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THE PROMISE AND REALITY OF PUBLIC SECTOR REFORM – A CASE STUDY OF THE IMPLEMENTATION OF TRINIDAD AND TOBAGO'S HEALTH SECTOR REFORM

Jochelle Greaves Siew

The London School of Economics and Political Science, UK.
Email: j.t.greaves-siew@lse.ac.uk Tel: +447732656814

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ABSTRACT

This research examines the relationship between control mechanisms selected for use by central governments during the implementation of public sector reform and the successful implementation of said reform. This investigation is carried out in light of a case study, namely Trinidad and Tobago's health sector reform. Previous research either offers a descriptive account of what conditions are necessary for perfect implementation or focuses on the debate between top-down and bottom-up approach supporters in terms of controlling implementation. Drawing on both sets of literature, this study goes further by offering insights into the importance of government control over public sector reform implementation by contributing a fresh perspective to existing research – recognition that the actions of the central government can constitute more important explanations for the outcome of public sector reform than those of the implementers. This paper presents relevant interdependent elements needed for determining what type of control mechanisms should be used to control implementing bodies, which include central acceptance of delegated tasks, balance between control and discretion, clear roles and performance goals that accurately reflect policy intent, objective measurement and effective monitoring, and a simple implementation structure. It is found that control mechanisms need to be planned and performed in light of the intent and performance goals of the reform in order for said reform to be successful. These findings provide policymakers with knowledge on how control mechanisms can be better employed in order to improve the performance of the public sector under the reform.

Contribution/Originality: This study provides an original investigation into how governments can better select and employ control mechanisms during policy implementation to improve the performance of public sectors under reform. It further demonstrates that central government's actions constitute more significant explanations for outcomes of public sector reform than those of its implementers.

1. INTRODUCTION

Public sector reform involves activities seeking to improve the public administration of the State, its roles and functions, as well as the effectiveness, equity and efficiency of the relevant public sector in a systemic and sustainable manner (Caiden, 1978; Cassels, 1995). Reforms with such intent often involve significant change in administrative functions, including spending, human resource management, and organizational control (Barzelay, 2003). Without such change, it is likely that existing structures and systems will not lead to a desired improvement of the relevant public sector or service delivery (Cassels, 1995).

The implementation of these reforms has been positioned within a policy cycle divided into several stages, namely agenda-setting, policy formulation, legitimation, implementation and evaluation (Nilsen, Ståhl, Roback, & Cairney, 2013). Traditionally, implementation is described using a top-down approach where it is presupposed and merely concerns following orders. In addition, any failed implementation is attributed to factors, such as poor compliance by implementers or unclear policy, which are identified from the perspective of government policy-makers (Hupe, 2008; Nilsen et al., 2013).

In response to the large focus on implementation failures without existing theories to explain or predict the impact of policies, especially considering those at lower levels who implement and deliver policies, a new wave of research emerged to fill this gap (Nilsen et al., 2013). With this new wave came a debate between top-down and bottom-up supporters. Inspired by agency theory and public choice theory, some scholars argue that top-down approaches to controlling implementation are necessary given the possibility of implementing actors diverging from planned policies and programmes due to discretion largely discussed by Pierre and Peters (2017) or other sources of power (e.g. information asymmetry; see (Niskanen, 1971)). Other scholars, however, point out issues that stem from centralised, top-down approaches, such as the disregard of crucial knowledge held at lower levels of the system (Elmore, 1979; Kelman, 2007). Amongst this discussion, some scholars have developed several preconditions that are needed for successful implementation (for instance (Hood, 1976; Wegrich, 2015)) including communication and coordination, compliance, and adequate time and resources.

Despite these advances in implementation research, few studies have specifically focused on control mechanisms used by central governments to manage implementers and achieve successful implementation of public sector reforms. Such an investigation could shed new light on the importance of government control over public sector reform implementation. Control in some form or the other is required by governments to achieve their desired goals in a pre-defined manner given its provision of instruments which influence performance and decision-making. How well a reform is implemented depends on the suitability and performance of control mechanisms. Just as previous studies point out that failure might be due to poor planning or choosing ineffective forms of administrative changes, it can also be related to poor choice and execution of government control mechanisms. Similarly, while implementation of the structural changes behind the reform itself might appear to be a success, oftentimes the actions of the central government are more important explanations for the outcome of the reform than those of the implementers.

Consequently, this research aims to examine the relationship between control mechanisms selected for use by central governments during the implementation of public sector reform and the successful implementation of said reform. This matter assessment is made in light of the case study of Trinidad and Tobago's health sector reform in order to demonstrate how the use of certain control mechanisms by central government can affect the implementation of reforms depending on the nature of the particular reform. It is expected that control mechanisms need to be planned and performed in light of the intent and performance goals of the reform in order for said reform to be successful. In Trinidad and Tobago's case, the health sector was reformed through decentralization measures. While some researchers have found evidence of certain factors, such as institutional capacity at the regional levels, negatively impacting the implementation of the reform (Bahall, 2012; Bissessar, 2008; Rafeeq & Paul, 2000), there have been no investigations into the forms of control executed by the government over the implementing bodies (the Regional Health Authorities).

This paper therefore further offers new insights into the national debate over the effectiveness of the health sector reform. On the one hand, renewed claims of the need to conduct a comprehensive review and subsequent overhaul of the system have arisen as a response to the significant failures to improve service delivery and the performance of the health system despite the reform beginning 25 years ago. On the other hand, certain mechanisms as planned at the pre-implementation stage may not have been effectively realized following the post-decision stage. Thus, a better understanding of how government control mechanisms impact successful

implementation is required to complement the implementation of the reform. The methodological approach taken by this research involves a qualitative analysis of the 1994 Regional Health Authorities Act and parliamentary debate transcripts, using a framework design based on a wide selection of relevant theory.

It is intended for this research to provide policymakers and citizens in Trinidad and Tobago with information on how control mechanisms can be better utilised in order to improve the performance of the health sector under the reform. In addition, it is hoped that it will provide lessons for other States considering to develop or strengthen similar national health sector reform initiatives by tailoring the analysis to their context and political reality, and using further studies in other jurisdictions to complement these findings. It is essential for decision-makers to understand how the use of certain control mechanisms by central governments can affect reform implementation depending on the nature of the particular reform so that some sector performance can be improved. The qualitative approach employed allows this research to explore practical ways to improve the use of such government control mechanisms. It is equally important to recognise that the actions of the central government can constitute more important explanations for the outcome of the reform than those of the implementers.

The paper adopts the following structure. Chapter two offers a background into the case study of Trinidad and Tobago's health sector reform, describing its origins, purpose and content, particularly focusing on the planned methods of executing control over the implementing bodies (Regional Health Authorities). The third chapter offers a literature review of theoretical contributions exploring public sector reform, implementation, and organisational control. Chapter four then focuses on the research methodology used, justifying the choices of design, data collection and analysis methods, and outlining the limitations of the research. Chapter five presents the findings and tackles the main thesis of this paper. It first identifies which planned control mechanisms actually operated in practice and in what manner. It subsequently discusses the relationship between control mechanisms selected for use by central governments during the implementation of public sector reform and the successful implementation of said reform in light of the case study. The final chapter offers some recommendations in light of the findings and discussion, before drawing a final conclusion.

