

**THE UNIVERSITY OF HULL**

**Charterism and Charterization within Health Services: A Public Choice Analysis of the  
Implementation of Patients' Charters in England and Hong Kong**

**Being a Thesis submitted for the Degree of  
PhD in Health Policy and Management  
in the University of Hull**

**by**

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**(March, 2002)**

Summary of Thesis submitted for the PhD in Health Policy and Management

By Ng Sze Fung Fowie

on

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the Implementation of Patients' Charters in England and Hong Kong

The UK *Patient's Charter* was launched in the National Health Service in 1991. Similarly, a *Patients' Charter* has been implemented in public hospitals managed by the Hospital Authority in Hong Kong since 1994. Although the *Patient's Charter* in England was replaced by the *Your Guide to the NHS* issued in 2001 by New Labour, the charter programme such as the Charter Mark Award scheme is still being practiced in public services including health services. In this research study, the implementation experiences of patients' charters in England and Hong Kong were analyzed by means of a comparative case study. Data were collected from different units of analysis involving staff at different levels as well as patients' groups and their representative bodies through different data collection methods such as semi-structured interviews, focus group, content analysis, and participative observation. Points of convergence and different approaches have been illustrated in both locations about implementation experiences. Both positive and negative impacts have been shown about the changes in management of health services. It is argued that current knowledge about 'Charterism' is limited to the UK context and that should be refined

into international arena, as shown from a bundle of tenets and principles of the Hong Kong experiences. By means of analyzing the case study, this has demonstrated effectively the utility of Public Choice Theory in understanding self-interest behaviours among actors involved in patient's charter in both locations. It is also argued that patients' charters can be effective Public Choice remedy tools to shift the provider-led health services into consumer-led health services.

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## Abstract

Patients' charters have been incorporated in health services systems among various countries including the United Kingdom and Hong Kong. By means of a comparative case study, this research looked at the implementation of patients' charters in the National Health Service in England and the Hospital Authority in Hong Kong from the perspectives of staff at different levels as well as patients' groups and their representative bodies. Points of convergence and different approaches have been illustrated in both locations from their experiences in implementing the charter. Together with the positive and negative impacts learned, it is argued that current knowledge about 'Charterism' is limited to the UK context and this should be interpreted within the international arena as shown from a bundle of tenets and principles of the Hong Kong experience. By means of analyzing the case study, the utility of Public Choice Theory is demonstrated in understanding the self-interest behaviours among the actors involved in patient's charter in both locations. It is also argued that patients' charters can be effective Public Choice remedy tools to shift provider-led health services into consumer-led health services.

Contents	Page
Abbreviations	9
List of Figures	13
List of Tables	14
List of Appendixes	17
 INTRODUCTION	 18
 CHAPTER ONE: RESEARCH CONTEXT OF THE STUDY	
1.1 Introduction	24
1.2 Charterism	25
1.2.1 The Rise of Charterism	25
1.2.2 Charters and Pledges	38
1.2.3 Charterization in the Private Sector	40
1.2.4 Charterism and Charterization	41
1.3 New Public Management	42
1.3.1 Elements of New Public Management	42
1.3.2 Scope of New Public Management	48
1.3.3 Critics of New Public Management	50
1.3.4 The Way Ahead and New Labour	53
1.4 Citizenship	60
1.4.1 Conceptual Framework of Citizenship	60
1.4.2 Citizenship and Consumerism	62
1.4.3 Citizenship and Accountability	64
1.4.4 Citizenship and the Third Way	65

1.5	Summary and Comment	66
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## CHAPTER TWO: RELATED THEORIES TO THE STUDY – A REVIEW

2.1	Introduction	67
2.2	Public Choice Theory	67
2.2.1	The Theory of Public Choice	67
2.2.2	Public Choice as Deductive Theory	74
2.2.3	Public Choice and Decision Making	75
2.2.4	Public Choice and New Labour	78
2.3	Implementation Theory	80
2.3.1	Importance of Implementation in the Study of the Policy Process	80
2.3.2	Policy and Policy Instruments	82
2.3.3	Top-Down Implementation Model	85
2.3.4	Bottom-Up Implementation Model	87
2.3.5	The Instrument – Choice Model	90
2.3.6	Advocacy Coalition Approach	90
2.4	Consumerism	92
2.4.1	Theory of Consumerism	92
2.4.2	Consumerism in the Health Service	93
2.4.3	Consumerism in the UK National Health Service	96
2.4.4	Consumerism in the Hong Kong Hospital Authority	99
2.4.5	Active Consumers	102
2.5	Summary and Comment	103

## CHAPTER THREE: RESEARCH METHODOLOGY

3.1	Introduction	105
3.2	Qualitative and Quantitative Debate	105
3.2.1	The Overstated Dichotomy	105
3.2.2	Research Questions Revisited	109
3.3	Choice of Qualitative Approach - Mixed Methods	111
3.3.1	Survey versus Case Study approach	111
3.3.2	Designing the Case Studies	116
3.3.3	Theory Development in Case Study Design	120
3.3.4	Validity & Rigour – Triangulation	121
3.4	Comparative Analysis	126
3.4.1	The Field of Comparative Analysis	126
3.4.2	Comparative Research in Health Services	128
3.4.3	How and What to Compare	131
3.5	The Research Plan	134
3.5.1	The Choice of Cases – UK Scene	134
3.5.2	The Choice of Cases – Hong Kong Scene	137
3.6	Summary and Comment	138

## CHAPTER FOUR: NATIONAL POLICY DEVELOPMENT – ENGLAND AND HONG KONG

4.1	Introduction	140
4.2	National Health Service	141
4.2.1	A Historical Review of the National Health Service	141
4.3	<i>Patient's Charter</i> and the <i>Citizen's Charter</i>	151

4.3.1	Charters in Health Care before the <i>Patient's Charter</i>	152
4.3.2	Patient's Charter and Charters in Health in Other Countries	154
4.3.3	The Patient's Charter Initiative in England	160
4.4	Hong Kong Hospital Authority	183
4.4.1	A Historical Review of Health Care System in Hong Kong	183
4.4.2	The Establishment of the Hospital Authority	189
4.4.3	The Business Planning Process of the Hospital Authority	198
4.4.4	The Review of the Health Care System	200
4.4.5	The Patients' Charter Initiative in Hong Kong	209
4.5	Summary and Comment	216

## CHAPTER FIVE: LOCAL DEVELOPMENT IN ENGLAND

5.1	Introduction	218
5.2	Implementation Issues at the local level	219
5.3	Staff and Patient Relationships	232
5.4	Management Issues	238
5.5	Summary and Comment	249

## CHAPTER SIX: LOCAL DEVELOPMENT IN HONG KONG

6.1	Introduction	254
6.2	Implementation Issues at the local level	255
6.3	Staff and Patient Relationships	265
6.4	Management Issues	280
6.5	Summary and Comment	287

## CHAPTER SEVEN: CONCLUSION

7.1	Introduction	290
7.2	Points of Convergence	291
7.3	Different Approaches	296
7.4	Contributions to Current Knowledge and Implications	302
7.5	Limitations of the Study	310
7.6	Recommendations for further research	313
7.7	Summary	316
	References	318
	Appendixes	347

## Abbreviations

A&E	Accident and Emergency
ACF	Advocacy Coalition Framework
ACHCEW	Association of Community Health Councils for England and Wales
AHAs	Area Health Authorities
APMHO	Alliance for Patients' Mutual Help Organizations
ATM	Automatic Teller Machine
CCT	Compulsory Competitive Tendering
CHC	Community Health Council
CHCs	Community Health Councils
CHR	Comparative Health Research
CME	Continuing Medical Education
COIN	Circulars on the Internet
CoS	Chief of Service
CQI	Continuous Quality Improvement
DHAs	District Health Authorities
DHSS	Department of Health and Social Security
DIY	Do-It-Yourself
DMT	District Management Team
DNAs	Did not Attends
DOM	Department Operations Manager
EBM	Evidence Based Medicine
FHSA	Family Health Services Authority
FHSAs	Family Health Service Authorities
FMI	Financial Management Initiatives



FPCs	Family Practitioner Committees
GBP	Great Britain Pound
GEM	Growth Enterprise Market
GOPD	Government Out-patient Department
GP	General Practitioner
GPs	General Practitioners
HA	Hospital Authority (Hong Kong)
HAHO	Hospital Authority Head Office
HAs	Health Authorities
HCA's	Health Care Assistants
HCE	Hospital Chief Executive
HCHS	Hospital and Community Health Services
HimPs	Health Improvement Programmes
HKMA	Hong Kong Medical Association
HKSAR	Hong Kong Special Administrative Region
HMCs	Hospital Management Committees
HSP	Health Security Plan
IHSM	Institute of Health Services Management
IOCU	International Organization of Consumer Unions
LTMDAC	Long term Medical Development Advisory Committee
MEDISAGE	Saving Accounts for the Long Term Care
MORI	Market & Opinion Research International
MP	Member of Parliament
MPs	Members of Parliament
NHS	National Health Service

NHSE	National Health Service Executive
NHSME	National Health Service Management Executive
NICE	National Institute of Clinical Excellence
NPM	New Public Management
OECD	Organization for Economic Cooperation and Development
OMELCO	Office of the (non-government) Members of the Legislative Council
PALS	Patient Advocacy and Liaison Service
PCC	Public Complaints Committee
PCGs	Primary Care Groups
PCRC	Patient and Community Relations Committee
PFI	Private Finance Initiative
PHA	Provisional Hospital Authority
POINT	Publications on the Internet
PPA	Progressive Public Administration
PR	Public Relations
PRC	People's Republic of China
PRO	Patient Relations Officer
Pty	Proprietary
Quangos	Quasi-non-governmental organizations
RHAs	Regional Health Authorities
RHBs	Regional Hospital Boards
RTHK	Radio Television Hong Kong
SDR	Staff Development Review
SHA	Special Health Authorities
SOPD	Specialist Out-patient Department

TQM	Total Quality Management
TV	Television
UK	United Kingdom
US	United States
USA	United States of America
WHO	World Health Organization
WM	Ward Manager

<u>List of Figures</u>	<u>Page</u>
<i>Figure One: Six Principles of Public Services</i>	28
<i>Figure Two: Charters in different parts of the United Kingdom</i>	31
<i>Figure Three: From Traditional or Progressive Public Administration to New Public Management</i>	44
<i>Figure Four: Three Major Components of New Public Management</i>	47
<i>Figure Five: The Spectrum of Policy Instruments</i>	84
<i>Figure Six: Type of Research</i>	107
<i>Figure Seven: Types of Research Designs for Case Studies</i>	117
<i>Figure Eight: A Model for Comparative Health Research</i>	132
<i>Figure Nine: A Basic Model to represent a Comparative Research Study Unit</i>	133
<i>Figure Ten: The National Health Service 1948-1974</i>	142
<i>Figure Eleven: The Reorganised National Health Service in 1974-82 in England</i>	143
<i>Figure Twelve: The Organization of the National Health Service 1982-1991</i>	144
<i>Figure Thirteen: The National Health Service in England, 1991-96</i>	146
<i>Figure Fourteen: The Structure of the NHS in England, 1996-99</i>	147
<i>Figure Fifteen: The Structure of the new NHS 1997</i>	149
<i>Figure Sixteen: Organization Structure of the Hospital Authority</i>	193
<i>Figure Seventeen: Committee Structure of the Hospital Authority</i>	194
<i>Figure Eighteen: Organisation Structure of the Hospital Authority Head Office</i>	196
<i>Figure Nineteen: The Top Management Structure of a Large Hospital – with multiple clinical departments</i>	197
<i>Figure Twenty: Compartmentalized Health Care Provision</i>	204

List of Tables	Page
<i>Table One: Public Administration versus Public Management</i>	45
<i>Table Two: Dimensions of the Third Way</i>	57
<i>Table Three: Comparison of Old Left, New Right and New Labour</i>	58
<i>Table Four: Ten prerequisite conditions to achieve Top-down Implementation</i>	86
<i>Table Five: Top-down versus Bottom-up Approaches</i>	89
<i>Table Six: Relevant Situations versus Research Strategies</i>	114
<i>Table Seven: A Schematic Comparison of Case Study with Experimental and Survey Approaches</i>	115
<i>Table Eight: NHS Value Statement</i>	170
<i>Table Nine: Nine Principles of Public Service Delivery</i>	179
<i>Table Ten: Ten Charter Mark Criteria</i>	181
<i>Table Eleven: Charter Mark Application Success Rate and Winners by Year</i>	182
<i>Table Twelve: Characteristics of Respondents of Interviews in UK</i>	223
<i>Table Thirteen: Congruence: number and percentage of respondents agreeing positive impressions towards named nurse</i>	226
<i>Table Fourteen: Congruence: number and percentage of respondents agreeing performance indicators were collected about Patient's Charter</i>	228
<i>Table Fifteen: Congruence: number and percentage of respondents agreeing patients rarely refer to Patient's Charter nowadays</i>	231
<i>Table Sixteen: Congruence: number and percentage of respondents agreeing a positive change in trusting relationship between staff and patients</i>	232
<i>Table Seventeen: Congruence: number and percentage of respondents agreeing increased number of complaints</i>	234

<i>Table Eighteen:</i> Congruence: number and percentage of respondents agreeing the lack of sense of responsibility of patients	236
<i>Table Nineteen:</i> Congruence: number and percentage of respondents agreeing the political background of <i>Patient's Charter</i>	239
<i>Table Twenty:</i> Congruence: number and percentage of respondents agreeing the facilitation of quality culture with <i>Patient's Charter</i>	241
<i>Table Twenty-one:</i> Congruence: number and percentage of respondents agreeing the top down approach of implementing <i>Patient's Charter</i>	243
<i>Table Twenty-two:</i> Congruence: number and percentage of respondents agreeing the continuation of <i>Patient's Charter</i>	244
<i>Table Twenty-three:</i> Congruence: number and percentage of respondents agreeing the support from NHSE was limited	246
<i>Table Twenty-four:</i> Characteristics of Respondents of Interviews in Hong Kong	255
<i>Table Twenty-five:</i> Congruence: number and percentage of respondents agreeing the wide availability of <i>Patients' Charter</i> (Patient group excluded)	261
<i>Table Twenty-six:</i> Congruence: number and percentage of respondents agreeing the relative important items of concerns from patients	262
<i>Table Twenty-seven:</i> Congruence: number and percentage of respondents agreeing a positive change in trusting relationship between staff and patients	266
<i>Table Twenty-eight:</i> Congruence: number and percentage of respondents agreeing that patients lacked responsibility	268
<i>Table Twenty-nine:</i> Congruence: number and percentage of respondents agreeing the new culture of avoiding complaints by satisfying request from patients	270
<i>Table Thirty:</i> Number of Complaints Received by the Medical Council of Hong Kong	277
<i>Table Thirty-one:</i> Congruence: number and percentage of respondents agreeing the political background of <i>Patients' Charter</i>	281
<i>Table Thirty-two:</i> Congruence: number and percentage of respondents agreeing charter can instill quality culture	282

<i>Table Thirty-three: Congruence: number and percentage of respondents agreeing to continue the <i>Patients' Charter</i></i>	284
<i>Table Thirty-four: Congruence: number and percentage of respondents agreeing the three versions of charter documents are confusing the public</i>	285
<i>Table Thirty-five: Congruence: number and percentage of respondents agreeing to use the same title as <i>Patients' Charter</i></i>	286

<u>List of Appendixes</u>	<u>Page</u>
<i>Appendix One: Sample Letter sent to NHSE</i>	347
<i>Appendix Two: Second Letter to NHSE</i>	349
<i>Appendix Three: Sample letter to NHS Trusts</i>	351
<i>Appendix Four: Sample letter to CHC</i>	353
<i>Appendix Five: Sample letter to Patients' group</i>	355
<i>Appendix Six: Patient's Charter: Guidelines for Good Practice</i> (ACHCEW, 1986 with main points only)	357
<i>Appendix Seven: The Best of Health: Charter for the Family Health</i> Service (Kinnock, 1986 with main points only)	358
<i>Appendix Eight: The Patient's Charter</i> (Department of Health, 1991a with main points only)	359
<i>Appendix Nine: The Patient's Charter and family doctor services</i> (Department of Health, 1993 with main points only)	361
<i>Appendix Ten: The Patient's Charter &amp; You</i> (Department of Health, 1995b with main points only)	363
<i>Appendix Eleven: Patients' Charter</i> (Hospital Authority, 1995)	370
<i>Appendix Twelve: Patients' Rights &amp; Responsibilities</i> (HKMA, 1993)	372
<i>Appendix Thirteen: Patients' Rights and Responsibilities</i> (DoH, 2000)	373



## INTRODUCTION

In various health care systems around the world, there are major reforms but in different directions. Initiatives are proposed and then implemented in numerous countries, such as the structural reforms of the health service, new arrangements of health care financing options, the incorporation of information technology within major infrastructures, as well as steps to improve the quality of health services for patients and their carers. The advance of Evidence Based Medicine (EBM), the emphasis on clinical governance, clinical protocols, audits and risk management, have all appeared regularly in such agendas. Governments' health policies are targeted towards making the best use of resources to provide the maximum health benefits to their citizens. Both the public and private health care sectors are searching for new ways to satisfy their patients' or customers' needs. More importantly, traditional relationships between patients and health care professionals are being transformed with an emphasis on shifting power to the 'customers', namely patients and their carers. Various moves, such as the *Patient's Charter*, patients' advocates or representatives, clear complaints procedures, better information, e-health, more choices for patients, together with interest in medical matters in the media, have all facilitated a revolution in the climate of health care and in patients' rights.

Indeed, such moves are not restricted to the health care market alone. In recent years, an emergent phenomenon put forward by the British government has been the development of various charters in the public sector and the privatized public utilities. All public service providers are required to publish their charters. Public sector managers and executives have to implement that which is stated within these charters

and to report their performance annually. Within the National Health Service, the *Patient's Charter* for England was launched in 1991. It was subsequently refined with newer versions of the charter. The existence of the *Patient's Charter* was carried on initially by the New Labour government and then was reviewed by a team led by Greg Dyke whose report on the new *NHS Charter* was published in November 1998. After some delay in the publication of the promised new charter standards, the Department of Health launched a new document, 52 pages long, called *Your Guide to the NHS* on 26<sup>th</sup> January 2001. This is to replace the *Patient's Charter* by providing a clearer guide to patients' rights, responsibilities, and the national standards and services people can expect from the NHS now and in the future. The Department of Health has said it will keep the *Guide* under review. From 2003, the Government will evaluate the success of the *Guide*, after which, the Department of Health will publish a revised version. On the other hand, the Charter Mark award system is still being implemented in the National Health Service, with some 171 winners among NHS organizations which were awarded a Charter Mark on 1<sup>st</sup> of February 2001.

The changing terminology from a 'Charter' to a 'Guide' seems to reflect the added component of more patient information in conjunction with the spirit of the original charter. The movement to publishing rights and standards with other information is continued and can be seen as being a major drive to improve the quality of services to customers of the health services. Health authorities and providers of health services will have to direct their efforts to implement the requirements stipulated in the charter and in the guide. Although there has been both praise and criticism of the initiative, the idea of adopting charters or similar documents in various services has not been confined to the UK. It has been incorporated in various countries such as Hong

Kong, Malaysia and Australia. In Hong Kong, the Hospital Authority (HA) published a *Patients' Charter* in 1994 for those patients who utilize services from public hospitals in Hong Kong. Patients and their carers can easily obtain a copy of the charter. In addition, the scope of services incorporating charters has been extended from public services to private services. Hence, charters have become a popular 'word' among both staff and patients in different countries. Charters are being used as a beacon to lead the operation of the public services and to create the image of an organization that listens to its customers and protects their rights. Clearly, the strong international interest in this approach is worth examining in more detail.

In this research, I will analyze 'Charterism' and 'Charterization' within the health services of England and Hong Kong through a comparative study of the implementation of the *Patient's Charter* in the respective health services. I will draw on a variety of theoretical concepts in this study, including 'Charterism', 'New Public Management', 'Citizenship', 'Public Choice Theory including decision making', 'Implementation modelling' and 'Consumerism' aiming to analyze current policy developments in the English NHS and the Hong Kong Hospital Authority. Hence, the research will investigate how the patient's charter initiatives have been implemented in the two health care systems through both national as well as local perspectives. In addition, the research will analyze the similarities and points of divergence between the implementation of charters in England and Hong Kong. Furthermore, it will question the nature and extent of change involved in health services and the public sector. It will explore whether the theory of Public Choice offers a means of understanding the implementation of such initiatives. From these research questions, this research study attempts to achieve several major objectives. On the one hand, it includes an evaluation

of the utility of Public Choice theory in understanding the implementation of the *Patient's Charter*. On the other hand, it presents a description and analysis of the process of implementation of the *Patient's Charter* in England and Hong Kong; the description and analysis of the changes in the management of public sector organizations in general as well as the English National Health Service and the Hong Kong Hospital Authority specifically. Hence, it is hoped that this research can enrich and contribute to current theoretical knowledge about 'Charterism' and 'Charterization' in health services as well as in the public sector in the context of an international trend in adopting charters. Finally, I will analyze the recent moves to replace the *Patient's Charter* with *Your Guide to the NHS* and the impact of the 'Third Way' politics of the New Labour government on the charter movement.

In chapter one, I provide a review of the research context of this study. This includes a review of literature about the rise of 'Charterism'. The word 'Charterism' is indeed rather new in the field compared to other established initiatives in public management. Nevertheless, as I illustrate, several authors have referred to this concept. I will introduce the concept of 'Charterization' as a means by which organizations make adjustments to their services. Then, I will explore the relevance of the doctrine of New Public Management to the running of public services in the context of the adoption of charters. Criticisms of New Public Management will also be addressed. I will bring out the debate on 'Reformed managerialism' under the New Labour government and its effect on contemporary public policy in the UK. In discussing the research context, one further important element is the theme of Citizenship. I will present a conceptual framework of Citizenship to show the debate needs to incorporate consumerism and accountability as well as the globalization thesis involved. The emergence of the so-

called 'third way citizenship' will be also explored since this third way approach is shaping health policy in various aspects. All these provide the basis for the objectives of the research and influenced the selection of the research methodology, which will be discussed in chapter three.

Chapter two provides a review of literature in respect of the main theoretical underpinnings: Public Choice theory, implementation theory and the theory of consumerism in the service sector and specifically health services. These theories are related to this study in various ways. In particular, Public Choice theory will be the major focus of this implementation study. I look at the development of the theory and its relationship with decision making. Popular models of decision making will be presented. This research explores implementation issues at national and local level. Therefore, I present different models of implementation in chapter two to facilitate the subsequent analysis of the data collected. It is equally important to have a more in-depth understanding of the theory of consumerism. I review this theory in relation to the National Health Service in UK and the Hospital Authority in Hong Kong. These theories assist in understanding the data gathered from the study and give insight into the consumers' rights movement.

Chapter three describes the elements of the research methodology in detail. Firstly, I review the common debate between qualitative versus quantitative research. Both can be very useful and at times research may need to involve a mix of approaches. Then, I present my arguments for choosing case studies as the major method to collect data. The reasons are made explicit in terms of the research questions and objectives as well as a consideration of resource constraints. I will show the logic of how the cases

were chosen in the two countries and what research tools were used in the case studies. I will discuss the value and theory of comparative analysis as well as how and what to compare. The research plan will then be delineated. Finally, I comment on the potential weaknesses of the chosen methodological approach in attaining the objectives of the research project as well as the obstacles involved in the collection of data.

The subsequent chapters, four to six, set out the data and its analysis, I focus on the presentation and analysis of data collected from the case studies employed. This involves both a 'surface' and a 'detailed' perspective in analyzing the data in trying to enrich knowledge about 'Charterism' and 'Charterization' in the health services and hence the broader public sector. To start with, chapter four describes in detail policy development at national level of the *Patient's Charter* within the National Health Service of UK and the Hospital Authority of Hong Kong. This chapter stresses the strategic approach to the implementation of the *Patient's Charter* in both systems. Chapter five leads to an analysis and discussion of local developments in England. This chapter is dedicated to the analysis of the local implementation of the *Patient's Charter* in the British system. Chapter six follows by discussing and evaluating experiences gained from the development of *Patients' Charter* in Hong Kong. Drawing from the respective implementation paths, comments can then be made about different aspects of the research, comprising the results, research methodology and objectives of the study. Finally, the thesis concludes by summarizing what is learned from the study in an attempt to contribute to knowledge of the area as well identifying those areas that merit future research. The limitations of this study will also be reported and discussed.

## CHAPTER ONE: RESEARCH CONTEXT OF THE STUDY

### 1.1 Introduction

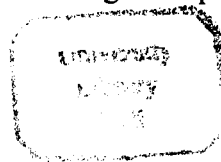
The *Patient's Charter* may mean different things to different people, especially to patients and their carers, health care providers, patients' groups, managers and hospital executives, as well as politicians. To the organization, *Patient's Charter* may be seen as a management tool adopted by managers. It serves different purposes with respect to the group of people who use it or refer to it. Nevertheless, it is particularly useful to look at the context of this research in order to facilitate a study of *Patient's Charter*. In particular, important concepts and issues must be reviewed in the preliminary chapters of the thesis. In this chapter, I examine and review three major concepts underpinning the research context. First, I will examine the rise of Charterism in the 1990s amidst the extensive use of charters in public services in UK and rolling out to other countries. The terms 'Charterism' and 'Charterization' are to be interpreted in the public sector arena. Notably, similar movements of performance pledges have been employed by the public sector in Hong Kong attracting considerable interest. Second, I examine the current array of New Public Management initiatives in the public sector to look at the scope of their influence as well as their critics. The basic evolving concepts behind New Public Management will be illustrated. The differentiation between Traditional Public Administration and New Public Management will be discussed to show their individual emphases. Then, I focus on more recent debates about 'Reformed managerialism' under the New Labour government (1997-). In this respect, I discuss the meaning of citizenship to differentiate active and passive citizens and its relationship with charters. Subsequently, there is a need for a brief introduction

to theories of consumerism and accountability. Both concepts will be explored under the proliferation of citizenship ideas. I will also outline the impact of globalization upon citizenship as well as under a 'Third way' citizenship. These three major concepts of Charterism, New Public Management and Citizenship will thus provide the basic background to this study.

## 1.2 Charterism

### 1.2.1 The Rise of Charterism

A charter can be referred to as a statement of fundamental rights, a list of democratic reforms as well as a call for progressive change in political relationships. The word 'Charterism' may appear a new term in the study of social policy and public management. However, the adoption of 'Charters' has a longer history than the recent charter initiatives adopted by the British government although I will focus on the twentieth century. In 1900, a *Charter of the Poor* was published in the UK by the Christian Commonwealth to explain the monitoring report of the Poor Law Commission (Webb et al., 1900). Later on, the Labour Party published the *Citizen's Charter* in 1921 (Labour Party, 1921). In 1937, the Standing Joint Committee of Industrial Women's Organizations, which was the Labour Party's Advisory Committee on Women's Questions, published a *Children's Charter* to indicate which social provision a community should make for its children (Labour Party, 1937a). During the same year, the Labour Party also published the *Blind Person's Charter*. This charter tried to enable the 76,000 blind people in Great Britain to exercise their rights to play a full part in the life of the community, and as citizens to have the right to proper provision by the





community (Labour Party, 1937b). In 1968, the Liberal Party produced a report entitled *The Consumer's Charter* to cover all aspects of concern for customers about products and services (Liberal Party, 1968). Likewise, the Labour Party led by Neil Kinnock published a *Labour's Charter for Consumers* in 1986 to put the public first and to ensure a fair deal for everyone (Labour Party, 1986). In 1991, the Labour Party also published a *Citizen's Charter* to indicate their better deal for consumers and citizens (Labour Party, 1991). In the health services, the Council of the British Medical Association wrote the document called *Charter for Health* in 1946 to give the profession's views on the basic principles of health (Orr, 1946). Therefore, it seems that different political parties and professions at different times have employed the concept of charter. Before the seeking of the meaning of Charterism, it is useful to look briefly at the importance of the language used in the initiative of *Patient's Charter* used by the Conservative government in the early 1990s.

In the UK, the charter movement was established as a governmental initiative in the early 1990s with the appearance of the citizen's charter initiatives and the publication of the white paper *The Citizen's Charter: Raising the Standard* (Citizen's Charter, 1991a). The Citizen's Charter (1991a) was described by the government as one of the most far-reaching documents issued by the central government in recent times, due to the fact that its scope could affect virtually all citizens' lives (Department of Health, 1991c). It was treated as a 10-year programme to raise the standard of public services and to make them more responsive to the wishes and needs of their users. Prime Minister, John Major, launched the white paper in 1991 with a call to apply the principles of the charter and thus give more power to the citizen (Farnham, 1991). He commented that the citizen's charter initiative was to 'cover all our public services, as

well as those large utilities which are now in the private sector. It is the widest ranging and most comprehensive ever undertaken by Government' (Hansard, 1991). Major claimed that for too long the provider of public services had held the dominant position. He would reverse this situation. He voiced his determination that the charter initiative would be at the centre of his government's decision making throughout the 1990s and would continually improve the quality of public services and make them first class (Major, 1992; Major 1996a).

The scope of Major's 'Big idea' (Chandler, 1996) affected all public services including schools, hospitals, town halls, council housing, police forces, courts, prisons, postal services, tax offices, benefit offices, job centres, railways and roads, as well as utilities such as gas and electricity, that had been privatized but were also to be included in the initiative (Citizen's Charter, 1991b; Citizen's Charter, 1994). Through the *Citizen's Charter*, reform was driven into the core of the public services, extending the benefits of choice, competition, and commitment to services more widely (Citizen's Charter, 1991a).

The white paper's aim was to improve the four themes of choice, quality, value and accountability in the public services. From that, seven major principles were advocated in this white paper as: Standards, Openness, Information, Choice, Non-discrimination, Accessibility, and Complaints and Redress. To draw the main points from the white paper, every citizen is entitled to expect a service with explicit standards, published and prominently displayed at the point of delivery. All services should be open, without secrecy about how they are run, how much they cost and who is in charge. Regarding the principles of information, full and accurate information

should be provided to users about what services are being provided. Targets should be published as well. The public sector should provide more choices if possible and consult users about services. Moreover, there should be no discrimination on grounds of race or sex. In addition, the services should be run to suit the convenience of customers rather than the staff. Clear complaints procedures should be well publicized so that users are able to make complaints about public services if things go wrong. As a result, the user is entitled to a good explanation, apology and redress where appropriate (Citizen's Charter, 1991a, p.5).

These seven principles were condensed and refined into six principles of public services in its first report (Citizen's Charter, 1992a) as follows:

Figure One: Six Principles of Public Services

**STANDARDS**

Setting, monitoring and publication of explicit standards for the services that individual users can reasonably expect. Publication of actual performance against these standards.

**INFORMATION AND OPENNESS**

Full, accurate information readily available in plain language about how public services are run, what they cost, how well they perform and who is in charge.

**CHOICE AND CONSULTATION**

The public sector should provide choice wherever practicable. There should be regular and systematic consultation with those who use services. Users' views about services, and their priorities for improving them, to be taken into account in final decisions on standards.

**COURTESY AND HELPFULNESS**

(cont'd)

Courteous and helpful service from public servants who will normally wear name badges. Services available equally to all who are entitled to them and run to suit their convenience.

#### PUTTING THINGS RIGHT

If things go wrong, an apology, a full explanation and a swift and effective remedy. Well publicized and easy to use complaints procedures with independent review wherever possible.

#### VALUE FOR MONEY

Efficient and economical delivery of public services within the resources the nation can afford. And independent validation of performance against standards.

(Citizen's Charter, 1992a, p.6)

Apart from the publication of the *Citizen's Charter*, a Citizen's Charter Unit, together with a panel of advisors appointed by the Prime Minister, was set up in 1992 in the Cabinet Office to oversee and co-ordinate the programme of action (Bynoe, 1996). In 1993, a telephone Charterline was also piloted for people to enquire about charters (Citizen's Charter, 1992a). Citizens could use this free service to ask for information about the various charters. The government also announced a new scheme of Charter Mark awards for excellence (Citizen's Charter, 1992b; Citizen's Charter, 1992c). A 'Charter Mark' was to be presented to those public organizations which meet the six key principles of the charter standard:

\* Publication of the standards of service that the customer can reasonably expect, and of performance against those standards.

- \* Evidence that the views of those who use the service have been taken into account in setting standards.
- \* Clear information about the range of services provided, in plain language.
- \* Courteous and efficient customer service, from staff who are normally prepared to identify themselves by name.
- \* Well-signposted avenues for complaint if the customer is not satisfied, with some means of independent review wherever possible.
- \* Independent validation of performance against standards and a clear commitment to improve value for money.

(Citizen's Charter, 1991a, p. 6)

These principles, developed from the previous six principles of public services in figure one, were the main criteria under which the public service organization should provide evidence of excellence in their application process to the Citizen's Charter Unit. Up to fifty Charter Marks were awarded each year to those organizations that had delivered services to the highest standard at present available and had systems in place to demonstrate their achievements (Citizen's Charter, 1992b; Citizen's Charter, 1992c). Public sector organizations submitted their applications and were then assessed. The first 36 Charter Marks were presented by Prime Minister Major himself in September 1992 to various winners, including schools, hospitals, government agencies, local authorities, privatized utilities, police services and a prison (Falconer, 1996). In 1995, there were in total 223 Charter Mark Winners out of 740 applications of which 39 winners were from the NHS (Blyth, 1995; Department of Health, 1995a). Staff members celebrated their achievements in gaining the award for their organizations. Charter Marks were displayed within the organization's premises and the official documents and

literature. Such actions and efforts were employed to provide benchmarks to others as well as a symbol of excellence, as one of the 1994 winners, Belfast City Hospital Trust Outpatient Department was reported as saying ‘we believe that achieving Charter Mark will help motivate our staff to improve our outpatient services even further as this quality award will be our benchmark for the future’ (Cabinet Office, 1995, p.4). However, there is no permanence of the award. The public sector organization can lose its Charter Mark if it cannot meet the requirements of the second round of the application. The scheme has continued in popularity among public service providers (Bynoe, 1996). If applications fail to get the Charter Mark award, the relevant organizations may be given a ‘Certificate of commendation’ signed by the Prime Minister. It is not sure from available information whether this practice has been continued by the Labour Government.

Under the umbrella of the *Citizen’s Charter*, public services are required to publish their own charters. By 1996, there were about forty charters published nationally (Falconer et al., 1997). These charters set out standards for individual public services and what to do if these are not met. They included charters for different parts of the United Kingdom (Citizen’s Charter, 1996b) and are listed below.

Figure Two: Charters in different parts of the United Kingdom

<i>United Kingdom: England, Scotland, Wales &amp; Northern Ireland</i>	
* Contributions Charter	
* Employer’s Charter	
* Taxpayer’s Charter (C&E)	(cont’d)

- \* HM Customs & Excise Charter Standards
- \* Taxpayer's Charter (IR)
- \* Traveller's Charter

*Great Britain: England, Scotland & Wales*

- \* Benefits Agency Customer Charter
- \* Child Support Agency Charter
- \* Jobseekers Charter
- \* Passengers Charter
- \* Redundancy Payments Service Charter

*England & Wales*

- \* Council Tenant's Charter
- \* Courts Charter
- \* Further Education Charter
- \* Higher Education Charter
- \* London Bus Passengers Charter 1995
- \* London Underground Customers Charter
- \* Patient's Charter
- \* Parent's Charter
- \* Road User's Charter
- \* Training & Employment Agency Charter

(cont'd)

### *Scotland*

- \* Further and Higher Education Charter
- \* Tenant's Charter
- \* Justice Charter
- \* Patient's Charter
- \* Parents Charter

### *Wales*

- \* Charter for Further Education (Welsh language version)
- \* Charter for Further Education (English language version)
- \* Charter for Higher Education (Welsh language version)
- \* Charter for Higher Education (English language version)
- \* Council Tenants Charter (Welsh language version)
- \* Council Tenants Charter (English language version)
- \* Patients Charter (Welsh language version)
- \* Patients Charter (English language version)
- \* Parents Charter (Welsh language version)
- \* Parents Charter (English language version)

### *Northern Ireland*

- \* Bus Passengers Charter
- \* Charter for Patients and Clients
- \* Child Support Agency Charter
- \* Courts Charter for N.I.
- \* N.I Citizens Charter
- \* Parent's Charter
- \* Railway Passenger's Charter

(cont'd)



- \* Social Security Agency Charter
- \* Tenants Charter
- \* Training and Employment Agency Charter

Under these some 40 main charters, there are more than 10,000 local charters (Major, 1996) and indeed more than 100,000 local charters as claimed by Falconer et al. (1997) covering local public services. In particular, local patient's charters were published by health authorities, local hospitals, local family health services and so on (Carr-Hill and Ng, 1992; Ng, 1992). The scope of these public services charters has covered more than 5 million public servants working in around 14,000 organizations nationwide (Bynoe, 1996). These charters affect almost every citizen in some way. Hence, *Citizen's Charters* were an established element in British government at central and local levels as well as within many quasi-non-government organizations (quangos) (Chandler, 1996).

The citizen's charter initiative was set up as a 10-year programme. It has attracted interest from governments of different countries such as France, the United States, Belgium, Australia, Italy and Kuwait, all of which have undertaken initiatives aimed at improving efficiency and service delivery in much the same way as the charter (Citizen's Charter, 1995; Goldsworthy, 1994; Schiavo, 2000; Clark, 2000). The Citizen's Charter Unit has been approached by at least 35 countries for exchange of ideas to learn from the UK experiences in *Citizen's Charter*. In 1994, the European Region of the World Health Organization also published the Declaration on the Promotion of Patient's Rights in Europe (WHO, 1994). This Declaration provides a framework for action, covering information, consent, confidentiality, privacy, care and

treatment. Similarly, Consumers International has produced a ten point *Patient's Charter* of basic rights (Consumers International, 1996). These rights include appropriate and accessible health care, freedom from discrimination, information and education, and informed consent about treatment. This charter was prepared for consumer groups to use as a basis for campaigning nationally. Hong Kong, a colony of the United Kingdom until 30 June, 1997, has undertaken the related initiatives of *Performance Pledges* in all government departments. The Performance Pledges initiative was launched by the last Governor of Hong Kong, Chris Patten in October, 1992 (Cooray, 1994). In the next section, I will discuss the *Performance Pledges* in more detail. Turning to the health services sector, public hospitals in Hong Kong have gone further by publishing their own *Patients' Charter* which is applicable to more than 40 public hospitals managed by the Hong Kong Hospital Authority, delivering around 90% of secondary care in Hong Kong.

The proliferation of charters in the public services of the United Kingdom has attracted interest from both the academic sector as well as other governments. Drewry (1993) uses the word 'Charterism' to explain the political philosophy of the charters and its critics, for example, the criticism of the problematic nature of the linguistic components of the phrase itself. According to Drewry, the emphasis of the *Citizen's Charter* is upon an individual's rights and choice but with little reference to their duties as citizens. On the other hand, Pollitt (1994) investigated the initial impact of the *Citizen's Charter* in a preliminary analysis. He referred to the characteristics of 'Charterism' such as the terms 'Standard' as the key operational concept of Charterism. He commented that the *Citizen's Charter* was the first 'Majorite' policy initiative but that empirical evidence on the impact of charters was patchy. In addition, the conceptual

basis in a number of important respects was confused, such as the white paper's references to customers but not citizens. The proclaimed standards also lacked legal standing or clear penalties for failure.

Falconer (1996) considered the development of the consumerist ethos in the public sector since the early 1980s, its encapsulation within the *Citizen's Charter* and its implications for accountability in public service delivery by analysing developments in health services, education, transport and housing. He argued that the central themes and principles of the original documents of the *Citizen's Charter* formed the tenets of 'Charterism'. He pointed that Charterism was interpreted as a framework of ideas around which further charters particular to a specific public service could be tailored. Hence the themes and principles suggested in the *Citizen's Charter* form the backbone of 'Charterism'. To review these again, the main themes are defined and interpreted as follows:

- *Standards*: The citizen must be told what service standards are and be able to act where service is unacceptable;
- *Quality*: The charter represents a sustained new programme for improving the quality of public services;
- *Choice*: Choice, wherever possible, between competing providers, is the best spur to quality improvement;
- *Value for Money*: The citizen is also a taxpayer, public services must give value for money within a tax bill the nation can afford.

From these central themes, further principles are developed and illustrated in the *Citizen's Charter* as shown again below such as:

- *Standards*: explicit standards, published and prominently displayed at the point of (service) delivery. These standards should invariably include courtesy and helpfulness from staff, accuracy in accordance with statutory entitlements, and a commitment to prompt action, which might be expressed in terms of a target response or waiting time. There should be a clear presumption that standards will be progressively improved as services become more efficient.
- *Openness*: there should be no secrecy about how public services are run, how much they cost, who is in charge, and whether or not they are meeting their standards. Public servants should not be anonymous.
- *Information*: full, accurate information should be readily available, in plain language about what services are being provided. Targets should be published, together with full and audited information about the results achieved. Wherever possible, information should be in comparable form, so that there is pressure to emulate the best.
- *Choice*: the public sector should provide choice wherever practicable. The people affected by services should be consulted. Their views about the services should be sought regularly and systematically to inform decisions about what services should be provided.
- *Non-discrimination*: services should be available regardless of race or sex.
- *Accessibility*: services should be run to suit the convenience of customers, not staff. This means flexible opening hours, and telephone inquiry points that direct callers quickly to someone who can help them (Citizen's Charter, 1991a).

Complaint procedures and redress mechanisms are fundamental to 'Charterism'. Falconer further argued that 'Charter Mark' programme was an important element of 'Charterism'. This programme recognizes benchmarking public services providers who can attain successfully the specific standards. In addition, providers once awarded have to improve the organization continuously or they will lose the Charter Mark eventually. This could reflect on senior managements' perceived ability. The political rhetoric of Charterism is portrayed as the publishing of a charter which is a statement of commitments, a set of promises to take particular action, together with the means for enabling citizens to judge how far and how well these commitments have been met. Although comments are made about the idealist nature of these claims, the theory and concepts of Charterism are worth further exploration and refinement (Prior, 1995).

### 1.2.2 Charters and Pledges

In the previous section, the initiative of *Performance Pledges* was briefly introduced. This came to the forefront in the public service sector in Hong Kong. In the 1990s, among the various reforms of the public sector in Hong Kong, one initiative was to incorporate *Performance Pledges* into all government departments. This was launched by the Hong Kong government before the handover of sovereignty to China. Cheng and Ngai (1997) highlighted the aim of the programme as to bring long-term productivity improvements in public services and better services to the community. Chris Patten, the governor (1992), claimed that the pledges would:

- set out in plain terms the standards of service which the public has a right to expect;

- include provision for effective monitoring of actual performance against the standards pledged;
- establish a right of appeal for dissatisfied clients;
- guarantee a right to a full and prompt explanation when these standards are not achieved;
- ensure disclosure of the criteria which determine the individual's entitlements to benefits and services.

Therefore, the *Citizen's Charter* provided a model to be transformed into Hong Kong as the *Performance Pledges* (Cooray, 1994). It is also worth noting that Mr. Major and Mr. Patten were both leading members of the British Conservative Party and had been in government together before. Suddenly, all government departments were required to publish *Performance Pledges* in a form which had never been made so explicit to the citizens of Hong Kong. Indeed, the *Performance Pledges* initiative in Hong Kong was described by Lewis (1995) as a basic building block of the long term productivity improvements programme, the Public Sector Reform Programme in Hong Kong. On the other hand, Lo (1993) considered *Performance Pledges* as an interim measure by the government to steer away from some of the controversies associated with the previous policy of privatization and corporatization. This new approach to managing service quality was adopted by over 50 departments. Within the health services, a *Patients' Charter* was published by the Hong Kong Hospital Authority instead of a *Performance Pledge* for the public. Charters were also adopted in Hong Kong for example, the *Safety Charter* (Hospital Authority, 1998), the *Charter for Youth* (Commission on Youth, 1993), the *Victim's Charter* (Attorney General's Chambers, 1996), *Occupational Safety Charter* (Labour Department, 1998) and the *Tax Payer's*

*Charter* (IRD, 2000a). However, there are only a small number of charters compared to pledges. Indeed, charters are more about rights and obligations of users in respect of the services while performance pledges are written towards the indication of performance indicators of standards for the coming year and the measurement of statistics of prior achievement against a standard. Some organizations thus were required to develop both initiatives, for example, the Inland Revenue Department published both the *Tax Payer's Charter* and the *Performance Pledge* and an annual report on performance pledges (IRD, 2000a; IRD, 2000b; IRD, 2001).

After the handover of sovereignty to China on 1 July, 1997, Hong Kong became the Hong Kong Special Administrative Region (HKSAR) of the People's Republic of China (PRC). The Chief Executive of the HKSAR Mr. Tung Chee Wa has continued to maintain these pledges in government departments. Citizens can easily get a copy of different *Performance Pledges* in district offices which are run by the government as a contact point between government and citizens. Each district in Hong Kong has one convenient district office to serve the local population. *Performance Pledges* were put on the display rack for citizens to collect free. Some of the pledges were posted on the official web site of the Hong Kong SAR government at <http://www.info.gov.hk>.

### 1.2.3 Charterization in the Private Sector

While government departments and public services providers were being 'charterized' as a result of new requirements from the policy arena, private organizations, especially, those trading with the public at large such as retailers, hotels and financial agencies have welcomed the idea of 'Charters' (Chandler, 1996). Many

have adopted similar moves in their 'Charterization' process, aiming to improve service quality to customers and hence to increase their competitiveness and their sales as well as market share. For example, the local bus company launched its *Customer's Charter* in Hong Kong (KMB, 2000). Similarly, it is not uncommon to see statements of standards and pledges in supermarket chain stores. Within the private sector, competition is at high levels. These providers are struggling to compete within the market by providing high quality products and services. They make promises to prospective customers by listing standards in advance. Due to the nature of the private sector which provides services to customers, direct contact with the customers can create business opportunities. Similarly in UK, the entrepreneur Sir Richard Branson's Virgin trains, after privatization from government ownership, published a *Passenger's Charter* which sets out the commitment to give passenger safe, high quality service and the right to expect compensation (Virgin Trains, 1998). This is available at railway stations along its network and from the web. Therefore, it is useful to investigate 'Charterism' as it can influence both the public and private sector.

#### 1.2.4 Charterism and Charterization

The labels of 'Charterism' and 'Charterization' are new terms which are not yet included in major dictionaries such as Oxford or Merriam-Webster's best selling dictionaries (Merriam-Webster, 2001). As discussed in the previous section, Drewry could probably be claimed to be the pioneer in using the term 'Charterism'. The adding of the suffix '-ism' is indeed common to the study of political sciences and sociology when associating a 'buzzword' with a specialized academic invention and topic. To illustrate the concept, I will use the term 'Charterization' to show the process and the



approach of incorporating 'Charter Initiatives' in services. For example, a local public utility can charterize its services in order to improve its services to its customers by advocating the principles involved in 'Charterism'. Clear objectives behind the motives to charterize services are needed so that the organization can develop a proper and comprehensive charter for customers without overstating standards which would be difficult to achieve. The point will be further developed in Chapter seven.

### 1.3 New Public Management

#### 1.3.1 Elements of New Public Management

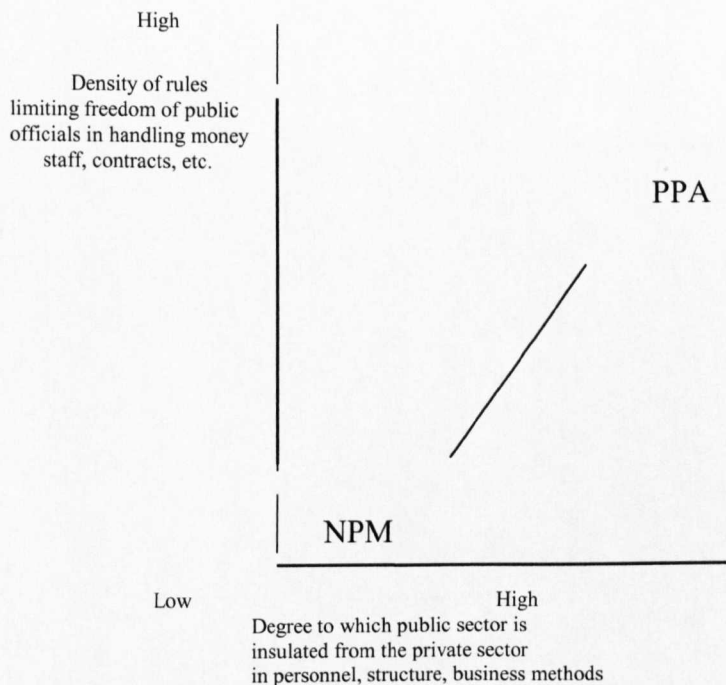
The doctrine of New Public Management (NPM) has been a central idea in public administration since the 1980s in countries of Western Europe, USA, Canada, Australia, New Zealand, and so on. Throughout these countries, governments have tried to find a new approach to public sector management and to reinvent government as advocated by Osborne and Gaebler (1992). The major drive behind the need to search for new ways to govern the public sector can be accounted for by economic pressures exerted on government. Government's priority is to contain public expenditure in eras of economic recession (Ridley, 1996). Farnham and Horton (1996) use the terms 'managerialism' and 'NPM' to describe the structural, organizational and managerial changes which have taken place in the public sector since the late 1970s. Indeed, it has been claimed that the origins of managerialism have been rooted in the 'New Right Ideology' and the 'New politics' as well as the classical scientific management theory of Taylor and Fayol in the management world (Farnham and Horton, 1993, p. 239). Early work by influential New Right theorists such as Friedman and Hayek configured the

ideology and rhetoric of the development of market approaches to public services management. They placed emphasis on the efficiency of the market approach as an aid to decision making as well as being a method to disseminate information. The market can also prevent the unethical behaviour of customer or provider resulting from moral hazard problems within an imperfect market. For example, consumer moral hazard can happen when patients make unnecessary visits to their private doctors because they have comprehensive coverage from medical insurance. Indeed, the Conservative Party, in particular, the previous leader, Margaret Thatcher, was influenced by the New Right Ideology and her 'Thatcherism' had an immense impact upon British government and especially welfare reform (Clarke et al., 2000). Conservative governments were strongly influenced by the New Right thinking and developed a strategy for the 'Marketization' of public services (Walsh, 1995). Public services were to undergo radical changes in structure and style into the new managerial era. Carter's (2000) review of key elements of NPM included hands-on professional management, explicit standards and measures of performance, a shift towards greater competition in the public sector, a stress on private sector styles of management, greater parsimony in resources use and more significant development of the internal market. The discourse of New Public Management was paramount in the public service sector.

The emergence of NPM can be interpreted by at least two models of an updated version of 'Neo-Taylorism' of scientific management, and the newer model of the 'Excellence' literature derived from the works *In Search of Excellence* (Peters and Waterman, 1982). These two models of interpretation overlap and differ with each other. Consequently, traditional 'Progressive Public Administration' (PPA) has now been largely replaced by 'New Public Management'. To explain the two models,

Dunleavy and Hood (1994) suggested that the models can include the move from 'Progressive Public Administration' (PPA) which has a 'high' density of rules limiting freedom of public officials in handling money, staff and contracts, to a 'low' density of such rules in the discourse of 'New Public Management' (NPM). There is also the move from PPA with a 'high' degree to which public sector is insulated from the private in personnel, structure and business methods to a 'low' degree in NPM. This move is represented in Figure Three below:

Figure Three: From traditional or progressive public administration to new public management



(Dunleavy and Hood, 1994, p. 10)

Lane (1994) has explored the divergences, advantages and disadvantages of the public management approach when compared with the public administration approach to public sector reform by analysing the introduction of internal markets in the public sector. Indeed, he claimed that the discipline of public administration was such a state of

crisis that it was being replaced by the new management paradigm. Programmes offered by tertiary educational institutions around the globe have changed their titles from 'Public administration' to 'Public management'. However, the public administration approach is still useful and important in respect of some of its core principles. Table One shows the core principles of public administration versus public management and their differences.

Table One: Public Administration versus Public Management

<u>Public Administration approach</u>	<u>Public Management approach</u>
Rules	Objectives
Due process	Efficiency
Anticipation	Adaptation
Responsibility	Direction
Formalism: case *	Innovation
Openness	Secrecy
Complaint: voice	Exit
Legality	Effectiveness
Vocation	Self-interests
Public interest	Profit

(Lane, 1994, p. 144)

To enhance anticipation and responsibility, each matter in public administration is approached as a so-called case \*, requiring a strict set of rules on how a matter is to be dealt with in a uniform and predictable manner. The case is the information-gathering unit, where the handling of the relevant data, stored in determinate fashion, is recorded in detail. (Lane, 1994, p. 145)

Morris and Haigh (1996) shared similar view with Lane. They argued that a transformation has emerged with a changed 'way of doing things and of getting things done' in public sector organizations (p. 72). These changes were characterized as a

movement from public services that were formerly administered, to public services that were subsequently to be managed.

Ferlie et al. (1996) reviewed NPM in action and identified four models of NPM. They demonstrated that NPM is a dynamic entity which can have many facets. Their four models of NPM included the following:

- *The Efficiency Drive*: the first model to emerge with the association of the introduction of business methods in the public sector. The Griffiths Report of the NHS Inquiry is a classic example (DHSS, 1983).
- *Downsizing and de-centralization*: the idea of a leaner and flatter organization structure and the introduction of the 'Market'.
- *In Search of Excellence*: the emphasis on the literature associated with the work of Peters and Waterman (1982) in which one can learn from excellent companies who listen to their customers, as well as indicating the important role of shaping organization culture to achieve organizational goals.
- *Public Service Orientation*: re-emerging the public sector with a distinct public service mission. Hence, mission statements and visions are being re-written to address their needs.

Similarly, Clark (1996) attempted to summarize the thoughts of various writers on New Public Management and then identified into three main components. These three main components are 'Marketization', 'Disaggregation', and 'Incentivization' to bring public service organizations more close to business organization practices. These are shown in detail in Figure Four below:

Figure Four: Three Major Components of New Public Management

#### MARKETIZATION

Introducing market competition into public services production.

- \* Separating out purchaser/regulatory and provider roles.
- \* Creating quasi-markets among public agencies, firms and non-profit organizations in health care, education, the personal social services and social housing.
- \* Compulsory competitive tendering and market testing.

#### DISAGGREGATION

Strengthening central strategic capacity by decoupling policy and executive functions:

- \* Tighter central control over the definition of policy and resource frameworks.
- \* Decentralizing responsibility for discrete blocks of executive activity to devolved service units.
- \* A shift from process to output in control and accountability mechanisms.

#### INCENTIVIZATION

Linking incentives to performance in order to foster greater entrepreneurialism and closer attention to cost cutting and organizational efficiency:

- \* Increased differentiation in pay at an individual level, and revenue-maximization incentives at the organizational level.
- \* Quantitative methods of performance and efficiency measurement.
- \* Human resource management strategies.
- \* The deprivileging of professionals and public sector workers.

(Clark, 1996, p. 24)

Hence, there is the separation of politics and management which Walsh (1995) described as 'Managerialism' and the first strand of the New Public Management while the second strand is the development of market mechanisms within the public services, based upon indirect control rather than direct authority. New Public Management has become a shorthand for a cultural shift from an administrative to a managerial culture.

Indeed, the origin of this international trend of New Public Management in public administration can be interpreted by a marriage of two different streams of ideas. Hood (1991) explained that the 'New institutional economics' was one partner. The

‘New institutional economics’ was based on public choice, transactions costs analysis and principal-agent theory, which argued for greater competition in the public sector through the use of contracts, competitive tendering and quasi-market; greater user choice of service provider; discipline and parsimony in the use of resources and disaggregation of public bureaucracies into decentralised units. The other partner to this ‘Marriage’ was successive waves of business-type managerialism of the public sector in the international scientific management movement regime which stressed ‘hands-on’ professional management, clear goals and objectives, performance management and reward (Ranade, 1997).

New Public Management has also been presented in the public sector agenda of different governments as a universal apparatus in its portability and diffuse nature as applied to different geographical areas, fields of interest, sizes and so on. Moreover, it is often seen as an ‘apolitical’ framework which is politically neutral within which many different values may be pursued effectively (Hood, 1991). Indeed, this framework has been argued as not being a machine which is exclusive to the New Right or any other political party ideology.

### 1.3.2 Scope of New Public Management

The influence of New Public Management is vast and diverse. In the United Kingdom, the change process began with, for example, the 1968 Fulton Report on the civil service, the 1974 reorganization of the health services, the Financial Management Initiative (FMI), Next Steps, privatization, contracting-out, marketing testing, internal market, performance related pay, as well as the *Citizen’s Charter* (Lewis, 1994; Marsh,

1991; Ranade, 1997; Thompson, 1992). In OECD countries, the literature suggests that there are considerable variations in the extent to which these countries adopted NPM during the 1980s. As Hood (1995) has claimed, the high NPM group in the OECD countries would comprise Sweden, Canada, New Zealand, Australia and the United Kingdom with France, Denmark, the Netherlands, Norway and Ireland also showing a number of marked shifts in the direction of NPM. On the other hand, the low NPM group would be likely to include Germany, Greece, Spain, Switzerland, Japan and Turkey. Other countries such as South Africa and Hong Kong have also placed emphasis on NPM (Hood, 1995). All follow somewhat fairly standard formula to achieve successful organizational change and to inspire the best practices of the excellent companies in the new era of globalization in the new global economy (Thomas, 1996). As Pollitt and Summa (1997) have commented, the NPM is like a bundle or 'shopping-basket' of different measures, with sometimes mutually supportive as well as mutually conflicting measures. It has become a popular label to be selected in the 'supermarket'. Of course, different people may have different experiences when they are consuming this particular 'label' or product.

The attempt to roll back the frontiers of the welfare state by the NPM has provided an undeniable impact on the management of the public sector. Thompson (1992) identified eight implications that can be observed from the change in public management. First, there is a more consciously managerial approach, emphasizing the strategic role of chief executives and leadership at all levels. Second, major changes in system and processes have focused upon outputs rather than inputs. Third, new relationships are derived from the establishment of client/contractor roles to stimulate competition as well as fostering and altering the relationship between groupings of



employees in what were formerly unitary bodies. Fourth, there are new frameworks of remuneration for performance management, staff appraisal and career development. Fifth, the contraction or downsizing of workforces and restructuring of the workforce people from the public to private sector, early retirement and even redundancy are noted. Sixth, the emphasis on quality of service provision, and increasing customer focus are given further impetus by the *Citizen's Charter*. Seventh, the explicit management of change recognizes the importance of real commitment to change rather than just talking about it. Last, organizational culture was shifted to incorporate a business-like culture, oriented towards customers. Hence, NPM had great influences on public services and their users.

Hewison (1999) has analysed the nature of NPM its relationship to nursing in the UK. She claimed that the nursing profession could learn from NPM how a diverse and diffuse ideology can affect the nature and organization of health care though the use of rhetoric. Hence, it would be a great challenge to the 'New Nursing' to try to shape the health policy by actively engaging with the health policy process in order to contribute to the Nursing profession and society. As she commented, 'analysis and understanding of the policy process reveals its 'arbitrary' nature and demonstrates that policies are not fixed entities that cannot be changed' (p. 1383). As a result, nurses have to be 'proactive' rather than 'reactive' (Hewison, 1999).

### 1.3.3 Critics of New Public Management

New Public Management is not without criticism despite its popularity. As Hood (1991) has analyzed, these criticisms can be elaborated in terms of four main areas.

First, there is the assertion that NPM is like the ‘Emperor’s New Clothes’ in which little has changed in reality except the use of this phrase by senior public managers. This is in particular respect of the differences between local implementation versus the objectives of the policy itself. Second, the claim that NPM has damaged public services by being ineffective and sacrificial in its ability to deliver on its central claim to lower costs per unit of service. Thirdly, NPM is viewed as a vehicle for particularistic advantage, especially in promoting the career interests of an ‘elite group of new managerialists’. Fourth, critics doubt the claim for the universality of NPM. It is argued that different administrative values will have different implications for fundamental aspects of administrative design. Writing the same time, Pollitt (1990), on the other hand, attacked NPM as putting the emphasis on efficiency while ignoring equity. Going forward to the Public Choice view (which will be discussed later in section 2.2), NPM seems to follow as well as conflict with the Public Choice arena. Pollitt argued that the NPM movement towards the advocacy of efficiency and accountability stemmed directly from the Public Choice attack upon traditional public bureaucracy. In this sense, NPM is similar to Public Choice in using strategies to increase efficiency and accountability. In contrast, NPM may decentralize trust to hands-on professionals to manage the public sector. Hence, those managers can be trusted to run the service for the public. Therefore, it is seen as conflicting with the belief in Public Choice theory because public sector managers cannot be trusted to operate autonomously due to their self-interest and the drive to maximize their benefits as explained by Public Choice Theory (Hill, 1997).

Similarly, Ranade (1997) criticized NPM in terms of three major arenas. First, the contradicting assumptions of the ‘Neo-Taylorist’ model and the ‘Excellence’ model put many constraints on managers. Ideally, managers in the public service would like to

manage by commitment rather than compliance. However, under the competitive environment created through various efficiency exercises, this may jeopardize the readiness of cohesive and quality culture if an endless succession of targets and cost-cutting exercises are imposed (Ranade, 1997, p. 126). Second, there is the failure to understand the distinctive roles and limitations of importing private sector management models into the public sector (Stewart and Ranson, 1988). Finally, government may easily choose the wrong lessons from the private sector. Indeed, one could easily find unsuccessful stories of business ventures in the private sector, no matter whether they are small business or multi-national organizations. Lane (1994), on the other hand, has commented on the possibilities of the acceptance of secret wage negotiations involving large salary differences. Under the NPM regime, managers may be paid market wages. As a result, there is every reason to believe that a self-interested motivation among managers will develop. Further, advocating internal markets may increase transaction costs involved in bidding processes. Regarding human resources management in the NHS, Carter (2000) studied the NPM and equal opportunities practices in a NHS Trust and their impact on issues of human resources management. He argued that the impact of NPM had been to reinforce rather than diminish ethnic inequality with the health service. The shift towards short-term contracts for staff, the increased use of performance indicators, performance-related pay, competitive tendering procedures and layering of the management structures have resulted in a more fragmented system lacking coordination but characterized by competition between different interest groups and professional groups within the NHS. These groups may try to advance their own interests, either personally or related to their own groups.

#### 1.3.4 The Way Ahead and New Labour

It is useful to digest the views of proponents and critics of NPM and rethink the conceptual framework of public management in the new millennium characterized by rapid globalization, economic complexity and uncertainty and the possible impact on the policy of the charter movement and the adoption of charters in other countries. Key issues identified are the diversity and complexity of public organizations; the managerial skills for network management between central and outer agencies such as contractors; diversified accountability systems; holistic performance management systems that can motivate staff; and the enhanced capacity for social learning, creativity and flexible responses. In the literature of the *Fifth Discipline*, Senge (1990) has promoted the spirit and practice of the learning organization for organizations to survive and learn to love change in various aspects especially in the arena of rapid changes happening within and outside the organizations. Hence, staff members of the organization should be prepared to adapt to change in this era of globalised economy. Yeates (1999) critically examined the ways in which broader elements of social policy may be said to be affected by globalization. Globalization, broadly speaking, indicates the qualitative changes in economic and political structures, trends and processes on a transnational and international scale. For example, economic globalization refers to those changes in capital flows, markets and trade in goods and services across different nations. Similarly, political globalization refers to the changing global context of political awareness, political processes and political activity (Holton, 1998). Globalization represents a paradigmatic shift in the dynamics of welfare state development. This is because global capital and the international institutions involved are able to erode national policy autonomy as well as shaping and determining the content of national

social policies. However, Yeates also added that one should recognize the importance of 'local' factors as well. These factors are important in shaping the process of globalization and ultimately its implications for welfare states and social policies. Hence, it is not surprised that charters are used in different countries with different targets and objectives. The challenges brought to public management by globalization are further intensified with the use of the 'World Wide Web' (Ferguson and Raine, 1999). E-commerce is also contributing to developments in open government with more informed citizens (Cabinet Office, 2001a). Many governments are posting relevant information on the web. Citizens are able to communicate interactively with the government web site. In Hong Kong, citizens can easily gain access to government services through the web address of <http://www.info.gov.hk> to get information, to submit applications for official documents as well as paying various fees to government departments. Similarly in the UK, the open government web site is located at <http://www.open.gov.uk> with both main political parties also having comprehensive web sites at <http://www.labour.org.uk> and <http://www.conservatives.com>. These types of developments in electronic governance may reinforce NPM by providing the infrastructure for communication and effective modernization of public services. The population is now more well-educated and more people are involved in life-long learning than before (SCMP, 2000). Computers are more widely available and used by citizens. All these factors will further challenge governments globally to meet demands from their citizens.

It is necessary to evaluate how the Labour Government and the associated 'third way' thinking of policy and management approach have affected public policies in the UK, in particular the development of the charter movement. In 1994, Tony Blair became

the leader of the Labour Party. A process of ideological transformation in the Labour Party, initiated under Neil Kinnock, culminated in Blair's affirmation of the 'third way' elements. The Labour government was then elected in May 1997. Powell (1999) has examined the impact of New Labour and the 'third way' on the British National Health Service with respect to health policy to see if policies based on a 'third way' are new or distinct from those of the old left and the new right. In essence, he has concluded that there were many differences between health policies of New and Old Labour, and some differences between New Labour and the Conservatives. In this sense, an understanding of the 'third way' ideology is helpful in interpreting the 2001 replacement of *Patient's Charter* with the *Guide* in the UK National Health Service.

Powell (2000) has critically analysed the 'third way' in Labour social policy to see if it represents a new and distinctive approach by analyzing previous public policies in UK. In Labour's manifesto of 1997, Tony Blair argued that the new and distinctive approach was developed differed from the solutions of the 'Old Left' and those of the 'Conservative Right'. Although, there is little agreement on the details of the third way, literature has confirmed Blair's approach by suggesting it is a matter of negative definitions, such as it is neither the 'Old Left' nor the 'New Right' (Le Grand, 1998). As Driver and Martell (2000) have commented, attempts to define a third way fall into two categories. On one hand, they begin by stating what the third way is not. On the other hand, an alternative approach defines what it is or might be. To treat the third way as 'Beyond the Old Left and New Right', it would be useful to briefly review the 'Old Left' or 'Old Labour' first. The 'Old Left' or 'Old Labour' was associated with the Keynesian economy of the state, egalitarian social democrats who tended to favour state and corporatist forms of economic and welfare governance. However, Labour

modernizers blamed the statist nature of the 'Old Left' because this was too concentrated on the redistribution but not the creation of wealth. In addition, there was too great a readiness to grant rights but not to demand responsibilities. Therefore, New Labour's third way seeks alternatives to state provision and government control and to promote wealth creation by being fiscally 'prudent' (Driver and Martell, 2000). These modernizers are also encouraging a notion of a balance of rights and responsibilities to create and foster a culture of duty within 'strong communities' (Klein, 2001). To differentiate the third way as beyond New Right, New Labour criticizes the particular aspects and approaches of the Conservatives. However, there are significant echoes of the right, such as favouring market solutions; having a laissez-faire view of the state and to giving economic individualism a high social value. Four elements have been identified by Tony Blair as central to the third way of policy (Blair, 1998). They are 'equal worth', 'opportunity for all', 'responsibility' and 'community'. Driver and Martell (2000) further explained these four elements in detail. There are the non-discriminatory treatments of all human beings in the elements of 'equal worth'. Secondly, the opportunity should be available for individuals to have the resources to develop their talents and exercise their liberty. Thirdly, Blair has stressed the importance for individuals of accepting their responsibilities and duties as citizens but not just asking for their rights and entitlements, such as emphasizing the interactive nature of NHS Direct. Fourthly, the idea and value of 'community' should be advocated and supported.

