients's opinions of hospital service quality in Hong Kong. *Total Quality Management and Business Excellence*, 8, 145 - 152.
- LANSKY, D. 1998. Perspective: Measuring What Matters To The Public. *BMJ*, 17, 40-41.
- LAPSLEY, I. 2009. New Public Management: The Cruellest Invention of the Human Spirit? *Abacus*, 45, 1-21.
- LARRINAGA-GONZÁLEZ, C., CARRASCO-FENECH, F., CARO-GONZÁLEZ, F., CORREA-RUIZ, C. & PÁEZ-SANDUBETE, J. 2001. The role of environmental accounting in organizational change-An exploration of Spanish companies. *Accounting, Auditing & Accountability Journal*, 14, 213-239.
- LAUGHLIN, R. 1987. Accounting systems in organizational contexts: a case for critical theory. *Accounting, Organizations and Society*, 12, 479-502.

- LAUGHLIN, R. 1991. Environmental disturbances and organizational transitions and transformations: some alternative models. *Organization Studies*, 12, 209-232.
- LAUGHLIN, R. 1995. Methodological themes; Empirical research in accounting: alternative approaches and a case for "middle-range" thinking. *Accounting, Auditing & Accountability Journal*, 8, 63-87.
- LAUGHLIN, R. 2004. Putting the record straight: a critique of methodology choices and the construction of facts: some implications from the sociology of knowledge'. *Critical Perspectives on Accounting*, 15, 261-277.
- LAUGHLIN, R. 2007. Critical reflections on research approaches, accounting regulation and the regulation of accounting. *The British Accounting Review*, 39, 271-289.
- LAUGHLIN, R. & BROADBENT, J. 1993. Accounting and Law: Partners in the Juridification of the Public Sector in the UK? *Critical Perspectives on Accounting*, 4, 337-368.
- LAUGHLIN, R. & BROADBENT, J. 1996. Redesigning Fourth generation Evaluation: An Evaluation Model for the Public-sector Reforms in the UK? *Evaluation*, 2, 431-451.
- LAUGHLIN, R., BROADBENT, J., SHEARN, D. & WILLIG-ATHERTON, H. 1994a. Absorbing LMS: the coping mechanism of a small group. *Accounting, Auditing & Accountability Journal*, 7, 59-85.
- LAUGHLIN, R., BROADBENT, J. & WILLIG-ATHERTON, H. 1994b. Recent financial and administrative changes in GP practices in the UK: initial experiences and effects. *Accounting, Auditing & Accountability Journal*, 7, 96-124.
- LAWRENCE, S. 1999. From welfare state to the civil society: The constitutive use of accounting in the reform of the NZ public sector. *Critical Perspectives on Accounting*, 10, 223-246.
- LAWRENCE, S. & SHARMA, U. 2002. Commodification of Education and Academic LABOUR--Using the Balanced Scorecard in a University Setting. *Critical Perspectives on Accounting*, 13, 661-677.
- LEEUEW, F. L. 1996. Performance auditing, new public management and performance improvement: questions and answers. *Accounting, Auditing & Accountability Journal*, 9, 92-102.
- LEIDECKER, J. K. & BRUNO, A. V. 1984. Identifying and using critical success factors. *Long Range Planning*, 17, 23-32.
- LEKAKUL, N. 2000. *Evaluation of Hospital Accreditation Project: A Case Study of Maharaj Nakorn Chiang Mai Hospital*. MSc Dissertation, Chiangmai University.
- LEVY, A. 1986. Second-order planned change: Definition and conceptualization. *Organizational Dynamics*, 15, 5-17.
- LIM, P. & TANG, N. 2000. The development of a model for total quality healthcare. *Managing Service Quality*, 10, 103-111.
- LIM, P., TANG, N. & JACKSON, P. 1999. An innovative framework for health care performance measurement. *Managing Service Quality*, 9, 423-33.
- LIN, B. & CLAUSING, J. 1995. Total quality management in healthcare: a survey of current practices. *Total Quality Management*, 6, 69-78.
- LINCOLN, Y. & GUBA, E. 1999. Establishing trustworthiness. In: BRYMAN, A. & BURGESS, R. G. (eds.) *Qualitative Research*. London: SAGE.
- LOCKE, E. & LATHAM, G. 2002. Building a Practically Useful Theory of Goal Setting and Task Motivation. *American Psychologist*, 57, 705-17.
- LOEB, J. M. 2004. The current state of performance measurement in health care *International Journal for Quality in Health Care*, 16, i5-i9.

- LOHMAN, C., FORTUIN, L. & WOUTERS, M. 2004. Designing a performance measurement system: A case study. *European Journal of Operational Research* 156, 267-286.
- LOMBARTS, M., RUPP, I., VALLEJO, P., SUNOL, R. & KLAZINGA, N. 2009. Application of quality improvement strategies in 389 European hospitals: results of the MARQuIS project. *Quality and Safety in Health Care*, 18, i28-i37.
- LOWE, A. 2004. Methodology choices and the construction of facts: some implications from the sociology of scientific knowledge. *Critical Perspectives on Accounting*, 15, 207-231.
- LUDERUS, E. 1996. The ACHS evaluation and quality improvement program (EQuIP): Helping to give confidence to our future. *Australian Emergency Nursing Journal*, 1, 21-25.
- LYNCH, R. & CROSS, K. 1991. *Measure Up! Yardsticks for Continuous Improvement*, Oxford, Blackwell.
