Performance Stories A Comparison of the Annual Reports Presented by the U.S. Department of Veterans Affairs and the English National Health Service

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PERFORMANCE STORIES

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ABSTRACT: Annual reports can contribute to the legitimacy of public service organizations in creating a favorable story around performance achievements. It is also the case that annual reports can have unintended consequences, provoking negative reactions on the part of their readers. Health services performance stories in the form of annual reports presented by the U.S. Department of Veterans Affairs and the English National Health Service between 2002 and 2005 are compared through a narrative analysis of structure and content. Conclusions are drawn as to the relative success each organization achieves in the telling of its performance story through annual reports. In dealing with the impact that performance stories have on legitimacy, further questions requiring answers from the readers of the reports are suggested.

KEYWORDS: annual reports, English National Health Service, health, performance, U.S. Department of Veterans Affairs

Annual reports record activity, results, and achievements and are part of the business of gaining and maintaining the legitimacy of public organizations. In addressing performance, the annual report will typically help frame an organizational identity, record achievements, and explain key management processes (Suchmann, 1995). An annual report, if successful in telling a convincing story about the performance of an organization, is a source of legitimacy. In the field of health care the legitimacy of organizations delivering public services is increasingly seen as problematic. The reasons given for this condition tend to stress funding pressures, changes in patterns of working, treatment philosophies, modes of service provision, and the introduction of new health technologies (Ferlie & Shortell, 2001; Twaddle, 1996). Because the public rather than the state itself always accords legitimacy, this presents problems for governments that run health services.
It is generally accepted that some caution must be exercised in reading annual reports. Typically they draw on a range of data and purport to be the most comprehensive account of an organization’s performance (Halachmi, 2002). Annual reports should not be taken as faithful reconstructions of the year’s achievements. “Facts” do not speak for themselves; rather, facts are chosen and organized by the authors of reports. In the current context of new public management (NPM), annual reports are used to subtly legitimate performance in the sense referred to by Power (2003) but are also frequently more explicitly political in intent. Annual reports may well also be incomplete, selective records of what was achieved and can be constructed around intent to variously mislead, exaggerate, or distort (Skerbek, 2005). It would be wrong, however, to assume that the desired legitimizing effect is always achieved. Annual reports of the type under question may well fail to reach intended readerships. Those persons who do read them, whether in government, the wider political system, or the media, may respond with skepticism or outright opposition to the portrayal of achievement contained in the report. The annual report is a “genre” in development. The effort to find an effective means of conveying performance stories is taking place in circumstances of performance anxiety engendered by aggressive NPM. For this reason, examining annual report narratives may reveal interesting information about the governance context in which the annual report was written and suggest ways in which the reaction of the intended audience can be better understood (Callaghan & Schnell, 2001; Citrin & Muste, 1999).

Performance management in its various forms is a central element of NPM. As discussed by contributors to the recently published *Public Service Performance: Perspectives on Measurement and Management* (Boyne, Meier, O’Toole, & Walker, 2007), there is an expanding scholarly interest in how public organization performance is conceived, measured, and managed. There is also an increasing awareness that in certain circumstances NPM and performance management produce unintended effects. This study is intended to add to the literature dealing with such emergent paradoxes in the application of NPM (Hood & Peters, 2004). How well public services are perceived to perform is generally thought to be an element in determining the level of trust in government (Heintzman & Marson, 2005). Public services have multiple bottom lines, making results difficult to measure in unambiguous terms. Consequently, performance stories will often be inherently difficult to tell. In addition to material improvements delivered by service providers, how the performance story is told must be considered important in realizing legitimacy. In this study, rather than, for example, attempting to test the integrity of performance metrics, describe the performance management schemes employed by the English National Health Service (NHS) and the U.S. Department of Veterans Affairs (VA), or suggest what sort of alternative approaches should be adopted, we deal with the technical aspects of how performance stories are told.
On the face of it, both the VA and the NHS report their performance in terms of metrics and text developed around familiar concepts and measures that capture quality, access, and costs. In terms of generating legitimacy, it is contended that, at least in part, “the devil is in the detail” of the performance story. A successful annual report, we can presume, increases trust in the organization and perhaps the government in general. The data and associated narrative contained in the report remove ambiguity around the claimed effectiveness of the service provided. On the other hand, a less successful report may, through the mistelling of the performance story, actually increase skepticism regarding the achievements of the service provider. It can do this in several ways, for example, by confusing the reader’s understanding of the service provider’s identity, presenting unsubstantiated claims, attempting unduly complex explanations of service process, or referring to data that is of dubious integrity. The result is a paradox, whereby efforts to convey a positive message of achievement lead to an unintended outcome, with a negative impact on the legitimacy of the service provider and government.

The examination of the structure and content of the narrative developed in annual reports is conducted on the basis that the analysis can help explain the relative success or failure of the annual report as a legitimation vehicle. Legitimation is accorded by the public, although the mediation of messages through newspaper and television reporting play major role to play in the process. This article makes no attempt to measure the impact of a respective annual report series as a source of legitimation for the NHS and VA. However, conclusions drawn in relation to performance stories told in the respective report series suggest the need to formulate further questions relevant to measuring impact.

The annual reports chosen for examination are narratives in the sense that they attempt to construct a performance story around events chosen to represent the health services delivered over a defined time period. Performance narratives tend to be structured around the presentation of selected achievements denoted by indicators, referred to here as performance plots. An example could relate to the number of outpatient operations performed each year. Performance narratives typically also attempt to develop what are referred to here as process plots, which explain how organizational challenges have been or will be met. An example of a process plot is the planned recruitment of specially trained psychiatric nurses leading to an increase in the number of mentally ill patients treated in the community. Although the number of plots and certain other aspects of the performance story may be quantified, narrative analysis is typically best used for exploratory purposes as opposed to direct testing for causality.

Methods

The existing literature on performance reporting contains studies focused on the technical properties of organizational report cards. Weimer and Gormley (1999)
define report cards as regular efforts by an organization to collect data on two or more other organizations. They also provide useful background explanation of the different ways in which performance can be represented in reports prepared in the context of seeking organizational legitimation. Annual reports need to be differentiated in the sense that they are self-reported performance stories rather than evaluations performed by external agencies, as is the case with report cards. Although therefore not directly comparable in terms of subject or purpose, Weimer and Gormley’s approach to the classification of typical report card elements (e.g., inputs, outputs, outcomes, process elements, and rankings) is a substantial contribution to understanding how text can be analyzed. Also concerned with organizational report cards, Coe and Brunet (2006) provided an analysis of alternative design strategies and their impact on consumer choice or public policy, again adding to our understanding of how text can be approached analytically. Weimer and Gormley wrote that a good report card should be valid, comprehensive, comprehensible, and relevant; have reasonable preparation costs; and be functional, which they define as encouraging a desired behavior. Coe and Brunet stated that report cards usually have an instrumental purpose when produced by a government agency. For example, a report card might be used to make a decision on the future funding of a program or be conceived as an attempt to reduce the information asymmetry between service providers and consumers so that consumers can make better-informed decisions.

The purpose of this study is to identify technical characteristics that were thought to be of likely significance in the impact made by annual reports. Annual reports have been examined previously in public management research by academics seeking to understand the aspects of the NPM. Skerbeck’s (2005, pp. 390–391) study of a single annual report from Copenhagen Business Schools is a notable example. Applying the sociological concept of a primary framework, the study locates, perceives, identifies, and labels strategies employed by the report writers to construct their performance story. Rather than analyzing the technical properties of the report itself, however, the study employs interviews with the report writers to work out their strategic intentions in constructing the document (in this case extracting maximum revenue from the Danish government).