In respect of the second approach of treating the definition of New Labour in a positive way, a further driving force can be traced to globalization theory which affects every country. Third way thinkers support the view that there are uncertainties and risk

associated with globalization. Public policy should be formulated to provide social capital which can be those stocks of social trusts, norms and networks that people can draw upon to solve problems such as neighborhood associations and sports clubs. Therefore, it can help the society to accumulate social capital. There is the active role for government for pragmatism. New Labour's approach breaks with the state/market approach in part by being more pragmatic and less ideological about the dichotomy. Powell's (2000) analysis of some of the main dimensions of the third way in comparison with the 'Old Left' and the 'New Right' are shown in Table Two.

Table Two: Dimensions of the Third Way

<u>Dimension</u>	<u>Old Left</u>	<u>Third Way</u>	<u>New Right approach</u>
Approach	Leveller	Investor	Deregulator
Outcome	Equality	Inclusion	Inequality
Citizenship	Rights	Both	Responsibility
Mixed economy of Welfare	State	Public/private civil society	Private
Mode	Command and control	Co-operation/ partnership	Competition
Accountability	Central state/ Upwards/national	Both?	Market/ downwards/local
Social expenditure	High	Pragmatic	Low

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(Powell, 2000, p. 42)

Anthony Giddens, who has been styled as 'Blair's third way guru' by Driver and Martell (2000, p. 156), offered a similar comparison of the New Labour Government with the Old Left and New Right and thus is tabled as Table Three.



Table Three: Comparison of Old Left, New Right and New Labour

<u>Social Democracy (the Old Left)</u>	<u>Neoliberalism (the New Right)</u>	<u>Third Way (the Centre-left)</u>
Class politics of the left	Class politics of the right	Modernizing movement of the centre
Old mixed economy	Market fundamentalism	New mixed economy
Corporatism: state Dominates over civil society	Minimal state	New democratic state
Internationalism	Conservative nation	Cosmopolitan nation
Strong welfare state, protecting from 'Cradle to the grave'	Welfare safety net	Social investment state

(Giddens, 1998, p. 20)

Some writers have developed acronyms to reflect the main values underlying the third way. For example, Le Grand (1998) used CORA to represent community, opportunity, responsibility and accountability. On the other hand, Lister (1999), quoted in Powell (2000) associated RIO with responsibility, inclusion and opportunity. Moreover, the acronym PAP has been cynically developed by Powell (2000) himself to represent pragmatism and populism. He argued pragmatism was at the heart of the third way and saw the popular New Labour phrase 'what counts is what works' as confirming this point. Powell considered Blair would keep what the Conservatives had got right, but would make changes to those things that were considered wrong. Indeed, public-private partnership initiatives such as Private Finance Initiative (PFI) have been carried on but simply termed as 'new' FPI (Passman, 1997). The populism characteristic of this 'Government by headline' approach in the press has been important to Labour to show

their determination to make tough choices. The third way appears to be neither distinct nor new, leaning to the right rather than the centre or centre-left. However, while both Left and Right remain important markers of contemporary policy and politics, the third way combines them in significant new ways. As Driver and Martell (2000) have commented, there is not just space for one third way but for many, with varying values and policy positions between the 'Old Left' and 'New Right'.

If so, what is the redefined New Public Management agenda? Culter and Waine (2000) have argued that New Labour has embraced the changes introduced to the welfare state by the Conservatives but has also tried to establish a new agenda of 'reformed managerialism'. Two elements are salient in this concept. There are changes in performance measurement in the public sector seeking a more rounded approach. Improved performance measures are being added to all public services such as the arrival of Best Value following the election of the New Labour government in 1997 (Clarke et al., 2000). Best Value is a core part of a new discourse of modernization which places increased emphasis on partnership, community consultation and service improvement, without necessarily requiring service providers to compete in the market place. The second element is that reformed public markets are combining 'partnership' with competition. Markets seem not to be a problem *per se* provided there are mechanisms which allow for 'partnership'. In such, partnership between local government and other local agencies involved is now commonplace (Craig and Manthorpe, 1999). Indeed, there is a global trend to see more strategic alliances being formed among health and human services organizations by means of cooperation, coordination, collaboration and coadunation for members organization to unite and combine into an integrated structure (Bailey and Koney, 2000). Of course, there are

costs involved in improved performance measures. More importantly, sometimes it is difficult to determine what is to be measured and to interpret the outcome of the measures correctly. In addition, partnership may not provide the optimum benefits from the resources consumed as there are high costs involved in partnership. As related to the *Patient's Charter*, any measurement of the outcomes of those standards will require resources to collate and analyse the data. Similarly, partnership between health service providers such as hospitals and the patients' groups will incur further costs.

## 1.4 Citizenship

### 1.4.1 Conceptual Framework of Citizenship

The debate about whether charters have initiated a new type of citizenship is central to the literature. For example, Prior et al. (1995) argued that the charter provided a limited view of citizenship. Hence, it is useful to explore the conceptual framework first and then to look at the debate centered on the charter movement. In reviewing the literature on citizenship, one often finds that it is somewhat elusive. Prior et al. (1995) explained the common confusions in the discussion of citizenship. They argued that the confusion was a result of ignoring the two distinct dimensions of the concept. On one hand, citizenship is considered as a 'status' which people possess. On the other hand, it is also considered as a 'practice' in which people engage. That is to say, citizenship is 'thus a concept both of "being" and "doing" ' (p.5). For example, the 'status' of citizen can locate the individual within a body of reciprocal rights and obligations between members of society. Citizenship, in a general sense, is about group membership. It involves a set of relationships between rights, duties, participation and identity. T. H.

Marshall (1950) examined the concept in detail. He argued that citizenship was an historically variable concept in which rights and obligations of citizenship were not inherent, but were the product of historical development and thus subject to change. He illustrated three categories in the 'status' of citizenship rights which have developed over three different historical periods. Firstly, legal or civil rights refer to those rights which can enable the citizen to participate freely in the life of the community and society. Hence, people can have freedom of speech, religious practice, property rights and contractual rights, and so on. Secondly, the political rights of citizens enable the individual to participate in the government of the community, through the rights to vote and suffrage. Thirdly, social and economic rights are concerned about the ability of an individual to participate in the general standard of well-being of the community. For example, rights to health care, education and other public services are provided by the government in different countries. However, we should be cautious in accepting those rights as readily immutable as they may change when societies evolve and hence the value system behind the right to health care based on need may be changed to the right to health care based on need and affordability to pay.

Prior et al. (1995) further indicated the debate between 'formal' citizenship as a status which gives individuals formal possession of rights and entitlements, and 'substantive' citizenship as a status which provides individuals with opportunity or capacity to know and realize their rights and entitlements. To illustrate the argument, citizens are normally entitled to use health services, but may be denied or obstructed because of lack of information to make choices.

The second notion of the concept of 'doing' or the 'practice' of citizenship explained the practice of citizenship in order to perform those rights and obligations. For example, citizens use their role to vote in the general election to exercise their rights. It is a matter of whether a citizen will exercise such rights or not. Recent changes in society have led to a rethinking of the concept of citizenship. Delanty (2000) has reviewed the main debates on citizenship and the implications of globalization. He argued that citizenship is no longer defined by nationality and the nation state, but is now being de-territorialized and fragmented into separate discourses of rights, participation, responsibility and identity. He described this new 'cosmopolitan citizenship' as a new practice of citizenship that goes beyond the parameters of the nation state. Hence, cosmopolitan citizens are the citizens of the world community but not of any particular state. Because the world is suddenly more connected than ever before, the importance of geographical constraints is being diminished. The four components of citizenship become separated from each other and no longer present as a coherent framework as they did in the classic model.

#### 1.4.2 Citizenship and Consumerism

Advocates of consumerist approaches to public services have stressed the importance of adopting market mechanisms of competition as much as possible and treating users as consumers. This empowerment of citizens as consumers recognized the rights of consumer to supersede the supplier. However, the practice of citizenship is thus reduced to the practice of the consumer. This debate is frequently ignored and therefore confuses both citizens and customers together.

Franham (1991) joined critics of the British government's perception of citizenship within the charter framework as seeing it as too narrow. He argued that the Conservative idea omitted the concept of social rights. Prior et al. (1995) provided illustrations of the two limitations of the 'customerization' of citizens. On one hand there is a limited ability to withdraw from the public service market. On the other, there is a restriction on choice within the public service. This is particularly so when there is limited or even just one sole provider of services. As a result, it is difficult to conceive of people as customers in many aspects of their relations with government. This question should be addressed in any debate of how far can customers be treated as citizens.

Such comments have led to literature proposing a 'New Right' conception of citizenship (Bellamy and Greenway, 1995) which explains the New Right conception of citizenship inspiring the original charter. Criticisms of the social democratic conception proposed by Marshall in the 1950s were put forward by New Right advocates. These involved three major criticisms according to Bellamy and Greenway (1995) and are to be found in separate arguments. First, there is a tension between civil rights and particular property rights and a tension between political rights and social rights. Secondly, certain groups are better at organizing themselves than others. As a result, some people's interests are better served than others. Thirdly, most citizens cannot influence the delivery of services. Therefore, social rights also encourage passivity. Citizens are then subject to paternalistic behaviors. Based on these critiques, the New Right conception of citizenship stresses the exercise of civil rights rather than political or social rights. Hence, the chief public realm is civil society, and the role of the state is restricted to upholding our rights to contract freely with each other. Citizens become

consumers in the free market and are guaranteed their rights. Despite the possible risk of market failure, public goods and services should be made available through market agencies as well.

#### 1.4.3 Citizenship and Accountability

Much of the coverage of contemporary policy issues in the media has shown its great interest in how government and policies are being made accountable to the public. For example, England's Universities are spending high sums a year on meeting external demands to be accountable (BBC, 2000a). Indeed, public accountability of some form is always needed as power is not normally exercised directly by citizens. It is sometimes exercised through representatives elected by citizens as well as through officials appointed to act on their behalf, such as ombudsmen. Prior et al. (1995) distinguished between the four levels of accountability; as accountability for policy; accountability for probity; accountability for procedures and accountability for performance. Accountability for policy concerns the extent to which policies meet the requirements of citizens, both individually and collectively. Accountability for probity looks at the legality of the exercise of power, and the financial regularity of procedures. Accountability for procedures considers the processes by which decisions are made and carried out. Accountability for performance stresses the claim for efficiency and effectiveness of policy. Therefore, it is apparent that caution has to be observed again in interpreting public accountability with reference to charters and citizenship. As discussed above, the reduction of the role of citizen to that of customer may be seen as a possible reduction of public accountability. The argument for this is the possible neglect

of accountability for policy as the recipients of services are not longer citizens but customer only.

#### 1.4.4 Citizenship and the Third Way

As discussed in sections 1.3.3 and 1.3.4 on the New Public Management and New Labour, there are debates about features of the third way of citizenship which move from dutiless rights towards conditional welfare (Powell, 2000). New Labour claims that the 'right' tends to stress the duties of citizenship while the 'left' tends to stress the rights of citizens (Blair 1998), the new politics involves both rights and duties in which there will be no rights without responsibilities. A new type of welfare citizens seems to dominate the imagination of contemporary policy makers. Barnes and Prior (2000) argued that the New Labour discourse includes the repositioning of the citizen as principally a bearer of 'duties and responsibilities' in relation to others and to society. This third model is based on a predominantly moral ideology which emphasizes the responsibilities or obligations of citizens to each other and to the state, rather than the individual rights of citizens to receive services, and the need for community awareness, rather than self-interest. Responsible citizens are activated by means to induce them to act responsibly. Voluntary measures such as education, providing information and promotion as well as coercive measures such as deliberate use of stigma, legal and administrative sanctions, and the enforcement of certain types of practice, for example, the Jobseeker's Allowance is being employed to help the jobseeker to act responsibly and actively to look for jobs.



## 1.5 Summary and Comment

In chapter one, much discussion was devoted to the rise of 'Charterism', the adoption of 'New Public Management' in governments and the debate about 'Citizenship' as well as the impact of New Labour's third way paradox. The sudden rise of the label 'Charterism' in the literature in the early 1990s was the result of a proliferation and the wide adoption of charter initiatives. Researchers then started to study this area. Public organizations commenced a charterization processes to modernize their service provision. 'New Public Management' can be usefully seen as related elements to the use of charters. However, criticisms about NPM were highlighted. Together with the rapid changes of globalization and the development of electronic governance, NPM has reinforced charter initiatives in shaping the public sector. It demands a revisit to the conceptual framework of 'Citizenship' in which a prominent debate is whether citizens should be treated solely as customers. During the first term of the New Labour government, the third way offered a new pathway claiming to retain the best elements from the Conservatives as well as initiating its own distinctive identity. As a result, the rhetoric of 'reformed managerialism' and the 'third way citizenship' continue to affect the practice of public services. Thus, the elements of this chapter have formed a solid base for the research context of this study.

## CHAPTER TWO: RELATED THEORIES OF THE STUDY – A REVIEW

### 2.1 Introduction

In this chapter, I select three major theories forming the backbone of the analysis in an attempt to facilitate collection of data and subsequent analysis. As the title of the research suggests, 'Public Choice Theory' will be a major focus. A Public Choice framework will be used to analyze implementation of the *Patient's Charter* in the National Health Service in the UK and the Hospital Authority in Hong Kong. I will therefore examine 'Public Choice Theory' and its relevance to charters as well as criticisms of Public Choice Theory itself. Moreover, issues about decision making will also be dealt with. In a study of the implementation of policies and initiatives, different implementation models are discussed and interpreted to give an overview of the common models available. Then I will further elaborate relevant aspects of theories about 'Consumerism' which have already been dealt with briefly in section 1.4.2. I will highlight the consumer movement in health services in general as well as in the National Health Service and the Hong Kong Hospital Authority specifically and will bring out the notion of responsible consumers.

### 2.2 Public Choice Theory

#### 2.2.1 The Theory of Public Choice

Dunleavy (1991) has commented that the literature about Public Choice is so diverse that no one text could realistically cover it all. However, it is not difficult to

acknowledge the major claims and elements of the theory and its development. Public Choice can be defined as the economic study of nonmarket decision making, that is to say, the application of economics to political science (Mueller, 1989). The subject matter involves those theories found in political science, for example, the theory of the state, voting behavior and rules, party politics, bureaucracy and so on. The major assumption is that a human being is an egoist, rational and utility maximizer (Downs, 1957). Indeed, the origins of the Public Choice school can be traced to the influences of writers on public finances and public goods, such as Wicksell and Lindhal in the late eighteenth centuries to early nineteenth centuries (Wicksell, 1967; Self, 1993). Their interests have been related to the question of ‘what governments should do to remedy various forms of market failure, and upon the provision and financing of those “pure public goods” which only governments can supply’ (Self, 1993, p.1).

The rapid growth of size of governments after World War Two marked a new era emphasizing Public Choice theory and the burgeoning of the Public Choice field of study. The economic theory of politics is often associated as equivalent to ‘Public Choice’. Indeed, the term ‘Public Choice’ comprises a number of approaches from different writers and their followers, including the Virginia, Rochester and Bloomington schools of Public Choice, the Chicago school of political economy, Anthony Down’s economic theory of democracy, Mancur Olson’s logic of collective action and others (Dryzek, 1992; Udehn, 1996). In particular, the Virginia school of Public Choice, led by James Buchanan and Gordon Tullock, founded the Public Choice Society in 1963 in USA, together with starting the journal ‘Public Choice’. Thus, they are considered the primary developers of Public Choice Theory and have proclaimed rights to use the term of ‘Public Choice’ as founders of the term. In this narrow sense, people consequently

associate 'Public Choice' with the Virginia version of the theory. In addition, James Buchanan received the Nobel prize in Economic Science in 1986 for his contribution to the founding of Public Choice and its subsequent development. He is now based at the Center for Study of Public Choice at George Mason University in US as Advisory General Director (Felkins, 1998).

As there is scope for a number of various approaches within the so-called Public Choice school, the emphasis here will be on the Virginia School, *per se*, and its influences on other English speaking countries, in particular. Lane (1995) has reviewed the Virginia school of Public Choice in considerable detail. He has commented that the Virginia approach to Public Choice argues that the public sector suffers from inherent systemic failure of both policy-making and policy implementation. This kind of political failure is even more severe than the market failure in economic terms. It rejects the welfare state. Generally speaking, the characteristics of Public Choice include the combination of politics with the use of economic method. It is oriented towards an understanding of the domain of Public Choice, that is politics and bureaucracy. Indeed, there are two fundamental notions within the Public Choice model, the 'methodological individualism' and the 'homo economicus model' (Buchanan, 1986).

Udehn (1987 quoted in Udehn, 1996), explained the term 'methodological individualism' by the means of the 'social phenomena must be explained in terms of individuals, their physical and psychic states, actions, interactions, social, situation and physical environment' (pp. 40-43). Similarly, Elster (1985) argued all the social phenomena of structures and change are in principle explicable in ways that only involve individuals. That is to say the individual is responsible for all social phenomena.

This kind of main-stream Public Choice methodological individualism has been described by Self (1993) as the stronger version of ‘methodological individualism’ in which there is the assumption that the individual will form his (*sic*) goals and preferences independently.

On the other hand, Downs (1957) has pioneered the use of novelty with ‘homo economicus’ in which a human will act rationally and for his (*sic*) own selfish ends as the self-interest axiom. Hence, two principles are arrived:

- 1) All social entities are fundamentally sets of individual actors.
- 2) Public sector actors behave as if they maximize their own interests.

(Lane, 1995, p.206).

It should be emphasized that the Public Choice theory in itself does not assume politicians or the bureaucrats as evil. As Buchanan (1978) has claimed, ‘there is no implication at all that politicians and bureaucrats behave any differently from other people. There is no implication that they are garbling, self-interested, maximizing, squeezing, any more than you or I or anyone else’ (p.157).

Economists frequently draw a distinction between ‘positive’ and ‘normative’ economics. That is simply the question of what ‘is’ the case, what rational actors would do and the discussion about what ‘ought’ to be done (McLean, 1987). Therefore, the above two principles belong to ‘positive’ Public Choice.

Apart from the positive theory of Public Choice, the Virginia version of the Public Choice approach also consisted of a normative theory, laid by the Wicksellian's 'unanimity rule' for policy-making. This can be explained as arguing that the obvious voting rule for the provision of a public good would seem to be unanimous consent, due to the fact that all individuals can benefit from provision (Mueller, 1979). Buchanan (1987) then derived two normative rules as elements of the Public Choice approach. Firstly, there is 'politics as exchange', the principle that political interaction is to be based on voluntary exchange. Hence, every public policy must be based on consent of citizens because unanimity is the criterion by which policy is judged to be in the interest of the citizen. Secondly, 'economic constitutionalism' or 'contractarianism' also forms the basis of public policy-making. This economic constitution is required to guide the relationship between the state and the individual if political interaction is based on voluntary exchange. To go further, the theory of economic constitutionalism is grounded upon an individual's capacity to attend to his (sic) own interests and engage in mutually beneficial trade (constitutional arrangement) with others, in the market or in the political realm (Self, 1993; Buchanan, 1986). Hence, these two new principles deal with the issue of the 'ought' discussed above.

In the public sector, different models of bureaucracy have been applied. Boyne (1998a) considered the Public Choice model of bureaucracy which has been prominent in the literature and the practice of policy makers. He argued that Public Choice Theory pays special attention to two major characteristics that are available in other models of bureaucracy. First, officials as bureaucrats have excessive power in their hands. Their self-interest is dominant over their altruism and is unresponsive to service needs. Second, organizational inefficiency is a common characteristic of the side-effect of

bureaucracy as well as oversupply in the public sector. Boyne continued by illustrating three specific characteristics of public bureaucracies that may lead to a lack of both efficiency and effectiveness. To start with, Public Choice theorists have argued that the monopolistic nature of the public service market leads to poor performance in public agencies because these officials have little incentive to contain costs or to improve services. Local people, therefore, have to accept what is being offered at a certain level of quality as they cannot easily use an exit strategy. If appropriate market structures are created within the public sector, bureaucrats may adapt their behaviors towards the better welfare of society rather than just their own selfish objectives. The second characteristic is the lack of information on organizational performance. According to Public Choice Theory, there are problems of having no unambiguous indicators of performance in the public sector. As a result, it is difficult to evaluate or influence the behavior of public agencies or individuals. Hence, the selfishness and monopoly power of bureaucrats eventually leads to drawbacks in production and delivery of the public services. The third characteristic is associated with the tendency to increased growth in the department, unit, or organization as a whole. In economic terms, margin benefits decrease when an organization has reached its optimal efficiency in relation to its size. However, bureaucrats continue to urge for further increases in the size of a public organization to increase their budget and safeguard their own interests and power. Furthermore, larger organizations tend to be slower in response to needs. Thus, Public Choice prescriptions will be injected to remedy the problems of bureaucracy by targeting those shortcomings. Hence, firstly, the structure of public service markets should have elements of competition between public organizations as well as between public and private organizations. This competition is necessary for 'allocative efficiency' and 'X-efficiency or the technical efficiency' (Boyne, 1996). Secondly,

public agencies are required to produce more information on their performance. Furthermore, organizations should be broken down into smaller units. This may include the separation of 'conglomerate' departments into 'single function' more visible organization, and disaggregating big bureaucracies into smaller units to compete within the market.

Similarly, Howlett and Ramesh (1995) have provided a comprehensive review of Public Choice Theory. As discussed above, the theory utilizes the individual as the basis unit of analysis. The chief assumption is that political actors, like economic ones, act rationally to maximize their utility and that the only political actor that counts is the individual. The theory then can explain various aspects of politics and public policy making. For example, voters are likely to vote for the party or candidate who can best serve their interest. Politicians, on the other way, are constantly looking for election to promote their well-being in terms of income, power and prestige. They will try to provide policies and programmes that will attract votes. Usually, popular policies and decisions will be offered before election while unpopular policies will be offered after the election. Similarly, bureaucrats tend to maximize their departmental operating budget which can further secure their power, position, prestige and even advance their positions and salaries. Hence, institutions must be designed in such a way so that the individual will behave to further the interest of the group, others and the society rather than just oriented to their own benefits.



### 2.2.2 Public Choice as Deductive Theory

In the study of public policy, Public Choice is indeed one approach in a range of theories which differ according to how they develop insights deductively or inductively as well as the fundamental unit of analysis. It has been claimed that one difficulty scholars and researchers have encountered in the study of public policy making is the range of various approaches available. Howlett and Ramesh (1995) selected common and representative samples from economic and political approaches to the study of public policy to illustrate a taxonomy of the general approaches to political phenomena. This taxonomy is built according to the method of theory construction and the fundamental unit of analysis. The method of theory construction can consist of 'deductive theories' and 'inductive theories'. Being an inductive approach, it attempts to apply universal maxims to the study of political phenomena from a bottom up perspective. These depend on the accumulation of multiple empirical studies to generalize the propositions. On the other hand, deductive theory begins 'from a relatively small number of basic postulates or assumptions accorded universal status and then apply these assumptions to the study of specific phenomena' (Howlett and Ramesh, 1995, p. 18). Regarding the unit of analysis, the taxonomy separates the units as individuals, group as well as institutions as the unit of analysis. Hence, Public Choice theory falls into the category of being the deductive approach with individual as the fundamental unit of analysis.

Public Choice Theory is not without its criticisms. Its simplistic nature and assumptions are both its advantage as well its drawback. Doubts are expressed about the practicality of the theory. In addition, the theory tends to have a poor predictive capacity.

Boyne (1998b) has gathered together the common critiques of Public Choice theory from the literature. The assumption of budget maximization has been criticized widely (Migue and Belanger, 1974; Dunleavy, 1991). It has been claimed that bureaucrats would attempt to maximize their 'discretionary budget' rather than the output or the total budget of an organization (Migue and Belanger, 1974). Simply speaking, services may be produced inefficiently but not necessarily oversupplied. Dunleavy (1991), in an important text on Public Choice, has argued that those senior government officials or bureaucrats target the bureau-shaping (in terms of changing the organization to meet the current situations) rather than budget-maximizing. They are more concerned about the 'core budget' which includes overhead costs and salaries rather than the wider 'programme budget' which involves payments to other individuals and organizations. In addition to the claim of over-emphasis on the tendency to budget maximization, there are criticisms about an under-emphasis on the constraints posed to bureaucrats' ability to achieve budget maximization especially when the bureaucrats are from different political parties. Regarding Public Choice prescriptions of competition, such as compulsory competitive tendering (CCT), problems may occur in which a number of transactional costs are associated with the contractual agreement. Furthermore, staffing efforts in the project are reduced as they are working towards the compliance of a contract rather than doing more than what is required.

### 2.2.3 Public Choice and Decision Making

Regarding how Public Choice affects and shapes decision making process, this section moves to look at some macro theories of decision making. References are generally based on a comparison between rational, incremental or mixed scanning

models of decision making (Pettigrew et al, 1988). Simon (1945) has argued that the rational decision maker should choose the alternative which will maximize the decision maker's values. Moreover, this selection is made after a comprehensive analysis of alternatives and their consequences. He further commented that the decision is 'organizationally' rational if it is oriented to the organization's goals and it is 'personally' rational if it is oriented to the individual's goals. Later work by Simon (1957) went further to describe decision making in practice to include the idea of 'bounded rationality' and 'satisficing' which allows the decision maker to simplify or limit the selection of possible alternatives and to select 'good enough' alternatives.

Charles Lindblom in 1959, on the other hand, developed a concept of an incrementalist model of decision making consisting of the key concepts of pluralistic 'partisan mutual adjustment'. This is the process of negotiation, bargaining and adjustment between different partisans or interest groups to influence decisions. Other key concepts include 'disjointed incrementalism' which involves examining policies that differ from each other incrementally, and which differ from the status quo and can be analyzed at different points without apparent coordination; and 'successive limited comparisons' which start from the existing situation and changing incrementally (Braybrooke and Lindblom, 1963; Lindblom, 1959; Lindblom, 1979). Hence the decision maker is 'muddling through' to arrive at a decision. As Walt (1994) has argued, incrementalism is concerned with what is happening, rather than what ought to happen as in a rationalist decision making process. However, Haywood and Alaszewski (1980) criticized incrementalism as they considered it was never clear if a particular policy was incremental or not in nature.

Dror and Etzioni both sought to arrive at a middle way between rationality and incrementalism. According to Dror (1964), the 'normative optimum model' involves the ideas of extra-rationality, incorporating use of judgment, creative invention, brainstorming and other approaches. Etzioni (1967), like Dror, introduced a 'mixed scanning model'. In his model, he distinguished between the 'fundamental decisions' which set direction and are important and the 'bit or incremental decisions' which need detailed exploration. This is synonymous with employing two cameras, the first having a broad-angle lens which would cover all parts of the sky without going into detail, while the second lens could reveal an in-depth examination of selected areas.

Although Smith and May (1980) conceived there to be an artificial debate between differences of rationalist and incrementalist models of decision making, it is useful to view the decision making models as normative or prescriptive in the rational model, while the other as explanatory or descriptive in incremental model. Returning to the theory of Public Choice, this is heavily biased towards the rational model of decision making as it assumes that all actors will try to maximize their individual interests to become egoist, rational and utility-maximizing individuals. They are debating at alternatives that give maximum values. In addition, the growth of Public Choice theory is seen partly as a result of the critique and rejection of both 'Classical pluralism and neo-pluralism' (Harrison et al., 1990, p. 18). Hence, Public Choice also rejects the pluralistic 'partisan mutual adjustment' of incrementalism.

In the 1970's, a very different model emerged into the literature. Howlett and Ramesh (1995) have reviewed the 'Garbage Can Model' of decision making. This model argues that problems and solutions are simply dumped into the 'garbage can' by

participants. It denies even the limited rationality permitted by incrementalism. Actors simply define goals and then choose means as they go along the ambiguous and unpredictable journey. Decisions are hence made in an ad-hoc and haphazard way.

#### 2.2.4 Public Choice and New Labour

Before setting the assessment of New Labour government and its associated third way paradigm against Public Choice, it is useful to revisit the Conservative reforms which attempted to alleviate the shortcomings of the bureaucratic model of public sector. Markets were created with a split into purchaser and provider of services in different part of the system to provide as much competition as possible. The classic example was the introduction of internal market to the NHS as proposed in the white paper *Working for Patients* (Department of Health, 1989a). All these market structures established between 1979 and 1997 reflected a Public Choice critique of bureaucracy. However, these are not true markets where consumer sovereignty suppresses provider sovereignty. They are managed or regulated markets where services continue to be influenced by provider preferences. Overall, markets have decreased the monopoly power of public agencies. The use of performance indicators and the charter movement reflected the domain of providing more information about the organization. Higher levels of monitoring and scrutiny were added. However, there were still problems associated with the complex nature of performance measurement (Boyne, 1998a). In terms of the organizational size of the government, many reforms were implemented by the Thatcher and Major governments in which civil service departments were disaggregated into, for example, Next Steps agencies (Butcher, 1991; Lewis, 1993).

Returning to the political preferences of the New Labour government, they coincide with the previous discussion about New Public Management and the third way in section 1.3.4, and many of the Conservatives' policies were left intact if these policies were judged appropriate. However, the plan to extend marketization has been downplayed in many areas. The Labour government has signaled to end the internal market in the NHS and has replaced it by the 'partnership' approach (Dixon, 2001; Powell, 1999). New 'Best Value' programmes have been injected to replace CCT (Powell, 2000). This represents New Labour's concern to draw back from competitive market structures. As indicated by the *NHS Plan*:

the last Government's 'internal market' attempted to address this problem. But by fragmenting the NHS, standards remained variable and best practice was not shared. Competition between hospitals was a weak lever for improvement, because most areas were only served by one or two local general hospitals. (Secretary of State for Health, 2000, p.59)

Regarding performance measurement, the Labour government has been particularly keen to further increase this component such as health authorities would be expected to meet new national standards on quality, access to services and information (Culter and Waine, 2000). However, it can be argued that such increase in the requirement of performance measurement is indeed a strengthening mechanism of the 'central sovereignty and hierarchy rather than consumer sovereignty and markets' (Boyne, 1998a, p. 48). The issues of organizational size are tackled by the New Labour government as well where there is evidence for the upsizing and relayering of public departments. More NHS Trusts are merged together to effective use of resources. These all represent a shift away from markets and contracts and towards bureaucracy and hierarchy (Boyne, 1998a). The recent announcement by the health secretary, Alan Milburn, to cut the number of health authorities in England from 99 to 30 and to abolish

the current 10 regional offices illustrates the movement (Guardian, 2001). By 2004, local primary care trusts will decide how much money to divide between GP surgeries, local hospitals and other local services. These trusts will account for up to 75% of the NHS budget by that time.

## 2.3 Implementation Theory

### 2.3.1 Importance of Implementation in the Study of the Policy Process

Debate between policy-making and policy outcomes has been made explicit since the 1970s. Early work on implementation research was an attempt to problematize the public administration reflex of separating politics and administration. Hjerm (1982) suggested that implementation research was less about the 'missing link' in the realization of already defined public policy but more about finding an approach to study the links missing in public administration conceptualizations of policy formation. It is of particular value to study and analyse how a policy set is being implemented. Pressman and Wildavsky (1973) considered that policy is not automatically implemented smoothly. There is a 'gap' or the 'missing link' which distinguishes the mid point between the policy making process on one hand and the implementation process on the other. Pioneering work on implementation theory by Pressman and Wildavsky was followed by a flourishing number of research studies into this area. Sabatier (1991) provided an account of how implementation research has evolved from 1970's to 1990's. It was characterized by an increasing number of studies in the 1970's to 1980's and then a decrease in the number of studies in the 1990's.

To review the concepts of 'implementation', Barrett and Fudge (1981) explored the concept afresh. Implementation can be viewed as a process of interaction between the setting of goals and actions geared to achieving them. There are assumptions of a series of logical steps from intention through decisions to action. Moreover, there should ideally be a distinction between the two steps in formulating intentions, namely policy making and the creation of programmes which form the 'input' to the implementation process. Moreover, implementation can be seen as the process of putting policy into effect, mainly concerned with co-ordinating and managing the various elements required to achieve desired ends. They further argued that implementation does not solely look at putting policy into effect, but also in terms of observing what actually happens or gets done and seeking to understand the reasons behind by asking 'how' and 'why'. Some commentators believe that the terms of discourse for discussing policy making and implementation are indeed misleading if looked at superficially (Baier et al, 1986). This is further reinforced by Hill (1997) who argued that there is a too ready adoption of a simple view of the whole policy process. However, Lane (1995) attempted to clarify the ambiguous notion of the concept of implementation, seeing implementation as firstly an end state or policy achievement. On the other hand, he saw implementation as a process of policy execution. Sometimes, a policy is executed but not its intended objectives. The implementation analyst should try to evaluate these two major foci which are the extent of successful implementation and the process of enforcing the policy.

The substantial volume of implementation research has suggested its value in helping the practice of implementation. Hyder (1984) argued that these academic analyses from implementation research can be of practical help to administrators and civil servants through widening their horizons and increasing their ability to cope with



new situations. Such problems and solutions are made more explicit among the real situations happening at different levels of the organization. Moreover, academic analysis can be a more effective way than the practice of acquiring understanding as it holds out the promise that we may be able to select the most appropriate strategy of implementation.

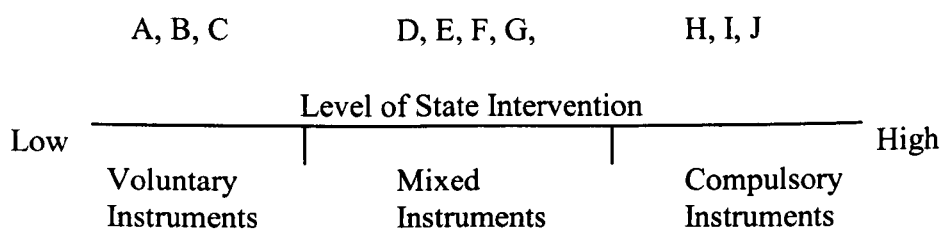
### 2.3.2 Policy and Policy Instruments

Before discussion of the models of implementation theory, it is helpful to re-visit the definitions of 'policy'. A simple explanation refers to a course of action adopted by a government, business or individual. Policy may refer to, for example, a very general statement of intentions and objectives; the past set of actions of government in a particular area; a specific statement of future intentions and a set of standing rules (Palmer and Short, 1994). As Howlett and Ramesh (1995) have commented, there are different definitions of policy and hence 'public policy'. However, certain key aspects can be identified among those various definitions. They are common in noting areas in which public policies are made as the results of decisions made by governments such that 'decisions made by governments to do nothing' are just as much policy as are 'decisions to do something'. That is to say, policy includes anything government chooses to do or not or not to do (Howlett and Ramesh, 1995; Dye, 1972). In addition, public policy is conceptualized as a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals, objectives and the way to achieve them within the process. Furthermore, a policy can be defined as a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern (Palfrey, 2000; Howlett and Ramesh, 1995).

Lowi (1972) provided and distinguished a typology of policy which has been widely used in the literature. It consists of the 'distributive policy, regulative policy, redistributive policy and constituent policy' (p. 30). Distributive policy corresponds to policy of distribution of resources, for example, tariff policy about tax. Regulative policies relate to regulations such as the control of unfair competition. Redistributive policy, such as social security, is concerned with the redistribution of resources while constitutive policy corresponds to the design and redesign of institutions. Such a classification is useful in the analysis of implementation. Indeed, different uses of the word 'policy' are explored in the literature widely, such as treating policy as a label, field of activity, an expression of general purpose, desired state of affairs, decisions of government, specific proposals, formal authorization, a programme, output, outcome as well as a theory, model and process. For example, Webb and Wistow (1982) consider 'policy' in personal social services in UK as 'government policies' which are concerned with perceptions of the proper role of the state in general and of central government in particular. The other use of 'policy' is to consider it as 'resource policies' which are concerned with the optimum desired levels and combination of financial, manpower, and capital resources. 'Policy' can also be considered as 'service or output policies' which are concerned with meeting social needs as well as the 'policies in related fields' which include other service policies that can impact upon social services. However, it should be noted that policy should be distinguished from 'decisions' in specific. One of the reasons is that policy is a broader area than decision making (Hogwood and Gunn, 1984).

After discussion of policy, the issue of policy instruments should also be addressed to facilitate understanding of the policy process. These policy instruments are also called policy tools or governing instruments. Howlett and Ramesh (1995) explained these instruments as the actual means or devices selected by the governments to implement policy. For example, an anti-pollution policy will employ a TV campaign to urge people not to pollute the environment. Indeed, Howlett and Ramesh have created a simple taxonomy to arrange the various instruments of public policy on a voluntary – compulsory axis as shown in Figure Five. This demonstrates the shift from low level of state involvement to high level of state involvement. To achieve policy objectives, instrument(s) can be used in different circumstances.

**Figure Five: The Spectrum of Policy Instruments**



*Key:*

- A – Family and Community
- B – Voluntary Organizations
- C – Private Markets
- D – Information and Exhortation
- E – Subsidies
- F – Auction of Property Rights
- G – Tax and User Charges
- H – Regulation
- I – Public Enterprises
- J – Direct Provision

(adapted from Howlett and Ramesh, 1995, p. 82)

The term ‘policy instrument’ embraces a core idea that is the type of mechanism used in a policy matters. For example, the choice of policy instrument can be affected by how and whether the policy is executed, how a proposed initiative is greeted during the policy formation as well as an investigation of the scale of effort to achieve the intentions of the policy makers. Bressers and O’Toole (1998) pointed out that there were increasingly important roles played by policy instruments in the theoretical development of public policy, for example, water policy as well as the interrelationship between policy networks and the selection of policy instruments. They referred to the policy network as the pattern of relationships between governmental authority and the set of actors toward which the governmental authority’s policy efforts are directed. Hence, governmental actors are not simply and unilaterally authoritative. They also need support from others, such as sectoral target groups and so on. Therefore, government should consider those health service stakeholders such as professions and patients’ groups when choosing the policy instruments of the charter.

### 2.3.3 Top-down Implementation Model

In a discussion of various implementation models, Sabatier (1986) attempted to analyze two popular but competing models of implementation theory and proposed an advocacy coalition model. The two popular sets of ‘Top-down’ and ‘Bottom-up’ implementation models are distinguished by their emphases. The top down model tends to be more simple and coherent but lacks substantial evidence. In contrary, the bottom-up model finds it usefulness in realism and applicability.

The top-down model of implementation approach points out that successful implementation depends upon the linkages between the top level and the organizations and departments at the local level. Any deficit in the implementation chain or the 'implementation deficit' should be controlled by top-down approach through the administration system. Hogwood and Gunn (1984) described how to achieve a top-down version of implementation. There are ten conditions as prerequisite as shown in Table Four:

Table Four: Ten prerequisite conditions to achieve Top-down implementation

- 1) Circumstances external to the implementing agency do not impose crippling constraints.
  - 2) Adequate time and sufficient resources are made available to the programme.
  - 3) Not only are there no constraints in term of overall resources but also, at each stage in implementation process, the required combination of resources is actually available.
  - 4) The policy to be implemented is based upon a valid theory of cause and effect.
  - 5) The relationship between cause and effect is direct and there are few, if any, intervening links.
  - 6) There is a single implementing agency which need not depend upon other agencies for success or, if other agencies must be involved, the dependency relationships are minimal in number and importance.
  - 7) There is complete understanding of, and agreement upon, the objectives to be achieved; and these conditions persist throughout the implementation process.
  - 8) In moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the task to be performed by each participant.
- (cont'd)

- 9) There is perfect communication among, and co-ordination of, the various elements involved in the programme.
- 10) Those in authority can demand and obtain perfect obedience.

(Hogwood and Gunn, 1984, pp. 199-206)

As they observed, a top-down model should be controlling of the actors in the lower levels in the chain to prevent interference. However, one particular criticism and problem of the top-down model is that it would be difficult to understand what is being implemented if we accept the word 'policy' is a complex term. This situation is further exaggerated when the policy is vague and ambiguous. Hill (1997) argued that implementers at a distance may be treated as those who should be responsible for any problems and inconsistencies in the framework of the policy set by top officials. Hence, the chance of conflicts increases which will obstruct smooth implementation. Another problem with the top-down model relates to issues of resources and structure. Does the top give the proper machinery and funding for the implementation of the policy? All these imply shortcomings of the top-down approach. As a result, other models of implementation are deemed more relevant.

#### 2.3.4 Bottom-up Implementation Model

One of the alternatives to a top-down approach is the bottom-up approach. It focuses on the implementation of actors and treats individual actions as the starting point to solve problems or to make decisions between alternatives, in particular when choices are conflicting or interacting. This approach identifies the network of actors in local areas and asks them about their objectives, activities and contacts. These contacts

are of particular importance to let decisions move up from street level bureaucrats to the top (Howlett and Ramesh, 1995; Hill, 1997).

Hill (1997) contrasted the two approaches using three different perspectives. The first corresponds to the view that the policy rule framework is seen as more flexible in a bottom-up approach when compared to a rigid top-down approach. In other words, a street-level interpretation of the framework should be taken into account. The second perspective is to treat policy as an output in the bottom-up approach versus policy seen as an input in the top-down approach. It is because the bottom-up approach will put more emphasis on the effect of the innovation while the top-down model puts emphasis on how a new intervention is implemented. The last perspective corresponds to the matter of accountability. Hence, accountability is seen as deference to a legislative process in the top-down model to achieve the objective of how top actors can secure effective implementation. On the other hand, the scope of accountability in the bottom-up doctrine is seen to depend upon adaptability to customer and regulatee and needs to achieve real accountability to the people.

Other scholars have also developed their own measures to compare top down and bottom up implementation models. Sabatier (1986) attempted to compare the two approaches with reference to focus, evaluative criteria and the actors in shown in Table Five below:

Table Five: Top-down versus bottom-up approaches

	Top Down	Bottom Up
Initial Focus	(Central) Government decision, e.g. new pollution control law	Local implementation structure (network) involved in a policy area, e.g. pollution control
Identification of major actors in the process	From top down and from govt. out to private sector (although importance attached to causal theory also calls for accurate understanding of target group's incentive structure)	From bottom (govt. and private) up
Evaluative criteria	Focus on extent of attainment of formal objectives (carefully analyzed). May look at other politically significant criteria and unintended consequences but these are optional.	Much less clear. Basically anything the analyst chooses which is somehow relevant to the policy issue or problem. Certainly does not require any careful analysis of official govt. decision(s).
Overall Focus	How does one steer system to achieve (top) policy-maker's intended policy results?	Strategic interaction among multiple actors in a policy network.

(Sabatier, 1986, p. 33)

The limitations of bottom up approach lie in an over-emphasis on the importance of the periphery compared to the centre. Hence, it may underestimate indirect influence from the centre. Moreover, it is claimed that 'bottom-uppers' are not primarily concerned with implementation of policy but rather trying to understand the mechanism of the interaction in a specific policy sector. In addition, the distinction between 'top-down' and 'bottom-up' model to policy implementation leads to a possible blur of the fact that both can bring insights to policy implementation. Hence, they should be combined to reach a comprehensive understanding of the subject as both can contribute positively to the implementation.



### 2.3.5 The Instrument – Choice Model

Another approach has emerged, the instrument–choice approach, in which policy implementation involves the application of one or more basic techniques of government to policy problems (Howlett and Ramesh, 1995). Therefore, both ‘top-down’ and ‘bottom-up’ designs have incorporated one or several policy instruments as discussed in section 2.3.2. Under this approach, the reasons for the choice of tools can be investigated, especially in two types of background. On the one hand, economists interpret the choice of tools as a technical exercise of matching the attributes of specific tools to the job. Political scientists, on the other hand, have focused on political forces which direct instrument selection (Howlett and Ramesh, 1995). This model can address why a government would like to choose a particular instrument from among the many available, and if any distinct patterns or styles of instrument choice can be discerned in the policy implementation process.

### 2.3.6 The Advocacy Coalition Model

Sabatier (1986) argued that this proposed conceptual framework can help to understand policy change over a ten to twenty years period. The advocacy coalition framework (ACF) was originated as a result of dissatisfaction with the implementation literature. An advocacy coalition refers to a subset of actors in the policy subsystem. In this view, this advocacy coalition framework of policy change combines the best aspects of ‘top-down’ and ‘bottom-up’ approaches. Sabatier considered that the implementation processes consist of an ‘advocacy coalition’ made up of those actors from a variety of public and private institutions at all levels of government who share a set of basic

common beliefs. They seek to manipulate the rules, budgets and personnel of governmental institutions in order to achieve these goals over time. The actors share a set of common beliefs and seek to realize their common goals over time. The sources of this framework include the policy network framework and the hypothesis that implementation is basically learning. This concept of advocacy coalitions aggregates most actors within a subsystem into a manageable number of belief-based coalitions (Jenkins-Smith and Sabatier, 1994). Regarding the basic premises of the ACF, they can include the following:

- 1) understanding the process of policy change and the role of policy-oriented learning will require a time perspective of a decade or more;
- 2) the most useful way to think about policy change over such a time span is through a focus on 'policy subsystems', that is, the interaction of actors from different institutions who follow and seek to influence governmental decisions in a policy area;
- 3) those subsystems must include an intergovernmental dimension, that is, they must involve all levels of government;
- 4) public policies (or programs) can be conceptualized in the same manner as belief systems, that is, as sets of value priorities and causal assumptions about how to realize them.

(Sabatier and Jenkins-Smith, 1993, p.16)

Therefore, an ACF facilitates a focus on policy-oriented learning when actors within the coalition have common values and try to achieve common objectives. This model can be applied in this research to see if there is evidence of an advocacy coalition

with common beliefs and interests such as the contribution to patient's interest or the manager's self-interest.

## 2.4 Consumerism

### 2.4.1 Theory of Consumerism

A related domain within the modern public management framework is consumerism. In the influential book *In Search of Excellence*, Peters and Waterman (1982) studied attributes which characterized excellent innovative companies in the United States. One of the eight developed attributes was to get close to the customer. They argued that those excellent companies offer good products and services because they do not regard the customer as 'a bloody nuisance, best ignored'. While 'other companies talk about it; the excellent companies do it' (p. 156). Peter and Austin (1985) further commented that successful companies need not a 'market orientation' but to 'smell of the customer'. These claims are also echoed within the literature of 'Total Quality Management' in both the business sector and the public sector in which organizations have to improve quality and customer satisfaction continuously at every level of the organization (Oakland, 1993; Joss and Kogan, 1995).

Potter (1988) examined the theory of consumerism and its relationship to public services. She noted that there is an imbalance of power between providers and consumers of goods and services. Consumerism has become an integral part in an attempt to redress this kind of imbalance of power in the private as well as the public sector. Five principles have been identified to provide the foundation for consumerism

(Potter, 1988). These are the principles of access, choice, information, redress and representation. Hence, people can maximize the benefits and utility offered by the goods or services. In order to secure customer sovereignty, they should be given a choice of products and services as wide as possible. Information is essential and is needed to allow people to evaluate and make proper choices. If something goes wrong, customers should be given the means to complain and explain their grievances as well as to receive fair redress. In terms of representation, customers' interests should be adequately represented to those who take decisions affecting their welfare. Customer groups, such as the National Consumer Council, were set up by the government in the UK in 1975 to represent the public view as a consumer on various matters (National Consumer Council, 1991). Although Potter argued that these principles are not necessary adequate enough in respect of the health service, his conclusion is that they are useful and helpful in suggesting how public services can do their job better. Consumerism sees the individual as a consumer in the marketplace. This consumer is assumed to have the ability to look for the best deal and may not feel loyalty to a particular brand. Hence, consumers can exercise their choice and exit strategy if the current provider is not satisfying their needs or even wants.

#### 2.4.2 Consumerism in the Health Service

Health services are notably different from other public services as there is special medical autonomy which characterizes the doctor-patient relationship (Harrison and Pollitt, 1994; Hogg, 1999). Beiecker and Beisecker (1993) compared two metaphors to characterize the doctor-patient relationship in the United States as 'paternalism' versus 'consumerism'. Paternalism assumes that the doctor is beneficent.

It implies a physician's autonomy to focus on obligations. On the other hand, consumerism assumes the doctor is self-centred. It focuses on rights as well as patient autonomy. Indeed, the interest in consumerism in US can be traced back to the 1960s in the context of moves by President Kennedy who proposed a consumer bill of rights to include the right to safety, the right to be informed, the right to choose, and the right to be heard (Cornacchia and Barrett, 1980). Interest in medical consumerism in the US was also the result of three factors:

the orientation of medical care away from treatment to prevention;  
provision of medical services within bureaucratic structures, as distinct  
from the solo practice of medicine, and the growth of consumerism as a  
social movement

(Reeder, 1972, p. 407)

In an attempt to incorporate Potter's five principles of consumerism into health services, there is a gap which does not address the critical question of what sort of services should be provided. Consequently, a question of what constitutes a good quality health services emerges. Potter (1988) argued that it is possible to incorporate Maxwell's definition of health care quality into the consumer's perspective to complement the gap. Maxwell (1984) recognized that the quality of care in health services cannot be measured in a single dimension. Therefore, he suggested six dimensions of quality with each requiring different measures and different assessment skills. These dimensions include the following:

'Access to services' - services should be available and accessible to everyone or to those groups/individuals given explicit priority.

'Relevance to Need' - appropriate and relevant to the whole community preferences and needs .

'Effectiveness' - effective in terms of benefits for individual patients.

‘Equity’ – fairness.

‘Social Acceptability’ - Acceptable in terms of the quality of service provided, and the manner in which it is provided.

‘Efficiency and Economy’ - from the viewpoint of the community as a whole and to the service users who have paid for services through taxes or rates.

(Maxwell, 1984, p. 1471)

The notion of who are the consumers in the health services needs extra attention and caution. Williamson (1995) categorized consumerism’s triple-layered structure as ‘patients and carers’, ‘consumer group members’ and ‘consumerists’. Such categorizations of consumers is crucial for health care professionals to decide which consumers to consult and to identify their needs. Patients and carers are personal in nature. ‘Patients’ are consumers who have a clinical relationship with a practitioner and ‘carers’ are also in a special relationship with practitioners in which they have the interest in both the services offered to the patient and to themselves. The ‘Consumer groups’ refer to community, advocacy, activist or self-help groups dedicated to identifying and articulating the interests of patients and other consumers in different settings and specialties and are local in nature. ‘Consumerists’ are national in nature. They are those consumers whose understanding of patients’ interests and concerns is wider and more abstract than that of any single consumer group or patient care group and devote themselves to services beyond those of personal or local concern. These different categories of consumer, as Williamson explains, are not mutually exclusive and one can move from one category to another or belong to more than one at the same time. These categories are particular useful for policy makers in health services to think

about how policy should be formulated to address the different needs of the various consumers of the health service.

#### 2.4.3 Consumerism in the UK National Health Service

The emphasis on consumerism was developed earlier in the US than in the UK National Health Service and the Hospital Authority in Hong Kong where the focus on public participation in the 1960s and 1970s shifted to a focus on consumerism in health services in the 1980s and 1990s (Stocking, 1990). Mark and Scott (1992) claimed that consumerism was initially addressed by the government in the NHS White Paper *Patients First* in 1979 where the government observed that the need of patients must be paramount (DHSS, 1979). During the 1980s, there was a resurgence of consumerism in the public sector and an even swifter move towards the orientation to consumers in the health services. A management expert, Roy Griffiths from the retail industry, was invited to lead a Management Inquiry into the use of resources in the National Health Service in 1983. His report stressed the importance of quality and patients' satisfaction (DHSS, 1983). As Winkler (1987) argued this was to be the supermarket model of consumerism in health care, seeing health care users in the same way as supermarkets saw their customers. Sir Roy Griffiths, in a lecture in 1987, told his audience that he had placed the consumer dimension centre stage in the health service (Griffiths, 1988). In addition, he quoted three points from his 1983 report to highlight the claim of consumerism:

... it is central to the approach of management, in planning and delivering services for the population as a whole, to ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community (Griffiths, 1983, p. 9)

Nor can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question (Griffiths, 1983, p. 10)

Sufficient management impression must be created at all levels that the centre is passionately concerned with the quality of care and delivery of services at local level (Griffiths, 1983, p. 15)

As a result, many initiatives towards consumerism were put forward and continued. In 1985, a special issue of the *Health and Social Services Journal* reviewed the variations in the extent to which health authorities took consumers into account, but many were employing measures such as appointing quality assurance managers, implementing patients' satisfaction surveys or similar methods, such as public relation training for staff members (Health and Social Services Journal, 1985).

In primary care, the consultation document *Primary Health Care: An Agenda for Discussion* (DHSS, 1986) and the white paper *Promoting Better Health* (DHSS, 1987) both reflected the government's firm intention to make the provision of health care services more publicly accountable. The primary health care plans aimed to improve value for money, to give patients the widest choice with high-quality services and to make the services more responsive to the consumer.

Prime Minister, Margaret Thatcher, was then to announce a review of the health service in 1989. The white paper *Working for Patients* (Department of Health, 1989a) claimed to put the needs of patients in first place and to extend patient choice to secure best value for money, especially through new arrangements of contractual funding between purchasers and providers of health services. It was assumed by government that



these policy measures of making increased use of market forces would encourage managers and professionals to act in the interests of patients as articulated by Griffiths (Allsop, 1992).

Despite the opposition of the professions in the initial stage, the new contractual arrangement for GPs proposed by the government (Department of Health, 1989b) was implemented with some initial empirical improvements, for example, giving consumers more choice by providing information about local services and increasing competition between providers as well as making it easier to change doctors and to secure greater value for money (Haines and Iliffe, 1992). These NHS reforms profoundly changed the balance of power between different stakeholders in health services such as hospital clinicians, purchasers, GPs and patients. Indeed some hospitals which responded to the pressures by being more customer focused improved their financial performance as well as improved health gain (Davis and Trethewey, 1996). To reinforce the movement, consumerism was to be 'fueled by the Citizen's and Patient's Charter' (Edwards, 1992, p. 131). The pace of the consumerism journey was improved since 1979 in the NHS with the Conservatives' reforms to encourage consumerism, participation and representation such as the *Griffiths Report*, *Working for Patients* and *Patient's Charter* (North, 1997). The current Labour government has also put emphasis on quality to serve health services consumers such as the *NHS Plan* (Secretary of State for Health, 2000).

#### 2.4.4 Consumerism in the Hong Kong Hospital Authority

Before 1990, all public hospitals in Hong Kong were managed by the Hospital Services Department of the government and all employees belonged to the work force of the Civil Service who it was claimed thus had a 'Golden Rice Bowl' (SCMP, 1999a). There was widespread criticism, for example, that service quality provided by the public hospitals was consistently poor, especially when compared with private hospitals. Camp beds and unfriendly staff were just some of the frequent examples of poor service cited (SCMP, 1999b). Patients and their carers had very little say, staff lacked motivation to perform better as their career advancement was based on seniority, rather than good performance. The organizational culture seemed to treat patients as silent recipients of services who seldom dared to question health care professionals. Many citizens who could afford higher charges shifted to the private sector to receive better and quicker health services (SCMP, 1995; Hay, 1992).

Although health care consumed a relatively low proportion of expenditure, about 9% of total public expenditure or 1.5% of the GDP in the late 1980s, government tried to improve poor services in an attempt to give better choice and services to the citizens of Hong Kong (Hong Kong Government, 1989). It employed an Australian Consultant Group to look at the matter. This resulted in a recommendation to set up a statutory body to manage all the public, sub-vented (those hospitals run by religious group receiving partial funding from government) hospitals in Hong Kong to improve the quality of health services (Scott, 1985). Although there were claims by Yuen (1994) that the motion included a conflict of interest for the party involved, it was subsequently approved by the government on the basis of the suggestions of the consultancy report

(Scott, 1985; Hutcheon, 1999). The Hong Kong Hospital Authority was formally set up under the Hospital Authority Ordinance in December 1990, to oversee all public and sub-vented hospitals and health care institutions in Hong Kong. It is an independent body, though it is accountable to the government through the Secretary for Health and Welfare (to the government of the Hong Kong Special Administrative Region of China through the Secretary for Health and Welfare of the Health and Welfare Bureau after 1 July, 1997). All existing staff members were invited to join or simply to be transferred as employees of the Hospital Authority within a period of three years. Cash allowances up to 60% of basic salary were included in the new package of employment to compensate for any loss of welfare enjoyed by the civil servants. However, the cash allowances have been withdrawn in respect of new recruits since 1998 (SCMP, 1998).

This marked the new era for health services in Hong Kong. The Hospital Authority published an annual corporate business plan and an annual report, both available to the public. By 1997, it was providing about 92% of the secondary and tertiary care and almost 100% of the extended and long term care in Hong Kong with only about 3% of primary care (Hospital Authority, 1997). The statement of core value of the Hospital Authority is 'Patient-Centred Quality through Team-work'. This major provider of the secondary and tertiary care in Hong Kong has five major corporate strategies which include the following:

- Creating Seamless Health Care
- Developing Outcome Focused Health Care
- Involving the Community as Partners in Health
- Cultivating Organization Transformation and Development

- Promoting Corporate Infrastructure Development and Innovation.

On 1 December 1991, the Hospital Authority formally took over the management of all the 38 public hospitals and institutions as well as the 37,000 staff. This was to be a major drive to transform the whole organization with a large number of staff (the second largest employer in Hong Kong) to a new culture with an emphasis on empowerment, accountability, customer-oriented, high quality and cost effective organization. At the end of 1997, HA managed 26,400 hospital beds (4.06 public beds per 1,000 population) with more than 48,000 full-time staff under a recurrent budget of \$26,022 million in 1998/99. In a keynote address by the former Chief Executive of the Hong Kong Hospital Authority, Dr. E.K. Yeoh, JP, the introduction of a 'Patient's Charter which sets out the rights and responsibilities of patients and targeted training on customer and communication skills have been instrumental in improving communications with and counselling of patients was proposed' (Yeoh, 1995, p.168). The new era also marked a new culture of continuously quality improvement in every level of the organization. Staff members were to be trained in the new corporate culture to make consumerism a high priority. Internal staff newsletters were published to share good practice experiences as well as to praise good work and service. The posts of patient liaison officer were to be set up in every hospital to serve as a bridge between patients and the hospitals in handling enquiries, complaints and so on. In addition, individual hospitals started to set up a patient resource centre within the hospital campus to provide more useful resources such as information about care after discharge as well as a contact point to serve the public, and patients as well as their carers.

#### 2.4.5 Active Consumers

In the UK public sector, there is another drive to inject an element of consumer-conscious regime into current knowledge of consumerism. Gilliatt et al. (2000) provided a critical perspective on the growth of consumerism in social policy and public life. The notion of the 'responsible consumer' has emerged in the current public arena. It seems that this kind of consumerism serves to co-opt service users into the management of scarcity, rationing, and technological change. It is argued that public organizations have become more flexible while a process of producer empowerment is being witnessed rather than consumer empowerment. A typology of the consumer can then be generated which lists the skills required. These consumers should have interpersonal skills; cognitive and interpretative skills; and production skills which are physical or bodily orientation towards orderly conduct, within the framework of the relations of consumption. An example of such production skill is stopping smoking to improve health. Another common characteristic of the responsible consumer is the active nature of being-a-consumer to apply those skills. Nowadays, more and more 'Do-It-Yourself' DIY type services are being provided for these kinds of customers. For example, ATM cash machines, self-assembly furniture, and even NHS Direct are some of the examples (Gilliatt et al., 2000). They also criticized the passive notion of the Conservatives' charter movement in which consumers are granted or given certain guarantees of service and information passively (Gilliatt et al., 2000).

Citizen participation in governance is a related feature of the debate. Recently, citizen participation has been being promoted in a number of services as a means to enhance user involvement, promote democratic legitimacy and develop the

responsiveness of organizations to their stakeholders. Public service managers are now being challenged to invite citizens to become participants in the process of governance. As Farrell commented, 'making this shift, and empowering citizens as the "third way", the public manager will face immense challenges' (Farrell, 2000, p. 36).

## 2.5 Summary and Comment

Much of the discussion in this chapter has been devoted to the debate around Public Choice Theory. A deeper understanding of the theory has provided the basis of the theoretical context for this research project. The assumption that a human being is a rational decision maker that tries to maximize his (*sic*) self-interest or the organizational interest is valid in a sense for survival within the public sector. Governments in different countries are targeting the shortcomings with some kind of Public Choice prescriptions. However, caution should be made if combining the decision making model and the public choice model together. The interpretation of the rejection of incrementalism in Public Choice should also be handled with care. Discussions were made about the values and critics of implementation models such as top down, bottom up and the advocacy coalition framework. These implementation models, together with the garbage can model, are extremely important for the considerations incorporated into the design of methodology of this research. This chapter has also brought out the fundamental questions of what policy is, how it relates to implementation as well as the concept of implementation itself as an end state or as a process. It is particularly interested in understanding the mechanics behind the pursuit of common objectives in the advocacy coalition model. We can see that the doctrine of NPM has extended the New Right ideology into the public sector as an apparently apolitical apparatus to manage public

services. Light has been shed on the usefulness of Public Choice in understanding New Public Management in its supportive as well as conflicting roles. The consumerist approach provides a more front-line interaction to highlight the importance of 'consumerism' in public services to advocate the well being of consumers to tackle the shift to rights to consumers. In addition, the recent third way approach emphasizing the emerging active and responsible consumer has led us to rethink the consumer movement. Building on these foundation theories and models, has provided strong pillars to study 'Charterism' and 'Charterization' within health services.

## CHAPTER THREE: RESEARCH METHODOLOGY

### 3.1 Introduction

In chapter three, I discuss the research methods adopted in this study. This chapter illustrates the choices of research methodology, the unique characteristics observed around the areas of comparative study, the data collection process and its analysis, as well as the potential weaknesses of this research. First, I start with a debate on the usefulness of qualitative and quantitative approaches. The strengths and weaknesses of the dichotomy are reviewed in the context of health services research. Moreover, some common misconceptions about the qualitative approach are clarified. Then I review the research questions and the objectives of this study. From that point, the chosen research methods are elaborated to show the appropriateness of using a case study approach with mixed tools in this study. I review in detail the case study method as a research strategy. I then explore the literature of comparative analysis and, in particular, issues surrounding comparative studies of health services. Both the value of comparative analysis as well as the logic behind the unique research approach are highlighted. The detailed research plan is then presented with reference to the chosen research design. The choices of the units of analysis are shown and discussed with their rationale. In line with other research studies, the strengths and weaknesses of the chosen research methods are discussed. I also illustrate the obstacles involved in the data collection process of this study.

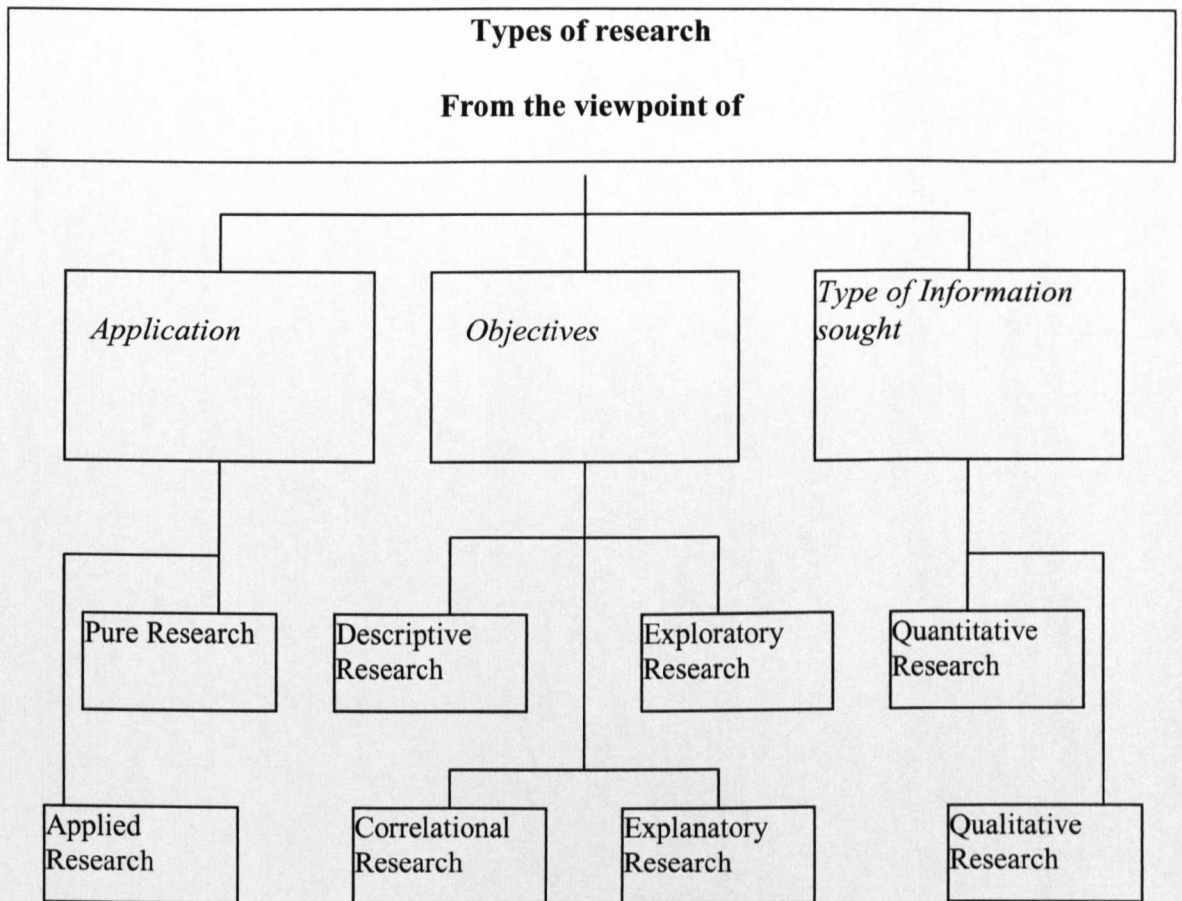
### 3.2 Qualitative and Quantitative Debate

#### 3.2.1 The Overstated Dichotomy



Research studies shape the world and affect everyone to some degree. The development of drugs, information technology, new ways of doing business and deeper understanding of archaeology are just some examples of how research can bring value to real life. The contribution of research has been tremendous. Apart from earning their livings, researchers around the globe are searching for new explorations, reviewing the past and postulating the future. Indeed, there are many approaches to investigating the problems in each discipline within Art and Science. Research in health and health services, of course, has incorporated a wide range of investigative methods such as description, investigation and evaluation in relation to appropriateness, effectiveness and costs. Bowling (1997) defined research as the systematic and vigorous process of enquiry that aims to describe phenomena and to develop explanatory concepts and theories. The objective or ultimate aim is to contribute to the body of knowledge. Some are trying to develop new items or concepts. Others are trying to refine current knowledge. Knowledge with a foundation in research evidence is essential for any profession (Hek et al., 1996). The consequence is that there is a need for a variety of research methods that can meet different tasks and objectives. For example, different tools of surveys, experiments, interviews, case studies, focus groups, ethnography are just some of the common research methods used by social and health researchers. Indeed, research can be classified from three perspectives as suggested by Kumar (1999) which includes the 'application' of the research study. The second perspective refers to the 'objectives' of undertaking research such as descriptive, exploratory, correlational and explanatory. The third perspective refers to the 'type' of information sought which include quantitative and qualitative research. This classification is shown in Figure Six below:

Figure Six: Types of Research



(Kumar, 1999, p. 8)

In any discussion of quantitative and qualitative approaches, a qualitative study tries to describe the variations in a phenomenon, situation, and attitude by acquiring qualitative data for analysis. It takes an interpretive, naturalistic approach to its subject matter. It focuses primarily on the kind of evidence that will enable the researcher to understand the meaning of what is going on (Jones, 1995). As Gillham (2000) has illustrated, qualitative methods can enable the researcher to carry out an investigation where other methods are not practical, simple nor ethically justifiable. The method can investigate situations where little is known about what is there or what is going on. It

can also explore complexities that are beyond the scope of more 'controlled' approaches. On the other hand, a quantitative approach tries to quantify the variations by gathering the quantitative data for subsequent analysis. Both approaches have their strengths and weaknesses. Much is dependent on the purpose of the research. In the context of health and health services research, there seem to be two conflicting voices from two schools. Pope and Mays (1993) described an interesting story based on the dialogue between the director of a large and successful health services research unit and a sociologist. The director had an impressive record of quantitative research. He was asked by the newly appointed sociologist why his recent qualitative research proposal was turned down. The director explained that small samples, looking at just two hospitals, were not scientific and credible. He would suggest a randomized controlled trial with a random sampling method instead. However, the sociologist was, of course, not convinced. He kept on blaming the director that it was no good having people who knew nothing about qualitative research applying their yardsticks of experimental science to all types of research. So what does the story tell us? To reflect on this case, one may argue that there has been a stronger and longer tradition of using quantitative methods in health and health services research. Indeed, Pope and May (1993, 1996) related their stories to their experiences of conversations with their colleagues, experiences of working in health and health care research, their encounters with clinicians, research funding bodies, and even journal editors. Therefore, their paper was trying to provoke debate and they tried to introduce readers to various types of qualitative research methods that were potentially useful. The most important point seems to be to understand the logic of choosing proper research methods that suit the research questions and objectives. We can view qualitative and quantitative methods as complementary to each other in their attempt to generate a richness of understanding

and interpretation. There are situations where health care professionals are asking questions which may not have quantifiable answers. There are also times when questions will require both quantifiable and qualitative answers. Quantitative methods aim for reliability through the use of research tools such as standardized questionnaires whereas qualitative methods aim for validity. There are situations which quantitative methods suit better and vice versa as well as situations that require both methods. Therefore, it would be premature to say which method(s) is better without understanding the objectives and the different circumstances around the research agenda. Indeed, some authorities have argued that the qualitative and quantitative distinction is inexact and somewhat artificial (Goodwin and Goodwin, 1984).

