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The ownership elephant: ownership and community-governance in primary care

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Abstract

Ownership of primary care is an often neglected but important health systems design parameter. The New Zealand Primary Health Care Strategy has established Primary Health Organisations (PHOs) as non-profit umbrella organisations, however in most instances their constituent general practices are for-profit small businesses. This viewpoint paper aims to: (a) define ownership and community participation; (b) summarise some of the evidence from the NatMedCa study pertaining to ownership-related differences; and (c) discuss the policy implications of different ownership forms in primary care, and the implications of merging different ownership forms under the umbrella of PHOs. Ownership confers governance responsibility (ultimate control) for an organisation, and accountability for its actions. Community governance involves vesting overall control of resources in users and the community, rather than with health service managers or health professionals. Results from three studies using the NatMedCa survey indicate that community-governed non-profits in New Zealand differ in a number of respects from their for-profit counterparts. As non-profit and for-profit ownership forms have different social roles, and as meaningful community participation in governance is determined in large part by ownership structures, there is a need for ownership frameworks to be used more widely in health policy making. Because of the ownership boundary that exists between non-profit community-governed PHOs and their constituent for-profit general practices PHOs may have little real ability to effectively govern their practices.

Organisations within the New Zealand primary care sector are evolving rapidly.[1] The Primary Health Care Strategy has established Primary Health Organisations (PHOs) as non-profit umbrella organisations, however in most instances their constituent general practices are for-profit small businesses.

In the UK, the US, Canada, New Zealand, and Australia private ownership of primary care maintains a dominant position, albeit with important local modifications in each country. The UK, the US, and New Zealand are experimenting both with different ownership arrangements,[2,3] and with increased community involvement in governance in primary care,[4–7] but there is no consensus about what constitutes the ideal ownership configuration. Indeed, there seems to be little agreement that ownership is an important structural variable in health systems design. Ownership is the 'elephant in the living room' that policy makers and practitioners in New Zealand tread carefully around but fail to acknowledge properly in the formulation and implementation of primary care policies.

Recent research evidence from the NatMedCa study sheds light on ownership-related differences between different types of primary care practice in New Zealand. This new evidence provides the opportunity for primary care practitioners and policy makers to explore the implications of different primary care ownership arrangements.

This viewpoint paper aims to:

- Define ownership and community participation,
- Summarise some of the evidence from the NatMedCa study pertaining to ownership-related differences, and
- Discuss the policy implications of different ownership forms in primary care as well as the implications of merging different ownership forms under the umbrella of PHOs.

Ownership

Ownership confers governance responsibility (ultimate control) for an organisation, and accountability for its actions. Primary care organisations can be classed as government owned and operated, or privately owned and operated, with the latter being divided into those responsible to a community-governance board versus those not responsible to such a board.

Community-governed non-profit practices are often referred to as third-sector organisations (indicating non-government non-profit status). As with most organisational typologies, there is an inevitable blurring of organisation forms. Typically, however, government organisations, irrespective of their specific governance arrangements, are primarily accountable to government; private for-profit organisations are primarily accountable to their proprietary owners or shareholders; and private non-profit organisations are primarily accountable to their governing body.

Despite blurring of ownership boundaries, clear differentiation between the public and private spheres is essential if there is to be accountability for the spending of public funds.

Community governance

Most general practices in New Zealand are owned and governed by general practitioners (GPs); in an ownership sense they are private for-profit practices (but it should be noted that this ownership classification does not in itself imply that a general practice actually makes a profit or operates as a successful business). While the classical distinction between non-profit and for-profit rests largely on the non-distribution constraint—a non-profit organisation may not lawfully pay its profits to owners or anyone associated with the organisation[8]—the terms 'third sector' and 'non-profit' are frequently used as shorthand for a package of organisational characteristics that includes governance arrangements where primary accountability is not to private proprietors or shareholders, but rather to users and community representatives.