Given the current study’s focus on the technical aspects of annual reports, the initial intention was to rely on content analysis for collecting data, a widely used method in relation to written communications. Classic content analysis operates on the basis that the words and phrases mentioned most often are those reflecting the most important messages in a communication (Holsti, 1969). Content analysis should depart from a hypothesis and be used to identify associations between variables. For example, in this study it would have been possible to count how many times particular verb constructions were used in a series of annual reports and discover whether this variable was in some way linked to policy and manage-
ment issues being addressed in the years examined. Such a method was pursued in Thomas’s (1997) study of linguistic structures in a series of annual reports published by a machine tool manufacturer between 1984 and 1988. During this time, the company moved from healthy profitability to a position of heavy losses. Verb structures showed an increase in passive constructions as profits decreased. In sentences written in passive voice, the subject receives the action expressed in the verb. The use of the passive voice indicates defensiveness on the part of management in this example. So, for example, the report might state “a resolution to the liquidity problem is being sought by the company.” The intention is to emphasize the act of resolution. The active voice, on the other hand, would have emphasized the agent: “The company is seeking a resolution to the liquidity problem.” Content analysis confirmed that certain words are used frequently in NHS and VA annual reports, but no particularly relevant trends were detected in relation to the aims of the study. Tests provided no promising leads on how to construct a relevant word-based hypothesis to test. Although attractive in terms of ease of application, a provisional examination of the utility of classic word- or phrase-based content analysis indicated that this would have produced little success in identifying key technical properties of annual report narratives in the context of this study. Although word or phrase counting did not appear to be worthwhile, it was clear that there were other elements of content that should be enumerated. For example, the number and type of performance measures employed in each report in all probability have some influence on the impact the report makes on its readers and should therefore be recorded.

Provisional examination of the reports indicated considerable differences in the compositional characteristics of the performance stories told. It became clear that to detect patterns a formal narrative analysis framework would be needed to break down the report narratives into constituent parts. Use of narrative analysis implies that the researcher is interested in the form of the text as well as the content, an important point in relation to the fairly complex compositional features evident in annual reports (Elliot, 2005, p. 42). The narrative analysis framework also needed to be flexible enough to utilize data from the content analysis of performance measures that would be performed. The literature on the use of narrative analysis in relation to topics of interest to students of public management is limited. Where the technique has been used in public management studies, it has tended to be concerned with narrative accounts provided by individual managers or clients rather than corporate narratives (Herzog & Claunch, 1997; Hummel, 1991).

In regard to annual reports made by public bodies, Corvellec’s (1997) study of Swedish public libraries is the only English-language example employing narrative analysis uncovered by an exhaustive literature review. Corvellec explained his approach as an adaptation of traditional narrative analysis of works of literature such as novels. The categories he employed closely followed the scheme designed by
Stegman (1987) in his examination of private-sector corporate reports. Corvellec did not attempt to enumerate words or phrases but instead used an interpretive approach informed by an appreciation of the meaning of performance, as well as an understanding of how a narrative is constructed. His analysis was based on reading and categorizing different aspects of the reports in relation to a prespecified framework. The relevant categories are:

- presentation—appearance, title, content;
- claimed audience;
- language;
- narrator perspective;
- narrative structure; and
- extent of serialization.

This study followed Corvellec’s general approach but adapted his framework slightly to fit the annual reports under examination. First, an additional category—monopoly rights on telling the story—was added, because we knew that potential competitors existed in the reporting of NHS performance in the United Kingdom. Second, in trying to understand how multiple plots were developed, a distinction was made between performance plots and process plots (explained further later). In addition, this study enumerates elements of content, namely those related to plot.

**Performance Stories and NPM**

Initial interest in learning more about the narrative aspects of annual reports was stimulated by a growing concern about the ability of the academic community to make sense of new performance management (Pollitt, 2006). A great deal has been written about public service performance management in general and health services performance in particular over the past 20 years. Much of the work has been focused on the describing, categorizing, or probing the accuracy of performance measures (Armstrong, 2001; Bevan & Hood, 2006; Holzer & Yang, 2004; Institute of Medicine, 2001; Walburg, 2006). This study is located in a literature that attempts to make the connection between performance management and legitimacy or trust in the state (Bouckert & Halligan, 2006; Bouckert, Van de Walle, Maddens, & Kampen, 2002). Legitimacy, although often central to the work of political scientists and organization theorists, remains a difficult concept in terms of establishing a reliable knowledge base. In broad terms, the concept of legitimacy refers to the “capacity of the system to engender and maintain the belief that the existing institutions are the most appropriate ones for society” (Lipset, 1984, p. 88; also see Aldrich & Fiol, 1994; McSwite, 1997). However, as Habermas (1984) noted, legitimacy is permanently contestable and usually scrutinized only when the order is in some sort of trouble. Pinning down sources of legitimacy in
practical terms has proved difficult, but as Offe (1984) suggested, welfare state services are the public’s vantage point for assessing the legitimacy of the state. It is, therefore, logical to seek a connection between performance and legitimacy in relation to state-provided health services. NPM tends to assume (at least tacitly) that well-thought-out schemes for raising efficiency and effectiveness and reducing costs convey an inherent source of legitimacy for the service concerned. Such a position may underestimate the extent to which the public perception of services is informed by the ability of the state to deliver a credible collective account of what service organizations are achieving (Jepperson, 1991). Examinations of the relevant performance stories are therefore likely to help us understand the basis of organizational legitimacy in the field of public services.

The VA and the NHS: Parallel Histories

The two organizations and their respective annual reports selected for scrutiny in this project relate to the health care systems run by the U.S. Veterans Health Administration (VHA) and the English NHS. (The NHS is also operational in Scotland, Northern Ireland, and Wales and produces separate reports for each jurisdiction of the United Kingdom.) Although there are significant contextual differences, the health care systems and associated reports do make for fairly good comparison. The VHA is a component of the VA, which also provides a range of other personal benefits to ex-military persons. The health system is provided by the VHA; annual reports that cover health care activities are produced by the VA rather than the VHA. The article, therefore, makes reference to either the VA or the VHA depending on the issues discussed.

The NHS in the United Kingdom is organized separately into four jurisdictions: England, Scotland, Wales, and Northern Ireland. This paper refers to the English NHS. Both the VHA and the NHS are large-scale, taxation-funded, free at point of use, integrated health care systems (primary, secondary, mental, and community health services under one organizational umbrella), using their own staff to deliver services. The NHS in England spent £76 billion in 2005–6 on a patient population of around 50 million. The VHA spent $33 billion in 2005–6 on a population of 5.4 million “unique patients” (consultation episode-based unit) spread across a much larger geographic area. (It should be noted that from 1996 to 2003, the number of veterans treated annually increased by nearly 100 percent.) The VHA patient population is older and displays higher levels of morbidity in comparison with the NHS patient population. It is possible for government to limit the size of the population granted access to VHA services in the United States, as occurred in 2003 when higher-income veterans were prevented from enrolling for care. In the case of the NHS, the state can control only the volume of demand through a waiting list system sometimes referred to as “rationing.” In most respects, however,
if comparative research is intended, the NHS and VHA are internationally the best-fit, free-at-point-of-use health care organizations in terms of size, purpose, funding, and relationship with government.

The two systems are subject to close political scrutiny, and, in the late 1990s, amidst widely reported fears of impending decay, both the VHA and the NHS underwent programs of radical reform involving structural and organizational change, new resource allocation systems, and measurement and accountability for quality and value (Marshall, Shekelle, Davies, & Smith, 2003; Tuohy, 1999).

It is relatively easy to find parallels in the recent history of the NHS and the VHA. In the 1980s and early 1990s, the VHA had a reputation as an expensive, inefficient, unresponsive bureaucracy prone to delivering substandard levels of care. The NHS, although by international standards a low-cost service, also suffered from accusations of administrative inefficiency and had always, since it was formed, used waiting lists (often lengthy) to manage demand (Ham, 1999).

In the 1980s concerns were voiced in many quarters of American society about the economic viability of the health care system in general. The VHA was arguably facing a legitimacy crisis in this period, with political support and public opinion for its continued existence in doubt (Iglehart, 1985). In the mid-1980s, the NHS remained a high-profile component of the postwar welfare state, parts of which were already being enthusiastically dismantled by the Thatcher government. As such, the NHS might have been considered ripe for privatization, but to even publicly discuss such controversial reforms presented insurmountable electoral problems.