### 3.2.2 Research Questions Revisited

It is useful to revisit the research questions and objectives to account for the subsequent choice of research methods. This research study is an attempt to look at the implementation of patient's charter initiatives in the English National Health Service and the Hong Kong Hospital Authority using a Public Choice perspective. In the Introduction, several major objectives of the research study were discussed, namely:

- 1) an evaluation of the utility of Public Choice Theory in understanding policy implementation of the *Patient's Charter*;
- 2) a description and analysis of the process of implementation of the *Patient's Charter* in England and Hong Kong;
- 3) a description and analysis of the changes in the management of public sector organizations in general as well as the NHS and HA in particular.

Therefore, this research seeks to ask how patient's charter initiatives were implemented in the respective health services. What were the changes (if any) involved in health services and the public sector? How does Public Choice Theory help understand the implementation of the initiatives? These questions formed the major exploratory areas (although not limited to these) of this research. Drawing on a comprehensive review of the rather brief history of the patient's charter initiatives and the latest development in the two respective locations, the research also aimed to undertake original study and to contribute to the broad knowledge of 'Charterism'. As Brause (2000) has commented, doctoral work is expected to break new ground and to contribute to the evolving knowledge base of a discipline. Of course, contributing to the evolving knowledge base of a discipline does not seem a 'breakthrough'. As more doctorate degrees are conferred, we could not expect an equal number of brilliant breakthroughs. However, Philips and Pugh (2000, pp. 63, 64) have claimed that it is not so difficult to be original. They summarized previous claims into fifteen different definitions of the originality of PhD thesis such as the following:

1. Setting down a major piece of new information in writing for the first time.
2. Continuing a previously original piece of work.
3. Carrying out original work designed by the supervisor.
4. Providing a single original technique, observation, or result in an otherwise unoriginal but competent piece of research.
5. Having many original ideas, methods and interpretations all performed by others under the direction of the postgraduate.
6. Showing originality in testing somebody else's idea.
7. Carrying out empirical work that has not been done before.

8. Making a synthesis that has not been made before.
9. Using already known material but with a new interpretation.
10. Trying out something that has previously only been done in other countries.
11. Taking a particular technique and applying it in a new area.
12. Bringing new evidence to bear on an old issue.
13. Being cross-disciplinary and using different methodologies.
14. Looking at areas that people in the discipline have not looked at before.
15. Adding to knowledge in a way that has not been done before.

(Philips and Pugh, 2000, pp.63, 64)

Hence, they assured students that this is a better way to conceive of originality rather than simplistically. The thesis can target at least one or more of the above points. In sum, there should be originality in terms of, for example, area of study, research design and/or of the outcomes of the research in the theses and a contribution to the field of knowledge (Cryer, 1996).

### 3.3 Choice of Qualitative Approach – Mixed Methods

#### 3.3.1 Survey versus Case Study Approach

As the title of this research indicates, the study involves gathering data from two different areas, namely England and Hong Kong, which are separated by thousands of miles, with different cultures and languages. However, it should be noted that Hong Kong was a colony of the United Kingdom until 30 June, 1997. There are still many British shadows among citizens in Hong Kong. For example, traffic lights and symbols

are quite similar as well as some government policies. However, the two different localities can be treated as individual cases for analysis and then for a qualitative comparative study. Within each case of England and Hong Kong, sub-cases can be identified to consist of, for example, hospitals as the units of analysis. Before going into detail, it is necessary to understand the research methods of the case study approach in greater depth and to illustrate the strengths and weaknesses of this research and its appropriateness for use in this study. It is also necessary to comment on the availability of other research methods such as surveys and their limitations in respect of this research.

To start with the case study, Kumar (1999) has noted that this approach can help a study of social phenomena through a thorough analysis of the individual case. Indeed, the case can be a person, group, episode, process, community, society or any unit of analysis. Case study research has become highly popular in sociology and in many other areas of social inquiry. Hammersley and Gomm (2000) have argued that, in one sense, all research is case study, for there is always some unit(s) in relation to which data are collected and/or analyzed. Two dimensions are important in a case study approach. First, it usually refers to research that investigates a few cases, possibly just one, in considerable depth. Second, it carries the implication that it collects unstructured data and carries out qualitative analysis. However, there are quantitative components in some case studies. Yin (1994) provided a detailed introduction and comprehensive review of this method and its application as a serious research tool. Although there are prejudices against the case study strategy concerning its potential lack of rigour, its popularity has encouraged researchers to prove that this is not the case (Yin, 1994).

The case study is treated as a ‘research strategy’ that can be used in many situations such as public administration research, management studies, community psychology and sociology and so on. Researchers have to ask three particular questions before selecting research methods. First, researchers should understand their research questions such as ‘how’, ‘why’, ‘what’, ‘where’, ‘who’. Second, the researcher should understand if the investigator has any control over actual events. Third, whether the focus is on contemporary as opposed to historical phenomena. Yin (1994) argued that case studies are the preferred research strategy when ‘how’ or ‘why’ questions are being posed, when the investigator has little control over events and when the focus is on contemporary phenomena within some real-life context. Case studies can be explanatory, exploratory and descriptive in nature. All can supplement each other to serve the purpose. It is also a way of investigating an empirical topic by following a set of pre-specified procedures. It can contribute significantly and uniquely to the knowledge of individual, organizational, social, and political phenomena. For Vaus (2001), who reviewed the case studies of Lynd and Merrell-Lynds’ *Middletown* (1929) and Whyte’s *Street Corner Society* (1943), these have made major contributions to the development of sociology as a discipline. Likewise, Freud’s (1955) study has contributed significantly to the field in psychoanalysis.

Table Six shows the different situations for different common research strategies. It should be noted that the answers to the above three questions will result in different options to choose proper and relevant research strategies. As we can see from the table, a case study approach is preferred when a ‘how’ or ‘why’ question is being asked about a contemporary set of events over which the investigator has little or no



control. A survey will generally be employed when the research questions stress the who, how many, how much and so on.

Table Six: Relevant Situations versus Research Strategies

Research Strategy	Research questions	Requires control over behavioral events?	Focuses on contemporary events?
Experiment	How, why	Yes	Yes
Survey	Who, what, where,  How many,  How much	No	Yes
Case Study	How, why	No	Yes

(adapted from Yin, 1994)

Similarly, Hammersley and Gomm (2000) have summarized the various dimensions of the meaning of ‘case study’ and the similarities and differences between experimental and survey research. These dimensions are shown in Table Seven below.

Table Seven: A Schematic Comparison of Case Study with Experimental and Survey Approaches

<i><b>Experiment</b></i>	<i><b>Case Study</b></i>	<i><b>Survey</b></i>
Investigation of a relatively small number of cases	Investigation of a relatively small number of cases (sometimes just one)	Investigation of a relatively large number of cases
Information gathered and analyzed about a small number of features of each case	Information gathered and analyzed about a large number of features of each case	Information gathered and analyzed about a small number of features of each case
Study of cases created in such a way as to control the important variables	Study of naturally occurring cases; or, in ‘action research’ form, study of cases created by the actions of the researcher but where the primary concern is not controlling variables to measure their effects	Study of a sample of naturally occurring cases; selected in such a way as to maximize the sample’s representativeness in relation to some larger population
Quantification of data is a priority	Quantification of data is not a priority. Indeed, qualitative data may be treated as superior	Quantification of data is a priority
The aim is either theoretical inference – the development and testing of theory – or the practical evaluation of an intervention	The main concern may be with understanding the case studied in itself, with no interest in theoretical inference or empirical generalization. However, there may also be attempts at one or other, or both, of these. Alternatively, the wider relevance of the findings may be conceptualized in terms of the provision of vicarious experience, as a basis for ‘naturalistic generalization’ or ‘transferability’	The aim is empirical generalization, from a sample to a finite population, though this is sometimes seen as a platform for theoretical inference

(Hammersley and Gomm, 2000, p.4)

Vaus (2001) argued that for many years the case study has been the ‘ugly duckling’ of research design as most research methods texts either ignore cases studies or they confuse them with other kinds of social research. He explained that case study

design has not been neglected. Some confuse case study teaching with case study research (Hammersley and Gomm, 2000). It is indeed not difficult to understand this confusion because it stems from the popular approach of using business case studies as learning materials in various business schools, for example, the Harvard Business School (Harvard Business School, 2001). Another misunderstanding is that the case study can only provide scant basis for scientific generalization. In fact, case studies, like experiments, are 'generalizable to theoretical proposition and not to populations or universe' (Yin, 1994, p.10). A third, frequent complaint about case studies is that they involve a longer time frame. However, this is situational and depends on the nature of the study. Some case studies take a long period while others do not. It should also be noted that case studies can have any mix of quantitative and qualitative evidence. As a result, one should not claim that case studies are purely qualitative. The methods used in case studies can be qualitative or quantitative, depending on the circumstances (Keen and Packwood, 1996). To summarize, a case study can be defined 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 (Yin, 1994).

### 3.3.2 Designing the Case Studies

Social researchers who have decided to employ a case study methodology have to plan their approach to the actual process of 'researching the case'. There are a number of ways to design case studies. These can be represented by the 2 x 2 matrix as suggested by Yin (1994) in Figure Seven:

Figure Seven: Types of Research Designs for Case Studies

	Single-case designs	multiple-case designs
Holistic (single unit of analysis)	A	B
Embedded (multiple units of analysis)	C	D

(adapted from Yin, 1994, p. 39)

As shown in the above figure, these four major types of designs of case studies are based on the two pairs of categories, namely single-case designs versus multiple-case designs. Within each design can be a single unit of analysis (holistic) or multiple units of analysis (embedded). Hence, they can be classified into:

- i) single-case (holistic) designs
- ii) single-case (embedded) designs
- iii) multiple-case (holistic) designs
- iv) multiple-case (embedded) designs

In determining the choice of single-case versus multiple-case, there are certain rationales. For example, a single-case study is used when it represents the critical case in

testing a well-formulated theory. It is also used when the case represents an extreme or unique case. In addition, it is also suitable for revelatory cases when an investigator has the opportunity to observe and analyze the phenomenon previously inaccessible to scientific investigation so as to reveal something from this particular case. Of course, the use of single-case study as a pilot study is also used as a prelude to multi-case study. On the other hand, multi-case study is employed for comparative studies, for replication logic and so on. Hence, the number of cases employed is a matter of reflection about the need of the number of case replications. The typical criteria regarding sample size then seems to be irrelevant (Yin, 1994, p.50).

When it comes to the unit of analysis, the definition of what constitutes the unit of analysis is related to the way the initial research questions have been identified and defined. It may be a small group of people within some kind of boundaries. A single-case study may need to have more than one unit of analysis in which attention is also needed to subunits. In contrast, a single-case holistic design will be used if the case study examines only the global nature of the organization. The multi-case embedded design is adopted where the subunits are analyzed and pooled together.

There are also the five suggested components suggested by Yin with the case study design that are relatively important, namely:

- i) the study's questions,
- ii) its propositions, if any,
- iii) its unit(s) of analysis,
- iv) the logic linking the data to the propositions, and

- v) the criteria for interpreting the findings

Items (i) and (iii) have already been discussed in the previous section. For item (ii), each proposition directs attention to something that should be examined within the scope of the study. The research questions will lead to the formulation of the propositions so that the research can collect the data in the right direction to study what is intended and to ask the correct questions. For example, a proposition to the questions of why hospitals want to implement the *Patient's Charter* may include the reason of trying to improve the services to patients or even a means to avoid responsibility by enabling a manager to pass the responsibility to his/her subordinates. Moreover, propositions can help the investigator to collect specific information within feasible limits. That is particularly important when there are resource constraints such as time and personnel. However, there are situations that do not need any propositions. For example, the exploratory study should state the purpose rather than any propositions.

The fourth and fifth issues represent the steps involved for the analysis of data. How does the investigator link the data to the propositions? One solution is to look for a pattern and to match them or simply the idea of 'pattern-matching'. The data from the different sources may be related to the theoretical proposition. These patterns can be of different nature such as time, arguments and behaviors. The fifth issue, the criteria for interpreting the findings, is more difficult and requires the investigator's knowledge of the subject, comprehensive skills, and of course the findings collected from the study. Therefore, the research design is fruitful in guiding the questions to be asked as well as indicating how data will be interpreted to give the real power of the case study approach (Stake, 1995).

### 3.3.3 Theory Development in Case Study Design

In case study research, the components discussed above are related to the construction of a preliminary theory relevant to the topic of the research study (Yin, 1994). This kind of theory development happens before the data collection stage. Hence, it is an important task in designing the case study research. The investigator may develop or test a theory. It may be useful to quote an example to illustrate the argument. Markus (1983) used a case study to look at the implementation of the new Management Information System (MIS) in a private corporation called 'Golden Triangle Corporation'. He proposed the theory with a statement showing that his study was to show why implementation only succeeds when an organization is able to re-structure itself rather than having the imposition of a new MIS on the old organization structure. In this regard, he presented the nutshell of a theory of MIS implementation in which organizational restructuring is needed to make MIS implementation work. This theory development is useful in enhancing the five components listed in section 3.3.2 as well. The objective is to have a sufficient blueprint to guide the subsequent procedures. Apart from this, theory development can facilitate the generalization of the case study's result. The term 'analytic generalization' is emphasized rather than 'statistical generalization'. It is indeed very important to understand the distinction between the two types of generalization. An inference is made about a population in 'statistical generalization' which is less relevant in case study research. In contrast, cases are not the sampling units and therefore the method of generalization in case study is heavily oriented towards 'analytic generalization'. From that, the previously developed theory is used as a template with which to compare the empirical results of case study. If data from cases support the theory, replication may be claimed. Stake (1995), on the other hand, argued

that the real role of a case study is ‘particularization’ rather than generalization, in which an investigator studies a particular case in detail to understand the uniqueness.

#### 3.3.4 Validity and Rigour – Triangulation

Validity is rather a common term in everyday life. However, this technical term has a unique meaning in research (Punch, 1998). It needs careful use in social science research. For example, Miles and Huberman (1984) explained the ‘descriptive/contextual validity’ and the ‘interpretive validity’ which qualitative research can achieve. The meaning of ‘descriptive/contextual validity’ refers to whether the account of the research is complete and thorough. It asks whether the account given in the research connects with the lived experience of people studied. Pope and Mays (1995) have argued that quantitative methods aim for reliability of consistency on retesting by tools such as standardized questionnaires. In contrast, qualitative methods emphasize validity more by exploring how people really behave and what people actually mean when their experiences, attitudes and behaviors are described. Simply speaking, validity is the extent to which a measurement truly reflects the phenomenon under scrutiny. Yin (1994), on the other hand, reviewed the four tactics that can be employed to increase the rigour of case study. These four tactics are:

- *Construct validity*: establishing correct operational measures for the concepts being studied;
- *Internal validity* (for explanatory or causal studies only, and not for descriptive or exploratory studies): establishing a causal relationship, whereby certain conditions are shown to lead to other conditions, as distinguished from spurious relationships;



- *External validity*: establishing the domain to which a study's findings can be generalized;
- *Reliability*: demonstrating that the operations of a study – such as data collection procedures can be repeated, with the same results;

Hence, in order to improve the construct validity, the researcher can use multiple sources of evidence, as well establishing chain of evidence. Of course, advice from academic advisors or key informants is welcomed. To improve internal validity further, pattern-matching can be employed during the data analysis stage for explanation-building. Regarding external validity, the use of replication logic in multiple-case studies can be adopted. To improve reliability, a researcher should write a case study protocol and develop a case study data base so that the operations of the study can be repeated. The discussion on external validity or generalizability needs further exploration. Mays and Pope (1995) gave examples of commonly heard criticisms about the rigour of qualitative research. First, there are claims that qualitative research is merely an assembly of anecdote and personal impressions, strongly subject to researcher bias. Second, qualitative research is weak in reproducibility and third it is criticized for lacking generalizability. In order to remedy these impressions, they reiterate similar strategies to Yin to ensure rigour in qualitative research by setting out two goals. On the one hand a researcher should create an account of method and data which can stand independently so that another researcher could analyze the same data in a similar way and get similar conclusions. On the other hand, researchers should give adequate descriptions in the research reports of their assumptions and methods, particular of data analysis, to produce a plausible and coherent explanation of the phenomenon under scrutiny. Going back to the notion of generalizability, Lincoln and Guba (1979) in their

article 'The Only Generalization is: There is No Generalization' criticised the frequently held idea that generalization is the aim of science. They then proposed an alternative to law-like generation initially put forward by Robert Stake of 'naturalistic generalization' (Stake, 1978).

Stake claimed that case studies are often a preferred method of research. The reason is that case studies are epistemologically in harmony with a reader's experience and thus a natural basis for generalization. This kind of naturalistic generalization recognizes the similarities of objects and issues in and out of context and by sensing the natural covariations of happenings. They derive from tacit knowledge which is concerned about how things are, why they are. That is to say, it tries to build up the body of tacit knowledge on the basis of which people act. Stake continued to argue that 'generalizations may not be all that despicable, but particularization does deserve praise' (Stake, 1978, p. 22).

To further relieve the concern about rigour, triangulation methods are often used in case study research. Gillham (2000) explained this approach by accumulating data from different methods but bearing on the same issue. He treated case study research as the main method while within it there are various sub-methods such as interviews, observations, document and record analysis, work samples, and so on. This multi-method approach gathers together both the advantages and disadvantages from these different methods. If they converge and support the proposition, then we can be reasonably confident that we are getting a good and true picture. If there are discrepancies, the researcher should be more cautious about interpreting the data. It does not necessary mean that one set of data (or any of them) is wrong but the picture will

need careful analysis. In fact, triangulation is a technical term used in surveying, military strategy and the navigation field to describe the technique whereby two known landmarks or reference points are used to define the position of a third (Merriam-Webster, 2001). Arksey and Knight (1999) have further explained the idea of triangulation. The basic idea is that data are obtained from a variety of sources, incorporating the use of different methods, investigators or theories. By approaching the research questions from different angles and bringing together a range of views, there is the potential to generate new and alternative explanations. For example, if different levels of employees are asked to provide multiple viewpoints about the reform of an organization, there will be better representativeness. Triangulation can achieve the purpose of confirmation as well as completeness. Denzin (1970) proposed four different types of triangulation which may be used or combined to enhance the quality of the research study. These four types are classified as methodological triangulation, data triangulation, investigator triangulation, and theoretical triangulation as follows:

- Methodological triangulation refers to the method of getting the data and interpreting it from a variety of methods. Some are ‘within-method triangulation’ which employs using a variety of techniques within one single method. For example, the survey method can employ a package of measures to focus on the collection of data around the same variable. The other can be ‘between-(or across-) method’ triangulation in which two or more distinct methods (for example, semi-structured interviews, observation and diary accounts) can be utilized to collect the data from different angles;
- Data Triangulation refers to the use of a research design involving diverse data sources to explore the same phenomenon. The data sources can be triangulated with

respect to person, time, and space. For example, the research can collect the data from different comparison groups at different setting at different time frame;

- Investigator triangulation employs different researchers, interviewers or observers with a shared interest in the focus of study. It is claimed that this method can remove any potential bias generated by a single researcher;
- Theoretical triangulation refers to the triangulation by using diverse perspectives and hypotheses in mind in approaching the research. Thus, the researcher can make a list of possible theoretical points of view with respect to the common set of research questions, and then derive a number of propositions. Subsequently, the researcher will collect the empirical data on whatever phenomenon the proposition at hand has directed attention towards. Then, each proposition will be tested against the data to assess the relevance, utility and power of each.

Therefore, triangulation usefully combines two or more theories, methods, or investigators in the study of a single phenomenon to circumvent the personal biases of investigators, overcome the deficiencies intrinsic to a single-investigator, single-theory, or single-method study so as to increase the validity of the findings (Kimchi et al., 1991). However, triangulation is not without its criticisms. Seale (1999) reviewed some of the criticisms of triangulation such as there being no guarantee of validity at all, as well as our lack of certainty how can we know whether multi methods are correct.

In this research, the research method of a qualitative comparative case study will be employed to reflect the research objectives of asking the ‘how’ and ‘why’ questions. There is no control over behavioral events and the foci are on contemporary events in the real life context. By means of using multi-case embedded studies with different tools

to collect data, the research is planned with this draft map to indicate the pathway. The details of the research plan as well as discussion of the various data collection tools will be discussed in section 3.5 of this chapter in more detail.

### 3.4 Comparative Analysis

This research involves a comparative analysis of two countries, namely England and Hong Kong (HKSAR of China), and their experiences in implementing the *Patient's Charter* in their respective public health care systems by means of using a case study approach. Therefore, it is particularly important to have a better understanding of comparative study and analysis in public policy research as well as health and health services research. Hence, this section provides an overview of comparative research to look at the rationale behind this approach as well as the reasons for its growing popularity among researchers. I start with a discussion of the emerging field of comparative studies in public policy and then in health and health services research. The cost and value of comparative analysis are demonstrated as well. Of course, the study will indicate what to compare and how to analyze the data in order to look for, for example, points of convergence or differences. Researchers involved in comparative studies hope to advise decision makers, policy makers as well as practitioners, by learning from the results of the comparative analysis.

#### 3.4.1 The Field of Comparative Analysis

Comparative studies in public policy such as health policy and urban policy started to emerge from the academic field in the 1970s. Scholars were interested in

understanding strongly, for example, what governments do and how and why they do it by investigating a cross-national study of political systems. Heidenheimer (1985) argued that this enterprise, carried out under the label of 'comparative policy studies', has been developed to provide an intellectual framework through which researchers can focus on national policies and other policies as well. One needs to grasp how policy studies occurred and recurred in various national settings so as to develop a comparative perspective. When policies have developed to be sufficiently visible on both sides of the world, academics then can apply their strong binoculars to compare them. Therefore, the launching decade of comparative policy studies started in the early 1970s. Heidenheimer et al. (1990) further argued that comparing public policy is a part of everyday life. Citizens compare policies and manifestos of different political parties during the election period. They also compare living standards between different states or localities if they plan to move their homes. They are aiming to get a better picture of the situation in order to make better and more rational decisions. The academic study of comparative public policy, can serve three different purposes. First, they are carried out to look for guidance in designing better policies. Second, they aim to gain a deeper understanding of how government institutions and political processes operate as they deal with concrete problems. Third, they deal with the growing interdependence between different nations in fast changing modern societies. Hence, comparative public policy is the study of how, why, and to what effect different governments pursue particular courses of action or inaction.

The globalization of problems has further intensified the need for comparative research. One of the external forces driving more comparative studies in social research is the growing internationalization and the concomitant export and import of social,

cultural and economic manifestations across countries' borders (Øyen, 1990). The advances in information technology have further increased the flow of information across borders. Øyen (1990) has outlined the different intents of cross-national research on the basis of, namely, the 'objective' of the study, the 'context' of the study, the 'unit of analysis' and 'trans-national'. The first intent refers to the interest of the countries being studied. The second tests the generality of research results concerning social phenomena in two or more countries. The third intent explores how social phenomena are systematically related to the characteristics of the countries researched. The last intent studies nations as components of a larger international system. Various terms have been used to identify comparative study such as:

Cross-country, cross-national, cross-societal, cross-cultural, cross-systemic, cross-institutional, and trans-national, trans-societal, trans-cultural, and comparisons on the macro-level, are used both as synonymous with comparative research in general and as denoting specific kinds of comparisons (Øyen, 1990, p.7)

It may be confusing enough to indicate the specific purposes with such a diversity of terms associated with comparative research.

### 3.4.2 Comparative Research in Health Services

In the field of health care or health services, comparative and cross-cultural health research have found their way in the arena of health and health services research. Such growing interest has resulted in an increasing number and publications of research studies using this approach. A simple computer search at the British Library database 'ZETOC' with keywords 'comparative study' and 'health' gives thousands of hits of such kind of publications over the last ten years. These range from comparative studies

in clinical epidemiology to health policies, health related course curriculum across countries or even across professional groups. Such diverse fields of comparison have helped scientists and researchers to discover the causes of disease, treatment effectiveness, in their search for value for money, better health care reform and so on. Øvretveit (1998) provided a practical guide to review the trend of comparative health research and to explain the steps involved. Like other commentators, he has attributed the growth of comparative health research to the globalization of markets and corporations, advances in information technology, greater cultural awareness and more cultural uniformity. However, there is also increasing fragmentation and the awareness of such differences and diversity among different countries. In his view, comparative health research (CHR) can be defined as:

Research that creates empirical or explanatory knowledge about health, health services or health systems, by making comparisons using scientific methods that are appropriate for the subject studied and for the purpose of the research. The aim of such research is to explore or explain the similarities and differences between comparable 'items' in different areas in order to improve health and the functioning of health services (Øvretveit, 1998, p. 6)

From this point, the object being studied can include treatments, organizations, health systems, health policies, health reform and the list goes on. Indeed, Øvretveit (1998) has indicated the aims of comparative health research can include one or more of the following points:

- CHR aims to discover whether an event, phenomena or entity that occurs in one place also occurs in another place;



- CHR aims to discover ‘significant’ similarities or differences between comparable ‘items’ in different areas;
- CHR aims to measure the size differences or gather data about the meaning of the ‘items’ or phenomena in different areas;
- CHR tries to understand, interpret or explain the similarities or differences between items in different places being studied;
- CHR tries to contribute to decisions about actions to improve health or the functioning of health services in a certain aspect;
- CHR tries to contribute to the adoption of improved practices or procedures by comparing a new more effective procedure to one customarily used elsewhere, or by comparing how commonly a practice can be used in different areas and what are the reasons for such differences.

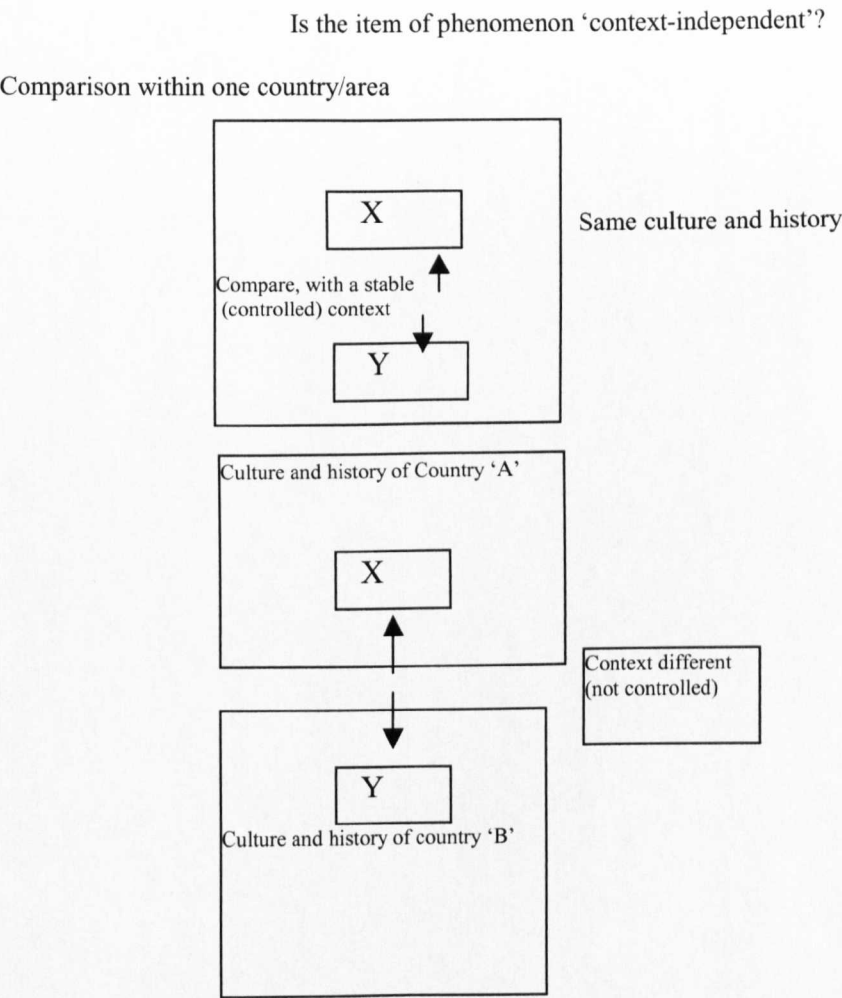
Hence, CHR can incorporate a variety of objects to be compared. For example, health status, population, treatments, health care organizations, different level of health systems, health policies, health care reform, education programmes are just some of the possible objects to be studied. Therefore, different approaches to research are needed to suit the different categories of comparative health research. Despite the benefits gained from comparative health research, there are costs associated with such study. In particular, it is difficult and expensive to gather data from different nations which may include expensive field trips to the sites. Therefore, major projects involving multi-nations comparative research will usually need significant funding.

### 3.4.3 How and What to Compare

Øvretveit (1998) has proposed a model of comparative study in an attempt to describe the concepts behind it so as to assist researchers planning comparative health research. A distinction has to be made between a 'whole object' or 'entity' and a 'characteristic' or 'dimension' of a whole object within comparative research. For example, the health system as the whole object can have characteristics such as ownership of health services or financing mechanisms. The health policy implementation process as the whole object can have the characteristics of the timescale and decision-markers. It is also equally important to look at the term 'item' which refers to the subject of comparison, regardless of whether the item is a whole object or a characteristic of it. In short, the 'whole object' or 'entity' which is compared involves two or more individuals; populations; organizations; systems; policies or interventions to organizations. The 'characteristic' or 'dimension' is a concept, dimension or variable which describes an aspect of the whole object compared. The 'item' is the general term for that which is compared. The item can be a characteristic, or process, or a whole object or entity. Going back to the proposed model, Øvretveit looked at the context-independence of the items in his model, shown in Figure Eight. As Figure Eight shows below, there are two studies that are different in nature. In the upper part of the study represented by the first square box, the context of the item is the same and the boundary is shown by the rectangle. This boundary is the apparatus which separates the whole object from its context, and is a term to describe how the context is related to the item. In the first study, the researcher may wish to ask how permeable is the boundary and how it is context-dependent. On the other hand, the lower half of the two boxes in the

figure represents a second form of studies in which the contexts are different in the two countries.

Figure Eight: A Model for Comparative Health Research

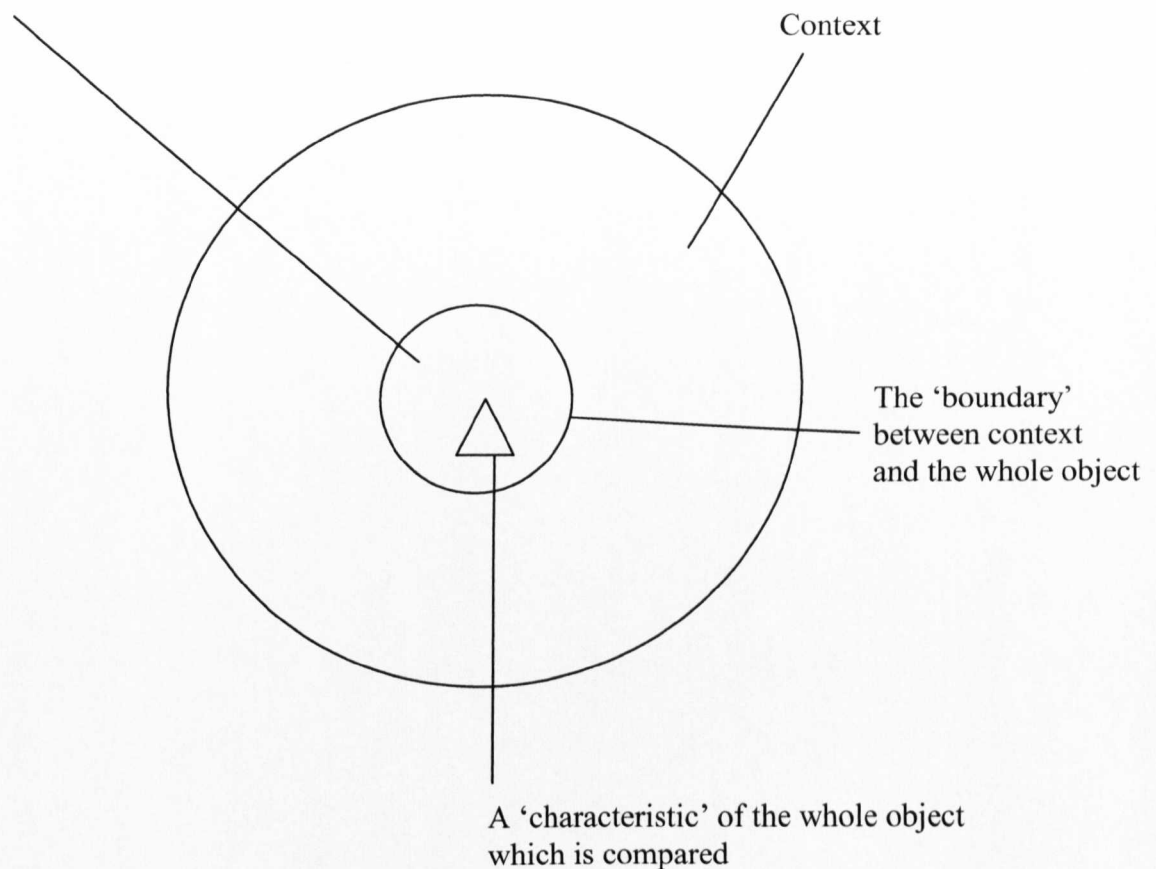


(modified from Øvretveit, 1998, p. 23)

Therefore, any comparative research study can start with a simple diagrammatic model to make better sense of the research study. It can be shown to indicate the ‘whole object’ which is to be compared and is shown in Figure Nine below:

Figure Nine: A Basic Model to represent a Comparative Research Study Unit

The 'whole object' which is compared  
(e.g. a population, or a health policy)



(Øvretveit, 1998, p. 55)

Regarding the methods of collecting data in comparative health research, eight designs are recommended which include 'survey or statistical comparison', 'case study comparison', 'audit comparisons', 'retrospective comparative case control', 'cohort comparison', 'comparison of outcome (or before and after) experiments', 'prospective experimental comparative case control', and 'randomized controlled trial'. As the previous section has argued, this research will adopt the case study comparison design.

### 3.5 The Research Plan

The discussion of sections 3.2, 3.3 and 3.4 have highlighted important areas to observe in the planning of research design. Therefore, this section summarizes the major relevant points and provides a blueprint for the design of this research study.

A qualitative comparative case study involves selection of cases to be studied in the respective public health system. It adopts a multiple case designs with (embedded) multiple units of analysis. The multiple sources of data also try to improve validity and rigour by the triangulation of methodological triangulation and some data triangulation. The two respective countries will have different culture and history, for example, the political system in which the context will be different among the two countries. The ‘whole object’ then corresponds to the implementation of *Patient’s Charter*. Several ‘characteristics’ are identified to help construct research questions which will be shown later. Data collection tools include mainly semi-structured interviews, as well as focus group, participant observation, documents content analysis and so on.

#### 3.5.1 The Choice of Cases – UK Scene

The scope of this research is targeted at the NHS in England, although the NHS includes Wales, Northern Ireland and Scotland as well. The NHS has been characterized by frequent changes in structure in how services are run, for example, the introduction of internal markets, the formation of Trusts, and the abolition of the internal market, the setting up of local commissioning bodies Primary Care Groups (PCGs), and the latest drive to replace Community Health Councils (CHCs). Nevertheless, the research has

tried to separate the scene into three major levels which correspond to the national level and the local level as well as the patients' groups and CHC level. At national level are the National Health Service Executive (NHSE) and especially the Patient's Charter Unit. At local level, acute Trust hospitals were selected as the cases. Regarding patients' groups, the Patients Association and a local CHC were selected. Within the Trust hospitals, managerial staff and front level nursing staff were selected as the units of analysis as well. To obtain agreement to carry out research interviews in Trust Hospitals was rather difficult, especially at a time of staff shortages and pressure in the NHS. A letter was drafted and sent to the hospitals and followed up by telephone to make an appointment. The research questions were piloted in advance and these were attached to the letter sent to the institutions. There were different emphases and wording in the letters sent to different organizations. Sample of the letters and research guiding questions are shown in Appendix One to Five. To ensure confidentiality, no name will be disclosed in this thesis nor any subsequent publications. I refer to the participants by their professional and job status. All interviews were recorded with permission from the interviewees. The use of a digital recorder helped to concentrate on the interview and to properly transcribe and store them with the help of computer and CD-R. At national level, difficulty was encountered when the Patient's Charter Unit refused the invitation to participate in the research. Despite a subsequent telephone conversation from my former supervisor, Professor Alaszewski, and a second letter with shortened questions, it seemed that I would have to search for other sources of data from the Patient's Charter Unit such as documents and newsletters. Luckily, I was able to gain access to some Trust hospitals despite being turned down by some. Regarding the third level, I was able to arrange an interview with one local CHC and a telephone interview with a

representative from the patients' group, the Patients Association. These institutions with successful access included:

Hull and East Yorkshire Hospitals NHS Trust

Milton Keynes General Hospitals NHS Trust

Pinderfields and Pontefract Hospitals NHS Trust

Hull Community Health Council

The Patients Association

Apart from interviews, I collected literature from the institutions studies as well as walking around the premises. Besides the interviews and focus group, I also attended two major conferences related to the topic. One was held in late 1998 when Mr. Greg Dyke had finished his report on the new *NHS Charter* (Dyke, 1998). During the conference, he was one of the speakers. The other conference was held in February, 2001 on the UK Patients' Movement after the government's announcement of the abolition of CHCs and the replacement of the *Patient's Charter* by the document *Your guide to the NHS*. During the conference, Mr. Nigel Crisp, Chief Executive of the NHS, gave the keynote address. Of course, document analysis was necessary to look at the implementation guidelines especially from the Department of Health and NHSE. Therefore, a through search was done at 'POINT' – 'Publications on the Internet' and 'COIN' – 'Circulars on the Internet' from the Department of Health web site at <http://www.doh.gov.uk> as well as a search of other relevant web sites. To consider previous studies and writing about *Patient's Charter*, a through library search was done with the help of the British Library database. Keywords such as Patient's Charter,

Charterism, Citizen's Charter, Charters, Patient's Rights and so on were used to retrieve materials. Visits to the specialized library at the King's Fund in London were also made.

### 3.5.2 The Choice of Cases – Hong Kong Scene

Compared to UK, the situation in Hong Kong seems more fluid and simple. The Hong Kong health care system has a different public and private mix in terms of financing and provision of services, in particular, primary care when compared to UK. However, secondary care is heavily funded and provided by the public sector similar to the UK. The Hong Kong Hospital Authority is responsible for the management of the 44 public hospitals/institutions in Hong Kong as well as some specialist out-patient clinics. However, Hong Kong is also facing challenges from rising demand from patients and limited resources. The government reformed the whole health and social services system in the 1990s and this continued to take place. In this sense, Hong Kong is similar to UK where reform is not a uncommon word.

Similar to the selection of cases in UK, the cases selected in Hong Kong also comprised three levels, namely head office level, the local hospital level, and patients' group level. However, there is no counterpart to CHCs in Hong Kong nor a special unit in the head office similar to the Patient's Charter Unit. Interview questions were adapted from the UK version to suit the Hong Kong situation. Luckily, access seemed easier in Hong Kong. This may be due to the fact that the investigator is both a Lecturer in the field and also a council member of the Hong Kong Society of Health Service Executives, so networks were already formed. As a result, access was gained for interviews in several acute hospitals together with others as shown below:



Hospital Authority Head Office

Queen Elizabeth Hospital

Tuen Mun Hospital

United Christian Hospital

Alliance for Patients' Mutual Help Organization

Similar to the UK data collection, managers and front line nursing staff were invited to interview and key personnel from the head office and patients' group were selected as well. Parallel strategies were employed to locate publications and other written materials. However, the Hong Kong version does not have much printed materials about the topic compared to the UK, nor specialized conferences about the topic though the investigator has presented some conference papers in this area (see Ng, 1997a; Ng, 1997b; Ng and Leung, 1999).

### 3.6 Summary and Comment

This chapter has provided an overview of the method of comparative health research employing a qualitative case study method. The reasons for the choice of the research areas were explained. Among the various available research methods in health and health services research, the case study approach seemed to be the most suitable in terms of the research objectives and the limited resource constraints of a sole investigator as well as the distances involved in this comparative study. However the research is looking at initiatives which are becoming more popular in different countries in both public and private sectors. By means of a case study approach, a better understanding of 'Charterism' will emerge. I have also incorporated the use of multi-

case embedded studies in order to enrich the data sources as well as the rigour of the study. Yin's work on case study and Øvretveit's work on comparative health research have helped to recognize the subtleness of comparative case studies as well as an appreciation of qualitative and quantitative dimensions. They draw attention to the need to appreciate different contexts such as the cultural and political systems of the countries being studied. In the chapters outlining the data, I discuss differences in the context with regard to UK and Hong Kong. Of course, the research design is not without its weakness. For example, the number and types of cases selected or even the performance of the interviewer are subject to some criticism and are discussed. The other drawback was that access to the Patient's Charter Unit was denied. However, researchers have to face such problems. Even well-planned proposals will encounter some problems. Overall, over-coming these is part of the learning process of doctoral research.

## CHAPTER FOUR: NATIONAL POLICY DEVELOPMENT – ENGLAND AND HONG KONG

### 4.1 Introduction

In this chapter, I provide an account of the national policy development of *Patient's Charter* in both the UK National Health Service with reference to England and the Hong Kong Hospital Authority to investigate the process of the development and implementation in the charter movement in these two locations. Although both health care systems were briefly introduced in sections 2.4.3 and 2.4.4, it is helpful to have an overall descriptive picture of the health care systems in the UK and Hong Kong as well as their public policy making processes and the recent health care reforms. Looking at the history of the NHS and the HA briefly will enable readers of this thesis, from either UK, Hong Kong or other countries, to appreciate the similarities and differences as these are crucial to allow readers to understand the background changes in both health care systems. Although there are long histories to both health care systems, the time frame will concentrate on the health care systems that have emerged and subsequently been reformed since the launch of the patient's charters. Some major issues will be highlighted such as the change of government from Conservative to Labour government in the UK and the handover of the sovereignty of Hong Kong to China, both of which happened in 1997. Key policy papers and documents will be highlighted. Furthermore, the policy development of patient's charter at the national level will be presented and analyzed to supplement previous materials in section 1.2. I also present other related charters produced in other countries, for example, Malaysia, South Africa, Australia and USA, to enrich the international context of this topic. In addition, other previous studies

in this area will be analysed to develop an understanding of the movement of 'Charterism' especially in the UK where most studies were located. This chapter will present the key implementation guidelines of patient's charter from the national level. The data from those interviews at the local level will be presented in chapters five and six.

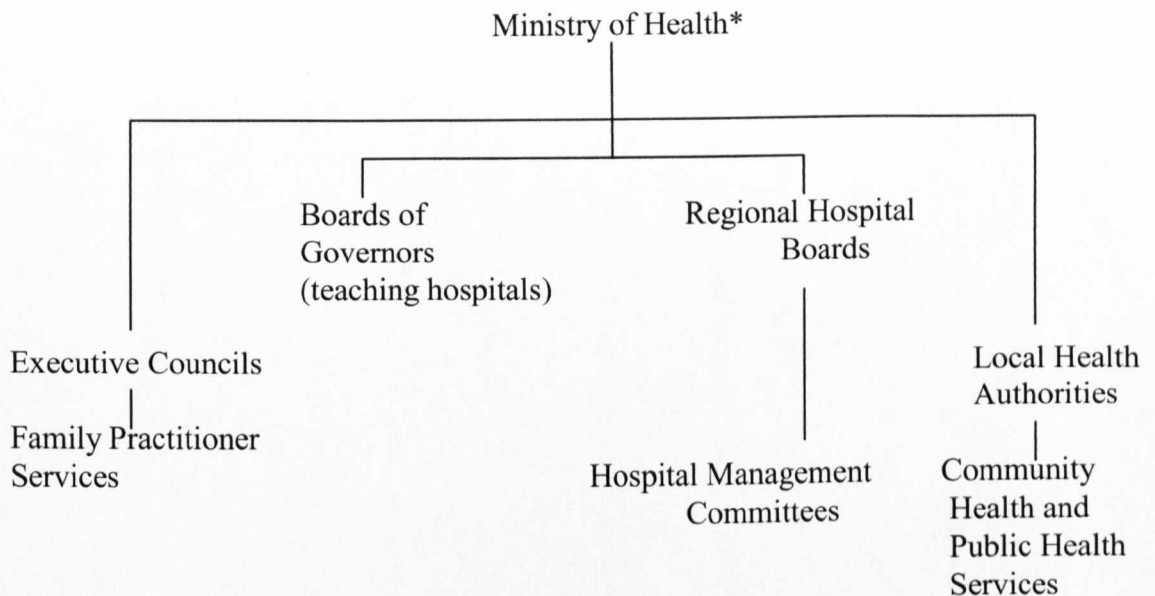
## 4.2 National Health Service

### 4.2.1 A Historical Review of the National Health Service

The National Health Service was founded on 5 July 1948 following the NHS Act of 1946 after the Second World War (Allsop, 1995). It celebrated its fiftieth anniversary in 1998. The meaning of being a 'National' health service was to design a health service available to the entire population which was comprehensive in service range, free at the point of delivery and of good standard. Aneurin Bevan, the Labour Minister of Health appointed by Prime Minister, Clement Attlee, who won the 1945 general election, was asked to implement a new health service. Bevan's plan developed an entirely new approach in the structure, financing and provision of health care. With the advances in health services, the founding principles upon which NHS was built have stood firm, with politicians considering to provide a quality service for all, regardless of ability to pay (Blair, 1997). Webster (1999) explained the major changes with the setting up of the NHS, which for the first time relied heavily on general taxation to run health services. Hospitals were administered at regional level in England and Wales by fourteen regional hospital boards (RHBs) which then administered at local level with about 400 hospital management committees (HMCs). Teaching hospitals retained their independent status

with their own board of governors. The initial structure of the NHS is shown in Figure Ten below:

Figure Ten: The National Health Service 1948-1974



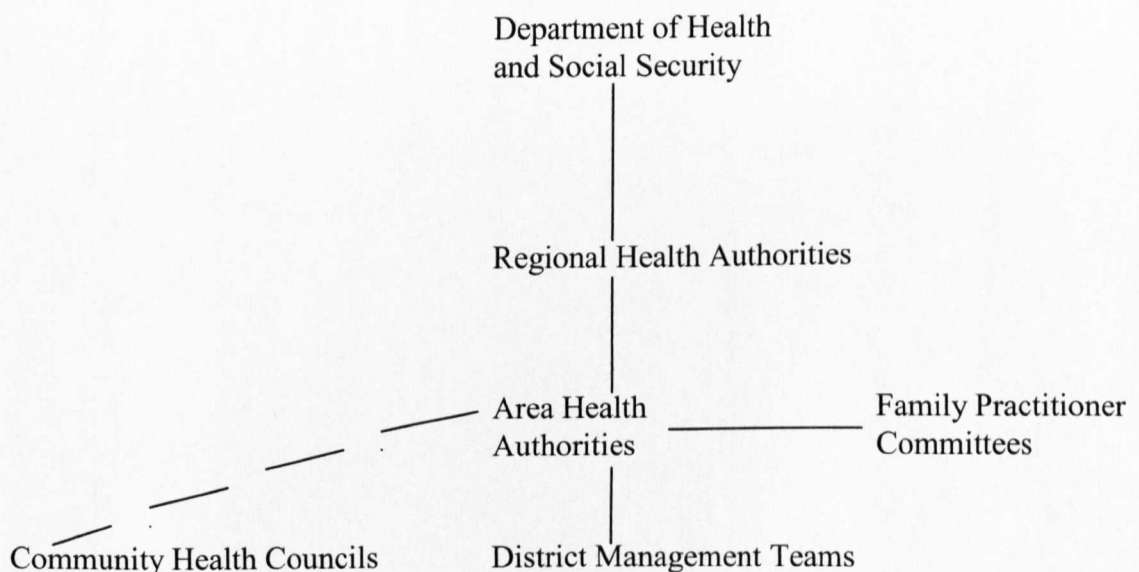
\* Superseded in 1968 by the Department of Health and Social Security

(Ham, 1999, p. 13; Baggott, 1998, p. 95)

Since then, a comprehensive system of consultant and specialist services has developed. Later, the Ministry of Health was combined with the Ministry of Social Security in 1968 to form a new Department of Health and Social Security (DHSS). Apart from the benefits brought to citizens from the NHS, a problem emerged in association with resource constraints. These led to a subsequent reorganization of the NHS in 1974 in order to try new ways to improve efficiency. Under the 1974 reorganization, local health services were integrated into the regional structure. For example, the RHBs were reconstituted as regional health authorities (RHAs) which were responsible for hospital and community health services (HCHS). The new structure of

area health authorities (AHAs) was established. These 40 AHAs were treated as local statutory tiers. Alongside each AHA was a Family Practitioner Committee (FPC) which handled the contracts of GPs, dentists, pharmacists and opticians. The lower tier in the service was the health districts, each of which was administered by a district management team (DMT). Community Health Councils (CHCs) represented the views of the public. The reorganized National Health Service from 1974 is shown in Figure Eleven:

Figure Eleven: The Reorganized National Health Service in 1974-82 in England

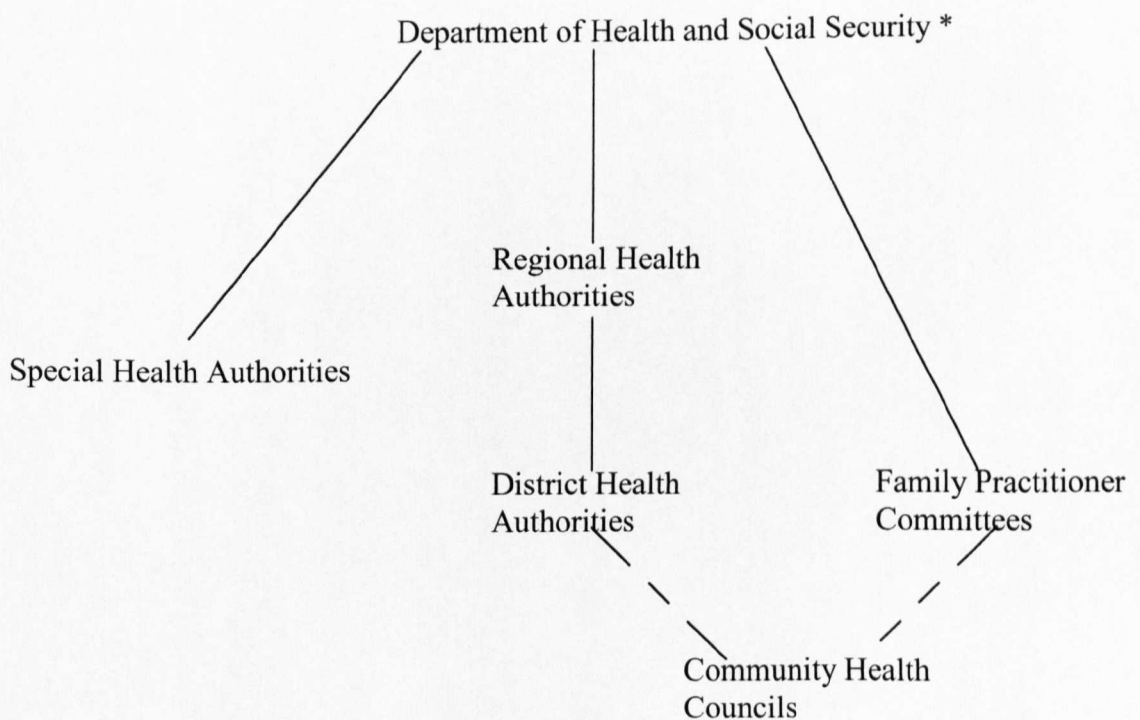


(Ham, 1999, p. 20)

Thatcher's Conservative government of 1979 marked a new era in the political history of the UK, as a 'watershed' (Baggott, 1998). Facing serious policy crises such as the Falklands and economic difficulties, Thatcher attempted to transfer many different aspects of the welfare state, influenced by 'New Right Ideology' and 'New Public Management' (Baggott, 1998; Hood, 1991). The health service was one target of these

various reforms. In 1982, the area tier of AHAs was abolished while districts were upgraded into district health authorities (DHAs). Another milestone happened in 1983 when Roy Griffiths, the business executive, gave his report on NHS which led to the introduction of general management in the NHS. In 1988, Griffiths led another investigation into community care. In the same year, the DHSS was split into the Department of Health and the Department of Social Security, with Kenneth Clarke as the first Secretary for Health. The organization of the National Health Service 1982-1991 is shown in Figure Twelve.

Figure Twelve: The Organization of the National Health Service 1982-1991



\* The DHSS became the Department of Health in 1998

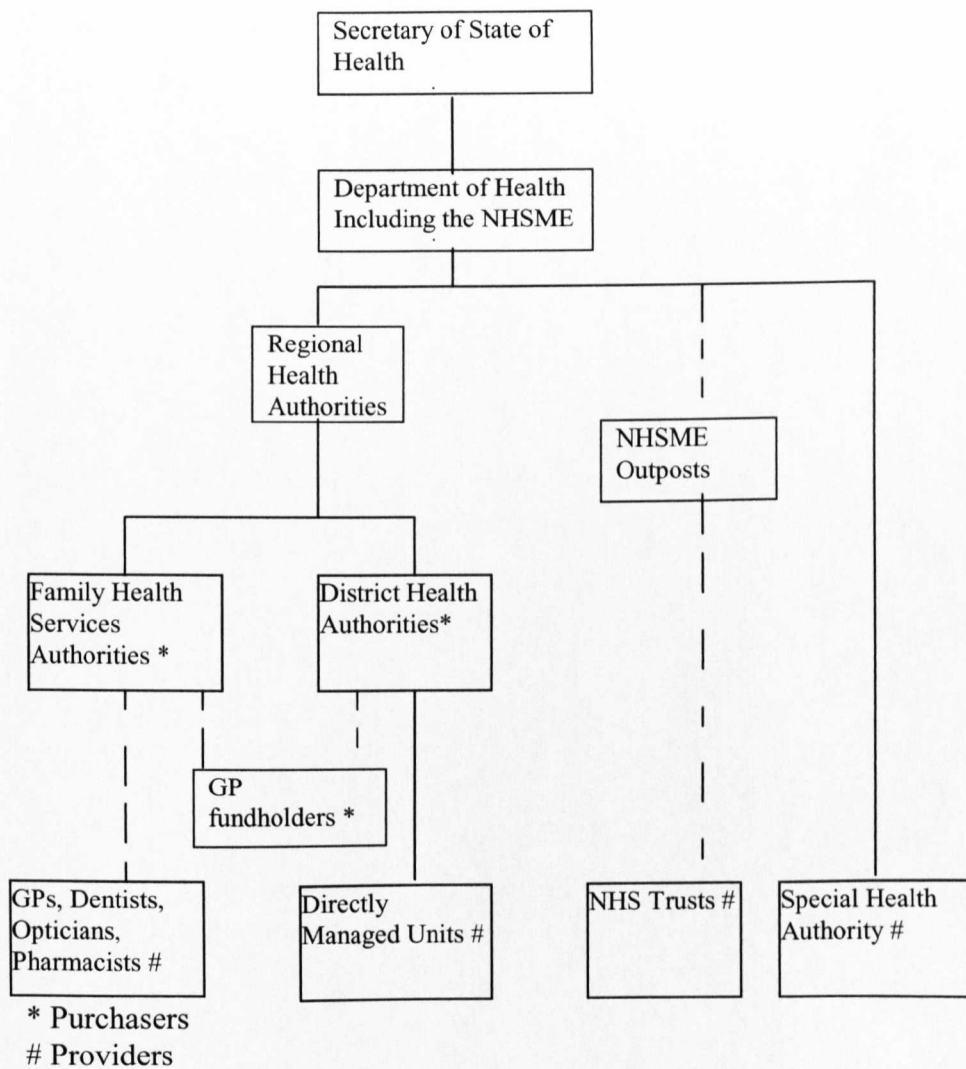
(Ham, 1999, p.24)

The white paper *Working for Patients* marked another major policy development (Department of Health, 1989a). This was enacted in the *NHS and Community Care Act* of April 1990, which introduced the internal market into health care with a purchaser and provider split. Hospitals and community services providers were encouraged to apply for 'Trust' status and to compete for resources in an internal market. This concept of internal market had been advocated by American Alain Enthoven in 1985 and was taken up by the Thatcher government. GP fundholders were set up to act as purchasers on behalf of patients if their general practice was large enough to have initially at least 11,000 patients on the list. In this sense, the NHS was trying to mimic the characteristics of the competitive market that could create greater efficiency. Between, the purchasers and providers were linked by 'contracts'. Hence, information such as the cost, volume and quality standard could be specified within the contract. The implementation of the setting up of NHS Trusts and GP fundholders was phased over years instead of a sudden change. The White Paper also introduced other key ways to achieve the Government's objectives, including the delegation of power and responsibility to local levels in determining pay and conditions of staff. Some financial and administrative barriers were removed to enable patients to travel to other NHS hospitals. More rigorous auditing and value for money activities were introduced throughout the service. The details of all major changes were published in a series of working papers shortly after the White Paper (Department of Health, 1989c). A new central management structure was set up with NHS Policy Board and the NHS Management Executive (NHSME) (later the NHS Executive, NHSE), plus eight regional offices. The NHS Management Executive was charged with the responsibility for overseeing the implementation of the reform on behalf of ministers (Ham, 1999, p. 41). A number of so-called 'NHS outposts' were



established to oversee the performance of the NHS trusts. The structure of the NHS in England from 1991-96 is shown in Figure Thirteen:

Figure Thirteen: The National Health Service in England, 1991-96

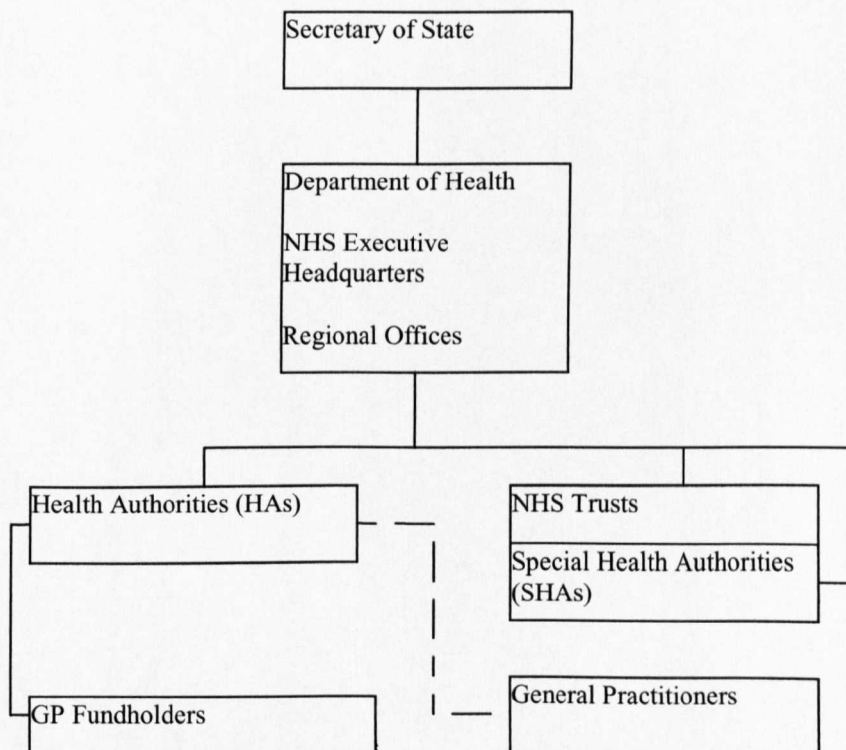


(Ham, 1999, p. 40)

John Major came into office in 1990 as leader of the Conservative government. Ham (1999) argued that the declared purpose of the white paper *Working for Patients* was to improve services to patients. Following the Griffiths report on general management which aimed to put the customer into a paramount position, Mr. Major

maintained a commitment to patients with the publication of the *Patient's Charter* in 1991 which set out a range of rights and responsibilities (Department of Health, 1991a). In 1992, an examination of the roles of RHAs and NHS Management Executive regional outposts in England was started, which in turn led to a comprehensive assessment of management arrangements at all levels. As a result, the NHS structure was streamlined by merging the functions of RHAs and the regional outposts in eight regional offices into the renamed NHS Executive. Moreover, the roles of DHAs and FHSAs were combined in unified health authorities to save costs by increased management efficiency. Therefore, a more centralised structure emerged and is shown in Figure Fourteen.

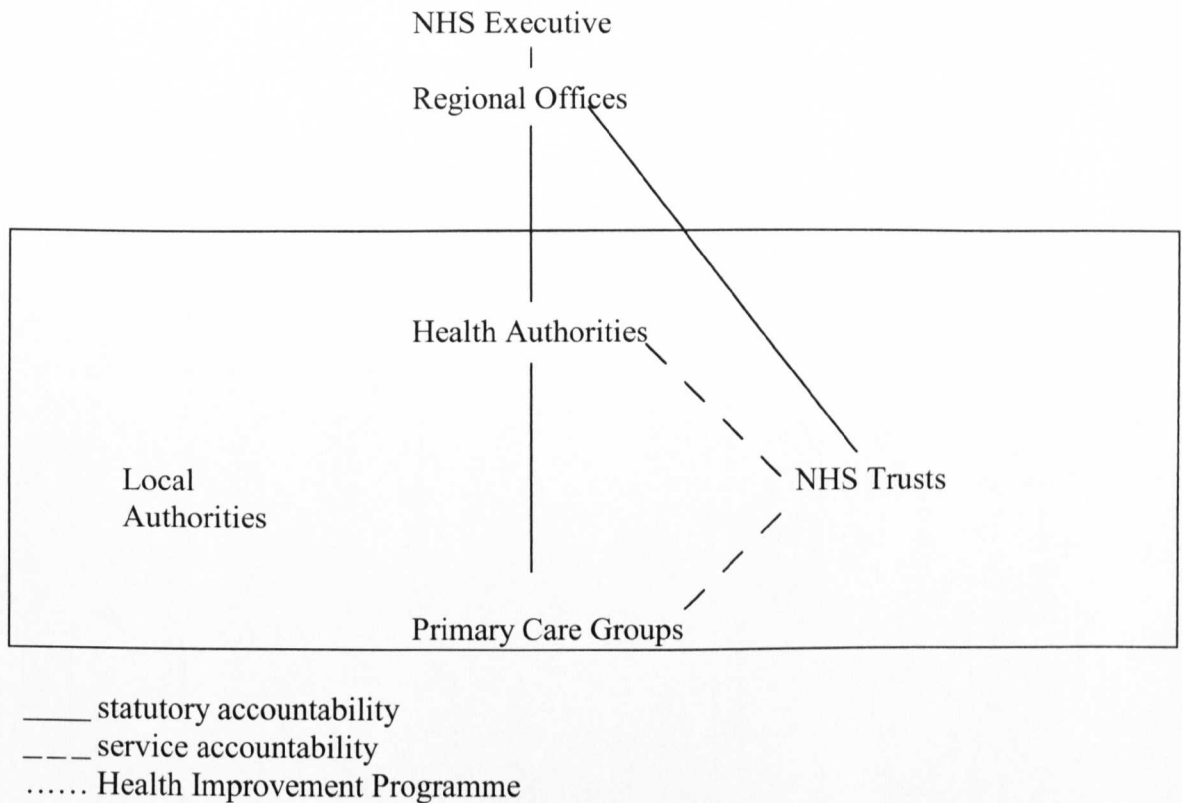
Figure Fourteen: The Structure of the NHS in England, 1996-99



(Ham, 1999, p. 47)

Tony Blair, the leader of the Labour party won the election of May 1997, marking the end of 18 years of Conservative government under Margaret Thatcher and John Major. The New Labour government of 1997 was not satisfied with the Conservative reforms of the NHS. Prime Minister Blair, assured 'a receptive electorate that Labour would rescue the NHS from the depredations of the internal market' (Webster, 1998, p.205). A white paper, *The new NHS – Modern • Dependable* was presented to Parliament early in the administration (Secretary of State for Health, 1997). The Labour government abolished the internal market and replaced GP fundholding with primary care groups (PCGs) (Fatchett, 1998). Health authorities were at the heart of the reorganization. They were to provide strategic leadership at a local level with a particular focus on developing health improvement programmes (HimPs) in conjunction with other NHS bodies, local authorities and other partner organizations. A 'Third way' of running the NHS based on partnership and driven by performance was proposed. The NHS structure was again modified and shown in Figure Fifteen:

Figure Fifteen: The Structure of the new NHS 1997



(Secretary of State for Health, 1997, p. 21)

A further policy paper *The NHS Plan: A plan for investment, a plan for reform* was presented to parliament (Secretary of State for Health, 2000). This *Plan* included a commitment to investing in the NHS with sustained increases in funding. The significant boost will raise the percentage of GDP spent on health care from 7 percent in 1999 to 7.6 percent in 2004 which is near the European average of 8 percent (Dixon, 2001). Regarding patients, the *Plan* will give some new rights to patients over the way the NHS works by setting out commitments that:

- letters about an individual patient's care will be copied to the patient;
- patients' views on local health services will help decide how much cash they get;

- patient advocates will be available in every hospital;
- if operations are cancelled on the day they are due to take place the patient will be able to choose another date within 28 days or the hospital will pay for it to be carried out at another hospital of the patient's choosing;
- patients' surveys and forums will be used to help services become more patient-centred.