2. NARRATIVE OF TRINIDAD AND TOBAGO'S HEALTH SECTOR REFORM

a. Overview of the Health System

Trinidad and Tobago has a two-tier health system – the first being public, universal and free-of-charge, and the second consisting of private facilities. The public health system is funded by the government through taxes and other national revenue streams (Pan American Health Organisation, 2017). Since the introduction of the 1994 Regional Health Authorities Act, these health services are provided and managed by 5 Regional Health Authorities ('RHAs'). The Ministry of Health allocates an annual budget to each RHA, which in turn submits regular reports on spending and performance. The 2019/20 budget for the Minister of Health was TT$ 6.041 billion and accounted for 11.6% of the 2019/20 national budget (Government of Trinidad & Tobago Ministry of Finance, 2019).

b. Origin of The Reform

Historically, the Ministry of Health has been the governmental body responsible for the delivery of health services, and it has carried out its mandate through highly centralized primary care facilities. Over time, citizens grew increasingly unsatisfied with the existing health system. In fact, the health sector had undergone several assessments, from the Moyne Commission Report in 1939, the Julien Commission Report in 1957, The Gaspar Grande Report in 1978 to the Health Sector Reform Report in 1994, which ultimately stimulated change. Each commission and task force behind these reports identified similar pressing shortfalls within the system – including but not limited to lack of medical equipment and drugs, improper resource (financial and human) management, and over-centralisation of decision-making – and recommended that the Ministry of Health create other bodies to act on its behalf in service delivery (Bissessar, 2008).

With attention being given to these significant issues related to the delivery of health care and the management of the health system itself, the government set out to identify policy solutions (Kingdon, 1995). In this case, policymakers also had the opportunity to alter current policy as there was a predictable policy window (Kingdon, 1995) given impending national elections. Under the aegis of the Inter-American Development Bank, the government at the time (led by the People's National Movement) was able to obtain the services of a consultant group to develop the framework design for and the details of the health sector reform. The group and its local counterparts used a participative approach to gather the views of the health system's internal and external clients on several issues. They also conducted formal studies and surveys to collect information on matters such as allocation of resources and costs.

Ultimately, the findings confirmed the notion that the Ministry of Health's highly centralised operation left it unable to effectively and efficiently respond to the dynamics of the health sector (Rafeeq & Paul, 2000). Consequently, the Regional Health Authority system was developed as the solution to the issues facing the health sector at the time, with the intention of creating a more patient-driven, bottom-up system able to provide effective management to achieve the goals of the Ministry of Health (Bahall, 2012; Bissessar, 2008). This new decentralised system was modeled largely after the United Kingdom's National Health System at the time (Bissessar, 2008).

c. *Structure of The Reform*

The reform of the health sector is defined in the 1994 Regional Health Authorities Act, and involves the administrative decentralisation of the public health sector by creating 5 RHAs which are delegated the responsibility of the day-to-day functioning of health facilities and service delivery and ensuring they follow the policy direction and goals of the Ministry of Health. The 5 RHAs include: The South West RHA (SWRHA) based in San Fernando, which serves approximately 500,000 people and is the largest by geographic area; the North West RHA (NWRHA) which also serves approximately 500,000 residents in densely populated Port of Spain and surrounding areas; the Eastern RHA (ERHA) based in Sangre Grande which serves another 120,000 residents; the North Central RHA (NCRHA)which serves an estimated 350,000 people; and the smallest, the Tobago RHA (TRHA), which serves roughly 60,000 residents from its base in Scarborough. To ensure coherence in service delivery, the Ministry focuses on policy development, planning, regulating, financing and monitoring and evaluation of the RHAs and the health system as a whole. This arrangement is not only aimed at bringing health services and delivery closer to customers (Bahall, 2012), but also allowing information and experiences to be shared, allowing cross-fertilisation of ideas between the Ministry and RHAs (Rafeeq & Paul, 2000).

Undoubtedly, the implementation of this new system required a significant and distinct change from the prevailing system and the development of a framework within which to achieve the complex changes. A high-level management structure was created, with several new management departments, as stewardship was a major pillar of this reform (Bahall, 2012). Prior to 1994, the Ministry of Health was headed by a Chief Medical Officer and a number of Principal Medical Officers, County Medical Officers and Medical Chiefs of Staff. Top management comprised the Chief Medical Officer, Principal Medical Officer Services, *inter alia.* With the introduction of decentralisation, management of the RHAs was expanded to include RHA managers (Chief Executive Officer, General Managers, Executive Medical Director of Health), County Medical Officers of Health, Facility Managers, and many other positions, which all form the executive team of each RHA that could be claimed to be top-heavy (Bahall, 2012; Trinidad and Tobago Ministry of The Attorney General and Legal Affairs, 2011).

d. *Planned Control Mechanisms*

In order to enable the successful implementation of the reform by the RHAs and perform its role as the regulator, monitor and evaluator of the RHAs, the government outlined several control mechanisms in the 1994 Regional Health Authorities Act through which the Ministry of Health would ensure the RHAs were carrying out

their responsibilities effectively and efficiently. This section delineates the specific areas over which the Ministry executes control and the mechanisms used to do so with the purpose of facilitating a later analysis of their execution and effectiveness.

As aforementioned, the Ministry of Health retains centralised power for all matters of determining policy. Therefore, it decides the policy direction and mandate of the RHAs which must then ensure that their daily operations are carried out so as to meet the goals of the Ministry. In addition, the Ministry directs each Board of the RHAs on matters it deems necessary and important, leaving a wide margin of appreciation within which the Ministry can intervene. Moreover, it also holds the power of approving the Chief Executive Officer (CEO) of each RHA Board, and reviewing and finalising any disciplinary decisions, such as the firing of an employee found guilty of misconduct.

In relation to monitoring RHA activities, there are several mechanisms by which the RHAs are obliged by the 1994 Regional Health Authorities Act to report information to the Ministry. For instance, a copy of the confirmed minutes of meetings must be forwarded to the Minister within one month of certification. In addition, within 6 months of the end of each financial year, the Minister must receive an annual report dealing with the activities of the Authority during that financial year. Similarly, at least once every three years, a comprehensive audit has to be prepared by the Auditor General or a qualified auditor appointed by him/her, which then needs be submitted to the Minister within 28 days of its receipt by the RHA. These reports are meant to support monitoring and performance evaluation by the Ministry. Despite this intent, however, there are no specific provisions within the Act or even general guidelines relating to feedback or sanctions (in the event of the RHA's failure to comply) on the part of the Ministry with regards to the operations of the RHAs.

Further, as the RHA financier, the Ministry executes total control over the allocation of their budget and other resources, as well as the granting of salaries and bonuses. The Ministry is required to approve all financial activities of the RHAs, such as, *inter alia*, increases in staff salaries, procurement tenders, the expansion or purchase of property, and raising additional funds.

e. Post-Implementation

Notwithstanding several attempts, Trinidad and Tobago continues to have a history of health sector reform that is yet to meet expectations, whether from the part of the customer or the provider. Despite the implementation of the reform, whether true to the reform plan laid out in 1994 or not, the Ministry of Health and Regional Health Authorities were unable to realise the goals of making a more patient-centred health system or improving service delivery. While certain performance indicators improved, such as a significant reduction in the maternal mortality rates (Pan American Health Organisation, 2018), many issues which the reform intended to address – including improper resource (financial and human) management, inadequate medical supplies, and inappropriate or lack of use of monitoring tools – still persist.