In the United States, while radical privatization, whether taking the form of a sell-off on the UK model or “vouchering out” veterans’ care to private providers, might have appealed to neoliberals, the prospect of being portrayed as unpatriotic and failing the veterans did not. Privatization was not an imminent possibility for either the NHS or the VHA. Nevertheless, it was increasingly the case that the problems associated with demonstrating value to Parliament and Congress and restoring confidence over quality and access became a priority for health service leaders (Wilson & Kizer, 1997; Young, 2000, p. 18). As part of the Government Performance and Results Act of 1993, major federal agencies, including the VA, are required to enter into a performance agreement that is administered through the Office of Management and Budget. In the United Kingdom, the NHS, like other public bodies, is held accountable along similar lines through a Treasury Spending Review–derived Public Service Agreement.

The reform of the VHA did not take place in isolation from the rest of the U.S. health care system. Around the same time that the future of the VHA came under scrutiny, the record of managed-care organizations began to suggest that health care costs could be brought under control (Fairfield, Hunter, Mechanic, & Rosleff, 1997; Hadley & Langwell, 1991; Iglehart, 1996). The practices of the managed-care organizations in controlling overall costs and guaranteeing certain standards
of quality at a predetermined price did, to some extent, influence aspects of the management model adopted by the VHA in the mid-1990s. The NHS, since the publication of the Griffiths Report in 1983, has been subjected to a managerialist agenda (later branded as NPM), in which the problems of controlling cost and quality have remained prominent. Having already undergone geographical and hierarchical restructuring in both 1977 and 1982, the NHS was given a “general management” command structure in 1984 designed to provide a stronger basis for holding the service accountable for performance (Harrison, Hunter, Marnoch, & Pollitt, 1992, pp. 51–73).

Both organizations were also seen as operating organizational systems that blocked the change envisaged by government. In the case of the VHA the diagnosis, which blamed an overreliance on obsolescent hospital-based care and a tendency to duplicate services, resulted in the 1996 Veterans Health Care Eligibility Reform Act (Perlin, Kolodner, & Roswell, 2004). The legislation allowed for the closure or rationalization of hospital facilities, actions that had previously been very difficult to implement. Two policy documents, titled “Vision for Change” (Kizer, 1995) and “Prescription for Change” (Kizer, 1996), set out the change program that was implemented in the 1990s. The program created 22 geographically defined Veterans Integrated Service Networks to replace a structure based around hospitals. Resources from this point on were allocated to each network rather than to facilities, creating financial incentives for coordination of care and resources instead of competition. In the United Kingdom, the policy diagnosis described the NHS as a producer-driven service that paid insufficient attention to patient choice. This was manifested most obviously in the long waiting lists for certain treatments. The cure involved a dose of reforms designed to stimulate competition among NHS providers. In 1987 the Thatcher government attempted to bring the market to the NHS by creating an organizational demarcation between service purchasers (primary-care doctors called fundholders and district health authorities) and providers (secondary-care organizations based on acute hospitals or community care operations that were subsequently designated as trusts). This system was referred to as the “internal market” (Spurgeon, 1993).

In the United States, subsequent political changes in the White House and Congress have not inspired further structural or systems reforms in the VHA. Although modifications, including amalgamations, have taken place, the structure and health system described in “Vision for Change” has been allowed to bed down. In sharp contrast, the election of a new UK government in May 1997 brought yet another round of reform to the NHS. Pledging itself to abolition of the internal market, the Blair government published a white paper, “The New NHS: Modern and Dependable” (U.S. Department of Health, 1997). Deeply influenced by NPM thinking and a need to differentiate itself from Thatcherism, Labor claimed to be concerned with establishing a “third way” of running the service located between
the market and bureaucracy that would be based on partnership and driven by performance (Levitas, 1998, pp. 112–127). Labor has enacted an unprecedented number of changes in the NHS in its nine years in office, with, for example, the most recent structural reforms amalgamating the 26 Strategic Health Authorities created in 2002 into 10 new authorities in 2006.

Both the VHA and NHS have attempted to develop core performance management systems. Since the mid-1990s, the VA has consistently strived to develop a value-based system for relating quality to cost across the range of services it provides, including health care. In VA terminology, quality and value are “objectified as a constellation of outcomes of interest to veterans and stakeholders” and located in “value domains.” The value domains include six dimensions of effectiveness through which the VA holds itself accountable. In the course of a decade, the VA claims to have developed an integrated and highly systematic approach to cost and quality (Perlin et al., 2004).

Throughout the 1980s, in the face of opposition or disinterest from the medical profession, the NHS struggled to implement a performance management system that embraced clinical activity (Marnoch, 1996, pp. 37–40). Since 1999, the clinical governance framework through which NHS service organizations and their staffs have been made formally accountable for the quality of patient care has been making a significant impact. The clinical governance system is the hub for a range of quality initiatives, which include clinical risk management, clinical audit, adverse incident reporting, learning networks, and continuous professional development patient complaints (Degeling, Maxwell, Iedema, & Hunter, 2004; Halligan & Donaldson, 2001; Walshe, 2003).

Comparing Annual Report Series

Both health care systems can be said to have a legitimacy problem that is related to both performance and performance representation (Bevan & Hood 2006; Dixon, 2000; Smith, 2005; Walburg, 2006; Walshe, 2003). Although we recognize that “performance” is recorded in many different forms in both the VHA and the NHS, we pay specific attention in this paper to comparing the 2002–5 series of annual reports. The concentration on a four-year series allows us to make a closer scrutiny of the content and structure of the reports than would have been possible over a longer time frame. In the United States, the VA Office of Management and Budget (2005) publishes an Annual Performance and Accountability report (including VHA performance) and in the United Kingdom the NHS Chief Executive (Department of Health, 2005a, 2005b) publishes the Report to the NHS. (The NHS post of chief executive as currently constituted dates back to 2000 and the current report series from 2002.)

The status of annual reports is variable. Annual reports may be less of an “ac-
count of record” by which the organization’s performance is known and judged than a single narrative competing with many others in a web of accountability and communication. It is not clear whether people outside the organization, or even within the organization, accord the annual report with monopoly status in the telling of the performance story. Further empirical work is required to establish evidence in relation to this issue. Among the factors that need to be considered are the competition from other reporting centers and the perceived status of the Office of the Chief Executive. In the case of the NHS, the degree of performance-narrative competition is high, with the reporting space busy with statements made by a number of institutional actors at various points in the year. The VA annual report insofar as it deals with health services performance appears, on the other hand, to occupy a less busy reporting space with consequent implications for the authority of the narrative presented. This is not to dismiss the possibility that “partial reports” dealing with particular elements of the VHA service—for example, data management—are attracting the attention of the same audience that the annual report series seeks and are possibly viewed as more authoritative within a limited context. The extent to which this is the case cannot be verified without further empirical work.

**The Narrative Analysis**

The narrative analysis revealed significant differences between the VA and NHS in the approaches adopted in communicating with audiences through annual reports.

**ANALYSIS OF NHS REPORT SERIES**

**Title**

The latest document from the relevant series of publications is titled Chief Executive’s Report to the NHS: December 2005 (Department of Health, 2005a). The precise details of the title are important, because there is also a Chief Executive’s Report to the NHS: May 2005 (Department of Health, 2005b). For reasons that are not made clear, two chief executive reports appear each year with no strong indication as to which has the most status. It can be inferred from the relative length of the respective documents and from the range of content that, in 2005, the end of the financial year (April to March in the United Kingdom) report published in May (50 pages) is the annual report proper and the December report (26 pages) has year-in-progress status. Both, however, refer to the previous 12 months. Looking further back, we can see that in 2002 the March report (9 pages) is clearly described as an interim report, with a fuller report due in December (23 pages). In 2003 the May report (19 pages) refers to the previous 12 months, whereas the December report (24 pages) deals with only the first 6 months of the new financial year. In 2004 the May report (48 pages) refers to the previous 12 months, as does the December report (52 pages). Strictly speaking, therefore, given these incon-
sistencies, it is questionable whether the May publication in the series is actually the annual report and the December report an interim report. Such uncertainty may have consequences for the perceived status of the documents. It is not entirely clear as to why the ambiguity has not been acknowledged or removed; alternative accounts have been suggested by NHS officials.

**Appearance**

The report comes each year in a cover featuring a simple abstract graphic in corporate NHS blue. The general visual appearance conveyed through typography and design represents a source of continuity. The reports consist of text, tables, charts, and diagrams. A small number of explanatory footnotes are provided. The report series does not use photographs.