(Secretary of State for Health, 2000, p. 6)

In addition, waiting times for treatment will be cut when extra staff are recruited as stated:

- by 2004 patients will be able to have a GP appointment within 48 hours and there will be up to 1,000 specialist GPs taking referrals from fellow GPs;
- long waits in accident and emergency departments will be ended;
- by the end of 2005 the maximum waiting time for an outpatient appointment will be three months and for inpatients, six months.

(Secretary of State for Health, 2000, p. 7)

Before the 2001 general election, different political parties announced their election manifestos. Labour set out New Labour's manifesto to transform Britain in the first decade of the 21<sup>st</sup> Century. Ten important goals for 2010 were introduced within the manifesto and included health relevant goal as follows:

- a healthier nation with fast treatment, free at the point of use;

(Labour Party, 2001)

Five pledges were launched on 9 May 2001 by Labour Party for the next five years in a 'card' for distribution to the public. The five pledges included economic pledge, schools pledge, health pledge, crime pledge and families pledge. It was stated that 20,000 extra nurses and 10,000 extra doctors will be employed in a reformed NHS of the health pledge. The victory of an historical second term of the Labour government led by Blair marked the continuation of the policy of the reform of public services. Regarding health, the Government will decentralize in a series of steps in the 10 year plan to reform the National Health Service. A new system of regulation of the health professions will aim to put patients first. There will be devolved power from the NHS to Primary Care Trusts, together with 75 per cent of the NHS budget by 2004 (The Queen's Speech, 2001). The self-declared values of the Labour Party are social justice, strong community and strong values, reward for hard work, decency, rights matched by responsibilities. Overall, the history of the NHS has been characterized by reforms especially when there are changes in leadership and government. However, the principles of the NHS have largely been kept intact since the start of the 'national' health services in 1948. This understanding of the background changes in structures will facilitate the analysis of the implementation of charter.

#### 4.3 *Patient's Charter and the Citizen's Charter*

The *Patient's Charter* (Department of Health, 1991a) was launched nationally in England in 1991 with a promise that each household would receive a copy of the summary (Department of Health, 1991b) through its mailbox. The charter set out seven existing rights and three new rights were introduced after 1 April 1992. This initial charter also listed the nine national charter standards. It placed the *Citizen's Charter*

Initiative into the structure of the National Health Service. Before a detailed account of the implementation of English *Patient's Charter* and the *Citizen's Charter*, I review previous drive of charters in United Kingdom before the *Citizen's Charter* or the *Patient's Charter* were announced and the international movement towards patient's charters and patients' rights.

#### 4.3.1 Charters in Health Care before the *Patient's Charter*

The idea of using the label 'Charter' to highlight the commitment to particular services and the groups of clients was not new in the UK. As illustrated briefly in section 1.2.1, the council of the British Medical Association had written a comprehensive statement of the profession's views on the basic principles of health called *A Charter for Health* (Orr, 1946). The central idea included in the statement was that any national policy on health should be directed towards the satisfaction of human needs and the promotion of human welfare. It was believed that the opinions expressed within the charter would command the assent of the medical profession as a whole. In 1986, the Association of Community Health Councils for England and Wales published the *Patient's Charter: Guidelines for Good Practice* (ACHCEW, 1986) as a statement of principles and as a framework for further consideration of the rights and responsibilities of patients and health care provision. The charter emphasized that everyone should have the right to be treated as customers of the NHS. Seventeen points or rights were listed. Three out of the seventeen rights were already established as legal rights and are marked with an asterisk in Appendix six. The Association believed that the rights in its charter should underpin the organization of health services and provide a basis for running services in the interest of users. During the same year, the Labour

Party also prepared a proposal for improving services provided by the local family health service including GPs, district and community nurses, health visitors, through a *Charter for the Family Health Service* (Kinnock, 1986) to ensure that patients would have more information and more choice. There were twelve main points in the charter which is shown in Appendix Seven.

Sheldon (1994) has argued that the origin of the *Patient's Charter* could be traced back to May 1970 with the *Charter of the Hospital Patients*, produced by the Hospital Committee of the (then) European Economics Community. He went on to reveal the eight rights in the Hospital Committee of the European Community's 1979 Charter as newer version of the previous charter. It included eight rights: access to services; to consent or refusal of treatment; information on which to make decisions, full information in advance of the risks of treatment; protection of privacy, including the confidentiality of medical records; freedom to complain, have complaints investigated and information on outcome; respect of religious beliefs; and considerate care including counselling, accommodation and administration assistance as well as medical and nursing services.

Hogg (1994), on the other hand, listed some of the charters produced by voluntary organizations when campaigning in the 1980s. These included, for example, the *Charter for Children in Hospital* produced by the now Action for Sick Children in 1984 and *A Charter for Carers* produced by the Carers' Alliance in 1989. Other charters were also produced by further interest groups, including people with HIV, cancer, disabilities, mental health problems, chronic pain sufferers (Hogg, 1994). Upward (1994) also identified charters drawn by user groups such as *The Brighton Users*



*Charter* and *Black Community Care Charter*. However, Window on World Health (1998) argued that the first time patients' rights were raised was in 1947 at the Nuremburg Trials, which associated patients' rights and the right to refuse medical experimentation on human beings. This became the 'Nurembreg Code' within the field of medical ethics (Window on World Health, 1998).

#### 4.3.2 Patient's Charter and Charters in health in Other Countries

The *Patient's Charter* has not been confined to the United Kingdom. Further to the brief discussion of the international movement in section 1.2.1, a more detailed account of how different countries are doing will be presented in this section. The Hospital Authority of Hong Kong published its *Patients' Charter* in 1994 (Hospital Authority, 1994a) to explain the 'rights' and 'responsibilities' of a patient when he or she is using the services of any of the Hong Kong's public hospitals or institutions which are managed by the Hospital Authority. A summary version of this charter is included in Appendix Eleven. Inside the wards of the hospitals, in-house TV commercials are used to promote the *Patients' Charter* with the help from popular movie stars of Hong Kong. In addition, the Hong Kong Medical Association and the Consumer Council of Hong Kong jointly produced a leaflet *Patients' Rights & Responsibilities* for distribution in private hospitals and private clinics (HKMA, 1993). A talking magazine hotline was also set up for patients and carers to listen to pre-recorded information. Details are shown in Appendix Twelve. Another *Patients' rights and responsibilities* is being promoted by the Department of Health in Hong Kong as well and is shown in Appendix Thirteen (DoH, 2000). In another Asian country, Malaysia seems to be rather in advance of the charter movement as both its *Patients*

*Charters* and *HIV/AIDS Charter for Doctors* are also available from the web (MMA, 1997; 1998). In Australia, the federal government has also publicized the *Public Patients Hospital Charter* as well. The charter states that Australian public hospital patients can expect:

- to be given a choice to receive public hospital services free of charge as a public patient;
- to receive treatment on the basis of clinical need regardless of financial or health insurance status;
- to have access to a basic range of public hospital services regardless of where the patients live in Australia;
- to be given a clear explanation of proposed treatment, including material risks and alternative treatment, before the patient agrees to treatment;
- to seek a second medical opinion (where possible);
- to give consent (except in exceptional circumstances) before a procedure is carried out, including consent to participation in medical research;
- to have access to their own medical records and to know that hospital staff have a general obligation to keep identifying personal information confidential;
- to be treated with respect, dignity and consideration for privacy;
- to be given information about their continuing health care before they are discharged from hospital;
- comment on or complain about their health care and to be given information on how to make a complaint to the appropriate Body in their State or Territory.

(see HSA of NSW, 1994)

Calnan (1995) reviewed other European experiences in an attempt to take into account of citizens' views on health care, finding a *Charter of Patient's Rights* was being developed in Poland. He found Finland had gone a further step in defining the rights of patients by law. Regarding health care systems reform within the European context, the *Ljubljana Charter on Reforming Health Care* (WHO, 1996) was recommended to all member states of the World Health Organization in Europe. The purpose of this charter is to articulate a set of fundamental principles of what the health care system should be (BMJ, 1996). In Greece, there was also the evolution of health care reforms including the legislation to introduce rights for hospitalized patients, based on the *European Charter of Patient's Rights* (Tragakes and Polyzos, 1998). According to the World Health Organization, 43 European countries have yet to enact laws on patients' rights. Since the WHO's *Declaration on the Promotion of Patient's Rights in Europe* in 1994 (WHO, 1994), more than eight countries have enacted laws on the rights of patients and four other countries including France, Ireland, Portugal and the United Kingdom have used a patient's charter as a tool to promote patient's rights (WHO, 2000).

In other continents, South Africa is laying down the draft of a *Rights Charter* for patients to set out entitlements in terms of health care (Jones, 1999). It is treated as a part of a national strategy to improve the quality of health services at all level of care, as well as being in line with the Government's endeavour to instill a culture of human rights in the country. Both rights and responsibilities are proposed. The rights include the following:

1. A healthy and safe environment;

2. Access to health care;
3. Confidentiality and privacy;
4. Informed consent;
5. Be referred for a second opinion;
6. Exercise choice in health care;
7. Continuity of care;
8. Complain;
9. Participate in decision-making that affects his/her care;
10. Be treated by a named health care provider;
11. Refuse treatment;
12. Knowledge of their health insurance/medical aid scheme policies
13. Right to emergency care

The responsibilities include the following:

1. Take care of his or her life and live in a healthy environment;
2. Care for and protect the environment;
3. Respect the rights of other patients and health providers;
4. Utilize the health system optimally without abuse;
5. Get to know his or her local health services and what they offer;
6. Provide health care workers with relevant and accurate information for diagnostic, treatment, rehabilitating or counseling purposes;
7. Advise the health care providers on his or her wishes with regard to death;
8. Comply with the prescribed treatment and/or rehabilitation procedures;
9. Ask what the related costs of the treatment and/or rehabilitation would be and arrange for the payment;
10. Take care of his or her own health records.

As we can see, different countries around the globe are interested in incorporating patient's charter initiatives for their health services. They have some common points such as the right to complain and to have informed consent. The international patient's rights movement is highly supported by the Consumers International. Consumers International is an independent, non-profit organization founded in 1960 as the International Organization of Consumer Unions (IOCU) by a group of national consumer organizations which recognized that they could build upon their individual strengths by working across national borders. Its head quarters is based in London and it is represented by several regional offices. Currently, it has a membership of more than 260 organizations in almost 120 countries. It strives to promote a fairer society through defending consumers' rights, including poor, marginalized and disadvantaged people by supporting and strengthening member organizations and the consumer movement. Campaigns are organized at the international level for policies which respect consumer concerns. The coverage includes different areas of being a consumer. For example, Consumers International has prepared a *Customer Charter for Global Business* which sets out best business practice in areas of interest to consumers such as ethical standards, competition, production standards, marketing, labeling, disclosure of information and consumer redress (Consumers International, 1997). Regarding patients' rights and quality of health care, Consumers International has developed a guide for patients and consumer activists (Consumers International, 1999a). This guide is designed to help organizations to discuss the issues surrounding patients' rights. Efforts are being made in many countries to develop a more balanced partnership between health care providers, doctors, nurses, pharmacists and

other workers and the people who use those services. This global campaign for the rights of patients helps countries to develop *Charters for Patients' Rights* to improve the relationship between health care providers and users (Consumers International, 1999b). Key issues are to be addressed in any declaration of patients' rights should include:

- the right to health care;
- access to information;
- choice;
- participation;
- respect for human dignity and right to humane care;
- the right to confidentiality;
- the right to redress for grievances

(Consumers International, 1999b)

Consumers International's regional office for Asia and the Pacific has done considerable work on patient's rights as well as information exchange between different members. Some description of the efforts made by different countries are highlighted by Consumers International (1999c). In India, the Consumer Action Group developed a draft charter of *Patient's Rights and Responsibilities* in 1993. In 1995, a citizen's charter scheme was developed which the Indian government intended to implement within the health sector. In South Korea, The Citizen's Alliance for Consumer Protection of Korea helped to develop a *Korean Patient's Charter*. In other countries, Israel's Palestinian Council for Health published a *Palestinian Charter for Patient's Rights*. In San Marino, a 1989 charter set out patient's rights and duties. In United States, various states have their bill of rights for hospital patients (Upward, 1994; Silver, 1997). Many Hospitals in

New Jersey had voluntarily adopted the *Patients' Bill of Rights* since the early 1970s. The American Hospital Association published the first document in America to express the rights of patients in hospital in 1973 as the *American Hospital Association Patient Bill of Rights*. This document had eventually influenced many states to develop their own distinctive patient rights bills (Silver, 1997).

#### 4.3.3 The Patient's Charter Initiative in England

The NHS reforms of 1989 and the *Citizen's Charter* both sought to extend patient choice, to secure best value for money and to put the needs of patients first. (Citizen's Charter, 1991a; Department of Health, 1989a). The *Citizen's Charter* was launched in 1991 aiming at improving public services and to make them more responsible to their users. The *Citizen's Charter* required national patient's charters in England, Scotland and Wales to be published. At the national level, the *Patient's Charter* (Department of Health, 1991a) was launched nationally in England on 30 October, 1991, by Mr. William Waldegrave, the Secretary of State for Health, setting out clearly for the first time the rights and standards that patients could expect from the National Health Service. Every household in England was sent a summary version of the charter (Department of Health, 1991b). This *Patient's Charter* set out the 'Rights' and 'Standards' which all patients were entitled to receive. The commitment to rights was guaranteed while the standards were those that the Government aimed to provide to the public, subject to resources and circumstances. The main content of the national *Patient's Charter* for England is set out in the following sub-headings and is shown in detail in Appendix Eight. It consists of seven well-established rights, three important

new rights for patients from 1 April, 1992 as well as national charter standards in nine key areas and local charter standards.

In a similar fashion, the *Patient's Charter for Scotland* was published on 24 September, 1991 together with a document which set out the detailed action plan for delivering the charter (Scottish Office, 1991a; 1991b; 1991c). The *Welsh Charter*, launched on 28 October, 1991 set out the Government's plans to improve the quality and range of health care services in Wales (Welsh Office, 1991).

The three published patient's charters for Scotland, Wales and England became important documents within the health services in Great Britain of the 1990s. All charters spelled out their commitment to the *Citizen's Charter*. As this research is concerned with the English *Patient's Charter*, I will confine my discussion to the national and local patient's charters. At the national level, the NHSME (later the NHSE) was responsible for the national charter including the main areas in which local standards of service which must be set, monitored and published on a consistent national basis. At local level, the Government believed that it would be more appropriate and accurate for other standards to be set locally. The *Citizen's Charter* required health authorities to produce charters specific to their own services. Each health authority's charter was to set out the main standards of service it had negotiated in its agreements with hospitals and others. As reiterated in the *Patient's Charter*, health authorities were required 'to develop and publish their own local charter standards from 1 April, 1992' (Department of Health, 1991a, p. 7).



What has then resulted since the initial phase of local charter initiatives in the NHS? Research by Carr-Hill and Ng to explore how local charters were being set up and implemented at local level revealed considerable variations. The distinction between rights and standards in the national charter was lost in many local charters. Furthermore, different charter documents were available in the same local area, from district, family health service authorities, trusts or even departments within trusts, which may give confusion to patients about which charters are relevant (Carr-Hill and Ng, 1992; Ng, 1992). Later on in September 1995, the Citizen's Charter Unit and the NHSE Patient's Charter Unit sponsored a workshop at the Health Services Management Centre of the University of Birmingham on involving users in developing local charters. After the workshop, a set of draft guidelines was developed and was published by the NHS Executive (NHSE, 1995a). This document listed reasons to have a local charter, how to get started, ways to involve users, methods to measure and monitor charters, and the strategies to disseminate charters. There should be stages in a continual process of dialogue with users about the kind of service they need. The dynamic process of setting the standards in the local charter would fit this approach.

The first version of the 1991 *Patient's Charter* required a named nurse, midwife or health visitor to be responsible for each patient. Many queries, criticisms as well as support were received from staff of the NHS (see Cole and Linda, 1992; Wright, 1992; Cole, 1993; Jack, 1995; Savage, 1995; Wright, 1995). The Patient's Charter Group then produced leaflets called *The Named Nurse: Your questions answered* and *The Named Midwife: Your questions answered* to answer common questions aroused in the implementation of the initiative (NHS, 1992a; NHS, 1992b). For example, questions such as how many patients should each named nurse to look after were addressed.

Another 21 page publication entitled *The Named Nurse, Midwife and Health Visitor* was disseminated to NHS organizations (Department of Health, 1993a). This document was the result of many people's experience gained during the developing phase of implementing the 'named nurse, midwife and health visitors' patient's charter standard. It provided principles and practice to implement the standard rather than a coercive top-down manner. Nurses were seen as having a vital role to act as patients' advocate. A 124 page publication with the same title of *The Named Nurse, Midwife and Health Visitor* was published by the Patient's Charter Unit in 1993 as well (NHS, 1993b). This book collected good practices in named nursing across a wide range of specialities. One year later, the Patient's Charter Unit produced a booklet *The Named Nurse, Midwife and Health Visitor – Checking that it happens* as part of its approach to monitor this standard (NHSE, 1994). This booklet was published after the workshops held by NHS Executive to harness good ideas practiced in the National Health Service for implementing and monitoring the standards. Questions were asked about the problems associated with implementation and the way how to measure the successfulness of implementing the charter standard. For example, one of the workshop delegates argued that:

... implementation will often depend upon the commitment of the ward sister/charge nurse. This means that, within the same hospital, some wards have fully implemented the standard and others not. This is neither good policy nor good public relations for any organization (NHSE, 1994, p. 10)

Ranade (1997) commented the initial public reception of the charter as 'qualified'. Apart from the estimated cost of GBP 1.4 million to send each household a copy of the charter, ministers and the NHSME took the implementation seriously and

kept up the pressure on health authorities. Extra finance was injected to meet the two-year waiting list target. Regional Health Authorities were instructed 'to give its achievement high priority' (Ranade, 1997, p. 153). Apart from rights and standards, the adoption of Charter Mark was an important element in the 1991 *Patient's Charter*. It stated that NHS would play a full part in the Charter Mark scheme when it was launched. The administration of the Charter Mark award scheme was managed by the Citizen's Charter Unit. This Charter Unit was set up to oversee the running of the citizen's charter programme. It has a number of mechanisms to make sure that public service managers are aware of, and implement, the charter programme as well as for users to contribute their opinions. These include Charter Quality Networks, *Charter News Bulletin*, and People's Panel to consult members of the public on their attitudes to public services and generate ideas about how they can be improved (Citizen's Charter, 1998).

In November 1992, the government launched its framework for the development of a patient's charter in primary health care. The *Patient's Charter and the family doctor services* was published in March 1993 (Department of Health, 1993b). This leaflet gave information about basic rights to general medical services and the standards of service which patients could expect to receive from their Family Health Services Authority as shown in Appendix Nine. From April 1993, all FHSAs were to publish their own local patient's charters, setting out the standards of service patients could expect. FHSAs were asked by the NHSME to concentrate on developing relevant standards such as moving patients' records efficiently and quickly from one surgery to another (Edwards, 1995). Although local primary care charters were voluntary, the national target was set for 60 per cent of practices to have one in place by March 1995. Performance at 1995

had already exceeded the target and reached 68 per cent with another 9 per cent in the process of developing the charter. This percentage increased to 78% by March 1996. In addition, this type of statistics of percentage of GP charters was treated as a new indicator in the NHS performance table (Citizen's Charter, 1995; Martin and Spiegel, 1995; NHSE, 1996a). In 1993, the Patient's Charter Group collected samples of good practice guide from existing NHS organizations about their arrangement of implementation and monitoring of standards (NHS, 1993a).

The charter became a dynamic document. A new 'improved' national patient's charter for England *The Patient's Charter & You* was launched in 1995 (Department of Health, 1995b). The major content is shown in Appendix Ten. New standards were added with existing standards raised. This updated patient's charter differentiates between 'rights' and 'expectations' instead of 'rights' and 'standards' in the 1991 version. In the 1995 version, 'rights' refer to those which all patients will receive all the time and 'expectations' are standards of service which the NHS is aiming to achieve. Exceptional circumstances may sometimes prevent these standards being met. The content of the charter covers the following sections, including 'rights and standards throughout the NHS', 'GP services', 'hospital services', 'community services', 'ambulance services', 'mental, optical and pharmaceutical services', 'maternity services' and 'hearing from you' sections. This charter required a new maximum waiting time guarantee of 18 months.

Caan (1996) observed that the Secretary of State for Health intended to develop a new patient's charter for mental health. By early 1997, a booklet called the *Mental Health Services Patient's Charter* was launched by the Department of Health and set out

a number of new and improved standards for adult mental health patients with effect from 1 April 1997 (Department of Health, 1997). In maternity services, a *Maternity Charter* was available from GP's surgeries, Community Health Councils, FHSA and so on (Department of Health, 1996b). The minister also announced the publishing of a booklet called *Patient's Charter: services for children and young people* targeted at children and young people (Department of Health, 1995c). These draft charter standards were published since August 1995 to gain feedback from health service staff, parents and children. Afterwards, the full charter for children was widely available at NHS outlets and from the Health Literature Line by freephone (Department of Health, 1996a). This charter describes the rights and standards that apply in particular to children's care. A poster is inserted together with the booklet for children and young people explaining rights and standards from their point of view. Another national charter for long term care clients and their carers was introduced in 1999 as *Better Care, Higher Standards: A Charter for long term care* (Department of Health, 1999). This particular charter is for anyone in England who is 18 or over and has difficulties associated with old age, long-term illness or disability and the carers who support people in these circumstances. This national charter also required the publication of local charters by June 2001.

The main charter *The Patient's Charter & You* was available in different languages such as Bengali, Gujarati, Hindi, Punjabi, Urdu, Chinese, Vietnamese, Greek, Turkish, Somali and Polish. For people who are blind, partially sighted and deaf, the *Patient's Charter* was also available in audio cassette, Braille, large print and sign language video. This is unique among the different charters in the UK. A national Health Information Service with a freephone number was available to the public asking for information on any NHS services, especially in relation to patient's charter. A

Patient's Charter Unit was also set up in the NHS Executive headquarters based in Leeds since the launch of *Patient's Charter* to oversee the development and implementation of the charter under the Human Resources and Corporate Affairs directorates in the NHSE (IHSM, 1996). A newsletter *Patient's Charter News* was published regularly for NHS organizations. For example, the 19<sup>th</sup> issue on March 1995 reported the launch of the New patient's charter by Virginia Bottomley, Secretary of State for Health. She claimed:

The whole point of the citizen's charter initiative is that public services should react to the needs and wishes of their users. In line with that approach we asked for public feedback on the charter. The new charter is the product of intensive consultation with the Service, patients, consumer groups and the public. We will continue to welcome suggestions for further improvements (NHSE, 1995b, p.1)

The Newsletter was used to disseminate good practice of local hospitals/Trusts as well as discussion of issues around privacy and dignity. Pinderfields and Pontefract Hospitals NHS Trust, for example, had considered privacy and dignity good practice and had conducted a privacy and dignity audit. A number of recommendations were made to improve the standard on single-sex accommodation, such as the provision of curtains to draw across glass partitions, and the choice to discuss personal information with health and other professionals either at bedside or in an interview/examination room (NHSE, 1997a).

The New Labour government believed that the 1995 version of the *Patient's Charter* focused too much on patients' rights and on easily measured administrative targets. It argued people are now more aware of their rights while some staff are defensive. The government claimed that the charter has had an impact on staff

throughout the NHS to tune the culture to make the delivery of quality services a key objective (NHSE, 1997a). In its manifesto, the Labour Party (1997) set out a commitment to introduce a new patient's charter concentrating on the quality and success of treatment. At that period of time, the King's Fund was planning a piece of research on the charter in the spring of 1997. Eventually, it was commissioned by the NHS Executive to carry out the research in the summer of that year. Its research findings were presented to the Government's Advisory Group on the *Patient's Charter*, chaired by Mr. Greg Dyke, in February 1998. The chief executive and chairman of Pearson Television, Greg Dyke, had been asked to lead a team to develop a new *NHS Charter*. Mr. Dyke had been a TV researcher and producer, providing him with a background in asking people questions and trying to understand. He is also a Labour Party supporter. The job of Mr. Dyke was to produce a meaningful report and over nine months or so, he consulted widely and visited many sites. As Alderman (1998) indicated, Mr. Dyke highlighted some problems with the existing charter as he found some staff saw it as an imposition, or as some political weapon and viewed as not particularly effective. He was also made aware of the morale problem, particularly among nurses. As Mr. Dyke argued:

The staff saw it as giving rights to people to bash them with. It gave people rights to things that aren't rights at all. One of the things we're going to do is to sort out what are rights and what are aspirations. There are nothing wrong with having aspirations but don't call them rights

(Alderman, 1998, p. 25)

The former health secretary Frank Dobson announced the development of a new charter which should emphasize a balance of the rights of patients and their responsibilities. Mr. Dyke was asked to develop proposals for the content, style and

format of this new *NHS Charter* to replace the old *Patient's Charter*. His report on the new *NHS Charter* was published in November 1998 (Dyke, 1998). According to Dyke (1998, p.5), the aims of the new charter should be:

- to explain to the patients the standards of care they can expect from the NHS and for this to be effectively monitored;
- to give the patient information to enable her or him to become a partner in determining the type of care and treatment they receive;
- to empower patients to be more explicit about their views of the service they receive including a clear explanation of means of redress;
- to improve levels of communication throughout the NHS.

Mr. Dyke recommended a different concept of charter with a shift of emphasis to a more localized approach. Three distinct elements are contained within his charter package. The first one is the NHS value statements which act as guiding principles underpinning the services. Five NHS value statements were proposed as shown in Table Eight:



Table Eight: NHS Value Statement

THE NHS – OUR COMMITMENT TO YOU

We want the NHS to be a health service of the highest quality and these are our aims:

FAIRNESS

We want to treat you fairly, according to your medical needs, regardless of your income, age, ethnic origin, religion, gender or where you live.

EXCELLENCE

We want to give you the best available service as quickly as we can and at times that suit you. The treatment you receive will be based on standards set nationally by the NHS and patients together.

PARTNERSHIP

We want you to work with us to deliver the best possible treatment and care. We want to learn how to improve our service and we really value what you think so please tell us – good or bad.

COMMUNICATION

We want to provide you with information that helps you make decisions about your own health care. We want to do this in a friendly, understanding and helpful way.

OUR STAFF

The NHS is the largest employer in Britain and we expect a lot from our staff, but we want them to feel valued and appreciated. Even at difficult times they are trying to do their best for you so please treat them with dignity and respect.

(Dyke, 1998, p. 14)

The second element is the development of local charters. Mr. Dyke and his group proposed that there should be local charters throughout the NHS including

hospitals, community trusts and primary care groups. The existing national version of *Patient's Charter* should be replaced by a statement of national minimum standards in those key areas, for example, the maximum waiting times or cancelled operations. The third element is the disease specific user guide. This series of 'disease specific' NHS user guides was conceived of as helping patients with a specific condition to understand the current treatment regimes available to them and make decisions based upon this information.

During the review of the charter, Mr. Dyke was asked, in particular, about the issue of patient responsibilities which was deemed to be missing or ignored from the current charter. Two distinct areas were investigated, such as the high number of people not turning up for out-patient appointments. It was estimated that the annual cost of these 'Did not Attends' (DNA) was about 110 to 275 million pounds. Another area was the growing problem of violence against NHS staff, particularly in Accident and Emergency (A&E) departments. Apart from these proposed changes, Mr. Dyke recommended that there 'needs to be both a widespread consultation and then an effective "selling" process to the constituencies which make up the NHS, and in particular the staff' (Dyke, 1998, p. 43). He believed that this process should not be rushed in order for the implementation of the new charter despite the political desire to get something done quickly.

Going back to the research study of the *Patient's Charter* by the King's Fund, results were published in Farrell et al. (1998) and Farrell (1999). This research aimed to review the workings of the *Patient's Charter* from the point of view of patients, carers and NHS managers and clinicians. It also focused on the future for the development of

any new NHS charter. The findings from this research were fed into the advisory group led by Greg Dyke. Problems were identified as well as some positive impacts raising awareness of patients' rights and the shift of the NHS culture towards a patient-centred approach. These common problems were identified such as:

- Top down, imposed, little staff ownership;
- Patients not involved in development of charter – it didn't address their concerns;
- Muddled rights and aspirations, no effective redress;
- Rights without responsibilities, engendered blame culture;
- Measured what was easily measurable, not what was most important;
- Encouraged health care providers to cheat;
- Did not measure clinical outcome or quality of care;
- Competition discouraged sharing of best practice;
- Many patients still unaware of rights.

(Farrell et al., 1998; Farrell 1999; Coulter, 1999)

On the basis of the research evidence collected, Farrell indicated the kinds of items people would like to see within the new *NHS Charter*. For example, there should be involvement of patients, carers and staff in local charter developments. On the other hand, equal attention should be given to primary, community and hospital services. The new *NHS Charter* is 'the only tool for quality improvement to which the public will have direct access and through which they can influence change in directions which meets their needs' (Farrell, 1999, p. 133). In terms of quality improvements, references have to be made to the several policy documents, including:

- the white paper, *The New NHS: Modern – Dependable* (Secretary of State for Health, 1997)
- the green paper, *Our Healthier Nation: A Contract for Health* (NHSE, 1998a)
- the consultative document, *A National Framework for Assessing Performance* (NHSE, 1998b)
- the consultative document, *A First Class Service: Quality in the New NHS* (Department of Health, 1998)

New initiatives were suggested from these policy documents such as National Institute of Clinical Excellence (NICE), clinical governance, NHS Direct to pursue quality improvements in addition to the *Patient's Charter*. The NHS celebrated its 50<sup>th</sup> anniversary (1948-1998) in 1998. Despite the King's Fund research and the Dyke's report, no response was given from the government in terms of the future of the new NHS charter. During the winter of 1999-2000, obvious difficulties were witnessed in the NHS because of the outbreak of influenza and the shortage of staff. These were made worse when Lord Winston, a Labour peer and high-profile doctor, complained publicly about the treatment received by his 86-year-old mother from the NHS as well as making unfavorable comparisons between health care in Poland and Britain (Dixon, 2001). The government also decided to inject more funding to the NHS and the NHS Plan was duly published in late July 2000 (Secretary of State for Health, 2000). The creator of the internal market, Alain Enthoven, has assessed the future prospects of the NHS with regard to the NHS Plan (Enthoven, 2001). He argued that NHS will be making history in the fields of public management and quality management if it can motivate and sustain continuous quality improvement in a public-sector monopoly. However, he claimed that the odds of success were not so high. Therefore, continuous searching of new

alternatives should be explored including the new *NHS Charter* to facilitate continuous quality improvement in the *NHS Plan*.

What is more radical within the NHS Plan is the package of radical reform to redesign the health service from the patient's point of view. Although the government is committed to the 'patient-centred' approach, it proposed the abolition of Community Health Councils (CHCs) to be replaced by new structures of a Patient Advocacy and Liaison Service (PALS), Patients' Forums and Citizens' Forums. This created serious concern throughout the sector. CHCs were created in 1974 by the Secretary of State for Health, Richard Crossman, in each of the 229 health districts in England and Wales as independent voice for patients in the NHS (Allsop and Mulcahy, 1996a). Although resources to CHCs have been limited, they deal with over 30,000 complaints a year (Burke, 2000). The role of CHCs is to keep the operation of the local NHS under review and to recommend improvements. CHCs have the right to visit most NHS premises and have access to limited information from trusts and purchasers. In addition, CHCs act as a source of information and advice to the public, especially for those with special needs. Of course, local patient's charters are available and disseminated at the local CHCs. Patients and their carers can ask for advice and information about the *Patient's Charter* in their localities. Despite the representation of patients and their carers, CHCs are to close. Opposition was raised by some MPs over their abolition during the passage of the Health and Social Care Bill. However, the *Health Service Journal* reported that the Labour government in its second term would introduce early legislation to axe community health councils (Health Service Journal, 2001a). Patient Advocacy and Liaison Services are being established in every NHS Trust including Primary Care Trust, beginning in major hospitals. These are taking over the advisory and supportive

role of CHCs in dealing with concerns and complaints about health services. PALS have direct access to the Trust's Chief Executive and the power to negotiate immediate solutions (NHS, 2001). Each Trust will also have a Patients' Forums, made up of patients and representatives from patient and voluntary organizations. Like the CHCs, they will have the right to visit and inspect any aspect of a Trust's work. The Forum will also elect one member to be a Non-Executive Director on the Trust board so as to put patients and their needs at the heart of decision-making. Citizens' Forums will also comprise local residents. They will be consulted about local health priorities and policies (McIver, 2000). Hence, the incorporation and dissemination of patients' rights are to be achieved.

After Dyke's report, health care organizations expected a new NHS charter. The revised patient's charter was originally due to be published in October 2000. However, it was delayed to early 2001. The *Health Service Journal* on 11<sup>th</sup> January 2001 claimed that the first draft as seen by the *Journal* had received apparently a cool reception (Health Service Journal, 2001b). It was sent out for consultation in September with just a week for responses. The draft of the new charter bore little resemblance to the old patient's charter. It emphasized patient's responsibilities as well as their rights. It also stated tips to better health. Two weeks later, the national *Patient's Charter* was eventually replaced by a *Guide* instead of using the label 'Charter' (News, 2001). Health Minister, Gisela Stuart launched *Your guide to the NHS* (Department of Health, 2001a) on 26 January 2001 as a replacement for the old style *Patient's Charter*. As Ms Stuart said:

We are meeting our manifesto pledge to replace the *Patient's Charter* with a clearer more useful guide for patients and the public. In the NHS Plan we reaffirmed that commitment. We are now fulfilling that commitment. *Your Guide to the NHS* explains how to get treatment, which services to access, where to get further information and sets out standards of service patients can expect now. Throughout the *Guide* we outline our vision and set out the direction of travel for improved standards.

(Department of Health, 2001b, p.1)

The press release continued:

The *Guide* also underlines the responsibilities which patients have towards the NHS. Well over a million appointments are missed each year where patients have not informed the clinic they were unable to attend. This means that patients who could have taken these appointment are waiting longer for no reason other than the thoughtlessness of someone else. People should realize that they too have a responsibility to the NHS – to look after the service that looks after them.

(Department of Health, 2001b, p. 2)

This *Guide* is different from the previous *A guide to the National Health Service* issued in May 1996 (NHSE, 1996b). The current *Your Guide to the NHS* has eight chapters which set out the 'NHS core principles'; 'Your commitment to the NHS'; 'How can I stay healthy?'; 'I am unwell...'; 'I have been referred to hospital for tests of treatment ...'; 'I need care and support'; 'What can I do if I have concerns or I want to complain?' and 'How can I get more information about the NHS?'. Roadmaps are used to tell patients and the public how to access the NHS, standards of care as outlined in the *NHS Plan*, including what patients can expect in the future, and what a person can do if they have concerns or want to complain in this 56 pages guide. Regarding the NHS' commitment, it underlines the main aims of the *NHS Plan* which reinforce the founding principles of the NHS. These help to raise patients' awareness of NHS services and makes clear what patients have a right to expect from the NHS. The *Guide* also underlines the responsibilities patients have towards the NHS. It reminds patients that they should keep their appointment or let someone know as soon as possible if they

cannot attend that appointment. They should return equipment when it is no longer needed, pay prescription and other charges promptly and treat NHS staff with respect. The 'roadmap' is a new indication to guide the patients how to get treatment. For example, those simply needing advice can contact NHS Direct or visit NHS Direct online or their local pharmacist. Regarding standards of care, the *Guide* stated that by 2004 no one should wait more than 4-hours in an accident and emergency department from arrival to admission, transfer and discharge. The average waiting times in accident and emergency will fall to 75 minutes. For other waiting times, patients can expect to wait no more than 26 weeks to attend an outpatient consultation. At the outpatient clinic, patients should be seen within 30 minutes of the appointment time. In the issues of privacy and dignity, single-sex hospital accommodation is offered. A new 24-hour NHS catering service with a new NHS menu will operate in all NHS hospitals from 2001. The *Guide* also indicates the future expectation, for example, the longest waiting time for a routine outpatient appointment will be three months and for inpatient treatment will be six months by 2005. Patients can also refer to the *Guide* for how to make a complaint if they are unhappy with any aspect of the care they receive. It also mentions the introduction of the new Patient Advocacy and Liaison Service (PALS) to all NHS and primary care by April 2002. An independent, statutory patients' forum will be set up in every Trust for patients to have their say in how local NHS services are run.

The *Guide* is widely available at health services premises as well as from the NHS website at <http://www.nhs.uk/nhsguide>. The booklet is published in languages including English, Arabic, Bengali, Cantonese, French, Greek, Gujarati, Hindi, Polish, Punjabi, Turkish, Urdu and Vietnamese. A Braille version and an audio cassette



recording are available as well. This arrangement is similar to the previous *Patient's Charter*.

Despite the change from 'Charter' to a 'Guide' in the NHS, the charter programme is still going on and so is the Charter Mark initiative. The NHS celebrated the Charter Mark 2001 award winner on 13<sup>th</sup> of February, 2001. A total of 84 NHS organizations were congratulated by health ministers John Hutton and Lord Hunt. As Hutton said:

The quality of this year winners is testament to the dedication of people working in the NHS today. The philosophy of never standing still, constantly reviewing services to meet the needs of patients to change and innovate is central to the success of today's winners. The Charter Mark recognizes this, and pays tribute to the hard work and determination of NHS staff.  
(Department of Health, 2001c, p. 1)

Indeed, the Labour Government has set up the New Charter Programme as 'Service First – the New Charter Programme'. A web site was set up and dedicated to this programme at <http://www.servicefirst.gov.uk>. 'Service First' is the new charter programme aiming to improve service delivery across the public sector since the launch of the citizen's charter programme in 1991. The Government says it is committed to modernizing public services that respond to the needs and wishes of people who use them on a daily basis (Service First, 1998). Since the Labour Government came to power in 1997, it has decided to review and consult in order to find out what can be done to improve the citizen's charter programme. As a result, it decided to rename the programme as 'Service First – the New Charter Programme' to better reflect the programme's emphasis on providing responsive public services to meet people's real needs. The programme is broader than its predecessor and encompass charters, Charter

Mark award, People's Panel and the Better Government for Older People Programme. It formed an integral part of the broader Better Government initiative in which the White Paper *Modernising Government* was launched by Tony Blair on 30 March 1999 (Blair, 1999). Within the White Paper, a series of new measures will be implemented by the Government to have a better and modernized Government. As reiterated in the White Paper, the Government have created 'Service First: the new Charter Programme' (The Stationery Office, 1999). The key themes of the 'Service First' programme have extended the previous principles of *Citizen's Charter* into new nine principles of public service delivery as shown in Table Nine:

Table Nine: Nine Principles of Public Service Delivery

<p><b>1. Set standards of service</b> Set clear standards of service that users can expect; monitor and review performance; and publish the results, following independent validation wherever possible.</p>
<p><b>2. Be open and provide full information</b> Be open and communicate clearly and effectively in plain language, to help people using public services: and provide full information about services, their cost and how well they perform.</p>
<p><b>3. Consult and involve</b> Consult and involve present and potential users of public services, as well as those who work in them; and use their views to improve the service provided.</p>
<p><b>4. Encourage access and the promotion of choice</b> Make services easily available to everyone who needs them, including using technology to the full, and offering choice wherever possible.</p>
<p><b>5. Treat all fairly</b> Treat all people fairly; respect their privacy and dignity; be helpful and courteous; and pay particular attention to those with special needs. (cont'd)</p>

<p><b>6. Put things right when they go wrong</b> Put things right quickly and effectively; learn from complaints; and have a clear, well publicized, and easy-to-use complaints procedure, with independent review wherever possible.</p>
<p><b>7. Use resources effectively</b> Use resources effectively to provide best value for taxpayers and users.</p>
<p><b>8. Innovative and improve</b> Always look for ways to improve the services and facilities offered.</p>
<p><b>9. Work with other providers</b> Work with other providers to ensure that services are simple to use, effective and co-ordinated, and deliver a better service to the user.</p>

(Service First, 1998, p.8)

Hence, this reflects the Government's vision of what every public service should be striving to achieve. These principles will guide the future development of public service charters. As mentioned previously, Charter Marks are awarded to public organizations who can meet the Charter Mark criteria. A Charter Mark web site was available at <http://www.chartermark.gov.uk> with information about the programme such as how to apply for the award. A supplementary guide for the NHS units was published to help the growing number of organizations within the NHS applying for a Charter Mark Award (Service First, 1999a). This complements the main Charter Mark guide for applicants which is published by the Service First Unit (Service First, 1999b). For example, evidence should be included to support applications with reference to ten Charter Mark Criteria. These ten criteria include the following:

Table Ten: Ten Charter Mark Criteria

**Criterion 1 – Set Standards**

Set clear standards of service that users can expect, and monitor and review performance and publish the results, following independent validation wherever possible.

**Criterion 2 – Be Open and Provide Full Information**

Be open, and communicate clearly and effectively in plain language to help people using public service, and provide full information about services, their cost and how well they perform.

**Criterion 3 – Consult and Involve**

Consult and involve present and potential users of public services as well as those who work in them; and use their views to improve the service provided.

**Criterion 4 – Encourage Access and the Promotion of Choice**

Make services easily available to everyone who needs them including using new technology to the full, offering choice wherever possible.

**Criterion 5 – Treat All Fairly**

Treat all people fairly, respect their privacy dignity, be helpful and courteous and pay particular attention to those with special needs.

**Criterion 6 – Putting Things Right when they Go Wrong**

Put things right quickly and effectively; learn from complaints, and have a clear, well published and easy to use complaints procedure, with independent review wherever possible.

**Criterion 7 – Use Resources Effectively**

Use resources effectively to provide best value for taxpayers and users.

**Criterion 8 – Innovate and Improve**

Always look for ways to improve the services and facilities offered, particularly the use of new technology.

**Criterion 9 – Work with Other Providers**

Work with other providers to ensure that services are simple to use, effective and coordinated, and deliver a better service to the user.

**Criterion 10 – User Satisfaction**

Show that your users are satisfied with the quality of service they are.

(Service First, 1999a)

These ten criteria are the first stage of the application process of the Charter Mark award. During this stage, the organization measures its service against the criteria

and makes an application. The application will be subject to expert scrutiny and may be visited by assessors in this second stage. Based on the evidence provided by the organization in the application, detailed feedback on how to improve the service further will be gained in the third stage. Results will be announced whether the award will be granted or not. Among the public services organizations, table eleven showed the figures of Charter Mark applications and winners by year:

Table Eleven: Charter Mark Application Success Rate and Winners by Year

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000
Success Rate	12.2%	22.6%	18.6%	30.3%	43.8%	38.5%	42.8%	68.1%	75.6%
Winners	36	93	98	224	323	365	514	1179	744

(Service First, 1999b, p. 4; Cabinet Office, 2001c, p. 2)

A newsletter has been published regularly since April 1999. In the latest, issue 8 *Modernising Government News*, reported the ceremony at Queen Elizabeth II Centre in London to award 744 organizations their Charter Mark for excellence. Ian McCartney, Cabinet Office Minister responsible for the Charter Mark Award Scheme, congratulate the recipients:

Charter Mark recognizes the efforts of front line staff who work on a daily basis to deliver first class services across the country. I congratulate them on their achievements and thanks them, on behalf of all of us, for championing public service.

(Cabinet Office, 2001b, p. 1)

The Charter Mark Award is currently held by over 2000 organizations compared with 36 holders in the first year of the scheme. A major consultation exercise to consider

the future development of the Charter Mark scheme was established with the publication of the consultation paper *Charter Mark Policy Development* (Cabinet Office, 2001c). Responses to the 39 questions were invited on or before 18<sup>th</sup> May 2001. As a result, NHS organizations can still participate in the Charter Mark programme despite the replacement of the *Patient's Charter* by the *Guide to the NHS*.

#### 4.4 Hong Kong Hospital Authority

##### 4.4.1 A Historical Review of Health Care System in Hong Kong

Similar to the National Health Service in UK, the public health care system in Hong Kong is a 'National' Health Service. Citizens are essentially covered by the protection of public health services under which no one should be denied adequate medical treatment through lack of means (Hospital Authority, 2001a). Access to affordable health care for all is the cornerstone of the government's health policy (Daryanani, 1994). The contemporary history of health services in Hong Kong is best represented as the pre- Hospital Authority era and the Hospital Authority era. A detailed account of the development of hospital and health care in Hong Kong can be found in Robin Hutcheon's book (Hutcheon, 1999). Nevertheless, some of the key issues and milestones are worth mentioning in this section so that readers are able to grasp the picture of the Hong Kong health care system and hence the development of patients' charter. Hutcheon reviewed the long history of Traditional Chinese Medicine as well as the opening of the first hospital in Hong Kong in 1887 for the treatment of Chinese people on European principles. This first hospital was made possible with the support by Dr. Ho Kai who graduated from medical school at Aberdeen University in Scotland and

eventually returned to Hong Kong to practice western medicine in 1880 (Hutcheon, 1999). The history of hospital services in Hong Kong was also characterized by the supplement of hospital provision run by voluntary and philanthropy groups, for example, the Tung Wah Group of Hospitals in addition to provision of the colonial government. These so called subvented (government assisted) hospitals existed together with two other types of hospitals, namely government hospitals and private hospitals in Hong Kong before 1991. These subvented hospitals were classified as public hospitals and constituted a large portion of hospital beds in Hong Kong in the late 1980s. Although subvented hospitals were technically non-government hospitals and owned by voluntary organizations, they were subject to both direct and indirect control from the government as well as receiving funding from the government.

Hong Kong was a colony of Britain until 30 June 1997 when the sovereignty was returned to China on 1 July 1997. In the 1950's, Hong Kong made a rapid recovery in this post-war period. The first local civil servant who became substantive Director of the Medical and Health Department was Dr. K.C. Yeo. He graduated in medicine from the University of Hong Kong and pursued his postgraduate training in tropical medicine and public health in Britain. The position of Directorship carried much weight in the senior ranks of Government in those days. Government policy in health and well-being in these early postwar years was summarized by historian George Endacott (quoted in Hutcheon, 1999, p.30) as providing medical facilities at low cost for those unable to afford the expense of consulting medical practitioners on their own account. This era also marked a major influx of refugees from China to Hong Kong. Most newcomers were living in huts or squatters and largely unemployed but living on charity. Therefore, government provided out-patient clinics at low cost of one Hong Kong dollar (approximately one

GBP = HK\$12). In cases of tuberculosis, leprosy, venereal disease as well as maternal and child services, services were free of charge.

Hay (1992) described the development of health care policy in Hong Kong as reflecting a near total lack of discussion of the overall objectives of Hong Kong government health care policy. He argued that the paralysis of health policy was due to several possible explanations such as the lack of ability to influence change from pressures outside the government as well as the relative stability of health services enjoyed by citizens in the early years. Nevertheless, the first Medical White Paper could be traced back to 1964 when the government described the minimum ratios of provision needed for hospital and clinic services to meet the urgent medical and health needs for the ten years from 1963 to 1972 (Hong Kong Government, 1964). It stated the ratio of hospital beds as targeted at 4.25 hospital beds per 1,000 populations. In addition, there should be one standard urban clinic to 100,000 urban population and one polyclinic with various specialities for every 500,000 population. The White Paper continued the policy of providing highly subsidized or even free medical care on the basis of need.

In April 1966 a protest against fare increases on public transport led to the outbreak of riots in Hong Kong (Wong, 1999). Riots were followed by the growing prosperity in citizens' living standards in the 1970s. In 1963, a massive new hospital was opened in Kowloon as the Queen Elizabeth Hospital, which was described as the biggest in the Commonwealth at that time. Currently, there are 1,850 beds with a staff force of 4,600 working at this major acute general hospital (Hospital Authority, 2002). The expansion of hospital and clinic services was rapid in order to meet public demand. However, the system was not well managed as commented by Wong (1999). Although



access to medical care was universal, quality and extent of care varied considerably. Conditions such as camp beds, over-crowded wards, unpleasant surroundings, lack of privacy, impersonal service and long waiting lines were not uncommon sense in the system (Ng, 1989). More medical professionals left the public system and moved to the private sector to enjoy better working environments and better rewards.

The second Medical White Paper came when the period covered by the first report was finishing. The government appointed the Medical Development Advisory Committee (MDAC) in March 1973 to give advice to the government on the next ten years of the further development in medical and health services in Hong Kong. The publication of the second Medical White Paper in 1974 started another important period in the history of the Hong Kong health care system. (Hong Kong Government, 1974). Under this policy document, the principles of heavily subsidized provision of medical care for the majority of the population of Hong Kong were reaffirmed. The system was open to all, regardless whether a person could afford private care. Charging for hospital services was nominal as patients paid two Hong Kong dollars as a daily maintenance charge, adopted in 1961. This was equivalent to about 2% of the cost of running the hospital bed during that period. A second medical school at the Chinese University of Hong Kong was recommended by this White Paper together with the expansion of other medical facilities such as family planning clinics and drug addiction treatment centers. It also highlighted the need to put resources to provide medical facilities to the population living in those new towns in the New Territories, apart from the dense populated areas of Kowloon and Hong Kong Island. A long term goal of providing 5.5 hospital beds per 1,000 population was established. Similar to UK policy, another feature of the White Paper was to introduce the concepts of regionalization of public health services. This

was made possible by the provision of a regional hospital with comprehensive facilities that could provide specialist care. One or more district hospitals were to act as gatekeepers to refer patients to the specialized regional hospital as well as to receiving patients discharged from the regional hospitals for follow up and rehabilitation. One or more polyclinics or specialized clinics were also needed in addition to a number of general out-patient clinics.

Both white papers made no suggestions to the development of private hospitals. There was a lack of interface between public and private hospitals. Private hospitals were allowed to charge fees with better quality services, especially hotel style services. Regarding health care practitioners in the public systems, they were salaried and could not practice in the private sector. Since the publication of the second White Paper, there was further silence in health policy for more than a decade. This lasted until February 1985, when the government commissioned a firm of Australian management consultants, W.D. Scott Proprietary (Pty) Co., to review medical services and the problems faced by health services. Their consultancy report was submitted to the Government in December 1985 by the Australian division of Coopers and Lybrand (Scott, 1985). The report drew attention to important factors that could affect subsequent future development of health services such as the rising cost of medical services, the rising community expectations and the lower morale of staff working in subvented hospitals because of lower fringe benefits when compared with the civil servants in public hospitals.

This report provided the groundwork for the establishment of the Hospital Authority. Its main recommendation was to separate government hospitals and

subvented hospitals from the Hospital Services Department. Instead, they should be managed by a nonprofit-making, statutory body (the Hospital Authority) which was eventually set up. The consulting group recommended that the proposed Hospital Authority should be separated from and yet accountable to the government through a Board which would be appointed by the Government. This Authority will then be funded by the Government to ensure continued provision of adequate hospital services particularly for the disadvantaged patients in Hong Kong. In order to alleviate the effect of morale problem between the two groups of employees, the new Authority will have common terms and conditions of employment for staff in all public sector hospitals to ensure greater mobility of staff and recognition of the role of the subvented hospital staff.

In March 1986, the Government sought public consultation about the Scott Report from March to August 1986. Staff member from subvented hospitals welcomed the proposal (Wong, 1999). However, civil servants working in the public hospitals were generally opposed to the proposal because of the possible loss of fringe benefits and job security as well as the civil servant status (Wong, 1999). As an initial step, a Provisional Hospital Authority (PHA) was established on 1 October 1988 to plan for the setting up of the statutory authority. Six working committees were formed, including the authority structure committee, finance committee, hospital management committee, committee on integration of public hospital services, legislation committee and the staffing committee. Subsequently, a seventh committee on management and financing of teaching hospitals was established in May 1989. The PHA saw it essential for the government to give a statement of the objectives of the Hospital

Authority. Hence, the government announced the agreed objectives of the Hospital Authority as:

In accordance with the Government's policy to safeguard and promote the general public health of the community as a whole and to ensure the provision of medical and health services for the people of Hong Kong, including particularly that large section of the community which relies on subsidized medical attention ... to recommend to the Government appropriate policies on fees and charges for the use of hospital services by the public, having regard to the Government's policy that no one should be prevented, though lack of means, from obtaining adequate medical treatment.

(Chung, 1989, p. 14-15)

#### 4.4.2 The Establishment of the Hospital Authority

The proposed Hospital Authority initially managed 34 public hospitals with more than 36,000 staff. It reviewed the weaknesses of the old public hospital system and suggested an overall new structure for the Hospital Authority. Subvented hospitals became public hospitals under the management of the Hospital Authority. The dual system became integrated into a unified system, with all staff employed on the same terms and conditions of their respective rank. Eventually, the Hospital Authority was formally established on 1 December, 1990 under the Hospital Authority Ordinance to manage all the public hospitals in Hong Kong. It is an independent organization which is accountable to the Government through the Secretary for Health and Welfare. The Secretary for Health and Welfare, together with his team of staff from the Health and Welfare Bureau, is responsible for the formulation of health policies and monitoring the performance of the Authority. One year later, the Hospital Authority formally took over the management of all the 38 public hospitals and institutions, together with 37,000 staff on 1 December, 1991. It now manages a Head Office, 44 public hospitals/institutions,

and 51 specialist outpatient centers plus 10 general out-patient clinics. In terms of bed numbers, the Authority managed a total of 28,517 hospital beds which represented 4.2 public hospital beds per 1,000 population as at 31 March 2000 (Hospital Authority, 2001b; 2001c). In terms of budget, it operates under a recurrent budget of Hong Kong \$28,029 million in 2000/01 with more than 50,000 full-time staff. Although the Authority is mainly responsible for the provision of a comprehensive range of secondary, tertiary as well as rehabilitation services, it also provides some primary medical services through 10 primary care clinics providing more than 700,000 general outpatient attendances per year. In 1999/2000, the statistics showed the number of attendances of Accident and Emergency at 2,361,600 as well as 1,089,330 inpatient discharges and 8,216,700 specialist outpatient attendances (Hospital Authority, 2001c).

The Hospital Authority thus became the second largest employer in Hong Kong apart from the Civil Service. Therefore, the scope of its influences is great and so as the coverage of *Patients' Charter* of the Hospital Authority. In order to manage such a large organization and its budget, it has adopted a modern management philosophy and has developed its own mission statements. The latest mission statements are as follows:

- \* To meet the difference needs of the patients for public hospital services, and to improve the hospital environment for the benefit of the patients;
- \* To serve the public with care, dedication and efficiency, and to encourage community participation in the system, resulting in better care and more direct accountability to the public;
- \* To provide rewarding, fair and challenging employment to all its staff, in an environment conducive to attracting, motivating and retaining well-qualified staff;

- \* To advise the Government of the needs of the community for public hospital services and of the resources required to meet these needs, in order to provide adequate, efficient and effective public hospital services of the highest standards recognized internationally within the resources obtainable;
- \* To collaborate with other agencies and bodies in the health care and related fields both locally and overseas to provide the greatest benefit to the local community.

(Hospital Authority, 2001c)

Besides mission statements, the Authority has established the following corporate vision:

- \* The Hospital Authority will collaborate with other healthcare providers and carers in the community to create seamless healthcare environment which will maximize healthcare benefits and meet community expectations.

(Hospital Authority, 2001c)

These mission statements and corporate vision guide the Hospital Authority to implement the Government's health care policy to safeguard and promote the general public health of the community as a whole. As a result of this comprehensive safety network, no one should be prevented medical attention through lack of means. Under the Hospital Authority Ordinance, the Hospital Authority is responsible for:

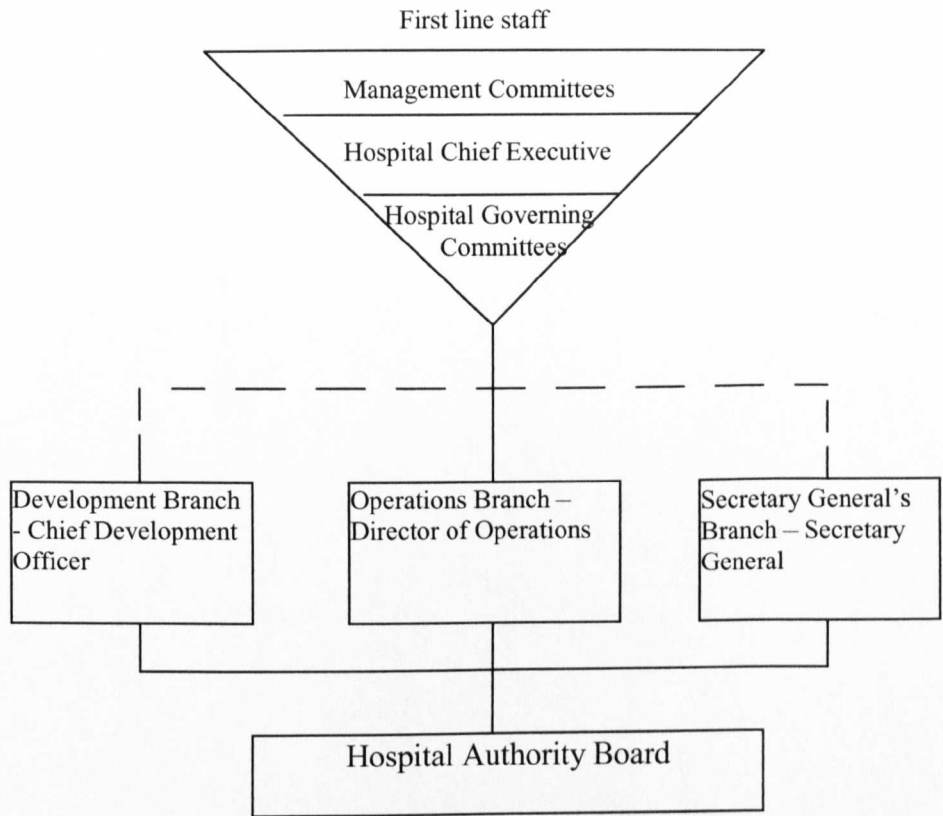
- \* advising the Government of the needs of the public for hospital services and of the resources required to meet these needs;
- \* managing and developing the public hospital system;

- \* recommending to the Secretary for Health and Welfare appropriate policies on fees for the use of hospital services by the public;
- \* establishing public hospitals;
- \* promoting, assisting and taking part in education and training of HA staff and research relating to hospital services.

(Hospital Authority, 2001c)

A totally new organization structure of the Hospital Authority was formed with a new head office. During the initial phase, the head office was situated in a commercial building. Later on, the new building of the headquarter at No. 147B Argyle Street of Kowloon was finished. It provides office space for the head office as well as lecture theatre, meeting rooms, library, canteen. In addition, a permanent exhibition area 'Health InfoWorld' was created within the new building where notice boards were displayed including information about patient's charter. On one hand, this is an exhibition area and a resource centre for health promotion activities. On the other hand, patient groups, community service agencies can hold various activities at the venue. These are open to the public with no or minimal charges. At the local level of hospitals, organization structure was reformed. New posts were created to reflect the importance of management. The simplified initial organization structure of the Hospital Authority is shown in Figure Sixteen:

Figure Sixteen: Organization Structure of the Hospital Authority



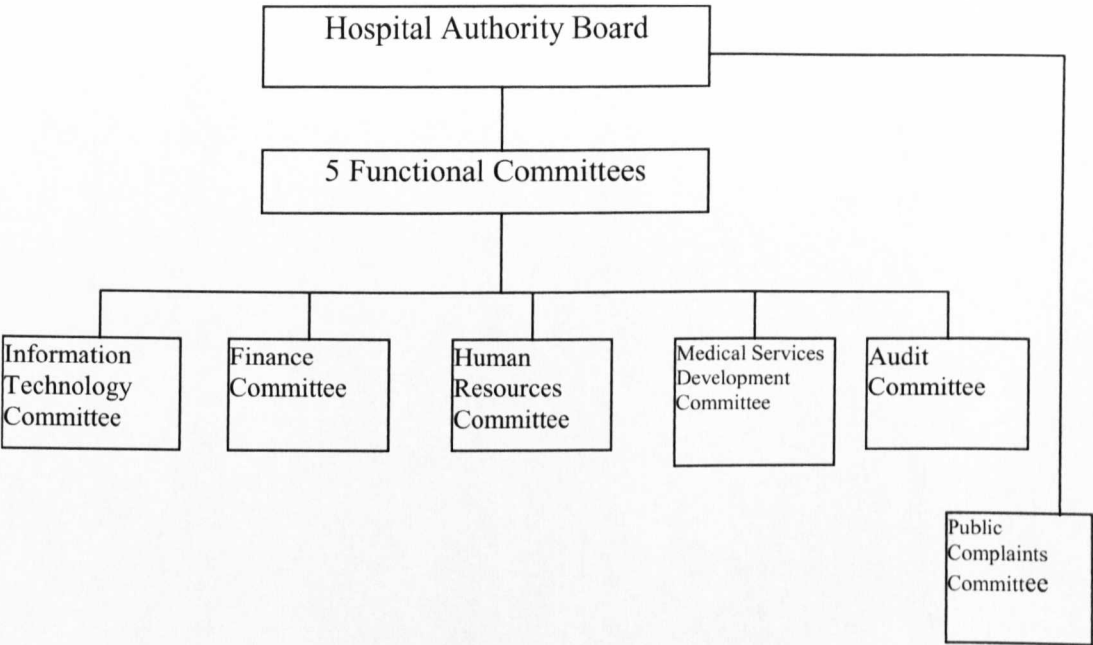
(Hospital Authority, 1992a, p. 31)

As shown in the above figure, the ‘reversed pyramid’ model put emphasis on front line valuable staff. The Hospital Authority Board is constituted of the Chairperson and other members including the Chief Executive of the Hospital Authority. The Chairperson is usually a well-known businessman (sic) in Hong Kong who is also dedicated to community services. For example, the previous Chairman was Mr. Peter Woo, JP, Chairman of a listed company on the stock market in Hong Kong. He is also active in community services to local universities. The next appointed Chairman, Dr. Lo Ka Shui, JP, was trained as a medical doctor but is now a businessman and also Chairman of the second stock exchange market in Hong Kong at the Growth Enterprise



Market (GEM). The Hospital Authority is run with the help of a committee system at the Board level to overlook the work of the Authority as shown in Figure Seventeen.

Figure Seventeen: Committee Structure of the Hospital Authority



(Hospital Authority, 2001c, p.6)

These various functional committees have delegated powers to deal with matters within their respective terms of reference. Their primary task is to assist the Hospital Authority to carry out its responsibilities for managing public hospital services efficiently. For example, the Public Complaint Committee (PCC) is highly relevant to the subsequent discussion of *Patients' Charter* in Hong Kong and the terms of reference will include the following:

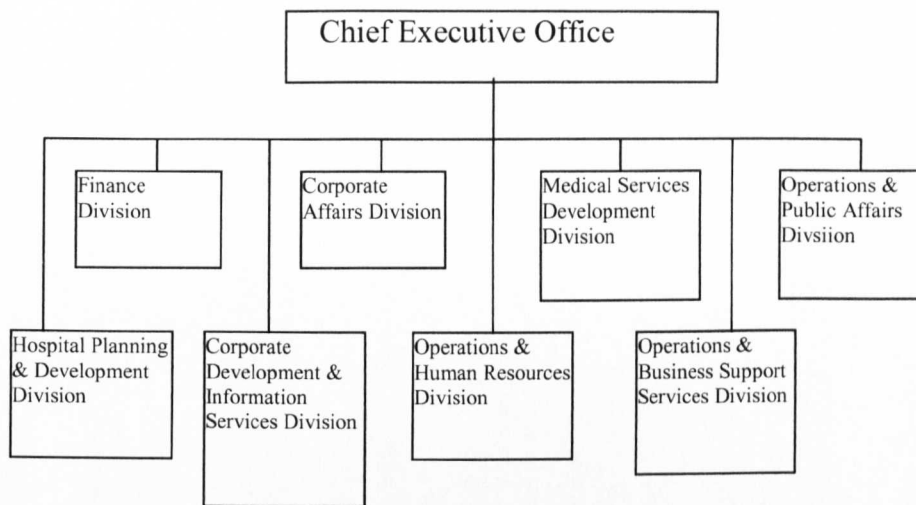
1. The committee shall independently:

- a. Consider and decide upon complaints from members of the public who are dissatisfied with the response of the hospital to which they have initially directed their complaints, and complaints referred by the office of Members of the Legislative Council;
  - b. Consider and decide upon such other complaints or classes or complaints as are referred to the committee by the Hospital Authority.
2. The committee shall:
  - a. cause the complaint to be investigated;
  - b. decide and reply; and
  - c. advise appropriate action to be taken.
3. Without prejudice to the complainant's other public channels of complaint or petition, the committee's decision shall represent the Hospital Authority's decision which shall be final.
4. The committee shall make regular reports to the Hospital Authority.