- MACFARLANE, F., TAVABIE, A. & DESOMBRE, T. 2003. Accredited professional development: a qualitative study of the feasibility, acceptability and practicality of a new scheme for CPD. *Education for Primary Care*, 14, 302-309.
- MACK, N., WOODSONG, C., MACQUEEN, K. M. & NAMEY, E. 2005. *Qualitative Research Methods: A data collector's field guide*, North Carolina, Family Health International (FHI).
- MAIL, R., ATAN, R. & MOHAMED, N. 2009. Emancipation process: an exploratory study on accounting change process informed by middle range theory. *Asia-Pacific Management Accounting Journal*, 4, 1-18.
- MAJLIS 1985. The act of the Islamic Republic of Iran's parliament (Majlis) on the establishment of Ministry of Health and Medical Education. Tehran: Islamic parliament of Iran.
- MAJLIS 1987. The act of the Islamic Republic of Iran's parliament (Majlis) on the establishment of Ministry of Health and Medical Education: Practical instruction for Article 8. Tehran: Islamic parliament of Iran.
- MAJLIS 1988a. The act of the organisation and duties of Ministry of Health and Medical Education: Article 1. Tehran: Islamic parliament of Iran.
- MAJLIS 1988b. The act of the organisation and duties of Ministry of Health and Medical Education: Article 2. Tehran: Islamic parliament of Iran.
- MALEYEFF, J., KAMINSKY, F. C., JUBINVILLE, A. & FENN, C. A. 2001. A guide to using performance measurement systems for continuous improvement. *Journal for Healthcare Quality*, 23, 33-7.
- MALINA, M. & SELTO, F. 2001. Communicating and controlling strategy: An empirical study of the effectiveness of the balanced scorecard. *Journal of Management Accounting Research* 13, 47-90.
- MALLOCH, K. 1999. The performance measurement matrix: A framework to optimize decision making. *Journal of Nursing Care Quality*, 13, 1-12.
- MANNION, R., DAVIES, H. & MARSHALL, M. 2005. Impact of star performance ratings in English acute hospital trusts. *Journal of Health Services Research Policy*, 10, 18-24.
- MARSHALL, C. & ROSSMAN, G. 2011. *Designing qualitative research*, 5th ed., Thousand Oaks, CA, SAGE.
- MAYS, G. 2004. Can accreditation work in public health? Lessons from other service industries. Working paper prepared for the Robert Wood Johnson Foundation. University of Arkansas for Medical Sciences.

- MAZUR, G., GIBSON, J. & HARRIES, B. Year. QFD Applications in Health Care and Quality of Work Life. *In: First international symposium on QFD, 1995 Tokyo.* 30-37.
- MCALARY, B. 1981. The reliability and validity of hospital accreditation in Australia. *Journal of Advanced Nursing*, 6, 409-411.
- MCINTYRE, D., ROGERS, L. & HEIER, E. 2001. Overview, history, and objectives of performance measurement. *Health Care Financing Review*, 22, 7-22.
- MCKEE, M. & HEALY, J. (eds.) 2002. *Hospitals in a changing Europe*, Buckingham: Open University Press.
- MELLAHI, K., JACKSON, P. & SPARKS, L. 2002. An exploratory study into failure in successful organizations: The case of Marks & Spencer. *British Journal of Management*, 13, 15-29.
- MELLAHI, K. & WILKINSON, A. 2004. Organizational failure: a critique of recent research and a proposed integrative framework. *International Journal of Management Reviews*, 5-6, 21-41.
- MEYER, J. W. & ROWAN, B. 1977. Institutionalized Organizations: Formal Structure as Myth and Ceremony. *The American Journal of Sociology*, 83, 340-363.
- MIHALIK, G. J., SCHERER, M. R. & SCHRETER, R. K. 2003. The high price of quality: a cost analysis of NCQA accreditation. *Journal of Health Care Finance*, 29, 38-47.
- MILLER, M. R., PRONOVOST, P., DONITHAN, M., ZEGER, S., ZHAN, C., MORLOCK, L. & MEYER, G. S. 2005. Relationship Between Performance Measurement and Accreditation: Implications for Quality of Care and Patient Safety. *American Journal of Medical Quality*, 20, 239-252.
- MINTZBERG, H. 1979. *The structuring of organizations*, Englewood Cliffs, NJ, Prentice-Hall.
- MODELL, S. 2001. Performance measurement and institutional processes: a study of managerial responses to public sector reform. *Management Accounting Research*, 12, 437-464.
- MODELL, S. 2002. Institutional perspectives on cost allocations: integration and extension. *European Accounting Review*, 11, 653 - 679.
- MODELL, S. 2009. Institutional research on performance measurement and management in the public sector accounting literature: a review and assessment. *Financial Accountability & Management*, 25, 277-303.
- MOGHIMI, A. 2004. Familiarity with evaluation concepts and establishing quality measures. Tehran, Iran: Ministry of Health; Centre for accreditation and supervision; Healthcare organisations evaluation group.
- MOH 1997a. The instruction of standards and principles of evaluation of the general hospitals. Tehran, Iran: Centre for healthcare accreditation and supervision; Healthcare organisations evaluation group.
- MOH 1997b. The instruction of standards and principles of evaluation of the general hospitals: Emergency department. Tehran, Iran: Centre for healthcare accreditation and supervision; Healthcare organisations evaluation group.