**Content**

In terms of content, three notable omissions deserve particular attention. First, in contrast to the VA reports, which contain a section dealing with performance measurement methodology, there are no explanations of the precise mechanisms of the performance system used in the NHS report, its annexes, or supplements. No attempt is made to explain the concept of performance employed or the scheme employed to order data. The clinical governance system is only briefly mentioned in the March 2005 report in a small section titled “Improving Quality.” The series never attempts to explain the clinical governance system, which in 2003 was estimated by the National Audit Office to cost upward of £150 million per annum to administer and take up 10 percent of NHS doctors’ time, therefore costing around £600 million in 2004 in the acute sector alone (Office of Strategic Health Authorities, 2005). Second, unlike the VA reports, the NHS reports are entirely dedicated to health services, but the report makes little or no reference to the world outside the NHS. Scarce mention is made, for example, of local government or privately provided social services into which NHS patients may be discharged. Third, in marked contrast to the VA report, the NHS report series is devoid of any financial statements and makes no reference to audited financial statements. Of course, this does not mean that the NHS finances are not audited; on the contrary, two government agencies are employed to perform this task. The comptroller and auditor general is the statutory external auditor of the summarized accounts of English strategic health authorities, primary care trusts, and NHS trusts. The Audit Commission is the external auditor of the individual accounts of these entities. In addition, a comprehensive assessment and rating of the performance of each NHS trust in England, including finance, is undertaken by the Healthcare Commission (the English NHS quality-inspection body). The absence of references to audited financial accounts in the annual reports undoubtedly reflects a decision on the part of the NHS to make the performance narrative accessible to a non-public-finance-aware readership. The NHS reports are markedly different from the VA reports in
this respect and very probably have less immediate authority with finance-aware readers as a consequence.

The content of the series is marked by inconsistency. In 2002 the NHS chief executive needed 32 pages for his two reports. This rose to 43 pages in 2003; in 2004 100 pages were required; and in 2005 the combined length of the two reports was reduced to 80 pages. The NHS annual reports are also not consistently constructed around the same content headings. The May 2005 report has a contents page that indexes a Chief Executive preface and a further six “chapters,” which are, in turn, broken down into two or three subsections, whereas the December 2005 report is based on 15 themes denoted only by subheadings in a continuous text. The May 2004 report is based on a preface and four chapters; the May 2002 report is also a continuous text organized around subheadings, but the December 2002 report uses chapters. It is interesting to speculate as to the effect of maintaining a standard set of contents. Would giving a selected set of content items permanent status in the annual report give the series a greater sense of authority? Alternately, would readers of the reports become bored with the same format? The latter conclusion appears to be favored at present.

A degree of consistency is achieved in relation to the sets of data provided to supplement the annual reports. The May Chief Executive’s Report is presented along with a statistical supplement (around 37 pages). In December, the report has a statistical supplement (also around 35 to 37 pages) with a further annex in the form of an Autumn Performance Report. The Autumn Performance Report (around 35 pages) consists of an analysis of achievements against 34 Treasury spending review–derived public service agreement targets.

Claimed Audience

The reports address a “primary audience” of “professionals,” according to the information pages presented on the Department of Health Web pages that link to individual reports. The 2005 reports identify a further “target audience” in the form of five categories of NHS trust chief executives, NHS trust board chairs, and NHS trust communications leads, along with the chief executives of local government and nondepartmental public bodies (quangos). Although NHS leaders will certainly be keen readers, as is the case with the VA report, which is addressed to the president of the United States, it is not entirely clear whether this is the final audience at which the report is really aimed. No reference is made to external audiences in the form of politicians or media commentators. The possibility that the public may access the annual report series through the NHS Web site is not acknowledged.

Language

The language employed in the annual report series is markedly different from the dry NHS administrative style employed in the 1980s. The need to “talk up”
the NHS is evident in the language used, which can be best identified as an NHS house style based on communications specialist inputs laced with clinical and public health terminology. The language would indicate that the annual report is at least partly conceived as a public relations package providing “ready-made” material for the media.

Reports record in optimistic language that, for example, more specialist clinics are operating, more patients are using walk-in centers, or more referrals are taking place. Between 28 and 47 performance measures are quoted in each of the reports. A content analysis showed that 90 percent of the performance measurement–based discussion is written from a “glass half full” perspective; for example, in describing performance in reducing the high (by international standards) inequalities associated with heart disease: “Over the past seven years, the absolute gap in mortality rates between the fifth of areas with the worst health and deprivation indicators and the country as a whole has narrowed by 22 percent” (Department of Health, 2005b, p. 39).

The exception is with data referring to waiting times, where, perhaps in acceptance of the established view of the NHS as a service that rations treatment to its patients, there is frequently an acknowledgement of the existence of continuing problems. For instance, reports may refer to a “maximum three-month wait for heart bypass grafts and cataract operations”; note the lowest-ever numbers on the waiting list, with far fewer people “waiting more than six months for treatment”; or record the “achievement of meeting the target of a nine-month maximum wait by March 2004.” On average, whether by deliberate choice or editorial omission, four or five such references to lengthy waiting times are made in each report. It is unclear how readers of the reports react to evidence of lengthy waiting times. Will journalists, for example, regard such acknowledgements as a sign that the reports should be trusted, having been presented by a chief executive with a strong sense of public responsibility to tell the truth about NHS performance? Alternately, do references to chronic failings over waiting times reinforce negative perceptions about performance and come to be interpreted as a sign of managerial weakness?

Narrator Perspective

The series of reports reviewed all contain a preface from Chief Executive Sir Nigel Crisp. (The December 2005 report was Crisp’s last, as he resigned on February 7, 2006.) In contrast with the VA, there is clearly a strong sense of intended “narrator presence.” In May 2005, for example, Crisp is keen to emphasize that the NHS is a “service in transition” halfway through the five-year-old NHS Plan. The need for building capacity in the form of recruiting staff and developing facilities is, he makes clear, still current. In making a conscious effort to focus attention on the future, there is an implied sense that the narrator is telling us to “be patient” in relation to service improvement outcomes. In encouraging “celebration” of
achievement, a damning portrayal of the NHS of the past (dated, it seems, to pre-2000) is invoked: “extraordinary long waiting lists, chaotic A&E, and very poor outcomes in some services” (Department of Health, 2005b, p. 4). Crisp’s 2004 report, on the other hand, emphasizes speed, with changes happening more quickly than anticipated. In 2003 “sustained progress” is the dominant theme in the preface. In each report a sense of the narrator’s engagement with the then-current criticisms of the NHS is often detected. For example, in 2004 the preface acknowledged the inability to measure productivity in overall terms, although it also cited four ways in which it could be partially measured. This was also referred to in the 2003 preface, with people said to be erroneously judging value for money by the record of acute services alone. The narrator conveys a very strong sense of being engaged in a policy implementation struggle in the preface section. This is continued to some extent throughout the body of the reports. The impact this has on readers and their inclination to accept the performance of the NHS as acceptable is unknown. Without further empirical work, we cannot be sure, for example, how a health correspondent on a national newspaper will perceive the stance adopted by the narrator.

**Narrative Structure**

As discussed previously, there is no basis in the content of the series for a consistent narrative structure anchored around the presentation of a standard set of figures and accompanying comment in standard titled chapters. Whereas the VA report is concise and lucid, the NHS version is frequently verbose and confusing. The narrative structure makes this failing inevitable. For example, in May 2005, chapter 2 introduces on page 5 five “key points”—faster, more convenient services; more personal care and better patient experience; action on health promotion and protection; quality innovation and reform; and value for money—which are further broken down into 21 “indicators” of achievement. In chapter 3 the report introduces another seven standards, which the Healthcare Commission uses to assess NHS organizations—safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health. The narrative then takes the reader through a series of nine events or policy initiatives that are presented in positive terms. No sense of the choice process that has been used to select the stories is conveyed. First discussed is the NHS response to the hospital infection problem with methicillin-resistant Staphylococcus aureus: “the NHS has made a promising start and the first six months of data for 2004/05 showed a 6 percent drop in bacteraemias compared with the same period in the previous year” (Department of Health, 2005b, p. 8).