The Family Planning Association and the New Zealand Aids Foundation are examples of non-profit/third sector organisations, as are PHOs, which are required by government to have meaningful community participation in their governance.[5]

Community governance seeks to ensure that the communities served by the organisation have control over key decision-making.[9] In New Zealand, community governance has distinguished a subset of primary care organisations located in the private non-profit sector (for example Health Care Aotearoa practices[10]), but

increasingly the Primary Health Care Strategy is introducing the principles of community governance more broadly in PHOs.[5] There are numerous benefits associated with community participation in primary care,[11–13] however the challenges and implications of implementing community governance of PHOs and general practices are considerable given the current predominance in primary care practices of a governance culture associated with private for-profit ownership where accountability and control reside with private proprietors.[13]

The concept (and practice) of community governance is distinct from the concept of clinical governance. Clinical governance refers to the exercise of collective accountability for the management of clinical performance, placing emphasis particularly on the role of clinicians, as well as managers.[14] Clinical governance has been interpreted as a response, in part, to the commercially driven health reforms of the 1990s which reduced the role of clinicians in decision making.[15]

Collective clinical accountability for quality is highly desirable; however, to the extent that clinical governance involves clinicians in the management of resources, there is potential conflict between the principles of clinical governance and the principles of community governance. The latter involves vesting overall control of resources in users and the community, rather than with health service managers or health professionals.

Currently the balance between community control, managerial control and clinical control varies considerably between different types of primary care organisation with apparently little consensus about what the 'right' balance is.

What can be learnt from the NatMedCa study?

Three recent studies comparing for-profit and community-governed non-profit primary care organisations, using data from the NatMedCa survey, highlight a range of important ownership related differences.[16–18]

The National Primary Medical Care Survey (NatMedCa), carried out over 2001/2002, was a nationally representative, multistage, probability sample of GPs and patient visits.[19] The primary purpose of the survey was to collect data on the content of patient visits. For two periods, each lasting 1 week, each selected GP completed a questionnaire for a 25% systematic sample of patient visits. The questionnaire was adapted from the annual US National Ambulatory Medical Care Survey (NAMCS) 2003.[20]

To obtain a nationally representative sample:

- Geographic locations were sampled, and
- GPs were sampled from locations, stratified by organisation type (independent; independent practitioner association; capitated; community-governed non-profit) and rural/urban (metropolis & cities; towns and rural areas).

GP and visit weights were calculated to take account of different sampling probabilities, so that approximately unbiased estimates of proportions, means, and measures of association between ownership status and visit characteristics could be calculated.[21] Practices in the study were categorised according to their ownership status—private for-profit and community-governed private non-profit.

Non-profits had to meet at least two of these three criteria:

- They had a community board of governance,
- There was no equity ownership by GPs or others associated with the organisation, and
- There was no profit distribution to GPs or others associated with the organisation.

The total visit sample consisted of 10,506 records gathered from 246 GPs, 48 (19.5%) of whom worked in non-profit practices and 198 (80.5%) of whom worked in for-profit practices. The overall GP response rate was 71.7% (70.7% in the for-profits and 72.7% in the non-profits).

Currently about 3% of New Zealand GPs work in community-governed non-profit settings.

Patient and visit characteristics[18]—Compared with for-profits, community-governed non-profits served a younger, largely non-European population, nearly three-quarters of whom had a community services card; 10.5% of whom were not fluent in English; and the majority of whom lived in the 20% of areas ranked as the most deprived by the NZDep2001 index of socioeconomic deprivation. Patients visiting non-profits were diagnosed with more problems. The problems presented to non-profit primary care GPs included higher rates of asthma, diabetes, and skin infections. The duration of visits was significantly longer in non-profits. No differences were observed in the average number of laboratory testes ordered. The odds of specialist referral were higher in for-profits when confounding variables were controlled for.

Practice characteristics[16]—Community-governed non-profits had lower financial and cultural barriers to access as measured, respectively, by their lower patient fees and their higher numbers of Maori and Pacific Island staff. Non-profits provided a somewhat different range of services; for example non-profits were more likely to provide community worker and group health promotion services and for-profits were more likely to provide sports medicine and emergency/accident call-out services.