(Hospital Authority, 2001c)

The executive function of the Hospital Authority consists of the senior management mechanism. The senior management structure of the Hospital Authority Head Office was formed since its establishment and has been subsequently adapted to the following figure:

Figure Eighteen: Organisation Structure of the Hospital Authority Head Office

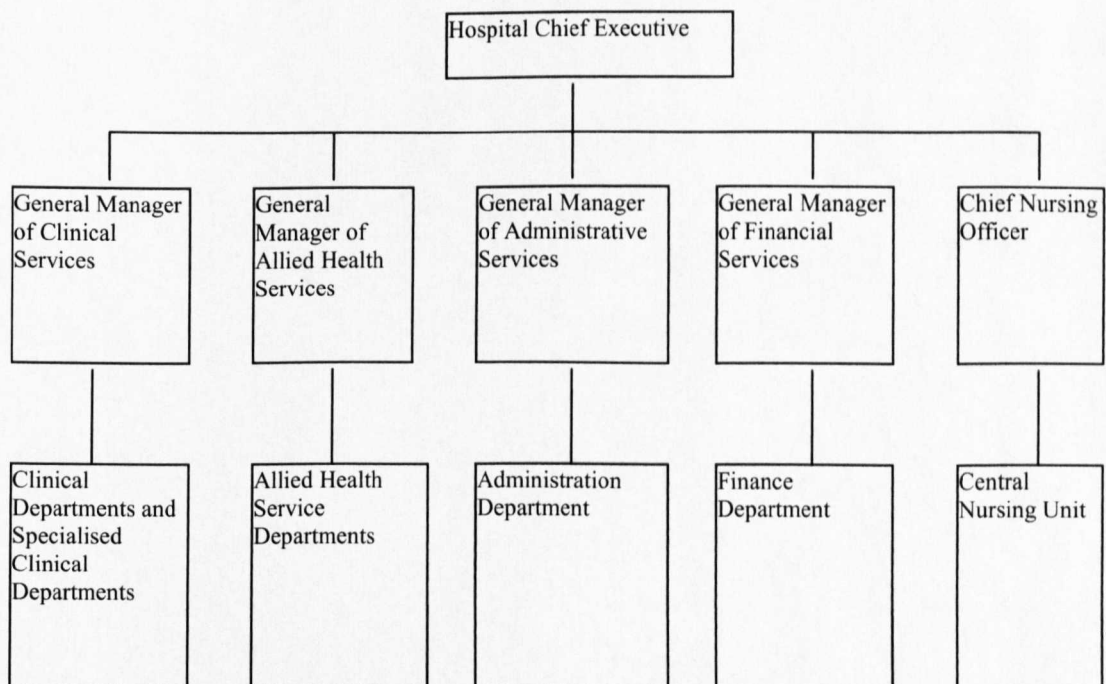


(Hospital Authority, 2001c, p.3)

At local hospital level, a new approach to hospital management was adopted. The Hospital Authority Head Office (HAHO) determined strategic issues for the local hospitals to implement. Before the setting up of the Hospital Authority, Government hospitals were managed by medical superintendents, who were usually junior in rank than consultants in the hospitals. Management problems were easily created due to the conflicts involved. The reform of the new approach of management of public hospitals considered effective management as the primary focus in order to provide high quality services to patients. To achieve this objective, individual hospitals should enjoy a higher degree of autonomy with decentralized decision making mechanism. A Hospital Chief Executive (HCE) should be employed to provide strong leadership to the hospitals. More open system of accountability and professional development were followed. In addition, a hospital governing committee was set up for each hospital, consisting mainly of members of the public. The committee overlooked the running of the hospitals and to monitor the operations of hospitals. It is worth noting the revised terms for staff members working within the Authority. Staff from the previous government hospitals

and subvented hospitals were invited to transfer to Hospital Authority terms of employment. A new package with attractive cash allowances was offered to each employee. Staff had to make their decisions within three years. If staff did not opt for the transfer, they could retain their status as civil servant. Therefore, there are two categories of staff working within the hospitals, namely employees of the Hospital Authority and Civil Servants. By 30 June, 1992, 56% of eligible staff had opted for Authority's terms of employment (Hospital Authority, 1992b). No matter their status, they are still treated as staff members and have to implement programmes such as *Patients' Charter* within hospitals. The initial top management structure of a large hospital with multiple clinical departments is shown in Figure Nineteen and is useful to help the understanding of implementation of *Patients' Charter* in Hong Kong:

Figure Nineteen: The Top Management Structure of a Large Hospital – with multiple clinical departments



(Chung, 1989, p. 150)

Patient services are delivered by various clinical specialty departments. Within each clinical department, such as surgery, a Chief of Service (CoS) who is a Consultant is responsible for managing the whole department and leads a team of managers including Departmental Operations Manager (DOM), Ward Manager (WM) and health care providers (doctors, nurses, allied health professionals and support staff). At ward level, a ward manager who is a nurse will manage the ward. Several ward managers are then supervised by the Department Operations Manager (DOM) who is a senior nurse manager, in that sense, nursing staff are managed by medical staff directly in the line function.

#### 4.4.3 The Business Planning Process of the Hospital Authority

One of the unique characteristics of the Hospital Authority is its publication of the annual business plan and the annual report which are available to the public. These two documents are important for subsequent analysis of implementation of *Patients' Charter*. Thompson (1996) examined the progress made by the public hospitals in Hong Kong in implementing a business planning approach. This new management initiative of the public hospital started with the publication of the first corporate business plan for the year 1992/93 (Hospital Authority, 1992b). Indeed, the use of business planning is widely adopted by private enterprises. The first corporate annual plan of the Hospital Authority presented different major sections, including introduction, purpose and mission, business description (the market analysis), service provision in relation to resource requirements, plans and targets, financial projections and a summary. It outlined the projected market demand and the targets to be achieved in different perspectives such as physical environment, information technology infrastructure, and

the introduction of quality assurance programmes. In section 5.2.9 of the business plan, the heading was written as patients' charter in which:

In an attempt to safeguard the rights of patients, consideration is being given to promulgating a *Patients' Charter*. The charter will also set out the responsibilities of the patients.

(Hospital Authority, 1992b, p. 37)

A Patient Relations Officer was recruited at each hospital to deal with initial complaints. Hence, the complaints and patient feedback system was suggested from the plan. Initial complaints were dealt with at the hospital level. Hence, the Patient Relations Officer could help the hospital in this area. If the complainants were not happy or satisfied with the response from the hospital, the case would be dealt with by a Public Complaints Committee (PCC). This committee also handled complaints referred by Office of the (non-government) Members of the Legislative Council (OMELCO) or the Commission for Administrative Complaints.

At local level, the HAHO issued a template for the hospitals to follow in developing the individual hospital business plans. At the hospital level, individual departments are also required to plan their actions which are then collated into the hospital business plan. Hence, Hong Kong's public hospital systems have undergone a rapid transition from the traditional bureaucratic and financially focused 5-year forecasts of the previous Hospital Services Department to the dynamic process of annual business planning exercises. Targets are also evaluated against the business plans in an attempt to pursue the 'seamless' health care management process.

#### 4.4.4 The Review of the Health Care System

Since the establishment of the Hospital Authority, many initiatives and improvements were injected into the services such as continuous quality improvement, *Patients' Charter* and staff development review (Ma and Koch, 1994; Thompson et al., 1999). More patients were shifted to the public sector. Increased demands were generated in the public sector which created much workload pressure to the frontline staff of the Hospital Authority while private hospitals were losing their market share (Ng, 1996). Although the Hospital Authority has more admirers than critics, it is particularly vulnerable to complaints from different stakeholders such as private hospitals whose client base has been seriously eroded and hence their business reduced (Hutcheon, 1999). Regarding primary care, the Government appointed a working party in 1989 to review and make recommendations on the delivery of primary health care in Hong Kong. Eventually, a report was submitted by the working party chaired by Professor Rosie Young to Sir David Wilson, Governor of Hong Kong (Young, 1990). This report highlighted the importance of the need for improving primary health care besides the improvements in hospital services by the Hospital Authority. A comprehensive primary health care service should be developed with proper interface with hospital and specialist services so as to aim for the WHO's strategy for achieving the goal of 'Health For All by the year 2000'. The recommendations from the working party included several main points. The foremost recommendation is for Government to make a clear commitment to adjusting the emphasis towards primary health care in Hong Kong's health care policy. There should be a distinction between 'public health services' including promotion of general health of the community and prevention of diseases and 'primary medical care' which provided first-contact curative care for the

individual patient. Government should ensure that there is a framework for delivering quality primary care without Government being the main service provider. No one should be prevented, through lack of means, from obtaining adequate medical treatment.

This report was treated as the guiding document since the 1974 White Paper *The Further Development of Medical and Health Services in Hong Kong*. The 1990 report recognized the importance of the private sector in providing some 85% of all out-patient consultations. It should be encouraged to collaborate with the public sector in raising the standards of practice to patients.

The Secretary for Health and Welfare, Mrs. Elizabeth Wong, announced further consultation on the reform of the health care system. The so-called 'Rainbow document' entitled *Towards Better Health* was published with a cover design of a rainbow in 1993 (Wong, 1993). While the existing policy that no one should be denied adequate medical treatment through lack of means remains paramount, the report indicated the need for reform from the pressure generated by the changing environment to meet the demands and expectations of the 21<sup>st</sup> century. The government has to decide how best to invest resources in health services. Any reform should reflect the commitment to the objectives of increased accessibility, more choice, better service, improved efficiency and cost-effectiveness and simpler administration. This document emphasized the further financing options of the health care systems in Hong Kong. Five possible options were identified by the government as a way forward including percentage subsidy approach, target group approach, co-ordinated voluntary insurance approach, compulsory comprehensive insurance approach and prioritization of treatment approach. The first two options were ways of fee charging and waiver. The third and fourth options were



ways of funding health services for the community and the fifth approach was a way of allocating resources. These approaches were not mutually exclusive. However, no adoption of the options was eventually taken except some of the pilot test of the class B beds (semi-private wards) and itemized charging suggested by the target group approach. Hence, health policy developments in Hong Kong had been highly resources and demand oriented. Since the rainbow document, health policy remained silent until the Harvard report in 1999.

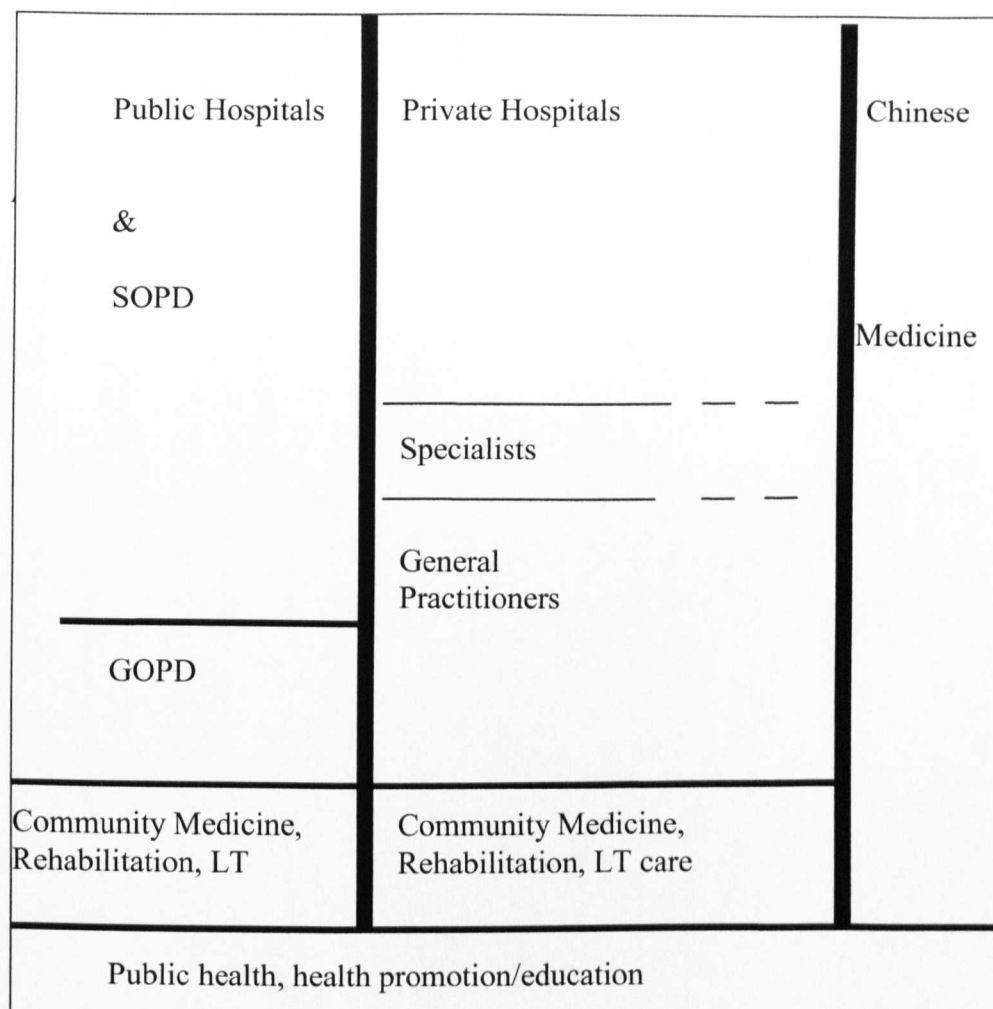
Over the years since the establishment of the Hospital Authority, Hong Kong has developed an enviable health care system in which it provides an accessible, quality, equitable and affordable health care service. The dual system of public sector and private sector have provided both a safety net and choice for patients to choose their treatment providers. Although Hong Kong has enjoyed very good health indices among different countries in the world, its health care systems need to evolve and to meet the constant changing societal expectations and needs. Hence, the government commissioned the School of Public Health of Harvard University in 1997 to conduct a study of the current health care system in Hong Kong. This study aimed to assess the current system and to propose alternative solutions and options to improve the financing and delivering of health care for the benefits of patients as well as Hong Kong society as a whole. The Harvard team was led by Professor William Hsiao and Dr. Winnie Yip, and was published in March 1999 as the so-called *Harvard Report* (Harvard Team, 1999). The report attempted to provide answers to five major questions:

- What are the strengths and weaknesses of the Hong Kong system of financing and health care delivery?

- Can the current arrangement for financing health care be sustained?
- What are the causes of the weaknesses in the health care system?
- What are the strategic options for improving the Hong Kong system?
- What institutions need to be put in place if Hong Kong chooses a particular option?

From this comprehensive study and analysis, the Harvard team reported that Hong Kong has a relatively equitable system in which access is not a problem. In addition, the establishment of the Hospital Authority in 1990 had brought steady improvement to certain specific aspects of quality and efficiency as well as cost-effectiveness. However, certain weak areas were identified including the high variation of quality of health care with some sub-standard medical practice affecting the quality. Examples included lack of ongoing medical education for GPs and a lack of grievance procedures inspiring confidence in patients. The privileges enjoyed by the medical profession in terms of professional power received criticisms as well. Regarding financial sustainability, the Harvard team claimed that the current financing system had a questionable long term financial sustainability. It projected that public health expenditure would increase from the current 2.5% to between 3.4 to 5.0% of GDP by the year 2016. Regarding the structure of the system, the Harvard team widely criticized Hong Kong's health care system, which is highly compartmentalized, threatening organizational sustainability, quality and efficiency of the system. This compartmentalization occurs between primary care and inpatient care, acute and community medicine, private versus public sectors and is shown in Figure Twenty:

Figure Twenty: Compartmentalized Health Care Provision



(Harvard Team, 1999, p.7)

The team argued that a policy of benign neglect could be the major cause of this compartmentalization. Hospitals are the dominant institutions providing health care in Hong Kong. The Harvard team then recommended five major options to improve the health care system for the government to consider. Option one is to retain the status quo. However, this will only postpone necessary change and exacerbate existing weaknesses. Option two is to cap government budget on health. However, this may compromise equity and leads to long waiting lists. Option three is to raise user fees but is difficult to achieve public consensus. Option four is to develop the Health Security Plan (HSP) and

saving Accounts for Long Term Care (MEDISAGE). Citizens are required to contribute to the account from their earnings. Option five is to feature a prepaid integrated health care called the competitive integrated health care in which HA will be reorganized into 12 to 18 regional Health Integrated Health Care option, either hospital- or GP-based integrated care systems. Both options four and five adopted the logic of ‘money following the patients’. The team also recommended several institutional requirements to be developed to implement the change programs. For example, an ‘Institute for Health Policy and Economics’ should be funded to conduct objective and rational analyses and to monitor the system’s performance. This institute should be linked to the major universities. The Department of Health should establish a separate ‘Office of Quality Assurance’ to develop practice guidelines, conduct regular independent patient surveys and disseminate useful information to the public. Moreover, the Department of Health should create an ‘Office for Patient Education’ to play the role of providing patients with adequate knowledge and information to judge the quality of care provided and to articulate their concerns and dissatisfactions. Since the release of the Harvard report, members of the public and professional groups were invited to give comments to the Bureau in writing. The Harvard team or the Bureau attended over 50 seminars and meetings to explain the content and recommendations of the report and listen to the views of the participants. Overall, the Health and Welfare Bureau received over 2,200 written submissions from different sectors of the community. Although views were diverse and varied about the proposed reforms, the public was generally supportive of the need for reforms. There was strong support for the strengthening of primary health care through the development of family medicine practice and improvement to general out-patient services. There was much concern about the heavy workload in the public sector that could be lessened with closer collaboration between the public and private

sectors. Regarding quality assurance, the main focus is on continuing medical education (CME) and patient complaint mechanisms. The community and the patients' groups supported the proposal to set up an independent Medical Ombudsman. Some of the respondents were not convinced of the existing arrangement in which it appears that the complaint mechanism against medical practitioners is biased in favour of the doctors and is not user-friendly or transparent enough. On the other hand, medical practitioners opposed the setting up of the Medical Ombudsman as their self-interest will be threatened. They considered it would not be fair to the profession to rely on a non-professional with limited knowledge about the field to appraise professional practice and conduct. There was a good measure of support for the establishment of an Institute for Health Policy and Economics to collect data and conduct health services research (Health and Welfare Bureau, 2000).

Fung et al. (1999) discussed the four guiding principles for health care reform proposed in the Harvard Report. They include equal access, reasonable quality, affordable care and shared responsibility. Indeed, the consultancy study by the Harvard Team is the first stage of the review of the health care system of Hong Kong. After the four-month consultation period, the Bureau started the second stage of the process. Based on the public submissions received and some further studies and the review of the three main pillars of the health care system, namely the organization and provision of health services (service delivery system), mechanisms to assure the quality of health care provided (system of quality assurance) and the funding and financing for health care services (health financing system), the Bureau published another Consultation Document *Lifelong Investment in Health: Consultation Document on Health Care Reform* in a second round of seeking views from the community (Health and Welfare

Bureau, 2000). After the second stage, the last stage will formulate and implement plans subject to the comments received in the second stage of consultation. Within the consultation document, the stated vision is to re-create a health care system which promotes health, provides lifelong holistic care, enhances quality of life and enables human development. The new objectives of the health care system for the future have reflected a shift in health policy to insist more responsibilities of patients and individuals:

- to protect the health of the population, prevent diseases and disabilities, promote lifelong wellness, and support continuous health sector development;
- To provide comprehensive and lifelong holistic health care which is humane, where care and comfort to the individual is as valued as medicine and technology-based interventions;
- To provide accessible, equitable, and quality services to members of the community on the basis of health needs;
- To remain cost-effective, sustainable and affordable both to the individual and the community;
- To reinforce the notion that the pursuit for better health is a shared responsibility among the individual, the community and Government.

(Health and Welfare Bureau, 2000, p.6)

Various proposed reforms are suggested to achieve these objectives. For example, the Department of Health should change its role to be an advocate for health to promote health, as well as working in concert with the Health and Welfare Bureau to strengthen preventive care. A radical change is proposed to transfer Department of

Health's general out-patient service to the Hospital Authority. Regarding quality assurance, a combination of education and training, systems support and regulatory measures are proposed. A credible complaint mechanism is proposed to protect patients through the setting up of a Complaint Office in the Department of Health. This office will help to give a fair and objective image to the public in addition to the *Patients' Charter*. This office will handle only cases related to patient care. It will investigate complaints and assist the complainants to obtain expert advice, brief the complainants of the facts known, and attempt to mediate between the complainant and the complained. At the request of complainants, the office could forward the findings to the relevant regulatory body. Then the professional group will determine whether or not to take disciplinary actions. Hence, the setting up of the Complaint Office is hoped to contribute to the credibility and transparency as the investigation will be performed by a third party. Moreover, complainants will have access to expertise and advice from the Office. Lastly, the final decision and discipline will rest with the professional bodies.

After the second stage of consultation period, more than 730 written submissions were received during the consultation exercise which took place between December 2000 and March 2001. Many of these submissions were submitted by the public, with others from health related stakeholders including health care professionals/groups, legislators, political parties, community organizations, private companies and academics. There was public consensus about the need for health care reform. Wide support was received in the areas of:

- the revamped role of the Department of Health as health advocate and strengthening of prevention care;

- the development of family medicine and community-based integrated services;
- introduction of Chinese medicine into the public sector;
- continuing medical education for all health care professionals;
- cost containment measures by the Hospital Authority;
- the revamping of the fees structure, subject to a safety net being made available to the poor and the needy. (Yeoh, 2001a)

#### 4.4.5 The Patients' Charter Initiative in Hong Kong

The brief review of the history and the latest reform in health care system of Hong Kong can facilitate the understanding of the implementation process of *Patients' Charter*. The development of *Patients' Charter* and patient's rights in Hong Kong are less complicated than in England. The Hospital Authority prefers the name *Patients' Charter* rather than *Patient's Charter*. Although the main focus in this research is the *Patients' Charter* from the Hong Kong Hospital Authority, it is necessary to look at related similar movements by other institutions in Hong Kong. The Hong Kong Medical Association (HKMA) was founded in 1920 with the aims to maintain and improve standards of medical practice in Hong Kong. It represents the interests of medical practitioners in Hong Kong and has a current membership of approximately 5000 registered medical practitioners in Hong Kong. The Hong Kong Medical Association and the Consumer Council jointly announced the Proclamation of *Patients' Rights & Obligations* on 2 October, 1992 (HKMA, 1992; Consumer Council, 1992; HKMA, 1993). Indeed, HKMA has been always concerned with patients' rights and has established a Patients' Rights Committee in August 1992. This committee consisted of representatives from HKMA, the Consumer Council, the Hospital Authority and the



Department of Health. The Committee's job was to establish a whole set of patients' rights and obligations, satisfactory to all parties and practical in implementation in both private and public sector. The Consumer Council has been supportive to the Hong Kong Medical Association in its efforts to promote patients' rights. The Consumer Council itself received about 55 cases of complaints against doctors or dentists per year in 1992 (Consumer Council, 1993). The Council believed that the 12 rights and 3 responsibilities contained in the *Patients' Rights and Obligations* (now the *Patients' Rights and Responsibilities*) served as the first step to protect consumers of health services. The Hong Kong Medical Association believes that the Hospital Authority should consider its pronounced set of patient's rights and obligations before drawing up the Authority's own *Patients' Charter* (HKMA, 1992). Apart from the physical format of a leaflet, it is also available from the internet and telephone hotline number 25295222 of the Hong Kong Medical Association (HKMA, 2001). In the implementation of patients' rights, the Consumer Council and HKMA agreed on a series of actions. On the side of HKMA, its Public Medical Education Committee disseminated the knowledge through its public medical education programmes on mass media such as Radio and Television. For example, the Radio Television Hong Kong (RTHK) TV production *Access* included questions on patients' rights. The RTHK and HKMA TV production *TV Doctor* commenced in October 1992 with a message of patients' rights in each of the 12 episodes. The *Talking Magazine* free telephone messages were available to the public at any time. In addition, the whole set of patients' rights and responsibilities were published in the monthly publication of the Consumer Council, *Choice* (Consumer Council, 1992). Besides, HKMA and the Consumer Council have agreed to put up bilingual posters in doctors' clinics to remind patients of their rights to know the fees and charges of consultation or procedure as well as the name, actions and side-effects of

the prescribed drugs. These two are major breakthroughs in the culture of consuming private health services among patients in Hong Kong. Unlike the United Kingdom, primary health care, especially general practice in Hong Kong is largely provided by the private sector. Patients visit the private clinics of their choice for consultation, treatment as well as the drugs from that particular clinic. Patients seldom ask the charges in advance and they do not know what kind of drugs have been prescribed to them. Hence, these new rights protect the patients and their carers. In regard to complaints from patients, every public hospital and clinic has appointed a Patient Relations Officer to receive complaints and deal with them. Other channels are also available in case patients are not satisfied with the investigation or result. In terms of professional disciplinary matters concerning registered medical doctors in Hong Kong, these are handled by the Medical Council of Hong Kong. This Council is a statutory body made up of 24 appointed and elected doctors and 4 lay members. Its functions consist of the registration of doctors, holding licensing examinations and maintaining the standard and disciplines of doctors. It can act on complaints or information. If a doctor is judged guilty of professional misconduct, then he or she can be sentenced to ranging from a warning letter to removal from the medical register (Lee, 2000). The Medical Council of Hong Kong has also published a booklet called *How the Medical Council deals with Complaints* (Medical Council, 2000). This explains the work of the Council and the procedures for making a complaint as well as how the Council will handle complaints.

The Hospital Authority spent one and a half year preparing its own *Patients' Charter*. During the drafting stage, consultative forums were held with doctors, nurses and allied health professionals as well as administration, supervisory and support staff of the Authority. Hospital Chief Executives were briefed about the concept and

objectives of the *Patients' Charter*. Before the official launch of the *Patients' Charter*, an internal document was circulated among staff members to explain the common questions and issues that concerned staff about the proposed *Patients' Charter* (Hospital Authority, 1993). Workshops were held at hospitals with training and induction programmes for staff members. Then the Hospital Authority's *Patients' Charter* was launched in mid 1994 (Hospital Authority, 1994a). The purpose of the charter is to explain both rights and responsibilities, as a patient of any of Hong Kong's public hospitals. Eleven rights and six responsibilities are advocated within the charter as shown in Appendix Eleven. It also contains a section soliciting comments and views about the charter and a section on how to make a complaint detailing how a Patient Relations Officer is available at every hospital or clinic to whom patients may make a formal complaint either verbally, or in writing. Then the Patient Relations Officer will pursue the matter on their behalf, and refer the complaint to the appropriate person(s) for investigation. As contained in the charter, a substantive reply to any complaint should be made within a reasonable period of time, together with an indication of any action that has been or will be taken. The charter was described as 'a beacon guiding improvement in hospital care' (Hospital Authority, 1994b, p.1). Starting from July 1994, a major drive was undertaken to inform the public of the content of the charter. Unlike the *Patient's Charter* in UK, it was not sent to individual households. Instead, explanatory leaflets were distributed and posters were displayed at prominent locations in hospitals. In addition, a 15-minutes educational video with a local popular singer and movie star Mr. Andy Lau was prepared for screening in hospital and clinic waiting areas to introduce the charter. The Patient Relations Officers prepared individual hospitals' programmes to promote the charter, and to educate the public about their rights and responsibilities. Apart from promotion at the hospital level, announcements of public interest were

broadcast on TV and radio as well as articles in the press. In early 1996, a series of promotional activities were held at district level with the support of the district board and the Alliance for Patients' Mutual Help Organizations (Hospital Authority, 1995a; Hospital Authority, 1996). For example, road show, quiz, seminar, free medical check up and exhibitions were held at various hospitals and districts. This major territory-wide campaign to promote *Patients' Charter* in Hong Kong was supported fully by the 18 District Boards (District Board was the mechanism of the District Administration Scheme commenced in 1982). Through the scheme, the Government can promote public participation in district affairs and helps the Government to be responsive to district needs and problems. District Boards were replaced by 18 Provisional District Boards from 1 July 1997. From 1 January, 2000, they were changed to District Councils. Additional funding was available to the Councils for improving local environment, promoting district activities, as well as increasing the accountable allowances of District Council members (ISD, 2000). Hence, the promotion campaign started with an essay writing competition jointly organized by the Alliance for Patients' Mutual Help Organizations (APMHO), the local newspaper *Ming Pao*, and the Hospital Authority in January 1996. A total of five local buses were painted to advertise the charter for a period of six months to one year. A patients' charter Games Day was held at local hospitals and over 200 patients and staff attended the function. As the Chairperson of the Alliance for Patients' Mutual Help Organizations commented about the territory-wide promotion campaign, the campaign was designed to gain the support and endorsement for the charter as well (Hospital Authority, 1996). The pamphlet of *Patients' Charter* was redesigned in 1997 to have a better overlook and a single bilingual version rather than one leaflet in Chinese and one leaflet in English. This 1997 version removed the sections of 'How to make a complaint'. One year later, it resumed

the practice of Chinese version and the English Version with the additional of the Hospital Authority web address into the pamphlet.

As mentioned in section 4.4.3, the annual business plan is the major policy document which directs the strategic issues of the whole Hospital Authority. The *Patients' Charter* was, of course, mentioned within the business plan such as:

The *Patients' Charter* will provide the parameter and impetus for improvements to patient care. The main focus will be on HA's commitment to improve hospital services. It also serves as a vehicle to communicate this commitment to staff. Efforts will be made to instill the knowledge of the *Patients' Charter* at training programmes of various health care professions ...

The promotion of the *Patients' Charter* facilitates the active contribution by the patient to his own health care. Communications to the public and to patients will be informational and educational in nature.

(Hospital Authority, 1994c, p.55)

The initial stage for staff and patient education on the *Patients' Charter* has been completed. The stage is now set for wider promotion of the charter. The Authority believes a heightened awareness of the rights and responsibilities of patients will go a long way towards establishing mutual trust and respect between providers and customers, which will materialize into better partnership in the care process and improvements in patient outcome and satisfaction ...

A territory-wide programme will be launched to educate the general public on patient rights and responsibilities. Inroads will also be established to include *Patients' Charter* in school curriculum at primary, secondary and tertiary level.

(Hospital Authority, 1995b, p. 50)

Targets with a time frame were set within the plan for the promotion of *Patients' Charter* including the achievement of education and informational programmes for patients by the fourth quarter of 1994 and the achievement of the target of continuing communication programme in hospitals by the first quarter in 1995 (Hospital Authority,

1994c, p. 96). By the fourth quarter of 1995, a territory-wide educational programme for the public on patients' rights and responsibilities and the inroads to include *Patients' Charter* in school curriculum at primary, secondary and tertiary level were to be established (Hospital Authority, 1995, p. 84).

Apart from the Hospital Authority and the Hong Kong Medical Association, the Department of Health of Hong Kong issued *Patients' rights and responsibilities* in different formats, including pamphlet, slides, posters, video, exhibition boards and the internet (DoH, 2000). This consisted of four categories of rights including 'The right to know', 'The right to decide', 'The right to keep information confidential', 'The right to complain' and five patients' responsibilities. Channels to make complaints were indicated clearly under 'The right to complain' including the channels to complain against public or private health care providers. A 24 hours telephone hotline (2833 0111) was available from the Central Health Education Unit of the Department of Health. Citizens could choose to listen to 'English', 'Cantonese', or 'Putonghua' or get a copy of the information by fax-on-demand (DoH, 2001). Hence, this version of patients' rights and responsibilities covered both the private and public sector. As a result in 2001, there were currently three similar patients' charters or rights and responsibilities being implemented in Hong Kong. One from the Hong Kong Medical Association and Consumer Council with an emphasis on private health care providers. The second one from the Hospital Authority was applicable to the Authority's hospitals, institutions and clinics. The third one from the Department of Health was more general and applicable to the public and private sectors.

#### 4.5 Summary and Comment

This chapter has presented the national policy development of the implementation of *Patient's Charters* and related documents in both England and Hong Kong. The section on the international movement of 'Charterism' and patients' rights initiatives have further reinforced the importance of the topic and the value of researching the issues. The overview of the health systems in both countries is useful in understanding the macro policies that inform the structure, financing, values, and objectives of the public health services towards a patient-centred quality health service. Much of the data are collected from policy documents, implementation guidelines, official promotion materials and so on. In England, the Conservative's *Citizen's Charter* brought the *Patient's Charter* into the front line of the National Health Service. Despite the change of Government, the Labour government continued the charter programme and further elaborated it into the 'Service First – New Charter Programme'. The Charter Mark award scheme is being continuously implemented in the health services despite the recent replacement of the *Patient's Charter* into the *Guide to the NHS*. No matter what the labels are, the underlining philosophies are apparent in advocating patient's rights and expectations as well as the recent highlighting of patients' responsibilities. This is consistent with the Labour Government's 'Third Way' policy emphasizing individual responsibilities as well as rights. One particular problem in the ten years history of the *Patient's Charter* is the overuse of charters in which patients and carers are easily confused and bored with too many versions of charters. Patients may receive different charters from different bodies at the same time. This also happens in Hong Kong. Patients can be confused by three documents of *Patients' Charter* and *Patients' rights and responsibilities*. While every organization has its self-interest and incentive

to issue a charter document, this should be coordinated smoothly for a seamless health care approach. The Hospital Authority of Hong Kong has been actively implementing the charter in its hospitals and institutions. It has gone further and earlier than UK in emphasizing the responsibilities of patients. The annual business planning exercise has been effective in disseminating targets from national level to local level of the requirement in *Patients' Charter*. Of course, national policy development and implementation are ideal in their outlook. It is hence necessary to understand and analyse the implementation of charters at local levels by critical examinations of data collected, especially from the interviews. These will be presented in subsequent chapters.



## CHAPTER FIVE: LOCAL DEVELOPMENT IN ENGLAND

### 5.1 Introduction

In chapter five, I present the data collected about the local implementation of *Patient's Charter* in England, in particular, the data collected from the research interviews at the various hospital Trusts as well as the patients' group and the Community Health Council. I will incorporate findings from other previous studies of the *Patient's Charter*. In addition, government publications and documents will be analysed to complement the findings of the study. The emphasis will be on an exploration of these experiences of implementing the *Patient's Charter* in their respective institutions/localities. I will present three themes arising from this research as indicated by the corresponding sections of the guiding questions used during the interviews where each section consisted of several guiding questions. First, these will explore how staff viewed the local implementation of the patient's charter initiative and second how they explained the changes in the relationship between patients and staff. Third, I will explore those issues surrounding management, politics and power in an attempt to understand local implementation and the rationale for the *Patient's Charter* in England. Additional questions were asked during the interviews about experiences of and comments on the Charter Mark. Comments collected from relevant conferences will be incorporated to enrich the data source. The presentation of the data will include a critical analysis and reflection to try to understand the charter movement in the National Health Service in England.

## 5.2 Implementation Issues at the local level

At local level, health authorities were required to publish information in relation to local and national charter standards as stated in the 1991 version of *Patient's Charter* (Department of Health, 1991a). Many hospitals or Trusts have published their own local patient's charters. The NHS is characterized by a large number of providers of service in the form of Trusts and GPs employing more than one million people. Apart from the earlier research by Carr-Hill and Ng (1992), discussed in section 4.3.3, two other research studies commissioned by the National Consumer Council explored the *Patient's Charter* and charters of other public services. The National Consumer Council is the independent voice of consumers in the United Kingdom and it is a non-departmental public body (National Consumer Council, 2001). It was set up by the government in 1975 and has been active in representing the interests of consumers of goods and services of all kinds, including both public and private sectors. Its first survey relating to charters was carried out by Market & Opinion Research International (MORI) in Spring 1993. This survey explored consumers' experiences of a range of health services such as GPs, hospital services and dentists. One section was concerned with the *Patient's Charter* to assess whether people knew about it, if they had seen it, or had read any of it (National Consumer Council, 1993). The findings showed that 64% of the respondents had heard of the *Patient's Charter*, with 24% having seen a copy of it, and 19% having read the *Patient's Charter*. While consumers appreciated the efforts of NHS, the Council was particularly concerned about issues raised by their findings about 'the low level of knowledge about complaints procedures for health services, and lack of awareness of the *Patient's Charter*' (National Consumer Council, 1993, p.43).

A second survey carried out by the National Consumer Council looked at local charters of most public services (National Consumer Councils, 1998). In this survey, the Council wrote to every police force, train operator, housing and social service authority, gas, electricity and water company in England as well as health authorities, NHS trusts, benefit offices, further and higher education institutions and a small number of doctors. A total of 823 out of 1,030 local service providers responded to the questionnaire (80 per cent response rate). In health related services, 20 health authorities and 80 trusts replied. Questions were asked about whether service providers had produced a charter, and if so whether they had consulted their users. The research also asked about the publication time of the local charter, whether local charters were produced in different ethnic languages or formats for disabled people, whether they were independently audited, or if there were plans to revise them. The team also asked whether consumers were aware of charters, their satisfaction with complaints-handling, and whether they were more satisfied with a service as a consequence of having a charter. The findings of the survey were both encouraging and disappointing as claimed in the report. For example, less than a quarter of the public services respondents had consulted their users in the local charters. More than half of the services did not know if consumer satisfaction with their services had risen or fallen since they introduced the charter. Local charters were available in 60 per cent of health authorities and 58 per cent of the NHS trusts. Other findings included:

More positively, most providers now have charters or intend to develop one. Most of those who have one have consulted their consumers about their needs and priorities and many have acted on what users told them. Most have an independent element in their complaints-handling procedures. (National Consumer Council, 1998, p.16)

These two studies provided a broader picture and macroscopic view of the implementation of public services local charters including local patient's charters. At the national level, the National Health Service Executive issued circulars and guidelines to the local level at health authorities, NHS Trusts and GP fundholders to give guidance on the implementation of *Patient's Charter*. For example, a guideline was issued in March 1995 from the Patient's Charter Unit of the NHS Executive Headquarter shortly after the launch of the revised *Patient's Charter* in January 1995 (NHSE, 1995c). This guideline provided information to help implementation, including the policy objectives of the new rights and standards as well as any definitions needed to clarify meanings within the 1995 *Patient's Charter*. The NHS Executive made use of other 'Executive Letters' as the means to explain and direct local level to implement the *Patient's Charter*. In 1997, the NHSE (1997b) outlined a programme of work for health authorities and NHS Trusts to ensure that the objectives of privacy, dignity and the provision of single sex hospital accommodation were delivered. Health authorities were asked to make regular progress reports to the NHS Executive against locally agreed targets for Trusts within their boundaries about the provision of single sex hospital accommodation. This geographical approach to monitoring was the 'same as that used successfully to monitor other key patient's charter standards' (NHSE, 1997b, p.2). Health authorities were expected to publish patient's charter annual reports by mid-July of each year to show how local Trusts had performed on charter rights and national and local charter standards (NHSE, 1997c). In order to help to reduce workloads, the NHS Executive recommended amalgamation of the health authorities' patient's charter annual reports with their annual reports on finance and other business. The combined reports should be published before the end of November each year. Later in September 1997, another executive letter was issued to all Chief Executives of health authorities and NHS Trusts about changes to

monitoring arrangements for the *Patient's Charter* starting from Quarter 2 in 1997/98 (NHSE, 1997d). One month later, a further letter was issued to announce the development of a new charter led by Greg Dyke with an aim to publish a draft by summer 1998 (NHSE, 1997e). This letter also confirmed the arrangements for implementing a new patient's charter standard on immediate assessment in A&E departments effective from 1 October 1997 and to be fully implemented by 1 April 1998. The standard was:

If you go to an Accident and Emergency Department needing immediate treatment you will be cared for at once. Otherwise you will be assessed by a doctor or trained nurse within 15 minutes of arrival ...

Following assessment you will be given a priority category which will be communicated to you. This priority will determine the urgency with which you will be treated. (NHSE, 1997e, p.3)

Similarly, various executive letters and health service circulars were issued to address the implementation of *Patient's Charter* at local level, such as the implementation guidance of the *Charter for mental health* (NHSE, 1997f); the next steps for the provision of single sex hospital accommodation (NHSE, 1997g); the changes to central collection of patient's charter key standard data (NHSE, 1998c); a monitoring tool for single sex hospital accommodation (NHSE, 1998d) and the tackling of violence towards GPs and their staff (NHSE, 2000). In this sense, clear messages were passed down from national to the local levels with the help of these documents from the NHS Executive.

Regarding the number and posts of the respondents in this study in England, Table Twelve shows a breakdown of the participants in the interviews. I will divide

them into four categories, namely managers, frontline staff, CHC and patients' group to differentiate between them while safeguarding confidentiality. Each interview lasted from 20 minutes to 30 minutes.

Table Twelve: Characteristics of Respondents of Interviews in UK

	Manager	Frontline Staff	Patient Group	CHC
Number of Respondents	4	7	1	1

From the research interviews in this study, a more local focus is possible: how was the *Patient's Charter* implemented in individual hospital Trusts? Firstly, not all hospital Trusts published their own local charters. For example, one hospital Trust in this study did not have its own local charter. As a senior manager claimed:

‘In this Trust, we just follow the national charter. My previous Trust has a local one. We will wait and see if there is a need to have a local one.’  
(Senior manager)

The distinction between national and local charters was useful to some Trust because local charter standards could be established and updated relevant to local needs. A local charter can indicate to local patients and carers the realistic standards of care. As a manager commented:

‘You have a national one, you have the public a certain expectation. If you can’t achieve it, they will question it. I think we need to be realistic whether we can produce this expectation. In this case, I think local charter really helps to say what we can actually deliver.’ (Nurse Manager)

‘I tend to give the local one to patient when they come to the CHC. I also give the national one upon request.’ (CHC Representative)

Secondly, a number of issues related to nursing staff were implemented and monitored at the local level. For example, the named nurse initiative was widely

incorporated at ward level. The named nurse system was implemented in every branch of the nursing profession (Dooley, 1999; Department of Health, 1993a). This initiative has been described as probably the single most important change to nursing practice since the introduction of the nursing process in the early 1980s (Dooley, 1999). Within the ward level, nursing staff explained the mechanism of the assignment of named nurse initiative:

‘Every patient in this ward has a named nurse. Usually we have about 4 patients to look after. A “E grade” nurse will have no more than 3 patients while a “F grade nurse” will have around 2 to 3 patients under the named nurse system.’ (D grade nurse)

‘The named nurse is important to nursing anyway, so it is something that we do and keep trace of.’ (Senior Manager)

‘I use a flow diagram to see what would happen to a patient when he comes to the hospital.’ (E grade nurse)

In another hospital, the workload was different with some six patients being cared by one nurse as their named nurse. Such loading was affected by the resources available at the point of time. Another factor was said to be the consideration of rank:

‘We are looking for how best we can make it. We work very well and on average there are six patients under a named nurse in a general ward. Obviously, it goes up and down which depends on the staffing resources. We try not to give more than that because it will be too many. Senior staff, for example, ward manager will have smaller group of patients because they have got other different responsibilities.’ (Nurse manager)

There were no specific guidelines from the national level about case loads for the named nurse initiative. As the NHS (1994) has indicated, no set figure can be given. The case load of each nurse will vary according to various factors. For example, in some settings a patient who is very ill may require:

the constant attention of one nurse, such as in an intensive care unit. The number of patients for each named nurse will depend to an extent on the patients' nursing needs. In addition, in settings where the geographical spread of patients is very great, the nurse's caseload would be much less than areas where the patients are concentrated closely together.

(NHS, 1994, p. 14)

It is important to have a fair skill mix and workload to implement the named nurse successfully for the benefits of patients and staff. The nursing staff should have sufficient and appropriate qualifications to implement the system (Hancock, 1992; Steven 1999) and time is needed to handle patients' care. The charter standard found in the 1991 *Patient's Charter* stated, 'The charter standard is that you should have a named, qualified nurse, midwife or health visitor who will be responsible for your nursing or midwifery care' (Department of Health, 1991a). Therefore, the nurse should be qualified in terms of skills and specialties. As reiterated by the national guidelines, all nurses on the register including staff nurses and enrolled nurses, can act as named nurses. The concern is about competence rather than too much emphasis on qualification (Department of Health, 1993a). Regarding issues around grading or rank of the nursing staff, the grade for the named nurse would vary according to the degree of responsibility and other functions being carried out. Nurses working as primary nurses would appear to have a good case for a minimum of scale 'E' (Wright, 1990; Department of Health, 1993a). It is believed that senior nurses should have a lower case load because of other management duties involved in addition to acting as a role model for other nursing staff about the named nurse initiative. From the interviews, one nursing director commented:

'There is a lot of debate about whether there should be a named nurse standard or whether it should be abolished. Personally, I think it should stay. I think it will be more wisely about what are the criteria and the necessary expertise to be the named nurse. In the past it can be anyone.'  
(Nursing Director)



How do patients see the named nurse initiative? Staff interviewed thought that patients usually do not care who is the named nurse or if there is the named nurse initiative at all. The reflection of the experience gained by a E grade nurse illustrated the point. She commented:

‘Patient don’t care if there is named nurse or not as long as they are being looked after carefully. It is not a matter of D or E grade nurses, it is about the care they are receiving.’ (E grade nurse)

Sometimes, the charge nurse of the ward seemed to automatically become the named nurse if in doubt. Junior staff will direct their questions to the charge nurse for advice if necessary. Patients would speak to their named nurses to find out in more details about his/her condition, treatment and care (NHSE, 1994). Within the ward, the distribution of named nurse to individual patients was posted on the notice board clearly. Patients and relatives seemed to find it easy to locate who is the named nurse for that particular patient.

Feeling from other nurses were mixed towards named nurse initiative. Both positive and negative impressions were gained. Indeed, some nurses queried their suitability when they had moved from one specialty to another. From the experiences of contact with his front line nursing staff, it was apparent that there was a variety of feelings (see Table Thirteen and quotations):

Table Thirteen: Congruence: number and percentage of respondents agreeing positive impressions towards named nurse

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	All No. (%)	n=11 (%)
Agreeing	3 (75)	5 (71)	8 (73)	

‘It’s mixed. Some staff see it in a very positive way, spelling out what responsibilities are. Some people see it negatively as it put more pressure on them. I personally think that providing people with the additional security for the patients will have less chance of mistakes.’ (Nursing Director)

‘A number of nurses who have been moved from one area to another area would say about the book of conduct and the *Patient’s Charter* that “I am not eligible to look after the patients in this specialty”.’ (Nursing Director)

The issue of the ‘single sex ward’ appeared to be important for some Trusts as it was discussed at many meetings. With the requirement of clinical governance, a whole new unit was set up as the department of clinical governance in one Trust. Many of the patient’s charter issues such as single sex wards and waiting lists will be dealt with under this department:

‘For instance, with the clinical governance agenda, the patient’s charter issues can be built into that so that there could be a review about what is happening ... In crisis situation, we may still have male & female within a single ward but are separated physically (screen).’ (Nursing Director)

‘Clinical governance is complementing with the *Patient’s Charter*. It is more relevant to what we are doing. I think clinical governance is what we should be moving but not marrying the two.’ (nurse)

‘I think it is complementary to clinical governance. At the end of the date, clinical governance is to improve the services. I think the public would not mind waiting if they can have the right treatment and diagnosis.’ (Senior Manager)

‘Mixed ward has become the press interest. Perhaps it is the only standard that attracts the interest nationally. We have recently done a complete audit of the Trust to see what progress we have made.’ (Senior Manager)

Apart from the interest in the issues of the ‘named nurse’ and ‘single sex wards’, there are also requirements to report performance indicators to health authorities and the National Health Service Executive. The project manager who was in charge of patient’s charter project in one Trust explained (see Table Fourteen and quotations):

Table Fourteen: Congruence: number and percentage of respondents agreeing performance indicators were collected about *Patient's Charter*

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	6 (86)	1 (100)	1 (100)	12 (92)

‘Yes, there are things need to be returned to the health authority, for example, waiting times and mixed wards. In generally, we are doing quite good ... There is a quarterly report which we have produced which has all the charter information. It is widely available to the wards and managers. It also goes to G.P.s to show how we are doing.’ (Project Manager)

‘We have to report back quarterly and annual basis to the health authority and we have a member of staff who is responsible to pull these data together.’ (Nursing Director)

‘The only three items that I report at the moment are waiting time at A&E, waiting time at out patients department and cancel operation ... DNA (Did Not Attend) is very serious here. Some 12% is quite a serious problem.’ (Senior Manager)

‘We audit the named nurse regularly and also aspect of the charter like the single-sex ward.’ (Nurse Manager)

At the A&E department, other performance indicators are particularly important such as the triage time and the trolley wait. All these waiting times were documented and reported. As the team leader recalled:

‘For every 6 months, they (health authority) publish a report of all hospitals in the region about the triage time, waiting list and put these in tables ... If our trolley waits is more than 2 hours, we have to report to the manager in charge. If wait for more than 3 hours, we have to report again. But trolley wait is a joke if there is no bed in the ward. Sometimes, we have got four, five or even 6 hours wait.’ (G grade nurse)

Another staff member of an A&E department talked about her experiences in implementing the charter and noted that A&E departments are busy and unique in the system. In his view, more realistic standards should be adopted:

'I think patients know what they need and should receive from us. They come around to ask how long should they wait before the 15 minutes triage. Some of them saying that they have been waiting for more than 15 minutes ... On a busy day, we don't always meet the target waiting time. We have an electronic bar in the waiting room which tells how long the waiting time to see a doctor. When we see the patients, we write down the time and to be input to the computer. We can print out the trolley wait statistics daily.' (E grade nurse)

'Since 1992, we are measuring two things as standards. Number one the triage waiting time and number two the trolley waiting time.' (A&E manager)

'It got to be realistic. At one time when the charter stated "You will be seen within 15 minutes", we thought it was unrealistic and unreasonable.' (G grade nurse)

'The people who write the charter have little understanding of what is really important. One of the standard that has changed was the standard for waiting time in A&E. Initially, it was 5 minutes upon arrival and there was a great debate about how realistic it was.' (Senior Manager)

The National Health Service Executive argued that staff members should know and understand clearly the meaning of the content of the charter (NHSE, 1994). They should be fully aware of the implications of the patient's charter on their daily routine duties. It was seen as particularly important to new staff so that they could understand the requirements of the charter. In terms of promotion and dissemination of the charter to patients and staff, various strategies were adopted. One Trust incorporated the leaflet about the *Patient's Charter* into the in-patient welcome pack. Initially, posters and leaflets were widely available at the hospital premises as well. The E grade nurse of the A&E department illustrated:

'They used to have new staff training about the charter standard. They will have an induction week to learn how to handle complaints.' (E grade nurse)

'At the school of nursing, it has the training about the *Patient's Charter*. When the charter came out, we used to have a lot of leaflets and health education to patients and our permanent staff. There used to be quite a lot

around with notice board. Now is dying away as other issues are coming, for example, Clinical Governance.’ (G grade nurse)

‘Sometimes the junior staff are not familiar with the charter ... we have leaflets at the waiting room of the A&E.’ (G grade nurse)

It was also seen as effective to incorporate the elements of the *Patient’s Charter* in job descriptions so that staff would consider the importance of the charter. An internal newsletter was used by one Trust to spread good practice among staff. The following quotes reviewed their experiences:

‘It is written in their job description. New staff will be trained as part of their induction programme. Workshops will also be held to highlight changes in case of new charter is published.’ (Nurse Manager)

‘We have a newsletter published by the Trust. It informs us of what is happening at the management level.’ (E grade nurse)

Local Community Health Councils kept copies of the local charters available to the public upon request while the national *Patient’s Charter* was available widely within the local CHC.

‘When they come to the CHC, we make them aware of the standard ... Trusts need to make sure local charters are available in all the wards and departments.’ (CHC Representative)

Patients from different parts of the country could also call to the Patients Association’s headquarter based in Middlesex to ask for their rights:

‘We have a number of people phone in. They want to know about what their rights are. We will advise the patients who to contact, for example, the local trust or the health authority ... it is not being promoted by the NHS as it used to be.’ (Patients Association Representative)

Hence there was a variety of ways to disseminate the charter to staff and patients. What is more important is whether patients actually use the charter. That is to say, if patients refer to the charter at all. According to the experience of staff, this varied and in

particular the degree of emphasis changed over time. Those comments are summarized and shown by the following different responses (see Table Fifteen and quotations):

Table Fifteen: Congruence: number and percentage of respondents agreeing patients rarely refer to *Patient's Charter* nowadays

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	2 (50)	4 (57)	1 (100)	1 (100)	8 (62)

‘No, I couldn’t name the occasion whereas patients say it’s my right.’ (D grade nurse)

‘Some do, some don’t, we don’t get many.’ (Nurse Manager)

‘They refer to the charter when complaining.’ (Senior Manager)

‘Very infrequently, because the majority of users of the service are unaware of the charter.’ (CHC representative)

‘Yes, they do. I think it has become part of the mechanism the individual or member of the public use to judge the services they are getting. They will use the standards to examine the standards of the hospital.’ (Nursing Director)

The degree of emphasis has decreased in recent years. Patients seldom used it by 2000 as reflected by the following quotations:

‘They don’t use it much now. When it first came out in the press, there were great emphases. We don’t have people mentioning it so much now.’ (G grade nurse)

‘They used to but they don’t do anything like that much now. When it is first come out, we have got more people saying the charter.’ (Project Manager)

‘A lot of patients do not know the existence of the charter at all. That’s right. They don’t know. The charter at the moment is hidden!’ (Patients Association representative)

From these responses, there was a feeling that patients were generally ignorant about the charter and the importance of charter had declined in recent years.

### 5.3 Staff and Patient relationships

The relationship between clinicians and patients is important in a number of aspects. For example, Dowrick (1997) considered the doctor-patient relationship in general practice. He argued that medical sociologists tend to stress the two uses of the relationship. One is the ideological construct to give the clinician a sense of professional expertise. The other is the way to exercise and maintain power. The trusting relationship also helps the treatment process in facilitating communication between the two parties. The trusting relationship between patients and staff was considered by nurses and managers to have changed since the launch of the charter. It was an evolutionary process. As the nursing director commented:

‘For first instance, the general public didn’t have any effect on the relationship. As there was more promotion, general public got their rights which could threaten to staff but now is more natural.’ (Nursing Director)

Table Sixteen showed the positive change in the relationship of trust between staff and patients with the impact from *Patient’s Charter*:

Table Sixteen: Congruence: number and percentage of respondents agreeing a positive change in trusting relationship between staff and patients

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	5 (71)	1 (100)	1 (100)	11 (85)

‘I think initially the relationship is a little bit strange because they were telling us “I read the *Patient’s Charter*”. But I think because it is the

newness. Now the patients still realize what they are entitled to.’ (G grade nurse)

‘Over the year we see the change of the relationship. How much the change was related to the *Patient’s Charter*, or how much it was related to the changes in the society as a whole. I am not sure. I think the society is less accepting for poor quality and people are used to free health services. I suspect the *Patient’s Charter* has raised the patient’s expectation ... In the last two months, we have long waiting time in A&E department and surgery because our hospital is not big enough. Some of the patients do quote the *Patient’s Charter* when they are asking about the waiting time. But we said that we would follow the charter as much as we can but equally we have the responsibility to treat emergency patients. I think the charter has changed the relationship.’ (Senior Manager)

‘I can’t comment on what is before hand. I think patients got more rights to know their treatment and hence more trusting relationship.’ (D grade nurse)

Apart from increased trusting relationship, staff placed greater emphasis on the named nurse issue and on treating the patient as an individual:

‘Because of the nature of the working colleagues here, it highlighted the importance of named nurse and focused on one person (the patient).’ (G grade nurse)

‘When patients come to hospital, they leave to our nurses’ and doctors’ hand ... The good thing about the charter is that they (patients) have a right to complain and to have a proper reply.’ (E grade nurse)

According to staff, patients were willing and ready to ask for the information about their conditions which can facilitate the understanding between staff and patients:

‘Patients and carers want to access to information. We still got questions from patients such as “Can I speak to the Doctor? Can I speak to the nurse in charge?” ’ (E grade nurse)

‘At A&E, they are more concerned with the 4 hours wait in trolleys.’ (Project Manager)

Changes were made at the supporting services such as car park arrangement for patients and their visitors according to their needs:



‘The car park was used to be parked by doctors but now we have changed the arrangement to let patients to park their cars.’ (Project Manager)

The CHC and Patients’ group shared this positive view about the changes in the trusting relationship between patients and staff since the launch of the charter. As the representative of CHC commented:

‘No, it shouldn’t change at all. Indeed, the relationship should get better. The government have said for a number of years that you must have involved the users and public involvement. Really it should be better.’ (CHC Representative)

‘Certainly, the trusting relationship has improved. However, I don’t think this is the consequence of the charter as a whole. The nation is now changed and the way we are more demanding and questioning whoever we are receiving the service from.’ (Patients Association Representative)

Hence, there was a general impression of an improved relationship of trust between staff and patients in an era of high expectations from the general public. Of course, there was evidence of negative comments and obstacles to the relationship and about the issue of complaints. As Allsop and Mulcahy have explained, a complaint can be interpreted as a challenge to expertise and authority of clinicians. It also represents a double challenge to have got something wrong technically as well as not to have used their knowledge in the interests of the patient and thus to have broken a basic trust (Allsop and Mulcahy, 1998a). From the respondents, several comments were made (see Table Seventeen and quotations):

Table Seventeen: Congruence: number and percentage of respondents agreeing increased number of complaints

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	7 (100)	1 (100)	1 (100)	13 (100)

‘Yes, the number of complaints were increased. I don’t know if it is related to the charter as a whole or of the new complaint system following the Wilson report. The issue is increasing rather than just the number. They are more complicated! ... but generally patients do not know the proper procedure for complaints.’ (CHC Representative)

‘Again, they (number of complaints) have increased but I don’t know if they are the consequences of the charter. I don’t think the charter make much differences in this aspects. I think what is different since the original charter is that complaints have taken a different priority in the NHS and the huge criticism of the complaint procedure. People of this nation are more willing to complain.’ (Patients Association Representative)

‘You tend to find more complaints that are not coming from patients, they are from relatives (third party).’ (E grade nurse)

‘Yes, patients use the charter occasionally but there is always something to upset them, for example, the waiting time is longer than normal. If you sit down and listen, talk to them and explain, you will eliminate the complaint but you still get some odd one.’ (G grade nurse)

‘I think to begin with, it become more difficult. They will complain and quote the charter. To begin with, there is a little bit friction. But now it is used to, people are more understanding of the benefits from the clear information about their care.’ (Nurse Manager)

There were patients who complained regularly as recalled by a speaker at a local conference:

‘Difficult complaints may include the regular complainers and the complaints involving abuse and aggression ... support are needed for staff in coping with abuse and aggression.’ (Customer Relationship Manager from Trust at the New NHS Charter Debate)

Complaints could happen if patients’ expectations were not met. The situations deteriorated if the standards were unachievable due to resources constraint:

‘When it first came out, “This is my right. I want this, I want that”, it just makes your headache.’ (G grade nurse)

‘I think the national charter help to standardize care throughout the country. But there are problems about the flexibility. If you raise people’s expectation to something that you cannot provide and that can cause conflicts.’ (G grade nurse)

Regarding the relationship and decision making between frontline health care staff and management, various respondents raised several aspects including workload issues, skill mix, management, and so on. On one hand, management had responsibility to initiate the implementation of the charter with limited resources to help this process. On the other hand, frontline staff needed the competencies and skills to deal with the requirements. It was noted that staff members were generally concerned about the lack of patients' responsibilities and the potential danger of violence against front-line staff. Previous reports from the press have indicated the problems of violence in the NHS. Apart from ambulance staff, other members of staff including nurses are at risk. Some nearly 70% of ambulance crews in one survey had been the victims of violence in 1997. Nurses also mentioned a high proportion of attack: 46% of respondents in one survey reported a violent crime as well (BBC, 1998a; BBC, 1998b). In interviews, respondents indicated the lack of sense of responsibility among patients. Moreover, several respondents raised the need for a staff charter to reduce violence and aggression (see Table Eighteen and quotations):

Table Eighteen: Congruence: number and percentage of respondents agreeing the lack of sense of responsibility of patients

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	7 (100)	1 (100)	1 (100)	13 (100)

‘Our Chief Executive and Chairman are very concerned about patient’s responsibility aspect particularly in terms of abuse to staff from time to time ... we receive a number of call from staff group. We need a staff charter as well.’ (Nursing Director)

‘The area of communications I want to cover today takes us into the area of patient responsibilities because when I was asked to understand this review

this was an area of specific concern. In particular I was asked to look at DNAs – the problem of 12% of patients who failed to turn up for hospital appointments.’ (Dyke, 1999)

‘Whose responsibility? A reduction in DNAs is achievable only if hospitals accept that they cannot simply dictate when the patient has to come for an appointment rather than negotiating a mutually convenient time.’ (The Institute of Health at the NHS Charter Debate)

Staff members voiced their concern about physical and verbal abuse especially in the A & E department. They summarize and repeat quotes:

‘I want a nurse charter to be put on the wall saying that “I expect you as a patient to be courtesy to staff” ... It is about mutual respect.’ (E grade nurse)

‘I would like to see the zero tolerance zone of both physical and verbal abuse to staff. We have got posters of zero tolerance on the wall of A&E. Violence is quite common especially verbal abuse when people get drunk. So patients have their charter, I would like to see something similar, not to the same complexity and not to the same degree.’ (G grade nurse)

‘Yes, we have got demanding patients and violent patients. I think it depends on how you speak. If you communicate well with them, explain what the waiting are, keep giving information to them, then it will be resolved ... Yes, verbal abuse, I have been shouted at.’ (E grade nurse)

‘There is a concern about violence but is not a severe case here. We are sending messages to the public we are doing what we can.’ (Senior Manager)

Staff felt their workload had increased because of the need to spend time responding to patients and their carers about their enquiries. However, better communication between staff and patients could prevent conflicts:

‘I think when the *Patient’s Charter* first came in. There are great focuses on numbers rather than on clinical situations. Therefore, there are frictions between managers and clinical staff but equally there are improvements in some other areas.’ (Senior Manager)

‘I think there are quite a lot of conflicts because they (managers) have their objectives but on the whole they are quite good ... the workload is a bit heavier because patients have the right to know what has happened to

them. We spent more time to talk to them and discuss their treatments. In a way, this has increased the workload.’ (D grade nurse)

‘It has changed the patients’ perspectives and our workload a bit. They are more aware of things but generally not a great deal.’ (G grade nurse)

‘The pressure on junior staff in this hospital has increased tremendously.’ (E grade nurse)

‘Again our trolley waits depend on the other part of the hospital. There is not much we can do until the ward starts to discharge patients. We have to make patient feeling comfortable so that they would not complain while they are here at our department.’ (E grade nurse)

‘We operate with a very decentralized structure here. Their approach is that we talk to the people what we need to do.’ (Project Manager)

The former Health Secretary Frank Dobson, also considered the *Patient’s Charter* had led to an increase in violent attack on NHS staff and had contributed to patient frustration (BBC, 1998c). That seems to be one of the reasons behind the government’s stated intention of replacing the old charter in order to give patients responsibilities as well as rights. These issues of patient responsibilities and the growing problem of violence against NHS staff were addressed by Dyke’s review of the patient’s charter in section 10 of the report (Dyke, 1998).

#### 5.4 Management Issues

A number of issues were raised in the interviews around respondents’ views about the political background of the charter and its specific uses as a management tool. These interviews took place before the new *NHS Charter* or, to be more accurate, the *Your Guide to the NHS* was published in July 2000. However, views about the proposed *New Charter* were collected from these participants. In terms of the political elements of patient’s charter, most respondents indicated that there were high political elements to

the background of the charter and the uses of it. Interview data can illustrate their interpretations of the change of government (see Table Nineteen and quotations):

Table Nineteen: Congruence: number and percentage of respondents agreeing the political background of *Patient's Charter*

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	5 (71)	1 (100)	0 (0)	10 (77)

‘When we see the revised *Patient's Charter*, I think you may well see a political turmoil in terms of demonstrating modern New Labour points of views. I actually think that the concepts and philosophies won't be any different. I think it will still be about identifying what the rights and standards are and the quality. I think different political views may have a slightly different views of what quality is and I think the concept of *Patient's Charter* is still intact.’ (Nursing Director)

‘Yes, certainly. It is a political tool that the party and the way health authority implementing it or not ... There is a different political party in power and I think the assumption is that it has stopped. There is no more charter.’ (Patients Association Representative)

Some respondents indicated the need for New Labour to initiate policies different from the previous Conservative or Majorite initiatives and to treat the charter as a political tool rather a tool for improving quality of care.

‘New Labour may want to get rid of Major's tools. I don't know what is in the new charter. It should not be much different. I think what is different may be the way how they are communicated and the message behind. I think with John Major' government, it has along the line. We have a health service that needs to be improved. I expect the Labour government approach to be more soft and moral.’ (Senior Manager)

‘I will be surprised if this government will go back to the charter. My feeling is that they would leave it behind.’ (Project Manager)

‘One of the difficulty is the change of government.’ (Project Manager)

‘Over the years the focus of the charter has faded considerably. When the first charter came out, there were guidelines issued on how things should be measured, defined, as well as guidelines of good practice. There were many guidelines on the named nurse. The second charter came and there were less emphasis. Now, with the change of government, they are lacking of their interest in this topic. So the measurable aspects of waiting time, for example, are given to the health authority but we do not know what they are interested in ... It is a political tool but not a tool to improve clinical services. (Senior Manager)

Some nurses associated the use of charters by the government to get votes and to allow government to claim that the waiting list was reduced. They saw it as a means to increase the popularity of the government:

‘I think yes, patients also get their rights. I think lots of charters in the public sector are motivated by getting vote but it is something that we need.’ (G grade nurse)

‘The government can make use of the charter and say about the trolley wait has come down.’ (E grade nurse)

‘It probably got a little bit of political element but not all of this. I think initially it is a political thing but at the end of the day, it was trying to emphasize patient’s rights and certain expectations ... In the management, they are using certain features of it and say that we are doing this measurable thing. The government want to make itself popular.’ (G grade nurse)

‘Politicians obviously use it when it initially comes in.’ (G grade nurse)

Hence, Charterism in UK reflects a high level of influence from political party politics. As commented in the media, the original *Patient’s Charter* was arguably one of the most important legacies of the Major Government and the charter programme was carried on even after the change of government in 1997 (BBC, 1998e). The media remarked that staff members saw the *Patient’s Charter* as something that was being politically imposed upon them. They did not believe it nor they did not think it was worthwhile.

The *Patient's Charter* was also considered by staff as a management tool to shape the culture of the organization. The NHS is characterized by its sheer size and the large number of employees who are generally dedicated to work for the benefit of the society. In the history of health services management, new methods, terms and management philosophies have emerged from time to time in the attempt to re-orientate the organization to the stated goals. Charterism is hence a new term to develop the quality culture of public organizations. As one manager commented (see Table Twenty and quotations):

Table Twenty: Congruence: number and percentage of respondents agreeing the facilitation of quality culture with *Patient's Charter*

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	5 (71)	1 (100)	1 (100)	11 (85)

‘I see it is a quality improvement tool. Yes, managers have used it to shape the culture. Whenever they are thinking about service development, they will look at the charter standard. It actually helps them to develop accurately.’ (Nurse Director)

‘It has become part of the culture now. I think people know there is a *Patient's Charter*. They have got some ideas of the content only. I think most staff would view it as a good thing.’ (Senior Manager)

‘I think they certainly use it for that (accountability).’ (CHC Representative)

‘It certainly was used as managerial tool but I don’t know if it is used now as quality check of some sort on the health services and a measurement of the effectiveness of the services. Certainly, there is flexibility within the charter. Some of the charter Standards from the manager’s point of views were very difficult to achieve and some of them were open to abuse.’ (Patients Association Representative)



*Patient's Charter* also helped managers and frontline staff to focus on important issues at their hospitals:

'It does, it is quite useful. It gives an ideal leverage when we are talking to staff. It is helpful to focus staff on what is important.' (Senior Manager)

'Each year there are difference focuses such as waiting times and there are much more measurement.' (Project Manager)

'We are given more managerial responsibilities nowadays.' (G grade nurse)

'I think it certainly is. I think it is also a valuable thing for the patient.' (D grade nurse)

'This is what we are doing. It has a sound basis of giving patients and relatives a say. You know that it is good to measure some of the issues that can be used as a management tool. Professionally, in nursing, I don't think it has changed our practice very much as all.' (G grade nurse)

Apart from its possible role as a useful management tool, a manager's authority can be changed with the use of the charter. Managers can make use of the charter to increase their authority and power in managing the hospital or department. One senior manager explained the situation:

'It gives the directions and obligations and helps the manager to focus on quality issues and product issues, not just getting people through. There are much more emphasis on consumer satisfaction.' (Nursing Director)

'It may increase the authority but it can also cause conflict because the clinician will always see the manager as the backhand of the government. If the Trust manager does not follow the charter standard, the Trust manager will lose his job. Therefore, it may increase the power but also the complexity.' (Senior Manager)

The charter can also help to raise the awareness of local CHCs among citizens. However, no additional resources were given by the government to deal with any greater workload associated with the charter.