The second story is concerned with a new contract for general practitioners, and the third with the implementation of a Modernisation Agency list of 10 high-impact changes (the content of the list is not provided). The fourth story deals with
the establishment of an NHS Institute for Learning, Skills, and Innovation; the fifth with NHS Connecting for Health (an IT program); the sixth with new staff contracts; and the seventh with NHS Foundation Trusts. Next is an independent assessment of health care providers and a discussion of the role of the Healthcare Commission, and, finally, the report explains the procurement of private-sector clinical services. Chapter 4 introduces a further series of 10 stories based on innovations, specialisms, or patient groups. Once again the lack of sequence in the stories is apparent. The NHS is frequently accused of being reactive and having a “trick of the week” approach to service innovation. The narrative structure of the report series may well strengthen this view.

Performance measures are presented in tables in chapters 4 to 7. As shown in Table 1, the number of performance measures used has risen steadily over the years from a starting figure of 28 in December 2002. In total, 47 performance measures are used in the most recent annual report of May 2005, of which only 17 were used in 2002. However, during the years 2004 and 2005, a reasonable degree of consistency was established, with the use of roughly 40 of the same measures repeated in both annual reports. The degree-of-performance measure “churning” (replacing one performance measure with another) is therefore relatively low, but the NHS reports continually add new performance measures to the story. Maintaining consistency in the use of a specified set of performance indicators is thought to increase the credibility of reports (Talbot, 1996). The increase in the number of performance measures used between 2002 and 2005 reflects a mixture of intentions to broaden the scope of the performance story and a tendency to provide greater detail with respect to specific performance objectives.

Based on the May 2005 report, Table 2 presents an analysis of the attributes of the 47 performance measures used. As can be seen, the bulk of performance measures (91 percent) capture aspects of process; only 9 percent of measures capture outcomes. The May 2005 report does capture trends successfully, with 89 percent of the measures used in 2005 presented along with at least one previous year’s performance. (In earlier years the extent to which trends are captured is not achieved to the same degree.) In 2005, 83 percent of the measures in the report captured an out-turn against a mandated performance or an increase against a target figure established in a plan. Only one performance measure (2 percent) captured patient/citizen satisfaction.

Table 1. Total Number of Performance Plots Used in NHS Annual Reports December 2002–May 2005

<table>
<thead>
<tr>
<th>Year</th>
<th>2002 (December)</th>
<th>2003 (May)</th>
<th>2004 (May)</th>
<th>2005 (May)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>28</td>
<td>30</td>
<td>43</td>
<td>47</td>
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A technique employed by both the NHS and VA intersperses the performance
narrative with individual organizational success stories from around England and the United States. Both organizations try to humanize their performance narratives with what are sometimes called vignettes. For example, the NHS report of May 2005 contains a story box about Wallasey Heart Centre in a chapter dealing with health promotion. The story explains the partnership model developed, the services offered, and the claimed success rate of the project. The NHS has used similar vignettes since 2002, initially presenting a collection of such stories as a separate chapter in the report.

**Monopoly Rights on Telling the Story**

Closer inspection of the health services reporting space reveals stiff competition for the Chief Executive’s Annual Report to the NHS. In fact, in 2005 at least five other annual reports are readily identifiable as serious alternatives to the performance story presented by the chief executive. The competition consists of the Department of Health Annual Report, the Chief Medical Officers Annual Report, the NHS Modernisation Board Annual Report, the NHS Live Report, and the Department of Health Autumn Performance Report. (The reports can be accessed via the Department of Health Web site.) The Department of Health Report deals with broadly similar topics as the NHS Annual Report, sometimes using the same data. It does have a greater emphasis on describing financial allocations from the center to the NHS, which to some extent narrows its scope and provides differentiation from the NHS series. The most recent Chief Medical Officer’s Report is noticeably more selective in coverage. It concentrates on public health issues (e.g., tobacco use and obesity), health expenditure and inequalities, clinical safety, and a possible flu pandemic and also contains a chapter on a specific disease (kernicterus—a brain disease found in newborn babies). None of these topics could be said to be outside the typical scope of the NHS Annual Report. The NHS Modernisation Board Annual Reports presents an NHS performance story through reference to patient experiences, with markedly little resort to population-based data to support claims. NHS Live Reports utilize a similar style in concentrating on local programs designed to improve the patient experience. The 2005 Department of Health Autumn Performance Report is an annex of the December NHS Annual Report and is focused exclusively on eight Treasury-negotiated public service agreement targets.

<table>
<thead>
<tr>
<th>Captures patient/citizen satisfaction (%)</th>
<th>Captures outcome (%)</th>
<th>Captures process (%)</th>
<th>Captures trends (%)</th>
<th>Captures outcome against a target (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures ( n = 47 )</td>
<td>2</td>
<td>9</td>
<td>9</td>
<td>89</td>
</tr>
</tbody>
</table>
and associated productivity issues for the NHS. Although performance stories may be told very differently with different balances set between the use of textual-based and metrics-based narrative, there is considerable overlap in the scope of the five reports in question. The NHS report is the broadest in scope of those reviewed, but its status as the account of record must to some extent be undermined by the considerable overlap in the issues covered by other national reports.

Competition exists on a different level in the form of the Healthcare Commission Annual Report, which focuses on individual NHS provider units (hospitals or community care organizations referred to as trusts) and is notably judgmental in its approach, which is often based on rankings of some description. This may make the Healthcare Commission report more attractive to the UK media.

**Multiplot Stories**

We can determine from the growing number of performance measures used and events and policies described that the NHS report series has no fear of developing too many plots. Arguably, the NHS is a huge organization undergoing change and requiring a performance story that adds new plots on an annual basis, and evidence confirming a tendency to develop new performance plots is easy to find. The range of 28 performance plots (or measures) used in 2002 had increased to 47 by 2005. However, analysis of the content of the series reveals another potential narrative weakness also related to multiple plots. The NHS reports, like their VA counterparts, attempt to supplement performance measurements with explanations of how the organization has met challenges. These explanations are referred to as process plots. An example of a process plot is an explanation given as to how the NHS provided an outreach service to treat chemotherapy patients in the community. Typically the process plot describes an initiative that has been running in a particular locality. Sometimes it is clear that these are one-off or pilot schemes. A content analysis revealed that the May 2005 report presents a total of 52 such process plots, organized under five chapter headings labeled as follows:

- Quality Innovation and Reform
- Faster, More Convenient Services
- Becoming Patient-Led
- Health Promotion and Protection
- Value for Money.

The May 2004 report included 32 process plots organized under four chapter headings as follows:

- Local Treatment, Redesigned Services, and Reform
- Faster Services, Improved Outcomes
- Greater Capacity, Staff, Facilities, and Equipment
- Funding the Improvements and Productivity.

Table 3 shows how the number of separate process plots contained in the annual
reports has increased. Whereas 26 of the May 2004 plots were also employed in the May 2005 report, some 26 new process plots added. Inconsistent use of process plots was also evident in the December reports published in 2004 and 2005. The December 2004 report contained 62 process plots, whereas the December 2005 report used only 20 process plots. In each year a certain degree of overlap is evident between May and December reports in terms of process plots provided.

As compared to the VA reports, the reader of any of the individual NHS Chief Executive’s Reports has considerably more process plots to deal with and, consequently, a more complex task of comprehending the performance message. In 2005, there were more than 50 discrete process plots in the NHS reports, whereas the VA reports used around 30. In summary, if comprehension of performance stories is important in establishing reports as sources of legitimacy, then the complexity of presentation caused by the use of different chapter headings, along with the apparent lack of restraint in adding and removing process plots each time a report is written, may be further undermining the legitimizing impact of the report series. Empirical work involving the readers of the reports is needed to answer this question.

Serialization

Annual performance reports constitute a series. The narrative should exploit the readers’ interest in understanding how performance is developing on a year-by-year basis. Although basically the same set of around 40 performance indicators is used in the reports presented in the three most recent years, 2003 to 2005, the narrative benefits of serialization are lost due to the number of new plots introduced each year. The inconsistent chapter structure of the report series also means performance measures are not readily located in a specified chapter on an annual basis, which additionally weakens the serialization effect.