- MOH 1997c. Standard regulations for the assistance, treatment and recovery of accident and emergency patients Tehran, Iran: Centre for healthcare accreditation and supervision; Healthcare organisations evaluation group.
- MOH 2004. Practical instruction for the quality evaluation of hospitals. Tehran, Iran: Centre for healthcare accreditation and supervision; Healthcare organisations evaluation group.
- MOH 2005. The comprehensive plan of reforming hospitals' economic and managerial structure. Tehran: Deputy for Management and Resources Development.

- MOH. 2006. *The bylaw number 27629/2/S - 24/05/2006 to the hospitals* [Online]. Tehran: Iran University of Medical Sciences and Health Services. Available: http://www.iums.ac.ir/page.php?slct_pg_id=2610&sid=18&slc_lang=fa [Accessed 28th June 2009].
- MOH. 2008. *The bylaw number 25337/2/S - 21/06/2008 to the hospitals* [Online]. Kerman: Kerman University of Medical Sciences and Health Services. Available: <http://www.kmu.ac.ir/sitewizard/admin/wizard/Default.aspx?PageId=3291> [Accessed 12th March 2010].
- MOHIT, A. 2000. Lessons Learned in the Eastern Mediterranean Region from Integration of Mental Health Within Primary Health care in I.R. Iran. In: WHO (ed.).
- MONTAGU, D. 2003. Accreditation and other external quality assessment systems for healthcare: Review of experience and lessons learned. London: UK Department for International Development, Health Systems Resource Centre.
- MOSADEGHRAD, A. & ANSARIAN, M. 2005. Developing a Model for Evaluation and Accreditation of Hospitals. *Iranian Journal of Public Health*, 34, 19-20.
- MOULLIN, M. 2002. *Delivering Excellence in Health and Social Care*, Buckingham, Open University Press.
- MOULLIN, M. 2004. Eight essentials of performance measurement. *International Journal of Health Care Quality Assurance*, 17, 110-112.
- MOULLIN, M. 2007. Performance measurement definitions: Linking performance measurement and organisational excellence. *International Journal of Health Care Quality Assurance*, 20, 181-183.
- MURRAY, C. J. L. & EVANS, D. B. 2003. *Health systems performance assessment*, Geneva, World Health Organization.
- NABITZ, U., KLAZINGA, N. & WALBURG, J. 2000. The EFQM excellence model: European and Dutch experiences with the EFQM approach in health care. *International Journal for Quality in Health Care*, 12, 191-202.
- NADZAM, D. & LOEB, J. 1998. Measuring and improving the performance of health care providers: Accreditation in the 21st century. *AJIC*, 26, 126-136.
- NANDRAJ, S., KHOT, A., MENON, S. & BRUGHA, R. 2001. A stakeholder approach towards hospital accreditation in India. *Health Policy and Planning*, 16, 70-79.
- NEELY, A. 2002. *Business Performance Measurement; Theory and Practice*, Cambridge, Cambridge University Press.
- NEELY, A., ADAMS, C. & CROWE, P. 2001. The performance prism in practice measuring excellence. *The Journal of Business Performance Management*, 5, 6-12.
- NEELY, A., ADAMS, C. & KENNERLEY, M. 2002. *The performance prism: the scorecard for measuring and managing business success*, Prentice Hall Financial Times.
- NICHOLAS, D. 1999. Using accreditation to improve quality. *The Quality Assurance Project's Information Outlet*, 8, 1-4.
- NICKLIN, W. & BARTON, M. 2007. CCHSA Accreditation: A change catalyst toward healthier work environments. *Healthcare Papers*, 7, 58.
- NICKLIN, W. & DICKSON, S. 2009. The Value and Impact of Accreditation in Health Care: A Review of the Literature. Ottawa: Accreditation Canada Organisation.
- NORREKLIT, H. 2000. The balance on the balanced scorecard a critical analysis of some of its assumptions. *Management Accounting Research*, 11, 65-88.
- O'CONNOR, E., FORTUNE, T., DORAN, J. & BOLAND, R. 2007. Involving consumers in accreditation: the Irish experience. *International Journal for Quality in Health Care*, 19, 296-300.

- O'LEARY, D. S. 2000. Accreditation's role in reducing medical errors. *BMJ*, 320, 727-728.
- O'NEILL, O. 2004. Accountability, trust and informed consent in medical practice and research. *Clinical Medicine, Journal of the Royal College of Physicians*, 4, 269-276.
- OLIVER, C. 1991. Strategic Responses to Institutional Processes. *The Academy of Management Review*, 16, 145-179.
- OTLEY, D. 2003. Management control and performance management: whence and whither? *The British Accounting Review*, 35, 309-326.
- ØVRETVEIT, J. 1998. *Evaluating Health Interventions: An Introduction to Evaluation of Health Treatments, Services, Policies, and Organizational Interventions*, Buckingham, Philadelphia, Open University Press.
- ØVRETVEIT, J. 2000. The economics of quality - a practical approach. *International Journal of Health Care Quality Assurance*, 13, 200-207.
- ØVRETVEIT, J. 2005. Which Interventions Are Effective for Improving Patient Safety? A Review of Research Evidence. Stockholm: Medical Management Centre, Karolinska Institutet.
- ØVRETVEIT, J. & AL SEROURI, A. 2006. Hospital quality management system in a low income Arabic country: an evaluation. *International Journal of Health Care Quality Assurance*, 19, 516-532.