New issues have also arisen due to the lack of equity in the distribution of resources amongst the RHAs. For instance, in 2016, it was reported that while the World Health Organisation states that the nurse-patient ratio should be 1 to 6, there was a ratio as high as 22 patients to 1 nurse at the San Fernando General Hospital (Guardian, 2016). Later, in 2019, the NCRHA reported being in a crisis given insufficient staff to monitor patients. The NCRHA actually had fewer nursing staff than the ERHA despite the ERHA having only one major hospital and NCRHA having several (Trinidad and Tobago Registers Nurses Association, 2019). Unsurprisingly, in 2015, a call for a comprehensive review of the RHA system was made. As a result, in 2017, a joint committee was formed in order for this review to be conducted (Trinidad and Tobago Parliament, 2017); though, results have not yet been published and the activities of the joint committee remain uncertain.

It is important to note that the RHA system was created under one administration in 1994, namely, that of the People's National Movement. However, in 1995, the People's National Movement demitted office, and the

implementation of the reform began under another government– that of the United National Congress. This implementation was seen to be 'extremely challenging and undertakings were not delivered as outlined in the reform plan' according to members of the implementing government (Trinidad & Tobago Parliament, 2015d).

The impact of the government's mechanisms through which it exercised control over the RHAs will be examined later in Chapter 5 of this paper in order to draw a conclusion as to how it contributed to the state of the implementation of the reform.

3. THEORETICAL BACKGROUND

a. Views on Implementation

i. Theoretical Approaches to Implementation Failure or Success

Implementation refers to a 'relatively late stage in a process of problem-solving' or 'problem-processing' which follows decision-making (Hupe, 2008). Many scholars (see, for instance, Hood (1976); Wegrich (2015) use the idea of perfect implementation to discuss the limits of implementation. In other words, they outline preconditions that need to be satisfied in order to achieve perfect implementation and explain why they are difficult to achieve. For example, Hood (1976) presents perfect communication and coordination amongst the various preconditions or agencies involved in the programme as a key element to achieve perfect implementation, despite it being unrealistic. Another example is perfect compliance (Hood, 1976). That is, those at the top merely give instructions to implementing actors who must follow them. However, this body of literature does not go beyond speaking in negative terms or pointing to abstract scenarios known as 'traps' where some factor causes the organisation to fall short of its intent in implementation. Despite this shortcoming, it is notable that normative ideas are often used to facilitate performance evaluation, diagnose failure and propose remedies, regardless of their lack of descriptive validity (Elmore, 1978). They provide useful ways to organise and simplify complex issues faced by public organisations.

On the other hand, some scholars, such as Elmore (1978) and Kelman (2007) offer more practicable ideas of what can be done to avoid implementation pitfalls or failure, rather than focusing on what 'ought' to be. Scholarly contributions like these provide prescriptions on ways to strengthen implementation prospects and reduce the likelihood of implementation failure (May, 2014). For instance, Kelman (2007) posits that monitoring provides central government with information on the performance of implementation bodies that does not meet expectations, which can then be used to formulate improvement plans or enable greater interaction with these bodies in order to grant them 'support'. Alternatively, implementing bodies can be required to prepare 'delivery plans' which explain how they intend to reach particular targets and lay out 'trajectories' for continuous performance improvement.

ii. Approaches to Controlling Implementation

Traditional literature describes implementation using a top-down approach, in which centralised organisations make decisions at the top (see, for instance, Galbraith (1977); Nadler and Tushman (1988); Mintzberg (1978)) and implementation is merely presupposed and concerns following direct orders (Nilsen et al., 2013); (Hupe, 2008). Consider, for example, Elmore (1978) model of implementation as systems management, where 'top management' holds the responsibility for policy-making and overall system performance, and allocates specific tasks and performance goals to lower units thereby monitoring their performance. A variant of this is for the implementing body to propose possible activities, first requiring the approval of the central government before proceeding (Kelman, 2007; Mintzberg, 1978). Any failed implementation is attributed to factors identified by central government, including poor compliance by implementers (Nilsen et al., 2013); (Hupe, 2008).

Several arguments have been presented in favour of centralized control and decision-making (Finer, 1941; Kelman, 2007). Firstly, those at the top are seen as being smarter, on the basis of the meritocratic assumption that as talent increases so too does hierarchical position. Fayol (1949) argues that centralisation 'belongs to the natural

order … (I)n every organism, sensations converge towards the brain or directive part, and from the brain or directive part orders are sent out which set all parts of the organism in movement.' Secondly, those in central government are seen as having a broader viewer of the interests and needs of the sector as a whole, and better equipped to make legitimate decisions on these interests and needs as they are elected (Finer, 1941; Kelman, 2007). Similarly, it is put forth that since those in central government bear ultimate responsibility for the success or failure of the relevant sector, they have greater incentive to make effective decisions. Finally, it is also claimed that strict, centralised control is necessary to prevent implementing actors from diverging from planned policies and programmes as a result of discretion granted (largely discussed by Pierre and Peters (2017)) or other sources of power (e.g. information asymmetry; see (Niskanen, 1971)).

The literature does, however, point out many of the issues posed by centralised control and decision-making. First of all, lack of information and certain cognitive limitations prevent even the smartest central decision-makers from being able to make a large proportion of effective decisions by themselves (Kelman, 2007; Mintzberg, 1978). Secondly, implementing bodies are 'closest to the work being performed' (Nadler & Tushman, 1988) and therefore are better informed on how to manage certain problems arising at lower levels of operation. Thirdly, by reducing local autonomy, the opportunity for implementing bodies to offer fresh insight and crucial knowledge held at lower levels is hindered (Elmore, 1979; Kelman, 2007; Mintzberg, 1978; Nadler & Tushman, 1988) Centralised control can thus actually subtract rather than add value to localised performance. Even in cases where this shortfall is recognised, central government still tends to overcentralise and extend its personal power as a force of habit of believing that they can do better when errors are made by implementing bodies (Kelman, 2007).

In fact, in response to traditional literature's exclusion of key considerations – including the nature of the work and activities of implementing bodies and those at lower levels who deliver policies – more recent scholarship has addressed this by arguing in favour of bottom-up approaches of control and offering improved analysis of elements that explain the impact of the implementation process (Nilsen et al., 2013). Bottom-up researchers have shifted attention away from elements at the top or centre of the system to those at the lower levels (Nilsen et al., 2013). The presentation of new analytical frameworks and models has led to a debate emerging between top-down and bottom-up supporters, particularly within principal-agent and public choice theories. The contents of this debate can be used to identify means of control which are available to central government (the principal) to ensure that implementing bodies (agents) work toward achieving the desired goals of the reform. These include positive incentives, sanctions and information to monitor compliance (Bossert, 1998).

Following the reasoning of centralised control supporters, guidelines for implementing actors to follow are 'developed at great distance from the problem' (Elmore, 1979). However, the nature of the work of implementing bodies calls for some discretion to be granted, particularly when a reform has taken place in the form of decentralisation as aforementioned, in order to adapt broad policy directives to more specific cases. With strict, centralised control, diversions and delays are more likely to occur as implementing bodies will constantly require checks to ensure compliance given their dependence on the monitoring body for guidance and reduced reliance on the expertise of implementing bodies (Elmore, 1979).