ANALYSIS OF THE VA REPORT SERIES

Title

The title of the VA annual report is Office of Budget Department of Veterans Affairs FY 2005 Performance and Accountability Report (U.S. Department of Veterans Affairs, 2005). The title, in containing a reference to the financial year, removes the doubts over status associated with the twice-yearly NHS reports reviewed. The title also conveys a message that this is a resource management–oriented report. The VA Office of Budget is described as the VA’s primary liaison with the Office

<table>
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<tr>
<th>Year</th>
<th>2002 (December)</th>
<th>2003 (May)</th>
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<tbody>
<tr>
<td>Number</td>
<td>38</td>
<td>29</td>
<td>32</td>
<td>52</td>
</tr>
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</table>

**Appearance**

The front cover of the 2005 report contains a highly stylized graphic featuring a group of wounded veterans positioned around a war memorial. The graphic used on the cover differs each year but always has military references. The presentation of the narrative itself displays a high degree of conformity to a VA house style in the years 2002 to 2005, with fonts, colors, and visual layout observably consistent. The reports consist of text, tables, charts, and diagrams. There are no explanatory footnotes, and the report series uses a number of photographs.

**Content**

The VA reports are considerably larger than the NHS reports, but it should be remembered that the reports deal with the organization’s performance across a range of services rather than just health. In marked contrast to the NHS series, a consistent four-part report structure has been maintained since 2004. The 2004 and 2005 reports, in terms of content, may have been influenced by an effort to emulate the reports issued by private corporations in accordance with the instructions set down by the Securities and Exchange Commission (SEC), the U.S. government agency that regulates the corporate governance of listed companies. Prior to 2004, the report was structured on the basis of about 27 separate chapters. A comprehensive table of contents is provided (roughly two to three pages of text per content item). Part I is titled “Management Discussion and Analysis” (the SEC requires companies to provide a “management discussion” in their annual reports) and attempts to rationalize the performance story through reference to the VA Mission, the mission-related basis of VA programs and system of measuring performance. It provides information on resources and management structure and a summary of the secretary’s agenda, including “performance shortfalls” and “financial highlights.” Part I also includes a performance overview and performance results by strategic goals. In this latter subsection, the importance of the narrative device of organizing the performance story content strictly in relation to VA strategic goals becomes evident. The scope of Part I was changed in 2005 to incorporate further performance data presented in tabular form. Another change to Part I in 2005 effectively turned it into a self-contained performance report in its own right, supported by supplementary detail contained in Parts II, III, and IV. The intended effect is to provide a more digestible performance summary for the reader and, at just under 100 pages, Part I delivers. A performance scorecard based on 24 key VA measures, also located in Part I each year, is another feature adding to ease of comprehension.

Part I also contains a record of progress in nine functional areas of management.
and a “faith-based community initiative” set out in the President’s Management Agenda (PMA).

Part II is based around performance summaries by departmental objective and consists of a measure-by-measure presentation of 130 VA-wide indicators. In this part of the report, a greater sense of the policy context in which performance is located is made apparent. This is achieved by providing a text-based narrative to accompany each objective and associated measures.

Part III comprises the financial section of the annual report and begins with a short letter from the chief financial officer, which establishes a second narrator presence (discussed further later). The section is written on the basis of technical accounting and management concepts, a series of consolidated financial statements, and statements on budgetary resources and financing. An independent auditor’s report is also included. The financial section provided each year constitutes roughly 20 percent of the annual report. The story is clearly “narrated” by professional accountants and aimed at a readership that understands public accounting practice. Additionally, since 2001, the annual reports contain responses to PMA issues and from 2004 have begun to report results of PART (Programme Assessment Rating Tool)-facilitated studies, which rate the effectiveness of selected elements of service (Moynihan, 2005). A scorecard based on a red/yellow/green traffic light system is provided in a dedicated PMA subsection of the financial section covering areas of management weakness identified by the federal Office of Management and Budget. The scorecard provides a easily comprehended set of performance plots with its stoplight ratings of performance status in specified management areas. The PMA list of management areas to be addressed in 2005 included human capital (yellow), competitive sourcing (red), financial management (red), e-government (red), budget and performance integration (red), real property (yellow), U.S. Department of Defense/VA integration (yellow), research and development investment criteria (yellow), improper payments (yellow), and faith-based initiatives (yellow). An arrow shows whether status has improved, declined, or remained constant since the previous year. Management-initiated progress from the previous year’s position is rated in exactly the same way. (Note the PMA performance plots are not been counted in Tables 3 through 5, because they apply to the VA as a whole rather than the VHA). In regard to PART, the VA annual report in 2005 contains a subsection recording the references to nine separate PART evaluations, including the medical program that had been given a “Results Not Demonstrated” rating in 2004. In 2005 the report recorded an improved rating of “Adequate.” The financial section enhances the annual report series status on the basis of its alignment with standard accounting and audit practices and articulation with PMA and PART initiatives. External validation of this type, although available, is a source of authority that the NHS annual reports do not attempt to draw on.

Part IV provides a list of definitions, abbreviations and acronyms, key officials, and,
in 2005, a summary of the Improper Payments Act of 2002. The VA reports have not grown in size at the same rate as their NHS counterparts. Whereas the NHS reports grew by 150 percent in page length between 2002 and 2005, the VA reports exhibit a more modest growth rate of 29 percent (255 pages in 2002 and 329 in 2005).

Claimed Audience

The report is addressed to the president of the United States, the president of the Senate, and the Speaker of the House of Representatives. As is the case with the NHS, the report series is clearly written for an audience of politicians and media commentators. Whereas the NHS narrative sometimes suggests it is intended to be patient accessible, the VA narrative is definitely not directed at the veterans themselves, although veterans’ advocacy groups are likely to be considered part of the readership.

Language

The VA is an organization in its own right but one that has a close association with the military. The initial suggestion of military roots, conveyed through certain examples of the language employed, is reinforced by the references in the text to military action in Iraq and Afghanistan. However, to claim that the VA report employs a military language pattern would be an exaggeration. More accurately, the report series is written in administrative American English, which, in turn, is distinguished from UK public service reporting by a tendency to state strategic goals, objectives, and measures in short, staccato sets of words. Scrutiny of the VA report series reveals an inclination to write in the present tense, conveying a sense of action. For example:

VA continues to set the national standard of excellence in quality and patient safety for the health care industry. Interactive technology strategies are being implemented to provide care in the least restrictive environments to allow patients and families maximum participation in disease management and health maintenance. (U.S. Department of Veterans Affairs, 2005, p. 26)

An assertive tone is denoted by the frequent use of the phrase “we will.” Notably, few abstract nouns (e.g., “partnership”) that are used frequently in the NHS report are used in the VA report. The significance of language on the impact of the report series as a source of legitimization requires further examination with reference to the reactions of different types of readers. A content analysis of the VA series failed to detect examples of the acknowledgment of “failings” comparable with the references to long waiting times in the NHS series.

Narrator Perspective

The secretary of veterans affairs, R. James Nicholson, is the main “narrator,” providing the cover letter for the annual report. The resource management orientation of the report series is emphasized further by the introduction of a second
narrator in the form of the chief financial officer’s letter of introduction to the financial section of the report. In his letter there is no acknowledgement of the type of policy implementation stories featured in the NHS narrative, which, through reference to plans, time scales, progress, and obstacles, tacitly acknowledges a struggle to enact change. Whereas the NHS reports use abundant text to discuss performance, the VA reports typically do not, allowing objectives and measures to be read on their own. Also, whereas the NHS chief executive preface provides a sense of personal engagement with policy implementation and reaction to specific issues, the VA secretary is more assertive in listing quantifiable achievements. A degree of patriotic solidarity with the U.S. military is also conveyed in the letter. The narrator tone intended appears to be one of qualified satisfaction with the VA progress against precisely understood targets.