‘In CHC, it has increased the awareness of CHC a little bit but we haven’t received any money so we cannot do more than what we are doing.’ (CHC Representative)

When asked about their comments on the implementation approach, many affirmed the shift towards the top down model of implementation (see Table Twenty-one and quotations):

Table Twenty-one: Congruence: number and percentage of respondents agreeing the top down approach of implementing *Patient’s Charter*

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	3 (75)	4 (57)	1 (100)	0 (0)	8 (62)

‘Certainly it is a top down implementation with no bottom up. This is indeed one of its criticisms. Patients have so little influences upon the standard set by politicians and managers. But the most encouraging thing is that a number of G.P.s are involving patients to generate their standards and come to an agreement with patients on what is or is not acceptable. So the management can give a practical point of view and patients can also get a practical point of view from their side.’ (Patients Association Representative)

‘Yes, definitely. “You will do this.” ’ (E grade nurse)

‘I think it is a mixed approach.’ (G grade nurse)

Other sources also confirmed this observation. As the NHS Confederation commented:

‘Health authorities and trusts would welcome a less top-down approach to the *Patient’s Charter*.’ (BBC, 1998d)

In interview, additional questions were asked about their experiences of and comments on the Charter Mark scheme to see if Trusts or units had been awarded any

Charter Mark and the impressions of staff in general. Some departments of the Trusts explored in this research had received a Charter Mark, as revealed by managers and other staff:

‘One of the area within our Trust has won the Charter Mark at the Day Surgery Unit. There are much acknowledgement received.’ (Nursing Director)

‘Some units have got it in our region. Yes, good morale among staff. Charter Mark is good, it is benchmark, isn’t it?’ (CHC Representative)

‘We have Charter Mark before. Staff are very pleased but for a short while and now has come down.’ (G grade nurse)

Although the interviews were conducted before the launch of the *Your Guide to the NHS*, some comments favoured the continuation of the charter. Suggestions were made about the content of any proposed new charter in areas such as patients’ responsibilities, higher standards and flexibility of standards (see Table Twenty-two and quotations):

Table Twenty-two: Congruence: number and percentage of respondents agreeing the continuation of *Patient’s Charter*

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	4 (100)	6 (86)	1 (100)	1 (100)	12 (92)

‘Oh, yes (supporting the charter). I think we should understand what the services are, what we ought to be providing in terms of quality. I also think it is worth they also need to develop their responsibilities that the charter might be extending ... There might not be significant changes to the existing one. I think what I want to see is some public health quality mechanisms to ensure the society are doing it.’ (Nursing Director)

‘I think it is. I would like to see the majority of things are the same. In other words, the standard doesn’t go down. The standards need to be either exactly the same of the moment or slightly higher. It you need addition

items, I think it is something broadly acute and community based rather than mental health although there is a mental health charter. I think it needs to be clear which is referring to acute, community, mental health and maternity charter standards.’ (CHC Representative)

The Patients Association was also involved in the consultation process of the new *NHS Charter*. Although the Association was supportive of charter, reservations were found about the suggested changes:

‘As I have said, our president is involved heavily in the consultation of the new charter. We have great reservations about the way that Mr. Dyke suggested the changes. Yes, there would be changes and again the charter itself could be improved and strengthened to include GP surgery and at the moment it is not compulsory and they set so vague and broad standards.’ (Patients Association Representative)

Some others claimed that they were neutral to the charter but still would like to see an improved patient’s charter:

‘I would like to see how it is related to the health authority, regional and local levels.’ (Project Manager)

‘I don’t know much about the new charter so I would not say yes or no.’ (G grade nurse)

‘I think the new charter is good. I have to say I am really not up to date, I just try treat a patient.’ (D grade nurse)

‘I support the system that works. It is inappropriate to do something that works and then stop it. Whether you call it a charter or not is not the matter.’ (Project Manager)

Suggestions were made by respondents about the content of any proposed new charter:

‘New charter should explain to patients what do we expect them to be ... This quality initiative got to be welcomed. I hope the new charter will have different tone and will be monitored in different ways.’ (Senior Manager)

‘It should not be fixed but should be flexible about guidelines, for example, to be seen within 10 minutes ... Just make it more flexible about the waiting time.’ (E grade nurse)

‘The current charter didn’t include, for example, the minimum requirement of the building which I like to see it included in the new charter.’ (E grade nurse)

Likewise, the new charter should stress the partnership approach and the importance of patients’ responsibilities:

‘I think it needs to emphasize the partnership between patients and professionals. From nursing point of view, we are the patient’s advocacy ... I think the new charter has the merits. More consultation is needed to become workable.’ (G grade nurse)

‘I think the new *NHS Charter* will say something about the rights and our expectations on patients about cancellation of appointments.’ (Senior Manager)

The Patient’s Charter Unit of the National Health Service Executive is the policy and executive body at national level in charge of the implementation of the patient’s charter. From the research interviews, it seemed that the support from the National Health Service Executive had been experienced as generally limited as reflected by the majority of respondents (see Table Twenty-three and quotations):

Table Twenty-three: Congruence: number and percentage of respondents agreeing the support from NHSE was limited

	Managers Agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	CHC Agreeing No. (%)	All n=13 No. (%)
Agreeing	3 (75)	4 (57)	1 (100)	1 (100)	9 (69)

Limits were explained by managers that some main elements needed to be supported, for example:

‘I think what it ought to do is to raise the profile. Only when it is raised people will think about what is necessary. Clear justifications to managers of what kind of support are needed for this initiatives.’ (Nursing Director)

‘If it is to be re-launched then patients need to be aware of it. When the first charter came out, every household has a booklet which I think it is a huge waste of money. There are more practical way of communication.’ (Patients Association Representative)

‘Extra money is needed. I don’t know if the current support is right but it is one thing to set the target. It is another thing to get a number of high skilled and competent people to do it.’ (Project Manager)

‘I don’t think they have done much work on the trolley wait.’ (G grade nurse)

‘I am quite keen that the NHSE will have a light touch. I believe the local managers have the best understanding of their problems.’ (Senior Manager)

Community Health Councils (CHCs) have also been involved in issues regarding charter standards. CHCs are independent bodies and have played a key role in exposing malpractice in various cases such Alder Hey, Bristol Children’s Hospital and Dr. Shipman in recent years (BBC, 2001a). In the preparation of local patient’s charters, the Trust may invite representatives from the CHC to give input. The CHC has the authority to visit the premises of the hospitals. Various responses from the study indicated how CHCs had been involved in the implementation of the *Patient’s Charter*:

‘They will spot visit the Trust and give feedback to us. They will relate to patient’s charter issues.’ (Nursing Director)

‘We don’t receive performance indicators about the charter from the Trust. We can question and they have to give back the data.’ (CHC Representative)

‘They will come and CHC tends to focus on the wrong things. When they visit the geriatric ward, they ask about whether there are games for them.’ (E grade nurse)

‘CHC will visit us to see if we are keeping up with the *Patient’s Charter*. They are happy and we are happy. We put emphasis on meeting the triage time which is part of the *Patient’s Charter*.’ (G grade nurse)

‘We have good relationship. I met the Chief Officer (of CHC) the other day of a month. We talked about complaint. We talked about patient’s

charter. They have some understanding of the problem we have.’ (Senior Manager)

‘I don’t know but previously they will refer to, and look for data. Are these available? If rights are implemented?’ (Nurse Manager)

Despite the usefulness of CHCs (Burke, 2000), the government has decided to abolish the CHCs and to replace them by the Patient Advocacy and Liaison Service (PALS). As the *Health Service Journal* (2001a) has indicated, CHCs will close early in Labour’s second term (see page 174 of this thesis). According to the government, there are weaknesses of the current system of the CHCs (NHS, 2001). For example, the performance of CHC is patchy and variable. CHCs currently have no rights within primary care which is a huge disadvantage because some 70% of all patient contact is usually through primary care (NHS, 2001). Three new structures will replace CHCs including the Patient Advocacy and Liaison Service, Patients’ Forums and Citizens’ Forums (McIver, 2000). However, these successor bodies may cost five times as much to run as claimed by Carr-Hill (Shifrin, 2001). The change has been opposed by consumer groups, doctors’ groups and many medical charities. They argue that the new service will not be sufficiently independent from hospital management to do the job properly. A Conservative MP, Nick Hawkins asked the prime minister if he would withdraw the “mad plan”. However, the government has vowed to press ahead with these controversial plans to ‘scrap’ the NHS patient watchdogs (BBC, 2001b). From 1 April 2002, the PALS are functioning and running services such as supporting patients by providing them with information and helping to improve communication. By this time, every Trust should have a Patient Advocacy and Liaison Service. Their role will be to give the public information, advice and a voice in the NHS. The Department of Health funded a first wave pilot scheme of the PALS in 85 organizations. There will be

another second wave of pathfinder PALS schemes in the autumn of 2001. Lessons learned will be incorporated into the future shape of the PALS across the NHS (Brealey, 2001).

### 5.5 Summary and Comment

Chapter four presented the findings from the aspect of local implementation of the *Patient's Charter* in England. Data were gained from interviews as well as some other sources. Various aspects of the local implementation of *Patient's Charter* have been addressed. Despite the recent replacement of the *Patient's Charter* with the *Your Guide to the NHS*, ten years of experience of the *Patient's Charter* in England has provided valuable data to enrich the knowledge of Charterism. These interpretations are highly relevant and valuable for the subsequent comparative analysis between the local implementation of patient's charter in Hong Kong and England. As more and more countries are adopting charters or related documents in their health services, experience from England can provide lessons for their implementation pathway.

It has been shown that named nurse, single sex wards and waiting lists were the three major concerns in the implementation of the local patient's charters in the hospital Trusts studied. Much work was needed to fulfill the requirements in the localities. Frontline staff members generally interpreted the named nurse initiative as a positive mechanism that is highly relevant to the nursing profession. Nursing managers may argue that they should have a lower ratio of patients under their name to reflect their other commitments or indeed their self interests. Nevertheless, it reflects the importance of both competence and skills among the nurses involved. Although patients were said



not to worry much about it, they were considered to have found the named nurse a helpful point of contact in asking for more information regarding their treatment. The other issue of single sex wards has been discussed in the press regularly such as the recent announcement of the funding received by Hull Royal Infirmary as part of government backed scheme to get rid of mixed-sex hospital wards (BBC, 2001c). Other stories were reported in the press about negative progress made by the government in the attempt to achieve the target of eliminating the number of wards shared by men and women in 95% of health authority areas by the end of 2002, as stated by the *Your Guide to the NHS* (BBC, 2000b). Despite the pledge of single sex wards by the *Patient's Charter* and the *Your Guide to the NHS*, resources must be available to implement this standard into reality. Regarding waiting lists issues, this research has indicated that it should be locally determined rather than imposed from the national level. Many responses have claimed difficulties in attaining the different waiting lists standards in out-patient departments, A & E departments, and so on. The latest replacement of the charter by *Your Guide to the NHS* (Department of Health, 2001a) has further raised the standards in respect of waiting lists. For example, if a GP or dentist refers a person urgently with suspected cancer, the person should be seen by a specialist within two weeks.

Although the *Patient's Charter* had been in existence for ten years, previous researchers have agreed that many patients are ignorant of the existence of the charter (National Consumer Council, 1993; Farrell et al., 1998; Farewell, 1999). This research has also confirmed the low level of awareness of the charter by patients from the perspective of staff experiences with their patients. At the hospital level, various passive promotion approaches have been used such as posters, leaflets, and welcome packs.

Hence, there may be a need to re-invent the marketing strategies to promote the more complicated *Your Guide to the NHS*.

Respondents generally agreed that an improvement in the relationship of trust between staff and patients can be achieved with the help of the charter. However, it can also cause conflicts and increase the potential readiness to voice complaints. Indeed, the issues of complaints have been an important topic in UK health services. The *Patient's Charter* has raised the noise level of complaints and the complexity of complaints. However, it seems that many patients still lack knowledge of the complaint procedures and channels. The government has decided to 'revamp' the NHS complaints procedure. A consultation document *Reforming the NHS Complaints Procedure: a listening document* seeks the public's views on reforming the current NHS complaints procedure (Department of Health, 2001d). *Your Guide to the NHS* has continued to guide service users how to make a complaint as well as what can be expected following the complaint.

The *Patient's Charter* in UK has a high political attachment to it. Respondents from the interviews and comments from other literature have related the charter to the Conservative party's ideology as identified with John Major. Although the document is about improving health services on the whole, it is not difficult to understand the motive of the New Labour government to replace the term 'Patient's Charter'. Hence, it will be useful to compare this move with the experience from Hong Kong in the final chapter. Similarly, managers of the health services can make good use of the charter as a mechanism to lead staff with a common language thus contributing to the benefits of patient care. It can be treated as a beacon to shape the culture of the organization.

Concerning issues of the model of implementation, comments from those interviewed suggested that the old charter was implemented using a top down model, leaving little space for bottom up suggestions and consultations. The use of top down model has the potential benefit of standardization of policies across the NHS. In terms of vast number of NHS Trusts, such top down implementation guidelines can regulate the actual application of charter standards and the reporting mechanisms to the NHS Executive. Therefore, the NHS Executive should continue the top down approach to spread the relevant policy implementation guidelines to the local level while allowing decentralized decision making at local level for health authorities and NHS Trusts to decide the most appropriate standards.

Despite the replacement of the *Patient's Charter* by the *Guide*, the New Charter Programme is continuing within other public services. The Charter Mark award is still valid in the health service. Whether this causes confusion or not deserves further research. However, the Charter Mark has benefits in acknowledging good practice as a benchmark. The Patients Association and the Community Health Councils have played an important role in helping the implementation of the Charter standards across the country and representing patients' interests. However, with the abolition of the CHC, the role of the PALS will need to be evaluated.

The results from this research about the local implementation of *Patient's Charter* in England reinforce the previous King's Fund study of the *Patient's Charter* (see Farrell et al., 1998; Farewell, 1999). For example, common areas of the findings included the low level of the awareness of the charter and suggested that the new charter should emphasize responsibilities. Together with the results gained from the experiences

in Hong Kong where limited research on patient's charter has been done, such studies can further enrich the knowledge of Charterism. From a theoretical perspective, this research had utilized Public Choice theory in understanding the policy implementation of patient's charter in both countries. I will revisit the theoretical perspective in the final chapter when the data from Hong Kong is presented. Similarly, a comparative perspective will be made in the final chapter to highlight points of convergence and the different approaches so as to discuss the implications of this study to the contribution of knowledge.

## CHAPTER SIX: LOCAL DEVELOPMENT IN HONG KONG

### 6.1 Introduction

In this chapter, I will consider the research findings in respect of the local implementation of *Patients' Charter* of the Hospital Authority in Hong Kong. It should be noted that the Authority has chosen to use the name *Patients' Charter* instead of *Patient's Charter*. I will include the data gathered from research interviews at the public hospitals, the Alliance for Patients' Mutual Help Organizations (APMHO) and the head office of the Hospital Authority (HAHO). However, there is no corresponding organization to Community Health Councils in England. Newspapers, official government documents and Hospital Authority documents will be incorporated in the discussion to enrich the data analysis. Although the guiding questions of the interview were similar to the questions used in the UK counterpart, some adaptations were made to reflect the local situations in Hong Kong such as the terms used. As the interviews were conducted in the local language of Cantonese in Hong Kong, the scripts were then transcribed into English as closely as possible. I will also refer to a local TV programme *City Forum* which is a weekly public forum to discuss contemporary issues with invited guest speakers. On one occasion, it discussed the complaints procedure reform of the health services in Hong Kong after a medical incident. Similar to chapter five, the analysis of the data will be divided into three themes. I will illustrate and analyse the new complaints procedure of the Hospital Authority to supplement the development of the charter. To achieve confidentiality for those respondents, I will present the grade of their posts without mentioning which hospitals they come from to avoid any

embarrassment. Where appropriate, I will present the percentage of those respondents who agree or disagree with the relevant points of argument.

## 6.2 Implementation Issues at the local level

The number of respondents and posts of the respondents varied between the hospitals. This was because each of the three cases of hospitals nominated their own staff who were knowledgeable about the *Patients' Charter* to represent their hospital in the case study. Luckily, I was able to gather data from both managerial grades and frontline staff. I will divide them into three categories: namely managers, frontline staff and patient groups. Table Twenty-four below is a breakdown of the participants for the interviews. Each interview lasted about 20 minutes to 30 minutes with some over 40 minutes. Those interviews were taped using a digital recorder for subsequent transfer to the computer for playing back and storage.

Table Twenty-four: Characteristics of Respondents of Interviews in Hong Kong

	Manager	Frontline	Patient Group
Number of Respondents	4	6	1

As discussed in section 4.4.5, there are currently three related documents of the patients' charter in Hong Kong. Firstly, *Patients' Rights & Obligations* was announced by the Hong Kong Medical Association and the Consumer Council in 1992 (HKMA, 1993) to cover mainly the private health services sector. This version has been expanded and updated and is now available from the web site of Hong Kong Medical Association (HKMA, 2001). The scope of the newer version covers patients using both the public

and private health services in Hong Kong, including clinics and hospitals. The second document is *Patients' rights and responsibilities* produced by the Department of Health of the Hong Kong Government covering both public and private health services. The third, the Hospital Authority *Patients' Charter*, is the main focus of this chapter. This *Patients' Charter* of the Hospital Authority was implemented in all public hospitals in Hong Kong from 1994. The charter therefore covers institutions and hospitals managed by the Hospital Authority. After the launch of the *Patients' Rights & Obligations* by the Hong Kong Medical Association and Consumer Council, the Hospital Authority started publishing its own *Patients' Charter* in an attempt to raise the awareness of patients' rights. As the senior manager of the Hospital Authority Head Office recalled:

‘During the time we made the *Patients' Charter*, we had some things in our mind. We were afraid of the low awareness of the *Patients' Charter* rather than worrying about the pressure to staff from patients asking for their rights. This was what the committee thinking about ... We realized the spirit of the *Patients' Charter*. We hoped staff would understand and accept the value behind and then to implement the charter at their daily work. Therefore, we did not want to have too many specific guidelines.’  
(Senior Manager at HAHO)

The Hospital Authority set up a Patient and Community Relations Committee (PCRC) (now disbanded) to draft the *Patients' Charter*. It was led by Mr. Anthony Neoh, the Chairman. This Committee also compiled the charter in 1992 in consultation with the British *Patient's Charter*. Just like the UK version, there was no legal backing to the charter (SCMP, 1992a).

One of the possible reasons why the senior manager quoted above was concerned about the low awareness of the *Patients' Charter* could be explained by the traditional culture of Chinese people in seeking medical services in public hospitals. In public hospitals, consultants enjoyed an almost ‘god-like’ reputation, patients were

neither respected nor accorded the sympathy and understanding of the staff. They eventually became numbers who at various times were the recipients of pills, potions and pans (Hutcheon, 1999). There were already calls for the Government to set up a patients' right watchdog to shoulder the responsibilities to promote and protect patients' right because patients were incapable of bargaining like normal consumers in the market (SCMP, 1992). During the interviews, several respondents made additional comments about the situations before the Hospital Authority was set up:

'We agreed that the awareness of rights was not strong especially among Chinese. Traditionally, doctors were like our father and mother.'  
(Representative from APMHO)

'In the old days, our patients were ignorant, they didn't know what was the treatment, didn't know the disease and didn't know they could ask questions. In the past, doctors and nurses were high in position and powerful. Patients just followed and listened without questioning.'  
(Senior Nurse)

'Doctors should be reminded not to return to the old days of being superior, with clinicians protecting each other and looking down upon poor people.'  
(A citizen from the City Forum, 2001)

'In the old days, patients would be blamed and scolded if he refused the treatment or he tried to consult another doctor.'  
(Nursing Officer)

'When I was still a student nurse undergoing training, patients were a bit ignorant, passive and even stupid.'  
(Registered Nurse)

Local newspapers also reported research about doctors' attitudes at a government-run chest clinic in 1994. The conclusion was that doctors were still putting themselves before the patients in their treatment processes. Doctors rarely bothered to explain a diagnosis or acknowledge patients' feelings. Consultation time lasted an average of between three to four minutes, in an extreme case just thirty-four seconds (SCMP, 1994a). The Hospital Authority responded to this report and commented on the



situation in which training was being given to staff on communication skills and a *Patients' Charter* was being released in 1994 which would help such communication.

To ease the potential worries and queries from staff about the *Patients' Charter*, the Hospital Authority issued a booklet for internal use to explain its purpose and the likely questions (Hospital Authority, 1993). The Director of Operations Dr. E.K. Yeoh (Secretary for Health and Welfare in 1999) gave his views of the proposed *Patients' Charter* in the booklet:

'Our aim is to be able to provide a quality patient-centred service for all who need it. The *Patients' Charter* is central to this new approach. It sets out the ways in which we seek to make the provision of health care a partnership between hospital and patient, in a positive and open relationship which will benefit everyone involved ... The *Patients' Charter* makes explicit what is already implicit in our accepted code of medical ethics and professional practices. It clarifies the relationship between patients and ourselves as health care practitioners, the fundamental basis of partnership. By clearly outlining the rights and responsibilities of patients, it facilitates the participation and contributions by the patient towards his own health care and can only augment the effectiveness of the care we provide.' (Yeoh, 1993, p. 3)

This internal document also served the purpose of collecting views and comments from staff members of the Hospital Authority. Indeed, government officials expressed concern over the implications of a *Patients' Charter* on resource allocation since the charter would be widely implemented (SCMP, 1992c). Compared with the UK, Hong Kong is much smaller. There is no such requirement for local hospitals in Hong Kong to publish their local patients' charter. At local hospital level, they received an implementation kit from the Hospital Authority Head Office for promotion of the *Patients' Charter* among staff. This was particularly important for frontline staff who did not have previous knowledge of the charter. As one manager explained:

‘During the initial phase, we had promotion kit with the information and even transparencies so that we asked our staff to sell the concept to other colleagues. We assigned a staff to talk to his department about *Patients’ Charter* and then talked to other departments subsequently to explain this initiative.’ (Executive)

Indeed, the Hospital Authority was making good use of the business planning process at national and local level in order to help the implementation and monitoring of the charter in each hospital. As discussed in section 4.4.3, hospitals are required to publish their annual plan and report to the Hospital Authority Head Office each year to list details of their different strategic and operational activities such as waiting times in A&E. A senior nurse explained the mechanism:

‘At section 3C of the annual report, it says, “Have you got a mechanism to promote *Patients’ Charter*?” ’ (Senior Nurse)

Another senior manager illustrated the need to hold induction programmes about *Patient’s Charter* to those new staff:

‘We have orientation induction programme for new staff as well as those old staff joining us from other hospitals. One of the elements is the *Patients’ Charter*. We have to capture this to report within the annual plan each year.’ (Senior Manager)

For example, it was mentioned in one hospital’s annual plan (source protected) that the hospital was committed to implementing the *Patients’ Charter* through structured programmes. Four reference standards were listed and the hospitals had to report their performance on these standards as either full compliance or non-compliance, together with some of the percentage figures in bracket below:

**Reference Standard**

- i) A senior staff with direct accountability to HCE is designated as the patients’ charter co-ordinator and is given the responsibility to spearhead the promotion and education of patients’ rights and responsibilities with staff and patients.

- ii) *Patients' Charter* pamphlets are given with some explanation to (w%) of in-patients and (x%) of out-patients. Patient's charter video is regularly shown at (y) no. of waiting areas/wards with TV/VCR facilities.
- iii) Communications sessions on the philosophy and content of the *Patients' Charter* is held with (z%) of staff to promote understanding and to share experience on addressing patients' enquiries and concerns on patients' charter.
- iv) At least one significant educational programme organized to promote patients' rights and responsibilities in the community.

(Annual Plan from a Public Hospital)

Hence, there was a commitment from the senior management of this hospital to promote and implement the charter. Management could report its performance in the annual report as well as including subsequent strategies for implementing *Patients' Charter* in their annual plan for the next financial year. Hospitals therefore devised some activities each year to promote the charter within their premises or within their community. For example, some schools had been invited to participate:

‘We have invited schools at our region to join the slogan competition to increase the awareness of the charter among students. We gave the winner a prize ... We also have exhibition in nearby shopping mall, we have bus painted with the charter.’ (Senior Manager)

At ward level, pamphlets and posters are used to disseminate the message to patients and carers. The researcher has walked around the hospital premises to observe the locations of these posters or leaflets where they were available. A poster was framed at the information counter so that most people could see it if they approached the information counter. Posters were also displayed in corridors. Regarding the leaflets, most individual wards have an information rack to hold and display all health education leaflets including the charter. In-patients receive a copy in their information pack as well. Some other good practice has been observed. In one ward, a poster of the charter was put on the door of the toilet entrance which patients could see very easily. Another

ward decorated a notice board at the entrance of the ward with title (in Chinese) ‘Patients’ Charter – Implementation Issues’ where visitors to the ward could easily observe it. A trophy was placed within the ward marked ‘Award recipient of the Patients’ Charter board design campaign’. This award was the reflection of the good work done by the ward to promote the charter on its notice board. Indeed, nurses also told the researcher about the current situation (see Table Twenty-five and quotations):

Table Twenty-five: Congruence: number and percentage of respondents agreeing the wide availability of *Patients’ Charter* (Patient group excluded)

	Managers agreeing		Frontline Agreeing		All n=10	
	No.	(%)	No.	(%)	No.	(%)
Leaflets, posters	4	(100)	6	(100)	10	(100)

‘We have leaflets and posters within the campus of the hospital although there is not much promotion on it compared with some years ago. Our out-patient clinic is still playing the singer Mr. Andy Lau’s video on patients’ charter ... In my ward, patients will receive a copy of the charter and a small piece of paper telling patients that they should tell the staff about things that ought to be known. This is unique in our hospital.’ (Ward Manager)

‘We will put one copy of the charter in their folder. In the hospital, we put it at the cashier for patients to collect. At out-patient department, physiotherapy, occupational therapy, we put there for patients to collect.’ (Senior Manager)

‘We refill leaflets of the information rack at our ward. However, it seems that we refill health information leaflets more frequent than the *Patients’ Charter* leaflet.’ (Registered Nurse)

‘I remember there was promotion in our hospital lobby about the *Patients’ Charter*.’ (Registered Nurse)

However, the charter was not widely recognized by the chronically ill patients. A survey was done in 1997 by the Alliance for Patient’s Mutual Help Organization among

310 chronically ill patients about issues of complaint and the *Patients' Charter*. The results were disappointing as claimed by the Alliance. Some 45.8 per cent of the respondents had never heard of the charter although it had been in place for 3 years by that time. 22 per cent had made a complaint to the hospital but some 40 per cent were dissatisfied with the results (SCMP, 1997).

It seems that patients and carers are not deprived of the chance to receive information about the charter. However, the charter is available in bilingual Chinese and English only without versions for ethnic minority groups. The version of the Hospital Authority *Patients' Charter* is rather simple compared with the *Patient's Charter* in England. There is no mention of named nurse nor single sex ward. As a result, the emphasis of the Hong Kong version is different. Patients are more concerned about the rights to information about their health care and the clear description of the medical condition as well as the right of access to medical information. Staff reviewed their experiences about the concern of the patients and carers (see Table Twenty-six and quotations):

Table Twenty-six: Congruence: number and percentage of respondents agreeing the relative important items of concerns from patients

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All n=11 No. (%)
Rights to information	4 (100)	6 (100)	1 (100)	11 (100)
Rights to Choice	3 (75)	5 (83)	1 (100)	9 (81)
Rights to Complain	4 (100)	6 (100)	1 (100)	11 (100)

‘They don’t hold the charter in hand but they know and say that this is my right.’ (Senior Nurse)

‘Most patients are concerned with the right to know information and the patient’s condition.’ (Registered Nurse)

‘Most frequently asked question is about their conditions.’ (Registered Nurse)

‘If the doctor doesn’t explain fully to the patient, we will explain to the patient that they can ask the doctor again as this is reflected in the charter.’ (Registered Nurse)

‘Their demand and expectation are higher! They will ask you daily and even expect you to provide a lot information to them.’ (Ward Manager)

One interviewee indicated that the right to choose whether or not to take part in a medical research programme was implemented with a positive view from patients to contribute to medical research:

- ‘Most patients say yes to medical research although they have the right to choose whether or not to take part in it.’ (Registered Nurse)

Every week patients are seen by a team of doctors led by a senior staff member in the ward round as a quality assurance mechanism. Patients generally follow the decisions of the doctor in charge. As discussed earlier, patients were said to be generally reluctant to challenge the doctor or seek another opinion. However, the charter has given patients the right to a second opinion and considered staff should cooperate and respect the patients’ choice. Hence, some patients make use of home leave to seek a second opinion. They requested doctors to give them a report in advance as indicated by the following experiences:

‘Since they know they can have the right to a second opinion, they do want to have more opinion. They get the report from the doctor and then ask for advice from the private doctor and come back to us.’ (Ward Manager)

‘They may seek the second opinion when they are on home leave.’  
(Nursing Officer)

It is difficult to believe that a staff member will actively suggest patients look for a second opinion. However, one nursing officer did suggest a patient seek another treatment:

‘Not too many nurses will suggest patients to get a second opinion. In my experience, I did suggest one patient to get second opinion since he was treated here for long time without improvement. Therefore, he started to ask his friend for information about another doctor and now he was cured.’  
(Nursing Officer)

The following case was raised by the staff member to show how a patient was making use of the charter to refuse a treatment. However, this treatment was beneficial to him and was needed. This also reflected a problem or dilemma between patients’ rights versus clinical decisions:

‘I had a trouble case that the patient needed to have the gastric tube inserted. However, he refused to accept this procedure using his right within the charter. The gastric tube was a good thing to him. Anyway, he refused it and it caused us trouble.’ (Registered Nurse)

Environments in public hospitals are always crowded, especially in those hospitals located in the city centre. Wards are arranged in cubicles, while beds are very close to each other. The charter protects their rights of privacy and confidentiality. Staff members are reminded to avoid unnecessary problems by taking measures of privacy and confidentiality as much as possible. The following are some examples:

‘Patients have the right to have privacy and dignity. We remind our staff to arrange the partition between beds in a better way. We also remind staff to close the curtain during examination. But these are necessary no matter whether there is the charter or not.’ (Senior Manager)

‘Public hospitals are already crowded with beds next to beds. Other can hear what the doctor is asking the patient.’ (Senior Manager)

‘The case notes of the patients were put on their bed table. If patients look at their own case notes, we will explain to him. If relatives or people from insurance companies who try to read the notes, we tried to stop them as it is related to privacy. For patients who have been here for longer time, we will explain to them the changes of their laboratory test results.’ (Nursing Officer)

Apart from the requirement to report to head office about the mechanism to the promote the charter, performance indicators such as average waiting times at A&E have to be reported and incorporated in the business plan. However, waiting time is not contained with the *Patients’ Charter*. Frontline staff also did not know if some data were collected about *Patients’ Charter*:

‘At my level, according to my knowledge there are no collection of data.’  
(Nursing Officer)

‘We have to report performance indicators such as waiting time and agreed procedures called procedure indicators, for example, a medical officer is needed to examine the patient instead of a houseman.’ (Executive)

*Patients’ Charter* in Hong Kong does not give detailed indicators under those rights and responsibilities. Therefore, it is not surprising front line staff are ignorant about this.

### 6.3 Staff and Patient relationships

In a previous study of doctor-patient relationships in Hong Kong, Smith (1999) argued that patients chose their doctors at out-patient clinics more for convenience of location than for whether the doctor communicated well with them. Moreover, the people of Hong Kong were not particularly concerned about patient-centered behavior on the part of their doctors. They were more concerned with being healed quickly, as well as cost and convenience. However, most were interested in doctor-centered



behaviors of explanation and advice giving, not listening and caring. Therefore, this seemed contradictory and presented a challenge to Hospital Authority's belief to employ patient-centered care.

When examining the data from the research study, participants gave their experiences about the change of the trusting relationship between staff and patient since the launch of the *Patients' Charter*. Both positive and negative comments were given. However, it is worthwhile to look at the details of both side of the story (see Table Twenty-seven and quotations):

Table Twenty-seven: Congruence: number and percentage of respondents agreeing a positive change in trusting relationship between staff and patients

	Managers agreeing		Frontline Agreeing		Patient group Agreeing		All n=11	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Positive Changes	3	(75)	4	(67)	0	(0)	7	(64)

One group of respondents gave their positive comments about the changing relationship between staff and patients as a result of the *Patients' Charter*:

‘The charter acts as a middleman listing their rights, entitlement. In a way, it helps to anchor their entitlement so as to decrease the chances for argument. Therefore, it helps the trust.’ (Executive)

‘Yes, they will trust us more after we communicate with them in detail.’ (Registered Nurse)

‘I think yes, positively. When we explain more to the patient, they will trust you more. They will also think that you are caring them.’ (Nursing Officer)

‘The culture has changed. In the old days, it was professional oriented. When professions said something, patients followed without questioning. After the *Patients' Charter*, the concept has been shifted. It is now more patient oriented with more respects to the rights. Patients are no more

lower in status or doctors are higher in status. The culture among staff has changed and started to have awareness of the values of patients.’ (Registered Nurse)

However, the relationship of trust was also judged to have deteriorated with the charter. It was claimed by some nursing staff that patients were less likely to believe in clinicians especially after the frequent reports of medical incidents in the media:

‘With a lot of media reporting the medical incidents, they (patients) will ask a lot of questions about their treatment and conditions. For example, they don’t trust you and ask, “What is this injection? What kind of drug is it?” Compared to the old days, they ask more questions with lesser faith.’ (Registered Nurse)

‘There were cases of medical incidents reported in the press in last few years. For those medical incident cases, they might make use of the charter to get their benefits but not really using the charter to protect their rights.’ (Senior Nurse)

‘Compared to the old days, now is even having lesser trust. In the old days when I was at the other hospitals, those patients said, “I trust you doctor”, “Do whatever is appropriate”, “Give our life to the hands of doctor ... now is different, they question about the treatment. “What will happen afterwards?” Now is a bit exaggerated and they look for legal clues and then sue you.’ (Nursing Officer)

‘It needs to be changed. Now is emphasizing too much on the commitment to patients. In some sense, it is destroying the relationship between patient and staff.’ (Representative from APMHO)

Staff members generally agreed that the promulgation of rights was too high while patients lacked a sense of responsibility. The charter itself has clearly stated the responsibilities of a hospital patient. To summarise these responsibilities, they include:

- Give your health care providers as much information as you can about your present health, past illnesses, and allergies and any other relevant details;
- Follow the prescribed and agreed treatment plan, and conscientiously comply with the instructions given;

- Show consideration for the rights of other patients and health care providers, by following the hospital rules concerning patient conduct;
- Keep any appointments that you make, or notify the hospital or clinic as early as possible if you are unable to do so;
- Do not ask health care providers to provide incorrect information, receipts or certificates;
- Do not waste medical resources unnecessarily.

(Hospital Authority, 1994a)

Despite the clearly written responsibilities of the charter, staff felt patients seemed to ignore their responsibilities but just emphasized their rights. There was high consensus among staff about this situation. Staff members made the following comments and illustrated with real cases (see Table Twenty-eight and quotations):

Table Twenty-eight: Congruence: number and percentage of respondents agreeing that patients lacked responsibility

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%)
Lack of responsibility of patients	4 (100)	6 (100)	1 (100)	11 (100)

‘Of course, they look at rights without taking care of responsibilities.’  
(Registered Nurse)

‘The patients are more concerned about the sick leave certificate.’  
(Registered Nurse)

‘I think patients need to know when they are ready for discharge. Patients always think that their treatment and care have not finished despite the fact that they are ready for discharge ... they are also lacking their own responsibility to look after themselves.’ (Ward Manager)

Promotion strategies employed by the hospitals were also said by respondents to be heavily biased towards patients' rights as shown by the following quotations:

'The promotion is towards the rights rather than the responsibilities. It needs to be addressed.' (Registered Nurse)

'The singer, Mr. Andy Lau's video is good but is too much rights oriented.' (Ward Manager)

'Under the influence of the media, they only stress the patients' rights.' (Senior Manager)

'Initially it was lacking of rights. However, it is too much stressed on rights nowadays. Therefore, a search for a balance between rights and responsibilities is needed ... the main issues is that patients have abused their rights.' (Executive)

'I think the whole charter and the section on responsibilities is weak. I think patients are only concerned about their rights.' (Nursing Office)

'Our feeling is that patients and their relatives are too stressed on rights rather than responsibility. Therefore, it has created frustration to the front-line staff. Some patients are abusing the system. They only knows their rights.' (Senior Nurse)

'Patient don't know their responsibility, no one is concerned about it. They only know about their rights. There is no promotion of responsibility and the emphasis is not there. Sometimes they requests are unjustified.' (Registered Nurse)

Illustrated below are two recent cases as examples to show the current situation at the hospitals. One patient had neglected his responsibility but continued to accuse staff. The other example was related to smoking within the ward. Hence, these two examples illustrated the problems faced by frontline staff:

'I think it needs to improve health care promotion for patients to know their responsibilities. We have a case who has to come to our hospital for an investigation. He was reminded to have fast 3 hours before the investigation and he should arrive punctually. What happened was he arrived late and ate something before the investigation and even broke into bad temper to our staff. This is definitely his responsibility. We have done our proper job and duties. It is not a good practice to the hospital at all. We have to rearrange the investigation for him. What's more, we have to call him and beg him to come back. I wonder if those medical incidents

reported in the media has created the weakness of the Hospital Authority. Right now, it seems that those who can speak louder and manipulate will get what he wants.’ (Senior Nurse)

‘In our ward, there were some female drug addicts who smoked on their bed within the ward! They didn’t care our rules and we have to call the security guard. You will also see cigarette butts at the corridor. The government can promote anti-smoking with rules and fines in restaurant and why not the hospital premises. Even our guards do not have the authority.’ (Nursing Officer)

As a result, staff felt patients are generally aware of their rights while ignoring their responsibilities. This causes further problems about complaints as patients have the right stated in the charter to make a complaint through channels provided for this purpose by the Hospital Authority, and to have any complaint dealt with promptly and fairly (Hospital Authority, 1994a). During the interview, comments indicated that a new culture among staff was formed to avoid complaints by trying to satisfy patients’ request. They shared their comments and observations about complaints in the hospitals (see Table Twenty-nine and quotations):

Table Twenty-nine: Congruence: number and percentage of respondents agreeing the new culture of avoiding complaints by satisfying request from patients

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%)
Avoidance culture	1 (25)	4 (67)	1 (100)	6 (55)

‘At management level, they think complaint is for improvement. However, at the front-line level, we are already working very hard and the patient is manipulating. If they complain, we have to write reports ... We try to satisfy their wants within our limited resources in order to avoid complaints. For example, we will give the side ward to those demanding patients who have asked for the side ward if it is empty although the purpose of the side ward is for the cases who need isolation or close monitoring.’ (Nursing Officer)

‘Yes, there is a culture of trying to avoid complaints by satisfying their request. It makes the junior staff very difficult in handling patient and making their decisions. Sometimes, you allow this for that angry patient but do not allow that for the other patient. It is just not fair. However, we have no choice but trying to balance it.’ (Nursing Officer)

‘A lot of complaints will be solved at ward level. Yes, there is a culture of avoiding complaints by satisfying patients’ request especially the ward in charge will try to avoid as much as possible.’ (Registered Nurse)

‘There is increased pressure to us. Patients are more willing to complain. It also depends on if the patients know their rights. If they know it, they will complain more easily.’ (Registered Nurse)

‘Yes, a lot more easier for them to complain at ward level.’ (Nursing Officer)

The situation deteriorated when the resources available could not meet the expectations from patients. For example,

‘I think there is an invisible pressure on us. I think the pressure comes from when the patient has a request beyond the resources can allow. Then we are in a middle position. However, the patient will think that it is our fault and start to voice out their complaints. For example, the camp bed issue will create problems. It is not me who do not give a bed to the patient but the resource problem. However, patient will claim that he is also paying the fees and why he has to suffer.’ (Registered Nurse)

‘We have a patient relations officer (PRO) who is an administrative staff but she knows about this. When she received a complaint, she will not give a definite answer to the patient or relative at once. She will call back to the ward and get the story. If it can be resolved, she will meet the patient again and explain the situation. She is using the counseling skill when handling the patient ... but from our point of view at the ward level, we will stop the complaint from reaching the PRO if possible. We always manage to do this. You know, there are a lot of procedures after the complaint has reached the PRO.’ (Ward Manager)

‘Yes, this was the worry about increased complaints at the time of the launch of the charter. In hospitals, we monitored the number and nature of complaints. We did not see any significant change before and after the launch of the charter during that time. Of course, there are always outlier cases including those angry complainants and those grateful appreciations. You have these two extremes no matter the charter or not.’ (Senior Manager)

The media was seen to have affected patients in voicing their complaints as more and more news about medical incidents were reported.

‘Hong Kong media reported the medical incidents frequently. Patients are more willing to complain. I think some other factors have contributed including the whole atmosphere of Hong Kong is that citizen will speak out and try to get their rights.’ (Executive)

In Hong Kong, several other bodies set up by the Government can accept complaints from patients such as Ombudsman and Equal Opportunities Commission. The Executive quoted above commented on the other bodies who can deal with hospital complaints and worried about their understanding of the charter:

‘I don’t know their understanding of the *Patients’ Charter* when patients lodge their complaints to bodies such as the Office of the Ombudsman, Equal Opportunities Commission or the Office of the Privacy Commissioner for Personal Data. These institutions do not ignore the charter. Are there any mechanisms for them to be monitored without expanding too much? You know staff members are worrying such as those abuse cases. Do they have mechanism to understand and measure it? Some patients just go to wherever accept his complaints. Isn’t it duplication and amplifying it without really solving the problem?’ (Executive)

The Alliance for Patients’ Mutual Help Organizations expressed its views on complaint mechanisms and its experiences in dealing with handling of complaints at both local level and at the Public Complaints Committee (PCC) level. This Public Complaints Committee was mentioned briefly in section 4.4.3. However, the complaint mechanism needs to be explained into greater detail. Recently, the Hospital Authority published a bilingual booklet *Hospital Authority Complaints System* (Hospital Authority, 2001d) in addition to the *Patients’ Charter*. The Authority is operating a two-tier system in handling patient and public complaints. The first-tier system is in place at the public hospital level to deal with complaints lodged directly within the public hospital against their staff or services. It also deals with all complaints lodged for the

first time. In Hospital Authority public hospitals, patients can lodge their complaints directly to Patient Relations Officer (or other staff designated for this purpose) or to the Hospital Chief Executive/Chief of Service/Heads of Units by four methods including by phone, in person, using the complaint form within the booklet or in writing. If patients are still not satisfied, they can lodge a complaint at the second-tier to the Hospital Authority Head Office or to the Authority's Public Complaints Committee where patients can appeal against the hospital's decision on the case. This Committee is formed under the Hospital Authority Board to independently consider and decide on all appeal cases or complaint cases directly received. This PCC is the final complaint handling authority/system of the Hospital Authority. Its mission is to 'ensure a fair and effective complaint handling system within HA in which all public complaints or appeals against HA are considered in an independent, impartial, just, thorough and prompt manner' (Hospital Authority, 2001d, p. 10)

The constitutions of the Public Complaints Committee need further attention. As at July 2000, it consisted of a Chairperson and eight members including lawyer, accountant, pastor, patient group representative, healthcare professionals, educator and academic, together with a rotating Hospital Authority Member. All members are non-executives and non-employees of HA except the rotating Hospital Authority member to assume fairness. However, this also raises questions about their workload in addition to their own professional full time jobs.

As mentioned in the interview with the executive and the information contained in the booklet about the complaints system of the Hospital Authority, other bodies who can accept complaints about health services include:



- Office of the Chief Executive of the Hong Kong Special Administrative Region
- Secretariat of the Legislative Council/District Councils
- Health & Welfare Bureau
- The Medical Council of Hong Kong
- Office of the Ombudsman
- Consumer Council
- Equal Opportunities Commission
- Office of the Privacy Commissioner for Personal Data

(Hospital Authority, 2001d)

In terms of the channels of complaints, patients and relatives can make use of the above proper and formal complaint mechanisms to voice their concerns to, for example, the Medical Council of Hong Kong. In addition, the media is especially interested in hearing stories about medical incidents. Kitinger (1999) agreed that there has been a dramatic increase in the number of articles published about the media and 'risk' in recent years. She also identified the key criteria in media attention to risk as conflict and blame. In Hong Kong, popular local newspapers such as *Apple Daily News* and *Oriental Daily News* have a phone number printed on the newspaper for citizens to call to disclose information or complain when they are not satisfied in areas including health services. Magazines such as *Next Magazine* and others follow the same practice. The *Patients' Charter* has given the right to patients and carers to complain and they can lodge complaints to formal and informal channels.

The representative of the Alliance for Patients' Mutual Help Organizations made the following comments about complaints mechanisms from her experiences in dealing

with the front line staff and managers at various hospitals. She commented that the culture was trying to avoid complaints:

‘Several dimensions need to be coordinated. How do they see the complaint mechanism? If staff and administration sees complaints negatively, then the outcome will be those who are shouting loudly will get their wants satisfied. That is not the proper picture’ ...

‘As the Alliance, we encourage patients to express their interest. We do not encourage them to complain. We believe that the individual experience may reflect some problems in the system’ ...

‘I also think that front-line staff is trying to avoid complaint. I spoke with some of the Hospital Chief Executives at the PCC. They claimed that they felt difficult to come to the PCC. On one hand, he acted as a middleman representing his staff but people just stared at you like an enemy. The HCE claimed “This is not effective and is very negative. This is not healthy”. ’ (Representative from APMHO)

Staff felt complaint channels were ample for patients to voice their grievances.

Patients lodge their complaints in different ways as indicated by the senior nurse:

‘There are several types of patients. Some come to me directly without mentioning to the ward. You won’t know if he wants to complain at all until he comes to you. Some will argue with you and then ask for a more senior person. Some are not even satisfied with the PRO and they want to see the HCE.’ (Senior Nurse)

The Medical Council of Hong Kong is a key body dealing with complaints and incidents involving registered medical profession in both private and public sector in Hong Kong. It was founded to assure and promote quality in the medical profession and was introduced briefly at section 4.4.5. As the name of the Council implies, it is empowered by law to consider the professional conduct of ‘registered medical practitioners’. Therefore, it has no jurisdiction over unregistered persons, hospitals or other organizations. The role of the Medical Council includes giving doctors license to practice medicine in Hong Kong. It also protects patients and guides doctors by promoting good medical practice, keeping an up-to-date register of qualified doctors,

promoting high standards of medical education and taking action where there is a complaint about a doctor's professional conduct or a concern about his or her fitness to practise (Medical Council, 2000).

The number of complaints received by the Medical Council had risen by 25 per cent in 1994 compared with the 1993 tally of 134 complaints (SCMP, 1996). There are a growing number of patients voicing their grievances to the Medical Council as a result of the increasing awareness of rights in doctors' surgeries. The Secretary of the Medical Council commented:

'The rise in the number of complaints is almost certainly due to the public's awareness of the Council's activities ... This is probably the result of more media coverage of enquiries and a *Patients' Charter* setting out rights and responsibilities of patients which was released last year.' (SCMP, 1994b)

The number of complaints continued to rise to a record number of 177 cases in 1995 (SCMP, 1996). The former President of the Hong Kong Medical Association Dr. K.H. Lee gave a public talk about 'Patients' Rights and Professional Code of Doctors' on 11 September 1999 to share his views with the public. The number of participants in this public talk was small (around 10 including the researcher). According to Dr. Lee, the number of complaints received was consistently rising each year as shown in the table below:

Table Thirty: Number of Complaints Received by the Medical Council of Hong Kong

Year	1995	1996	1997	1998
Complaints Received	177	168	190	245
Preliminary Investigation	#78	#42	#44	#56
Full Inquiry	*14	*9	*10	*7
Upheld	*13/#21	*4/#5	*6/#7	*6/#8

(Source: Lee, 1999)

The issue of complaints has been highlighted with the decisions of the Medical Council in the case of a surgeon who made a mobile phone call while conducting an operation in a public hospital. This surgeon was accused of misconduct for making a mobile phone call about purchasing a BMW car during an operation to remove polyps from the patient's large intestine in May 1999. The patient who was a taxi driver had an emergency operation for a perforated bowel a day later. After a 14-hours hearing, a 9-member panel of the Medical Council found this doctor as not guilty because the Council found that the perforated bowel was not the result of the doctor's telephone conversation. The Hospital Authority at an earlier time had already investigated the case at the Public Complaints Committee. The decision of the Committee was to give a warning to this doctor with suspension of promotion opportunity and pay rises for five years (SCMP, 2001a). The decision of the Medical Council attracted tremendous interest in the media and the accusation from patients' groups and the public of 'doctors covering doctors'. The credibility of the Medical Council was said to have been lost like a company gone bankrupt (HK iMail, 2001). Subsequently, the local English newspaper,

*South China Morning Post* investigated complaints received by the Medical Council since 1994. It found that only one doctor had been permanently struck off the register by the Council since 1994 despite an average of 200 public complaints each year. Only 6.6 per cent of the complaints were put to hearings with 4.4 per cent resulting in guilty verdicts. Critics in the media considered the punishments lenient. Only one doctor had been both suspended and reprimanded out of the 1407 complaints since 1994 (SCMP, 2001b). The row escalated later after the Council issued a clarifying statement following an emergency meeting saying that the Council did not accept the use of telephones during any operation or procedure without due justification. Again, the media claimed that this gave too much leeway to doctors (SCMP, 2001c).

The Secretary for Health and Welfare, Dr. E. K. Yeoh, made a statement against the case of using mobile phones in operating theatres and announced plans to reform the Medical Council in the midst of a public outcry after the incident (SCMP, 2001e). As Dr. Yeoh claimed:

‘On the use of mobile phones, I just want to state clearly that we do not think mobile phones should be used in operating theatres or anywhere near any medical equipment.’ (SCMP, 2001d)

The issue was brought up at the Legislative Council where there was a motion debating the mechanism for handling complaints concerning medical incidents. Dr. Yeoh elaborated:

‘It seems that today discussions focused mainly on the complaints system of the Medical Council and its improvement measures. However, I think it may be more appropriate to first consider patients’ complaint system as a whole ... We should look at complaints positively and treat every complaint as a chance for improvement.’ (Yeoh, 2001b)

Three main problems were identified in the existing complaints system as claimed by Yeoh (2001b). The system was regarded as complex and confusing since multiple complaints channels were available. The credibility of the complaints systems had been questioned in particular for complaints against the practice of doctors. The complaint process was not user-friendly nor transparent as well. Therefore, an independent complaints office was deemed by government necessary for Hong Kong (Yeoh, 2001b; SCMP, 2001e).

Similarly, members of the public challenged the Medical Council's decision in an internet chat room (SCMP, 2001f). Doctors who joined the chat room have accused patients of being stupid and of destroying the doctor-patient relationship. Members of public voiced their anger of doctors' attitudes towards them. Later on, the chat room was deleted to avoid further verbal conflicts (SCMP, 2001f). Issues of complaints and complaint mechanisms became a hot topic in the health services of Hong Kong.

In a public forum conveyed by the Radio Television Hong Kong (RTHK) to discuss health care professionals and patients' rights, invited speakers included legislators, representatives from doctors' associations, patients' association and academics. These agreed that using mobile phones in the operating theatre was not appropriate. They suggested that the Medical Council should increase its number of non-medical representatives to let them to have a monitoring role with the Council (City Forum, 2001).

In an internal staff opinion survey conducted by the Hospital Authority at the end of 1999, some 1,800 staff of different professions were asked about their views on

issues such as work relations, job satisfaction and career advancement as well as the *Patients' Charter*. This internal report was made available to the local newspaper *South China Morning Post*. Some 70 per cent of the hospital staff believed that *Patients' Charter* had led to many unnecessary complaints from patients. They thought charter did more harm than good and encouraged patients to lodge time-wasting and unfounded complaints (SCMP, 2001g). The findings illustrated that staff still held a negative view on the promotion of patients' rights. Many staff regarded patients as troublemakers.

#### 6.4 Management Issues

In this research, views were collected about the charter as managerial and political tools. The charter was launched after the Government's request for *Performance Pledges* in all departments of the Government. To review possible political explanations of the *Patients' Charter* in Hong Kong, the respondents in this research were asked for their views of whether the current charter consisted of any political elements related to, for example, Government, political parties and ideologies, professional groups and so on. Respondents did not sense any at all or indeed they had no idea about it as some claimed they were not familiar with politics (see Table Thirty-one and quotations):

Table Thirty-one: Congruence: number and percentage of respondents agreeing the political background of *Patients' Charter*

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%) n=11
Ideology of Chris Patten	0 (0)	0 (0)	0 (0)	0 (0)
Benefits to health services stakeholders	2 (50)	1 (17)	1 (100)	4 (36)

‘I don’t know. I am not sensitive to politics. But the question is now patient groups can make use of the charter to get something (advantage).’  
(Senior Nurse)

‘It is just difficult to say.’ (Registered Nurse)

‘I have not thought about this before.’ (Nursing Officer)

Other respondents considered there were benefits from the charter to stakeholders, such as different health care professions, which could help them to co-operate together. The *Patients' Charter* seemed to act as a common term among these professional groups:

‘The charter was agreed by health services stakeholders. They could join together rather than conflicting with each other to pursue the common interest.’ (Executive)

‘Not quite but at the time of 1992 and 1993, the Hong Kong Medical Association and Consumer Council have issued the *Patients' Charter*. The atmosphere was there. That was the society’s request and was not really requested or pressed by government. Therefore, I don’t see the pressure on us politically.’ (Senior Manager)

‘If they use this document properly, they can gain benefit but HA charter is not too good because patients completely ignore their responsibility.’  
(Nursing Officer)



The charter was also being considered as a tool for public relations (PR) purpose. It could help the Hospital Authority project a positive image to highlight its commitment to patients. However, there were criticisms about the need for a practical approach versus the need for public relations:

‘It is difficult to tell but you can chase the information of the group PCRC previously set by Hospital Authority as a sub-committee of the board. They were talking about public relationships. If you think the charter in this way which it came out from there, then you can say the charter is a public relation tool ... It is also a problem. It is difficult to change the charter now as the sub-committee has closed ... It is meaningless to talk about packaging and PR. It should be related to services but not packaging or PR. It should focus on the practical approach to improve services.’  
(Representative from APMHO)

The charter can be used as a management tool if properly implemented. Health services managers can make use of *Patients’ Charter* to instill a quality culture to the frontline staff and to increase the authority of management. For example, some managers had incorporated the spirit of the *Patients’ Charter* into the staff development review (SDR) for performance appraisal (see Table Thirty-two and quotations):

Table Thirty-two: Congruence: number and percentage of respondents agreeing charter can instill quality culture

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%)
Quality Culture	4 (100)	6 (100)	1 (100)	11 (100)

‘For staff, their performance is better than before ... their performance appraisal of SDR (Staff Development Review) reflects the charter commitment. We give higher marks to those with appreciation letters.’  
(Nursing Officer)

‘Macroscopically and visionary, the answer is yes.’ (Ward Manager)

In addition, staff would emphasize patient-centre care in holistic and team approach:

‘Our staff will always put patients first by following the charter standard, for example, their rights to know their conditions.’ (Registered Nurse)

‘We are in the same line (boat). All professions treat patient using ‘patient-centred approach’. However, we need to lead the health care assistants (HCAs) as well so that they can have a better attitude to patients since they will spend more time with patients.’ (Ward Manager)

‘Yes, it has the influence on patient-centred care with emphasis on their needs as first priority. Our senior management will stress patients’ need. They want nursing staff to suit this.’ (Registered Nurse)

Staff would follow the standards and treat their patients with courtesy as there was no incentive not to do so:

‘Charter helps to maintain nursing standard as nurses are more cautious in care. They know that they have to re-do it once again if they are not doing the care up to the standard. So why not do it better in the first place.’ (Ward Manager)

‘Say, we can use it to remind staff who is not courtesy.’ (Nursing Officer)

‘In a way “yes”. It makes people follow those written things. The society has a trend of these types of things. It helps our staff to follow this trend in our hospitals ... It’s rather top down. We start from the Chief Nursing Officer to implement, structurally from top to bottom.’ (Executive)

‘Yes, it can. Now is not using the old approach of ignoring patient any more.’ (Nursing Officer)

The *Patients’ Charter* was also treated as the means to achieve continuous quality improvement and total quality management. It appeared to act as a tool for managers to spread their messages. One senior manager explained:

‘Yes, you can say this. At least, it helps to articulate this thing ... When we look back the Continuous Quality Improvement initiative (CQI), it has a lot of means. *Patients’ Charter* is one of the means. Charter is a good tool to increase patients’ awareness of their responsibilities and rights as well as a mean to identify area of improvement. Over the years, we use Total

Quality Management (TQM), CQI, etc and make use of the *Patients' Charter* to articulate these initiatives.' (Senior Manager)

As at February 2002 there had been no announcement from the Hospital Authority that it will review the charter. The implementation is proceeding. A majority of respondents saw the need to continue the charter while most agreed that the Hospital Authority may be deliberately keeping a lower profile when compared to the launch because patients are already more aware of their rights rather than responsibilities (see Table Thirty-three and quotations):

Table Thirty-three: Congruence: number and percentage of respondents agreeing to continue the *Patients' Charter*

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%)
Continue Patients' Charter	4 (100)	6 (100)	1 (100)	11 (100)

'Yes, it is very valuable to continue to have it.' (Registered Nurse)

'Well, I think it is necessary ... When you are a patient, you do want to have one. Therefore, I think it is good.' (Senior Nurse)

'It should be continued. People are getting more educated and the level is high.' (Registered Nurse)

Staff felt that the charter should include more elements to reflect patients' responsibilities:

'Yes, it should be continued but should increase the responsibility.' (Nursing Officer)

'Now is in a pace of no need to promote the charter as before. Instead it needs another form to promote to address the balance between rights and responsibilities ... now is in a stage of afraid of too high awareness.' (Executive)

However, there were also some other views:

‘Not hearing much from HAHO now.’ (Senior Nurse)

‘It is only a document launched to articulate HA value, obligations which HA has agreed. It is not a must to use charter to promote services or to train staff. Sometimes, it is better to use professional ethics, code of practice because Hong Kong is professionally driven and administrative driven public system. I think you cannot go back, it is already declared.’ (Senior Manager)

When respondents were asked about the various versions of the charter in Hong Kong, they revealed confusion with the different versions of the charter related documents in health services (see Table Thirty-four and quotations):

Table Thirty-four: Congruence: number and percentage of respondents agreeing the three versions of charter documents are confusing the public

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%)
Confusing	2 (50)	6 (100)	1 (100)	9 (81)

This was less evident among the managers. For example, a nurse argued that:

‘As a citizen, I think it is better to have a coordinated document in health care. I don’t care if you are having services at HA, private or Department of Health providers. People just don’t like if they come to HA has this version and then go to private to have another version.’ (Nursing Officer)

‘Yes, it will confuse. I don’t know the other two.’ (Registered Nurse)

‘As a citizen, it is confusing. I don’t know the other two copies.’ (Registered Nurse)

‘I don’t know about the other two but it is better to group into one version.’ (Nursing Officer)

‘We need to change channel. It is very confusing to patients. It can be coordinated.’ (Representative from APMHO)

However, half of the senior managers argued that it did not matter to have three versions of charter related documents in Hong Kong:

‘These three different documents are just three different methods to promote things towards the common goals. It doesn’t matter at all. They just modify to suit their needs to attain the goals.’ (Executive)

‘I haven’t seen the other two. To private doctors, it may be good or bad. However, a rapport can be established between patient and staff in private sector.’ (Senior Nurse)

Some discussions had been evidently made at head office about the content and areas for improvement of the charter. The senior manager gave some light:

‘We have discussed this in 2000. We gathered from the survey and identify area of improvement, for example, communication. Regarding the title, some feedback claimed the title is not patients’ charter but is patients’ and health services workers’ charter but there will be not much new things for the content.’ (Senior Manager)

Others have agreed the content is good enough but make comments on the title itself as they consider the current charter reflects too much on patients (see Table Thirty-five and quotations):

Table Thirty-five: Congruence: number and percentage of respondents agreeing to use the same title as *Patients’ Charter*

	Managers agreeing No. (%)	Frontline Agreeing No. (%)	Patient group Agreeing No. (%)	All No. (%)
				n=11
Title as <i>Patients’ Charter</i>	3 (75)	5 (83)	0 (0)	8 (73)

‘The content is OK but the problem is the lack of promotion of responsibility. This is what we think the weak area for improvement.’ (Senior Nurse)

‘I don’t know why they use the word “Charter” but the Chinese name is quite good. May be “Charter” is used internationally and therefore should

not be a problem. Recently, I was in Chicago and they use the title patients' charter as well.' (Senior Nurse)

'It seems too grammatical, people may not understand the word "Charter". They need to see the content in order to understand it. It is clearer to use rights and responsibilities ... just add the responsibilities but I can't give an example.' (Nursing Officer)

'Regarding the content, no comment but don't emphasize on just rights.' (Registered Nurse)

'Indeed, we don't like to use the name as "Patients' Charter", that is not comprehensive, we think that it is a two-way approach. Patients' rights in a sense can be the doctors' responsibilities and vice versa. The label is indeed not just about patients.' (Representative from APMHO)

Hence, the Hospital Authority and indeed the health policy making body of the Health and Welfare Bureau, may need to consider updating the document and title when the Bureau is revising the complaints systems. The *Patient's Charter* and complaints system may be able to supplement each other to improve the standards of services.

## 6.5 Summary and Comment

The analysis of the implementation of *Patients' Charter* in hospitals of the Hospital Authority indicated a changing emphasis in the promotion of the charter since its launch in 1994. Initially, the Authority was trying to raise awareness of patients' rights among what it saw were generally passive and uninformed patients. Patients in Hong Kong had been influenced by traditional value systems and beliefs that doctors and other health care professions are superior in their relationship within the treatment process. Over the years of the *Patients' Charter* in Hong Kong, combined with the atmosphere of a demanding society and an accountable government, the ideas of patients' rights have been prominent and amplified while the sense of responsibilities

among patients have been less articulated. This suggests the charter can be used as an effective tool to promote patients' rights and to improve the quality of services. However, those interviewed raised the issue of balancing a promulgation of patients' rights and responsibilities. Staff felt caution should be taken in spreading the message to patients so that they are not only given opportunities to receive and see a copy of the *Patients' Charter* but to understand the meaning behind these rights and responsibilities to achieve the mutual benefits. From the strategic requirements of the business planning process of the Hospital Authority, hospitals at local level do not have any motives to ignore the charter because they have to report to head office about the implementation of the charter in the annual report. This is effective at least in generating momentum within hospitals to continue the implementation and promotion of the charter from a top down perspective. From the angle of the availability of the charter, patients and carers are able to see a copy of the charter within the ward or the hospital compound. However, frontline staff especially nurses and health care assistants, who spend most time in contact with patients and relatives, have an active role in promoting and implementing the charter. The respondents in the interviews indicated that the charter could improve the trusting relationship between staff and patient by increased communication and understanding of their treatments and expectations. However, staff identified side effects of patients having less faith in the relationship, complicated by the right to complain and the media's great interest in medical incident cases. Although the charter is quite a simple document with only eleven rights and six responsibilities and without specific performance indicators, it appears to have helped to create a positive culture in terms of a patient-centred approach among health care professionals. Patients are, in particular, said to be concerned about rights to information related to their medical conditions, rights to choices related to seeking second opinions and the right to complain. However,

a negative culture is perceived by staff with the emergence of a 'complaint culture' among patients who are more ready to voice their dissatisfaction. A new culture among staff is emerging to try to avoid complaints by satisfying unhappy patients and this was evident from the conversation of the respondents. Part of the explanation for this changing scenario lies in patients' rights to complain which is reinforced by media reports about medical incidents.

Although the performance pledges initiatives and the patients' charter initiative were made available during the time of Governor Patten, data from the respondents did not suggest a belief in political elements behind the ideology of the charter. Some explanations saw the charter as a form of common language among different health care stakeholders to achieve common goals. It is also a tool or means for improving quality services within the arena of continuous quality improvement and total quality management adopted by the Hospital Authority. Although the title of the charter concerns patients, health care staff should not be neglected in the mutual relationship. They found it confusing and complicated to have three versions of patients' charter related documents being promoted by three separate organizations with overlapping coverage of health services. The policy making body of the Health and Welfare Bureau may need to rethink this approach and to propose a charter to cover aspects of both private and public health services sectors.



## CHAPTER SEVEN: CONCLUSION

### 7.1 Introduction

In this final chapter, I will bring out additional analysis and conclude the findings of this research. In this comparative study, I will consider those areas which have thrown up similarities as well as different approaches that have emerged in respect of the implementation of patients' charters in the two respective localities, namely England and Hong Kong. It also explores the common characteristics and experiences of adopting patients' charters in both health services. These experiences are potentially valuable for other countries to consider if they plan similar initiatives. Apart from these points of convergence, the different approaches adopted by the respective governments, health authorities and the hospital levels are illustrated to explore the alternative meanings of charters across national boundaries. I will revisit a number of concepts and issues related to earlier chapters about Charterism, New Public Management, Citizenship, Consumerism, Implementation theory, and of course Public Choice Theory. From this study, I will try to enrich the current knowledge of Charterism and Charterization as well as to evaluate the utility of Public Choice Theory in understanding the implementation of the patient's charter. Hence, it is hoped that the thesis is able to contribute to the current knowledge with the results from four different aspects, namely the findings from England; the findings from Hong Kong; the comparative aspects between England and Hong Kong and the theoretical interpretation of Charterism and Public Choice Theory. There are also discussions of the implications from this study. Like other research studies, this research has shortcomings, limitations and weaknesses. I will identify and discuss the weaknesses of this research with

reference to the choice of the research topic, research methodology, data collection and other issues. Subsequently, I will identify several areas and topics that deserve further research relevant to the charter movement in the health services of England or Hong Kong as well as other countries. These research areas are useful for further students or researchers to consider when they configure their health services research.

## 7.2 Points of Convergence

Although the concept of using a charter was not new in the history of United Kingdom, the introduction of the citizen's charter programme in July 1991 attracted considerable international interest in this approach to running public services. As mentioned briefly in section 1.2.1, for example, it has already inspired and then been followed by other European countries which have created similar measures as the *Citizen's Charter* to improve the quality of their public sectors. Italy has introduced the *Carta dei servizi*. France has its *La Charte des services publics* while Portugal has implemented a *Carta para a qualidade nos services publicos* (Schiavo, 2000). These are similar to the UK *Citizen's Charter* in terms of philosophy and content. Further in Canada, the Senate Special Committee on Medicare put forward a *Patients' Charter of Rights* as a reform option for consideration at a national level (Flood and Epps, 2001). All these have demonstrated the international interest in 'Charterism' from various governments attempting to reform public services. Politicians and managers in these countries may benefit from a comparative sketching of the implementation experiences of charters between countries that have different scenarios in their public services.

This research gave an overview of the case study of the implementation of patient's charters in England and Hong Kong in their public sector health services. From a comparative point of view, both England and Hong Kong have a common feature with the idea of using the 'Charter' approach in running public services. In the United Kingdom, the *Patient's Charter* was just one of a series of charters under the *Citizen's Charter* as advocated by the Conservative government of John Major. Similarly, the last Governor of Hong Kong, Chris Patten who was also from the Conservative party in Britain, launched the performance pledges initiative in Hong Kong soon after he took the office as Governor of Hong Kong. This initiative was the Hong Kong version of citizen's charter (Lee, 2001). Patten adapted the citizen's charter concept into *Performance Pledges* in Hong Kong. Eventually, the Hospital Authority also launched a *Patients' Charter*. In this narrow sense, the origins of both patient's charters were related to the Conservative ideology of radically altering public services.