For-profits were more likely to have specific items of equipment, such as cautery machines and proctoscopes, despite being on average smaller practices with fewer full-time equivalent doctors. Non-profits performed better in terms of written policies on quality management; for example, they were more likely to have written policies on complaints, critical events and quality management. The greater percentage of non-profits with these 'process' quality indicators may reflect the larger staff that was available to them. In general, these quality measures were not a requirement of their funding contracts. Non-profits were more likely carry out locality service planning and community needs assessments.

The majority of the differences in practice characteristics persisted when comparisons were restricted to:

- Practices serving similar low-income and non-European populations,
- Practices that were capitation funded, and
- For-profits that employed more than one GP. This suggests that the non-profits are not merely adapting to the needs of the patient population, or the incentives

associated with capitation funding, but were operating in a substantially different way compared with for-profits.

Staffing and primary care teams[17]—Primary care teams were largest and most heterogeneous in community-governed non-profit practices; the majority employed doctors, nurses, managers, reception staff, administrative staff, and community workers, and 34.6% employed midwives. Next most heterogeneous in terms of their primary care teams were practices that were members of an independent practitioner associations (IPA) which employed the majority of the country's GPs (71.7%).

'Independent practices' (those that were not members of an IPA) had the most parsimonious practice teams. A majority of both IPA and independent practices employed doctors, nurses, and reception staff—but only a very small percentage employed community workers or midwives. Community-governed non-profits employed a higher proportion of women GPs than did IPA and independent practices.

There were marked ethnicity differences between staff employed at the different types of practices, with community-governed non-profits employing more Maori and Pacific staff, including both doctors and nurses.

Policy implications

Community-governed non-profits in New Zealand serve a poor, largely non-European population who present with somewhat different rates of various problems compared with patients at for-profits. Community-governed non-profits have reduced financial (i.e. lower patient fees) and cultural barriers to access (i.e. more Maori and Pacific Island staff) compared with their for-profit counterparts. They also provide a different range of services, are more likely to have a population-orientation to service planning, are more likely to have quality-management policies, and have larger and more diverse staff teams on average.

These results are consistent with theoretical predictions relating to the social role of the non-profit sector. Various partly complementary and partly competing theories seek to explain the role and scope of private non-profit activities in different countries.[22–27] Theories suggest that non-profit organisations predictably fulfil a range of social functions that may be of great use to policy-makers and communities. In particular, they have a role catering for the diverse needs of minority populations not catered for by the government and for-profit sectors.

Non-profits are able to respond to the needs of minority community interests; for example, minority ethnic groups, because their governance boards are more able to closely represent minority groups compared with their for-profit business counterparts, whose governance structures are likely to reflect the interests of the proprietary owners or share holders. From a theoretical standpoint, this responsiveness to minority needs may reflect a basic motivation arising from the failure of government and for-profits to serve minority populations, but it may also reflect the interdependency of government and the non-profit sector insofar as the non-profit sector, unlike government, is unconstrained by the needs of the 'median voter'.[22] The capacity of non-profits to independently represent the interests of minorities assumes great importance in New Zealand, where Maori have striven to establish primary care services tailored to meet their needs, and have used the non-profit form as a vehicle for increasing self-determination.[10]

Explanations for the observed differences are likely to include a clear mission amongst the community-governed non-profits to serve the needs of vulnerable population groups, and a more managerialist management culture (as opposed to a predominantly health professional management culture). But to what extent does financing explain the observed differences between for-profits and community-governed non-profits?

While differences between non-profits and for-profits are likely to be associated with their ownership and governance arrangements, it is hard to separate out the dual influences of community-governance and the different financial incentives facing GPs in the two types of practice.

In the NatMedCa studies cited above, non-profits were defined partly on the basis of no equity ownership by GPs and no profit distribution to GPs (that is, financial surpluses did not directly represent extra income for GP practice owners), hence it is likely that financial incentives had some influence on such characteristics as patient mix, patient charges, staffing arrangements, and referral patterns. This is due to the fact that, historically, the level of government subsidies for primary medical care has required GPs to charge a co-payment.

While the level of co-payments has been at the discretion of GPs and influenced by patients' ability to pay, co-payment-related income has undoubtedly determined in part the level of investment GPs have been able to make in practice infrastructure and service provision. There are no recent data on the total amounts of government funding going to different types of practice. At the time of the NatMedCa study, all practices were free to determine their level of patient co-payments for consultations.