**Narrative Structure**

The VHA is dealt with as an integral part of an annual performance report that discusses all VA programs, including pensions, reentry into civilian life, disability compensation, education support, home purchase and retention, insurance, and burials. Constructing such a wide-ranging annual report represents a major narrative challenge. An obvious solution in presentational terms would have been to devote separate chapters to each of the major VA programs. Instead, a much more complex narrative is attempted whereby the VHA performance story is integrated with other VA program stories. On the face of it, this seems an unwieldy means of presenting a performance story, with health pensions, educational programs, and other programs all dealt with together. This conclusion, however, would ignore the compelling impact of a narrative structure tightly organized around the VA’s four strategic goals (SGs): SG1—Restoration and Improved Quality of Life for Disabled Veterans, SG2—Smooth Transition to Civilian Life, SG3, Honoring, Serving, and Memorializing Veterans, and SG4—Contributing to the Nation’s Well-Being. SGs, it is implied, are derived from the VA mission. The VA mission statement is itself a quote from Abraham Lincoln: “To care for him who shall have borne the battle, and for his widow, and his orphan.” The casual reader might think the strategic goals were also written by Abraham Lincoln himself, given the sense of status, authority, and dignity they are accorded in the reports. In contrast to the NHS, the VA employs a highly disciplined narrative scheme in which all performance measures are associated with particular strategic goals and objectives. Furthermore, the VA reports contain full explanations of the core system of performance measurement employed, presumably further strengthening the sense of integrity associated with the series.

In comparison with the NHS report, there is generally less text used in constructing the narrative. The structure of the self-contained Part I is, in particular, more heavily reliant on tables and numbers. A certain sense of precision and
control is always associated with stories expressed in terms of percentages and numbers. This is emphasized by the five-year time series that is used to demonstrate progress, by the data provided to link an activity to a financial obligation, and by the calculations made as to the percentage of total VA resources consumed by an activity. The report is, to be precise, published by the VA Office of Budget rather than the VA as a whole, perhaps explaining the intention to emphasize the cost of activities.

The narrative is, in each of the years reviewed, structured around a hierarchical performance measurement system: four strategic goals, supported in 2005 by 21 strategic objectives that were in turn sustained by 130 performance measures/associated targets, some 24 of which are designated “mission critical.” A content analysis showed that 5 of the 21 objectives were health related, and, of the 130 measures, 29 were health services related in 2005. The performance narrative develops around a performance sequence that cascades down through mission, goals, objectives, and measures. Each performance measure is associated with a specific SG and objective. Of the 29 health-related measures, 13 were used in relation to five objectives in the 2005 Department Level Summary presented in Part I.

As can be seen in Table 4, the VA has a tendency to add new performance plots on an annual basis, although at a more modest rate than the NHS, which doubled its range of performance plots over the same period.

The Department Level Summary is a device that allows for a digestible number of performance measures to be selected for presentation to the audience. The NHS report series does not attempt to identify key measures that it wishes to emphasize in this way. In this scheme the health services performance of the VHA is accounted for as follows:

- SG1: Restoration and Improved Quality of Life for Disabled Veterans: one health service–related objective (specialized health services) supported by two measures (scores on a prevention index and progress with community support).
- SG 2: Smooth Transition to Civilian Life: one health service–related objective (reentry into civilian life) and two supporting health service–related measures (percentage of VA Medical Centers contracted to serve as TRICARE network providers and the development of two implementation guides for health care informatics).
- SG 3: Honoring, Serving, and Memorializing Veterans: one health service–related
objective (delivering health care) supported by seven measures (a clinical practice guidelines index, a prevention index, timeliness of primary care appointments, timeliness of specialty care appointments, patient satisfaction with inpatient treatment, patient satisfaction with outpatient treatment, access to noninstitutional care within VHA programs).

- SG 4: Contributing to the Nation’s Well-Being: two health service–related objectives (medical research and development and academic partnerships) supported by two measures (number of peer-reviewed publications and continued satisfaction of medical residents and other trainees).

The bulk of the health services measures, therefore, relate to SG3, which is concerned with Honoring, Serving, and Memorializing Veterans. All seven performance measures are used to support Objective 3.1:

> Provide high-quality, reliable, accessible, timely, and effective health care that maximizes the health and functional status for all enrolled veterans with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care. (U.S. Department of Veterans Affairs, 2005, p. 26)

The brief narrative explanation of strategic goals expresses confidence in the VA's role in setting national standards of excellence in quality and safety in the health care industry and the development of veteran-focused care systems and technology strategies (Annual Report 2005, Part I, p. 26). The intention to convey an impression that the operational performance measures used equate naturally with mission-derived strategic goals never wavers throughout the series. This is an important narrative ploy in the VA series.

In comparison with the NHS, the VHA performance story is told through a smaller number of performance measures. It is likely that the circumstances whereby the VHA's health services only “share” part of the VA performance story in the annual reports impose a discipline over the ability of contributors to refer to more than a certain number of performance measures.

Based on the 2005 report, Table 5 presents an analysis of the attributes of the 13 performance measures used in the Department Level Summary. This data set is chosen on the basis that the narrative structure is intended to emphasize this particular set of measures. As can be seen, the bulk of performance measures (77 percent) capture aspects of process. However, in comparison to the NHS, the VA range of performance measures is proportionately more outcome oriented (23 percent as opposed to 9 percent). The performance measures capture trends, with 84 percent of the measures used in 2005 presented along with at least one previous year’s performance. In 2005, 77 percent of the measures in the report captured an out-turn against a mandated performance target or increase against a figure established in a plan. Significantly more performance measures in the VA report succeed in capturing patient/citizen satisfaction (23 percent) than is the case with the NHS (2 percent).

Whereas both the NHS and the VA employ personalized story boxes to bring
humanity and local connections to the performance story, the VA is also prepared to use individual patients in its vignettes. For example, in 2005, the swift recovery of a Marine Corps corporal of British origin, facilitated by VHA staff, is featured. The vignette records the corporal, seriously injured in Iraq and barely able to speak on return to the VHA Medical Center at Palo Alto, California, recovering the ability to speak freely at his citizenship swearing-in ceremony.

**Monopoly Rights on the Story**

In comparison with the NHS, the VA annual report series has a relatively clear field in which to make an impact. No significant other “whole-service” report existed in 2005 to challenge the Office of Budget Department of Veterans Affairs FY 2005 Performance and Accountability Report as the account of record. As acknowledged previously, partial-service reports dealing with a particular part of the VHA operation might provide a lesser degree of competition.

**Multiplot Stories**

The VA typically uses about 30 health services performance measures in its annual reports. (Examples provided are drawn from the Departmental Level Summary.) If a performance measure can be taken to indicate a performance plot, then, compared with the NHS with around 50 performance plots, the VA has in this respect created a less complicated narrative. This conclusion is reinforced by the disinclination on the part of the VA to refer to as many events and initiatives as the NHS does in its reports. The VA also adopts a more disciplined approach to process plots. The VA reports, like their NHS equivalents, include a number of process plots, explanations of how problems have been solved or identified for action. Analyses indicate that the annual reports contain about 30 process plots each year. As explained previously, the scope of Part I (Management Discussion and Analysis) of the annual report was changed in 2004 to incorporate selected performance data in a tabulated form; further additions in 2005 effectively created a self-contained performance report supported by supplementary statistical and narrative detail contained in Part II (Performance Section). The following observations are made in regard to the 2005 style of report.

Whereas the NHS reports fail to manage process plots according to a recogniz-
able scheme, the VA has a clearly defined strategic goal/objective-based system for organizing process plots, or what it refers to as “management challenges.”

Part II contains a subsection containing detailed information on management challenges associated with particular strategic objectives. The management challenges are specified in lists provided by two separate inspectorates—the VA Office of Inspector General (OIG) and the Government Accountability Office (GAO). In 2005 the OIG identified the following areas as management challenges: part-time physician time and attendance, staffing guidelines, quality management, long-term health care, security, and safety.

The GAO produced the following list in 2005: access to acute care, long-term care, and specialized health care services; patient safety; management of resources and workload to enhance health care delivery; resources and workload management; VA/U.S. Department of Defense efficiencies.

Initially the management challenges are presented in note form alongside bar charts recording out-turns against strategic objectives. The management challenges are then in a separate chapter compiled in a tabular form. A further chapter contains a table with VA responses and explanation as to how the problems identified will be tackled. An overall presentation of the performance plot is then delivered in the chapter titled “Complete Narrative.”