Thus, effective delegation of responsibility and discretion is required for broad policies made by central government to be more effectively and efficiently implemented to meet the system and the public's needs, particularly in unanticipated situations. Control can be exercised *ex-ante* by the monitoring body – for example, through policy design and budget allocations – to ensure that policy goals are clear enough for implementing bodies' operations to align with them. Similarly, rather than using invasive methods of control at unnecessary moments, mechanisms, such as in-depth performance assessments, can be employed only when performance does not meet the expected standards or goals, or public funds have been misused (Brehm & Gates, 1997; Pierre & Peters, 2017). In this way, the monitoring body's resources are not over-exhausted or spread across too many operations of the implementing bodies that require tight control.

b. *Synthesising Views to Find Elements for Successfully Controlling Implementation*

In light of the literature used to theorise the success or failure of implementation and available control mechanisms to central government, a synthesis of the various perspectives has been created in order to identify the elements of concern to this research – that is, those that impact the effectiveness of various tools that can be used to control implementing bodies' activities.

i. *Central Acceptance*

In order for successful implementation to be achieved, there is the need for support of and commitment to the reform, regardless of its nature, from within central government (Conteh, 2016). For instance, if decentralisation is used, central government officials must be willing to transfer the functions and responsibilities that they previously performed to implementing bodies. Often, the point of reforms (especially in the form of decentralisation) is for central government to reduce their involvement in the management and delivery of services by focusing on policy formulation, monitoring, and regulation. Despite this, it is not unsurprising to find that, despite good intentions, the central government functions in a similar manner following the reform as it always has or extends its power even further (Cassels, 1995; Kelman, 2007). For example, the control over funds usually remains in the hands of those in key positions in the old system, leading to the new structure working ineffectively (consider Pressman and Wildavsky's clearance points). While it may seem an evident consequence, this is often overlooked and negotiation with central government is typically required to secure delegated responsibility (Cassels, 1995).

ii. *Balance Between Control and Discretion*

As discussed above, the nature of implementation work requires discretion to be granted to implementing bodies as they perform their delegated tasks (Elmore, 1979; Gilson, 2015; Lipsky, 1980). However, it is vital that central governments utilise control mechanisms that facilitate a much-needed equilibrium between fostering discretion and effectiveness and the effective monitoring of implementing activities. At the end of the day, the central government's key concern is that policy is being implemented as planned, and control in whatever manner is required to ensure this is accomplished. How well implementation is carried out depends heavily on the suitability and use of control mechanisms. For instance, if public sector reform takes the form of decentralisation, then it is expected that the control mechanisms (e.g. bi-annual reports and feedback processes) employed by the central government would support this.

iii. *Clear Roles and Performance Goals That Accurately Reflect Policy Intent*

Central government should have the capacity to clearly define and specify the tasks of implementing bodies and their performance goals in detail so that they can be understood and agreed upon by all relevant actors (Cassels, 1993). This is a critical factor for improving the functioning of existing public sectors. It is also desirable and inevitable for room for discretion to be accounted for in even the most meticulously planned programme. Such planning allows for managerial problems relating to the correct performance of tasks to be avoided. However, it also creates a framework or blueprint by which projects can be planned, implementation monitored and controlled, and against which performance can be objectively measured (Elmore, 1978).

iv. *Objective Measurement and Effective Monitoring*

As mentioned above, a clear plan that reflects the policy intent of the central government allows for objective measurement and performance monitoring. It thus provides central government with information on whether the performance of implementing bodies is below par and forms the basis for further attention to be paid to that particular body, whether through more frequent monitoring or requirements for improvement plans (Kelman, 2007).

In addition to this, for monitoring to truly be effective, there must further be an arranged system of management controls by which feedback can be provided to implementing bodies and failure to meet standards or comply with the framework is sanctioned (Cassels, 1993). According to Elmore (1978), failures of implementation are, 'by definition, lapses of planning, specification, and control'. A hindering condition of successful implementation is a weak mechanism for ensuring compliance with programme goals and plans.

v. Simple Implementation Structure

Authority should not be fragmented or dispersed amongst several levels or agencies. There must be clear lines of reporting and accountability to facilitate easy and effective monitoring and performance review. This also allows for implementing bodies to better grasp their role and responsibilities in the system by not having several lines of authority to follow. Similarly, the number and type of implementing bodies should be minimised to prevent greater dependency on several agencies for success, and the stifled capacity and growth of some (Mintzberg, 1978). Having only a few implementing actors ensures that resources are not over-exhausted on monitoring unwarranted ones.

c. General Reflections

Taken together, the contributions discussed above have identified and explained several key perspectives taken on (perfect or failed) implementation and the different approaches to managing it. However, there have been no independent studies into the mechanisms of control that are used by central governments to control implementation of public sector reform and how they affect the success of said reform. In this sense, this paper seeks to shed light on the importance and consequences of government control over public sector reform implementation, and contends that control mechanisms need to be planned and performed in light of the goals and intent of the reform in order to be successful. This assertion will be examined in light of the case study described in Chapter 2, using the elements in the section above which have been developed by the researcher's synthesis of previous academic work as a framework design for analysis.

4. METHODOLOGY

This research examines the relationship between control mechanisms selected for use by central governments during the implementation of public sector reform and the successful implementation of said reform. This question is addressed in light of the case study of Trinidad and Tobago's health sector reform. A qualitative approach employing several instruments is utilised to articulate the significant features of the public sector reform case which make it distinctive when drawing upon more general theories of implementation and organisational control. Both primary and secondary data collection and analysis took place between March and July 2020.

In order to determine the relevant factors for primary research collection and compilation, such as degree of discretion granted and different forms of monitoring performance, a wide range of literature was reviewed, covering topics from public sector reform (e.g. Cassels (1993); Cassels (1995)) to implementation theories (e.g. May (2014); Wegrich (2015); Hupe (2008)) to literature on principal-agent theory and organizational control (e.g. Elmore (1979); Kelman (2007)). The array of literature and theory is used to make sense of the causal process by which the case outcome occurred. It is also drawn on to identify relevant factors to be considered in the discussion of findings and create a theoretically-informed framework design around which primary research is carried out. In this sense, theory is not used as an accurate representation of reality, but rather for its utility as a problem-solving device given that it directs attention to the various mechanisms that central government can use to structure and control behaviour of implementers.

Following this, a textual analysis of Trinidad and Tobago's Hansard (transcripts of parliamentary debates) was conducted. These debates took place over the course of 5 days between late 2014 and mid-2015 and were premised on the potential need for a comprehensive review of the system. They focused on discussing the state of the health

system at the time in light of the reform which began in 1994, with some emphasis on issues of control, accountability and decentralisation. The first debate took place on the 18th of November 2014, the second on the 27th of January 2015, the third on the 24th of March 2015, the fourth on the 28th of April 2015, and the final on the 26th of May 2015. The transcripts were retrieved online from the official parliamentary archive which is published for public consultation. Textual analysis (Braun & Clarke, 2006) involved coding all the data after identifying and reviewing preconceived key themes based on the literature and theory previously explored. Each theme is examined to gain insight into each speaker's perceptions and motivations, as well as the general issues surrounding the government's control of the reform's implementation. This method of analysis was chosen in order to facilitate the accessibility and understanding of both the central government, and regional authorities' attitudes towards and experiences of the reform from an empirical perspective (Bauer, Süerdem, & Bicquelet, 2018). Moreover, textual analysis prevents biases on behalf of the subjects that would otherwise occur during alternative methods of primary research, such as interviews, given the subjects' self-consciousness and awareness of being studied by the researcher (Bauer et al., 2018).

