FINDING THE UNSEEN, LISTENING TO THE UNHEARD: USING PRIMARY SOURCES FOR RESEARCH IN THE NEW ZEALAND HEALTH SECTOR

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Abstract

The purpose of this paper is to describe and discuss a research project on policy and structural change in the New Zealand health sector (ca. 1986-). The project compiled primary and secondary documents, and interviews of key informants. The methods used to locate and access material, and the extent of the material found and recorded is described. The usefulness of the sources, the efficient use of project resources and the prioritising of research methods are discussed. Examples of the matching of documentary and interview information are given. The paper concludes that qualitative scoping in the initial stages of policy research is crucial. The extent of accessible material in this research area means that selective focus is essential. The role of the interviewer in uncovering oral information can be a major element in the success of a project. There is a tension between selecting interviewees for insider information and for their view of policy effects.

INTRODUCTION

Since the mid-1980s, the New Zealand health sector has been in a state of continual transition. The transition began with the passage of the *Area Health Boards Act 1983.* In the late-1980s, changes in organisation and financial management were required as part of the fourth Labour government's state sector reforms. The health system was then completely reconfigured under the National government's "health reforms", the implementation of which commenced in 1991. The Health and Disability Services Act

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1993 enabled the new market-oriented purchasing and delivery structures, although modifications to the system and the way in which services were configured and delivered continued beyond this point. Following the 1996 election, the health reforms were "re-reformed" with the combining of the four purchasing regional health authorities into one centralised purchaser, the Health Funding Authority. The system is again undergoing fundamental restructuring under the Labour-Alliance coalition government formed at the 1999 election.

As numerous aspects of this transition remained under-researched, the New Zealand Health Sector Transition Project (HSTP) was initiated in 1998 by the authors of this paper.[2] In particular, there had been only limited research into:

- the processes and origins of change;
- policy choices, the changing shape of the sector, and the effects of this on constituent agencies and stakeholder groups;
- perceptions of change and change processes; and
- the impact on relationships within the health sector.

The central purpose of the HSTP was, therefore, to research policy and structural change in the health sector both historically, covering prior restructurings, and as developments emerged. Of primary interest were the processes of change and the events leading up to and from crucial changes. The project explored a spectrum of policy areas: central agencies and local service provision arrangements, urban and rural provision, primary and secondary care, personal and public health, and so forth.

The HSTP sought to collect a wide range of paper documentation for subsequent analysis, and emphasis was given to material from primary sources. Primary sources were defined as those where an editorial process or mediation had not modified the author or speaker's voice. While the primary documents sought were generally unpublished, some published material such as the "Stent Report" (Health and Disability Commissioner 1998) and other official and unofficial papers were also regarded as primary documents in themselves. The document search was followed by interviews with a number of participants and close observers of policy formation and implementation processes, generally at the central government level.

Several researchers in the area of New Zealand health sector change have used similar combinations of documentary and oral sources (e.g. Malcolm and Barnett 1996, Ashton

[2] The HSTP was initially funded in 1998, and again in 2000, by the University of Otago. The research was conducted by one half-time Research Fellow and an academic staff member of the University dedicated 20% of the time to the Project. The HSTP has produced a variety of publications, and others are currently in different stages of development (e.g. Gauld 1999, Gauld 2000). A book (Gauld 2001) drawing on HSTP research has been published, also.

1998, Jacobs and Barnett 2000). Others have used statistics (Brown 1999), and survey methods (Perkins et al. 1995, Donelan et al. 1999). However, it is difficult to establish the extent to which primary sources have been used in other studies. Of the over 200 journal articles and book chapters relating to aspects of the New Zealand health sector changes in the transition period, most are largely descriptive, or appear only to use published and secondary sources. Many of the articles do not describe their methodology, and are commentaries rather than research reports.

This article reports on the experience of gathering primary sources for research on health policy and health sector changes in New Zealand. It describes some of the work of the HSTP, including the process of locating and obtaining documents and the ways in which interviews were organised. Some examples of the sorts of material gathered are given. With the benefit of hindsight, we offer comments on the approach taken by the HSTP, the various sources of information elicited, and the implications for researchers and policy makers.