Government funding of primary care practices was determined within a complex contracting framework. Some Maori and community-governed practices received government assistance for their establishment, as did the independent practitioner associations to which most for-profit practices belonged.[28] The operational funds for all practices were negotiated largely within a framework that did not distinguish between non-profit and for-profit status. Funding of programmes outside of standard medical consultation work was allocated through a modified form of tendering. Most community-governed practices did not participate in referred services budget-holding programmes which, in their early years (1990s), delivered significant new funding to practices for service development.[29,30] More research comparing financing, profits, and GP incomes is required to further elucidate the above issues.

A more complete discussion of ownership frameworks and the pros and cons of different primary care ownership arrangements can be found elsewhere.[31] A few points deserve emphasis here. While private for-profit ownership of primary care facilities is the norm in many countries, including the UK, the US, Canada, Australia, and New Zealand, each country has its own particular mechanisms for encouraging the alignment of private for-profit interests with those of government.

For example, in the UK, GPs are held in a very tight contracting and funding embrace by government, and their opportunities for unchecked entrepreneurialism are severely restricted. The main argument advanced in support of private for-profit ownership is efficiency, but there are few empirical data that provide support. Some insights are provided by the literature on the US hospital sector.

In a review of the US literature, Gray concluded that (in respect of general hospitals, psychiatric hospitals, and nursing homes) non-profits overall tended to care for more uninsured patients, provided a wider array or services, had quality advantages, and had similar or lower costs.[32] Indeed, the quality issue is illustrated in a meta-analysis of studies of mortality in US hospitals by Devereaux et al,[33] who found a 2% increased risk of mortality in private for-profit hospitals in the US (equating to about 14,000 excess deaths[34]).

The disadvantages of private for-profit ownership include the loosening of direct accountability to government; the potential intrusion of private for-profit interests into public good programmes; and the existence of market failures in health and the consequent need for extensive government involvement. In primary care, many of the conditions necessary for perfect markets are violated to some degree. For example, information asymmetries between doctors and service users are frequently huge; primary care is responsible for providing a range of public good services such as immunisations and drug and alcohol treatments; in small towns and rural areas there is frequently a lack of competition; and there are marked positive externalities associated with primary care such as reduced social costs resulting from the provision of preventive care and screening.

Market failure is addressed in various ways. In the UK and New Zealand contracts and funding mechanisms have been important tools for government.

Does it matter whether for-profit primary care organisations are part of a large conglomerate that is listed on the stock exchange, or are smaller proprietary organisations? Proprietary organisations are independent, owner-operated organisations (typical of general practices in New Zealand, Australia, and the UK), and investor-owned organisations are usually part of multi-facility systems whose stock is publicly traded and whose owners therefore have little if any direct contact with the institution.[35]

While it might be expected that ownership-related differences in structure and patterns of treatment between private for-profits and non-profits will be relatively small in countries such as New Zealand and the UK (due to the proprietary style of general practice), this was not the case in the NatMedCa studies: ownership-related differences were marked and are likely to be related, at least in part, to the presence of community governance in the non-profits.

The non-profit sector is diverse and non-profit status does not provide any guarantee that an organisation is focused on non-profit public-good service. Experience from the US and elsewhere suggests that non-profit status can provide an effective vehicle for the pursuit of profit objectives (disguised profit distribution).[36,37]

Taking into account the differences observed in the NatMedCa studies between community-governed non-profit practices and for-profits, and the theoretical literature concerning the different social roles of the non-profit and for-profit sectors, what then are the implications of merging different ownership forms under the umbrella of PHOs: can the objectives of non-profit community-governed PHOs be aligned successfully with their constituent for-profit general practices?

PHOs have no mandate or power to breech the ownership boundary that separates them from their privately owned constituent general practices. Indeed, given that

different general practices are likely to have substantially different cost structures and business objectives from one another, it seems unlikely that a community-governed PHO can exercise real control over its private for-profit general practices—in regard to patient fees and staffing arrangements for example.