- ØVRETVEIT, J. & GUSTAFSON, D. 2002. Evaluation of quality improvement programmes. *Quality and safety in health care*, 11, 270-275.
- ØVRETVEIT, J. & GUSTAFSON, D. 2003. Improving the quality of health care: Using research to inform quality programmes. *BMJ*, 326, 759-761.
- ØVRETVEIT, J. & HAM, C. 2002. *Action Evaluation of Health Programmes and Changes: A Handbook for a User-focused Approach*, Oxon; England, Radcliffe Publishing.
- PACCIONI, A., SICOTTE, C. & CHAMPAGNE, F. 2008. Accreditation: a cultural control strategy. *International Journal of Health Care Quality Assurance*, 21, 146-158.
- PAPALEXANDRIS, A., IOANNOU, G., PRASTACOS, G. & ERIC SODERQUIST, K. 2005. An Integrated Methodology for Putting the Balanced Scorecard into Action. *European Management Journal*, 23, 214-227.
- PARASURAMAN, A., ZEITHAML, V. A. & BERRY, L. L. 1988. SERVQUAL: a multiple item scale for measuring consumer perceptions of service quality. *Journal of Retailing*, 64, 12-40.
- PARASURAMAN, A., ZEITHAML, V. A. & BERRY, L. L. 1991. Refinement and reassessment of the SERVQUAL scale. *Journal of Retailing*, 67, 420-450.
- PARASURAMAN, A., ZEITHAML, V. A. & BERRY, L. L. 1994. Alternative scales for measuring service quality: A comparative assessment based on psychometric and diagnostic criteria. *Journal of Retailing*, 70, 193-194.
- PARKER, C. 2000. Performance Measurement. *Work Study*, 49, 63-66.
- PARKER, L. & ROFFEY, B. 1997. Methodological themes. *Accounting, Auditing & Accountability Journal*, 10, 212-247.
- PATON, R. & MORDAUNT, J. 2004. What's Different About Public and Non-Profit 'Turnaround'? *Public Money & Management*, 24, 209-216.
- PETTERSEN, I.-J. & SOLSTAD, E. 2007. The role of accounting information in a reforming area: A study of higher education institutions. *Financial Accountability & Management*, 23, 133-154.

- PETTIGREW, A. 1995. Longitudinal field research on change: theory and practice. *Longitudinal Field Research Methods: Studying Processes of Organisation Change*. Thousands Oaks: SAGE.
- PFEFFER, J. & SALANCIK, G. 2003. *The external control of organizations: A resource dependence perspective*, Stanford University Press.
- PICHOIR-DREW, M. 2005. *CCHSA Accreditation: A catalyst for change and a building block for social capital. Case study of health authority in New Brunswick; MSc thesis*. Health Administration Department, University of Ottawa.
- PICKERING, E. 1995. Evaluating the benefits and limitations of an accreditation system. *World hospitals and health services*, 31, 31-5.
- PINK, G. H., MCKILLOP, I., SCHRAA, E. G., PREYRA, C., MONTGOMERY, C. & BAKER, G. R. 2001. Creating a balanced scorecard for a hospital system. *Journal of Health Care Finance*, 27, 1-20.
- PISKORZ, K. Year. Impact of accreditation on nursing care. In: Proceedings of the Polish National Committee on Quality Assurance Conference, 2002 Olsztyn. 83-89.
- POLLITT, C. 2006. Academic Advice to Practitioners—What is its Nature, Place and Value Within Academia? *Public Money & Management*, 26, 257-264.
- POMEY, M., CONTANDRIOPOULOS, A., FRANCOIS, P. & BERTRAND, D. 2004. Accreditation: a tool for organizational change in hospitals? *International Journal of Health Care Quality Assurance*, 17, 113-124.
- POMEY, M., LEMIEUX-CHARLES, L., CHAMPAGNE, F., ANGUS, D., SHABAH, A. & CONTANDRIOPOULOS, A. 2010. Does accreditation stimulate change? A study of the impact of the accreditation process on Canadian healthcare organizations. *Implementation Science*, 5, 1-14.
- PONGPIRUL, K., SRIRATANABAN, J., ASAVAROENGCHAI, S., THAMMATACHAREE, J. & LAOITTHI, P. 2006. Comparison of health care professionals' and surveyors' opinions on problems and obstacles in implementing quality management system in Thailand: a national survey. *International Journal for Quality in Health Care*, 18, 346-351.
- POPAY, J., ROGERS, A. & WILLIAMS, G. 1998. Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research*, 8, 341-351.
- POPE, C. & MAYS, N. (eds.) 2006. *Qualitative research in health care*, 3rd ed., Oxford: Blackwell Publishing.
- POPE, C., ZIEBLAND, S. & MAYS, N. 2000. Qualitative research in health care: Analysing qualitative data. *BMJ*, 320, 114-116.
- POPOVICH, J. A. M. 1998. Multidimensional performance measurement. *Journal of Nursing Care Quality*, 12, 14-21.
- POPPER, K. 1959. *The logic of scientific discovery*, Hutchinson.
- POWELL, A., RUSHMER, R. & DAVIES, H. 2009. A systematic narrative review of quality improvement models in health care. Social Dimensions of Health Institute, The Universities of Dundee and St Andrews.
- POWER, M. & LAUGHLIN, R. 1996. Habermas, law and accounting. *Accounting, Organizations and Society*, 21, 441-467.