GETTING GOING WITH SECONDARY SOURCES

Prior to searching for primary documents and finding suitable interviewees, the HSTP explored secondary material for issues, context and the names of potential interviewees. A literature search was conducted using several electronic databases, including Medline, Index New Zealand (serials), the New Zealand National Library catalogue, and the New Zealand Bibliographic Index (generally non-serials). The most productive search words were "health reform(s)" and "restructuring". Over 200 relevant articles, and a number of books and book chapters were found. Among the problems health policy researchers must confront is the fact that many occasional and annual reports by government agencies and other health sector groups are not listed in any of the common referencing services. In recognition of this, efforts were also made to locate "gray" literature – material produced by government departments and other organisations that is available to the public but not deposited with the National Library. Approaches to relevant agencies for the catalogues of their publications went some way toward filling this gap.

The Ministry of Health operates a computer database that enables searches for New Zealand newspaper articles of relevance to the health sector printed since 1990. However, the Ministry's own newspaper clipping collection only dates back to 1993, meaning that pre-1993 articles need to be retrieved from alternative sources such as newspaper publishers' archives. The Ministry's clippings are an excellent source of information on health sector change and of quotations from health sector figures, the search for which would otherwise be more labour intensive. Moreover, the clippings can be used to build a nationwide picture derived from the perspectives and experiences of different regions. This national picture often receives only limited

attention in major metropolitan newspapers. The clipping collection proved valuable to the HSTP as a starting point for searching in government files, giving relevant dates, names and places for particular developments. *Literature Sources for Health Services Research,* by Nelson and Norris (1997) was also useful.

PRIMARY DOCUMENTARY SOURCES

In New Zealand, since 1982, access to the documentation of most public bodies has (in theory at least) been open through the existence of the Official Information Act 1982. The official constraints upon open access are those of cost ("reasonable" costs for items such as search time and photocopying can be charged to requestors), commercial sensitivity, personal privacy and "the effective conduct of public affairs". The unofficial constraints include finding the specific documents that will answer the questions posed. As described below, this can be an exhaustive process. In some cases, obtaining the active cooperation of the agencies concerned can also be a constraint.

Agency File Catalogues

The HSTP's efforts in accessing official information were made much easier by the work of two independent policy researchers who had previously negotiated access to Ministry of Health archives. The precedent they created and their advice on which files might provide the most relevant information simplified processes. In short, consulting other researchers or those with a knowledge of records and policy developments is often crucial.

The HSTP targeted nearly all agencies with an interest in health policy and sector change operating at a national level, including, for example, the Department of the Prime Minister and Cabinet, the Ministry of Health, Treasury, the State Services Commission, the New Zealand Nurses Organisation, and the New Zealand Public Service Association. It soon became apparent that the extent of the documentation obtainable meant that, within the resources available for the 1998 phase of the HSTP, the scoping of the documentary material became a priority. So that we could establish the priorities for the future extraction and use of documents, we needed to know the extent and types of material available, and the difficulties in finding material relating to specific policy areas.

The main method used for this scoping was to request relevant parts of each organisation's file catalogue. Of the 25 public and private bodies approached by the HSTP, 17 provided some form of file catalogue. These ranged from listings of nine files to over 1,000, for a total of over 6,000 named files. Ideally, researchers need to negotiate access to an agency's electronic file catalogue, and then conduct or help to conduct searches for relevant files, using a range of search words. The HSTP achieved this in

three cases. In one agency, an initial 120 files were suggested by the agency as relevant for the project. However, from a search of the agency's electronic catalogue, a further 1,000 titles were found that appeared to be pertinent.

In addition to the public and non-government agencies approached, searches were made at the National Archives (for official records) and the Alexander Turnbull Library (for private papers such as those deposited by former Cabinet Ministers). Researchers should be aware that it can require considerable skill and experience to effectively use the National Archive's manual catalogues. The good news is that an electronic database is under construction. Over 1,000 relevant files were found in the National Archives catalogues. However, as these files were from one agency, this only scratched the surface of the potential material. Alexander Turnbull holdings are listed on a searchable electronic catalogue, and it required only a few hours to get printouts on 34 likely groups of files.

As well as scoping file catalogues, requests were made to selected agencies for specific files. The files were viewed by HSTP staff to determine whether they were relevant, and over 3,900 pages were eventually obtained.

In requesting and viewing files, priority was given to briefing papers for Cabinet or Cabinet committees, radio transcripts, and some electronic mail printouts. The latter are often succinct and candid, yet represent a small fraction of the amount of documentation now held only in electronic form. Access to this data, and the fact that many such records are deleted, is a concern to policy researchers (Hutt and Howden-Chapman 1998:147-8). It must also be of concern to policy makers who are no longer able to access the complete documentation which officials once delivered to agency archives.