In addition to the parliamentary debate transcripts, the 1994 Regional Health Authorities Act serves as the source to identify which control mechanisms were selected for planned use by the central government during the implementation of the reform. This allows for a later comparison of the provisions of the Act with the textual analysis of the Hansard that shows which mechanisms are actually employed in practice and in what manner in order to make inferences regarding the impact of the form and use of the selected control mechanisms on the nature of the implementation's success or lack thereof. The combination of both the parliamentary debate transcripts for the post-implementation period and the policy (post-decision but pre-implementation) provide an accurate view of the different stages of thinking as they took place, as well as to wider governmental and political priorities of the times. These inferences are then further supported with references to case studies in which similar control mechanisms were utilized during the implementation of reforms that took place in other countries. The qualitative approach taken also allows this research to explore practical ways to improve government control mechanisms as they regard reform implementation. One limitation of the primary research method employed is the absence of interviews. Due to the ongoing Coronavirus pandemic, the researcher was unable to secure interviews with relevant representatives from either the Regional Health Authorities or the Ministry of Health. Interviews would have assisted in refining descriptions of how and why certain situations and conditions evolved throughout the implementation of the reform. However, the alternative utilised – parliamentary debate transcripts – allows for this limitation to be restricted as it is still possible to understand the dynamics behind the reform and its implementation, including conflicts, changes in perspectives, and the opinions and impressions of relevant those involved. A related and unavoidable limitation is the lack of published data from the past 5 years as the debates analysed took place in 2014 and 2015. As a result, without the use of interviews and more recent transcripts, the progress or state of the review which was called for is presently unknown.

5. FINDINGS AND DISCUSSION

The findings of this research are presented in Figure 1 seen above and will be further examined in the discussion below in order to determine how the tools used by the central government to control implementing bodies can impact the success of a reform's implementation.

Unlike traditional literature's description of implementation being top-down (see, for instance, Galbraith (1977); Nadler and Tushman (1988); Mintzberg (1978)). Trinidad and Tobago's implementation of the health sector reform was planned to take a decentralised approach in order for the system to be more bottom-up and patient-driven. According to the reform plan presented to the public and in parliament, there was evident acceptance by the Ministry of Health to delegate some of its functions to the RHAs which were laid out in that very plan (Trinidad and Tobago Ministry of The Attorney General and Legal Affairs, 2011).

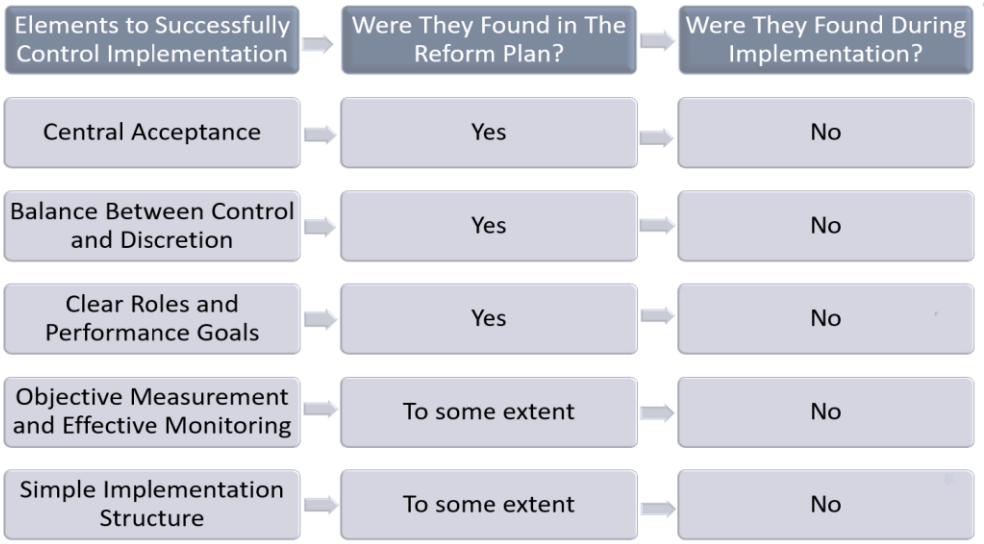

Figure-1. Summary of Findings.
Source: Trinidad and Tobago Ministry of The Attorney General and Legal Affairs (2011); Parliament of Trinidad and Tobago Parliament (2014); Trinidad and Tobago Parliament (2015a).

Despite this fact, and the point of this decentralisation being so that the central government reduces its involvement in the management and delivery of services, the Ministry of Health actually demonstrated unusually strong actions during the reform's implementation. On several occasions, it has retained power only to re-delegate it to the RHAs and then retain it once more, in a pendulum-like manner. For instance, in 2003, when the services being delivered by the RHAs were thought by the Minister of Health at the time to be handled inefficiently, the Minister recentralised those services and then re-decentralised them through private arrangements (Bahall, 2012). This practice is still recurrent. However, given that resources were being used to fund this initiative, and focus on improving the RHAs shifted to the privatised service, the capacity of the RHAs was restricted (Bahall, 2012).

As warned by the literature (Cassels, 1995; Kelman, 2007) this phenomenon is not unique to Trinidad and Tobago, but can also be seen in other countries as well. For example, in Sierra Leone's approach to the decentralisation of its health system, the central government retained certain financial powers despite having agreed to devolve certain competences such as the procurement of equipment and medicines to local councils (Conteh, 2016). One explanation for this is found in the literature (Bahall, 2012) – often, governments may feel forced to please the public, ultimately feeling as though they cannot rely on implementing bodies to fulfil their obligations, resulting in the government taking back delegated powers or, in other cases, they may hand over powers to implementing bodies.

The most significant impact this over-centralisation, or failure to accept delegation, has on implementation is that it prevents implementing bodies from being able to carry out their delegated responsibilities effectively, if at all, as they would constantly need to make requests to the monitoring body before carrying out particular activities (Elmore, 1979). In order to avoid this or lessen the impact, implementing bodies need to be aware of over-centralisation and negotiate with the central government in order to ensure that they have secured their delegated responsibility (Cassels, 1995). In addition, instead of re-centralising the tasks or decentralising them to another body, the government can execute control in less intrusive manners. For instance, in this case study, the Ministry of Health could have intervened to help poorly performing RHAs execute their tasks more effectively by using its regulatory power and resulting augmentation to provide guidance and build RHA capacity. In this way, the Ministry's resources are also not unnecessarily over-exhausted.

The Ministry evidently struggles with finding a balance between granting discretion to RHAs and allowing for effective delegation to take place, and controlling their activities. It either allocates responsibilities that the RHAs are not well-equipped to handle or fails to effectively delegate key tasks to them. Thus, it is important for central

governments to reflect on the capacity of implementing bodies to assume new functions and analyse the evolving role it will hold following the implementation of the reform. Consider, for example, that the Ministry expected the RHAs to establish their own medical facilities, such as hospitals, without them having the proper competences or capacities to do so, such as a facilities expert (Trinidad & Tobago Parliament, 2015a). This responsibility is just one example of a task that should have been kept at a centralised level. This presents a significant hindrance to the successful implementation of the reform since one of the largest challenges in decentralising the health system is to strike the right balance between decentralised and centralised functions in order to achieve the goals of the reform.