Under current funding arrangements (i.e. with partial government subsidies for general practice) such control is both impractical and would violate the ownership rights of private GPs. In essence, both the research evidence and theory suggest that community-governed PHOs may have little real ability to govern their constituent for-profit general practices.

For PHOs to exercise real governance control over their member practices, the ownership boundary between PHOs and practices will have to be eliminated either through the conversion of practices to non-profit community-owned entities with objectives aligned to those of the PHO, or through government ownership of both PHOs and practices.

Conclusions

Historical and contemporary policies have favoured private for-profit ownership of primary care in the UK, the US, Canada, Australia, and New Zealand. However, private for-profit dominance should not be regarded as a constant, but rather as a design variable amenable to incremental policy manipulation. Few observational studies have directly compared characteristics of community-governed non-profit primary care practices with their for-profit counterparts.[11]

The NatMedCa studies cited above provide evidence that ownership and governance have an important influence on the structure and function of primary care practices in New Zealand. These studies provide no insights into the total amount of government funds going to different types of practice, and further research will be required to determine the efficiency of the different ownership models analysed here.

Communities, purchasers, primary care professionals, and policy makers should consider more actively experimenting with different ownership arrangements in order to gain sufficient local experience to enable informed choices to be made regarding ownership. The capacity of community-governed non-profit practices to serve diverse ethnic and low-income population groups highlights for communities, policy makers, and purchasers the role of ownership and governance in shaping the purpose and function of primary care practices.

In conclusion, ownership of primary care is an often neglected but important health systems design parameter. As non-profit and for-profit ownership forms have different social roles, and as meaningful community participation in governance is determined in large part by ownership structures, there is a need for ownership frameworks to be used more widely in health policy making.

Finally, because of the ownership boundary that exists between non-profit community-governed PHOs and their constituent for-profit general practices, PHOs may have little real ability to effectively govern their practices.

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References:

1. Cumming J, Raymont A, Gribben B, et al. Evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy, First Report, May 2005. Wellington: Health Services Research Centre; 2005.
2. Pollock A, Player S, Godden S. How private finance is moving primary care into corporate ownership. BMJ. 2001;322:960–3.
3. Neuwelt P, Crampton P. Community participation in the primary health care sector in Aotearoa/New Zealand. In: Dew K, Davis P, editors. Health and Society in Aotearoa/New Zealand. Auckland: Oxford University Press; 2005, p194–210.
4. NHS Executive. The NHS Plan: a plan for investment, a plan for reform. London: Department of Health; 2000.
5. King A. The Primary Health Care Strategy. Wellington: Ministry of Health; 2001. Available online. URL: http://www.moh.govt.nz/moh.nsf/0/7bafad2531e04d92cc2569e600013d04?OpenDocument Accessed September 2005.
6. Politzer R, Yoon J, Shi L, et al. Inequality in America: the contribution of health centers in reducing and eliminating disparities in access to care. Medical Care Research & Review. 2001;58:234–48.
7. Sardell A. The U.S. Experiment in Social Medicine. Pittsburgh: University of Pittsburgh Press; 1988.
8. Hansmann H. Economic theories of nonprofit organization. In: Powel W, editor. The Nonprofit Sector: A Research Handbook. New Haven: Yale University Press; 1987.
9. Grierson M. Consumer participation, social workers and community organisations. Third Sector Review. 1996;2:43–55.
10. Crampton P, Dowell A, Woodward A. Third sector primary care for vulnerable populations. Soc Sci Med. 2001;53:1491–1502.
11. Crawford M, Rutter D, Manley C, et al. Systematic review of involving patients in the planning and development of health care. BMJ. 2002;325:1263–5.
12. Khoury A, Weisman C, Jajoura C. Ownership type and community benefits of women's health centers. Med Care Res Rev. 2001;58:76–99.
13. Neuwelt P, Crampton P, Crengle S, et al. Assessing and developing community participation in primary health care in Aotearoa New Zealand: a national study. N Z Med J. 2005;118(1218). URL: http://www.nzma.org.nz/journal/118-1218/1562
14. Barnett P, Malcolm L, Wright L, Hendry C. Professional leadership and organisational change: progress towards developing a quality culture in New Zealand's health system. N Z Med J. 2004;117(1198). URL: http://www.nzma.org.nz/journal/117-1198/978
15. Malcolm L, Wright L, Barnett P, Hendry C. Building a successful partnership between management and clinical leadership: experience from New Zealand. BMJ. 2003;326:653–4.