The VA and NHS approaches to describing the management achievements and challenges are markedly different. Whereas the NHS annual reports contain a large number of process plots with no obvious explanation as to why they have been included, the VA selects, orders, and develops its process plots according to a system based on a hierarchy of strategic levels and demonstrates the importance of specified challenges through reference to the inspections carried out by its own OIG and the externally positioned GAO. Based on the OIG and GAO lists of management challenges, Table 6 shows that the VA is more disciplined in attempting to include process plots in its annual reports when compared to the NHS, which attempted to use more than 50 plots in 2005. The significance of different approaches to managing the number of plots employed is an issue that should be examined in relation to the impact that performance stories have on their readers.

**Serialization**

As can be deduced from the preceding discussion, the VA report series has a stronger sense of serialization than its NHS counterpart. This is related to the sense of permanency implied in relation to strategic goals, objectives, and measures. An element of illusion may be at work. Whereas trend data is included in 77 percent of the performance measures used in 2005 Department Level Summary, only seven of the measures featured in the equivalent Department Level Summary in 2003. (One measure moved from SG3 in 2003 to SG1 in 2005.)
Using a Narrative Analysis Framework

The framework used in the study was required to provide appropriate analytic guidance in dealing with two distinct organizations and their annual reports operating in different political systems. In this respect it proved successful, and a similar analysis could be repeated on reports from different organizations. The ability to replicate an analytic process is an important indicator of the appropriateness of a research method. The research involved a sequence of steps that could be repeated when each of the eight reports was examined. Adherence to a workable analytic framework made it easier to analyze complex performance stories in terms of a predetermined schedule of observation and judgment. A less structured approach would have undermined the potential to replicate the study. The approach that was followed allowed for a relatively seamless combination of qualitative interpretation and enumeration. This added to the depth of the analysis conducted. The analytic process in narrative research is best carried out by a single researcher or a closely synchronized team who can be trusted to make the same consistent judgments when faced with potentially ambiguous material. It was possible for the author to review and analyze all the reports without assistance. Another methodological feature of the study was comparison. Without the process of organizational and international comparison, it would have been difficult to gain a sense of perspective regarding key technical characteristics that define the telling of performance stories in annual reports.

Conclusions

The performance stories of the NHS and VA/VHA are constructed very differently. On the basis of the comparison conducted, it is pertinent to ask “what works best” when public organizations try to tell their performance stories in the form of annual reports. This is an interesting problem to address. Contextual factors cannot be readily dismissed, so although the type of narrative developed in the NHS series may undermine efforts to create a sense of achievement, it is also possible that the NHS reports actually reflect the sheer scale of difficulties in both achieving change and measuring change in a £76 billion organization. Weaknesses in the narrative might also be attributable to the propensity of government in the United Kingdom to continually enact reforms rather than allowing changes to take root in the NHS.
The extent to which the VA annual reports enjoy monopoly rights on the telling of the performance story, it has been argued, is also an important contextual factor boosting their status as a source of legitimacy for the organization.

Tactical choices may also have major consequences for the success of the performance story. For example, it can be noted that the VA is prepared to urge its audience to “celebrate” perceived success in developing a performance management system. By contrast, the NHS appears to avoid discussing the clinical governance system or in more general terms explain how it measures performance. Perhaps the performance management system is seen as flawed by senior NHS managers. Alternately, the NHS Chief Executive has been constrained in narrative terms by a need to “keep quiet” about the amount of effort that goes into performance management. (Reducing the cost of regulation is actually listed as an objective in 2005.) This would not surprise health policy observers in the United Kingdom, where it is widely assumed that the public and the clinical staff employed by the NHS will be dismissive of health services management initiatives in general. Therefore a billion-pound program such as clinical governance may well be treated as something best ignored in public communications wherever possible. Celebration of performance management is not yet seen as a viable source of legitimacy for the NHS.

The striking contrast between the VA annual report series, anchored as it is in externally audited financial statements and responses to national performance initiatives (PMA and PART) and the complete absence of financial statements in the NHS series, must have consequences in terms of the levels of credibility and trust generated around the respective reports. Another factor that emerges through the process of comparison is the lack of a clear external benchmark competitor in the case of the NHS. Health services are largely monopolized by the NHS in the United Kingdom. In sharp contrast, the VHA is in performance terms linked to competitive relationships with many different alternative providers of health services in the United States. The current VHA is confident enough to describe itself as a benchmark provider in terms of cost per patient, patient satisfaction, performance improvement, quality in disease prevention, and treatment clinical informatics (Kizer, Demakis, & Feussner, 2004). We can assume that a certain legitimacy flows from such external comparisons.

When considering the possibility of unintended effects created by the annual reports examined, the process of comparison suggests several weaknesses in the NHS annual reports as sources of legitimacy. Whether intentionally, and in spite of its efforts to list many achievements, the NHS annual report series will to many observers read as an implementation narrative. This is, in part, a consequence of the narrator position adopted by the chief executive, the failure to eliminate references to chronic problems with waiting times, and the lack of apparent discipline in limiting the number of process plots developed around service initiatives. By
comparison the VA series is tightly constructed around a more limited and stable set of performance plots and well-argued process plots. There is consequently less likelihood of unintended effects occurring such as the undermining of organizational identity, masking too many performance claims, unsubstantiated performance claims, or unduly complex performance explanations.

Concentrating on the annual report narratives themselves, we find a number of key differences. For example, does the lack of a standard set of contents undermine the authority of the annual report series? Alternately, does a rigid adherence to a standard set of performance plots cause readers of the reports to lose interest? Does the number of plots developed to tell the performance story have consequences for the legitimizing impact of a performance story? Does the ability to “serialize” the performance story around a set of performance plots make a difference to the strength of the reports’ contribution to organizational legitimacy? The most recent VA reports look to be influenced by an attempt to emulate the report format prescribed by the U.S. SEC for private-sector corporations. By contrast, the NHS report writers appear to have considerable creative license in terms of content and structure. Is this significant in developing a narrative as a source of legitimacy? Marked differences in the language employed by the two organizations were also evident; whereas the VA appears to favor linguistic brevity, the NHS writers are allowed to be more expansive in a bid to engage the reader.

Both organizations track Web site hits from people accessing the reports online; they also monitor newspaper and television coverage closely. Regular changes in structure and format suggest that both the VA and NHS are conscious of the impact made by compositional features of the reports. Although both organizations closely monitor media and public reaction to the publication of performance data, they do not have a formal system for measuring the impact of narrative construction on the readers of annual reports. This is not surprising, although there is technically at least the prospect of developing a readability index based on how easily performance stories are understood by key members of the target audiences. Researchers in communications have made considerable progress in determining the readability level of a passage by examining word difficulty and sentence length. There are a number of examples of research that has employed such techniques in relation to reports produced by private-sector corporations (Jameson, 2000; Subramanian, 1993; Thomas, 1997). A convincing means for calculating the difficulty a reader has in reading and understanding a paragraph, section, or entire annual report may be developed at some point in the future. However, readability scores are acknowledged to measure only the surface characteristics of a text—semantic characteristics relating to words used and syntactic characteristics as defined by the length or structure of sentences (Stevens & Stevens, 1992). In evaluating how well the reader understands ideas, there is also the issue of the cohesiveness of annual report texts, which communications researchers have failed to account
for in relation to readability. An annual report might be made more cohesive by changing its format rather than its writing style (e.g., type styles, layout, design, and use of graphics). There is also the interaction that takes place between a reader with unknown cognitive capacities and the text itself to be considered. Although text characteristics can be measured using a software package, such tools cannot cope with the context of the communication in the sense of allowing for the readers’ differing cognitive abilities and levels of interest in the material. Arguably, reports of the type examined are aimed at a fairly homogeneous, well-educated, issue-informed, technically sophisticated reader, which may reduce the problem of varied cognitive capacity. In developing a readability index for annual reports or other related performance documents, experiments might be conducted with volunteer readers drawn from the media and political worlds. Another possibility would be to “screen test” actual documents with selected readers. In practice, recruitment difficulties would need to be negotiated along with certain ethical considerations that would be apparent to media volunteers. Instead, the best alternative in discovering how well performance stories are told in annual reports is likely to involve a post-publication impact survey analysis with a carefully chosen sample of readers. As it stands, there is a strong possibility that performance stories do not make the intended impact on politicians, the media, and the public.

References


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