- PROPPER, C. & WILSON, D. 2003. The Use and Usefulness of Performance Measures in the Public Sector. *Oxford Review of Economic Policy*, 19, 250-267.
- PURBEY, S., MUKHERJEE, K. & BHAR, C. 2006. Performance measurement system for healthcare processes. *International Journal of Productivity and Performance Management*, 56, 241-251.

- QUALITY ASSURANCE PROJECT 2005. The Zambia Accreditation Program Evaluation. Operations Research Results. U.S. Agency for International Development Agency (USAID) by QAP.
- RADHARAMANAN, R. & GODOY, L. 1996. Quality function deployment as applied to a health care system. *Computers & Industrial Engineering*, 31, 443-446.
- RAISI, A. 2006. *Comparative study of the hospital accreditation system in the selected countries and developing a model for Iran*. PhD Thesis, Iran University of Medical Sciences.
- RAWLINS, R. 2001. Hospital accreditation is important. *BMJ*, 322, 674.
- REITER, K., NAHRA, T., ALEXANDER, J. & WHEELER, J. 2006. Hospital responses to pay-for-performance incentives. *Health Services Management Research*, 19, 123-134.
- RENHOLM, M., LEINO-KILPI, H. & SUOMINEN, T. 2002. Critical pathways: a systematic review. *Journal of Nursing Administration*, 32, 196-202.
- REZNICH, C. & MAVIS, B. 2000. Pilot test of family medicine faculty development fellowship accreditation guidelines. *Family Medicine*, Nov-Dec;32, 709-19.
- RICHARDSON, S., CULLEN, J. & RICHARDSON, B. 1996. The story of a schizoid organization How accounting and the accountant are implicated in its creation. *Accounting, Auditing & Accountability Journal*, 9, 8-30.
- RIDGWAY, V. F. 1956. Dysfunctional Consequences of Performance Measurements. *Administrative Science Quarterly*, 1, 240-247.
- RILEY, W., PARSONS, H., MCCOY, K., BURNS, D., ANDERSON, D., LEE, S. & SAINFORT, F. 2009. Introducing Quality Improvement Methods into Local Public Health Departments: Structured Evaluation of a Statewide Pilot Project. *Health Services Research*, 44, 1863-1879.
- RITCHIE, J. & LEWIS, J. (eds.) 2003. *Qualitative research practice: A guide for social science students and researchers*, London: SAGE.
- RITCHIE, J. & SPENCER, L. 1994. Qualitative data analysis for applied policy research. In: BRYMAN, A. & BURGESS, R. G. (eds.) *Analysing qualitative data*. London and New York: Routledge.
- ROA, D. & ROONEY, A. 1999. Improving health services delivery with accreditation, licensure and certification. *Quality Assurance Brief*, 8, 4-11.
- ROBBINS, S., P. & COULTER, M. 2002. *Management*, New Jersey, Prentice-Hall International, Inc.
- ROCKWELL, D. A., PELLETIER, L. R. & DONNELLY, W. 1993. The Cost of Accreditation: One Hospital's Experience. *Hospital and Community Psychiatry*, 44, 151-155.
- ROLAND, G. 2004. Understanding institutional change: Fast-moving and slow-moving institutions. *Studies in Comparative International Development (SCID)*, 38, 109-131.
- ROONEY, A. & BARNES, K. 2001. Assessing the cost effectiveness of hospital accreditation in two developing countries. Joint Commission Resources (JCR) and The Joint Commission, Council for Health Services Accreditation of South Africa, KwaZulu Natal Province, and Zambian Central Board of Health, University Research Co., LLC/Center for Human Services for the Quality Assurance Project, WHO, USAID.
- ROONEY, A. & VAN OSTENBERG, P. 1999. Licensure, Accreditation, and Certification: Approaches to Health. *Quality Assurance Project*. Bethesda.
- ROONEY, A. & VANOSTENBERG, P. 2004. International accreditation: what's good practice in Sao Paulo is good practice in Istanbul. *Journal of Ahima*, 75, 38-9.

- ROSE, R. C., ULI, J., ABDUL, M. & NG, K. L. 2004. Hospital service quality: a managerial challenge. *International Journal of Health Care Quality Assurance*, 17, 146-159.
- RUEF, M. & SCOTT, W. R. 1998. A Multidimensional Model of Organizational Legitimacy: Hospital Survival in Changing Institutional Environments. *Administrative Science Quarterly*, 43, 877-904.
- SAATY, T. L. 1980. *The Analytical Hierarchy Process*, New York, McGraw-Hill.
- SADAGHIANI, E. 1997. *Evaluation of Healthcare and Hospital Standards*, Tehran, Science & Art and Moeen.
- SADAGHIANI, E. 1998. *Organizatin and Management of Hospital*, Tehran, Jahan Rayane.
- SADAGHIANI, E. & ZARE, H. 2005. The study of accreditation and evaluation system of healthcare organizations. In: MANAGEMENT & PLANNING ORGANIZATION (ed.). Tehran: Healthcare Insurance Organization
- SALMON, J. W., HEAVENS, J., LOMBARD, C., TAVROW, P. & FOREWORD BY HEIBY, J., AND COMMENTARIES BY WHITTAKER S, MULLER M, KEEGAN M, AND ROONEY AL. 2003. The Impact of Accreditation on the Quality of Hospital Care: KwaZulu-Natal Province, Republic of South Africa. In: U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) (ed.) *The Operations Research Results2*. Bethesda MD, the USA: by Quality Assurance Project, University Research Co, LLC.