Radio transcripts, particularly those from Radio New Zealand, often offer the only record of the unedited words of policy makers. Such transcripts compare well with Hansard records of Parliamentary questions and debates as accounts of official policy under scrutiny. Cabinet briefing papers can be a particularly useful source of information as they will often summarise issues and debates and lay out options for the consideration of Ministers. The main problem with Cabinet papers is locating relevant material from the different headings under which they may have been filed.

Since 1998, when the HSTP commenced, the extent of official and other documentation available from internet websites has greatly increased. One gateway to this material is through the website www.govt.nz, which has a document search facility. Web access to Hansard records is also available.[3] However, while valuable, only a tiny fraction of

[3] At http://www.knowledge-basket.co.nz/gpprint/hansard.html

the most valuable material for policy research is issued electronically. Website documents tend not to be those which policy researchers place priority on, such as background papers and advice to Ministers and Cabinet. Historical material which can be pieced together to provide a picture of how issues and changes developed also may not be available on such sites. This said, the Labour-Alliance government has made a point of releasing background information on its health reforms, most of which is available via the aforementioned website.[4]

Interview Research

As noted, the HSTP was interested in the perceptions of policy change and, for this reason, conducted a series of interviews. We initially compiled a list of over 200 people likely to be good sources of information on the history and processes of health sector change. Selection criteria included the length of experience within the sector, unique viewpoint, and proximity to information and change processes. We gathered the names of potential interviewees from government directories and other publications, and through personal communication. Our inquiries through the process of interviews added another 100 names.

From the list, we selected and located 34 potential interviewees, of which 32 were contacted, 27 interviews arranged, and 24 interviews conducted from July to September 1998. We sent initial contact letters, which were followed by a phone call and confirmation letter. Interviewees were offered a veto over the subsequent use of statements. The tape-recorded, semi-structured interviews averaged 50-60 minutes. All interviewees had been involved in making health policy, either as advocates or as officials. Twenty-two had worked at some stage as officials and, of these, 20 interviewees had worked at a national level. Interviewee experience in the health sector during 1986-98 ranged from six years or more (five interviewees), to ten years or more (six), and all of the period (13 interviewees). While service in the Department/Ministry of Health or another government health agency was a common thread for many (16), some interviewees also had experience in other departments such as Treasury (three), as well as outside of the public service.

The initial approach to the transcribed interviews, which contained over 300,000 words, was to extract passages germane to particular themes. The extraction process included categorising extracts and piecing together the perspectives of different interviewees around various events. As the initial use of the material will be anonymous, it also involved removing elements that might reveal the identity of interviewees.

[4] Other sites worth checking are those of the Minister of Health: www.executive.govt.nz/minister/king and the Ministry of Health: www.moh.govt.nz

In general, the interviewees' responses were candid and considered. To date, around 60,000 words relevant to the work of the HSTP have been extracted from the transcripts. This indicates the availability of a large resource of material that could be used by those interested in health sector change.[5]

EXAMPLES OF DOCUMENTARY AND INTERVIEW MATERIAL

Interview material can be compared with published statements on the same topic, as a check for the consistency of argument or emerging trends and themes. Below are examples of extracts from published and interview materials gathered by the HSTP. The extracts relate to some of the motives for, processes of and reaction to the move of management ideas and practices into the New Zealand health sector.

The perceived lack of concern by health professionals with costs appears to have been a large factor in the changes from 1991.

> "In 1991 the major message was that 'these people have no idea of how much money they are spending, or no accountability for how they are spending it, they can't be trusted, they need to be managed', and that I think was one of the major drivers of the reforms." (Official B)

This statement can be seen in the light of published comments on "professional capture" which continued after 1991. The chairman of the Midland Regional Health Authority was reported in 1994 as seeing:

> Resistance to the reforms stemming largely from two factors: the fear among New Zealand communities that something vital is being taken away, and the fear among health professionals that they are losing control of a domain that had been theirs to rule...(described) as "professional capture" – a health system controlled by health professionals who want to hold on to a tradition in which "they feel most comfortable operating". (Robson 1994)

In 1996, Dr Brent Layton, Chairman of the Canterbury Health CHE and, until 1996, the chairman of the Crown Health Association (the association of the CHEs), was reported as saying that:

> The CHE labour market is highly restrictive. Arguments about clinical issues are used for job protection...Doctors and nurses have a ready weapon with patient safety. (Slater 1996)

[5] A source book of "quotable quotes" is currently in production.