16. Crampton P, Davis P, Lay-Yee R, et al. Does community-governed non-profit primary care improve access to services? Cross-sectional survey of practice characteristics. Int J Health Serv. 2005;35:465–78.

17. Crampton P, Davis P, Lay-Yee R. Primary care teams: New Zealand's experience with community-governed non-profit primary care. Health Policy. 2005;72:233–43.

18. Crampton P, Davis P, Lay-Yee R, et al. Comparison of private for-profit with private community-governed not-for-profit primary care services in New Zealand. Journal of Health Services Research & Policy. 2004;9(S2):17–22.

19. Raymont A, Lay-Yee R, Davis P. The National Primary Medical Care Survey (NatMedCa) 2001/02. Wellington: Ministry of Health; 2004. Available online. URL: http://www.moh.govt.nz/natmedca Accessed September 2005.

20. The National Ambulatory Medical Care Survey (NAMCS). Hyattsville, MD: National Center for Health Statistics; 2004. Available online. URL: http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm Accessed September 2005.

21. Korn E, Graubard B. Epidemiologic studies utilizing surveys: accounting for the sampling design. American Journal of Public Health. 1991;81:1166–73.

22. Salamon L, Anheier H. Social origins of civil society: explaining the nonprofit sector cross-nationally. Voluntas: International Journal of Voluntary and Nonprofit Organizations. 1998;9:213–48.

23. Weisbrod B. Towards a theory of the nonprofit sector. In: Phelps E, editor. Altruism, Morality and Economic Theory. New York: Russell Sage; 1975.

24. Anheier H, Seibel W. The third sector in comparative perspective: four propositions. In: Anheier H, Seibel W, editors. The Third Sector, Comparative Studies of Nonprofit Organizations. New York: Walter de Gruyter; 1990.

25. Kendall J, Knap M. The Voluntary Sector in the UK. Manchester, UK: Manchester University Press; 1996.

26. Powell W, editor. The Nonprofit Sector: A Research Handbook. New Haven: Yale University; 1987.

27. Schlesinger M, Gray B, Bradley E. Charity and community: the role of nonprofit ownership in a managed care health system. J Health Polit Policy Law. 1996;21:697–751.

28. Malcolm L, Mays N. New Zealand's independent practitioner associations: a working model of clinical governance in primary care? BMJ. 1999;319:1340–2.

29. Love T. Chapter 3 – Continuing change in primary care: issues for Independent Practice Associations and Primary Health Organisations. In: Gauld R, editor. Continuity Amid Chaos – Health Care Management and Delivery in New Zealand. Dunedin: University of Otago Press; 2003, p69–82.

30. Malcolm L, Wright L, Seers M, Guthrie J. An evaluation of pharmaceutical management and budget holding in Pegasus Medical Group. N Z Med J. 1999;112:162–4.

31. Crampton P, Starfield B. A case for government ownership of primary care services in New Zealand: weighing the arguments. Int J Health Serv. 2004;34:709–29.

32. Gray B, Carrino G, Collins S, Gusmano M. The empirical literature comparing for-profit and nonprofit hospitals, managed care organizations, and nursing homes: updating the Institute of Medicine Study. New York: The New York Academy of Medicine; 1999.

33. Devereaux P, Choi P, Lacchetti C, et al. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. CMAJ. 2002;166:1399–1406.

34. Hopkins Tanne J. Mortality higher at for-profit hospitals. BMJ. 2002;324:1351.

35. Gray B. Nonprofit hospitals and the for-profit challenge. Bull N Y Acad Med. 1990;66:366–75.

36. James E. The nonprofit sector in comparative perspective. In: Powel W, editor. The Nonprofit Sector: A Research Handbook. New Haven: Yale University Press; 1987.

37. Weisbrod B. The Nonprofit Economy. Cambridge, Massachusetts: Harvard University Press; 1988.