As is the case with Trinidad and Tobago, Liwanag and Wyss (2018) found that the experience of the devolution of the Philippines' health sector pointed to the need for some form of re-centralisation to take place to make up for certain inadequacies at the local levels which had taken on the functions. Moreover, granting discretion to local or regional levels does not necessarily imply that it is best for the central government to delegate all of its decision-making responsibilities or entirely relinquish its control. While the literature rightly points out that for any decentralised system to operate effectively the delegated bodies must be allowed decision space and room to share their expertise (Elmore, 1979; Gilson, 2015; Lipsky, 1980), it is critical that central governments employ some form of control to facilitate an equilibrium between fostering discretion and effectiveness of these bodies and the effective monitoring of their activities. This is to ensure that at the end of the day the goal of the policy is achieved as coordination problems and inconsistency in implementation are often inevitable when policy is designed at the central level and implemented at regional levels (Mintzberg, 1978).

Similarly, seemingly poor implementation by delegated bodies can be prevented *ab initio* by ensuring that the responsibilities of the bodies, as well as performance targets or standards, are clearly explained (Cassels, 1993). This clarity, despite being provided for in the 1994 Regional Health Authorities Act, did not appear in practice in Trinidad and Tobago's reform. For example, there was an issue between the remit of the RHAs' executive management and the remit of the Boards of Directors. According to the 1994 RHA Act, the Board is tasked with formulating policy alongside the Ministry, while the executive management enacts policy and manages the health facilities under their control. However, often, the RHAs' Board involves itself in the management of the health facilities, creating conflict between themselves and executive management (Trinidad & Tobago Parliament, 2015b). As expected, unless these issues are resolved, effective management of the RHAs will continue to be undermined and will compromise the efficient delivery of quality health care that is required and demanded by the clients of Trinidad and Tobago's public health sector. Likewise, given the unclear division of responsibilities between the RHAs and the Ministry of Health, there is often the passing of blame between both sets of bodies (Trinidad & Tobago Parliament, 2015d).

Therefore, clarifying the functions of each body and position is necessary to also facilitate proper accountability for monitoring, performance measurement and sanctioning. The lack of clarity experienced is possibly due to the reform actually being implemented under a new political administration (Trinidad & Tobago Parliament, 2015a), and thus the roles and goals may have been altered without specification or description. Although, a more plausible explanation is that the only tool planned for outlining performance standards and roles for the RHAs and facilitating measurement and monitoring of RHA performance – the annual services agreement – is inadequate. This is exactly the situation of Trinidad and Tobago's reform (Trinidad & Tobago Parliament, 2014). The services agreements failed to delineate the performance standards expected to be met by the RHAs as they were meant to; rather, they served as a record of budgetary allocation (Trinidad & Tobago Parliament, 2015a). This exacerbated the ambiguity faced by new and old employees concerning their responsibilities as they were not clearly explained, leading to duplication as will be further discussed later in this chapter. For instance, a dual track exists in the health system, whereby two sets of employees report to two different employers – The Ministry and the RHAs (Trinidad & Tobago Parliament, 2014). The reform cannot successfully move forward unless clarity is provided, targets and standards of service delivery are set and there are consequences or solutions for any failure.

As a corollary of this missing clarity, the Ministry is also unable to conduct objective measurement and effective monitoring of the RHAs operations. In fact, it seems to be the area of greatest challenge given its dependence of clarity on roles and standards, as well as effective sanctioning. Without effective monitoring, the Ministry lacks necessary information on the performance of implementation bodies that do not meet expectations, which further leaves them unable to formulate improvement plans or enable greater interaction with these bodies in order to grant them 'support' (Kelman, 2007). One prime example of the lack of monitoring on the part of the Ministry concerns the Minister of Health at the time of the occurrence. In 2014, funding issues and drug shortages in hospitals were reported. Yet, in Parliament, the Minister of Health himself declared complete ignorance of these reports and the situation of the health service, stating that these issues were new to him and, while a consultant was looking into challenges under the programme, funding was not among them (Trinidad & Tobago Parliament, 2015a).

Further, even when the Ministry had enlisted task commissions to investigate the performance of the RHA system, the resulting findings and recommendations have not been acted upon. An example of this is the disregard for the Gladys Gafoor enquiry report in 2010 (Bissessar, 2008). In addition, according to the Auditor General's Report of 2014, internal accounting was noticeably lacking. "…A review of a sample of 34 payments totalling $135…million revealed that invoices were not committed in the Vote Book as required by Financial Regulations 66 and 67 to allow for prudent cash management. […] From the sample reviewed, one payment voucher"—of—"$1,290,167. 14 was not provided for audit. […]Documents required to verify the validity of expenditure of $770,611.00 for optometry equipment were not produced for audit" Bissessar (2008). This occurrence is not new to the system. In 2001, investigations into a particular RHA revealed that the employment contracts of the RHA's employees included salaries and allowances in excess of TT$150,000 per annum, *ultra vires* the RHA Act (Bissessar, 2008).

Moreover, even with some form of reporting on behalf of the RHAs, there is no meaningful assessment or feedback given to them on the part of the Ministry (Bahall, 2012) which means that RHAs would be unable to determine what changes need to be made on their part (Elmore, 1978). A large contributing factor to the Ministry's inability to properly monitor and evaluate the performances of the RHAs is that it lacks the full capacity to do so. The Ministry has no specific department focusing on collecting and analysing data provided by the RHAs, and as aforementioned the annual services agreements do not provide sufficient data to allow effective monitoring of the RHAs. It is therefore important for the Ministry to assess how much information is available, the capacity of the central authorities to process this information and the quality of the information, and address the shortcomings of the system. Thus far, the Ministry has only made attempts to address identified performance gaps by hiring more managers and supervisors to oversee the performance of the RHAs (Bahall, 2012). However, this only contributes to the issues of unclear lines of authority and reporting, and the creation of a more complex implementation structure.

One recommendation made during a parliamentary debate regarding possible measurement tools took inspiration from the United Kingdom's approach and concerned encouraging real assessment of how individual hospitals and health care facilities are performing under each RHA's remit by identifying certain indices – for example, under themes of equity and efficiency – to be used to determine how each facility would be ranked in the system (Trinidad & Tobago Parliament, 2015c). In Kelman (2007) analysis of service delivery performance in the United Kingdom, it was found that the monitoring body engaged in critical discussions with implementing agents in order to understand the reasons for decreased performance from their perspective. This allows the implementing agents to contribute to problem-solving by, for instance, creating an action plan to address said problem.

Lastly, sanctioning seems to also be an issue in the system, even when limited monitoring is being performed. Current disciplinary regulations make it very difficult to discipline poorly acting employees of the RHAs, creating an environment which makes it challenging to ensure performance is as desired, (Trinidad & Tobago Parliament, 2015a). Therefore, these regulations need to be adjusted or replaced so that they can be enforced when necessary.

Some sanctions available to the Ministry for consideration include fines or jail time (for breaking regulations of 'formal decision space'), intervention (whether intrusive or not), firing of employees, or the withdrawal of positive incentives, such as decreasing allocated funding (Bossert, 1998) .