The anti-competitive aspects of health professional regulation continued to be of concern. In 1997, Professor David Stewart (Assistant Vice Chancellor, Division of Health Sciences, University of Otago, Chairman of the 1992 Advisory Group on Funding of Clinical Training to the Health Reforms Directorate, and Member of the 1992 National Interim Provider Board) suggested that it was necessary to abolish all present registration and licensing, and make health purchasers, employers or indemnity insurers responsible for certification (Stewart 1997). At the same forum, Roger Kerr suggested that:

> The benefits from a reduction in industry-specific regulation in other sectors of the economy highlight the merit of greater reliance on market incentives to advance the interests of consumers. (Kerr 1997)

In contrast, Dr Alister Scott of the New Zealand Medical Council considered that:

> It seems limiting in the extreme to undertake a purely economic analysis of the impact of occupational regulation in the health sector, and to view regulation as simply to do with applying a correction to asymmetry of information in a market, dealing with externalities, and responding to limitations of supply. Regulation should be as much or more to do with quality and achieving social objectives. (Scott 1997)

The "professional capture" view contrasts with a belief in cooperation. The appointment in the later 1980s, of non-health-professionals to manage health services, soon led to a realisation of the need for a collaborative approach. By 1990 the change to general management within public health services had produced a situation where:

> The need for a partnership approach to health management decisions is likely to remain an important issue for some time to come. To reach a situation where managers and health professionals share agreed goals and objectives will require multi-faceted strategies. If effective strategies are not developed there is likely to be a negative impact on health care standards, the quality of health service decisions, and retention of health professionals. (Department of Health 1990b)

The Department of Health's advice to the incoming government in 1990 pointed out that for the Area Health Boards:

> Virtually all general managers come from a non-medical background, and tensions exist between board management and the senior clinicians. (Department of Health 1990a)

One of the more persistent views we found, in interviewing advisers and officials about the period, was the idea that any form of cost containment requires cooperation from health professionals.

> "When we moved to the Area Health Board structure, the notion of professional capture was there. The Board didn't want to talk to the staff. So the general managers had the rider from the powers to be at the time, that you put in a general management paradigm to control. This was coming from government level. After about two years, the general managers came and saw us. And said, 'We know we haven't talked to you, but we need a strategic plan. We don't understand the business, we can't do it. We need you to do it.'" (Adviser K)

The changes during 1986-91 were seen by one senior clinician as resulting in an excessive emphasis on monitoring health staff performance.

> This is management by mistrust, and the price will be less resources for patients, and more going into dubious management practices. (Crawford 1991)

With the changes to primary care planned in 1992, which entailed contracting between doctors and regional health authorities, a doctor was reported as saying that:

> More and more of the positions in hospitals are managerial positions, and medical and nursing staff who actually carry out the work are becoming less. ...The power given to managerial staff is creating major problems. For instance the managerial staff (in a hospital) prepared a list of work which they expected to be carried out by each surgeon. The surgeons were not consulted...the lists were total nonsense and incapable of being achieved. (Kyd 1992)

However the then Minister of Health considered that:

> The changes to the health system are not based on a simple managerial approach with emphasis on the cost of procedures. (Upton 1992)

By early 1993 a newspaper editorial said that:

> There are perceptions that the new reforms will mean...services run in the main by hugely overpaid bureaucrats working with Government-appointed crown health enterprise boards, whose membership will be dominated by

> successful business people with only a minority of members with medical expertise. (Editor 1993)

In 1996, a doctor wrote to the Minister of Health about:

> The loss of the collaborative approach that we had as professionals until the last three or four years. Because of the shift in emphasis to the new marketing and competitive ethos...consumerism is rife in the health area. (1996)

The Ministry of Health, in its 1996 briefing to the incoming Minister, bluntly stated that, after at least seven years of the general management model for hospitals, and three years of the CHE system:

> There is lack of support among the public and clinicians...for the role of managers within the publicly owned providers – the CHEs. (Ministry of Health 1996:6)

The reaction by some at the official and political level was a call for a more collaborative approach by management (Coalition Government 1997). The Steering Group on the 1996 government coalition health agreement wrote:

> We are concerned that some health professionals feel alienated by business management and CHEs' commercial objectives...Crown-owned providers should also seek to increase health professionals' participation in (the) managing of the organisation. This means more involvement in contracting, planning and day-to-day management of services. At the same time, health professionals must recognise the importance of management. The need for management skills will grow rather than diminish, and we support professional health management development. (Steering Group to Oversee Health and Disability Changes 1997:40)