- SCHYVE, P. M. 2000. The evolution of external quality evaluation: observations from the Joint Commission on Accreditation of Healthcare Organizations. *International Journal for Quality in Health Care*, 12, 255-258.
- SCOTT, I. 2009. What are the most effective strategies for improving quality and safety of health care? *Internal Medicine Journal*, 39, 389-400.
- SCOTT, W. 2008a. Approaching adulthood: the maturing of institutional theory. *Theory and Society*, 37, 427-442.
- SCOTT, W. 2008b. *Institutions and organizations: Ideas and Interests*, 3rd ed., SAGE.
- SCOTT, W. & MEYER, J. 1983. *Organizational Environments: Ritual and Rationality*, Beverly Hills, CA, SAGE.
- SCRIVEN, M. 2009. Meta-Evaluation Revisited. *Journal of MultiDisciplinary Evaluation*, 5, iii-viii.
- SCRIVENS, E. 1993. An external evaluation of the hospital accreditation programme. *Hospital Accreditation Programme*. Bristol: University of Bristol.
- SCRIVENS, E. 1995a. *Accreditation: protecting the professional or the consumer?*, Buckingham, Open University Press.
- SCRIVENS, E. 1995b. International trends in accreditation. *International Journal of Health Planning and Management*, 10, 165-181.
- SCRIVENS, E. 1996. A Taxonomy of the Dimensions of Accreditation Systems. *Social Policy & Administration*, 30, 114-124.
- SCRIVENS, E. 1997a. Assessing the value of accreditation systems. *European Journal of Public Health*, 7, 4-8.
- SCRIVENS, E. 1997b. Putting continuous quality improvement into accreditation: improving approaches to quality assessment. *Quality in Health Care*, 6, 212-218.
- SCRIVENS, E. 2002. Accreditation and the regulation of quality in health services. In: SALTMAN, R. B., BUSSE, R. & MOSSIALOS, E. (eds.) *Regulating entrepreneurial behaviour in European health care systems*. Buckingham · Philadelphia: Open University Press.

- SCRIVENS, E. 2007. The future of regulation and governance. *The Journal of the Royal Society for the Promotion of Health*, 127, 72-77.
- SCRIVENS, E. & LODGE, J. 1997. Accreditation: protecting the professional or the consumer? *Journal of Management Studies*, 34, 167-169.
- SCRIVENS, E. E. J., KLEIN, R. & STEINER, A. 1995. Accreditation: what can we learn from the Anglophone model? *Health Policy*, 34, 193-204.
- SEALE, C. 1999. Quality in qualitative research. *Qualitative inquiry*, 5, 465-478.
- SEKIMOTO, M., IMANAKA, Y., KOBAYASHI, H., OKUBO, T., KIZU, J., KOBUSE, H., MIHARA, H., TSUJI, N. & YAMAGUCHI, A. 2008. Impact of hospital accreditation on infection control programs in teaching hospitals in Japan. *American journal of infection control*, 36, 212-219.
- SELZNICK, P. 1949. *TVA and the Grass Roots*, Berkeley, University of California Press
- SHADPOUR, K. 2000. Primary health care networks in the Islamic Republic of Iran. *Eastern Mediterranean Health Journal*, 6, 822-825.
- SHAHHOSEINI, R., TOFIGHI, S., JAAFARIPOOYAN, E. & SAFIARYAN, R. 2011. Efficiency measurement in developing countries: application of data envelopment analysis for Iranian hospitals. *Health Serv Manage Res*, 24, 75-80.
- SHANIKAT, M. 2008. *Organisational change and accounting information systems: a case study of the privatisation of Jordan Telecom*. PhD Thesis, School of Accounting and Finance, University of Wollongong.
- SHAW, C. D. 2000. External quality mechanisms for health care: summary of the ExPeRT project on visitatie, accreditation, EFQM and ISO assessment in European Union countries. *International Journal for Quality in Health Care*, 12, 169-175.
- SHAW, C. D. 2001. External assessment of health care. *BMJ*, 322, 851-854.
- SHAW, C. D. 2003a. Evaluating accreditation. *International Journal for Quality in Health Care*, 15, 455-456.
- SHAW, C. D. 2003b. How can hospital performance be measured and monitored? Copenhagen: WHO Regional Office for Europe's Health Evidence Network (HEN).
- SHAW, C. D. 2004a. Developing hospital accreditation in Europe. In: DIVISION OF COUNTRY SUPPORT (ed.). WHO Regional Office for Europe.
- SHAW, C. D. 2004b. The external assessment of health services. *World Hospitals and Health Services*, 40, 24-7.
- SHAW, C. D. 2004c. Toolkit for accreditation programs: Some issues in the design and redesign of external health care assessment and improvement systems. Melbourne, Australia: International Society for Quality in Health Care.
- SHAW, C. D. 2007. Which way to organizational excellence? Not this way; ask a professional. *Journal of the Royal Society of Medicine*, 100, 206-207.
- SHAW, C. D. & BROOKS, T. E. 1991. Health service accreditation in the UK. *Int J Qual Health Care*, 3, 133-140.
- SHAW, C. D., KUTRYBA, B., BRAITHWAITE, J., BEDLICKI, M. & WARUNEK, A. 2010. Sustainable healthcare accreditation: messages from Europe in 2009. *International Journal for Quality in Health Care*, 22, 341-350.