Regarding the content of *Patients' Charter* in Hong Kong, this was clearly inspired by the UK version of the *Patient's Charter*. Therefore, reference has been made to the UK *Patient's Charter* of 1991 when Hong Kong was drafting the *Patients' Charter* for the Hospital Authority. Hence, it is not surprising to see common areas of those rights in both charters such as the right to receive health care; the right to know of conditions and treatment; the right to complain; the right to take part or not in medical research; the right to access to medical records; the right to a second opinion; and the right to confidentiality, as they have all appeared in both charters. Of course, there were other differences between the content of them. For example, the 1991 version of the British *Patient's Charter* consisted of standards with performance targets such as waiting times while the *Patients' Charter* in Hong Kong did not specify performance

targets and standards. On the other hand, the Hong Kong version listed six patients' responsibilities while the UK version was quiet about patients' responsibilities in the 1991 and the 1995 versions, with only a section on how patients can help. In section 7.3, more comments were made about the differences between the patients' charters in both places.

Despite the apparent similarities and differences about rights and responsibilities, both charters were common in one thing: they were devoid of direct juridical force. Although both countries have incorporated the wording 'Charter', there was no legal force behind them. If patients and their carers were deprived of their rights, they could make use of the charter to voice their requests or to complain to relevant institutions or to appropriate independent bodies. However, the charter itself could not be treated as a legal document to challenge relevant parties if something went wrong. This is congruent with the observation by Goldsworthy (1994) when she examined other countries interested in the charter movement. A consistent message she heard was that changes could be made without the need for large-scale law-making. Hence, there was no need to give a charter 'legislative teeth'. This makes it possible for a quick drawing up of the charterization process.

In England and Hong Kong, the respective health services executive arms have promoted the charter favoring a top down perspective in spreading the messages to staff, patients and the public. In England, the Patient's Charter Unit of the National Health Services Executive has made use of various health service circulars, guidelines and executive letters to give instructions to guide the local implementation of the requirements of the charter as well as how to report back their performance indicators.

Health Authorities have collated the data from local Trusts and reported back to the NHS Executive. In this way, the NHS Executive coordinated the implementation of the *Patient's Charter* from the top level. In Hong Kong, the implementation of the *Patients' Charter* at hospital level was addressed in the annual business plan and annual report processes of each public hospital. The head office of the Hospital Authority initiated this top down strategy through the business planning process requiring Hospital Chief Executives to fulfill the requirement of implementing the charter while leaving room at local level of how the charter was actually promoted and implemented. The major directive was in respect of the physical promotion of the *Patients' Charter* to patients, carers as well as staff working in the hospitals as indicated by the requirement under 'section 3' of the business plan of each hospital managed by the Hospital Authority.

In terms of the promotion of the patients' charters, both localities have put considerable efforts into disseminating the meaning and contents of the charter to the public as well as staff, especially those newly appointed staff and transferred staff. Copies of patient's charters were made widely available at various premises in common formats such as leaflets and posters. Training programmes were incorporated for newly appointed staff to help them to understand the philosophy of the charter and the implications for their practice. The case studies have revealed the existence and scale of these arrangements.

Regarding the implications of a changing relationship between staff and patients, hospital staff at UK and Hong Kong both recalled their patients' experiences in referring to the charter. In the literature review, patients in both England and Hong Kong were claimed to have lower status while clinicians were considered to have higher status

especially in the past. The introduction of patient's charter was considered as a mechanism to enhance the consumerist elements of both areas and to improve the relationship between patients and staff. As indicated from the case study, patients were in general said by staff to be more willing and ready to ask questions concerning their conditions and rights since the launch of the charter. However, they were judged to be more concerned about their rights and to ignore their responsibilities. Staff members were particularly worried about demanding patients and their relatives. They thought more complaints were received as patients were more ready to voice their grievances or to ask for better services. A common feature has then emerged among staff members who reported trying to avoid complaints from patients. At the same time, the media were also said to be increasingly interested in reporting medical incidents. Staff said these created pressures on them especially in situations where resources are inadequate. Consequently, staff felt they had to try to satisfy patients' wants as much as possible. As a result, some staff indicated that there should be ways to promote messages to patients, such as the importance of being a responsible patient, in addition to being a demanding patient. Some felt the idea of the patient's charter was being abused by patients and their carers.

In terms of the similarities of the experiences gathered about those management issues from the two localities, the case studies revealed that patients' charters were considered to be effective management tools to instill quality culture into the health services in both locations. Managers reported that their ability to make use of the charter to shape the culture of the service to emphasize quality services to patients. In this sense, the charter can serve as a beacon to lead the way in this quality journey. In addition, the authority of management can be reinforced. Managers can make use of the charter to

facilitate the achievement of better quality services to customers with its explicit standards and indicators. It can help managers to focus on core and important issues of the hospitals such as managing waiting lists and mixed wards. Therefore, the charter has a 'packaging effect' so that everyone including the public, politicians and the providers of public services can focus on the same picture to have a shared vision of the desired outcome (Goldsworthy, 1994). A majority of respondents in both areas agreed that the charter should be continued with more support needed from the executive arms at higher level. They considered charter should be improved and expanded as well.

### 7.3 Different Approaches

Despite the points of convergence, the implementation of patient's charters in both localities had considerable differences in many areas. The UK version of *Patient's Charter* has chosen the name of 'Patient's' while the Hong Kong version used the title *Patients' Charter*. Although it is a matter of English usage with the position of the apostrophe, it can reflect the importance of putting the emphasis of 'Patient's' as an individual in the UK version whereas 'Patients' are a category in the Hong Kong version. With a similar argument, the position of the apostrophe of *Citizen's Charter* signaled that the charter is about individuals (Deakin, 1994). The Hong Kong *Patients' Charter* is relatively simple in terms of content by its separation of eleven rights and six responsibilities. However, the *Patient's Charter* in UK was more complicated in terms of contents especially its different versions. The earlier version of the 1991 *Patient's Charter* in UK consisted of ten rights, and other standards in which standards were further classified as 'National Charter Standards' and 'Local Charter Standards'. Every citizen was entitled to receive those services mentioned as rights while health services

providers were aiming to provide those services in the category as standards of service. These classifications were further revised in the 1995 version. Instead of standards, the 1995 *Patient's Charter* listed rights and expectations, where expectations were those standards of service which the NHS was aiming to achieve. It was acknowledged that exceptional circumstances may sometimes prevent these standards from being met. The 1995 version of the *Patient's Charter* also consisted of a section on 'How you can help the NHS' to reflect a patient's responsibilities. However, this is a 'soft' approach as it simply set out their responsibilities. The UK version of 1995 was further separated into different sections such as GP services, Hospital Services, Community Services, Ambulance Services as well as Dental, Optical and Pharmaceutical Services to list out those rights and expectations. In Britain, the *Patient's Charter* was available in different ethnic languages and in special formats for the different needs of disabled people. However, the Hong Kong *Patients' Charter* has been available in English and Chinese printed format as well as recorded message only.

A fundamental difference between the patient's charter in UK and Hong Kong is the publication of local patient's charters in the UK. There is currently no such requirement in Hong Kong. As Hong Kong is relatively small in size, it is not surprising that the Hospital Authority has advocated a single version of patients' charter across its hospitals and institutions. However, it should be noted that there are currently two other charter related documents published by the Department of Health and the Hong Kong Medical Association with the Consumer Council which have caused confusion. Indeed, local needs were reflected and addressed in local patient's charters in UK across different regions and districts. Hundreds of local patient's charters were available from local health authorities, trusts and general practices. The *Patients' Charter* in Hong



Kong did not have a standard in respect of the system of named nurse, midwife or health visitor for patients. From the case study, staff in the UK explained the local and varied implementation of the named nurse initiative in their institutions in terms of who could be the named nurse as well as their workload in terms of number of patients to look after. As the literature has shown, they were generally supportive of the named nurse initiative although some claimed that workload had increased as a result (NHSE, 1994). Nevertheless, the named nurse initiative may be seen as a way to improve the professionalism of nurses.

Although both charters have respected patients' privacy and dignity, this was highlighted by a focus on single sex wards as a major issue in UK. Local Trusts have tried to provide patients with single sex wards and the media has been particularly interested in cases of mixed wards. Local Trusts have to record and report back the performance indicators of single sex wards. In contrast, hospitals in Hong Kong have been running single sex wards for many years. Overcrowded wards are the problem not mixed wards in the public hospitals in Hong Kong. Hence, the media in Hong Kong are interested in reporting the use of camp beds in wards as the Hospital Authority has a commitment to remove all camp beds inside wards (Grant and Yuen, 1998).

The Charter Mark scheme is unique in UK as a major part of the Government's drive to modernize public services as well as its approach of managing the charter scheme to recognize good practice. This is seen to demonstrate to people, or customers, improvements in the delivery of services. Under the auspices of the Charter Mark scheme, public service providers, including those from health service, can apply for the award if they meet high standards and can fulfill the ten criteria set including 'set

standards', 'be open and provide full information', 'consult and involve', 'encourage access and the promotion of choice'. 'treat all fairly', 'put things right when they go wrong', 'use resources effectively', 'innovate and improve', 'work with other providers' and 'provide user satisfaction'. From the case study, staff recognized improvements to morale when their organizations won a Charter Mark award. An additional benefit may be gained since organizations have to maintain their standards in order to retain their status as a Charter Mark recipient. In Hong Kong, no such national counterpart as the Charter Mark is available. Individual hospitals may organize an award for those wards which are judged to promote the spirit of patients' charter as indicated from the case study.

Major performance indicators such as named nurses, single sex wards and waiting times were collected and reported to NHS Executive by Trusts in the UK. Politicians in UK are particularly sensitive to such changes of performance indicators as reflecting the performance of the government (BBC, 2000c). Election manifestos have made use of the claims to improve the performance of those indicators such as waiting time as a commitment to citizens (BBC, 2000d). However, there was no apparent performance indicator stated within the Hong Kong *Patients' Charter*. Nevertheless, performance indicators such as waiting time at A&E were collected and reported in the annual reports of the hospitals in Hong Kong. In this sense, the *Patients' Charter* in Hong Kong is supplemented by a requirement of the annual business plans and annual report of the public hospitals.

In terms of staff and patient relationship, the research revealed the problem of verbal and physical abuses to staff were of great concern to frontline staff in the UK

especially in Accident and Emergency departments. This was said to reflect a lack of responsibility of patients and the abuse of staff rights. A *Staff Charter* was advocated by some staff to highlight their rights. The problem of physical and verbal abuse is not apparent in Hong Kong as indicated from the case study. One of the reasons may be the presence of police at Accident and Emergency Departments.

A marked difference was found among opinions from interviews in both locations in terms of the background of the patient's charters. In UK, a majority of respondents associated the *Patient's Charter* with the Conservative government led by John Major. The ideology of political parties is relevant to charters and so a change of government will affect the emphasis on charters in the UK. The charter movement was seen as part of the common approach used by John Major to change public services. Successive Conservative governments under the leadership of Margaret Thatcher and John Major had introduced various reforms of the British public sector. Doern (1993) argued that *Citizen's Charter* was partly a vehicle for symbolically differentiating Major from his predecessor. Similarly, Kavanagh (1998) gave an account of the reordering of British politics from Thatcher era and the transition to Majorism. Although Thatcher has claimed that 'There's no such thing as Majorism' (BBC, 1999), the case study has revealed the strong attachment of the Majorite approach with the charter movement. However, there was no such association or interpretation of the *Patients' Charter* in Hong Kong in terms of political parties or government from the respondents. Although it has been argued that Chris Patten, the last Governor of Hong Kong, has adapted the *Citizen's Charter* concept into Hong Kong, the political background of the *Patients' Charter* was not recognized by the respondents in this research.

Although both locations reported an increased number of complaints, the channels for complaints were different and worth interpretation. The UK *Patient's Charter* indicated the channels to pursue a complaint about staff or hospitals and confirmed patients' right to have their complaint investigated and to receive a full and prompt written reply from the general manager or chief executive. The local Community Health Council was able to provide independent help and advice on making a complaint. Furthermore, the Health Service Commissioner (or Ombudsman), completely independent of the NHS, can consider re-investigating the case if patients are not satisfied with the investigation by the NHS. In Hong Kong, the *Patients' Charter* states the right to make a complaint through channels provided for this purpose within the Hospital Authority, and to have any complaint dealt with promptly and fairly. Patients can complain to the ward manager, Patient Relations Officer and then to the Hospital Chief Executive. There is no mention of other complaint channels such as the Medical Council of Hong Kong, Office of the Ombudsman, Consumer Council and so on. The roles of patients' associations such as those roles played by the Alliance for Patients' Mutual Help Organizations are neglected. Together with the other two versions of charter related documents from Department of Health and Hong Kong Medical Association with the Consumer Council, patients in Hong Kong are said to be easily confused. Hence, the Hospital Authority has realized this weakness of a lack of information about complaint mechanisms. The Authority has produced a booklet to introduce the various ways to lodge complaints as a consequence (Hospital Authority, 2001d).

#### 7.4 Contributions to Current Knowledge and Implications

In this section, the research is explored in an attempt to illustrate its contribution to current knowledge and the implications. The previous sections 7.2 and 7.3 have highlighted the similar and different experiences in implementing the patients' charters in both localities. Hence, this section will look at the contribution to the current knowledge of 'Charterism', 'Chaterization' and the implications with reference to various theories. Such analysis will be reflected against the results from the case study for particularization so as to try to enrich the current knowledge of 'Charterism' in health services as well as the appreciation of the use of Public Choice Theory in understanding the implementation of the patient's charter. This thesis has tried to enrich the current concepts of 'Charterism' that have been advocated in the UK. To revisit the existing concepts of 'Charterism', Drewry's use of the term 'Charterism' in 1993 attracted considerable interest from researchers and social scientists (Drewry, 1993). Although the term 'Charterism' did not appear much in the literature when compared with the term 'Charter', other researchers have incorporated 'Charterism' into their literature and vocabulary. For example, the work of Pollitt (1994), Prior (1995), Falconer (1996), Falconer et al. (1997) and Minogue (2000) has all incorporated the term 'Charterism'. Current knowledge of 'Charterism' has implied the use of various charter documents in UK to run public services and to enshrine the principles of the *Citizen's Charter*. Although these authors did not give a comprehensive interpretation and definition of 'Charterism', a combination of their beliefs and understandings have contributed to the key operational concepts and the main tenets of 'Charterism'. It is proposed that the key operational concepts of 'Charterism' include those 'standards' of services. The tenets of 'Charterism' are associated with the central themes and

principles of the *Citizen's Charter* developed in UK. Hence, 'Charterism' refers to an emphasis on 'Standards', 'Quality', 'Choice', 'Value for Money', 'Openness', 'Information', 'Non-discrimination', and 'Accessibility' with additional important elements of 'achievement of the Charter Mark', 'the processes of Complaint Procedures and Redress'. This framework of ideas is particularly useful for tailoring further charters specific to public services. Therefore, current knowledge of 'Charterism' is highly specific to the UK citizen's charter initiative. In this respect, it is helpful to elaborate the knowledge further with the input from this case study.

The value of a comparative approach in understanding the implementation of patient's charters in UK and Hong Kong is that it has helped to expand and refine 'Charterism' into the international arena. As indicated previously, several countries have made use of various charters to run their public services. The current interpretation of 'Charterism' is hence a limited version if applied to the UK alone. It is helpful to make use of the experiences of Hong Kong to refine the concept and knowledge of 'Charterism'. Therefore, an expanded scope of the language of 'Charterism' is useful to describe and refer to those initiatives incorporating charters to run a public or even a private service, in different countries. From the case study of implementing *Patients' Charter* in Hong Kong, there are limitations to the previous explanation and interpretation of 'Charterism' in the UK arena when applied to the Hong Kong context. For example, the *Patients' Charter* in Hong Kong did not follow exactly the *Citizen's Charter* of the UK. The Hong Kong version of 'Charterism' did not involve the element of the Charter Mark, for example. However, those other elements of 'Standards', 'Quality', 'Choice', 'Openness', 'Non-discrimination', 'Information', 'Complaints channels' are found in the Hong Kong version although there is a lack of a clear

indication of the various complaint mechanisms. 'Charterism' in Hong Kong has put greater emphasis on the responsibilities of patients in addition to their rights. Together with their experiences of those impacts, a new theme for 'Charterism' should reflect the international dimensions of adopting charters as the tools for improving services in different countries. Hence, any refined 'Charterism' should be applicable to the international arena and no longer confined to the UK. Governments and public services organizations can make use of 'Charterization' in their services to instill change to achieve their desired objectives. This enshrines the incorporation of charter related documents with stated standards and a wide range of underlying principles or terms which may include: 'Standards', 'Quality', 'Choice', 'Value for Money', 'Openness', 'Information', 'Non-discrimination', 'Accessibility', 'Charter Mark', 'Complaint Procedures', 'Redress', 'Non-legalised', 'Packaging effect', 'Rights', 'Performance Indicators', 'Responsibility' and 'Apolitical'.

The impact of 'Charterism' upon health services in both areas is worth further refinement. The similarities of the implementation experiences of patient's charter in both locations have revealed that both positive and negative impacts result. Although Wilson (1996) has also argued the impact of the *Citizen's Charter* is being met with indifference and is not easily reconciled with Governmental rhetoric, the case studies have shown that both locations have revealed impacts that are contributing to health services developments. In implementation of the charter, the relationship between staff and patients can be improved. Communications between the two can be enhanced. Patients and relatives appear more able to ask questions while staff members say they are more willing to solve their queries. Drawing on Alford's (1975) terminology, the 'repressed interests' (patients) can now upgrade their status against the 'dominant'

(professionals). 'Charterism' is also useful for services to 'charterize' their provision without the need to undergo vigorous and lengthy procedures which legalize the details. This is particularly useful when charterizing a service in a short period of time. Whether 'Charterism' is regarded as a pure public relations activity or not, it appears to provide a symbolic effect in shaping the behaviours of providers. Accountability has been advocated with clear complaint channels. However, as the case studies have shown, negative impacts such as the avoidance of complaints were revealed by the staff respondents. Sometimes, staff say they have to satisfy patients' unreasonable wants in order to avoid their complaints. This complaint avoidance culture is a by-product of 'Charterism' in UK and Hong Kong. Hence, other countries and services may wish to consider how to avoid this negative implication of complaint avoidance culture.

This research has sought to evaluate the use of Public Choice Theory in understanding the implementation of the patient's charter. As discussed in section 2.2, Public Choice Theory argues that public sector actors behave as if they maximize their own interests as well proposing that all social entities are fundamentally sets of individual actors. These actors have little incentive to contain costs or to improve services. Therefore Public Choice prescriptions are needed to alleviate the shortcomings. Connelly (1997) has already argued that Public Choice Theory turns the assumptions of economics to the study of politics. It assumes that actors lack altruism but are motivated primarily by self-interest. He used the acronym 'SERUM' to capture the assumptions of Public Choice Theory as self-interested, egoistic, rational, utility maximisers. According to Connelly, politicians and bureaucrats are more concerned about themselves rather than the interests of those citizens they are serving. Products and services are eventually producer-led but not customer-led. Therefore, remedies



should be given to bring incentives to producers in order to meet the preferences of consumers. In this case study of two localities, Patients' charters can be treated as tools of Public Choice remedies to allow public services to improve their services and to shift provider-led services to become customer-led. Health services managers, politicians, clinical staff, patients' groups, patients and their carers are seen as self-interested actors who try to maximize their benefits in the health care market. As the case studies have shown, Public Choice Theory is useful in understanding the implementation of patient's charters in UK and Hong Kong in at least two ways. Firstly, it helps to explain and interpret the self-interested behaviours of those actors before and even in the presence of the *Patient's Charter*. For example, health services managers can increase their authority and power with the use of the charter to maximize their influences upon clinicians. Clinical staff, especially doctors, were claimed to be superior in the doctor-patient relationship. Even in the presence of the *Patient's Charter*, clinical staff members try to safeguard their rights and interests and request a staff charter to protect them and to avoid complaints. On the other hand, patients are said to be particularly ready to show their self-interest behaviour as patients become more assertive and lodge more complaints. For example, the self-interest of patients is said to be particularly prominent as they are concerned about their rights while not considering their responsibilities as patients. This phenomenon was highlighted in the research interviews with staff. Regarding politicians, the theory can explain their concern about key performance indicators in the health services such as waiting lists, mixed wards and so on in order for them to show the public their positive performance in public services so as to attract votes. Secondly, the theory is useful to address the Public Choice remedial regimes employed to shift the health services into a consumer led orientation. The charter is treated as a beacon to improve patients' rights, standards of services so as to

inject consumerism and the culture of quality into the health services in both locations. Boyne (1998a) reviewed the Public Choice model of bureaucracy in which three specific characteristics of public bureaucracies are believed to lead to a lack of efficiency and effectiveness. These three characteristics are the monopolistic structure of public service markets, the absence of valid indicators of organizational performance, and the large size of many government agencies. The Conservative government believed that the structure of public services market should be more competitive with the use of market, internal market or quasi-markets. In terms of charters, the philosophy and the implementation experiences allowed providers to have more open information and apparently unambiguous performance indicators. This is the second Public Choice prescription to force public agencies to produce more information on their performance. Therefore, 'Charterism' fits in the Public Choice prescriptions to alleviate the problems associated with the public sector. As from the experiences of implementing patient's charters, these standards and indicators are useful to patients and carers as users of the services since the standards can be incorporated as performance targets when negotiating competitive contracts between rival providers. Hence, openness can facilitate a Public Choice prescription into a competitive structure. To couple the third Public Choice prescription of reducing the size of bureaucracy, Charterization of public services can have an indirect effect on providers to re-engineer their production processes so as to realize the needs of customers and to improve efficiency. Thus, Public Choice Theory is useful in interpreting the implementation of patient's charters and indeed 'Charterism' from these two perspectives.

Nevertheless, the *Patient's Charter* should not be considered on its own in public management. Other theories and concepts are useful in understanding the

popularity of charters in different countries. The discussion of New Public Management in section 1.3 has already argued that 'marketization', 'disaggregation' and 'incentivization' were the main components of New Public Management. This is different from traditional ways of managing public services. Instead, NPM emphasizes an efficiency drive, downsizing and de-centralization, the search for excellence and an orientation to public services. From the two case studies in UK and Hong Kong, patients' charters fit mainly the 'search of excellence', 'an orientation to public services' by improving standards and the 'incentivization' through the Charter Mark scheme. As Dawson and Dargie (2000) have commented, there has been a general shift in the discussion of New Public Management over the last ten years. New Public Management was originally conceptually defined in terms of managerialism and rational choice. However, subsequent debates have included a discussion of ethics, accountability, democracy, regulation, and the intrinsic nature of the public sector. Hence, 'Charterism' can facilitate this shift by increased elements of accountability with clear complaint procedures.

Taylor's (1992, p. 87) commentary on social policy raised the question of *A Big Idea for the nineties? The rise of citizens' charters* as the title of his article. The citizen's charter programme in UK was launched in 1991 and the programme had a comprehensive ten year remit designed to give more power to the citizen (Keeble, 1996). Although there has been a change of government from Conservative to Labour, the initiative has been carried on (but with a different pace) after its ten years existence in England. In revisiting the notions of citizenship and consumerism, commentators have already criticized the common confusion of treating consumers as citizens or consumer-like citizens (see Taylor, 1992; Doern, 1993; Prior, 1995; Falconer, 1996;

Wilson, 1996; Connelly, 1997; Falconer et al., 1997). As Easton (1996) has stressed, the citizen is now defined as a user of services rather than a member of an organic community. Hence, a citizen's role is to appraise services and for providers' pay to be related to performance. From the case studies, patients, carers and patients' groups are treated as the direct and indirect recipients of health services. Rather than being citizens as advocated by Marshall (1950), these consumers are now treated as consumer-like citizens with injected consumerism backing by explicit standards of services and so on. Hence, the case studies reinforced the current phenomenon of the confusion of treating patients and their carers as citizens. However, their power can be enhanced through the patient's charter in both locations by shifting the balance of the caring relationship with the use of rights to information and choice. Paternalism is now being shifted to consumerism. Therefore, consumers can hold suppliers accountable. As Rawlings and Willett (1996) have agreed, standards are being set and suppliers are being held accountable for all the important standards within the relationship.

Policy needs to be implemented. Dalton et al. (1996) argue that what seems a brilliantly conceived policy may completely fall apart because nobody can or will implement it. Therefore, policy can have both intended and unintended consequences from its stated objectives. The value of the case studies is to focus on the implementation process where there are many actors and 'street level bureaucrats' who deliver the services. They can shape the implementation of the policy by their discretionary actions. In both England and Hong Kong, the executive arms have chosen to a large extent a top-down approach to implement their respective patients' charters. This reflects their intention to regulate the requirements of the implementation of the charter to enhance compliance. The implementation of the charters has been achieved by

giving instruction and guideline from the NHS Executive in UK through executive guidelines and from the Hospital Authority Head Office in Hong Kong through the business planning process. To supplement the implementation, key performance indicators have to be recorded and reported back to the executives. A policy that is executed need not result in the accomplishment of its objectives. As such, the complaint avoidance behaviours exhibited by staff in both locations are examples of the unintended results from the implementation of patient's charter.

### 7.5 Limitations of the Study

This research has limitations in a number of aspects. It is appropriate to categorize these limitations into several perspectives; namely the choice of the research topic, the research methodology and the actual data collection as well as the analysis of the research findings. To start with the choice of the research area, this is an area that has attracted some interest from social scientists, in particular with reference to the UK context. In the attempt to research 'Charterism', a comparative study of the implementation of patient's charters in both UK and Hong Kong was deemed appropriate to take a broader picture rather than just researching a single country. Hence, this research supplements current knowledge about 'Charterism' in UK with another dimension. Although both areas have incorporated patient's charters in their public health services, the emphasis of patient's charters has changed as this research progressed. With the change of government to New Labour, the emphasis shifted. Although Mr. Dyke was appointed by the Labour government to review the *Patient's Charter* so as to propose a new *NHS Charter*, the result was a quiet withdrawal of the *Patient's Charter* and its replacement by *Your Guide to the NHS*. As Crompton (2001)

has commented, this guide is not a charter at all. It does not even allude to the concept of a right. Much of it is firmly focused on patients' responsibility to look after themselves and to use the right avenues in the NHS. It appears that interest in the *Patient's Charter* has declined in the UK. Nevertheless, the charter initiative is still carrying on with the 'Charter Mark' scheme for public service providers including health service providers. However, Hong Kong is continuously incorporating *Patients' Charter* in public hospitals under the management of the Hospital Authority. Posters, leaflets and other promotion methods are still available in wards. Despite these difficulties in terms of shifting priorities, this research is still of value in contributing to knowledge.

Concerning the chosen research method, this research employed a case study approach for a comparative study of the implementation of patient's charters in England and Hong Kong. Under the umbrella of case study, various methods of data collection have been used, namely content analysis of documents and other sources of written materials; semi-structured interviews; focus group and participant observation in order to gather multiple sources of data from different units of analysis including head office/executive level, hospitals senior management level and ward level as well as from representative patients' groups. The use of a case study approach is helpful in understanding the deeper interpretation of patient's charter by these stakeholders. However, other approaches can be included or substituted to replace the case study methods in order to research the patient's charter. For example, a wide scale quantitative survey would be useful to look at the current situation regarding *Patient's Charter* among these providers. However, it seemed that case study is the better approach for this thesis because of its ability to explore perspectives in some depth.

Before the data collection, the choice of sampling units had its difficulties and limitations. Firstly, a sampling unit should be accessible to the researcher in terms of both physical access and consent for interview. This latter proved particularly difficult to gain as staff (including senior staff) were in busy acute Trusts. Another difficulty was the availability of the researcher who was based in Hong Kong and had to make use of vacation leave to come to England to conduct interviews. Luckily, the researcher was still able to gain access to most of the intended sampling units. However, it was regrettable that the access to the Patient's Charter Unit of NHSE in Leeds was denied. Alternative sources of data had to be collected to solicit information from the National Health Service Executive and the Patient's Charter Unit. Research also involves time, commitment, planning and resources such as traveling expenses. Hence, the data collection phase in UK provided opportunities for the researcher to experience the hard work behind the scene. Data collection in Hong Kong was much smoother without major problems in gaining access.

Interviews were recorded using digital recorder. This allowed the researcher to transcribe the interviews easily and accurately. Storage of the data was also easier through computer. However, the analysis of data from different sources of information was one of the most difficult tasks in this research. With guidance from the research supervisor, the difficulties of digesting considerable amounts of data and information could be overcome.

## 7.6 Recommendations for further research

Knowledge is ever changing and evolving over time. Research is needed to pursue new knowledge and insights in different disciplines. Similarly, the development of charter movement is flourishing and adapting in an international context. Based on the experiences from this research, several recommendations are listed and elaborated for other researchers to consider when they are trying to develop this area of research interest. These recommendations correspond to the research in patient's charter; research in 'Charterism', research on complaints as well as research in the area of patients and consumer groups.

This research project has investigated the development and implementation of patient's charter in UK and Hong Kong. It is potentially useful to enlarge the scale of this research to look at international movements and developments of patient's charters and/or relevant strategies across the globe such as bills of rights in the USA. The current literature is limited as most research has stemmed from one country or at most been comparative between two localities. Although the World Health Organization has commissioned the Centre for Health Services Studies at the University of Kent at Canterbury as a collaborating Centre for Patients' Rights and User Views and Citizens' Participation with a work plan for 1998 – 2002 (CHSS, 2001), currently there is a lack of large scale research. Results from this kind of study will be useful to inform health policy makers in different countries about the movement and impact of patient's charters or indeed patients' rights across the globe.



Apart from further research on the patient's charter, another area to investigate is the impact of the change of *Patient's Charter* to the *Your Guide to the NHS* in the UK. The guide has been in existence since January 2001, and its acceptance and impact are both worth further research. The guide was launched by Health Minister Gisela Stuart as a replacement for the 'old style patient's charter' (Department of Health, 2001b). It also fulfils the Labour Party Manifesto commitment to replace the *Patient's Charter* with a clearer guide to patients' rights, responsibilities and the national standards and services people can expect from the NHS currently and in the future. The guide consists of a roadmap telling patients how to get advice and treatment from the NHS and the standard of service they can expect. This rhetoric initially concerned patient groups who saw it as a way of diminishing patients' rights and replacing them with expectations (Health Service Journal, 2001c). Hence, the current *Guide* is indeed a major potential area for research.

In terms of the patient's charter movement in Hong Kong, limited research has been pursued in this area apart from few articles written by the researcher. As mentioned in previous sections, there are currently three versions of patients' charter related documents in the health services of Hong Kong advocated by Hospital Authority, Department of Health and the Hong Kong Medical Association with the Consumer Council. Hence, new research could explore how these are being applied and implemented in both public and private sectors and in different levels of service such as primary health care. This will provide useful insight to policy makers in an era of health care reform in Hong Kong. More importantly, it could affect the policy adopted by China because of frequent

exchanges in health policy initiatives and experiences between mainland China and Hong Kong.

A particularly important phenomenon has appeared in both UK and Hong Kong regarding the issues surrounding medical incidents and complaints against health services providers. This is another major area for further research in both locations especially in terms of the recent reports of medical incidents in UK and Hong Kong. Medical incidents such as the Bristol heart babies scandal and the ongoing Harold Shipman inquiry are just some of the examples (BBC, 2001d; BBC, 2001e). Indeed, it has been claimed that up to 30,000 people die in the UK as a result of medical errors (Independent, 2000). In the UK, relevant research has been undertaken by Allsop and Mulcahy (1996a; 1998a; 1998b; 1999). However, there are no similar studies in Hong Kong regarding these issues. Hence, there is a need to develop relevant research in Hong Kong. Another relevant research area concerns complaint mechanisms and the composition of complaints committees. Further research is needed on the alignments and roles of different professional representatives including lay people in various health services committees (Hogg and Williamson, 2001).

Apart from the suggestions of researching medical complaints and medical incidents, the roles of patients' groups in shaping health policy are worth further research. Wood (2000) has already explored the growing number of patients' associations relating to a specific medical condition or illness in UK and USA. He surveyed over 200 of these associations in each country. Another project, funded by the Economic and Social Research Council, to study health consumer groups

and the national policy process has been undertaken by a research team from the Department of Public Policy of De Montfort University (Patients Forum, 2001). However, there are no similar studies in Hong Kong. Again, this is a neglected area that merits research. Therefore, there are plenty of areas for research in particular in the context of Hong Kong. Funding should be targeted at these areas so as to contribute to the health policy process.

### 7.7 Summary

It has been shown that patients' charters and related initiatives have been incorporated by many countries. Through the comparative case studies of the implementation of patients' charters in England and Hong Kong, their similar and different experiences of implementing the charter have been sketched. Positive impacts were supplemented by negative impacts such as the development of a complaint avoidance culture among staff. The current interpretation of 'Charterism' has been limited to the UK context. From this research, the knowledge of 'Charterism' has been refined to incorporate international dimensions together with the bundles of beliefs and tenets of 'Charterism' for other countries to consider when or if they 'Charterize' public or even private services. The thesis has also highlighted the usefulness of Public Choice Theory in interpreting the self interested behaviours of those actors even in the presence of patients' charters as well as the importance of patients' charters as tools for Public Choice remedy to public service. However, the *Patients' Charter* represents a limited version of citizenship treating citizens as patients or customers. With the

recent replacement of UK *Patient's Charter* by the *Your Guide to the NHS*, further research areas are emerging.

## References

ACHCEW (1986), Patient's Charter: guidelines for good practice, London: Association of Community Health Councils for England and Wales.

Alford R.R. (1975), Health Care Politics, Chicago: University of Chicago Press.

Allsop J. (1992), *The Voice of the User in Health Care*, in Beck E., Lonsdale S., Newman S. and Patterson D. (eds), In the Best of Health?, London: Chapman & Hall.

Allsop J. (1995), Health Policy and the NHS: Towards 2000, (2<sup>nd</sup> edn.), Harlow: Longman Group Limited.

Allsop J. and Mulcahy L. (1996a), Regulating Medical Work: Formal and informal controls, Buckingham: Open University Press.

Allsop J. and Mulcahy L. (1996b), *Diplomatic services*, Health Service Journal, 11 January, pp. 26-27.

Allsop J. and Mulcahy L. (1998a), *Maintaining professional identity: doctors' responses to complaints*, Sociology of Health & Illness, Vol. 20, No. 6 pp. 802-824.

Allsop J. and Mulcahy L. (1998b), *Doctors' responses to patient complaints*, in Rosenthal M., Mulcahy L. and Lloyd-Bostock S. (eds), Medical Mishaps: Pieces of the Puzzle, Open University Press.

Allsop J. and Mulcahy L. (1999), *A half open door: a commentary on NHS complaint systems*, Journal of Contemporary Law, Vol. 3, No. 3, pp. 170-193.

Arksey H. and Knight P. (1999), Interviewing for Social Scientists, London: Sage.

Attorney General's Chambers (1996), The Victim's Charter, Hong Kong: Government Printer.

Baggott R. (1998), Health and Health Care in Britain, (2<sup>nd</sup> edn.), London: Macmillan Press Ltd.

Baier V.E., March J.G. and Saetren H. (1986), *Implementation and Ambiguity*, Scandinavian Journal of Management, May, pp. 179-212. (no issue number)

Barrett S. and Fudge C. (1981), *Examining the policy-action relationship*, in Barrett S. and Fudge C. (eds), Policy and Action: essays on the implementation of public policy, London: Methuen & Co. Ltd.

Bailey D. and Koney K. M. (2000), Strategic Alliances among Health and Human Services Organizations: from affiliations to consolidations, London: Sage.

BBC (1998a), *Health: Violence strikes ambulance staff*, BBC News, 26 October, at [http://news.bbc.co.uk/hi/english/health/newsid\\_201000/201426.stm](http://news.bbc.co.uk/hi/english/health/newsid_201000/201426.stm)

BBC (1998b), *Health: Nurses fear attacks at work*, BBC News, 26 October, at [http://news.bbc.co.uk/hi/english/health/newsid\\_201000/201342.stm](http://news.bbc.co.uk/hi/english/health/newsid_201000/201342.stm)

BBC (1998c), *Health: Patient's Charter blamed for attacks on NHS staff*, BBC News, 28 October, at [http://news.bbc.co.uk/hi/english/health/newsid\\_202000/202942.stm](http://news.bbc.co.uk/hi/english/health/newsid_202000/202942.stm)

BBC (1998d), *Health: Charting the NHS path*, BBC News, 9 December, at [http://news.bbc.co.uk/hi/english/health/newsid\\_231000/231165.stm](http://news.bbc.co.uk/hi/english/health/newsid_231000/231165.stm)

BBC (1998e), *Health: new charter ducks contentious issues*, BBC News, 9 December, at [http://news.bbc.co.uk/hi/english/health/newsid\\_231000/231948.stm](http://news.bbc.co.uk/hi/english/health/newsid_231000/231948.stm)

BBC (1999), *UK Politics: Downing Street's Greek tragedy*, BBC News, 11 August, at [http://news.bbc.co.uk/hi/english/uk\\_politics/newsid\\_417000/417521.stm](http://news.bbc.co.uk/hi/english/uk_politics/newsid_417000/417521.stm)

BBC (2000a), *High cost of university openness*, BBC News, 23 August, at [http://news.bbc.co.uk/hi/english/education/newsid\\_892000/892850.stm](http://news.bbc.co.uk/hi/english/education/newsid_892000/892850.stm)

BBC (2000b), *Hospitals slow to scrap mixed sex ward*, BBC News, 26 January, at [http://news.bbc.co.uk/hi/english/health/newsid\\_619000/619898.stm](http://news.bbc.co.uk/hi/english/health/newsid_619000/619898.stm)

BBC (2000c), *Blair catches mid-term chill*, BBC News, 18 January, at [http://news.bbc.co.uk/hi/english/uk\\_politics/newsid\\_608000/608775.stm](http://news.bbc.co.uk/hi/english/uk_politics/newsid_608000/608775.stm)

BBC (2000d), *NHS waiting list pledge met*, BBC News, 17 May, at [http://news.bbc.co.uk/hi/english/health/newsid\\_751000/751858.stm](http://news.bbc.co.uk/hi/english/health/newsid_751000/751858.stm)

BBC (2001a), *Health Check: Talk about CHCs*, TV Programme on 5 February

BBC (2001b), *No patient watchdog retreat – Blair*, BBC News, 25 April, at [http://news.bbc.co.uk/hi/english/uk\\_politics/newsid\\_1296000/1296773.stm](http://news.bbc.co.uk/hi/english/uk_politics/newsid_1296000/1296773.stm)

BBC (2001c), *Shake-up of hospital wards*, Humber Online, 16 August, at <http://www.bbc.co.uk/humber/news/082001/16/hri.shtml>

BBC (2001d), *Delivering a verdict: Ian Kennedy*, BBC News, 17 July, at [http://news.bbc.co.uk/hi/english/health/newsid\\_1368000/1368976.stm](http://news.bbc.co.uk/hi/english/health/newsid_1368000/1368976.stm)

BBC (2001e), *Shipman 'may have killed 236'*, BBC News, 5 January, at [http://news.bbc.co.uk/hi/english/health/newsid\\_1101000/1101480.stm](http://news.bbc.co.uk/hi/english/health/newsid_1101000/1101480.stm)

Beisecker A.E. and Beisecker T.D. (1993), *Using Metaphors to Characterize Doctor-Patient Relationships: Paternalism Versus Consumerism*, Health Communication, Vol. 5, No. 1, pp. 41-58.

Bellamy R. and Greenaway J. (1995), *The New Right Conception of Citizenship and the Citizen's Charter*, Government and Opposition, Vol. 30, No. 4, pp. 469-491.

- Blair T. (1998), The Third Way: New Politics for the New Century, London: Fabian Society.
- Blair T. (1997), *Foreword by the Prime Minister*, in Rivett G. (1997), From Cradle to Grave: Fifty years of the NHS, London: King's Fund.
- Blair T. (1999), *A Message from the Prime Minister – Modernising Government White Paper*, at <http://www.dfee.gov.uk/modgov/pmmg.htm>
- Blyth L. (1995), *Introduction from the Chairman of the Charter Mark Judging Panel*, at <http://www.open.gov.uk/charter/judintro.htm>
- BMJ (1996), *Education and Debate: The Ljubljana Charter on Reforming Health Care*, British Medical Journal, Vol. 312, 29 June, pp. 1664-1665.
- Bowling A. (1997), Research Methods in Health, Buckingham: Open University Press.
- Boyne G. A. (1996), *Competition and Local Government: A Public Choice Perspective*, Urban Studies, Vol. 33, pp. 703-721.
- Boyne G. A. (1998a), *Public Services Under New Labour: Back to Bureaucracy?*, Public Money & Management, July-September, pp. 43-50. (no issue number)
- Boyne G. A. (1998b), *Competitive Tendering in Local Government: a review of theory and evidence*, Public Administration, Vol. 76, Issue 4, Winter, pp. 695-712.
- Brause R.S. (2000), Writing Your Doctoral Dissertation: Invisible Rules for Success, London: Falmer Press.
- Braybrooke D. and Lindblom C.E. (1963), A Strategy of Decision: policy evaluation as a social process, New York: The Free Press.
- Brealey M. (2001), *Features: Help is at hand*, NHS Magazine, 5 October, at <http://www.nhs.uk/nhsmagazine/feat3.asp>
- Bressers H.T.A. and O'Toole L. J. (1998), *The Selection of Policy Instruments: a Network-based Perspective*, Journal of Public Policy, Vol. 18, No. 3, pp. 213-239.
- Buchanan J.M. (1978), *Summing Up*, in Buchanan J. M., Rowley C.K., Breton A., Wiseman J., Frey B. and Peacock A.T. (eds), The Economics of Politics, London: The Institute of Economic Affairs.
- Buchanan J.M. (1986), Liberty, Market and State, Brighton: Wheatsheaf Books.
- Buchanan J.M. (1987), The Constitution of Economic Policy, Stockholm: Nobel Foundation.
- Burke A. (2000), *Guest Editorial: The NHS Plan: stifling the patient's voice?*, British Journal of Community Nursing, Vol. 5, No. 11, p. 11.

- Butcher T. (1991), *Improving Civil Service Management: The Next Steps Programme, Talking Politics*, Vol. 3, No. 3, Spring, pp. 110-115.
- Bynoe I. (1996), *Beyond the Citizen's Charter: new directions for social rights*, London: Institute for Public Policy Research.
- Caan W. (1996), *Letters: The Patient's Charter for mental health, a token gesture*, *British Journal of Health Care Management*, Vol. 2, No. 6, p. 320.
- Cabinet Office (1995), *Mark Your Mark: Charter Mark Awards 1995. Guide for applicants*, London: Cabinet Office and the Central Office of Information.
- Cabinet Office (2001a), *Press Release: UK and Greece Share Vision for 21<sup>st</sup> Century Public Services*, CAB 098/01, 3 April, Cabinet Office Press Office.
- Cabinet Office (2001b), *Modernising government news*, Issue No.8, 13<sup>th</sup> February, Cabinet Office Press Office.
- Cabinet Office (2001c), *Charter Mark Policy Development: Consultation Paper*, at <http://www.servicefirst.gov.uk/2000/chartermark/chartermarkconsult.rtf>
- Calnan M. (1995), *Citizens' Views on Health Care*, *Journal of Management in Medicine*, Vol. 9, No. 4, pp. 17-23.
- Carr-Hill R. and Ng F. (1992), *A Confusion of Charters*, *Health Service Journal*, 5 Nov, pp. 20-23.
- Carter J. (2000), *New Public Management and Equal Opportunities in the NHS*, *Critical Social Policy*, Vol. 20., No. 1, pp. 61-83.
- Chandler J.A. (1996), *Introduction*, in Chandler J.A. (ed.), *The Citizen's Charter*, Aldershot: Dartmouth Publishing Company Limited.
- Cheng T.C.E. and Ngai E.W.T. (1997), *Managing Service Quality in the Hong Kong Government Through Performance Pledges: A Preliminary Study*, *Asian Journal of Business & Information Systems*, Vol. 2, No. 1, Summer, pp. 133-149.
- CHSS (2001), *The World Health Organization: Centre for Patients' Rights and User Views and Citizens' Participation*, Centre for Health Services Studies, University of Kent at Canterbury, at <http://www.ukc.ac.uk/CHSS/who.html>
- Chung S.Y. (1989), *Report of the Provisional Hospital Authority*, Hong Kong: Government Printer.
- Citizen's Charter (1991a), *The Citizen's Charter: raising the standard*, Cm 1599, London: HMSO.
- Citizen's Charter (1991b), *The Citizen's Charter: a guide*, London: HMSO.



Citizen's Charter (1992a), The Citizen's Charter First Report: 1992 - a guide, London: HMSO.

Citizen's Charter (1992b), The Citizen's Charter: The Charter Mark, London: HMSO.

Citizen's Charter (1992c), The Citizen's Charter: The Charter Mark application form and your questions answered, London: HMSO.

Citizen's Charter (1994), The Citizen's Charter, Second Report: 1994, Cm 2540, London: HMSO.

Citizen's Charter (1995), The Citizen's Charter: The Fact and Figures, Cm 2970, London: HMSO.

Citizen's Charter (1996b), *Citizen's Charter - Index of Charters*, at <http://www.open.gov.uk/charter/list.htm>

Citizen's Charter (1998), *Citizen's Charter Unit*, at [http://www.cabinet-office.gov.uk/1998/co\\_report/section3/groups/ccu.html](http://www.cabinet-office.gov.uk/1998/co_report/section3/groups/ccu.html)

City Forum (2001), *City Forum: Health care Professionals and Patients' Rights*, 22 April, RTHK on internet at [http://www.rthk.org.hk/rthk/tv/city\\_forum/20010422.html](http://www.rthk.org.hk/rthk/tv/city_forum/20010422.html) (In Chinese)

Clark D. (1996), *Open Government in Britain: discourse and practice*, Public Money & Management, Jan-Mar., pp. 23-30.

Clark D. (2000), *Citizens, Charters and Public Service Reform in France and Britain*, Government and Opposition, Vol. 35, No. 2, pp. 152-169.

Clarke J., Gewirtz S. and McLaughlin E. (2000), *Reinventing the Welfare State*, in Clarke J., Gewirtz S. and McLaughlin E. (eds), New Managerialism, New Welfare?, London: Sage.

Cole A. and Davidson L. (1992), *Let's Name Nurses*, Nursing Times, March 11, Vol. 88, No. 11, pp. 24-26.

Cole A. (1993), *Name-Check*, Nursing Times, April 7, Vol. 89, No. 14, pp. 30-31.

Commission on Youth (1993), Charter for Youth, Hong Kong: Government Printer.

Connelly J. (1997), Citizens, Charters and Consumers, Social Science Occasional Papers Series No.2, Southampton: Southampton Institute.

Consumer Council (1992), Consumer Council News, 2 Oct, Hong Kong: Consumer Council.

Consumer Council (1993), *Patients' Rights and Responsibilities*, Choice, Issue 193, Hong Kong Consumer Council. (In Chinese)

Consumers International (1996), Campaigning for Patients' Rights: A Consumer Action Kit, London: Consumers International

Consumers International (1997), *Consumer Charter for Global Business*, at [http://www.consumersinternational.org/campaigns/trade/charter\\_en.html](http://www.consumersinternational.org/campaigns/trade/charter_en.html)

Consumers International (1999a), *Campaigning for Patients' Rights: A Guide for Patients and Consumer Activists*, at <http://www.consumersinternational.org/campaigns/patientsrights/consumeraction.html>

Consumers International (1999b), *The Rights of Patients*, at <http://www.consumersinternational.org/campaigns/patientsrights/english.html>

Consumers International (1999c), *National Activities on Patients' Rights and Quality of Health Care*, at <http://www.consumersinternational.org/campaigns/patientsrights/activities.html>

Cooray A. (1994), *Towards More Efficient Administration: Citizen's Charter in the United Kingdom and Hong Kong's Performance Pledge Programme*, Hong Kong Public Administration, Vol. 2 No. 2, pp. 159 - 176.

Cornacchia H.J. and Barrett S. (1980), Consumer Health: A guide to intelligent decisions, (2nd edn), St. Louis: Mosby.

Coulter A. (1999), *Editorial: Patient's Charter*, Health Expectations, Vol. 2, pp. 147-149.

Craig G. and Manthorpe J. (1999), *Unequal Partners? Local Government Reorganization and the Voluntary Sector*, Social Policy & Administration, Vol. 33, No. 1, March, pp. 55-72.

Crompton S. (2001), *Are we losing our rights as patients?*, The Times, 17 July, at <http://www.thetimes.co.uk/article/0,,72-2001242410,00.html>

Cryer P. (1996), The Research Student's Guide to Success, Buckingham: Open University Press.

Culter T. and Waine B. (2000), *Managerialism Reformed? New Labour and Public Sector Management*, Social Policy & Administration, Vol. 34, No. 3, September, pp. 318-332.

Dalton T., Draper M., Weeks W. and Wiseman J. (1996), Making Social Policy in Australia: An Introduction, St. Leonards, New South Wales: Allen & Unwin.

Daryanani R. (1991), Hong Kong 1994, Hong Kong: Government Information Services.

Davis R. and Trethewey M. (1996), *Customer focus for improved health gain*, British Journal of Health Care Management, Vol. 2, No. 6, pp. 321-323.

- Dawson S. and Dargie C. (1999), *New Public Management: An assessment and evaluation with special reference to UK health*, Public Management, Vol. 1., No. 4, pp.459-481.
- Deakin N. (1994), *Accentuating the Apostrophe: the Citizen's Charter*, Policy Studies, Vol. 15, No. 3, pp. 48-58.
- Delanty G. (2000), Citizenship in a global age, Buckingham: Open University Press.
- Department of Health (1989a), Working for Patients, Cm 555, London: HMSO.
- Department of Health (1989b), General Practice in the National Health Service: the 1990 contract, London: HMSO.
- Department of Health (1989c), National Health Service review working papers (Package of 8 booklets), London: HMSO.
- Department of Health (1991a), The Patient's Charter, London: HMSO.
- Department of Health (1991b), The Patient's Charter: a summary, London: HMSO.
- Department of Health (1991c), *William Waldegrave Launches Framework for Patient's Charter*, Press Release, H91/342, London: Department of Health.
- Department of Health (1993a), The Named Nurse, Midwife and Health Visitor, London: Department of Health.
- Department of Health (1993b), The Patient's Charter and family doctor services, London: Department of Health.
- Department of Health (1995a), *Record Number of NHS Charter Mark Winners*, Press Release, 95/560, 4 December, London: Department of Health.
- Department of Health (1995b), The Patient's Charter & You, London: Department of Health.
- Department of Health (1995c), *Minister sets out plans for Children's Health Charter Standards*, Press Release, 95/406, Department of Health.
- Department of Health (1996a), The Patient's Charter: Services for Children & Young People, London: Department of Health.
- Department of Health (1996b), The Patient's Charter: Maternity Services, London: Department of Health.
- Department of Health (1997), *The Mental Health Services Patient's Charter Booklet Launched*, at <http://www.disabilitynet.co.uk/info/impairment/mhcharter.html>

Department of Health (1998), A First Class Service: Quality in the New NHS, London: HMSO.

Department of Health (1999), Better Care, Higher Standards: A Charter for long term care, London: Department of Health.

Department of Health (2000), The NHS Plan: A plan for investment, a plan for reform: A Summary, London: Department of Health.

Department of Health (2001a), Your Guide to the NHS, London: Department of Health.

Department of Health (2001b), Your Guide to the NHS Launched, Press Release 2001/0055, Department of Health.

Department of Health (2001c), NHS Celebrates Charter Mark 2001 Award Winners, Press Release, Reference 2001/0082, Department of Health.

Department of Health (2001d), Reforming the NHS Complaints Procedure: a listening document, Department of Health

Denzin N.K. (1970), The Research Act in Sociology: A Theoretical Introduction to Sociological Methods, London: Butterworths.

DHSS (1979), Patients First: consultative paper on the structure and management of the National Health Service in England and Wales, London: HMSO.

DHSS (1983), NHS Management Inquiry Report (the Griffiths Report), London: Department of Health and Social Security.

DHSS (1986), Primary Health Care: an agenda for discussion, Cmnd 9771, London: HMSO.

DHSS (1987), Promoting Better Health: the Government's programme for improving primary care, Cm 248, London: HMSO.

Dixon J. (2001), *Health Care: Modernising the Leviathan*, The Political Quarterly, Vol. 72, No. 1, Jan-Mar., pp. 30-38.

Doern G.B. (1993), *The UK Citizen's Charter: Origins and Implementation in three agencies*, Policy and Politics, Vol. 21, No. 1, pp. 17-29.

DoH (2000), *Patients' rights and responsibilities*, at [http://www.info.gov.hk/dh/do\\_you\\_k/patient.htm](http://www.info.gov.hk/dh/do_you_k/patient.htm)

DoH (2001), Leaflet on 24-hour Health Education Hotline of the Department of Health, Hong Kong: Department of Health.

Dooley F. (1999), *The named nurse in practice*, Nursing Standard, Vol. 13, No. 34, May 12, pp. 33-38.

- Downs A. (1957), An Economic Theory of Democracy, New York: Harper and Row.
- Dowrick C. (1997), *Rethinking the doctor-patient relationship in general practice*, Health and Social Care in the Community, Vol. 5, No. 1, pp. 11-14.
- Drewry G. (1993), *Mr. Major's Charter: empowering the consumer*, Public Law, Summer, pp. 248-256.
- Driver S. and Martell L. (2000), *Left, Right and the Third Way*, Policy & Politics, Vol. 28, No. 2, pp. 147-161.
- Dror Y. (1964), *Muddling Through – 'Science' or 'Inertia'?*, Public Administration Review, Vol. 24, pp. 153-157.
- Dryzek J.S. (1992) *How far is it from Virginia and Rochester to Frankfurt? Public Choice as critical theory*, British Journal of Political Science, Vol. 22, No. 4, Oct, pp. 397-321.
- Dunleavy P. (1991), Democracy, Bureaucracy and Public Choice: economic explanation in political science, New York: Harvester Wheatsheaf.
- Dunleavy P. and Hood C. (1994), *From Old Public Administration to New Public Management*, Public Money & Management, July-September, pp. 9-16.
- Dye T.R. (1972), Understanding Public Policy, Englewood Cliffs, NJ: Prentice-Hall.
- Dyke G. (1998), The NHS Charter: A Different Approach, Wetherby: Department of Health.
- Dyke G. (1999), *Speech at the New NHS Charter Debate*, 3 March, Royal College of Physicians, London, Harrogate Public Sector Management Centre Limited.
- Easton S. (1996), *The Meaning of Citizenship*, in Willett C. (ed.), Public Sector Reform & The Citizen's Charter, London: Blackstone Press Limited.
- Edwards B. (1992), *The Increasing Power of the Consumer*, in Owen A.V. (ed.), The Health Debate Line: 45 interviews for "Leading for Health", London: British Medical Journal.
- Edwards B. (1995), *The Patient and the NHS*, in Ham C. (ed.), The 1994/95 NHS Handbook, (9<sup>th</sup> edn), Tunbridge Wells: JMT Publishing.
- Elster J. (1985), Making Sense of Marx, Cambridge: Cambridge University Press.
- Enthoven A. (1985), Reflections on the Management of the NHS, London: Nuffield Provincial Hospitals Trusts.
- Enthoven A. (2001), *The NHS Plan from an American perspective*, British Journal of Health Care Management, Vol. 7, No. 2, pp. 73-74.

Etzioni A. (1967), *Mixed-scanning: a third approach to decision making*, Public Administration Review, Vol. 27, pp. 385-392.

Falconer P. (1996), *Charterism and Consumerism*, in Pyrer R. (ed.), Aspects of Accountability in the British System of Government, Wirral: Tudor Business Publishing Ltd.

Falconer P., Ross K. and Conner M. (1997), *Empowering the Citizen: Consumerism and Charterism in the UK*, Conference: Public and Private Sector Partnerships, Sheffield: Sheffield Shu Press, pp. 67-80.

Farnham D. (1991), *The Citizen's Charter: Improving the quality of the public services or furthering Market Values?* Talking Politics, Vol. 4, No. 2, Winter, pp. 75-80.

Farnham D. and Horton S. (1993), *The New Public Service Managerialism: An Assessment*, in Farnham D. and Horton S. (eds), Managing the New Public Services, London: Macmillan Press Ltd.

Farnham D. and Horton S. (1996), *Public Service Managerialism: A Review and Evaluation*, in Farnham D. and Horton S. (eds), Managing the New Public Services, (2<sup>nd</sup> edn), London: Macmillan Press Ltd.

Farrell C., Levenson R. and Snape D. (1998), The Patient's Charter: Past and future, London: King's Fund Publishing.

Farrell C. (1999), *The Patient's Charter: a tool for quality improvement?*, International Journal of Health Care Quality Assurance, Vol. 12, No. 4, pp. 129-134.

Farrell C.M. (2000), *Citizen Participation in Governance*, Public Money & Management, Jan-March, pp. 31-37.

Fatchett A. (1998), Nursing in the new Modern, Dependable?, London: Bailliere Tindall.

Felkins L. (1998), *Introduction to Public Choice Theory*, at <http://magnolia.net/~leonf/sd/pub-choice.html>

Ferguson M. and Raine J. (1999), Developments in electronic governance, Birmingham: British Council.

Ferlie E., Ashburner L., Fitzgerald L. and Pettigrew A. (1996), The New Public Management in Action, Oxford: Oxford University Press.

Flood C. and Epps T. (2001), *Can a Patients' Bill of Rights Address Concerns About Waiting Lists?*, The Second Annual Health Law Day, 12 October, Solarium-Falconer Hall, Toronto, pp. 1-24.

Freud S. (1955), Two Case Histories (Little Hans and Rat Man), London: Hogarth Press and the Institute of Psycho-Analysis.

Fung H., Tse N. and Yeoh E.K. (1999), *Health Care Reform and Societal Values*, Journal of Medicine and Philosophy, Vol. 24, No. 6, pp. 638-652.

Giddens A. (1998), *After the Left's Paralysis: the third way can provide a framework for political and economic thought that cuts across the old divides of social democracy and neoliberalism*, New Statesman, Vol. 127, Issue 4383, pp. 18-21.

Gillham G. (2000), Case Study Research Method, London: Continuum.

Gilliatt S., Fenwick J. and Alford D. (2000), *Public Services and the Consumer: Empowerment or Control?*, Social Policy & Administration, Vol. 34, No. 3, September, pp. 333-349.

Goldsworthy D. (1994), *The Citizen's Charter*, Public Policy and Administration, Vol. 9, No. 1, Spring, pp. 59-67.

Goodwin L.D. and Goodwin W.L. (1984), *Qualitative vs. Quantitative Research or Qualitative and Quantitative Research?* in Downs F. (1999) (ed.), Readings in Research Methodology, (2<sup>nd</sup> edn), Philadelphia: Lippincott.

Grant C. and Yuen P. (1998), The Hong Kong Health Care System, Sydney: University of New South Wales.

Griffiths R. (1988), *Does the Public Service Serve? The consumer dimension*, Public Administration, Vol. 66, pp. 195-204.

Guardian (1996), *PM's 'big ideas' turn five*, Guardian, 20 September, United Kingdom.

Guardian (2001), *Labour's NHS power shift*, Guardian, 25 April, United Kingdom.

Haines A. and Iliffe S. (1992), *Primary Health Care*, in Beck E., Lonsdale S., Newman S. and Patterson D. (eds), In the Best of Health?, London: Chapman & Hall.

Ham C. (1999), Health Policy in Britain, (4<sup>th</sup> edn.), Hampshire: Palgrave.

Hammersley M. and Gomm. R. (2000), Case Study Method: key issues, key texts, London: Sage.

Hancock C. (1992), *The named nurse in perspective*, Nursing Standard, Vol. 7, No. 1, pp. 39-42.

Hansard (1991), *Citizen's Charter*, House of Commons Hansard Debates, 22 Jul, Column 763.

Harrison S., Hunter D.J. and Pollitt C. (1990), The Dynamics of British Health Policy, London: Unwin Hyman.

Harrison S. and Pollitt C. (1994), Controlling Health Professionals: the future of work and organization in the NHS, Buckingham: Open University Press.

Harvard Business School (2001), *The Learning Model*, at <http://www.hbs.harvard.edu/mba/experience/learn/thelearningmodel/index.html>

Harvard Team (1999), *Improving Hong Kong's Health Care System: Why and For Whom?*, Hong Kong: Printing Department of the HKSAR.

HAS of NSW (1994), *Public Patients Hospital Charter*, *Newsletter of the Health Services Association of New South Wales*, Vol. 3, Issue 1, March, p. 10.

Hay J.W. (1992), *Health Care in Hong Kong: An economic policy assessment*, Hong Kong: The Chinese University Press.

Haywood S. and Alaszewski A. (1980), *Crisis in the Health Service: The politics of management*, London: Croom Helm.

*Health and Social Service Journal* (1985), *Consumerism in the NHS*, 30 May, Special Issue, Centre Eight, pp. 1-8.

Health and Welfare Bureau (2000), *Lifelong Investment in Health: Consultation Document on Health Care Reform*, Hong Kong: Printing Department of the HKSAR.

Heidenheimer A.J. (1985), *Comparative Public Policy at the Crossroads*, *Journal of Public Policy*, Vol. 5, No. 4, pp. 441-465.

Heidenheimer A.J., Heclo H. and Adams C.T. (1990), *Comparative Public Policy: The politics of social choice in America, Europe, and Japan*, New York: St. Martin's Press.

Hek G., Judd M. and Moule P. (1996), *Making Sense of Research: an introduction to nurses*, London: Cassell.

Hewison A. (1999), *The New Public Management and the New Nursing: related by rhetoric? Some reflections on the policy process and nursing*, *Journal of Advanced Nursing*, Vol. 29, No. 6, pp. 1377-1384.

Hill M. (1997), *The Policy Process in the Modern State*, (3<sup>rd</sup> edn), London: Prentice Hall Harvester Wheatsheaf.

Hjern B. (1982), *Implementation Research – The Link Gone Missing*, *Journal of Public Policy*, Vol. 2, No. 3, pp. 301-308.

Holton R. J. (1998), *Globalization and the Nation-State*, Basingstoke: Macmillan.

HKMA (1992), *Joint Press Conference of the Hong Kong Medical Association and the Consumer Council on the Proclamation of Patients' Rights and Obligations*, Hong Kong Medical Association.

HKMA (1993), *Patients' Rights & Responsibilities*, Hong Kong Medical Association and Consumer Council.



HKMA (2001), *Patients' Rights and Responsibilities Hotline Script*, at <http://www.hkma.org/english/pubmededu/right.htm>

Hong Kong Government (1964), *Development of Medical Services in Hong Kong*, Hong Kong: Government Printer.

Hong Kong Government (1974), *The Further Development of Medical and Health Services in Hong Kong*, Hong Kong: Government Printer.

Hogg C. (1994), *Beyond the Patient's Charter: working with users*, London: Health Rights.

Hogg C. (1999), *Patients, Power & Politics: from Patients to Citizens*, London: Sage.

Hogg C. and Williamson C. (2001), *Whose interests do lay people represent? Towards an understanding of the role of lay people as members of committees*, *Health Expectations*, Vol. 4, Issue 1, pp. 2-9.

Hogwood B.W. and Gunn L. (1984), *Policy Analysis for the Real World*, London: Oxford University Press.

Hong Kong Government (1989), *Hong Kong*, Hong Kong: Government Printer.

Hood C. (1991), *A Public Management for All Seasons?*, *Public Administration*, Vol. 69, Spring, pp. 3-19.

Hood C. (1995), *The 'New Public Management' in the 1980s: Variations on a theme*, *Accounting, Organization and Society*, Vol. 20, No: 2/3, pp. 93-109.

Hospital Authority (1992a), *Employees Handbook*, Hong Kong: Hospital Authority.

Hospital Authority (1992b), *Hong Kong Hospital Authority Business Plan 1992/93*, Hong Kong Hospital Authority Printer.

Hospital Authority (1993), *Your Introduction to Patients' Charter: putting patients first*, Hospital Authority.

Hospital Authority (1994a), *Patients' Charter*, Hong Kong: Hospital Authority Printer.

Hospital Authority (1994b), *Hospital Authority Newsletter*, Issue 13, July, pp.1 –12.

Hospital Authority (1994c), *Hong Kong Hospital Authority Business Plan 1994-1995*, Hong Kong: Hospital Authority Printer.

Hospital Authority (1995a), *Patients' Charter Promotion Activities*, Hospital Authority. (In Chinese)

Hospital Authority (1995b), *Hong Kong Hospital Authority Annual Plan 1995-1996*, Hong Kong: Hospital Authority Printer.

Hospital Authority (1996), Hospital Authority Newsletter, Issue 18, February, Hospital Authority, pp. 1 – 12.

Hospital Authority (1997), Annual Plan 1997/98, Hong Kong: Hospital Authority Printer.

Hospital Authority (1998), *Safety Charter Signed for 50,000 Health Care Workers*, at [http://www.ha.org.hk/hesd/nsapi/driven.sol?Mival=ha\\_view\\_contentdc\\_id=10051](http://www.ha.org.hk/hesd/nsapi/driven.sol?Mival=ha_view_contentdc_id=10051)

Hospital Authority (2001a), *Overview of Health Care Services in Hong Kong*, at [http://www.ha.org.hk/hesd/nsapi/?Mival=ha\\_visitor\\_index&intro=ha%5fview%5ftemplate%26group%3dHCI%26Area%3rdHKO](http://www.ha.org.hk/hesd/nsapi/?Mival=ha_visitor_index&intro=ha%5fview%5ftemplate%26group%3dHCI%26Area%3rdHKO)

Hospital Authority (2001b), An Introduction to Hospital Authority (Booklet), Hong Kong: Hospital Authority.

Hospital Authority (2001c), *about Hospital Authority*, at [http://www.ha.org.hk/hesd/nsapi/drivernsapi20.so/?Mival=ha\\_view\\_template&group=AHA](http://www.ha.org.hk/hesd/nsapi/drivernsapi20.so/?Mival=ha_view_template&group=AHA)

Hospital Authority (2001d), Hospital Authority Complaints System, Hong Kong: Hospital Authority.

Hospital Authority (2002), *Queen Elizabeth Hospital*, at [http://www.ha.org.hk/hesd/nsapi/?Mival=ha\\_view\\_content&c\\_id=100149](http://www.ha.org.hk/hesd/nsapi/?Mival=ha_view_content&c_id=100149)

Howlett M. and Ramesh M. (1995), Studying Public Policy: Policy cycles and policy subsystems, Ontario: Oxford University Press.

Health Service Journal (2001a), *CHC axe to fall early in Labour second term*, Health Service Journal, 24 May, p. 5.

Health Service Journal (2001b), *Delayed Charter leaves NHS staff guessing on standards*, Health Service Journal, 11 January, p. 9.

Health Service Journal (2001c), *Worries over patients' rights overshadow Milburn pledges*, Health Service Journal, 1 February, p. 5.

HK iMail (2001), *Medical Council called bankrupt in mobiles row*, Hong Kong iMail, 24 April, Hong Kong.

Hutcheon R. (1999), Bedside Manner: Hospital & Health Care in Hong Kong, Hong Kong: The Chinese University Press.

Hyder M. (1984), *Implementation: The evolutionary model*, in Lewis D. and Wallace H. (eds), Policies Into Practice: national and international case studies in implementation, London: Heinemann Educational Books.

IHSM (1996), The IHSM Health and Social Services Year Book 96/97, London: The Institute of Health Services Management.