Another possible explanation for this lack of clarity and inability to adequately conduct performance measurements or monitoring stems from another important element that was missing in the reform's implementation – a simple implementation structure. Not only are there more managerial positions than required, but there are also more RHAs and Boards than needed and is reasonable for any Minister to oversee. There are several ways for the Ministry to address this issue. Firstly, a smaller scale option, as put forth by Cassels (1993), would be to provide and publish detailed job descriptions for all persons employed in the RHAs at all levels. This would allow the implementation of a proper performance management system to be put in place, and subsequently would create opportunities to improve said performance. In addition, for those meeting and surpassing standards, they would be able to receive recognition and reward. A more drastic measure would be to alter the health system once more by reducing the number of RHAs. Currently, the health system has far too much duplication of services given the 5 RHAs, 5 Boards, 5 General Managers and so on. By reducing the number of RHAs and limiting management positions, there would be clearer lines of reporting and therefore simpler and more effective monitoring and performance reviews.

Consider the TRHA and health services in Tobago for which responsibility and accountability is muddled. The 1996 Tobago House of Assembly Act, under the Fifth Schedule of the 1994 RHA Act, gives the Tobago House of Assembly responsibility for health services in Tobago. Hence, it would be reasonable to assume that the TRHA, as the provider for health care in Tobago, comes under the THA's remit. In practice, the TRHA receives funding from the RHA. Yet, the TRHA is placed under the Ministry for Tobago Development. The Ministry of Health also plays a role in the provision of healthcare in Tobago – for instance, it constructs facilities – as it is ultimately responsible for health policy in both islands (Trinidad & Tobago Parliament, 2015d). It is recommended that the Tobago House of Assembly acquires or develops the capacity to monitor the TRHA or, alternatively, it should be considered that the TRHA may not be needed at all given that health care was already decentralised to the Tobago House of Assembly prior to the reform in 1994. It is irrational and goes against the intent of the reform for there to be so many bodies involved in the management of this, or any, RHA. In addition, this reduction measure is much more cost-effective and prevents the capacity and growth of some RHAs from being stifled (Mintzberg, 1978). Indeed, either option will allow for implementing bodies to better understand their roles and responsibilities in the system.

In light of the findings and discussion, it can be concluded that Trinidad and Tobago's health sector reform has not been implemented as fully intended by the reform plan, even though it is uncommon for any programme or reform to implemented entirely as planned. However, this research can contend based on its findings that a large reason behind this experience is because of the forms of control mechanisms used by central government to manage its implementing bodies. In addition, the elements identified as being necessary for successfully controlling reform implementation are seen to be interdependent. If one element is not appropriately handled, then the effectiveness of the other elements will be affected as is seen in the case study. Trinidad and Tobago's Ministry of Health failed to employ suitable tools to control its RHAs, including those mandated by the 1994 RHA Act, thereby affecting its ability to ensure that the reform's implementation was carried out effectively and efficiently.

The findings of this paper highlight that central governments should pay attention to the forms of control utilised so that the implementation of reforms (particularly in some form of decentralisation) is enhanced, rather than hindered. Control mechanisms needs to be planned and executed in light of the intent and performance goals of the reform in order for it to be successful. In Trinidad and Tobago's case, instead of enhancing the decentralisation of the system, the Ministry utilised over-centralised forms of control, impacting the RHAs ability to effectively carry out its planned, delegated responsibilities. It is important, nonetheless, to maintain the role played by the central government, particularly concerning its ability to assist implementing bodies in performing

their functions well. Policy must explore the optimal balance between decentralised and centralised functions. Given the limited scope of this paper and its research methodology, however, it is not intended that these findings be generalised to fit all contexts without further and more extensive research being conducted.

6. CONCLUSION

This paper uses a qualitative case study of Trinidad and Tobago's health sector reform in order to examine the relationship between control mechanisms selected for use by central governments during the implementation of public sector reform and the successful implementation of said reform. This study contributes to implementation research by specifically focusing on a key, but neglected aspect – recognition that the actions of the central government can constitute more important explanations for the outcome of public sector reform than those of the implementers. It sheds new light on the importance of government control over public sector reform implementation. The findings provide policymakers with knowledge on how control mechanisms can be better utilised in order to improve the performance of the public sector under the reform. Moreover, they provide lessons for other States considering to develop or strengthen similar public sector reform initiatives by tailoring the analysis to their context and political reality, and using further studies in other jurisdictions to complement these findings.

In this sense, the analysis outlines the relevant elements needed for determining what type of control mechanisms should be used to control implementing bodies in order to discuss how implementation of reforms, specifically decentralisation policies, does not operate in a vacuum. The factors include central acceptance of delegated tasks, balance between control and discretion, clear roles and performance goals that accurately reflect policy intent, objective measurement and effective monitoring, and a simple implementation structure. These elements have also been founded to be interdependent. If one element is not appropriately treated, then the effectiveness of the other elements is affected. For instance, performance measurement relies heavily on clear and accurate descriptions of the responsibilities of the implementing bodies, as well as the performance standards expected to be met or surpassed, in order for there to be prescriptions against which present operations can be measured. One further important condition is the role maintained by the central decision-maker, especially in assisting local levels unable to perform their functions well. It is useful for the selection of policy options to also include the optimal balance of decentralised and centralised functions, and focus on the control mechanisms that can be used to ensure that the implementation of the reform is effective in improving the relevant public sector.

With regards to the specific case study used to illustrate the core intent of this research, it can be concluded that Trinidad and Tobago's health sector reform has not been implemented as fully intended by the reform plan, nor has it accomplished the goal of improving performance and service delivery with the reform. The research concludes that a large reason for this is that the central government employs unsuitable control mechanisms in order to manage the bodies implementing the reform. Rather than enhancing the decentralisation of the system, the Ministry utilises over-centralised forms of control, which impacts the implementing bodies' ability to effectively carry out their delegated responsibilities.

However, the fact that performance of the health sector has not improved to the intended extent does not mean that the reform must be reversed. The debate is not centred on whether there should be more decentralisation or re-centralisation; rather, it should focus on what control mechanisms would be most suitable for controlling the operations of the bodies responsible for carrying out the implementation. The study finds that control mechanisms need to be planned and performed in light of the intent and performance goals for the reform to be successful. Further, the current initiatives by central governments to control the implementation of public sector reforms must be carefully re-examined, particularly with regards to how such a change would impact the success of said implementation.

Along these lines, approaches such as the ones suggested by Kelman (2007) should be adopted, including the monitoring body engaging in critical discussions with implementing agents in order to understand the reasons for decreased performance from their perspective, rather than immediately intervening and re-centralising those functions. This allows for implementing agents to contribute to problem-solving by, for instance, creating an action plan to address said problem, as well as prevent the over-exhaustion of resources at the central level.

Given the limited scope of this paper and its research methodology, however, these findings should not be generalised for application in all contexts. Instead, there remains the need for further and more extensive research along these lines in various countries across the globe to be conducted in order to complement this particular research. Future studies should employ even more comprehensive research methodologies than were possible for this research. For instance, cross-national analyses can be used and relevant actors, such as those in central government responsible for deciding on carrying out a reform, as well as managers and employees of implementing bodies, can be interviewed in order to delve further into the evolution of the entire implementation process where the issue of control is central.

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REFERENCES

Bahall, M. (2012). Reform of the trinidad and tobago health service: The limits of decentralisation. *Social and Economic Studies*, *61*(4), 105-129.

Barzelay, M. (2003). The process dynamics of public management policy change. *International Public Management Journal*, *6*(3), 251-402.