The practicality of any domination by non-health-professional managers is questioned by some, as one of our interviewees suggested:

> "You cannot run a hospital without involving the senior medical staff. In the end the decisions that add up to the aggregates are taken in face-to-face confrontations between doctors and patients. If you ignore that the system's simply not going to work.
>
> "I think reforms come and reforms go, but unless you have the goodwill and the ear of your medical staff, you're not going to get anywhere at all. When push comes to shove, the guy who's shoving the needle up the arm is going

> to be the deciding factor. It's the old joke; no one says, "Make way, make way I'm an Accountant.
>
> "The trouble was that in setting up the CHEs there was a belief that health is no different from anything else. What you needed was generic management skills. So if you can run a bus company, you can run a hospital. It's untrue. You cannot run a health care system; more particularly you cannot run a hospital unless you have a firm grasp of the nature of health, health care, health services and the interaction. Health is a very slippery, difficult concept. It has large overtones of being an art. You have to always remember in the final analysis there is a clinical judgment and a clinical call.
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> "So I think this notion that you can just unpack your bags from Heinz, or Watties, and run a hospital is fundamentally untrue. Having said that, there are plenty of excellent people running Heinz or Watties who can, if they're given the challenge, come up to speed quickly and run a good hospital. But that's not the same point." (Interviewee A)

The reactions listed above may, to some extent, illustrate the conflict between health service and other cultures. The conflicts in the New Zealand health sector, perceived by some as being generally between health and commercial value systems (Bowie 1994, Hornblow 1997), may also be between a more diverse group of cultures – managerial, organisational and political (Bryson 1994).

DISCUSSION

Why focus on interview and documentary material, and only access primary sources, rather than a wider range of material? This decision was a compromise between the need for triangulation and the need to work within the available funding. Other sources such as focus groups and surveys were beyond the HSTP's initial means. Predominantly qualitative methods allowed for a feel of the range of issues, the context, and the extent of the sources available. As with any in-depth research endeavour, there was a need for such an emphasis at this scoping stage of the project. As the social context of documentary analysis is crucial (i.e. what beliefs, events and people were driving particular policy directions?), in-depth interviews provided an essential first step to understanding this. The interviews helped in the piecing together of relationships and interactions between individuals, groups and communities involved in the complex and convoluted world of policy change. They also provided a direct gateway to narratives, enabling examination of the ways in which events and roles are recounted. These areas of context are critical when exploring policy making and the policy process (March and Olsen 1996, Collins et al. 1999).

Interviews allow those who are by training and occupation discrete and cautious to express that which they may not put to paper, and for researchers to learn from respondents about direct experiences of developments and events. This two-way process depends on the preparation of questions, sequencing of interviews, and sufficient knowledge of the people and proceedings referred to by interviewees. In the process of any interview a number of strands of inquiry will emerge, and judgement is needed about whether limited time should be used to follow up promising leads. The HSTP was fortunate in that interviewees were uniformly supportive. It is not uncommon in interview situations for interviewers to experience difficulty in gaining the cooperation of interviewees (Minichiello et al. 1990).

Interviews have a further advantage of sometimes providing clues of where to look for information. While interviewees may not wish to be quoted, they can suggest or reveal documentary or interview sources that can be attributed. The disadvantage of anonymous quotations is that evidence cannot be challenged and examined in the light of the source. To do so requires transcripts that have been agreed as attributable by interviewees, a process which requires considerable work in itself, and which may also result in evasive or less insightful responses from interviewees.

Interviews also have the potential disadvantages of privileging some viewpoints and missing some or many aspects of the whole picture of a subject area. These problems are shared with many methods, quantitative and qualitative. Interview material needs extensive context, and continual testing by the use of counterfactuals and the use of other data sources. Interviews also need to be supplemented by other methods of information collection.

The transcribing of interviews for subsequent analysis is a labour-intensive process frequently underestimated by researchers. The interview and transcription process undertaken by the HSTP confirmed a general rule that, for every hour of interview time, at least 10-20 hours are required to set up and prepare for interviews, transcribe tape-recorded dialogue, and process transcripts to a point at which they can be used. The advantage of the interview method is that it elicits information not otherwise available, as well as unique perspectives. Focused follow-up questions can also penetrate to information that a fixed question survey cannot reach.

Locating, accessing and organising primary material is like mining for shale oil. Even when access to material has been negotiated and relevant material successfully located, the extraction and processing required to produce something useable can require considerable resources. For the HSTP, the main problem with the primary documentary material was not gaining access to documents, but the amount of time required for the scanning of files for relevance, and the cataloguing of material

obtained. Subject areas such as "integrated care", "core health services", or "community trusts", for example, will each span a few thousand pages of files.