- SHEAHAN, M. 1999. Customer focus: patient, organization and EQuIP in collaboration - evaluation and quality improvement program. *Journal of Quality in Clinical Practice*, 19, 139-144.
- SIERPINSKA, L. & KSYKIEWICZ-DOROTA, A. Year. Influence of accreditation on the teamwork of medical staff as a direction for improving patient care. In: Proceedings of Polish National Committee on Quality Assurance Conference, 2002 Lublin. 90-95.

- SILVERMAN, D. 2010. *Doing qualitative research*, 3rd ed., Thousand Oaks, CA, SAGE.
- SIMONS, R. 2005. *Levers of organization design: how managers use accountability systems for greater performance and commitment*, Boston, Harvard Business School Press.
- SIMONS, R., KASIC, S., KIRKPATRICK, A., VERTESI, L., PHANG, T. & APPLETON, L. 2002. Relative importance of designation and accreditation of trauma centers during evolution of a regional trauma system. *Journal of Trauma*, 52, 827-834.
- SITZIA, J. 1999. How valid and reliable are patient satisfaction data? An analysis of 195 studies. *International Journal of Quality in Health Care*, 11, 319-328.
- SMITH, K. K. 1982. Philosophical problems in thinking about organizational change, in Paul S. Goodman et al. (Eds). *Change in organisation*. San Francisco: Jossey Bass.
- SMITH, P. 1993. Outcome-related Performance Indicators and Organizational Control in the Public Sector1. *British Journal of Management*, 4, 135-151.
- SMITH, P. C. 1995. On the unintended consequences of publishing performance data in the public sector. *International Journal of Public Administration*, 18, 277-310.
- SMITH, P. C. 2002. Measuring health system performance. *European Journal of Health Economics*, 3, 145-148.
- SMITH, P. C. 2005. Performance Measurement in Health Care: History, Challenges and Prospects. *Public Money and Management*, 25, 213-220.
- SMITH, P. C., MOSSIALOS, E. & PAPANICOLAS, I. 2008. Performance measurement for health system improvement: experiences, challenges and prospects. World Health Organization. European Observatory on Health Systems and Policies.
- SNYDER, C. & ANDERSON, G. 2005. Do Quality Improvement Organizations Improve the Quality of Hospital Care for Medicare Beneficiaries? *JAMA*, 293, 2900-2907.
- SOIN, K. 1996. *Organizational change and the introduction of activity based costing in a UK clearing bank*, PhD Thesis. Sheffield Hallam University.
- SPECKBACHER, G. 2003. The economics of performance management in nonprofit organizations. *Nonprofit Management and Leadership*, 13, 267-281.
- SRINIVASAN, A. V. 2008. *Managing a Modern Hospital*, 2nd ed., New Dehli, SAGE.
- STAKE, R. 1999. *The art of case study research*, 6th ed., Thousand Oaks, CA, SAGE.
- STEWART, L. J. & BESTOR, W. E. 2000. Applying a balanced scorecard to health care organizations. *Journal of Corporate Accounting & Finance*, 11, 75-82.
- STONER, J. A. F., FREEMAN, E., R. & GILBERT, D. R. 1995. *Management*, London, Prentice-Hall International.
- STRAUSS, A. & CORBIN, J. 1998. *Basics of qualitative research: Techniques and procedures for developing grounded theory*, 2nd eds., London, SAGE.
- STUFFLEBEAM, D. 2001. Evaluation models. *New directions for evaluation*, 2001, 7-98.
- SUCHMAN, M. 1995. Managing Legitimacy: Strategic and Institutional Approaches. *Academy of Management Review*, 20, 571-571.
- SUNOL, R., NICKLIN, W., BRUNEAU, C. & WHITTAKER, S. 2009a. Promoting research into healthcare accreditation/external evaluation: advancing an ISQua initiative. *International Journal for Quality in Health Care*, 21, 27-28.
- SUNOL, R., VALLEJO, P., THOMPSON, A., LOMBARTS, M., SHAW, C. & KLAZINGA, N. 2009b. Impact of quality strategies on hospital outputs. *Quality and Safety in Health Care*, 18, i62-i68.
- SUTHERLAND, K. & LEATHERMAN, S. 2006. Regulation and Quality Improvement. London: The Health Foundation.
- SWEENEY, J. & HEATON, C. 2000. Interpretations and variations of ISO 9000 in acute health care. *International Journal for Quality in Health Care*, 12, 203-209.

- TANER, T. & ANTONY, J. 2006. Comparing public and private hospital care service quality in Turkey. *Leadership in Health Services*, 19, i-x.
- TARIMO, E. 1991. Towards a Healthy District. In: WHO (ed.). Geneva.
- TELLIS, W. 1997. Application of a case study methodology. *The Qualitative Report*, 3, 1-17.
- TEUBNER, G. 1987. *Juridification of social spheres: a comparative analysis in the areas of labor, corporate, antitrust, and social welfare law*, Berlin, Walter De Gruyter Inc.
- THOMPSON, B. L. & HARRIS, J. R. 2001. Performance Measures Are We Measuring What Matters. *American Journal of Preventive Medicine*, 20, 291-3.
- TOUATI, N. & POMEY, M. 2009. Accreditation at a crossroads: Are we on the right track? *Health Policy*, 90, 156-165.
- TUOMELA, T. 2005. The interplay of different levers of control: A case study of introducing a new performance measurement system. *Management Accounting Research*, 16, 293-320.