Independent (2000), *Is there something rotten at the heart of the medical profession*, Independentdigital, 18 June, at <http://www.independent.co.uk/story.jsp?story=5877>

IRD (2000a), *The Tax Payer's Charter*, Inland Revenue Department, Hong Kong at <http://www.info.gov.hk/ird/charter/charter.htm>

IRD (2000b), *Performance Pledge*, Inland Revenue Department, Hong Kong at <http://www.info.gov.hk/ird/charter/pp.htm>

IRD (2000c), *Annual Report on Performance Pledge*, Inland Revenue Department, Hong Kong SAR, Government Printer.

ISD (2000), Hong Kong: The Facts – District Administration, Hong Kong: Printing Department of the HKSAR.

Jack B. (1995), *Using the named nurse system to improve patient care*, Nursing Times, 1 November, Volume 91, No. 44, p. 34-35.

Jenkins-Smith H.C. and Sabatier P.A. (1994), *Evaluating the Advocacy Coalition Framework*, Journal of Public Policy, Vol. 14, No. 2, pp. 175-203.

Jones J.S. (1999), *Patients to get Rights Charter*, South African Medical Journal, Vol. 89, No. 10, p. 1049.

Jones R. (1995), *Why do qualitative research?*, British Medical Journal, Vol. 311, 1 July, p. 2.

Joss R. and Kogan M. (1995), Advancing Quality: Total Quality Management in the National Health Service, Buckingham: Open University Press.

Kavanagh K. (1998), The Reordering of British Politics: Politics After Thatcher, Oxford: Oxford University Press.

Keeble P. (1996), *The Concept and Operation of the Citizen's Charter*, Management Services, May, pp. 10-14.

Keen J. and Packwood T. (1996), *Case Study Evaluation*, in May N. and Pope C. (eds), Qualitative Research in Health Care, London: BMJ Publishing Group.

Kimchi J., Polivka B. and Stevenson J.S. (1991), *Triangulation: Operational Definitions*, in Downs F. (1999) (ed.), Readings in Research Methodology, (2<sup>nd</sup> edn), Philadelphia: Lippincott.

Kinnock N. (1986), The Best of Health: Charter for the Family Health Service, London: The Labour Party.

Kitzinger J. (1999), *Researching risk and the media*, Health, Risk & Society, Vol. 1, No. 1, pp. 55-59

Klein R. (2001), The New Politics of the NHS, (4<sup>th</sup> edn), Harlow: Pearson education.

KMB (2000), *KMB Service Charter*, Kowloon Motor Bus Company Ltd. at <http://www.kmb.com.hk/english.php?page=about&file=charter/index.html>

Kumar R. (1999), Research Methodology: A Step-By-Step Guide for Beginners, London: Sage.

Labour Department (1998), Occupational Safety Charter, Hong Kong: Government Printer.

Labour Party (1921), The Citizen's Charter, London: Labour Party.

Labour Party (1937a), Children's Charter, Herts: Watford Printers Limited.

Labour Party (1937b), The Blind Person's Charter, , London: Labour Publications Department.

Labour Party (1986), Labour's Charter for Consumers, London: Labour Party.

Labour Party (1991), Citizen's Charter: Labour's better deal for consumers and citizens, London: Labour Party.

Labour Party (1997), New Labour because Britain deserves better: Labour's General Election Manifesto, London: Labour Party.

Labour Party (2001), *Ambitions for Britain – Labour's General Election manifesto*, at [http://www.labour.org.hk/lp/new/labour/labour.www\\_main.main?p\\_full=1&p\\_language=us&p\\_cornerid=364783](http://www.labour.org.hk/lp/new/labour/labour.www_main.main?p_full=1&p_language=us&p_cornerid=364783)

Lane J. (1994), *Will Public Management Drive out Public Administration?*, Asian Journal of Public Administration, Vol. 16, No. 2, Dec., pp. 139-151.

Lane J. (1995), The Public Sector: concepts, models and approaches, (2<sup>nd</sup> edn), London: Sage.

Le Grand, J. (1998), *The Third Way Begins with CORA*, New Statesman, 6, March, pp. 26-27.

Lee J.C.Y. (2001), *The Changing Context of Public Sector Reform and its implications in Hong Kong*, in Cheung A.B.L. and Lee J.C.Y. (eds), Public Sector Reform in Hong Kong, (2<sup>nd</sup> edn), Hong Kong: The Chinese University Press.

Lee K.H. (1999), Patient's Rights & Professional Code of Doctors, Public talk on 11 September, Hong Kong Museum of Medicine.

Lee K.H. (2000), *Medical Complaints Resolution mechanism*, Conference on Consumer Redress Mechanism, 26 April, at <http://www.consumer.org.hk/redress/20000426/keekh/speeche.htm>

Lewis N. (1993), *The Citizen's Charter and Next Steps: A New Way of Governing?*, *Political Quarterly*, Vol. 64, No. 3, pp. 316-326.

Lewis N. (1994), *Reviewing Change in Government: new public management and next steps*, *Public Law*, Spring, pp. 105-113.

Lewis N. (1995), *Public Sector Reform in the United Kingdom and Hong Kong: The Ethical Connection*, *Hong Kong Public Administration*, Vol. 14, No. 1, pp. 37-53.

Liberal Party (1968), *The Consumer's Charter*, London: Liberal Publications Department.

Lindblom C.E. (1959), *The Science of Muddling Through*, *Public Administration Review*, Vol. 19, pp. 79-88.

Lindblom C.E. (1979), *Still Muddling, Not Yet Through*, *Public Administration Review*, Vol. 39, pp. 517-526.

Lo M.K. (1993), *Reflections on Responsive Public Administration in Hong Kong: The Citizen's Charter, Performance Pledges and Beyond*, *Asian Journal of Public Administration*, Vol. 15, No. 2, pp. 201-224.

Lincoln Y.S. and Guba E.G. (1979), *The Only Generalization is: There is No Generalization*, in Gomm R., Hammersley M. and Foster P. (2000) (eds), *Case Study Method: Key Issues, Key Texts*, London: Sage.

Lister R. (1999), *Work for those who can, security for those who cannot: a Third Way in Social Security Reform?* Paper presented at Social Policy Association in Annual Conference, Roehampton, 20-22 July quoted in Powell M. (2000), *New Labour and the Third Way in the British Welfare State: a new and distinctive approach?*, *Critical Social Policy*, Vol. 20, No. 1., pp. 39-60.

Lowi T.J. (1972), *Four systems of Policy, Politics, and Choice*, *Public Administration Review*, Vol. 32, July/August, pp. 298-310.

Lynd R.S. and Merrell-Lynd H. (1929), *Middletown: a Study in Modern American Culture*, New York: Harcourt, Brace and World.

Ma H.C. and Koch H. (1994), *Establishing Continuous Quality Improvement in a Hong Kong Hospital*, *International Journal of Health Care Quality Assurance*, Vol. 7, No. 2, pp. 19-25.

Major J. (1992), *Foreword by the Prime Minister*, in Citizen's Charter (1992d), *The Citizen's Charter First Report: 1992*, Cm 2101, London: HMSO.

- Major J. (1996), *Foreword by the Prime Minister*, in Citizen's Charter (1996a), The Citizen's Charter – Five Years On, London: HMSO.
- Mark A. and Scott H. (1992), *Management in the National Health Service*, in Willcocks L. and Harrow J. (eds), Rediscovering Public Services Management, London: McGraw-Hill.
- Markus M.L. (1983), *Power, politics and MIS implementation*, Communications of ACM, Vol. 26, pp.430-444.
- Marsh D. (1991), *Privatization under Mrs. Thatcher: A review of the literature*, Public Administration, Vol. 69, Winter, pp. 459-480.
- Marshall T.H. (1950), Citizenship and Social Class, Cambridge: Cambridge University Press.
- Martin M. and Spiegel N. (1995), *A Charter by other name*, Health Service Journal, 9 Nov., pp. 30-31.
- Maxwell R.J. (1984), *Quality Assessment in Health*, British Medical Journal, Vol. 288, 12 May, pp. 1470-1472.
- Mays N. and Pope C. (1995), *Rigour and qualitative research*, British Medical Journal, Vol. 311, pp. 109-112.
- McLean I. (1987), Public Choice: an introduction, Oxford: Basil Blackwell.
- McIver S. (2000), *Goodbye CHCs: welcome PALS and forums*, Newsletter of the Health Services Management Centre, University of Birmingham, Vol. 6, Issue 3, p. 3.
- Medical Council (2000), How the Medical Council deals with Complaints, The Medical Council of Hong Kong.
- Merriam-Webster (2001), *Merriam-Webster Collegiate Dictionary Online*, at <http://www.m-w.com/dictionary.htm>
- Migue J. and Belanger G. (1974), *Towards a general theory of managerial discretion*, Public Choice, Vol. 17, p. 27-43.
- Miles M.B. and Huberman A.M. (1994) Qualitative Data Analysis: a source of new methods, London: Sage
- Minogue M. (2000), Should Flawed Models of Public Management be Exported? Issues and Practices, Public Policy and Management Working Paper Series No. 15, Manchester: Institute for Development Policy and Management, University of Manchester.
- MMA (1997), *HIV/AIDS Charter for Doctor*, at <http://www.mma.org.my/charters/hiv.htm>

- MMA (1998), *The Patient's Charter*, at <http://www.mma.org.my/charters/Patient's.htm>
- Morris D.S. and Haigh R.H. (1996), *The Citizen's Charter and Quality Management*, in Chandler J.A. (ed.), *The Citizen's Charter*, Aldershot: Dartmouth Publishing Company Limited.
- Mueller D.C. (1979), *Public Choice*, Cambridge: Cambridge University Press.
- Mueller D.C. (1989), *Public Choice II*, Cambridge: Cambridge University Press.
- National Consumer Council (1991), *National Consumer Council Annual Report 1991*, London: National Consumer Council Publication.
- National Consumer Council (1993), *Consumer Concerns 1993: A consumer view of health services: the report of a MORI survey*, London: National Consumer Council Publication.
- National Consumer Council (1998), *Local Charters: A survey of public services*, London: National Consumer Council Publication.
- National Consumer Council (2001), *National Consumer Council: about NCC*, at <http://www.ncc.org.uk/about.htm>
- News (2001), *NHS guide replaces Patient's Charter*, *The Pharmaceutical Journal*, Vol. 266, p. 239.
- Ng A. (1989), *Medical and Health*, in Tsim T.L. and Luk H. L.K. (eds), *The Other Hong Kong Report*, Hong Kong: The Chinese University Press.
- Ng F. (1996), *Demarketing in Health Services: The collaboration between public and private hospitals in Hong Kong*, *Abstracts of Papers: International Hospital Federation Pan Regional Conference 1996/Hong Kong Hospital Authority Convention 1996*, 31 March – 3 April, Hong Kong Convention and Exhibition Centre, p. 70.
- Ng F. (1997a), *Patient's Charter and Total Quality Management in Health Services*, '97 *Hong Kong-Shanghai Conference on Hospital Management*, 20-21 March, Holiday Inn Golden Mile Hotel, Hong Kong (In Chinese)
- Ng F. (1997b), *Towards Quality Health Services: the challenges of Patient's Charter in Hong Kong*, *Proceedings of the 2<sup>nd</sup> International Conference on Quality and Reliability*, 1-3, September, Hong Kong Polytechnic University, Hong Kong, pp. 439-443.
- Ng F. and Leung J. (1999), *Charterism in the Health Services: The Implementation of Patient's Charter in Hong Kong*, *Proceedings of the 16<sup>th</sup> International Conference of the Internal Society for Quality in Health Care*, 13-15 October, Melbourne, Australia, session 30 Ref: 99-181.

Ng S.S.F. (1992), From Patient's Charter to Local Charter Standards: A national study of local Patient's Charter in England, MSc dissertation, University of Hull, Unpublished.

NHS (1992a), The Named Nurse: Your questions answered, Leeds: The Patient's Charter Group.

NHS (1992b), The Named Midwife: Your questions answered, Leeds: The Patient's Charter Group.

NHS (1993a), Monitoring the Patient's Charter: Good Practice Guide, Leeds: The Patient's Charter Group.

NHS (1993b), The Named Nurse, Midwife and Health Visitor, Leeds: The Patient's Charter Unit.

NHS (2001), *Putting patients first*, Information sheet, at <http://www.nhs.uk/representation/index.html>

NHSE (1994), The Named Nurse, Midwife and Health Visitor – Checking that it happens, Leeds: Patient's Charter Unit.

NHSE (1995a), Guidelines on Involving Users in Developing Local Patient's Charters, Leeds: NHS Executive.

NHSE (1995b), *New Patient's Charter Launched*, Patient's Charter News, Leeds: Issue 19, March, p. 1

NHSE (1995c), *Revised and expanded Patient's Charter: implementation*, HSG(95)13, 3 March, NHS Executive.

NHSE (1996a), *NHS Quarterly Review: January - March 1996*, at <http://www.open.gov.uk/doh/review.html>

NHSE (1996b), A guide to the National Health Service, Leeds: NHS Executive.

NHSE (1997a), Patient's Charter News, Leeds: Issue 27, Winter, p. 1, 6-7.

NHSE (1997b), *The Patient's Charter: Privacy and Dignity and the Provision of Single Sex Hospital Accommodation*, EL(97)3, 24 January, NHS Executive.

NHSE (1997c), *Patient's Charter and Health Authority Annual Reports*, MISC(97)15, 2 April, NHS Executive.

NHSE (1997d), *Patient's Charter: Changes to Monitoring Arrangements for 1997/98*, EL(97)40, 19 September, NHS Executive.

NHSE (1997e), *Patient's Charter: Developing a New Charter and Changes to the Immediate Assessment in A&E Standard*, EL(97)60, NHS Executive.



- NHSE (1997f), *The Patient's Charter and mental health services: implementation guidance*, EL(97)1, 16 January, NHS Executive.
- NHSE (1997g), *The Patient's Charter: Privacy and Dignity and the Provision of Single Sex Hospital Accommodation*, EL(97)43, 7 August, NHS Executive
- NHSE (1998a), *Our Healthier Nation: A Contract for Health*, Cm 3852, London: HMSO.
- NHSE (1998b), *A National Framework for Assessing Performance*, London: HMSO.
- NHSE (1998c), *Changes to Central Collection of Patient's Charter key standards data in 1998/99*, HSC 1998/138, NHS Executive.
- NHSE (1998d), *Mixed Sex Hospital Accommodation: monitoring tool*, HSC 1998/143, NHS Executive.
- NHSE (2000), *Tackling Violence towards GPs and their staff*, HSC 2000/001, NHS Executive.
- North N. (1997), *Consumers, Service Users or Citizens?* In North N. and Bradshaw Y (eds), *Perspectives in Health Care*, London: Macmillan.
- Oakland J. (1993), *Total Quality Management*, (2<sup>nd</sup> edn), Oxford: Butterworth/Heinemann.
- Orr J.R. (1946), *A Charter for Health*, London: George Allen & Unwin Ltd.
- Osborne D. and Gaebler T. (1992), *Reinventing Government: How the entrepreneurial spirit is transforming the public sector*, New York: Addison-Wesley.
- Øvretveit J. (1998), *Comparative and Cross-cultural health research*, Oxford: Radcliffe Medical Press.
- Øyen E. (1990), *The Imperfection of Comparisons*, in Øyen E. (ed.), *Comparative Methodology: Theory and Practice in International Social Research*, London: Sage.
- Palfrey C. (2000), *Key Concepts in Health Care Policy & Planning*, London: Macmillan Press Ltd.
- Palmer G. and Short S. (1994), *Health Care and Public Policy: An Australian Analysis*, (2<sup>nd</sup> edn), Melbourne: Macmillan Education.
- Passman D. (1997), *A New Lease of Life for the Private Finance Initiative*, *British Journal of Health Care Management*, Vol. 3, No. 6, pp. 294-296.

- Patients Forum (2001), The Patients Forum: Report of the Patients Forum 2001 Conference: Shaping the Agenda – the UK Patients' Movement, 15 February, Conway Hall, London: The Patients Forum.
- Patten C. (1992), Our Next Five Years: The Agenda for Hong Kong, Address by the Governor at the opening of the 1992/93 Session of the Legislative Council, Hong Kong Government Printer.
- Peters T.J. and Austin N. (1985), A Passion for Excellence: the leadership difference, Glasgow: Collins.
- Peters T.J. and Waterman R.H. (1982), In Search of Excellence: lessons from America's best run companies, London: Harper & Row.
- Pettigrew A., McKee L. and Ferlie E. (1988), *Understanding Change in the NHS*, Public Administration, Vol. 66, Autumn, pp. 297-317.
- Philips E.M. and Pugh D.S. (2000), How to get a PhD: a handbook for students and their supervisors, (3<sup>rd</sup> edn), Buckingham: Open University Press.
- Pollitt C. (1994), *The Citizen's Charter: A Preliminary Analysis*, Public Money & Management, April - June, pp. 9-14.
- Pollitt C. and Summa H. (1997), *Trajectories of Reform: Public Management Change in Four Countries*, Public Money & Management, Jan - Mar., pp. 7-18.
- Pollitt C. (1990), Managerialism and the Public Services, Oxford: Blackwell.
- Pope C. and Mays N. (1993), *Opening the Black Box: an encounter in the corridors of health services research*, British Medical Journal, Vol. 306, 30 Jan., pp.315-318.
- Pope C. and Mays N. (1995), *Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research*, British Medical Journal, Vol. 311, pp. 42-45.
- Pope C. and Mays N. (1996), Qualitative Research in Health Care, London: BMJ Publishing Group.
- Potter J. (1988), *Consumerism and the Public Sector: How well does the coat fit?*, Public Administration, Vol. 66, Summer, pp. 149-164.
- Powell M. (1999), *New Labour and the Third Way in the British National Health Service*, International Journal of Health Services, Vol. 29, No. 2, pp. 353-370.
- Powell M. (2000), *New Labour and the Third Way in the British Welfare State: a new and distinctive approach?*, Critical Social Policy, Vol. 20, No. 1., pp. 39-60.
- Pressman J.L. and Wildavsky A. (1973), Implementation, Berkeley: University of California Press.

Prior D. (1995), *Citizen's Charters*, in Stewart J. and Stoker G. (eds), Local Government in the 1990s, London: Macmillan.

Prior D., Stewart J. and Walsh K. (1995), Citizenship: Rights, Community & Participation, London: Pitman Publishing.

Punch K.P. (1998), Introduction to Social Research: quantitative & qualitative approaches, London: SAGE.

Ranade W. (1997), A future for the NHS? Health care for the Millennium, (2<sup>nd</sup> edn), London: Longman.

Rawlings P. and Willett C. (1996), Consumer Empowerment and the Citizen's Charter, in Willett C. (ed.), Public Sector Reform & The Citizen's Charter, London: Blackstone Press Limited.

Reeder L.G. (1972), *The Patient-Client as a Consumer: some observations on the changing professional-client relationship*, Journal of Health and Social Behavior, Vol. 13, pp. 406-412.

Ridley F.F. (1996), *The New Public Management in Europe: comparative perspectives*, Public Policy and Administration, Vol. 11, No. 1, Spring, pp. 16-29.

Sabatier P.A. (1986), *Top-Down and Bottom-Up Approaches to Implementation Research: a critical analysis and suggested synthesis*, Journal of Public Policy, Vol. 6, No. 1, pp. 21-48.

Sabatier P.A. (1991), *Two decades of implementation research: from control to guidance and learning*, in Kaufmann F.X. (ed.), The Public Sector: Challenge for coordination and learning, Berlin: de Gruyter.

Sabatier P.A. and Jenkins-Smith H.C. (1993), *The Study of Public Policy Processes*, in Sabatier P.A. and Jenkins-Smith H.C. (eds), Policy Change and Learning: An Advocacy Coalition Approach, Boulder: Westview Press.

Savage F (1995) *Political implications of the named-nurse concept*, Nursing Times, 11 October, Volume 91, No: 41, pp. 36-37.

Schiavo L.L. (2000), *Quality Standards in the Public Sector: Differences between Italy and the UK in the Citizen's Charter Initiative*, Public Administration, Vol. 78, Issue 3, pp. 679-699

SCMP (1992a), *Patients' Charter 'to guarantee right to treatment'*, South China Morning Post, 28 September, Hong Kong.

SCMP (1992b), *Research group calls for patients' rights watchdog*, South China Morning Post, 29 June, Hong Kong.

SCMP (1992c), *Charter concern*, South China Morning Post, 16 September, Hong Kong.

SCMP (1994a), *No title provided*, South China Morning Post, 25 June, Hong Kong.

SCMP (1994b), *Patients' complaints increase by 25 pc*, South China Morning Post, 5 July, Hong Kong.

SCMP (1995), *Demand for cover increases*, South China Morning Post, 22 January, Hong Kong.

SCMP (1996), *Medical grievances rise*, South China Morning Post, 29 March, Hong Kong.

SCMP (1997), *Complaints to hospitals 'get nowhere'*, South China Morning Post, 6 August, Hong Kong.

SCMP (1998), *Nurses fear recruits' pay cut*, South China Morning Post, 7 February, Hong Kong.

SCMP (1999a), *Sack Surplus Bureaucrats*, South China Morning Post, 26 December, Hong Kong.

SCMP (1999b), *Return to bad old days of hospital camp beds feared*, South China Morning Post, 7 May, Hong Kong.

SCMP (2000), *Education 'a life long endeavour'*, South China Morning Post, 20 January, Hong Kong.

SCMP (2001a), *Verdict on doctor who used phone in operation defended*, South China Morning Post, 13 April, Hong Kong.

SCMP (2001b), *Only one doctor struck off for life since 1994, Medical Council attacked for disciplinary record*, South China Morning Post, 26 April, Hong Kong.

SCMP (2001c), *Ruling allowing doctors to use mobiles attacked Medical Council provokes chorus of protest*, South China Morning Post, 19 April, Hong Kong.

SCMP (2001d), *Health chief condemns phone use by surgeons*, South China Morning Post, 20 April, Hong Kong.

SCMP (2001e), *Health chief warned not to meddle with medics' autonomy*, South China Morning Post, 1 May, Hong Kong.

SCMP (2001f), *War of words breaks out over phone-call medic*, South China Morning Post, 18 April, Hong Kong.

SCMP (2001g), *Patients' rights charter a waste of time, say medics*, South China Morning Post, 24 March, Hong Kong.

- Scott W.D. (1985), Report on the Delivery of Medical Services in Hospitals, Hong Kong: Coopers & Lybrand.
- Scottish Office (1991a), The Patient's Charter: a charter for health, Scotland: HMSO.
- Scottish Office (1991b), The Patient's Charter: a charter for health: a guide, Scotland: HMSO.
- Scottish Office (1991c), Framework for Action, Scotland: HMSO.
- Seale C. (1999), The Quality of Qualitative Research, London: Sage.
- Secretary of State for Health (1997), The new NHS: Modern Dependable, Cm 3807, London: The Stationery Office.
- Secretary of State for Health (2000), The NHS Plan: A plan for investment, a plan for reform, Cm 4818-I, London: Department of Health.
- Self P. (1993), Government by the Market? the politics of public choice, London: Macmillan.
- Senge P.M. (1990), The Fifth Discipline: The Art and Practice of Learning Organization, New York: Doubleday.
- Service First (1998), Service First: The New Charter Programme, London: Cabinet Office.
- Service First (1999a), Supplementary Guide for NHS Units, at [http://www.servicefirst.org.uk/1999/mark/nhs\\_units.htm](http://www.servicefirst.org.uk/1999/mark/nhs_units.htm)
- Service First (1999b), How to apply for a Charter Mark 1999: guide for applicants, London: Cabinet Office.
- Sheldon T. (1994), *Fighting Back*, Health Service Journal, 27 Jan, pp. 24-26.
- Shifrin T. (2001), *CHCs' successor bodies 'set to cost five times as much to run'*, Health Service Journal, 25 January, p. 4.
- Silver M.H.W. (1997), *Patient's rights in England and the United States of America: The Patient's Charter and the New Jersey Patient Bill of Rights: a comparison*, Journal of Medical Ethics, Vol. 23, pp.213-220.
- Simon H.A. (1945), Administrative Behaviour, Glencoe Ill: The Free Press.
- Simon H.A. (1957), Administrative Behaviour, (2<sup>nd</sup> edn), New York: Macmillan.
- Smith D.H. (1999), *What Hong Kong Patients Want and Expect from Their Doctors*, Health Communication, Vol. 11, No. 3, pp.299-310.

Smith G. and May D. (1980), *The Artificial Debate between Rationalist and Incrementalist models of decision making*, Policy & Politics, Vol. 8, No. 2, pp. 147-161.

Stake R. E. (1978), *The Case Study Method in Social Inquiry*, in Gomm R., Hammersley M. and Foster P. (2000) (eds), Case Study Method: Key Issues, Key Texts, London: Sage.

Stake R.E. (1995), The Art of Case Study Research, London: SAGE

Steven A. (1999), *Named nurse: in whose best interest?*, Journal of Advanced Nursing, Vol. 29, No. 2, pp. 341-347.

Stewart J. and Ranson S. (1988), *Management in the public domain*, Public Money and Management, Spring, Vol. 8, No. 1, pp. 13-19.

Stocking B. (1990), *Foreword*, in Winn L. (ed.), Power to the People: the key to responsive services in health and social care, London: King's Fund Centre.

Taylor D. (1992), *A Big Idea for the nineties? The rise of citizen's charters*, Critical Social Policy, vol. 11, Winter, pp. 87-94.

The Stationery Office (1999), *Modernising Government*, Cm 4310, at <http://www.official-documents.co.uk/document/cm43/4310/4310.htm>

The Queen's Speech (2001), *Ambitions for Britain – The Queen's Speech*, at [http://www.labour.org.uk/lp/new/labour/URBANITY.PORC\\_NEWS\\_DISPLAY?p\\_row\\_id=AAAHZjAA](http://www.labour.org.uk/lp/new/labour/URBANITY.PORC_NEWS_DISPLAY?p_row_id=AAAHZjAA)

Thomas P.G. (1996), *Beyond the Buzzwords: coping with change in the public sector*, International Review of Administration Sciences, Vol. 62, pp. 5-29.

Thompson D. (1996), *Business planning in Hong Kong hospitals: the emergence of a seamless health care management process*, Health Services Management Research, Vol. 9, pp. 192-207.

Thompson D., Snape E., Redman T. and Stokes C. (1999), *Public Sector Reform: The Case of Management Performance Appraisal in a Hong Kong Public Sector Hospital*, Asian Journal of Public Administration, Vol. 21, No. 1, June, pp. 114 – 144.

Thompson P. (1992), *Public Sector Management in a Period of Radical Change: 1979-1992*, Public Money & Management, July - Sept., pp. 33-41.

Tragakes E. and Polyzos N. (1998), *The Evolution of Health Care Reforms in Greece: Charting a Course*, International Journal of Health Planning and Management, Vol. 13, pp. 107-130.

Udehn L. (1996), The Limits of Public Choice: a sociological critique of the economic theory of politics, London: Routledge.

- Upward J. (1994), *The People's Charter*, Health Services Journal, 13 January, p. 26.
- Vaus D. de (2001), Research Design in Social Research, London: SAGE.
- Virgin Trains (1998), *Passenger's Charter*, at <http://www.virgintrains.co.uk/about/charter.htm>
- Walsh K. (1995), Public Services and Market Mechanism: competition, contracting and the new public management, London: Macmillan.
- Walt G. (1994), Health Policy: An introduction to process and power, Johannesburg: Witwatersrand University Press.
- Webb A. and Wistow G. (1982), Whither State Welfare? Policy and Implementation in the Personal Social Services, 1979-80: London, Royal Institute of Public Administration.
- Webb S. (Mrs.), Webb S. (Mr.), Gorst J.K.C., Shaw G.B., Gooch G.D. and Lansbury G. (1900), Charter of the Poor, (3<sup>rd</sup> edn), London: Christian Commonwealth Co. Ltd.
- Webster (1998), The National Health Service: A Political History, Oxford: Oxford University Press.
- Webster C. (1999), *The National Health Service – Historical Review*, in Merry P. (ed.) NHS Handbook 1999/2000, Tunbridge Wells: JMH Publishing.
- Welsh Office (1991), Health: a charter for patients in Wales, Wales: HMSO.
- WHO (1994), A Declaration on the Promotion of Patients' Rights in Europe, Copenhagen: WHO Regional Office for Europe.
- WHO (1996), The Ljubljana Charter on reforming health care, Geneva: World Health Organization.
- WHO (2000), *43 European countries have yet to enact laws on Patient's Rights*, at <http://www.health.fgov.be/WHI3/kranttekstmay/000525m01who-eyrope.htm>
- Whyte W.F. (1943), Street Corner Society: the Social Structure of an Italian Slum, Chicago: University of Chicago Press.
- Wicksell K. (1967), A new principle of just taxation, in Musgrave R.A. and Peacock A.T. (eds). Classics in theory of Public Finance, New York: St. Martin's Press.
- Williamson C. (1995), *A Manager's Guide to Consumers*, Health Service Journal, 30 November, pp. 28-29.
- Wilson J. (1996), *Citizen Major? The Rationale and Impact of the Citizen's Charter*, Public Policy and Administration, Vol. 11, No. 1, Spring, pp. 45-62.

Window on World Health (1998), *Patients' Rights in the European Union, Editorial, Window on World Health, Vol. 2 Number 1, 1998* at <http://www.health.fgov.be/WHI3/periodical/months/wwwv2n1tekst/WWH19019801.htm>

Wong E. (1993), Towards Better Health: A Consultation Document, Hong Kong: the Government Printer.

Wong V. C.W. (1999), The Political Economy of Health Care Development and Reforms in Hong Kong, Aldershot: Ashgate Publishing Ltd.

Wood B. (2000), Patient Power? The politics of Patients' Associations in Britain and America, Buckingham: Open University Press.

Woods R. (2000), *Social Housing: Managing Multiple Pressures*, in Clarke J., Gewirtz S. and McLaughlin E. (ed.), New Managerialism New Welfare?, London: Sage

Wright S. (1990), My Patient: My Nurse. The Practice of Primary Nursing, London: Scutari.

Wright S. (1992), *A Question of Accountability*, Nursing Times, March 11, Vol. 88, No. 11, pp. 27-29.

Wright S (1995), *The named-nurse initiative: what is the point?* Nursing Times, Volume 91, No. 47, pp. 32 – 33,

Wrinkler F. (1987), *Consumerism in Health Care: beyond the supermarket model*, Policy and Politics, Vol. 15, No. 1, pp. 1-8.

Yeates N. (1999), *Social Politics and Policy in an Era of Globalization: Critical Reflections*, Social Policy & Administration, Vol. 33, No. 4, Dec., pp. 372-393.

Yeoh E.K. (1993), *Introduction*, in Hospital Authority, Your Introduction to Patients' Charter: putting patients first, Hospital Authority.

Yeoh E.K. (1995), *Health Care in Transformation: new horizons*, Hong Kong Medical Journal, Vol. 1, No. 2, June, pp. 167-171.

Yeoh E.K. (2001a), *Public Consensus on need for health care reform*, Press Release 17 July at <http://www.info.gov.hk/hwb/english/PRESS/PRES0717.HTM>

Yeoh E.K. (2001b), *Motion debate on Mechanism for handling complaints concerning medical incidents*, at <http://www.info.gov.hk/gia/general/200105/09/0509324.htm>

Yin R.Y. (1994), Case Study Research: Design and Methods, (2<sup>nd</sup> edn), London: Sage

Young R. (1990), Health For All, The Way Ahead: Report of the Working Party on Primary Health Care, Hong Kong: The Government Printer.



Yuen P.P. (1994), *The Corporatisation of Public Hospital Services in Hong Kong: a possible public choice explanation*, Asian Journal of Public Administration, Vol. 6, No. 2, Dec., pp.165-181.

Appendix One: Sample Letter sent to NHSE

(Name),  
Patient's Charter Unit,  
NHS Executive Headquarters,  
Quarry House,  
Quarry Hill,  
Leeds, LS2 7UE

Mr. Fowie Ng,  
Lecturer (Health Services  
Management),  
c/o Institute of Health Studies,  
University of Hull,  
Hull, HU6 7RX

Your Fax: 01143 546114

Email: s.f.ng@cas.hull.ac.uk

28 January, 2000

Research Project: Implementation of Patient's Charter

Dear (Name),

Thanks for the telephone conversation yesterday. For your further information, the Institute of Health Studies at the University of Hull is currently undertaking a research project of the comparative study of the implementation of Patient's Charter in UK and Hong Kong, supervised by Professor Andy Alaszewski. It is expected that a better understanding of the international trend of adopting charters will be achieved.

Being a former postgraduate student at the Institute of Health Studies, I undertook a research study about Patient's Charter in 1992 with Dr. Roy Carr-Hill and published in the Health Service Journal (copy to be attached). I am now working as a Lecturer at the Open University of Hong Kong as well as the Honorary Secretary of the Hong Kong Society of the Health Service Executives. Since then, I am developing the interest in this area in both UK and Hong Kong and hope to publish in journals as well as to submit for a PhD thesis.

It is hence crucial to have more information from the policy and executive unit about the implementation of the Patient's Charter. I am therefore writing to you to ask for your kindest support for an interview of 15 – 20 minutes at a time suitable for you in your office, say any time next week on 1 or 2 Feb. I also enclose the guiding questions of the interview for your reference. Of course, a confidential feedback report will be available to you when the project is finished in around July this year especially with regard to the development in Hong Kong which might be of interest to you as well.

Look forward to receive your favourable reply.

Thanks a lot.

Yours Sincerely,

Fowie Ng

## Guiding Questions for the Research Interview about the Implementation of Patient's Charter

*Confidentiality will always be assured*

### *Section One: Implementation at the local level*

1. How is the charter implemented at the local level compared to what is required by the NHSE guidelines?
2. How is your Patient's Charter Unit promoting and disseminating the charter to Trusts and Patients at different level?
3. What sort of local important performance indicators are required to be submitted to the NHSE? How are they reviewed at the national level?

### *Section Two: Frontline Staff and Patient*

4. Based on your experience, how is the trusting relationship between patients and staff has changed since the launch of the charter? Does it improve or make the relationship more difficult?
5. Do patients use the charter? How do they refer to it?
6. What would be the major facilitator(s) and obstacle(s) for implementing the charter?

### *Section Three: Management Issues*

7. To what extent do you see the Patient's Charter as a managerial tool? Why?
8. To what extent do you see the Patient's Charter as a political tool? Why?
9. To what extent does the Charter fit in the current government policies such as NICE, NHS Direct, Clinical Governance, etc.?
10. Overall, do you support to continue to have the charter? What would be the major change to the NHS charter after the Dyke's report?
11. Any other comment about any aspects of the charter?

Appendix Two: Second Letter to NHSE

(Name),  
Patient's Charter Unit,  
NHS Executive Headquarters,  
Quarry House,  
Quarry Hill,  
Leeds, LS2 7UE

Mr. Fowie Ng,  
Lecturer (Health Services  
Management),  
c/o Institute of Health Studies,  
University of Hull,  
Hull, HU6 7RX

Your Fax: 01143 546114

Email: [s.f.ng@cas.hull.ac.uk](mailto:s.f.ng@cas.hull.ac.uk)  
Fax: 01482 466402

7 February, 2000

Research Project: Implementation of Patient's Charter

Dear (Name),

I refer to my previous letter dated 28 January 1999 and the subsequent telephone conversation with Professor Andy Alaszewski.

I understand that it is the critical moment for the Patient's Charter Unit to develop the New NHS charter. Although it seems that it is a rather sensitive issue, I am seeking our support in giving your comments of the five enclosed questions after my careful review of the Dyke's report and the King's Fund report. Strict confidentiality will be followed. No names will appear in any publications.

It would be highly appreciated if you can drop a few lines to my email at [s.f.ng@cas.hull.ac.uk](mailto:s.f.ng@cas.hull.ac.uk) Alternatively, I can call you in this week for a telephone interview instead.

Look forward to receive your positive reply.

Yours Sincerely,

Fowie Ng

## Implementation of Patient's Charter

*Confidentiality will always be assured*

1. From your experience in dealing with the local trusts, what would be the major facilitator(s) and obstacle(s) for implementing the charter as suggested by the NHSE?
2. To what extent does the Charter fit in the current government policies such as NICE, NHS Direct, Clinical Governance, etc.?
3. What sort of local important performance indicators are required to be submitted to the NHSE? How are they reviewed at the national level?
4. Based on your experience, how the trusting relationship between NHSE and staff at trust level (e.g. chief executive, director of nursing, director of quality) has changed since the launch of the charter? Does it improve or make the relationship more difficult?
5. How well is the charter perceived as a managerial tool and a political tool in running the NHS by the NHSE?

Appendix Three: Sample letter to NHS Trusts

(Name),  
(Post),  
(xxx) NHS Trust,  
Address

Mr. Fowie Ng,  
Lecturer (Health Services Management),  
c/o Institute of Health Studies,  
University of Hull,  
Hull, HU6 7RX  
Email: s.f.ng@cas.hull.ac.uk

27 January, 2000

Research Project: Implementation of Patient's Charter

Dear (Name),

The Institute of Health Studies at the University of Hull is currently undertaking a research project of the comparative study of the implementation of Patient's Charter in UK and Hong Kong, supervised by Professor Andy Alaszewski. It is expected that a better understanding of the international trend of adopting charters will be achieved. As one of the major trust hospitals in the region, Hull and East Yorkshire Hospitals NHS trust is being selected as one of the sample for the study.

Being a former postgraduate student at the Institute of Health Studies, I undertook a research study about Patient's Charter in 1992 with Dr. Roy Carr-Hill and published in the Health Service Journal (copy attached). I am now developing the interest in this area in both UK and Hong Kong and hope to publish in journals as well as to submit for PhD. I am therefore writing to you to ask for your kindest support to allow me for a 15 minutes interview at a time suitable for you in this or next week. It would also be highly appreciated if arrangement can also be made to interview one or two frontline nursing staff.

I also enclose some of the guiding questions of the interview for your reference. Look forward to receive your favourable reply.

Thanks a lot.

Yours Sincerely,

Fowie Ng

## Guiding Questions for the Research Interview about the Implementation of Patient's Charter

*Confidentiality will always be assured*

### *Section One: Implementation at the local level*

1. How is the charter implemented at your institution compared to what is required by the NHSE guidelines?
2. Do you have a particular staff/ team who are responsible for the implementation of the Patient's Charter? Can you briefly talk about the advantages involved.
3. How is your institution promoting and disseminating the charter to your staff at different level?

### *Section Two: Staff and Patient Relationship*

4. Based on your experience, how is the trusting relationship between patients and staff has changed since the launch of the charter?
5. Has the working relationship and decision making between frontline staff and management changed with the charter? How?
6. In what ways has the tasks of the frontline clinical staff changed in order to suit the requirement of the charter?

### *Section Three: Management Issues*

7. To what extent do you see the Patient's Charter as a managerial tool? Why?
8. To what extent do you see the Patient's Charter as a political tool? Why?
9. How has the authority / power of the management changed with the use of charter?
10. Overall, do you support to have the charter? How would you like to see in the new NHS charter?
11. Any other comment about any aspects of the charter?

Appendix Four: Sample letter to CHC

(Name),  
(Post),  
(xxx) Community Health Council,  
Address,

Mr. Fowie Ng,  
Lecturer (Health Services Management)  
c/o Institute of Health Studies,  
University of Hull,  
Hull, HU6 7RX

Email: s.f.ng@cas.hull.ac.uk

31 January, 2000

Research Project: Implementation of Patient's Charter

Dear ( Name),

Thank you for accepting my request for an 15-20 minutes interview on 3 Feb Thursday 10:00am at your office. For your further information, the Institute of Health Studies at the University of Hull is currently undertaking a research project of the comparative study of the implementation of Patient's Charter in UK and Hong Kong, supervised by Professor Andy Alaszewski. It is expected that a better understanding of the international trend of adopting charters will be achieved. It is crucial to have information from the CHC about the views on Patient's Charter.

Being a former postgraduate student at the Institute of Health Studies, I undertook a research study about Patient's Charter in 1992 with Dr. Roy Carr-Hill and published in the Health Service Journal (copy to be attached). I am now working as a Lecturer at the Open University of Hong Kong as well as the Honorary Secretary of the Hong Kong Society of the Health Service Executives. Since then, I am developing the interest in this area in both UK and Hong Kong and hope to publish in journals as well as to submit for PhD thesis. I am very pleased to have your kindest support to allow me for the interview this Thursday.

I also enclose the guiding questions of the interview for your reference. Look forward to see you. Of course, a confidential feedback report will be available to you when the project is finished.

Thanks a lot.

Yours Sincerely,

Fowie Ng



## Guiding Questions for the Research Interview about the Implementation of Patient's Charter

*Confidentiality will always be assured*

### *Section One: Implementation at the local level*

1. How is CHC involved in the implementation of the Patient's Charter?
2. Do you have a particular staff/ team who is responsible for helping patients or working with NHS trusts in the implementation of the Patient's Charter? Can you briefly talk about the advantages involved.
3. How is your institution promoting and disseminating the charter to patients and relatives at the local level?

### *Section Two: Staff and Patient*

4. Based on your experience, how is the trusting relationship between patients and CHC staff has changed since the launch of the charter? Does it improve or make the relationship more difficult?
5. Has the working relationship and decision making between frontline health care staff and patients changed with the charter? How?
6. Do patients use the charter? How do they refer to it?

### *Section Three: Management Issues*

7. To what extent do you see the Patient's Charter as a managerial tool? Why?
8. To what extent do you see the Patient's Charter as a political tool? Why?
9. How has the authority / power of the management changed with the use of charter?
10. Overall, do you support to continue to have the charter? How would you like to see in the new NHS charter?
11. Is there enough support from the Patient's Charter Unit of the NHSE? What would you like the NHSE to involve?
12. Any other comment about any aspects of the charter?

Appendix Five: Sample letter to Patients' group

(Name),  
(Post),  
The Patients Association,  
Address,

Mr. Fowie Ng,  
Lecturer (Health Services Management)  
c/o Institute of Health Studies,  
University of Hull,  
Hull, HU6 7RX

Email: s.f.ng@cas.hull.ac.uk

Date

Research Project: Implementation of Patient's Charter

Dear ( Name),

For your further information, the Institute of Health Studies at the University of Hull is currently undertaking a research project of the comparative study of the implementation of Patient's Charter in UK and Hong Kong, supervised by Professor Andy Alaszewski. It is expected that a better understanding of the international trend of adopting charters will be achieved. It is crucial to have information from the CHC about the views on Patient's Charter.

Being a former postgraduate student at the Institute of Health Studies, I undertook a research study about Patient's Charter in 1992 with Dr. Roy Carr-Hill and published in the Health Service Journal (copy to be attached). I am now working as a Lecturer at the Open University of Hong Kong as well as the Honorary Secretary of the Hong Kong Society of the Health Service Executives. Since then, I am developing the interest in this area in both UK and Hong Kong and hope to publish in journals as well as to submit for PhD thesis. Of course, the research cannot be claimed to be comprehensive without the input from the Patients Association – the representative group for the patients in UK. Hence I am writing to you to ask for your permission so that I can come to your office for an interview for about 20 minutes next week. I will call you in advance for an appropriate time.

I also enclose the guiding questions of the interview for your reference. Look forward to see you. Of course, a confidential feedback report will be available to you when the project is finished.

Thanks a lot.

Yours Sincerely,

Fowie Ng

## Guiding Questions for the Research Interview about the Implementation of Patient's Charter

*Confidentiality will always be assured*

### *Section One: Implementation at the local level*

1. How is the Patients Association involved in the implementation of the Patient's Charter?
2. Do you have a particular staff/ team who is responsible for helping patients or working with NHS trusts in the implementation of the Patient's Charter? Can you briefly talk about the advantages involved.
3. How is your institution promoting and disseminating the charter to patients and relatives at the local level?

### *Section Two: Staff and Patient*

4. Based on your experience, how was the trusting relationship between patients and the staff of Patients Association changed since the launch of the charter? Does it improve or make the relationship more difficult?
5. Has the working relationship and decision making between frontline health care staff and patients changed with the charter? How?
6. Do patients use the charter? How do they refer to it?

### *Section Three: Management Issues*

7. To what extent do you see the Patient's Charter as a managerial tool? Why?
8. To what extent do you see the Patient's Charter as a political tool? Why?
9. How has the authority / power of the management in the Patients Association changed with the use of charter?
10. Overall, do you support the continuation of the charter? What would you like to see in the new NHS charter?
11. Is there enough support from the Patient's Charter Unit of the NHSE? What would you like the NHSE to involve?
12. Any other comment about any aspects of the charter?

Appendix Six: Patient's Charter: Guidelines for Good Practice (ACHCEW, 1986 with main points only)

All person have a right to:

1. health services, appropriate to their needs, regardless of financial means or where they live and without delay; \*
  2. be treated with reasonable skill, care and consideration; \*
  3. written information about health services, including hospitals, community and General Practitioner services;
  4. register with a General Practitioner with ease and to be able to change without adverse consequences;
  5. be informed about all aspects of their condition and proposed care (including the alternatives available), unless they express a wish to the contrary;
  6. accept or refuse treatment (including diagnostic procedures), without affecting the standard of alternative are given;
  7. a second opinion;
  8. the support of a relative or friend at any time;
  9. advocacy and interpreting services;
  10. choose whether to participate or not in research trials and be free to withdraw at any time without affecting the standard of alternative care given;
  11. only be discharged from hospital after adequate arrangements have been made for their continuing care;
  12. privacy for all consultation;
  13. be treated at all times with respect for their dignity, personal needs and religious and philosophic beliefs;
  14. confidentiality of all records relating to their care; \*
  15. have access to their own health care records;
  16. make a complaint and have it investigated thoroughly, speedily and impartially and be informed of the result;
  17. an independent investigation into all serious medical or other mishaps whilst in NHS care, whether or not a complaint is made, and, where appropriate, adequate redress;
- \* Already an established legal right*

Appendix Seven: *The Best of Health: Charter for the Family Health Service* (Kinnock, 1986 with main points only)

1. Labour wants everyone to have easy, prompt access to top quality health advice and treatment, through the local family health service.
2. The services in inner city and rural areas will be brought up to the standards of the best elsewhere.
3. We will promote local family health care teams - family doctors, nurses, health visitors and other professionals working together to treat ill health and promote good health
4. Access to advice and treatment will be improved by making surgery hours more convenient, especially for women, and providing better public transport links.
5. Patient's choice will be widened and made easier by the publication of a practice statement giving full details of the services provided at each health centre, surgery and clinic. Complaints procedures will be strengthened and simplified.
6. The average size of doctors' lists will be reduced gradually to give more time for each individual patient and better prescribing.
7. Family health care teams will be responsible for promoting good health and for preventive work such as cervical and breast cancer screening.
8. Patients will be encouraged to get involved in the work of the local health care team. People suffering from similar problems will be helped to set up mutual help groups.
9. Labour will reduce prescription and other charges and eventually abolish them. Better prescribing practices will be encouraged.
10. The work of Family Practitioner Committees will be taken over by health districts (as in Scotland) who will be given the job of monitoring the health needs of everyone in their area.
11. Health authorities will be empowered to take action to meet the health needs of their area, and to promote improvements in collaboration with local councils and other bodies.
12. Health authorities will have the power to appoint salaried family doctors where necessary, and to provide top quality deputising services. Other family doctors and practices will be given the option of being salaried.

Appendix Eight: *The Patient's Charter* (Department of Health, 1991a with main points only)

The seven existing and well-established rights consists of:

- 1) To receive health care on the basis of clinical need, regardless of ability to pay;
- 2) To be registered with a GP;
- 3) To receive emergency medical care at any time, through your GP or the emergency ambulance service and hospital accident and emergency departments;
- 4) To be referred to a consultant, acceptable to you, when your GP thinks it necessary, and to be referred for a second opinion if you and your GP agree this is desirable;
- 5) To be given a clear explanation of any treatment proposed, including any risks and any alternatives, before you decide whether you will agree to the treatment;
- 6) To have access to your health records, and to know that those working for the NHS are under a legal duty to keep their contents confidential;
- 7) To choose whether or not you wish to take part in medical research or medical student training;

The three new rights from 1st April, 1992:

- 1) To be given detailed information on local health services, including quality standards and maximum waiting times;
- 2) To be guaranteed admission for treatment by a specific date no later than two years from the day when your consultant places you on a waiting list;
- 3) To have any complaint about the NHS services - whoever provides them - investigated and to receive a full and prompt written reply from the chief executive or general manager;

There are nine standards of service which the NHS will be aiming to provide for the public:

- 1) Respect for privacy, dignity and religious and cultural beliefs;
- 2) Arrangements to ensure everyone, including people with special needs, can use services;
- 3) Information to relatives and friends about the progress of your treatment, subject, of course, to your wishes;
- 4) An emergency ambulance should arrive within 14 minutes in an urban area, or 19 minutes in a rural area;

- 5) When attending an accident and emergency department, you will be seen immediately and your need for treatment assessed;
- 6) When you go to outpatient clinic, you will be given a specific appointment time and will be seen within 30 minutes of it;
- 7) Your operation should not be cancelled on the day you are due to arrive in hospital. If, exceptionally, your operation has to be postponed twice you will be admitted to hospital within one month of the second cancelled operation;
- 8) A named qualified nurse, midwife or health visitor responsible for your nursing or midwifery care;
- 9) A decision should be made about any continuing health or social care needs you may have, before you are discharged from hospital;

From 1 April, 1992, authorities were required starting to set and publicize clear local Charter Standards, including:

- 1) Waiting time for first outpatient appointment;
- 2) Waiting times in accident and emergency departments, after the initial assessment of your need for treatment;
- 3) Waiting times for taking you home after treatment, where your doctor says you have a medical need for NHS transport;
- 4) Enabling you and your visitors to find your way around hospitals, through enquiry points and better signposting;
- 5) Ensuring that the staff you meet face to face wear name badges.

Appendix Nine: *The Patient's Charter and family doctor services* (Department of Health, 1993 with main points only)

As a patient using general medical services of the National Health Service you have the following rights:

- to be registered with a family doctor
- to change your doctor easily and quickly
- to be offered a health check:
  - when joining a doctor's list for the first time
  - if you are between 16 and 74 and you have not seen your doctor in the previous three years, and
  - a yearly home visit if you are 75 years old or over
- to receive emergency care at any time through a family doctor
- to have appropriate drugs and medicines prescribed
- to be referred to a consultant acceptable to you when your family doctor thinks it necessary, and to be referred for a second opinion if you and your family doctor agree this is desirable
- to have access to your health records, subject to any limitations in law
- to know that those working for the NHS are under a legal duty to keep the contents of your health records confidential
- to choose whether or not to take part in medical research or medical student training
- to be given detailed information about local family doctor services through your Family Health Services Authority's local directory
- to receive a copy of the doctor's practice leaflet, setting out the services he or she provides
- to receive a full and prompt reply to any complaint you make about NHS services

By 1 April 1993, your local FHSA will have produced a local patient's charter for the services it provides. Included in this charter will be the following National Standards of service which you can expect to receive as a patient.

**Your Family Health Services Authority**

**Must:**

- where you are not registered with a family doctor, find you one within two working days
- help you change doctors easily and quickly, and send you details of how to change and list of doctors within two working days
- provide you with information about local medical services – this will include information on performance against quality standards and the name of your FHSA's Patient's Charter Officer, whom you can contact about Patient's Charter matters
- transfer your medical records quickly when you change doctor. This means within two working days for urgent requests and six weeks for routine requests for transfer
- provide a full and open response to any comments, suggestions or complaints which a member of the public makes about services; and



aim:

- when dealing with your comments, suggestions and complaints
  - to acknowledge your comments, complaints and suggestions within two working days
  - where appropriate, to advise your family doctor within two working days of receipt
  - to clear informal complaints within one month of receipt
  - to clear formal complaints within six months of receipt (formal complaints are handled within a legal framework)
  - to provide both you and your family doctor with monthly progress reports until your complaint has been cleared.

Appendix Ten: *The Patient's Charter & You* (Department of Health, 1995b with main points only)

**Rights** - which all patients will receive all the time; and

**Expectations** - these are standards of service which the NHS is aiming to achieve. Exceptional circumstances may sometimes prevent these standards being met.

*Rights and Standards throughout the NHS*

ACCESS TO SERVICES

You have the **right** to:

- \* receive health care on the basis of your clinical need, not on your ability to pay, your lifestyle or other factor;
  - \* be registered with a GP and be able to change your GP easily and quickly if you want to;
  - \* get emergency medical treatment at any time through your GP, the emergency ambulance service and hospital accident and emergency departments; and
  - \* be referred to a consultant acceptable to you, when your GP thinks it is necessary, and to be referred for a second opinion if you and your GP agree this is desirable.
- You can **expect** the NHS to make it easy for everyone to use its services., including children, elderly people or people with physical or mental disabilities.
- If your child needs to be admitted to hospital, you can **expect** them to be cared for in a children's ward under the supervision of a consultant paediatrician. Exceptionally, when a child has to be admitted to a ward other than a children's ward, you can **expect** a named consultant paediatrician to be responsible for advising on their care.

PERSONAL CONSIDERATION AND RESPECT

- \* You have the **right** to choose whether or not you want to take part in medical research or medical student training.
- You can **expect** all the staff you meet face to face to wear name badges.
- You can **expect** the NHS to respect your privacy, dignity and religious and cultural beliefs at all times and in all places. For example, meals should suit your dietary and religious needs. Staff should ask you whether you want to be called by the first or last name and respect your reference.

PROVIDING INFORMATION

You have the **right** to:

- \* have any proposed treatment, including any risks involved in that treatment and any alternatives, clearly explained to you before you decide whether to agree to it;
- \* have access to your health records, and to know that everyone working for the NHS is under a legal duty to keep your records confidential;
- \* have any complaint about NHS services (Whoever provides them) investigated and to get a quick, full written reply from the relevant chief executive or general manager;
- \* receive detailed information on local health services. This includes information on the standards of service you can expect, waiting times and on local GP services.

### *GP Services*

#### REGISTERING WITH AND CHANGING DOCTORS

- \* You have the **right** to be registered with a GP.
- You can **expect** your Family Health Services Authority (FHSA) to find you a GP within two working days.
- \* You have the **right** to change your GP easily and quickly.
- You can **expect** your local FHSA to send you a list of doctors within two working days together with details of how to change doctors.
- If you have changed your GP, you can **expect** your local FHSA to send your medical records to your new GP quickly. This means within two working days for urgent cases and six weeks for all other cases.
- \* You have the **right** to receive information about the services your GP provides and to see on request a copy of your GP's practice leaflet, which sets out this information.

#### HEALTH CHECKS BY YOUR GP

You have the **right** to:

- \* be offered a health check when you join a GP practice for the first time;
- \* ask for a health check if you are between 16 and 74 and have not seen your GP in the last three years; and
- \* be offered a health check once a year in your GP's surgery, or at your own home if you prefer, if you are 75 or over.

#### DRUGS AND MEDICINES

\* You have the **right** to be prescribed appropriate drugs and medicines.

\* If you are a pensioner, a child under 16 or under 19 in full-time education, pregnant or a nursing mother, suffering from one of a number of specified individual conditions, or on income support or family credit, you have a **right** to get your medicines free.

## YOUR GP's PRACTICE CHARTER

We are working with GPs and their health care teams to encourage them to produce GP practice charters.

## *Hospital Services*

### REDUCING WAITING TIMES

\* From April 1995, the NHS is broadening this 18-month **guarantee** to cover all admissions to hospital.

- In addition from April 1995, you can **expect** treatment within one year for coronary artery bypass grafts and some associated procedures. (If your consultant considers your need for treatment is urgent, you can **expect** to be seen much more quickly than this).

- Your operation should not be cancelled on the day you are due to go into hospital or after you have gone in. If it is, you can **expect** to be admitted again within one month of the cancellation.

### OUTPATIENT WAITING TIMES

- From April 1995, when your GP or dentist refers you to the hospital, nine out of ten people can **expect** to be seen within 13 weeks. Everyone can **expect** to be seen within 26 weeks.

### YOUR CARE IN HOSPITAL

- If you go to an accident and emergency department you can **expect** to be seen immediately and have your need for treatment assessed.

- When you go to an outpatient clinic you can **expect** to be given a specific appointment time and be seen within 30 minutes of that time.

- From April 1995, if you are admitted to hospital through an accident and emergency department, you can **expect** to be given a bed as soon as possible, and certainly within three to four hours. From April 1996 this standard will be improved to two hours.

- You can **expect** a qualified nurse, midwife, or health visitor to be responsible for your nursing or midwifery care. You will be told their name.

- If you agree, you can **expect** your relatives and friends to be kept up to date with the progress of your treatment.

## SINGLE-SEX WARDS

\* Except in emergencies, you have the **right** to be told before you go into hospital whether it is planned to care for you in a ward for men and women.

- In all cases, you can **expect** single-sex washing and toilet facilities.

## CATERING SERVICES

- From April 1995, if you have to stay in hospital, you can **expect** to be given a written explanation of the hospital's patient food, nutrition and health policy and the catering services and standards you can expect during your stay.

## THE HOSPITAL ENVIRONMENT

- You can **expect** enquiry points and clear signposting in all hospitals to help you and your visitors to find your way around.
- You can **expect** to be cared for in an environment which is clean and safe.
- During the time you spend in hospital you can **expect** reasonable measures to be taken for your personal protection and safety. You can also **expect** to have facilities to keep personal money and belongings safe.

## LEAVING HOSPITAL

- Before you are discharged from hospital, you can **expect** a decision to be made about how to meet any needs you may continue to have. Your hospital will agree arrangements with agencies such as community nursing community nursing services and local authority social services departments. You and, if you agree, your carers will be involved in making these decisions and will be kept up to date with information at all stages.

## YOUR HOSPITAL'S OWN STANDARDS

- You can also **expect** your health authority to set local standards on:
  - . waiting times for you to receive treatment in accident and emergency departments after your need for treatment has been assessed; and
  - . waiting times for taking you home after you have been treated if your doctors says you have a medical need for NHS transport.
- You can **expect** your hospital to display information on the Patient's Charter including these local standards and whether they are meeting them.
- You can **expect** your hospital to make it clear to you how can complain or make comments and suggestions whilst you are in hospital.

- You can **expect** your hospital to publish regularly details of the number of complaints they have received and the time they took to deal with them.

### *Community Services*

#### APPOINTMENT TIMES

- There are nurses, health visitors and midwives working in your community. From April 1995, if you need a home visit from one of these professionals, you can **expect** to be consulted about a convenient time. You can then **expect** a visit within a two-hour time band.

#### SEEING COMMUNITY NURSES AND MIDWIVES

- You can **expect** to receive a visit from someone in the district nurse team or the mental health nurse:
  - . within four hours (in the daytime), if you have been referred to them as an urgent patient;
  - . within two working days, if you have been referred to them as a non-urgent patient and you have not asked them to see you on any particular day; and
  - . by appointment on the day you ask for, if you give the district nursing services more than 48 hours notice.
- You can **expect** to receive a visit from your midwife if you and your midwife agree this is necessary.
- You can **expect** to receive a visit from a health visitor:
  - . between 10 and 14 days after the birth of a baby;
  - . within five working days if you are newly registered with a GP and have children under five years old.

#### COMMUNITY CARE CHARTERS

In addition to these new standards for Community Services the NHS is working with local authorities to help produce local community care charters which will cover the standards of service you can expect from, for example, home care services, aids and equipment for daily living and day care.

### *Ambulance Services*

- If you call an emergency ambulance (999 call), you can **expect** it to arrive within 14 minutes in an urban area, or 19 minutes in a rural area.

### *Dental, Optical and Pharmaceutical Services*

## YOUR DENTIST

- If you are not registered with an NHS dentist, your local FHSA will help you to find one. You can **expect** your local FHSA to respond to such request within five working days.
- You can **expect** your dentist to let you know the expected cost of a course of NHS treatment before that treatment begins.
- \* If you are registered with a dentist, you have the **right** to receive advice in an emergency, and treatment if your dentist considers it necessary.

## YOUR OPTOMETRIST

- You can **expect** to receive advice on whether you can get an NHS sight test and advice about vouchers towards the cost of glasses or contact lenses.
- You can **expect** a thorough eye examination which should include checks for any disease or abnormality as well as checking your sight.
- You can **expect** your optometrist to inform you if they find any indication that medical treatment or further investigation is necessary and to refer you to your GP accordingly.
- \* Immediately after your eye test, you have the **right** to receive a signed, written prescription which you can use to get your glasses. You have the **right** to take this prescription to any optometrist or dispensing optician of your choice. If you do not need a prescription, you have the **right** to a written statement telling you this.

If you are fitted with contact lenses, you can **expect**:

- . to be given all the necessary information and instructions about their cost, use and maintenance;
- . to receive the necessary aftercare for a period of at least six months after fitting, and advice on how often you should be seen afterwards.

## YOUR COMMUNITY PHARMACIST

You have the **right** to:

- \* decide which pharmacy to use for your prescriptions;

You can **expect** your medicines and medical appliances to be supplied in suitable containers and be labelled with clear instructions on how to use them.

You can **expect** your pharmacist to explain these instructions to you if you are not sure.

- \* have your prescription dealt with promptly.

You can see a pharmacist without an appointment. At busy times of the day you may have to wait, but you can **expect** to be given an explanation for any delay and told when your prescription will be ready.

Most prescription medicines will be dispensed from stock held in pharmacies. When any medicine is not in stock, you can **expect** to be told when it will be available. If you prefer, you have the prescription back, so you can go to another pharmacy.

If the pharmacy is closed, you can **expect** to find information about arrangements for getting prescriptions outside normal hours, including weekends, on the door or window of the pharmacy. Your local paper normally includes this information, too.

### *The Patient's Charter and Maternity Services*

The Government has published a special charter for pregnant women and new mothers.

### *Learning from You*

\* You have a **right** to have your complaint investigated and to receive a full and prompt written reply from the general manager or chief executive.

### *How you can help the NHS*



## Appendix Eleven: *Patient's Charter* (Hospital Authority, 1994a)

The purpose of the Patient's Charter is to explain both your Rights and Responsibilities when you use the services of any of Hong Kong's public hospitals. Knowing and understanding your rights and responsibilities will make your relationship with health care providers a mutually beneficial one.

The Charter sets out the ways in which the community and the hospitals work as partners in a positive and open relationship with a view to enhancing the effectiveness of the health care process.

### RIGHTS

#### *Rights to Medical Treatment:*

- \* The right to receive medical advice and treatment which fully meets the currently accepted standards of care and quality.

#### *Rights to Information:*

- \* The right to information about what health care services are available, and what charges are involved.
- \* The right to be given a clear description of your medical condition, with diagnosis, prognosis (i.e. an opinion as to the likely future course of any illness), and of the treatment proposed including common risks and appropriate alternatives.
- \* The right to know the names of any medication to be prescribed, and its normal actions and potential side-effects given your condition.
- \* The right to access to medical information which relates to your condition and treatment.

#### *Right to Choices:*

- \* The right to accept or refuse any medication, investigation or treatment, and to be informed of the likely consequences of doing so.
- \* The right to a second medical opinion.
- \* The right to choose whether or not to take part in medical research programmes.

#### *Right to Privacy:*

- \* The right to have your privacy, dignity and religious and cultural beliefs respected.
- \* The right to have information relating to your medical condition kept confidential.

#### *Right to Complaint:*

\* The right to make a complaint through channels provided for this purpose by the Hospital Authority, and to have any complaint dealt with promptly and fairly.

## RESPONSIBILITIES

\* Give your health care providers as much information as you can about your present health, past illnesses, and allergies and any other relevant details.

\* Follow the prescribed and agreed treatment plan, and conscientiously comply with the instructions given.

\* Show consideration for the rights of other patients and health care providers, by following the hospital rules concerning patient conduct.

\* Keep any appointments that you make, or notify the hospital or clinic as early as possible if you are unable to do so.

\* Should not ask health care providers to provide incorrect information, receipts or certificates.

\* Should not waste medical resources unnecessarily.

## Appendix Twelve: Patients' Rights & Responsibilities (HKMA, 1993)

Patients' Rights and Responsibilities pronounced by HKMA & Consumer Council

### RESPONSIBILITIES

To play an active and responsible role in the healthcare process, you should

1. be frank to your doctors in revealing your medical conditions.
2. endeavour to co-operate with any agreed form of management.
3. be well informed by your insurers of the detailed scope of coverage of your medical insurance policies.
4. not request doctors to issue incorrect receipts, certificates or document, or to make incorrect entry into medical records.
5. be responsible to meet the required fees and charges for medical services provided to you.

### RIGHTS

Each patient has the following rights:

1. To be informed and explained about the medical conditions, including diagnosis, prognosis and common complications.
2. To be given a clear explanation of the treatment proposed, including common risks and appropriate alternative treatments, before agreeing to the treatment.
3. To know the names, the actions and the common serious side-effects of the drugs prescribed.
4. To refuse any medication, investigation or treatment, and to be informed of the consequences of doing so.
5. To have a second medical opinion.
6. To have one's privacy, dignity, and religious and cultural beliefs respected.
7. To have information relating to one's medical condition kept confidential.
8. To be entitled access to and correction of personal data in accordance with the provisions of Personal Data (Privacy) Ordinance.
9. To know the fees and charges prior to consultation or receiving any procedure.
10. To make complaints and obtain a fair investigation and reply
11. To choose whether or not to take part in medical research or medical student training.

*Remarks:* Talking magazine hotline number is (852) 2529 5222

### Appendix Thirteen: *Patients' Rights & Responsibilities* (DoH, 2000)

Patients' Rights and Responsibilities pronounced by Department of Health

#### *Patients' rights*

##### The right to know

1. Patients have the right to know the medical fee or charges in advance.
2. Patients have the right to know the details of their illness, including diagnosis, progress, investigations, methods and effectiveness of treatment.
3. Patients have the right to know the name, dosage, method of administration, uses and side effects of the prescribed medications.
4. Patients have the right to know the purposes and common complications of any treatment procedures or investigations before they are performed, and whether there are any other alternatives.
5. Patients have the right to obtain the information concerning their illness. They have the right to obtain a medical report or a copy of the medical record from relevant medical institutes or doctors. A fee may be required, so patients should ask in advance.

##### The right to decide

1. Patients have the right to consult more than one doctor before making decision to accept any treatment.
2. Patients have the right to decide whether to accept or refuse any medical advice from doctors. If patients decide to refuse the suggestions from doctors, they should understand the consequences of their decision and be responsible for it.
3. Patients have the right to decide whether or not to participate in medical research.

##### The right to keep information confidential

Without patients' prior consent for disclosure, any information disclosed by patients during the process of management of their illness should be kept confidential by all medical personnels. However, in order to help the management of the illness, doctors may disclose the information to other relevant medical personnels. Under special circumstances, if doctors suspect that the patients have committed crime or participated in illegal activities, the information may be disclosed to relevant authorities.

##### The right to complain

Patients should understand and exercise their own "right to know" and try to communicate with medical personnels. This can ensure a better understanding of their own illness and the treatment process. If finally they are still dissatisfied with the medical personnels, they can make complaints.

Besides these rights, patients' dignity, culture and religious belief should also be respected.

##### Patients' responsibilities

1. Patients should tell doctors frankly about their present illness, past medical history and other relevant information.
2. Patients should cooperate with medical personnels on any mutually agreed treatment plans or procedures.
3. Patients should not ask medical personnels to provide false medical information, to issue false receipts, sick leave certificates or medial reports.
4. Patients have the responsibility to pay the reasonable fee charged by relevant doctors or medical institutes.
5. Patients should follow rules stipulated by clinics or hospitals and respect the rights of other patients and medical personnel.