Documentary research in the field of New Zealand health policy, therefore, needs to be very focused, or sufficient resources need to be set aside to examine, copy, catalogue and make sense of the voluminous material available. The implication for policy makers, in an era when staff and agencies are routinely in transition, is that institutional knowledge of the history of policy areas, key developments and documents is a crucial ingredient to understanding the work which has been previously done and the extent and locations of material available.

The limits of the subject area – health sector transition – continually emerged as an issue during the work of the HSTP. In interviews, for instance, both interviewees and interviewer were aware of uncertain borders between the "health sector" and the rest of the community, and between health services policy (which most restructurings have tended to focus upon) and health outcomes policy. Many of the major questions in health policy are to do with areas outside the conventional confines of the health sector. For example, the relationship between government policy on relative incomes, housing, education, employment, and social cohesion,[6] and the health sector, is also an area where easier access to and greater utilisation of primary sources would be beneficial for those working in health policy. For this to occur, of course, there is a need for the government of the day to support not only intersectoral policy work, but also administration. The latter brings with it numerous problems of financing, relationship building, coordination and integrated service development. (Peters 1998)

For the HSTP, and health policy researchers per se, a number of sources remain to be scoped in even a preliminary way. The extent and nature of the records and papers of the parliamentary select committee process, and the records of many non-government and business organisations in the health sector remain unprobed. There also remains a need to record the views of those from many other areas within and beyond the health sector, particularly those who are able to articulate the experience and viewpoint of people outside of the core health policy community. Obvious targets would include non-government health and social service providers and users, and front-line health professionals and officials working in the public sector.

[6] For concise arguments on the relationships between these factors and New Zealand health outcomes, see National Advisory Committee on Health and Disability (1998) and a background paper to that report (Howden-Chapman and Cram 1998).

CONCLUSIONS

The experience with the HSTP indicates that the major methodological problem with conducting policy research in the health arena is not access to information, but focus. As discussed in this article, the HSTP, with its limited resources, assembled a wide array of information. While this has been a useful starting point in terms of gaining an important insight into the broader context of change and the range of issues and documentation surrounding transitions, a tighter focus on a particular component of the health sector under change may have also been judicious. The project scoped a range of policy areas: central-local arrangements, funding and provision governance and implementation, primary and secondary care, and personal and public health. All of these areas warrant close scrutiny, and each could be studied in depth in the context of health sector transition.

Researchers may experience difficulties in gaining access to some agencies or material relating to particular issues. Negotiating entry and the right to use primary sources may take time and a range of resources and skills that have little to do with analysis and writing. A culture of relatively open access to public documents is developing in New Zealand, meaning that the amount of accessible information is constantly increasing. This means the main challenge is to define the research programme in such a way as to match the project resources to the range of documents available. Alternatively, projects must be planned in the knowledge that only a small fraction of the relevant material can be surveyed, let alone used.

HSTP experience with health sector interviews suggests that a crucial issue is how to select interviewees from an extended list of those who would be potentially information-rich. There are a number of constraints to the information available from interviews about policy making and health sector change. Professional habits of discretion, the political volatility of much health policy, and prudence will limit the material revealed, even when interviews are anonymous. Unless the interviewee has a longstanding and close relationship with the interviewer, the interviewee may be unsure of the opinions and beliefs of the interviewer. This may further inhibit comment and revelation.

Partial solutions to this situation include enlisting a wide range of interviewees, and seeking those who have the confidence to be articulate and revealing in interviews. Further solutions include employing interviewers with intimate knowledge of the field concerned, who are able to provide reassurance to the interviewee. Reassurance can be bolstered by the personal reputation and manner of the interviewer, the provision of common points of reference (ideally people known by both interviewee and interviewer) and the reputation of the project and its host institution. A project is more likely to develop trust if it is long running and scrupulous in providing information to

interviewees and delivers on its commitments to them. In the close-knit world of policy, one disaffected interviewee has the potential to make the future of a research project difficult.

Policy research induces a tension between the wish to question those who have or have had power and insight, and the need to reveal the effects of policy. The HSTP's emphasis on those close to the policy and decision-making process meant that some groups who were strongly affected by the changes were not represented in our research, and that their perspectives remain largely unreported in policy or health sector research. The voices of those beyond central government and core public service providers are often the least heard.

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