- TYRRALL, D. & PARKER, D. 2005. The fragmentation of a railway: A study of organizational change. *Journal of Management Studies*, 42, 507-537.
- URRUTIA, I. & ERIKSEN, S., D. 2005. Application of the balanced scorecard in Spanish private health-care management. *Measuring Business Excellence*, 9, 16-26.
- USAID 2005. Egyptian Hospital Accreditation Program: Standards. In: EGYPTIAN MINISTRY OF HEALTH AND POPULATION (ed.) 6th ed.
- VAN OSTENBERG, P. 2005. Issues in Developing National Accreditation Programs to Improve the Quality and Safety of Patient Care. Joint Commission International.
- VOELKER, K. E., RAKICH, J. S. & FRENCH, G. R. 2001. The balanced scorecard in healthcare organizations: a performance measurement and strategic planning methodology. *Hospital Topics*, 79, 13-24.
- WAGGONER, D. B., NEELY, A. D. & P. KENNERLEY, M. 1999. The forces that shape organisational performance measurement systems:: An interdisciplinary review. *International Journal of Production Economics*, 60-61, 53-60.
- WALBURG, J., BEVAN, H., WILDERSPIN, J. & LEMMENS, K. (eds.) 2006. *Performance Management in Health Care*, London & New York: Routledge.
- WALSHE, K. 2002. The rise of regulation in the NHS. *BMJ: British Medical Journal*, 324, 967.
- WALSHE, K. 2003. *Regulating healthcare: a prescription for improvement?*, Maidenhead, Philadelphia, Open University Press.
- WALSHE, K. 2007. Understanding what works--and why--in quality improvement: the need for theory-driven evaluation. *International Journal for Quality in Health Care*, 19, 57-59.
- WALSHE, K. 2009. Pseudoinnovation: the development and spread of healthcare quality improvement methodologies. *International Journal for Quality in Health Care*, 21, 153-159.
- WALSHE, K. & SHORTELL, S. M. 2004. Social regulation of healthcare organizations in the United States: developing a framework for evaluation. *Health Services Management Research*, 17, 79-99.
- WALSHE, K. & SMITH, J. (eds.) 2006. *Healthcare Management*, London: Open University Press, McGraw Hill, UK.
- WALSHE, K., WALLACE, L., FREEMAN, T., LATHAM, L. & SPURGEON, P. 2001. The external review of quality improvement in health care organizations: a qualitative study. *International Journal of Quality in Health Care*, 13, 367-374.

- WALSHE, K. & WALSH, N. 2000. Evaluating accreditation programmes in healthcare. In: WALSHE, K., WALSH, N., SCHOFIELD, T. & BLACKWAY-PHILIPS, C. (eds.) *Accreditation in Primary Care: towards clinical governance*. Oxon, England: Radcliffe Medical Press Ltd.
- WEERT, C. V. 2000. Developments in professional quality assurance towards quality improvement: some examples of peer review in the Netherlands and the United Kingdom. *International Journal for Quality in Health Care*, 12, 239-242.
- WEINER, B., ALEXANDER, J., SHORTELL, S., BAKER, L., BECKER, M. & GEPPERT, J. 2006. Quality improvement implementation and hospital performance on quality indicators. *Health Services Research*, 41, 307-334.
- WERNER, R. M. & ASCH, D. A. 2007. Clinical concerns about clinical performance measurement. *Annual Family Medicine*, 5, 159-63.
- WEST, E. 2001. Management matters: the link between hospital organisation and quality of patient care. *British Medical Journal*, 10, 40-48.
- WHETTEN, D. A. 1989. What Constitutes a Theoretical Contribution? *The Academy of Management Review*, 14, 490-495.
- WHITE, S. 1988. *The recent work of Jürgen Habermas: reason, justice and modernity*, Cambridge University Press.
- WHITTAKER, S., BURNS, D., DOYLE, V. & FENNEY, L. P. 1998. Introducing quality assurance to health service delivery - some approaches from South Africa, Ghana and Kenya. *International Journal for Quality in Health Care*, 10 263-7.
- WHO 1978. Declaration of Alma Ata. Geneva: WHO.
- WHO 2003. Quality and accreditation in health care services: A global review. Geneva: Department of Health Service Provision.
- WHO. 2006. *Iran Selected Indicators* [Online]. Available: <http://www.who.int/whosis/en/> [Accessed 6th June 2007].
- WILLIAMS, S. C., SCHMALTZ, S. P., MORTON, D. J., KOSS, R. G. & LOEB, J. M. 2005. Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004. *New England Journal of Medicine*, 353, 255-264.
- WILLMOTT, H. 1993. Breaking the paradigm mentality. *Organization Studies*, 14, 681-719.
- YIN, R. 2003. *Applications of Case Study Research*, 2nd ed., Thousand Oaks, SAGE.
- YIN, R. 2008. *Case study research: Design and methods*, 4rd ed., London, SAGE.
- ZABADA, C., RIVERS, P. A. & MUNCHUS, G. 1998. Obstacles to the application of total quality management in health-care organizations. *Total Quality Management*, 9, 57-66.
- ZAIRI, M. 1994. *Measuring performance for business results*, London and New York, Chapman & Hall.
- ZAKUS, D. & SKINNER, J. 2008. Modelling organizational change in the International Olympic Committee. *European Sport Management Quarterly*, 8, 421-442.
- ZENDE, V. 2006. Dynamics of accreditation of private hospitals. *Express Healthcare Management; November*, p.mumbai.