Bauer, M., Süerdem, A., & Bicquelet, A. (2018). *Textual analysis*. London, UK: Sage.

Bissessar, A. (2008). External agencies and domestic reform: The case of the health sector in Trinidad and Tobago' In AM Bissessar (ed) governance and institutional re-engineering (pp. 245-261). Newcastle Upon Tyne, UK: Cambridge Scholars Publishing.

Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: Decision space, innovation and performance. *Social Science and Medicine*, *47*(10), 1513-1527.Available at: https://doi.org/10.1016/s0277-9536(98)00234-2.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.Available at: https://doi.org/10.1191/1478088706qp063oa.

Brehm, J., & Gates, S. (1997). *Working, shirking, and sabotage: Bureaucratic response to a democratic public*. Ann Arbor, MI: Univ. of Michigan Press.

Caiden, G. (1978). Administrative reform: A prospectus. *International Review of Administrative Sciences*, *44*(1), 106-120.Available at: https://doi.org/10.1177/002085237804400109.

Cassels, A. (1993). Perspectives on health sector reform' In WHO *In Health sector reform, Report on a consultation, WHO*.

Cassels, A. (1995). Health sector reform: Key issues in less developed countries. *Journal of International Development*, *7*(3), 329-347.Available at: https://doi.org/10.1002/jid.3380070303.

Conteh, F. (2016). The promise and reality of decentralization: A critical appraisal of Sierra Leone's primary health care system. *Critical African Studies*, *8*(3), 350-369.Available at: https://doi.org/10.1080/21681392.2016.1223550.

Elmore, R. (1978). Organizational models of social program implementation. *Public Policy*, *26*(2), 185-228.

Elmore, R. (1979). Backward mapping: Implementation research and policy decisions. *Political Science Quarterly*, *94*(4), 601-616.Available at: https://doi.org/10.2307/2149628.

Fayol, M. (1949). *General and industrial management*. London, UK: Pitman.

Finer, H. (1941). Administrative responsibility in democratic government. *Public Administration Review*, *1*(4), 335-350.Available at: https://doi.org/10.2307/972907.

Galbraith, J. (1977). *Organization design.* Reading, MA: Addison-Wesley Publishing.

Gilson, L. (2015). Michael Lipsky, street level bureaucracy: Dilemmas of the individual in public service' In M Lodge et al (eds). The Oxford Handbook of Classics in Public Policy and Administration (pp. 383-404). Oxford, UK: OUP.

Government of Trinidad, & Tobago Ministry of Finance. (2019). Trinidad & Tobago 2019/2020 Budget Highlights.

Guardian. (2016). Hospitals at crisis point'. July 17. Retrieved from: https://www.guardian.co.tt/article-6.2.356092.046984917a.

Hood, C. (1976). *The limits of administration.* London, UK: Wiley.

Hupe, P. (2008). Implementation. In H.K. Colebatch & R. Hoppe (eds). Handbook on Policy, Process and Governing (pp. 169-185). Chelthenham, UK: Edward Elgar.

Kelman, S. (2007). Improving service delivery performance in the United Kingdom: Organization theory perspectives on central intervention strategies. *Journal of Comparative Policy Analysis: Research and Practice*, *38*(4), 93-419.

Kingdon, J. (1995). *Agendas, alternatives and public policies* (2nd ed.). NY: HarperCollins.

Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services.* NY: Russell Sage.

Liwanag, H., & Wyss, K. (2018). What conditions enable decentralization to improve the health system? Qualitative analysis of perspectives on decision space after 25 years of devolution in the philippines. *PLOS One*, *13*(11), 1-20.Available at: https://doi.org/10.1371/journal.pone.0206809.

May, P. (2014). Implementation failures revisited: Policy regime perspectives. *Public Policy and Administration*, *30*(3/4), 277-299.Available at: https://doi.org/10.1177/0952076714561505.

Mintzberg, H. (1978). The structuring of organizations. *Pearson.*

Nadler, D., & Tushman, M. (1988). Strategic organization design: Concepts tools and processes. *Foresman and Company.*

Nilsen, P., Ståhl, C., Roback, K., & Cairney, P. (2013). Never the twain shall meet? - a comparison of implementation science and policy implementation research. *Implementation Science*, *8*(1), 63–75.Available at: https://doi.org/10.1186/1748-5908-8-63.

Niskanen, W. (1971). *Bureaucracy and representative government.* Chicago, IL: Aldine-Atherton.

Pan American Health Organisation. (2017). Trinidad and Tobago. Retrieved from: https://www.paho.org/salud-en-las-americas-2017/?p=4311. [Accessed December 15, 2020].

Pan American Health Organisation. (2018). No direct maternal deaths reported in Trinidad and Tobago in 2018. Retrieved from: https://www.paho.org/en/news/20-7-2018-no-direct-maternal-deaths-reported-trinidad-and-tobago-2018. [Accessed December 15, 2020].

Pierre, J., & Peters, B. (2017). The shirking bureaucrat: A theory in search of evidence? *Policy & Politics*, *45*(2), 157-172.Available at: https://doi.org/10.1332/030557317x14845830916703.

Rafeeq, H., & Paul, R. (2000). Health sector reform in the republic of trinidad and tobago. *Pan American Journal of Public Health*, *8*(1/2), 45-54.

Trinidad, & Tobago Parliament. (2014). Review of the regional health authority system in Trinidad and Tobago. Retrieved from: http://www.ttparliament.org/hansards/hs20141118.pdf. [Accessed December 15, 2020].

Trinidad, & Tobago Parliament. (2015a). Review of the regional health authority system in Trinidad and Tobago. Retrieved from: http://www.ttparliament.org/hansards/hs20150127.pdf. [Accessed December 15, 2020].

Trinidad, & Tobago Parliament. (2015b). Review of the regional health authority system in Trinidad and Tobago. Retrieved from: http://www.ttparliament.org/hansards/hs20150324.pdf. [Accessed December 15, 2020].

Trinidad, & Tobago Parliament. (2015c). Review of the regional health authority system in Trinidad and Tobago. Retrieved from: http://www.ttparliament.org/hansards/hs20150428.pdf. [Accessed December 15, 2020].

Trinidad, & Tobago Parliament. (2015d). Review of the regional health authority system in Trinidad and Tobago. Retrieved from: http://www.ttparliament.org/hansards/hs20150526.pdf. [Accessed December 15, 2020].

Trinidad and Tobago Ministry of The Attorney General and Legal Affairs. (2011). Regional health authorities act (1994, 2011). (Chap. 29:05). Retrieved from: https://rgd.legalaffairs.gov.tt/laws2/alphabetical_list/lawspdfs/29.05.pdf. [Accessed December, 15, 2020].

Trinidad and Tobago Parliament. (2017). Establish joint select committee to review levels of health care delivery. Retrieved from: http://www.ttparliament.org/chamber_business.php?mid=11&id=347. [Accessed December 15, 2020].

Trinidad and Tobago Registers Nurses Association. (2019). Acute staff shortage at NCRHA. Retrieved from: https://ttrna.org/index.php/news-2/21-acute-staff-shortage-at-ncrha. [Accessed December 15, 2020].

Wegrich, K. (2015). Jeffrey L. Pressman and Aaron B. Wildavsky, Implementation. In M Lodge et al (eds): The Oxford Handbook of Classics in Public Policy and Administration (pp. 342-358). Oxford, UK: OUP.